TERMINAL CARE, TERMINAL JUSTICE: THE SUPREME COURT OF CANADA AND SUE RODRIGUEZ

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On February 12, 1994, Sue Rodriguez ended her life. According to her friend and supporter, M.P. Svend Robinson, who was present at her death, she was assisted by an anonymous physician who attended at her home and helped her accomplish the manner of death she had publicly declared she wanted. She controlled — to the extent that someone with a relentless, intractable condition could — the circumstances, timing and manner of her death. Sue Rodriguez achieved in her death what she could not persuade the Supreme Court of Canada to do during her lifetime. By placing the manner of her death on the public record, she forcefully demonstrated that death is indeed part of life. Bearing witness to her own cause, she preserved the power to take an initiative with her life by determining the time and manner of her death.

In the case of *Rodriguez v. British Columbia,*[1] Sue Rodriguez, a 42 year old woman suffering from amyotrophic lateral sclerosis (ALS), an untreatable intractable neurological disorder, asked the court to find that section 241(b) of the *Criminal Code* violated her individual rights under the *Charter*. That provision of the Code makes it an indictable offence to aid or abet a person to commit suicide, whether suicide ensues or not. In particular, Sue Rodriguez argued that, while she would prefer to continue to live as long as she still has the capacity to enjoy life, she was suffering from an incurable disease, understood the inevitability of how her life would end, and wished to control the circumstances, timing and manner of her death. However, she argued, by the time that she is no longer able to enjoy life, she will be physically unable to terminate her life without the assistance of a physician. Such assistance would constitute a violation of the *Criminal Code*, which prohibits the assistance of suicide. This result, she maintained, deprived her of her rights to live her remaining life with the inherent dignity of a human person, the right to control what happens to her body while she is living, and the right to be free from governmental interference in making fundamental personal decisions concerning the terminal stages of her life (531). In a five to four decision, the majority of the Court upheld the constitutionality of the *Criminal Code* provision with the result that Ms. Rodriguez could not legally engage in a physician-assisted suicide.

The Supreme Court of Canada judgment does not inquire deeply into the circumstances of Sue Rodriguez, and contains little information about her. In one brief passage, it contains a description of her condition:

> Sue Rodriguez is a 42-year-old ... mother of an 8 1/2-year old son. [She] suffers from amyotrophic lateral sclerosis ...; her life expectance is between 2 and 14 months but her condition is rapidly deteriorating. Very soon she will lose the ability to swallow, speak, walk and move her body without assistance. Thereafter she will lose the capacity to breathe without a respirator, to eat without a gastrotomy and will eventually be confined to a bed.
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> Ms. Rodriguez knows of her condition, the trajectory of her illness and the inevitability of how her life will end ... (530-31).

In the majority opinion, Sopinka J. refers to Sue Rodriguez by name only once, whereas McLachlin J. and Lamer C.J., respectively, refer to her by name no fewer than fifteen times. Cory J., in the course of a concurring opinion of only two pages, does so four times (four times more than the majority judgement which is fifteen times longer). These figures are symbolic of the manner in which the Justices looked at the circumstances of her case. The majority was preoccupied with abstract principles, not Sue Rodriguez, yet, the dissenters also failed to compose decisions appropriate to the circumstances of the terminally ill.

The judgement is carefully crafted, engaging at the level of legal principle rather than considering the life of Sue Rodriguez. Writing for the majority, Sopinka J. based his opinion on arguments concerning the state's interest in preserving the "sanctity of life". This line of argument led the court to inquire into the meaning of life, and, in the opinion

of Sopinka J., to decline to second-guess the legislators' prerogative to protect life by prohibiting anyone to assist in a suicide. Basing his opinion entirely on section 7 of the *Charter*, Sopinka J. engaged in a two-stage analysis: he acknowledged in the first place that section 241 (b) impinged on the security interest of Sue Rodriguez in controlling the timing and manner of her death, but argued in the second place that the resulting deprivation was not contrary to the principles of fundamental justice (584). Sopinka J. found the notion of the 'sanctity of life' to have a double aspect in section 7: first, as one of the three values protected by section 7 (life, liberty and security of the person), and then again as an aspect of the principles of fundamental justice with respect to "the state interest in protecting life" (595). The opinion makes no effort to reconcile what appears to be a contradictory usage of "sanctity of life" with respect to the same section of the Charter — first, as an individual right to life and, second, as a societal or state interest which may be employed to temper or restrict individual rights.

Overlooked by the majority of the Court was the important question concerning the substantive nature of the life protected by section 7. Writing in dissent, both McLachlin J. and Cory J. saw death as an integral component of life and therefore, the right to die with dignity as an essential component of the right to life. Relying on the judgement of McEachern C.J.B.C., who held that Sue Rodriguez was seeking to die with dignity, Lamer C.J. substantially agreed with this interpretation.

At the heart of the issues covered by the Rodriguez case is an argument about the relationship of embodiment to agency. By agency we mean the capacity to act as well as the legal autonomy or liberty to make choices to act. While no-one would seriously take issue with the notion that embodiment is essential to personhood and therefore a necessary condition for rational agency, the operative issue in the Rodriguez case is whether rational agency may be employed against one's own embodied existence through the action of another.[2] Sue Rodriguez required medical assistance in order to maintain the dignity of her life by enabling her to have some autonomy over the timing and manner of her death. The "fierce will" which many observers detected in Sue Rodriguez centred on her determination to have some control over her life in a body which progressively slipped out of the control of her mind. Choosing the time and manner of her death would be the final effort to exercise control over her body even though this would require her to seek the assistance of a physician as her agent. To deny her that right would guarantee that she would be deprived of agency not just within her own body as a consequence of a progressive, degenerative disease, but also over her body through communicating her desires to others. To Sue Rodriguez and others like her, it is precisely the circumstances of her own embodiment which led her to exercise a choice to end her embodied existence.

Sopinka J. chose to regard capacity to act as a "quality of life" issue, and noted the expansive interpretation of palliative care in medical jurisprudence as an adequate guarantee of patient autonomy in exercising choice regarding end-of-life decisions. The fact that Sue Rodriguez chose not to avail herself of the option to shorten her life by choosing palliative care over life-prolonging medical procedures and technologies proves that this was not the issue for her. Rather, it was precisely her own autonomy and agency as the essential attributes of her own personhood that were at issue. She wanted to prove with her death not just her abhorrence of dependency, but her capacity to act. To die while still capable of organizing and communicating her choices was the only reason why she would choose to put the circumstances of her death on the public record. Instead of negating societal values, Sue Rodriguez reaffirmed the supreme value attached to agency in our society — not just the liberty to act, but the value of action.

Sue Rodriguez regarded her body as her own property, and by implication as an instrument of her will. When it was no longer capable of performing as that instrumentality, she wanted to end her life. As she put it: "Whose body is this? Who owns my life?" Her attitude was, therefore, symptomatic of the ways in which embodiment is viewed in our culture. By looking at her own body as property, she reflects the way in which the liberal emphasis on rational agency — the essence of liberty — transforms embodied existence into the object of will. Her language presupposes a division of the self between will and embodiment. For her, physician-assisted death was a way to impose reason's authority over her increasingly recalcitrant body. It was the final restoration of the norms of our society. The nature of Sue Rodriguez' disease was such that her life could continue beyond the point at which she was capable of communicating her choices to others. Her body would literally entomb her, rather than enable her to act. Possibly she could learn to communicate by using less physically demanding means, but there was no question that her capacity to act and, eventually, her capacity even to communicate her will was rapidly diminishing.

A concern with events and actions pervades the reasoning of the Court. The majority wished to draw an absolute distinction between actions deliberately intended to bring about death and those which "passively" allow death to take its "natural" course (605-6). The majority cited the Law Reform Commission of Canada approvingly: "In the case of assisted suicide or euthanasia, however, the course of nature is interrupted, and death results directly from the human action

taken" (606). What the Court failed to note, is that to find that life may be prolonged "unnaturally" begs the question of what 'life' is.

Instead, the majority fell back on a familiar species of rational agency, "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" (607). This distinction conveniently erases Sue Rodriguez, who surely had no intention of dying or causing her own death before she was afflicted with ALS. In her case, pain was not the cause of the impairment of her body's functioning, but in fact ensued only once the body was at the very boundary of sustaining life. Palliative care, therefore, could only begin once this threshold was reached, an option which Sue Rodriguez was adamantly against.

All of the dissenters focused their arguments on maintaining the agency of Sue Rodriguez. McLachlin J. stated plainly:

> ... what value is there in life without the choice to do what one wants with one's life ... One's life includes one's death. Different people hold different views on life and on what devalues it. For some the choice to end one's life with dignity is infinitely preferable to the inevitable pain and diminishment of a long, slow, decline. Section 7 protects that choice against arbitrary state action which would remove it (624).

Curiously, McLachlin J. makes an equality-like argument by reference to the principles of fundamental justice in section 7, arguing that the restriction on that right by virtue of her disability, or by reference to other vulnerable individuals who may suffer death by influence or coercion, is arbitrary and does not meet the test of conformity with the principles of fundamental justice. While Mclachlin J. used section 7 to make an equality argument, Lamer C.J. chose to base his opinion on the basis of the equality provisions of section 15(1). Implicit in his analysis is the idea touched on explicitly by McLachlin J., that autonomy is an essential attribute of life and it is this attribute which should be protected through the equality provisions of section 15. Lamer C. J. does this by relying on the dissenting opinion of McEachern C.J.B.C. in the court below:

> I have no doubt that a terminally ill person facing what the Appellant faces, qualifies under the value system upon which the Charter is based to protection under the rubric of either liberty or security of the person. This would include at least the lawful right of a terminally ill person to terminate her own life, and in my view, to assistance under the proper circumstances.
>
> It would be wrong, in my view, to judge this case as a contest between life and death. The Charter is not concerned only with the fact of life, but also with the quality and dignity of life. In my view, death and the way we die is part of life itself (536).

Lamer C.J. affirmed that section 241 (b) of the *Criminal Code* breaches the equality provisions of section 15 by denying the possibility of assisted suicide to a disabled person, when it would be lawful for an individual to commit suicide on their own. It seems Lamer C.J. resorts to section 15 out of a concern *not* to read into section 7 a *right* to suicide. Thus, he concentrated on the discriminatory effect of the legislation based on the personal characteristic of disability. Lamer C.J. followed McEachern C.J.B.C. in seeking a remedy specifically tailored to the circumstances of Sue Rodriguez. These circumstances, which are not easily generalizable, include not only terminal illness compounded by physical disability, but also mental competence and psychic good health.

Constitutional litigation is a blunt instrument. Through it, courts may elucidate general abstract principles and strike down legislation which offends these principles, but it is not especially well-suited to offer particular remedies for specific circumstances. In this case, the majority preferred to erase the particular circumstances of Sue Rodriguez in order to defer to the will of the legislators in protecting "the sanctity of life." Lamer C.J. opted for the unusual expedient of tailoring an exception for Ms. Rodriguez which could later be codified in legislation. The procedures, initially laid down by McEachern C.J.B.C., included the requirement of an application to a court, a coroner-monitored psychiatric examination, and a certification which would be time-limited. In so doing, Lamer C.J. recognized the potential for abuse which would have resulted had section 241(b) been struck down and assisted suicide decriminalized.

This case testifies to the limitations of legal reasoning, particularly legal reasoning which is framed in dichotomous terms. Most of the discussion focused on the problem of agency of the "patient," Sue Rodriguez, and very little on the agency of the attending physician, the one who might be called upon to assist in the death of Ms. Rodriguez and would be liable to criminal sanction under the terms of the *Criminal Code*. (One legitimate concern of the majority was that the decriminalization of assisted suicide might give rise to a "macabre specialty" personified in Dr. Kevorkian.) This latter effect appears to be the result of detaching legal principles from the actual contexts of decision-making, between physician and patient, between the patient and her intimate circle of family and friends. But are there not grounds for questioning the dichotomies in this case?

FIGURE 1

Dichotomous Concepts in the Rodriguez Case

universal abstract principle	⟺	contextual decision-making
mind	⟺	body
public	⟺	private
society	⟺	individual
self	⟺	other
passive	⟺	active
death	⟺	suicide

Each of these sets of polar opposites in Figure 1 were engaged by this case. The first, contextual decision-making versus universal principles was endorsed by the legalization of the end of life decisions of Sue Rodriguez. The second, mind and body, by the very idea of agency which Rodriguez sought over her own body and which different Justices read as intrinsic or extrinsic to the value of life. The public and private dichotomy was engaged by the whole circumstance of Sue Rodriguez's death as well as the Court decision which framed it. The juxtaposition of individual and society was central to the opinion of the majority which denied Rodriguez the right to assisted suicide which the dissenting judges would have granted. The self and other dichotomy was implicated by the two concepts of agency engaged in this case: the agency of the doctor assisting the death of another and the agency of the patient in seeking an end to her own life. The distinction drawn between active and passive euthanasia, and that made between death and suicide are both distinctions which grow problematic as technology increasingly plays a role in the extension of life. If instead of reading these as opposing principles that courts must choose between but, rather, as different points engaged by end of life decisions, the polarization of the argument surrounding assisted suicide would be permitted to find its appropriate context in the complex of decisions attendant on the end of life process of a terminally ill person. After all, it is an artificial distinction in this case to speak of death as a single irrevocable event, when it is part of a known process whose end is foreseeable and irrevocable. It is this context which was disregarded by the majority in their appeal to abstract principles. The public, with the outpouring of sympathy which surrounded the death of Sue Rodriguez, implicitly recognized this.

The care of the terminally ill tends to blur the boundaries between the opposing principles outlined above. Madam Justice McLachlin pointed out in her opinion the ways in which even the principle of the "sanctity of life" is not as consistent or as clear cut as the majority implied. For example, homicide may on occasion be justifiable; likewise, determining what constitutes "suicide" requires a social context. Acts of courage or self-sacrifice, such as the heroic action of a fire fighter rushing into a burning building, is not considered suicide. Therefore, suicide is a social construct which is often loaded with pejorative meaning and interpreted as irrational. Such was not the reaction attendant on the death of Sue Rodriguez. Indeed, her death could be interpreted as the defence of a certain kind of rationality, as a final act of autonomy in the face of the failing circumstances of her embodiment.

One attempt at a feminist re-reading of the issue of physician-assisted suicide concentrates on a re-working of language and context. Leslie Bender argues that a focus on physician care of the dying would at least help avoid the sharp dichotomization of "death" and "suicide."[3] It is her hope that by moving to a care-based paradigm of medical ethics and eschewing abstract dichotomous principles, the substance of normative discourse in medical ethics and law could be changed.[4] By attending to the particularized needs of patients and the intimate context in which the patient arrives at decisions, physicians may allow the patient to act for herself. In the particular circumstances of the Rodriguez case, however, even the dissenting judgement in the British Columbia Court of Appeal specifically rejected the prospect of including physician-assisted death under the rubric of palliative care:

> McEachern C.J. rejected the appellant's contention that reasonable management of terminal illness does not engage the common law, stating that physician-assisted suicide could not be considered palliative care. According to McEachern C.J., the only route open to Ms. Rodriguez was under the Charter (536).

Charter principles already having been engaged, the only route open was to construct a remedy which would not overly compromise the waning autonomy of dying patients. Ironically, the elaborate process prescribed by McEachern C.J.B.C. and endorsed by Lamer C.J. would bring the state into the decision-making process. The state would oversee the entire end of life process, from certifying that the patient had a terminal disease to assessing the patient's mental competence. Under these procedures, every aspect of physician-assisted dying would become a public act.

Rather than gloss over the fact that active intervention at the end of life affects an extremely vulnerable population, few of whom share Ms. Rodriguez's mental and social resources, we must instead confront this fact. There are clear dangers in

looking at the Rodriguez case as a paradigmatic case of assisted suicide. Dr. Kevorkian is a retired pathologist, without experience caring for terminally ill patients. He got to know his first suicide patient at the time he was preparing to aid her in her death. Suicide was not just one among a number of options of the patient he was "caring" for, but the only one. The "caring" role was limited to suicide. In another case, Ann Humphry, the former wife of Derek Humphry, author of *Final Exit*, was suffering from terminal breast cancer. She announced that she would opt for suicide rather than cause him or her to suffer the final stages of disease. He responded with complete and unhesitating agreement rather than reassure her that she could never be a burden to him and that he wanted to be with her as long as she wanted to stay alive. She felt abandoned.[5] The question, therefore, is not whether vulnerable populations exist rather, the question is whether criminalizing assisted suicide is the best way to approach the problem of vulnerability. Here, the problem is whether existing laws make it more likely rather than less likely for macabre specialists like Kevorkian to emerge, and whether the laws currently existing actively discourage physicians from providing appropriate care at the request of dying patients. The bias of the discussion in the *Rodriguez* case was on dying as a single event, rather than as a prolonged process punctuated by a definable ending. This perception was aided by Rodriguez herself, who focused attention on this single, final, event. Yet, if we return to the question of the relationship of agency and embodiment, this focus is also an artifact of a particular conception of life.

The case of Dr. Quill and Diane illustrates a rather different aspect of assisted death.[6] Diane was a patient who had decided against continued chemotherapy for the treatment of leukaemia. When she asked about help in dying, Dr. Quill directed her to the Hemlock Society. She asked for and was given a prescription for barbiturates to aid in sleeping. Some months later she called her doctor and friends to say goodbye and asked her husband and son to leave her alone for an hour while she died peacefully in her couch at home. When the case against Dr. Quill was presented to a grand jury, they refused to return an indictment.[7]

Oddly enough, in a case where the role of agency played such a large part, the court in *Rodriguez* inquired very little into the role of the physicians who were to be the agents of the patient in hastening death. Implicitly, the court seemed to accept the notion that the physician was the mere "agent" or instrumentality of the appellant. Peter Ubel notes that the idea that physicians should not assist in suicide is grounded in the Hippocratic Oath: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."[8] However, he points out that this socially constructed conception of the physician's role only as healer can legitimately be interrogated. The rational patient's goal in consulting the physician may not always be to restore health — "many times this is impossible." "Health" is broad enough to include easing pain and relief of suffering among the proper goals of medicine. As Ubel suggests, "[t]he proper way to deal with patient suffering, and the role the medical profession should have in dealing with it, are not *a priori* truths inseparable from the nature of medical practice ... professions as socially constructed occupational roles, do not seem to fit such a prior analysis."[9]

If dying were seen more generally as a part of life and as part of a prolonged process which is intrinsic to embodiment, then, there may be less likelihood that life will be valued only in terms of will and agency. Moreover, greater attention to the intimate context of dying would distinguish medically-assisted dying from the more pejorative connotations of suicide. Instead of a sharp focus on the agency of the dying patient or the agency of the individual physician attending the dying patient, the focus should be more generally on the social context of the dying patient. The meaning of assisted death then would be transformed. If, as in the Diane and Rodriguez cases, dying were accepted as a process which connects one to one's own intimate social network, it would negate the usual connotations of suicide, with their implications of isolation from loved ones and rejection, even aggression, against society. It would appear perverse to apply the same vocabulary to two such utterly dissimilar events, a distinction so stark as to suggest at least legal significance with respect to the meaning of section 241(b) of the *Criminal Code*. Voluntary death at the end of a terminal illness surrounded by supportive family and friends would seem to be the opposite of suicide.

The kind of inquiry into the context of decision making alluded to above would require a different process of fact collection than the one traditionally followed. Applied ethics of this type rely on specific details — generating a need for thick descriptions and multiple view points, including not just the patient and her doctors, but also her family and friends. To apply, as the majority did, a fixed rule or principle to the case does little to reveal the moral complexity of the issues. A sharp focus on rights language, especially in the context of section 7 of the *Charter* as was entered into by the majority as well as the dissenting opinions by Justices McLachlin and Cory, would tend to preclude the exercise of "thick description" called for here. Rights language draws dichotomies which have the effect of fragmenting a context which needs to be examined in full. Dying with dignity should not be too easily identified with the right to suicide.❑

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33. See Ryder, "The Demise and Rise of the Classical Paradigm in Canadian Federalism: Promoting Autonomy for the Provinces and First Nations" (1991) 36 McGill L.J. 308 at 310, fn. 4.

34. See Macklem, "Distributing Sovereignty: Indian Nations and Equality of Peoples" (1993) 45 Stanford L. Rev. 1311.

35. *Murphy v. C.P.R.*, [1958] S.C.R. 626, 643.

36. For an argument that it is, see Ryder, *supra* note 33 at 314-5.

37. *Bank of Toronto v. Lambe* (1887), 12 A.C. 575, 587; *Union Colliery v. Bryden*, [1899] A.C. 580, 585; *A.-G. Ontario v. A.-G. Canada (Reference Appeal)*, [1912] A.C. 571, 581, 584; *A.G. Can. v. A.G. Ont. (Labour Conventions)*, [1937] A.C. 326, 354; *Murphy*, *supra* note 35; *Jones v. A.G. N.B.*, [1975] 2 S.C.R. 182, 195; *Re Agricultural Products Marketing*, [1928] 2 S.C.R. 1198, 1296; *Re Resolution to Amend the Constitution*, [1981] 1 S.C.R. 754, 820-1.

38. See Foster, *supra* note 17 at 350, fn. 20; McNeil, *supra* note 17 at 119.

39. *Supra* note 1 at 761.

40. *Ibid.*, per Hutcheon J.A. at 763; Lambert J.A. at 729-30. Accord: Slattery, *supra* note 10 at 278-87; Royal Commission on Aboriginal Peoples, *supra* note 10 at 35: the *Indian Act* did not "deprive Indian peoples of all governmental authority, even if it severely disrupted and distorted their political structures and left them with very limited powers."

41. *Supra* note 1, per Macfarlane J.A. at 520, 547; Wallace J.A. at 601; Lambert J.A. at 603.

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Endnotes

1. [1993] 3 S.C.R. 519; internally cited page references in this paper refer to this report.

2. For further discussion of the cultural and legal significance of embodiment see: R. Mykitiuk, "Fragmenting the Body" (1993) 1(2) *Australian Feminist Law Journal*.

3. Leslie Bender, "A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia" (1993) 59 *Tenn. L. Rev.* 519.

4. Bender, *ibid.* at 534.

5. Trip Gabriel, "A Fight to the Death: Was Ann Humphry's "Final Exit" Intended to Pull the Plug on Her Ex-husband's Right-to-die Movement?" *New York Times* (8 December 1991) ss.6 (Magazine), 46 cited in Peter A. Ubel, M.D. "Assisted Suicide and the Case of Dr. Quill and Diane" *Issues in Law and Medicine*, 8:4 (Spring 1993) 487 at 491.

6. Timothy E. Quill "Death and Dignity — A Case of Individualized Decision Making" (1991) 324 *New Eng. J. Med* 691.

7. Lawrence K. Altman, "Jury Declines to Indict Doctor Who Said He Aided in a Suicide" *New York Times* (27 July 1991) at 1.

8. Ubel, *supra* note 5 at 497.

9. *Ibid.* at 498.