by Terence McQuiston M.D.

A FRESH PROPOSAL FOR EUTHANASIA LEGISLATION IN CANADA

Here follows first an preface concerning my political experience with legalized euthanasia, then the summary of my proposal for the new legislation, and then the full text of my proposal for the new legislation with appendices.

PREFACE: MY EXPERIENCE IN THE POLITICS OF LEGALIZED EUTHANASIA

I am very familiar with the Dutch experience of legalized euthanasia, and have studied the issues around legalizing euthanasia over the years, involving myself politically during the 2009-2010 debate on BQ MP Francine Lalonde's bill to legalize physician-assisted suicide.

As in Canada, legal euthanasia had its impetus in the Netherlands not by a decision of parliament but by a 1984 Supreme Court judgment overruling the criminal code prohibition of the practice. Thus, the Netherlands have had a 31 year head start on Canada, providing Canadians the opportunity to learn from and hopefully avoid their mistakes both in the legislation and the practice of euthanasia.

At the time of the Lalonde bill's debate, I had correspondence with my Liberal MP, Michelle Simson, concerning the bill and Ms. Simson's involvement with the subsequent parliamentary committee on palliative care. In the course of this work, I networked through my physician contacts in the Netherlands to learn more about the Dutch experience of euthanasia, and helped a Dutch professor of biomedical ethics write an open letter to Canadians—and especially to MPs— on the challenges of attempting to contain the practice of euthanasia by legal regulations. *(See Appendix A, "Legislating Euthanasia: Lessons from the Dutch Experience, March 2010".)*

In 2014, I traveled to Rotterdam and Utrecht to learn more and had an hour-long interview with Prof. Theo Boer who was then serving on one of the government-mandated euthanasia review committees.
(See Appendix B for his interview with the British press, "Update on Dutch Euthanasia July 2014")
He and I met again on January 8, 2016 when he was in Toronto at a conference on Biomedical Ethics.
In Canada it is commonly reported that legalization of euthanasia in the Netherlands has resulted in only a small number of people being euthanised, and that the number is not increasing. However, from Prof. Boer and others I have learned that statistics in the Netherlands, some from government agencies, give a very different picture. These statistics show that the "slippery slope" of increasingly widespread euthanasia is indeed happening, although it's taken 20 years to really get going. *(It appears that cultural change happens gradually. For a summation of my personal findings, see Appendix C, " Interpreting the Statistics".)*
If we in Canada don't want our society to follow suit,
we need a fresh and creative approach to regulating legal euthanasia.

SUMMARY OF MY PROPOSAL FOR THE NEW LEGISLATION

1. **Define euthanasia clearly.**

2. **State that euthanasia is *not* health care and that legal euthanasia will be separate from the health care system.**

3. **Create a new class of professional Euthanists with their own training and their own governing body to oversee their work.**

4. **Appoint non-physicians to adjudicate applications for legal euthanasia.**

5. **Consider a requirement that the last step in administration of euthanasia should be by the applicant (i.e., that the deed should be assisted suicide rather than passive, though voluntary, euthanasia).**

6. **Replace the entire Criminal Code provision that forbids assisting suicide with a new Criminal Code provision that forbids euthanasia that has not been authorized through the new protocol created to govern euthanasia.** *(Appendix F shows what such a protocol could look like.)*

7. **In the preamble to the legislation, make it clear what is federal versus provincial jurisdiction on the matter of euthanasia and why you hold this to be so.**

8. **Make sure that the new law will be enforceable.**

The Proposal explains and details each of the above points in order, providing the rationale and addressing possible objections.

THE FULL PROPOSAL FOR THE NEW LEGISLATION

Recommendation #1: Define euthanasia clearly.

Terminology has enormous power both to clarify and to obfuscate. Unfortunately much terminology has entered the debates around euthanasia whose purpose is not to clarify but rather to de-sensitize.
Euthanasia is a term widely understood, and I shall use it throughout this proposal to mean **any deliberate, benignly motivated act whose *purpose* is to shorten or end a person's life.**

My emphasis on "purpose" may seem to many like hair-splitting:
What's the difference between a physician doing something to kill a patient immediately, and something that will result in their death in a week from not drinking fluids?
From the outside these two choices may look little different, but from our inside perspective of our patient's last days, the difference is huge. The difference is in the purpose, and this is inextricably part of our fiduciary relationship with our patient. A physician such as myself doing palliative care may indeed have to weigh the negative side effects on longevity of a treatment necessary for comfort, but our purpose is still not to kill but to care. Our patients must never have to wonder about our purpose in medical care whose intricacies may otherwise bewilder them.

Also, to entertain in our minds an option to kill greatly affects our morale and our will to persevere in caring for difficult cases. Our role with my patient must be personal and caring; the Colleges of Physicians and Surgeons have made that very clear, and so they should. Consistency with that caring relationship requires that we strive always to minimize suffering and to enhance the quality of whatever life remains to them. To kill them violates that relationship. This has been the wisdom of our profession since the days of Hippocrates. It continues to be the position of the World Medical Association and the vast majority of national medical associations and colleges.

Moreover, if you're going to retain a Criminal Code provision against assisting suicide in at least some circumstances, when charges are laid for violation of the provision, a court of law will want to discover the purpose or intent of the deed in order to decide on conviction and sentencing.

I will include in this definition of euthanasia both assisted suicide and also euthanasia administered by someone else with the recipient's desire and consent. (The latter is termed "voluntary euthanasia" in the Netherlands.)
In this proposal, I will restrict my use of the term euthanasia to refer only to cases where the person to be euthanazied desires it and is capable of giving informed consent at the time of the desired euthanasia, since that is the sole context of the Supreme Court's order to Parliament of February 6, 2015 and they made no requirement for Parliament at this stage to consider euthanasia for the cognitively impaired or for those who have issued advance directives that call for euthanasia in future circumstances where they might no longer be mentally competent to give informed consent.

Please eschew euphemisms such as "assisted dying".
When we are considering an issue as profound as putting a living person to death, we need clarity, and therefore clear, mutually understood language. Clarity must not be sacrificed to the desire to cushion with euphemisms the feelings that may arise in people's minds when they contemplate euthanasia.
Particularly regrettable is the term "physician assisted dying" used in the Quebec euthanasia legislation and elsewhere. To the lay public, that sounds a lot like what has always been meant by "palliative care".

Another source of confusion is that although the English word "dying" can refer to the moment of death, it is also commonly used to refer to the last days or weeks of a terminal illness. Therefore, the use of the term "dying" invites confusion.
Moreover, the physician, as envisaged by the Quebec legislation, is not merely "assisting" death; he/she is the one executing death. Death would not otherwise have happened at that juncture had the physician not killed the patient. "Physician administered death" expresses much more clearly what they're talking about. Whether or not we agree with it, surely Canadians need clear language to understand each other when discussing euthanasia together.

Recommendation #2: **State that euthanasia is *not* health care and that legal euthanasia will be separate from the health care system.**

Effective, painless, readily available euthanasia within legislated boundaries can be *BETTER* provided outside the health care system than within it, as my proposal will show.
--But some will say, Surely it has to be part of health care. Are there not extreme cases where a compassionate physician has to resort to euthanasia in order to put an end to suffering?
The decision for death is philosophical, not clinical.
In fact, there are no medical indications for euthanasia.
Proponents of physician-administered euthanasia like to argue that however well palliative care can be done, there will always be extreme cases where euthanasia is necessary to alleviate suffering. They reinforce their position with case histories of horrible suffering in a terminal illness. However, when I as a physician look closely at the cases they cite, I see botched palliative care as the cause of the ongoing suffering, rather than an unmet need for euthanasia. Good palliative care can always relieve suffering, even in if it's necessary (as in some extreme cases) to render the person asleep in order to do so. There is no clinical indication for a physician to kill a his/her patient.
--But some will say, isn't this hair-splitting? In palliative care, physicians already administer drugs for symptom relief that they know will likely shorten their patient's life as a side effect. How is that different from euthanasia?
The difference, and it is vast, is a difference of intent and purpose. The question of purpose is crucial for patients' trust in us and also for our own morale in striving to serve them. See Recommendation #1, par. 2.
--But some will say, surely only physicians know how to do euthanasia effectively and painlessly.
Not so. The knowledge and skill-set needed to kill someone painlessly is remarkably simple. Non-physician professional euthanists could easily be trained to do it effectively and painlessly. Indeed, I have heard that in ancient Rome there was a class of non-physicians doing this work.
(See Recommendation #3 on an alternative suitable for 21st century Canada.)
In summary, there is no reason why Canada needs to use its health care system in order to provide regulated timely, effective, painless euthanasia. There is a better way, which this proposal will show.

FOUR REASONS WHY IT IS VITAL TO ESTABLISH THAT EUTHANASIA WILL BE DISTINCT FROM HEALTH CARE:

A) If euthanasia is practised as part of the health care system it will damage the health care system.

The noted 20th century anthropologist Margaret Mead said that if society ever chooses to get into euthanasia, physicians should be the last ones doing it. I support her contention.

A system wherein euthanasia is carried out by health care workers compromises the trust of weak, conflicted or unsophisticated patients who need to know beyond a shadow of a doubt that whatever their doctors and nurses propose or do to them is *NOT* for the purpose of killing them.
Furthermore, a system wherein euthanasia is carried out by doctors will tend to sap the strength and morale of physicians and other health care workers who need to give their all to suffering patients. Alongside engaging all their mental resources to caring for their patients, they will also have to entertain the countervailing idea of euthanasia, with the implication that rather than caring for their patients, they should be party to killing them. This is like asking doctors and nurses to keep shifting gears between forward and reverse: very hard on the transmission.
LET'S LEARN FROM THE DUTCH EXPERIENCE OF EUTHANASIA IN THE HEALTH CARE SYSTEM. They were the pioneers, and they've been at it for over twenty years, so it behooves us to learn from their experience.
IT APPEARS TO ME AND OTHERS THAT THE PRACTICE OF EUTHANASIA WITHIN THE DUTCH HEALTH CARE SYSTEM HAS IN FACT DAMAGED THE SYSTEM.
See Appendix D "Damage of euthanasia to the Dutch health care system."

B) <u>If you, our legislators, leave to physicians the adjudication of applications for euthanasia, regulation of your system for legal euthanasia will soon become a mess.</u>

But some will say, most applications for euthanasia will be occasioned by the applicants' health problems. Their physicians understand their problems best, so wouldn't they be best able to decide whether the problem is severe enough to warrant euthanasia?
Of course in such cases the input of the applicant's physician(s) is needed in the decision-making on whether to authorize euthanasia.
The issue here is whether the physicians are the <u>best</u> people to make the final legal adjudication on whether to authorize euthanasia in the applicant's case.

WHY PHYSICIANS SHOULD NOT BE THE ADJUDICATORS OF EUTHANASIA APPLICATIONS:

When I as a physician read the vague and subjective language of the Supreme Court of Canada's (SCC's) decision, I must ask just <u>how</u> "grievous" does an irremediable condition have to be to qualify for euthanasia? Just <u>how</u> "intolerable" does suffering have to be to qualify? Only the patient can tell us.
The result, in effect, would be euthanasia on demand, limited only by the very variable, subjective, and personal resistance of individual physicians to approve such requests. "Doctor-shopping" will surely result, whereby an applicant for euthanasia who's turned down by the first doctor they approach, will just keep on trying others till they find one who agrees with them. *I've read that in Oregon, where assisted suicide is legal in some circumstances, one of the euthanasia advocacy groups maintains a list of euthanasia-friendly doctors in order to help such doctor-shopping.*
Legislative models such as in The Netherlands that place us physicians in the role of adjudicators have the effect of simply placing our subjectivity alongside our patients' subjectivity, with the result that our decisions are inconsistent and appear arbitrary, breeding disrespect for the law (as ineffectual) and protests over perceived inequality of access to the "service".
For a Canadian example of this dynamic, recall why the Supreme Court eventually disqualified the system of Therapeutic Abortion Committees. The various local committees varied hugely in how they adjudicated requests, so that no one could take the system seriously anymore. With respect to euthanasia, the same problem has arisen in the Dutch and Belgian systems.

If lawmakers want to put any restrictions at all on euthanasia, the adjudicators of applications for it need very <u>clear</u> and <u>objective</u> criteria by which to judge applications. <u>This type of assessment and judgement is quite different from clinical decision making for which we physicians are trained</u>. <u>Rather, it's legal decision</u>

making, for which we have no more training or experience than anyone else in society outside the legal profession.

Others have shared my concern on this question of physicians as adjudicators of euthanasia applications, including the British House of Lords and a United Nations Committee on Human Rights. To quote from Prof. Jochemsen in Appendix A, " In 2009 the Human Rights Committee of the United Nations Covenant on Civil and Political Rights investigated Dutch euthanasia practice and expressed concern "at the extent of euthanasia and assisted suicides.....a physician can terminate a patient's life without any independent review by a judge or magistrate to guarantee that this decision was not the subject of undue influence or misapprehension." Evidently, the Committee didn't trust our aptitude as physicians for this task nor should they, I think.

More recently, I read on a pro-euthanasia web site that when the House of Lords was debating Lord Falconer's bill in 2014 to legalize physician-assisted suicide, an amendment was proposed and passed unanimously transferring the responsibility for this decision making from physicians to magistrates.

IS THERE AN ALTERNATIVE TO PHYSICIANS ADJUDICATING EUTHANASIA APPLICATIONS?

Yes. See Recommendation #4 on an alternative means of adjudication which I believe would be much more efficient and consistent, and therefore be much more likely to gain society's acceptance and perhaps even respect.

Appendix E shows how non-physicians appointed to the task of adjudication can do the job better than physicians would, while still benefiting from full physician input concerning the applicant's case.

C) You will be designing a new protocol for both the practice and regulation of euthanasia outside the health care system, and in effect forbidding euthanasia within the health care system.

(Euthanasia within the health care system will in effect be forbidden because the Criminal Code revision will forbid euthanasia outside your new protocol. See Recommendation 6 and Appendix F, A Legislated Protocol.)

Such an approach can only make sense if euthanasia is not health care.

In this contention, you have the backing of the World Medical Association, and the vast majority of national medical bodies world-wide. The Canadian Medical Association is deeply divided on the issue, but as a member of the CMA it seems to me that the reason that half our members support legal euthanasia by physicians is because it's never occurred to them that anyone other than physicians could do it. When it comes to actually doing it, the CMA's own most recent survey shows that only about 20% of our members would actually be willing to do it. I think that even that number would shrink with a great sigh of relief if it were seen that euthanasia is available to Canadians without our profession needing to get involved. We feel deeply its dissonance with our clinical care.

D) Euthanasia must be solely under the control of the federal government, not the provinces,

if this or any other proposal for legal euthanasia is to work effectively, justly, and dependably.

HERE ARE THREE REASONS WHY:

1. OTHERWISE THE FEDERAL GOVERNMENT WILL PROVE IMPOTENT TO AFFECT THE PRACTICE OF EUTHANASIA IN THIS COUNTRY.

-- If euthanasia is health care, the provinces will be in charge because health care is their jurisdiction under the *(now)* Constitution Act. Should we imagine that you the federal legislators can construct a workable system together with the provinces? Quebec is clearly in no mood to share power on this issue. Ontario and probably some others also seem enthusiastic to get involved. The Federal government will need to stand up to them.

-- If euthanasia is health care, then whatever you do federally will end up functioning as a mere fig leaf for whatever the provinces decide to do, and whatever you do with the Criminal Code will be enforceable only at the provinces' pleasure. For example, see how the federal government was impotent to restrain the Quebec government's euthanasia legislation even though it clearly violated the Criminal Code of Canada.

(See more on this issue in Recommendation #7on federal / provincial jurisdiction, and in Recommendation #8 on making the new law enforceable.)

2. THE PROVINCES HAVE SHOWN THEMSELVES INCOMPETENT TO INTEGRATE THE CRIMINAL CODE WITH THE PRACTICE OF LEGAL EUTHANASIA.

   We should not be surprised at this, because the Code was never part of their constitutional mandate or legislative activity. Criminal Code legislation is "off their radar". They have no experience with it and so don't show any evidence of having thought about it. The Quebec legislation is especially egregious in this regard.

   If we in Canada are still to deem counseling and assisting suicide as criminal in some circumstances, we cannot leave euthanasia legislation to the provinces.

3. YOU WILL BE DOING THE PROVINCES A FAVOUR BY RELIEVING THEM OF A MAJOR CONFLICT OF INTEREST IN THEIR ROLE AS HEALTH CARE PROVIDERS.

   Throughout our political and legal systems, it is a standard principle that we must be alert to and prevent conflict of interest, in order that our corporate activities be both just and <u>also seen as just</u>. Rules against conflict of interest are necessary not because we think each other would be crooks without them, but because conflict of interest represents an insidious bias that can trip up the best of us.

   The provincial governments have a very serious conflict of interest in the matter of euthanasia. To anyone who checks costs, it is clear that euthanasia is far cheaper than either palliative or long-term care. Health care costs continue to rise and provincial governments are understandably desperate to contain them. They deny that such considerations affect their thinking on euthanasia, and I suppose we must give them the benefit of the doubt on their conscious intentions. Nevertheless there's a huge built-in bias here. For their own credibility they deserve to be relieved of this conflict of interest. In any case, for the sake of the vulnerable we <u>must</u> relieve them of it by handing euthanasia over to the federal government.

My proposal will show that non-physicians can practice quality euthanasia just as well as physicians can, and non-physicians with some legal background can adjudicate applications for euthanasia better and much more equitably than physicians would, so <u>there is no need to involve the health care system</u> in order to have effective, well-regulated legal euthanasia in Canada.

Recommendation #3: **Create a new class of professional euthanists, with their own training and their own governing body to oversee their work.**

Euthanists may facilitate applications for legally authorized suicide assistance, but should not be the adjudicators of these applications. This would be done by the newly appointed Adjudicators. *(See Recommendation #4.)*

Individual physicians may apply, if they wish, to become licensed euthanists. *(I don't like this, but I don't see politically how it can be forbidden.)* However, because this activity is not health care and is thus distinct and separate from their medical work; they should be prohibited from performing euthanasia on their own patients.

I think it would be best if regulation of the euthanists were directly administered nationwide by the federal government (the activity is not health care, after all). This would ensure equality of access to euthanasia nation-wide. It would also prevent complications from so-called suicide tourism, such as has developed in Switzerland and which the Quebec euthanasia legislation seeks to prevent.

Where would the euthanists obtain the lethal substances necessary for their work?

The best way to put a person to death painlessly is by a drug overdose, and only drug companies manufacture the drugs that the euthanists would use. Since their activity is not health care, they should be supplied with these drugs through the Ministry of Justice. This function could conveniently be seconded to Health Canada's Drugs Special Access Program. (See http://www.hc-sc.gc.ca/dhp-mps/acces/drugs-drogues/index-eng.php).

WOULD THE SUPREME COURT BE SATISFIED WITH THIS PROVISION?

Some have pointed out that their judgement spoke only of physicians doing the deed.

Therefore, if we design a euthanasia system where the administrators of the lethal substance are a new class of professional euthanists rather than physicians, would that satisfy the SCC?

Hopefully they would be satisfied. Their February 6, 2015 decision addressed the complaint of a plaintiff who wanted to obtain help from a physician to end her life, so of course their judgement talked about physicians doing it. But wasn't their underlying concern that she should be able to obtain effective and painless euthanasia without impediment? If so, what objection would they have if your new legislation provided for this more effectively and enforceably by the agency of non-physicians?

I see nothing in their judgment to suggest that they had reason to consider this alternative for the purpose of addressing the complaint; therefore we should not assume that they will react to it negatively.

Recommendation #4: **Appoint non-physicians to adjudicate applications for legal euthanasia.**

WHO THE ADJUDICATORS SHOULD BE*:*

The adjudicators of applications for suicide assistance under the new protocol should be appointees of the federal government. To be objective, they must have no direct interest or prior involvement in the individual cases coming before them, and they need to have some legal training. (Legal decision-making is quite different from clinical decision -making). They could be magistrates, or they could be other people with the aforesaid qualifications. If they are not already members of a body of such people (e.g., magistrates), then they should be vetted and appointed specifically to the role of euthanasia adjudicator through the appropriate federal ministry (e.g. Justice -- NOT the Ministry of Health).

Recommendation #5: Consider a requirement that the last step in administration of euthanasia should be by the applicant (i.e., that the deed should be assisted suicide rather than passive, though voluntary, euthanasia).

The State of Oregon made this a requirement in their 1994 euthanasia legislation, and their subsequent experience suggests that this may have had an inhibitory effect on the spread of euthanasia in that state. (Dutch and Belgian legislation makes no such requirement.)

Practically speaking this means, for example, that the euthanist hands the applicant the deadly pills plus a glass of water, but it's up to the latter to actually put these in the mouth and swallow them. If the lethal substance is to be injected intravenously, the euthanist sets everything up, but the applicant turns on the stopcock that allows the lethal substance to flow into their vein and put them to death.

If the applicant is physically unable to do this, the euthanist must wait for the applicant to say or signal, "I want to die; go ahead." The thought is that this requirement brings home to the applicant the reality of what is about to happen in way that had not hitherto fully sunk into their thinking, and they therefore may delay or reverse their previously stated request.

Recommendation #6: **Replace the entire Criminal Code provision that forbids assisting suicide with a new Criminal Code provision that forbids euthanasia that has not been authorized through the new protocol created to govern euthanasia. The Criminal Code should also forbid counseling to commit suicide outside the bounds of the euthanasia legislation.**

Rather than trying to specify the situations in which you would approve euthanasia, specify the situations in which you intend to prevent it. I think the question of enforceability should guide you in deciding on which situations of euthanasia you will seek to prevent with the new legislation. (*See Recommendation #8 "THREE TYPES OF CASES" on this question.)*

A well-designed protocol can be clear, efficient, enforceable, and also effective in preventing euthanasia in cases where you the legislators want to prevent it. *(See Appendix F for an example of how the new protocol for processing applications for legal euthanasia might look.)*

Given the gravity of putting a human being to death, or of being party to that deed by assisting their suicide, a lengthy prison term is the appropriate penalty for violating this provision of the Criminal Code . This is also necessary in order to have any deterrent effect.

Recommendation #7: **In the preamble to the legislation, make it clear what is federal versus provincial jurisdiction on the matter of euthanasia and why.**

Canada is unique in that it will be the first federal country to legislate euthanasia. If you let the provincial governments into this activity, you will open the door to confusion and bickering in and out of court between the federal and provincial governments, each with a different protocol for the practice of euthanasia. This will enormously complicate enforcement of any Criminal Code restrictions on euthanasia created in the new legislation. (Am I right in understanding that in Ontario and Quebec the enforcement of the Criminal Code depends on their provincial police forces? This will already present a challenge for enforcement of new Criminal Code provisions; how much more so if it is provincial legislation that determines eligibility for euthanasia?)

In Recommendation #2 I've laid out several reasons why euthanasia should NOT be regarded as a form of health care. If euthanasia were understood to be health care, then clearly this would be a provincial prerogative which is what the Quebec and perhaps other provincial governments want. However, if it is not health care, it is not immediately clear which level of government would have the prerogative. The (now)

Constitution Act's division of powers provides no clear direction because its framers never imagined government would become involved in euthanasia. However, if euthanasia is defined as *not* being health care, then there is a strong case that it should be a federal responsibility, as follows:

1) The (now) *Constitution Act* stipulates that residual (including unspecified) powers belong to the federal government.
2) Where the Act does countenance the legal killing of people (as in warfare or the execution of criminals), it is the federal government's unique prerogative to define who should or should not die.

(Yes, euthanasia does necessarily involve killing a person. "Killing" doesn't sound nice, so some will object to the word's use here, but we do need clarity about such an important matter. If we check the dictionary definition of 'killing', we see that euthanasia qualifies.)

<u>Recommendation #8</u>: **Make sure that the new law will be enforceable.**

Some questions to be considered that pertain to enforceability are:

-- Could a new Criminal Code provision such as the Supreme Court has demanded, permitting euthanasia in some cases while prohibiting it in others, turn out to be unenforceable? Would juries convict for violations of it? See below, THREE TYPES OF CASES.

-- Would the Supreme Court uphold the new law in the face of future human rights challenges that are certain to occur, supported by very well-funded euthanasia advocacy groups? See below, THREE TYPES OF CASES. The first two represent infringements on the applicant's right to life, and the third on the right of others to protection from harm.

-- Would prosecution occur in Ontario and Quebec where investigation and prosecution depend on the provincial governments? See below, ISSUES OF PROVINCIAL ENFORCEMENT.

To make a law that cannot effectively be enforced would prove counterproductive to the goal of legislating regulated euthanasia. Better no law at all than an unenforceable one? Recall how juries refused to convict Dr. Henry Morgenthaler for violating the abortion law. Because of this and the Supreme Court's disqualifying the Therapeutic Abortion Committee system, Canada now has no law restricting abortion at all, and in this we are unique among industrialized countries. I think this has come about because the original crafting of the liberalized abortion law was naive. If we're not careful to construct a law that will be enforceable in the long term, we risk stumbling into a culture of euthanasia-on-demand. Do we want that?

If Canada follows the Dutch or Belgian models of euthanasia legislation, we are likely to see very few circumstances of suicide assistance where juries would convict and the courts would uphold the new law. (The jury system, I believe, is unique to jurisdictions drawing on the British legal tradition. This system was established centuries ago in order to enhance protection for the accused. Yet even in other countries such as the Netherlands where convictions are made only by judges, convictions aren't happening. As Prof. Jochemsen has warned: "The more the practice spreads, the less political motivation there seems to be to contain it. Prosecutors are reluctant to prosecute and the courts are reluctant to convict." How much more problematical will it then be for us to obtain convictions by juries of violation of the new euthanasia law?) All the above notwithstanding, I do think there still are some circumstances where the courts would uphold the new law against human rights challenges (which will certainly arise whatever you do), and where juries would be willing to convict. Here they are:

THREE TYPES OF CASES

where juries might still convict and where courts might still uphold the law in the face of Human Rights challenges to it:

1) <u>Cases where the euthanasia adjudicator might have a reasonable concern that if the applicants were refused euthanasia, they might later change their minds about life, and be glad that they had not died:</u> In such cases, the protocol might be seen as actually saving lives that should be saved.

Examples:

a. The depressed person who has just suffered a major loss -- lost their job, spouse filed for divorce, the initial shock on learning of terminal cancer diagnosis or of quadriplegia after an accident, etc. Awful as their quality of life is at the moment, people can and do get over these crises with help. (To illustrate, a quadriplegic speaker on this topic quoted a survey of quadriplegics in which 90% said 'Yes' to the question, 'Are you glad to be alive?')
b. Immaturity: the youth who wants to die because her boyfriend has left her for someone else while all her acquaintances laugh at her.
c. The depressed person who has not received all the help his family and society can offer for his despair, either being unaware of the help's availability or having been deprived by his illness of the mental energy to reach out for help. As a physician, society has accorded me the power to send a depressed suicidal patient into police custody to be taken to a hospital for immediate psychiatric care in the hope that having recovered they'll be glad we intervened. (I recall one such patient after whom I had to send the police, and a long time afterward came back to thank me for it with a big bouquet of flowers.)
d. The ambivalent or conflicted person in whom a desire to die and a desire to live co-exist. Later on, they may settle into a clear decision one way or the other, for death or for life.
   If that future clear decision turns out to be for death, they will be able to obtain legal assistance at that time and get their final clear wish.
   If, on the other hand, that future clear decision turns out to be for life, they will only have that option because their initial application for euthanasia was refused. The law will have saved their life and they may indeed be grateful for that.

2) <u>Cases where undue outside influence on the applicant's request for suicide assistance might be at work</u>:
Examples:

a. A family over-eager to get their inheritance was found to be persuading mother to ask for euthanasia.
b. Cases of a mentally incompetent applicant whose application was facilitated by others "for their own good" and there is no particular reason to assume they'd want euthanasia under the present circumstances (e.g. they had never written any advance directive for euthanasia signed when they were competent).

3) <u>Cases where others would suffer from the applicant's death:</u>
Examples:

a. Children of the applicant. The loss of a parent by whatever means is suffering for the bereaved at any age. It tends to be worse and with longer term consequences the younger the ones are who are bereft. It's even worse if the cause of death is suicide. Suicide is a choice and any choice gives a message when made in the context of a relationship. Those who counsel bereft children will testify that a common is the child's sense that Mummy or Daddy has abandoned them. The counselors response is to say, No, Mummy was taken from you against her will by her illness; she loved you and really wanted to stay with you. It's much harder to reassure the child when the parent chose suicide, which is necessarily a choice involving abandonment of the child.
b. Although the choice of the parent to leave the relationship by suicide has less potential to devastate adult offspring, it still wounds, and has great potential to raise guilt feelings: "If only we had visited Dad more often." "We loved him; did he not know that?" "If only we had known that he was feeling this badly." Such issues can haunt a person for years after.

ISSUES OF PROVINCIAL ENFORCEMENT:

If I understand correctly, although investigation and the laying of charges for violation of the new Criminal Code provision (forbidding euthanasia not approved by an official Adjudicator under the legislated euthanasia application protocol) in most of Canada depends on the federally directed RCMP , in Ontario and Quebec we would be depending on the provincial police forces. Their efforts may turn out to be lax if their provincial governments are in fact hostile to the new law. The Quebec government, in particular, may take it ill in that it disqualifies their own new euthanasia law. Moreover, in every province, prosecution and trial of violations of the Criminal Code depends ultimately on the provincial attorneys-general. Their zeal to ensure that this happens cannot be assumed. (Recall Prof. Jochemsen's rueful observation that "the more the practice spreads the less political motivation there seems to be to contain it. Prosecutors are reluctant to prosecute and the courts are reluctant to convict.")

Therefore***, political work by the federal government will be needed at some point soon to win the provincial governments' support of the new legislation and ensure that they will do more than pay lip service to enforce it.***