

LESSONS FROM CANADA IN THE BATTLES ABOUT LEGALIZING EUTHANASIA: FROM KINDNESS TO KILLING[†]

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To make the case against euthanasia and physician-assisted suicide, we must first understand how the case for it is made. We need to identify pro-euthanasia advocates' strategies and their arguments for euthanasia and respond to them, if, as I do, we think that legalizing euthanasia is a dangerous idea. Paradoxically, this need is even stronger after euthanasia is legalized, as it has been in Canada, if we are to have the best chance of limiting its harmful impact.

So what are the pro-euthanasia strategies and arguments used by legalization of euthanasia proponents?^{†††}

First, a general observation: mainstream media is overwhelmingly pro-euthanasia. Here is an example: This is the front page of Canada's national newspaper, *The Globe and Mail*, the morning after the Supreme Court of Canada ruled in the *Carter* case that the Canadian Criminal Code's absolute prohibition of assisted suicide and euthanasia was unconstitutional and these interventions must be allowed in certain circumstances.¹

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^{†††} Except where indicated otherwise, I am using the word euthanasia to include physician-assisted suicide and vice versa, as in very large part both raise the same ethical and legal issues.

1. Sean Fine, *A 'Right to Life' is Not a 'Duty to Live,'* THE GLOBE AND MAIL, Feb. 7, 2015 at A3.

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THE GLOBE AND MAIL

WEEKEND
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SATURDAY, FEBRUARY 7, 2015



“It was a day of bittersweet triumph for supporters of assisted suicide as the Supreme Court’s unanimous decision means new choices for terminally ill Canadians and tough questions for families, physicians and politicians across the country.”

As you can see, intentionally inflicting death—killing—is re-characterized as kindness,² which in fact accurately reflects the approach taken

2. *Id.*

by the Supreme Court. This re-characterization was mediated through an emphasis on suffering, its relief as kindness, and acceptance of physician-assisted suicide and euthanasia—described as medical treatment and palliative care—as acceptable means to relieve suffering.

So, in more detail, what strategies did pro-euthanasia advocates employ to achieve this radical change in societal values and the institutions of law and medicine? In other words, how did Canada arrive at this point?

I. THE STRATEGIES

A. *STRATEGY 1: The “We All Agree On Most Issues” Approach*

Starting debates on euthanasia by placing an emphasis on the fact that “we all agree on most issues” sounds anodyne. This is, however, a pro-euthanasia strategy.

The issue on which there is the greatest agreement is the need for fully adequate palliative care for all who need it. In practice, however, this can be more of a pious hope than a reality. Emphasizing this agreement deemphasizes that we disagree strongly on the most important issue in the euthanasia debate, namely whether intentional killing by physicians ought to be allowed and legalized. Emphasizing that we all agree also tends to make those who disagree with euthanasia seem as though they are disagreeable and at fault for being so.

I often recommend starting from agreement not disagreement when discussing contentious ethical issues, as it gives a different tone to the debate. But I now believe that is not a good idea in the euthanasia debate, if we believe it should not be legalized.

It merits noting here that neither the Supreme Court of Canada,³ nor the Quebec *Act respecting end-of-life care*,⁴ nor the Canadian Medical Association⁵ require palliative care to be available and offered before a person can have access to euthanasia. That raises the issue of whether a person can give an informed consent to euthanasia if they have not been offered all

3. *Carter v. Canada*, [2015] 1 S.C.R. 331 (Can.). The Court did acknowledge that the trial court judge added a warning that patients should be informed of their diagnosis including palliative care interventions, but did not indicate in its ruling that these were required. *Id.* at para. 106.

4. *End of Life Care Act*, S.Q. 2014, c.2 (Can.).

5. See Canadian Medical Association, *Euthanasia and Assisted Death*, CMA POLICY, 3 (2014), <https://www.cma.ca/Assets/assets-library/document/en/advocacy/policy-research/cma-policy-euthanasia-and-assisted-death-update2014-pd15-02-e.pdf#search=Euthanasia%20and%20Assisted%20death> [hereinafter *Euthanasia and Assisted Death*].

reasonable alternatives to it, especially as research shows that even people requesting euthanasia can change their minds when given good palliative care.⁶

B. *STRATEGY 2: This Strategy has four parts:*

- i) *Reinterpretation of the Right to Life*
- ii) *Placing the Focus on a Suffering Individual Who Wants Euthanasia*
- iii) *Emphasizing the Cruelty of Denying “Assistance in Dying” and*
- iv) *Advocating the Person’s “Right” to Choose*

The Supreme Court of Canada’s interpretation of the **right to life** in sec 7 of the Canadian Charter of Rights and Freedoms,⁷ which is part of the Canadian Constitution, has two components: First, the Court ruled the “right to life” is not a duty to live.⁸ And, second, prohibiting assisted suicide breaches the right to life because it shortens life as the person has to commit suicide while still able to do so without assistance, but could choose to live longer if assistance were available. In short, the Court converted the right to life to a right to physician-assisted suicide and euthanasia (PAS-E), a right to death.

The Supreme Court of Canada’s opening paragraph in the *Carter* case **focuses on the suffering of an individual:**

It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician’s assistance in dying and may be *condemned to a life of severe and intolerable suffering*. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. ***The choice is cruel.***⁹

8. HARVEY MAX CHOCHINOV, DIGNITY THERAPY FINAL WORDS FOR FINAL DAYS, 3–34 (2012).

7. Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act, 1982, c.11 (U.K.).

8. *Id.*

9. *Carter v. Canada*, [2015] 1 S.C.R. 331, para. 1 (Can.) (emphasis added). Note: The plaintiff on whom the Court focused in the *Carter* case, Gloria Taylor, was requesting physician-assisted suicide;

The last four words tell us what the Court's decision will be. Here it is:

Section 241 (b) and s. 14 of the *Criminal Code* unjustifiably infringe. 7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.¹⁰

The Supreme Court turns to the stories of individuals' suffering and difficult deaths to support this ruling and the "right to choose":

The stories in the affidavits vary in their details: some witnesses described the progression of degenerative illnesses like motor neuron diseases or Huntington's disease, while others described the agony of treatment and the fear of a gruesome death from advanced-stage cancer. Yet running through the evidence of all the witnesses is a constant theme—that they suffer from the knowledge that they lack the ability to bring a peaceful end to their lives at a time and in a manner of their own choosing.¹¹

We must listen to and take into account such stories, but they are not all that we need to hear and to take into account.

Note that the absence of access to PAS-E is characterized as a form of suffering, and the legal prohibition of PAS-E means it is state imposed suffering, which the Court rules must be relieved by providing access.

C. *STRATEGY 3: The "No Difference" Arguments—Arguing that Euthanasia is Just an Incremental Change and No Different from Other*

consequently, the Court's rulings deal expressly with this intervention, but the judgement makes it clear that their holdings apply equally to euthanasia.

10. *Id.* at ¶ 147.

11. *Id.* at ¶ 14.

End-of-Life Medical Treatments Which We Already Accept

Making euthanasia and assisted suicide part of medical practice is not, as pro-euthanasia advocates claim, a small incremental change consistent with interventions that we accept as ethical and legal, such as honouring patients' refusals of life-support treatment that allow them to die.¹² Rather, euthanasia is different-in-kind from these interventions with respect to both the physician's primary intention and the legal cause of death.

Legalizing euthanasia represents a seismic shift in our fundamental societal values. I predict that history will decide that it was one of the defining events of the first decades of the 21st Century and possibly the entire century of our western democratic societies in terms of each one's shared collective foundational values.

1. "No Difference" From Other Medical Treatments Argument

The argument that euthanasia is no different from pain management or refusals of life-support treatment was accepted in the *Carter* case and the legality and ethical acceptability of these interventions was used to establish a right to die.

But the right to refuse treatment is not based on a "right to die," let alone a "right to be killed," but on a right to inviolability—a person's right not to be touched, including by medical treatment, without their informed consent.

In pain management, the intention and goal is to relieve pain—not, as in euthanasia, to kill the patient. Another major distinction between pain management and euthanasia is that competent pain management is more likely to prolong life than to shorten it.

Moreover, legalizing euthanasia is not an incremental development but a radical change in the nature of medical practice and the role of physicians.

The Supreme Court adopts a "no difference" from other medical treatments at the end-of-life approach in analyzing what respect for the section 7 Canadian Charter of Rights and Freedoms rights to "liberty and security of the person"¹³ require, making these rights protective of a very broad scope for the exercise and dominance of individual autonomy and, concurrently, more easily breached by any restriction on a person's "choice":

12. See MARGARET SOMERVILLE, BIRD ON AN ETHICS WIRE: BATTLES ABOUT VALUES IN THE CULTURE WARS 117–66 (2015).

13. Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act, 1982, c.11 (U.K.).

An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The law allows people in this situation to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment, but denies them the right to request a physician's assistance in dying. This interferes with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty. And, by leaving people like Ms. Taylor to endure intolerable suffering, it impinges on their security of the person.¹⁴

2. "No Difference" Between "Terminal Sedation" and "Palliative Sedation," Argument

When used correctly as part of palliative care, palliative sedation is not euthanasia.¹⁵ The person dies a natural death from their underlying illness.

Sedation can, however, be used as "slow euthanasia" (terminal sedation, which must be distinguished from palliative sedation). The Quebec *End-of-Life Care Act* allows terminal sedation. It provides for what it calls "continuous palliative sedation" and defines this as being "irreversible,"¹⁶ which of course it is not unless it's used that way.

In palliative sedation as part of standard palliative care, physicians often allow the patient to become conscious from time to time and use the lightest possible sedation consistent with relieving pain and suffering. As well, it's only used as a last resort and not often. None of that is true under the Quebec Act's provisions. Moreover, under the Quebec Act a substitute decision maker can consent to "continuous palliative sedation" for a patient.¹⁷

The UK introduced a protocol called the Liverpool Care Pathway,¹⁸ which was interpreted by some physicians to allow the use of terminal sedation in the same sense as in the Quebec Act. Its use was investigated. They found that some elderly people were being deeply sedated, put in a bed out of the way, and no one—no doctors or nurses—cared properly for them while they died, sometimes over a period of two weeks, from dehydration and starvation. It was also learnt that some hospitals received a bonus from the NHS (National

14. *Carter v. Canada*, [2015] 1 S.C.R. 331, para. 66 (Can.).

15. *Euthanasia and Assisted Death*, *supra* note 5, at 2.

16. *End of Life Care Act*, S.Q., 2014, c.2, S.3, 24 (Can.).

17. *End of Life Care Act*, S.Q., 2014, c.2, S.25 (Can.).

18. See *News Analysis: What is the Liverpool Care Pathway?*, NHS CHOICE, (Nov. 2, 2016) <http://www.nhs.uk/news/2012/11/November/Pages/What-is-the-Liverpool-Care-Pathway.aspx>.

Health Service) for every patient who died on the protocol. There was outrage, including in the House of Lords, and the protocol was prohibited.¹⁹

3. The Supreme Court Accepted the Argument That if Suicide is Not a Crime, Assisting it Should Not be a Crime

This is the argument that there is “no difference” between suicide and assisted suicide. But suicide was decriminalized to try to save life—so people would not be afraid to seek medical help—not to take life as in euthanasia.

Some, possibly most, jurisdictions which have legalized PAS-E have seen a general rise in suicide rates, which raises the issue of legalizing euthanasia being a threat to public health and damaging suicide prevention interventions and programs.

4. “No Difference” in Outcome Argument

The “going to die anyway” justification of euthanasia is the argument that there is “no difference” in outcome whether a person dies from underlying illness or a lethal injection. The euthanasia debate is not about *if* we die—we all will die—but *how* we die.

D. *STRATEGY 4: Euphemizing Euthanasia by Calling It: “Medical Treatment” and “Medically Assisted Death”*

Euthanasia is not medical treatment because it is irreconcilable with medicine’s mandate to heal.²⁰ The conception of the medical mandate as “healing” is difficult to describe but encompasses the idea that healing is a “relational process involving movement towards an experience of integrity and wholeness” and “operationally . . . [is a] transcendence of suffering” so that a person “can die healed.”²¹

A strong majority of physicians don’t see euthanasia as medical treatment and are one of the most opposed groups to euthanasia—palliative care physicians are the most opposed.²² In the Netherlands, “mobile euthanasia

19. See Sarah Bosely, *Liverpool Care Pathway for Dying Patients to be Abolished After Review*, THE GUARDIAN (July 15, 2013), <https://www.theguardian.com/society/2013/jul/15/liverpool-care-pathway-independent-review>.

20. J. Donald Boudreau & Margaret A. Somerville, *Euthanasia is Not Medical Treatment*, 106 BRIT. MED. BULL. 45, 55 (2013).

21. *Id.*

22. *Id.*

units,” which would go to the patient to carry out euthanasia, were introduced as a response to physicians’ resistance to undertaking euthanasia.²³

It’s true that some physicians are opposed to euthanasia for religious or moral or ethical reasons, but medicine must not disown its ethical tradition or basic precepts and would do so at its ethical peril. Euthanasia seriously harms medicine and its value-carrying role in society, especially its role in upholding the value of respect for human life at both the individual and societal levels. In a secular society, unlike one with a widely shared religion as was the norm in the past, law and medicine are the main institutions carrying this value.

It endorses suicide to call assisted suicide medical treatment—euthanasia advocates distinguish “assisted death” from typical suicide by the “going to die anyway” justification for the former. But PAS-E establishes suicide as a legitimate response to suffering.

And words matter in the euthanasia debate. Compare the language of “state-sanctioned suicide” or “physicians killing their patients” with “medically assisted death” (MAD), the term used by pro-euthanasia advocates. They know that suicide/euthanasia terminology reduces support for inflicted death and avoid such language. We also need to keep in mind that our choice of language affects our emotions and intuitions, including moral intuitions, which are important as complementary “ways of knowing” in ethical decision-making.²⁴

E. *STRATEGY 5: Sanitizing Euthanasia by Associating It with Medicine*

People in general believe physicians are ethical and do not act unethically; consequently, physicians carrying out euthanasia gives it a veneer of being ethical. Medicine’s involvement alters the public’s view; for instance, in America people who supported capital punishment sought to make it more acceptable to the public by physician involvement.²⁵ But we need to take the “white coat” off euthanasia and keep it out of medicine. If it is legalized, someone other than physicians should carry it out. My colleague Dr. Donald Boudreau and I have suggested a new profession and discipline, perhaps called “thanatologists and thanatology,” respectively. We discuss, elsewhere, who

23. *Id.*

24. Margaret Somerville, *The Ethical Imagination: Journeys of the Human Spirit* (Toronto: House of Anansi Press, 2006)

25. BOUDREAU & SOMERVILLE, *supra* note 20 at 55..

thanatologists might be, how they would be trained, and the scope of their practice.²⁶

F. *STRATEGY 6: Labeling the People Who Oppose Euthanasia and Their Values as Religious and Dismissing Them and Their Arguments on that Basis*

This strategy avoids having to deal with the substance of the arguments against euthanasia. It is frequently used, by people without good factual knowledge of the risks and harms of euthanasia, especially risks and harms at the institutional and societal levels, and the risks and harms to vulnerable people, those with disabilities, who are mentally ill or suffer from dementia, or who are old and fragile.

The people using this strategy also take the anti-democratic stance that religion and religious people have no right to a voice in the public square, in particular, in debates regarding public and social policy and the values that should inform those policies.²⁷

G. *STRATEGY 7: Appealing to Empathy and Compassion*

Pro-euthanasia advocates often put forward a rhetorical question: You euthanize your dog because you love him and he's suffering, why not do the same for those people you love—your mother—who are suffering? The short answer is that your mother is not a dog.

This is to raise the issue of human exceptionalism: Is there any moral or ethical difference between humans and animals or are we just another animal in the forest? Princeton philosopher, Professor Peter Singer, a strong advocate of legalizing euthanasia,²⁸ believes the latter and is probably the best-known exponent of this idea. He argues that to treat humans and animals differently is “speciesism,” a form of wrongful discrimination.²⁹ I believe that proposing that there is no relevant moral difference between humans and animals is currently the world's most dangerous idea.³⁰

26. *Id.* at 51–52. See also Margaret Brazier, *Euthanasia and the Law*, 52 BRIT. MED. BULL. 317, 322–23 (1996).

27. See SOMERVILLE, *supra* note 12, at 13–15, 45.

28. E.g., Peter Singer, *Speciesism and Moral Status*, 40 METAPHILOSOPHY 567, 579 (2009).

29. See *id.* at 571–73.

30. See SOMERVILLE, *supra* note 12, at 43–45.

H. *STRATEGY 8: Proposing that Death is a Benefit to Justify Euthanasia*

This justification of euthanasia proposes that dying is only “bad” if a person is deprived of a life that is good. If life is not good, dying is not bad, indeed, it is a benefit. Canadian philosopher Wayne Sumner’s “deprivation theory” was accepted in the Supreme Court of British Columbia in the *Carter* case.³¹

Normally we assume that death is one of the worst fates that can befall us, which is why in both ethics and law the causing of death is taken to be such a serious matter. But what makes death such a bad thing in the normal case is what it takes away from us—the continuation of a life worth living. The disvalue of death is therefore a direct function of the value of the life thereby lost. This is the *deprivation account* of the badness of death: death is bad for us by virtue of depriving us of the goods of continued life. On this account, showing that death would be bad for a person requires a comparison between two possible futures for that person: the one in which he dies and the one in which he lives on. If the goods of further life would outweigh the evils then it would be better for the person to continue living, and death would therefore be a harm to him since it would deprive him of this good future.³²

On the other hand, if the “evils” of continued life outweigh its goods, death is not a harm as nothing good is lost. This is a *quality of life* argument couched in different terms: those of non-deprivation. The person’s quality of life is seen as being so poor that they are not deprived of any benefit—indeed, they are benefited—by their life being taken. This reasoning necessarily requires recognizing that there can be a “life not worth living” and that one can be “better off dead,” which, if accepted, are dangerous and deeply worrying concepts for vulnerable people, such as those with disabilities, who are mentally ill or suffer from dementia, or who are elderly and fragile.

31. Benny Chan & Margaret Somerville, *Converting the ‘Right to Life’ to the ‘Right to Physician Assisted Suicide and Euthanasia’: An Analysis of Carter v. Canada (Attorney General)*, *Supreme Court of Canada*, 24 Med L.R. 143,158 n. 77 (2016).

32. *Carter v. Canada*, [2015] B.C.L.R. 4th, ¶ 351 (Can. B.C. S.C.).

II. INSIGHTS FROM THE STRATEGIES

I will only briefly mention some of the insights examining the pro-euthanasia strategies provides. I have examined them in much greater detail elsewhere.³³

A. *What Does Calling Support for Euthanasia a “Progressive Value” Tell Us?*

The messages of “progressive values” relevant to euthanasia include the following:

- The euthanasia debate invokes a conflict between respect for individual autonomy and respect for human life. “Progressive values” advocates give priority to respect for individual autonomy over other values. In the case of euthanasia, the respect for individual autonomy takes priority over the values of respect for human life both in relation to individuals and in society, in general, and protection of the common good. That prioritization places vulnerable people, in particular, at serious risk of abuse.
- “Progressive values” adherents seek control and implement this through claims to rights to “choose.” Including euthanasia as a “choice” in how we die gives the illusion of control— we can control the time, place and manner of our death; we can get death before it gets us. Euthanasia might be what the social psychologists call a “terror reduction mechanism” or a “terror management device” through which we seek control over what terrifies us, in this case death, in order to manage our fear of it.
- Progressives reject history (human memory) and tradition, seeing them, on the whole, as “restrictive” and labelling those whose values are informed by them as “restrictives” (people with conservative or traditional values).
- Progressives question authority. This is linked to having personal control—by prioritizing respect for individual autonomy and self-determination—and antipathy to religion: “It’s my body and my life and no one else has the right to tell me what I can or cannot do.”
- Progressives are often hostile to religion and the values it promotes. For this reason, I believe we should speak of “respect for life,” not “sanctity of

33. See SOMERVILLE, *supra* note 12, at 137–66. Additionally, I am indebted for these insights to Jonathan Haidt’s research in his book “The Righteous Mind: Why Good People Are Divided by Politics and Religion” (New York: Pantheon, 2012).

life,” to avoid this value being summarily dismissed by progressives as simply a religious one.

It merits noting that the above characteristics are all complementary and reinforce each other, and that the euthanasia debate is part of the culture wars, as it involves the same value conflicts as are involved in the other conflicts that constitute those wars.³⁴

B. What Can We Learn from History – “Human Memory”?

Here are some facts to ponder:

- Rejection of euthanasia by physicians dates at least from the Hippocratic Oath which is 2,400 years old. The Oath separated the two roles of the witch doctor—the role of healer and the role of death inflictor—so that physicians became solely healers. Why, after such a long period of time when there is so much more we can do to relieve the pain and suffering of terminally ill people, do we suddenly again want to make physicians death inflictors?³⁵
- Loss of trust in physicians if they kill, is a long-established warning. Moreover, because physicians have opportunities to kill that other people do not, it must be made very clear that this is not within their professional mandate or role.
- We must be acutely aware of the dangers of the search for perfection (in the case of euthanasia, a “perfect” death) through technoscience (a lethal injection). We can imagine a progression from a “perfect death” with euthanasia to a “perfect society,” that is, as some Danish scholars were reported as saying, “One with no people with disabilities for instance, no people with Down’s syndrome in Denmark by year 2033.” This is to endorse the validity of quality of life, “life not worth living,” criteria.

Citing the Nazis as a relevant example for consideration in today’s euthanasia debates is decried by pro-euthanasia advocates as totally irrelevant and unfounded fear-mongering and is avoided by those who are anti-euthanasia for fear of providing an easy target that could be used to weaken their case and dismiss their voice in the public debate.

34. Margaret Somerville, *Bird on an Ethics Wire*.

35. See Margaret A. Somerville, *Legalizing Euthanasia: Why Now?*, 68 *AUSTRALIAN Q.* 1, 4 (1996); see also MARGARET SOMERVILLE, *DEATH TALK: THE CASE AGAINST EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE* 78–81 (2001).

But an article in the *New York Times* of October 8, 1933, entitled *Nazis plan to kill incurables to end pain; German religious groups oppose move*,³⁶ resonates so clearly with rhetoric and arguments in our contemporary debates. And it contains such powerful warnings and, in retrospect, provides such a chilling example of where seeing people as losing their human dignity, and with that protections of their lives if they become fragile and vulnerable can lead, that I would like you to read it in its entirety. Do so with the claims in the present euthanasia debate in the public square in mind:

Berlin, Oct. 7, - The Ministry of Justice, in a detailed memorandum explaining the Nazi aims regarding the German penal code, today announced its intention to authorise physicians to end the sufferings of incurable patients. The memorandum, still lacking the force of law, proposed that "It shall be made possible for physicians to end the tortures of incurable patients, upon request, in the interests of true humanity". This proposed legal recognition of euthanasia - the act of providing a painless and peaceful death - raised a number of fundamental problems of a religious, scientific and legal nature. The Catholic newspaper *Germania* hastened to observe: "The Catholic faith binds the conscience of its followers not to accept this method of shortening the sufferings of incurables who are tormented by pain." In Lutheran circles too, life is regarded as something that only God alone can take. A large section of the German people, it was expected in some interested circles, might ignore the provisions for euthanasia, which overnight has become a widely discussed word in the Reich.

In medical circles the question was raised as to just when a man is incurable and when his life should be ended. According to the present plans of the Ministry of Justice, incurability would be determined not only by the attending physician, but also by two official doctors who would carefully trace the history of the case and personally examine the patient.

In insisting that euthanasia shall be permissible only if the accredited attending physician is backed by two experts who so advise, the Ministry believes **a guarantee is given that no life still valuable to the State will be wantonly destroyed.**

36. Associated Press, *Nazis Plan to Kill Incurables to End Pain; German Religious Groups Oppose Move*, N.Y. TIMES, Oct. 8, 1933.

The legal question of who may request the application of euthanasia has not been definitely solved. The Ministry merely has proposed that either the patient himself shall “expressly and earnestly” ask it, or “in case the patient no longer is able to express his desire, his nearer relatives, acting from motives that do not contravene morals, shall so request.”³⁷

“A guarantee is given that **no life still valuable to the State** will be wantonly destroyed”,³⁸ this statement is based on a presumption that not all human lives are valuable. “**Human doings**” will not be euthanized, but “human beings” who were perceived as “useless” could be and were.

C. We Need To Consider the Impact of Legalizing Euthanasia at Different Levels and in the Future

Consideration of the impact of legalizing euthanasia just at the micro level of individual persons, which is the sole focus of the pro-euthanasia lobby and makes the strongest case for its legalization, is not sufficient. We need also to look at its impact at the meso or institutional level, the macro or societal level, and the mega or global level. As well we must consider the impact of its legalization, not just in the present, but also in the future: We need to ask ourselves, “How do we *not want* our great-grandchildren to die? How will they die if euthanasia becomes the norm?”

Just as we now realize our actions could destroy our physical ecosystem and we must hold it in trust for future generations, we must likewise hold our metaphysical ecosystem—the collection of values, principles, beliefs, attitudes, shared stories, and so on that bind us together as a society—in trust for them. That requires that we always react to pain and suffering with deep compassion and assistance to relieve it, but that we kill the pain and suffering and not the person with the pain and suffering.

D. Euthanasia Unavoidably Opens Up “Slippery Slopes”

We only have to turn to the Netherlands and Belgium to see the slippery slopes that legalizing euthanasia opens up. The “logical slippery slope” is the expansion of the situations where euthanasia is permitted: from competent consenting adults to children, people with dementia, and those just “tired of

37. *Id.* (emphasis added).

38. *Id.* (emphasis added).

life,” or the terminally bored. Then, there is the “practical slippery slope,” the abusive use of euthanasia.

Slippery slopes cannot be prevented once intentionally inflicting death is allowed because the initial justification of inflicting death necessarily allows for the expansion of justifications (the logical slippery slope). For example, the justification of respect for autonomy *and* relief of suffering, becomes respect for autonomy *or* relief of suffering; and there is expansion from adults to children, from physical illness to mental illness. As well, once euthanasia is legally permitted, the law is breached (the practical slippery slope).

E. We Need to Talk About Whether Euthanasia Is Right or Wrong, Not Just Its Risks, Harms and Benefits

The discussion about whether euthanasia is intrinsically right or wrong almost never occurs, almost certainly because it would be to reject the philosophy of moral relativism (nothing is intrinsically right or wrong, it all depends on the circumstances and often personal beliefs or preferences), which is ubiquitous in post-modern Western democracies and grounds the pro-euthanasia case. Moral relativism reflects a utilitarian-based ethics not a principle-based one. A central difference is that the latter is grounded in the belief there are some absolute truths that should inform our ethics, the former rejects this view.

F. Where Does the Canadian Debate Go from Here?

The Supreme Court of Canada’s judgment in the *Carter* case was not the end of the Canadian debate about legalizing euthanasia.

Issues that have been and are now the focus of debate include: How should the Supreme Court’s ruling be interpreted? Who should assess competence to consent to euthanasia? What constitutes “clear consent to the termination of life”? What fulfils the “grievous and irremediable medical condition (including an illness, disease or disability)” requirement? When does the person have “suffering that is intolerable”? Should access to PAS-E be expanded to children, people with dementia or those with mental illness, but not physical illness? Are the requirements for access to PAS-E an unjustifiable breach of the right to autonomy of competent adults who want to die and give their informed consent?

The Supreme Court gave the government of Canada twelve months from the date of the judgment to legislatively implement its ruling and extended it

by four months. The Canadian government tabled legislation in Parliament and Bill C-14 “Medical Assistance in Dying” was passed June 6, 2016.

The same pro-euthanasia and anti-euthanasia opponents are now facing off regarding this legislation. The former want “physician assisted death” to be open to many people on relatively easy to fulfill conditions, the latter want its use to be as restrictive as possible with the most stringent requirements for access possible consistent with complying with the Court’s ruling and comprehensive and effective monitoring and reporting and strict application of the required conditions.

And there are collateral issues. Some of the provincial medical licensing authorities are trying to make physicians who have conscientious objection to euthanasia provide “effective referrals,” refer patients who qualify for euthanasia to another physician they know will provide euthanasia, which would constitute complicity of the objecting physician in euthanasia. This demand is creating an overt and highly conflictual confrontation with respect to rights to freedom of conscience for healthcare professionals.

CONCLUSION

Euthanasia is not just an incremental expansion of current ethically and legally accepted end-of-life decisions, such as respecting refusals of life-support treatment, as pro-euthanasia advocates argue. Acting with an intention to kill is different-in-kind from allowing a natural death.

Euthanasia is not medical treatment. Defining it as such, presents serious dangers to patients, the trust-based physician-patient relationship, vulnerable and fragile people, medicine, and society. If euthanasia is legalized by society, we must take the “medical cloak” off it and have some specially trained persons other than physicians mandated to administer it.

We need to ask ourselves: if euthanasia is permitted, how do we think our great-great-grandchildren will die? What kind of society will we have left to them? Will it be one in which no reasonable person would want to live?

It seems that most politicians and many people in western democracies such as Canada do not recognize the momentousness of a decision to legalize physician-assisted suicide or euthanasia. It’s not an incremental change, but a radical and massive shift in our society’s and civilization’s foundational values. A prominent Australian politician, Jeff Kennett, who is arguing for legalizing euthanasia, speaking in a radio interview, captured the trivialization of death that informs support for euthanasia in these words: “*As far as I’m concerned, when you are past your ‘use by’ or ‘best before’ date, you should*

be checked out as quickly, cheaply and efficiently as possible.”³⁹ But we are not products to be checked out of the supermarket of life.

And what would be the *cumulative effect* of the use of euthanasia on vulnerable people? Consider, for instance, that Belgium is now allowing euthanasia of people with Alzheimer’s disease. What would be the impact of that on the shared values that bond us as a society and in setting the “ethical tone” of our society?

It’s wisely said that we can’t judge the “ethical tone of a society” by how it treats its strongest, most privileged, most powerful members, but “by how it treats its weakest, most in need, most vulnerable members.”⁴⁰ Dying people belong to the latter group. Fr. Alfred Delp, a Jesuit German priest executed by the Nazis, put it this way:

A community that gets rid of someone—a community that is allowed to, and can, and wants to get rid of someone when he no longer is able to run around as the same attractive or useful member—has thoroughly misunderstood itself. Even if all of a person’s organs have given out, and he no longer can speak for himself, he nevertheless remains a human being. Moreover, to those who live around him, he remains an ongoing appeal to their inner nobility, to their inner capacity to love, and to their sacrificial strength. Take away people’s capacity to care for their sick and to heal them, and you make the human being into a predator, an egotistical predator that really only thinks of his own nice existence.⁴¹

I am fervently hoping that no other jurisdictions will follow Canada down the slippery slope it has opened up by stepping over the clear line set by the rule that we must not intentionally kill another human being or help them to kill themselves; the one exception to the former being when that is the only way to save innocent human life. As British moral philosopher Dame Mary Warnock has put it in another context: “You cannot successfully block a slippery slope except by a fixed and invariable obstacle.”⁴² In the case of euthanasia that obstacle is the rule that we must not intentionally kill.

39. SOMERVILLE, *supra* note 12, at 95 (quoting Jeff Kennett).

40. Margaret Somerville, *New Generics Functions as Eugenics*, NAT’L POST (Oct. 10, 2002), <http://www.consciencelaws.org/ethics/ethics032.aspx>.

41. *It Is a Rebellion: Alfred Delp’s Timeless Message Against Euthanasia*, IGNATIUS INSIGHT (May 4, 2009), http://www.ignatiusinsight.com/features2009/adelp_euthanasia_may09.asp.

42. Robin McKie, *A Leap Forward or a Step too Far? The New Debate Over Embryo Research*, THE GUARDIAN (Dec 4, 2016), <https://www.theguardian.com/science/2016/dec/04/embryo-research-leapforward-step-too-far>.