
Assisted Suicide, Causality and the Supreme Court of Canada

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The recent majority judgment of the Supreme Court of Canada in *Rodriguez v. Canada (A.G.)* reflects what could be called a "standard causality" position regarding the causing of death in various circumstances in medicine. The author compares that position to what he labels the "empirical causality" view and the "normative causality" view. He concludes that the "standard causality" position reflected in this decision is deficient in that it denies but-for causality of death in contexts other than assisted suicide and euthanasia by a facile equation of but-for causality and criminal liability, and by its relative inattention to the normative reasons other than causality which can justify maintaining the illegality of assisted suicide. As for the "empirical causality" view, it is deficient since it assumes that, because but-for causality of death is present in instances of withdrawal of treatment, assisted suicide and euthanasia, they are all equally morally and legally acceptable or unacceptable. Only a "normative causality" analysis does not equate but-for causality and criminal liability and focuses on the prior normative and policy considerations which do or should influence the determination of the existence of normative causality, illegality and criminal liability in cases of assisted suicide.

La récente décision majoritaire de la Cour suprême du Canada dans l'affaire *Rodriguez c. Canada (P.G.)* traite de ce que l'on pourrait qualifier de «causalité standard» à l'égard de ce qui est la cause de la mort dans différentes circonstances en médecine. L'auteur compare cette position avec deux autres approches qu'il intitule «causalité empirique» et «causalité normative». Il conclut que la position de la Cour quant à la «causalité standard», telle que reflétée dans cette décision, est déficiente en ce que, premièrement, elle exclut la causalité adéquate (*but-for causality*) pour déterminer la cause de la mort dans des contextes autres que le suicide assisté et l'euthanasie en traitant comme équivalentes la causalité adéquate et la responsabilité criminelle, et deuxièmement, elle se préoccupe peu des raisons normatives, autres que la causalité, qui pourraient justifier le maintien du caractère illégal du suicide assisté. En ce qui concerne la «causalité empirique», elle est déficiente en ce qu'elle suppose que, puisque la «causalité adéquate» de la mort est établie dans les cas de désistement au traitement, de suicide assisté et d'euthanasie, ils sont tous moralement et juridiquement ou bien acceptables, ou alors inacceptables. Seule l'approche de la «causalité normative» n'assimile pas la «causalité adéquate» à la responsabilité criminelle et s'intéresse aux considérations normatives et politiques qui influencent ou devraient influencer la détermination de la «causalité normative», l'illégalité et la responsabilité criminelle dans le cas du suicide assisté.

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Introduction

Physicians, nurses and family members are often hesitant about terminating a patient's life support measures, either when requested (now or in advance) by the patient, or when supporting a permanently unconscious patient's life is judged by others to have become "futile". Their reluctance can have a variety of explanations, the most obvious being the enormity of the decision in view of the patient's resulting death. Concern may also arise with regard to the issue of futility: Has life support really become futile in this case? What are or should be the criteria for determining futility? Who should make such a determination?

A third concern which frequently arises is that stopping life support is often seen as equivalent to causing the patient's death. It looks and feels, at least to some of those involved, especially the team members who actually stop the respirator or remove the feeding tubes, as if one is killing the patient. After all, it is sometimes said, if we had not stopped the life support, the patient would have continued to live, or at least would not have died then. Whatever qualms exist will typically be moral ones, though at times accompanied by vague or explicit fears about criminal or civil liability.

Responses from ethics and law to questions about causality in the context of life and death decisions may arguably be grouped into three major views or strands. They are not in every respect mutually exclusive, and in some respects that which distinguishes the views and their proponents is more a question of emphasis and level of analysis than of diametrically opposed positions. With that proviso, the views can legitimately be separated for purposes of analysis and comparison. The first position will be labelled in this paper as the "standard

causality" view or explanation. The second will be designated the "empirical causality" view. The third will be referred to here as the "normative causality" position.

Of interest in this paper are the causality stances adopted in the majority judgment of the Supreme Court of Canada in *Rodriguez v. Canada (A.G.)*.¹ By focusing almost exclusively on the matter of causality, this comment will not directly address the core of the *Rodriguez* judgment, which dealt primarily with constitutional issues. Nevertheless, in that decision the assumptions and stances on the matter of criminal liability for causing death implicitly or explicitly contributed to the conclusions about whether assisted suicide should be allowed for Sue Rodriguez. Although the three positions to be examined are as much positions on ultimate criminal liability as they are positions on causality, it is the latter, and its role in criminal liability, which is of primary interest in this paper.

I. The "Standard Causality" Position

What will be described under the label of "standard causality" is not, strictly speaking, a "position" on causation, and certainly not a coherent one. It could more accurately be characterized as a series of somewhat incoherent elements and stances comprising the present state of the law on criminal liability in this area. Among the elements in addition to but-for causality are those of intent and distinctions between act/omission, natural/artificial and lawful/unlawful. The "standard causality" view can best be described by applying it to the five different circumstances which follow. A *competent patient* is entitled to refuse or terminate life-supporting treatment, and to continue to provide it in the face of such a (present or advance) refusal would constitute assault. To terminate treatment is therefore not interpreted as causing the patient's death, but simply as allowing the patient to die by respecting his or her autonomy or right to self-determination. To stop a respirator in this situation, for example, is regarded as letting the patient die, not as killing him or her; as an omission, not as an act; as simply passive euthanasia, not as active euthanasia.²

If it is established that a patient is *permanently unconscious*, then a family member is entitled to request that futile life support measures be stopped. The cause of death in such cases is said to be the patient's disease or condition, which medicine is powerless to alter, not the act of stopping the respirator. What is involved here is commonly said to be more in the nature of an omission than an act.³

A terminally ill patient may (possibly "must") be provided with an appropriate form and amount of *pain medication* to control that patient's pain, even

¹[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.]. Due to space limitations, this comment will not consider the causality stances of the three minority judgments.

²*Nancy B. v. Hôtel-Dieu de Québec*, [1992] R.J.Q. 361, 86 D.L.R. (4th) 385 (Sup. Ct.); *Mallette v. Shulman* (1990), 72 O.R. (2d) 417, 67 D.L.R. (4th) 321 (C.A.); *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

³*Airedale N.H.S. Trust v. Bland*, [1993] 1 All E.R. 821. [1993] 2 W.L.R. 316 [hereinafter *Airedale*].

if death is thereby "indirectly" hastened. Because the physician has a duty to alleviate pain, and because it is the alleviation of pain that he or she intends and not to cause the patient's death, then here too the cause of death is said to be the patient's disease or condition, not the pain medication.⁴

The "standard causality" explanation goes on to distinguish all three of the above situations from those of *assisted suicide* and *voluntary euthanasia*. Assisted suicide is prohibited by paragraph 241(b) of the *Criminal Code* and is considered by many to be immoral because to so assist is at least to participate in causing another's death. As for voluntary active euthanasia, the final act causing death is that of the doctor, nurse or family member. Death from assisted suicide includes an "act" of assistance, not merely an omission. Death from active euthanasia is by the "act" of another who is no longer simply "omitting", for example, respirator support. In both cases, death is not natural, that is, it is not caused by the patient's disease or condition.

II. The "Empirical Causality" Position

The second view, labelled in this paper as the "empirical causality" position, takes a different tack. Though ethically, legally and logically persuasive for many, the first or "standard causality" explanation is not uniformly reassuring for health care practitioners at the deeper experiential level. Some continue to feel that it is counter-intuitive and does not account for the widely shared belief that their decisions and activities in *all* five circumstances are in some manner, to at least some extent, causative of the deaths which follow.

Similarly, but more emphatically, a number of philosophers, jurists and others maintain that the withdrawal of life support is as much a cause of death as assisted suicide and active euthanasia. After all, they claim, stopping a life-supporting respirator is the empirical cause, the cause-in-fact, of the death. Had the life support system not been terminated, the patient would not have died, or at least would not have died then. It is therefore suggested by those who espouse this second view, that assisted suicide, and possibly voluntary euthanasia as well, should be as ethically and legally allowable as are competent refusals of life support, family decisions to stop life support on grounds of futility, and the provision of appropriate pain control even if death is hastened. Those espousing this view tend not to be impressed by counter-arguments against the decriminalization of assisted suicide which highlight the potential dangers of abuse or the added pressures on the vulnerable and those who believe that they are a burden to their family or friends.⁵ Others come to the opposite conclusion for the same reason. In effect, they agree that in all these circumstances death is being caused by the act of another and not solely by the patient's disease or condition. However, for that very reason, they maintain that patient and family autonomy concerning life-sustaining technology and pain control measures should be

⁴Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Report No. 20) (Hull, Que.: Supply & Services Canada, 1983).

⁵J. Rachels, *The End of Life: Euthanasia and Morality* (New York: Oxford University Press, 1986); D. Brock, "Voluntary Active Euthanasia" (1992) 22:2 *Hastings Center Rep.* 10; Note, "Physician-Assisted Suicide and the Right to Die with Assistance" (1992) 105 *Harv. L. Rev.* 2021.

restricted because otherwise they will lead inevitably to the decriminalization of assisted suicide and voluntary euthanasia.

III. A “Normative Causality” Approach

The third position, the one advocated in this paper, is labelled here as a “normative causality” view. A more comprehensive label would be “a normative approach to criminal liability”. It is suggested that both the first and second positions are inadequate and much in need of further qualification. First of all, the “standard causality” view is deficient in that it does not acknowledge that stopping a life-supporting respirator is indeed the empirical, scientific or “but-for” cause of death. In such cases, it is not sufficient to claim that the disease or the patient’s condition is the cause of death. While this is particularly evident when the patient is not terminally ill, even if terminally ill, the patient would not otherwise have died at that time. In the final analysis, criminal liability for causing death cannot simply be based upon distinctions between acts and omissions. After all, in medical practice it is by no means clear whether the relevant practice, for instance, of switching off a respirator or stopping medical feeding and hydration, is an act or an omission. In this regard, the third position takes more seriously the experience and hesitations of some health care professionals referred to above, though it does not stop there.

Compared to the second or “empirical causality” view, however, the third position emphasizes not simply scientific causality, the cause-in-fact of a death, but normative or legal causality as well. This more nuanced and comprehensive analysis holds that empirical, scientific or “but-for” causality cannot alone account for what distinguishes assisted suicide from voluntary euthanasia, or what distinguishes both from withdrawal of life support or appropriate pain control resulting in death. Nor can empirical causality alone serve as the basis for deciding upon the criminality of assisted suicide or voluntary euthanasia. Other elements of greater moral and legal significance are, especially, those of duty, legality and estimates of the social consequences of decriminalization.

Act/omission distinctions are not solely determinative of criminal or tort liability. When there is a duty to act, failure to do so could make the omission actionable. However, “whether there is such a duty to act is a legal conclusion, not a matter of policy-free factfinding.”⁶ Causality in law is, in the final analysis, a normative or policy choice. To stop a life-supporting respirator at a competent patient’s request, or because life support has become futile, is legal. However, if life support is neither refused nor futile, then a court could find that the physician’s act (or omission) was the legal cause of the patient’s death. In both cases, the physician’s act is the empirical cause-in-fact of the death. Concluding in the first case that the patient’s condition was the cause of death is, from the perspective of this normative causality analysis, only a shorthand affirmation, a policy-based conclusion, that a court would not find the physician liable or responsible for the consequences which occurred, that the act was not the legal or proximate cause of death.⁷

⁶Note, *ibid.* at 2029. This in substance is the position of Lamer C.J. in *Rodriguez*, *supra* note 1 at 561.

⁷Note, *ibid.* at 2030. See also, D.W. Brock, “Forgoing Life-Sustaining Food and Water: Is It Kill-

As for the provision of appropriate pain control, from the perspective of this third normative position a similar analysis applies. In effect, our society, criminal law and courts have made an implicit policy decision that it is acceptable in view of medicine's mandate to relieve suffering, to provide pain control measures sufficient for its alleviation, even if they also hasten death. The normative and legal criterion is not whether death is caused, but whether the dosage is appropriate for that person's pain.

IV. Normative Concerns about Assisted Suicide

What then can distinguish withdrawing life support treatment from assisted suicide? What could justify imposing criminal liability for the latter but not for the former? From the perspective of this "normative causality" analysis, such justification is not found by stating that the withdrawal of life support is an "omission" and assisted suicide is a "provision" (of death assistance). There are arguably three main policy justifications for maintaining criminal liability for assisted suicide.

One possible policy justification is the traditional ground of protecting a vulnerable minority, the psychologically unsound.⁸ Some who accept this as a valid concern claim that it does not justify the prohibition of assisting the suicides of rational persons.⁹ Others respond that rational suicide may be rare and may often be the result of failure to recognize treatable depression or to provide effective pain management. Furthermore, it is suggested that the social sanctioning of rational suicide and assisted suicide may result in an increase in irrational suicide and irrational assisted suicide, and put increased pressure on the elderly and those who feel that they are burdensome to kill themselves or request suicide assistance.¹⁰

A second policy reason advanced for maintaining the criminal liability of assisted suicide is that assisted suicide could be used as a way of disguising murder. That was the reasoning behind the formulation in the American Law Institute's *Model Penal Code*, which made causation of suicide criminal homicide if it involved force, duration or deception.¹¹ This same concern influenced the Law Reform Commission of Canada to propose the maintenance of criminal liability for aiding suicide.¹² The number of reported cases in which persons

ing?" in J. Lynn, ed., *By No Extraordinary Means: The Choice to Forgo Life Sustaining Food and Water* (Bloomington, Ind.: University Press, 1986) 117.

⁸As has been noted, historically in Anglo-American common law there were two other grounds for the assertion of state interest in preventing suicide and prohibiting suicide assistance. One was religious belief, which served as the basis of the denial of funeral rites to suicides. Another was sovereign cupidity, as evidenced by the forfeiture of a suicide's goods, in the feudal period, to his liege lord, and by the fourteenth century, to the coffers of the Crown. In present-day secular societies, only the third historical ground, namely the protection of the vulnerable, merits consideration. See M.T. CeloCruz, "Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?" (1992) 18 Am. J. Law & Med. 369 at 373-76.

⁹*Ibid.* at 397.

¹⁰See Y. Kamisar, "Are Laws against Assisted Suicide Unconstitutional?" (1993) 23:3 Hastings Center Rep. 32 at 37.

¹¹*Model Penal Code* § 210.5(1) (Proposed Official Draft 1962).

¹²*Supra* note 4.

who caused suicide were charged with murder, or could have been, makes this concern a legitimate one.¹³

A third policy argument made against decriminalizing assisted suicide is that distinguishing assisted suicide from voluntary euthanasia can be so difficult that legalizing the former could lead to condoning the latter. Whether or not one subscribes to the view of Joseph Fletcher that voluntary euthanasia is simply a form of suicide,¹⁴ there clearly are circumstances in which the activities involved make it hard to distinguish the two. Consider, for example, the physician who places the glass with a lethal dosage beside the patient, or hands it to the patient unable to lift it, or pours it down the throat of a patient unable to hold the glass. Who performs the final act, the one that results in death?

Clearly, the strength of this argument depends upon the ability to establish the undesirability of a policy permitting voluntary euthanasia independent of cause-in-fact similarities with assisted suicide, and even if the latter could be justified in some respects. One plausible policy concern is that, in the case of euthanasia, the final act leading to death is caused by the doctor (or whomever), not the patient, whereas in assisted suicide causality is shared. There are, as well, legitimate concerns about whether voluntary euthanasia conditions, guidelines, safeguards and procedures could ever be devised and enforced in a manner that adequately protects vulnerable patients. Such concerns are similar to those raised in regard to assisted suicide, but are arguably more serious in the context of euthanasia.

V. The "Standard Causality" Position in *Rodriguez*

How does the majority judgment in *Rodriguez* deal with the matter of causing death in all five circumstances indicated above, particularly that of assisted suicide, which is its primary focus? On which of the three views outlined above does that judgment rely?

The majority judgment written by Mr. Justice Sopinka generally reflects what this paper has labelled the "standard causality" position. He stated that the assisted suicide that Sue Rodriguez was seeking was contrary to the historical understanding of the sanctity of life, one of the values protected by section 7 of the *Canadian Charter of Rights and Freedoms*.¹⁵ It is "choosing death instead of allowing natural forces to run their course."¹⁶ The implication is that, by contrast, when life-supporting treatment is refused or stopped, death *is* the result of natural forces and is not caused by the physician who stops the respirator.

Mr. Justice Sopinka rejected the argument that paragraph 241(b) of the *Criminal Code* is over-inclusive and contrary to the principles of fundamental justice since the prohibition of assisted suicide extends to those unable to com-

¹³For numerous examples, see C.D. Shaffer, "Criminal Liability for Assisting Suicide" (1986) 86 *Colum. L. Rev.* 348 at 364-66.

¹⁴*Morals and Medicine* (Boston: Beacon Press, 1954).

¹⁵Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter the *Charter*]. See *Rodriguez*, *supra* note 1 at 585.

¹⁶*Rodriguez*, *ibid.* at 586.

mit suicide on their own.¹⁷ He stated that the prohibition is one aspect of an appropriate balance between, on the one hand, the valid interest of the State in preserving life and protecting the vulnerable, and on the other hand, the autonomy and dignity of the individual. That conclusion was based upon several arguments. First of all, the blanket prohibition of assisted suicide has not been revised to date by Parliament, and the decriminalization of attempted suicide did not signify a societal condonation of suicide. Secondly, the blanket prohibition of assisted suicide is the norm in Western democracies, none of which has yet found it to be unconstitutional, and there is no consensus in favour of decriminalizing assisted suicide. Thirdly, the serious concerns about appropriate safeguards, should exceptions be permitted, justify the blanket prohibition. Fourthly, on the basis of personal autonomy and dignity, there are some narrow exceptions permitted to the sanctity of life principle.

For our purposes we need only consider here the fourth point. Mr. Justice Sopinka acknowledged¹⁸ that courts and commentators have established the right of patients to refuse treatment even if its withdrawal results in death, the right of family members to have such treatment stopped if it has become “futile” or “therapeutically useless”, and the legitimacy of appropriate palliative care even if death is thereby hastened. Here again, the majority opinion appears to favour the “standard causality” position in the arguments made and sources selected to support the view that while the former are legitimate exceptions, assisted suicide and euthanasia are not. At the same time, however, there is some acknowledgement of the distinction between empirical and normative causality.

Mr. Justice Sopinka cited with approval the recent House of Lords decision in *Airedale N.H.S. v. Bland*, which allowed the withdrawal of medical feeding from a patient in a persistent vegetative state with the consent of the patient’s parents, but which rejected “the taking of active measures to cut short the life of a terminally ill patient.”¹⁹ On the one hand, the rejection of active euthanasia in that decision appears to be based on a presumed cause-in-fact distinction between active and passive euthanasia, rather than on policy considerations supporting the illegality of active euthanasia, regardless of whether the physician’s act is an empirical cause of death in both active and passive euthanasia.

On the other hand, there is a suggestion that despite the professed Rubicon between active and passive euthanasia on cause-in-fact grounds, it could nevertheless be crossed in some instances were it not for the inability to prevent abuses. Mr. Justice Sopinka noted approvingly that the basis for the rejection of active euthanasia in *Airedale* (and of assisted suicide by the Law Reform Commission of Canada) “is twofold it seems — first, the active participation by one individual in the death of another is intrinsically morally and legally wrong, and second, there is no certainty that abuses can be prevented by anything less than a complete prohibition.”²⁰

¹⁷*Ibid.* at 584.

¹⁸*Ibid.* at 598-601, 606-607.

¹⁹*Ibid.* at 598, citing *Airedale*, *supra* note 3.

²⁰*Ibid.* at 601.

What this somewhat inconsistent view appears to mean is that, on the one hand, a third party's empirical causing of death from active euthanasia makes it intrinsically wrong, but if a way could be found to prevent abuses, then despite the empirical causing of death and the inherent immorality, that cause-in-fact would no longer be considered the legal or proximate cause of death. A more straightforward analysis, from the perspective of "normative causality", would not assign immorality or illegality on the basis of third party empirical causing of death, but on the basis of other normative policy reasons such as the danger of abuses.

There is yet another example of ambiguity in the majority opinion regarding causality of death and the distinction between active and passive forms of treatment. Justice Sopinka stated that there are two competing viewpoints.²¹ One view finds that in both withdrawal of life support and assisted suicide, death is foreseen and does follow as a result of the action taken. This is essentially what this paper has labelled the "empirical causality" position. The other view claims that in withdrawal of life support, "the death is 'natural' — the artificial forces of medical technology are removed and nature takes its course,"²² whereas in the case of assisted suicide, "the course of nature is interrupted, and death results *directly* from the human action taken."²³ This is in effect what this paper has designated the "standard causality" position.²⁴

Regardless of which view one adopts, Sopinka J. concluded that the physician must nonetheless respect the patient's instructions and "is therefore not required to make a choice which will result in the patient's death as he would be if he chose to assist a suicide or to perform active euthanasia."²⁵ In effect, however, this conclusion is consistent only with the "standard causality" position. After all, even though requested by the patient, the physician's withdrawal of life support is the empirical cause-in-fact of death and remains a choice that will "result in the patient's death."²⁶ If, on the other hand, Mr. Justice Sopinka meant that the physician's withdrawal of life support in that case is not the "legal" cause of the patient's death, since the normative policy in this case gives precedence to patient autonomy, then his position would be consistent with what has been designated in this paper as the "normative causality" position.

It may not be far-fetched to claim that the very fact that the majority judgment placed as much emphasis as it did on the matter of societal consensus is an implicit acceptance of the "normative causality" position. Although Mr. Justice Sopinka concluded that there is at present no societal consensus in favour of decriminalizing assisted suicide, he implied that should there be evidence of

²¹*Ibid.* at 606.

²²*Ibid.*

²³*Ibid.* [emphasis in original].

²⁴Mr. Justice Sopinka cited (*ibid.* at 606) a study paper written by this writer for the Law Reform Commission of Canada in support of the "standard causality" approach, namely, *Sanctity of Life or Quality of Life in the Context of Ethics, Medicine and Law* (Ottawa: Supply & Services Canada, 1979). That was indeed the analysis this writer proposed at that time. However, as readers of this comment will be aware, that is no longer the case.

²⁵Rodriguez, *ibid.*

²⁶*Ibid.*

such a consensus, the blanket prohibition against it could be modified.²⁷ The judgment appears to accept that in assisted suicide the physician's act is a cause-in-fact of the patient's death (a choice resulting in the patient's death). Therefore, to envisage the possibility of its decriminalization, in at least some circumstances, means that in the event of decriminalization the physician's assistance would not constitute a culpable, normative or legal cause of death. By Sopinka J.'s own reasoning, it could become an instance of a justifiable cause of death.

VI. Intention and Normative Causality

We come, finally, to the subject of intent. Mr. Justice Sopinka acknowledged that, "[t]he administration of drugs for pain control in dosages which the physician knows will hasten death constitutes active contribution to death by any standard."²⁸ He went on to distinguish such palliative care from assisted suicide on the basis of intent: "However, the distinction drawn here is one based upon intention — in the case of palliative care the intention is to ease pain, which has the effect of hastening death, while in the case of assisted suicide, the intention is undeniably to cause death."²⁹

This analysis is in one respect similar to the "normative causality" view. It acknowledges in effect that a physician's pain control treatment, if it hastens death, is for that reason a cause-in-fact of the patient's death, just as it would be in assisted suicide. It is, of course, the case that, in the psychological sense, a physician would typically intend something different in each case: pain control in the first, and death in the second.

However, from the perspective of causality and criminal liability, what makes intent culpable in the legal sense is the intent to commit an unlawful act, not merely the intent to cause death *per se*. The normative question is whether or not causing death in a particular instance is legally justified or not, and whether or not the physician is acting in a legally protected manner. The prior normative policy choice made by our society, criminal law and courts is that causing (hastening) death in the pain control circumstance is acceptable in view of the medical mandate to alleviate suffering, and is therefore not an unlawful act. Similarly, causing death by terminating life support at a competent patient's request is not unlawful in view of that patient's right to refuse it.

²⁷The reliance upon and determinations about societal consensus on the subject of issues as contentious and evolving as assisted suicide is laudable in principle, but in practice has its dangers and limits. A first problem concerns the weight that should be assigned to such consensus in formulating and revising law and public policy, assuming consensus can be found. A second problem is where one should look to find it. It is by no means evident that legislation, court decisions or law reform commissions in this country or other western democracies reflect present-day societal views. Current polls may seem to be more reliable sources. They appear to reflect considerable and growing support for the decriminalization of assisted suicide, and suggest that legislation on this subject in Western democracies is increasingly unreflective of public consensus. On the other hand, polls may not themselves be reliable in view of ambiguities in both questions and responses. A referendum may appear to be an accurate indication of public stances, but it too can be prone to the same ambiguities and reflects only the views of those who voted.

²⁸Rodriguez, *supra* note 1 at 607.

²⁹*Ibid.*

What relieves the physician of culpable intent is not simply that there is no intent to cause death, but more to the point, there is no intent to commit an illegal act. Death is in fact being caused, and the physician knows it and may even desire it, but assuming the dosage is appropriate for that patient's pain control, there is no intent to commit an unlawful act. Equally, what at present makes the intent culpable in assisted suicide is not the intent to assist the taking of life *per se*, but the intent to commit a presently unlawful act, to act in a legally prohibited manner. What brands that act as lawful or unlawful at a point in time are the same normative or policy-based considerations which lead to deciding which of several causes of death will be considered "the" cause of death for legal purposes. A society's values and norms are not static and will always be subject to challenges and evolution. On the one hand, defining what ought to be criminal acts merely by reference to what is presently unlawful is inadequate and circular. On the other hand, new normative and social considerations may well justify the existing prohibition.

Conclusion

What then does the "normative causality" analysis add in comparison to the essentially "standard causality" approach reflected in the majority judgment of Mr. Justice Sopinka? In some respects, not a great deal. No claim can reasonably be made that the Supreme Court would have concluded otherwise had a more overt "normative causality" approach been adopted. Nor would the reasons advanced in support of that conclusion necessarily have been significantly different. After all, normative policy factors, such as concerns about abuse, played at least as significant a role in the decision to maintain the blanket prohibition of assisted suicide as did assigning (shared) causality for death to the assisting physician. As for the "normative causality" analysis, merely because it finds empirical causation of death in withdrawal of life support, assisted suicide and active euthanasia, does not necessarily mean that this approach is inherently more inclined to promote the decriminalization of assisted suicide and active euthanasia. Normative reasons such as fears of abuse, or an increased risk to vulnerable patients, can be just as, or even more, persuasive from this "normative causality" outlook.

Nevertheless, there are arguably at least two important correctives which a "normative causality" analysis could have added to this decision. First of all, by acknowledging empirical causality in all five circumstances considered, the judgment would have been more reflective of the perceptions of many physicians and family members who have to make the decisions about stopping life support and administering appropriate but lethal pain control. Secondly, by acknowledging that the common denominator in all five circumstances is the physician's act (or omission) causing death in an empirical, but-for sense, the focus could have been more directly on how they are arguably distinct for other normative reasons. They are not likely to be seriously weighed by law reformers, legislators and courts until a more sophisticated and comprehensive approach to the relationship between causality and criminal liability is adopted.
