DIGNITY IN DEATH: A COMPARATIVE ACCOUNT OF THE UNITED STATES, CANADA, AND THE NETHERLANDS

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Dignity is held up by many countries as a foundational legal norm. But nations which share this norm apply it in contradictory ways. This article explores how the United States, Canada, and the Netherlands have constructed and expressed different conceptions of dignity in the context of medical assistance in dying. At a structural level, differing conceptions of dignity are reflected in unique approaches to constitutional interpretation and federalism in each jurisdiction. Further, each jurisdiction has different sets of actors who express and advocate for their own conceptions of dignity and have played different roles in the development of MAID policy. Differing conceptions of dignity are also reflected in the religion, public opinion, and political history of each jurisdiction. The seemingly incoherent approaches to dignity across jurisdictions are reflective of constitutional structures and actors, which contribute to internally consistent — albeit contested — conceptions of dignity.

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I. INTRODUCTION

The concept of human dignity is at the core of international human rights law, the domestic law of many states, and prevalent moral theories.[1] Perhaps because of this ubiquity, dignity has been raised by groups in favour of and opposed to the legalization of medical assistance in dying (MAID).[2] Dignity is cited as a core reason for the adoption of

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1 Paolo G Carozza, "Human Dignity in Constitutional Adjudication," in Tom Ginsburg and Rosalind Dixon, eds, *Comparative Constitutional Law* (London: Edward Elgar, 2011) 459 at 459.

2 MAID is used here as an inclusive term, to refer to deaths caused by physicians or other healthcare practitioners at the voluntary request of the patient (or their substitute decision-makers, where appropriate). MAID can be distinguished from physician-assisted suicide (PAS), in which a physician prescribes and/or prepares the lethal medication, which is then ingested under the patient's own power (this is of particular concern in the US, where the law requires self-administration, even if that

legislation, court judgments, and administrative decisions. But dignity can lead a court to find a right to MAID just as it can lead a court to find no such right.[3] Dignity's mere invocation tells us little about whether MAID should be legal. This raises several questions, including how the use of dignity differs between jurisdictions, and whether those differences inform the practice of MAID.

In what follows, I examine the roles of differing conceptions of dignity in the context of MAID law in the United States of America, Canada, and the Netherlands. These jurisdictions present a diverse array of approaches to MAID, both in their current frameworks and in their geneses. Under the US Constitution, no right to MAID exists. Where states have legislated to provide MAID, the scope of the right is narrow; in other states, opposition is stated in stark terms. In Canada, MAID is regulated federally (with the exception of Quebec), and was legalized after a court decision found the prohibition of MAID unconstitutional. In the Netherlands, MAID has been practised without legal scrutiny since at least the 1970s. There, MAID is available to competent minors, the mentally ill, and by advance directive for those with dementia. The Netherlands also has a regime for euthanasia of terminally ill newborns. Dignity underlays the approach in all jurisdictions, but there is a chasm between the policy outcomes. A similar chasm exists between the differing conceptions of dignity.

The aim of this paper is to provide an in-depth understanding of the varying meanings of dignity as a concept within the context of MAID across Canada, the US, and the Netherlands.[4] This includes an exploration of how conceptions of dignity are constructed and expressed by a variety of actors in constitutional systems, legislatures, courts, the medical establishment, and organized religion. This picture will show that despite a facially incoherent approach to dignity across jurisdictions, an internally coherent understanding of dignity is reflected in each individual jurisdiction's MAID laws and expressed diffusely across each constitutional system. These different conceptions of dignity are reflected in each jurisdiction's legal history, political realities, culture, religion, and in the advocacy of parties to litigation. Though this paper focuses on the use of dignity in the context of MAID, it is not the case that MAID is *sui generis* with respect to dignity. As will be noted below, legal conceptions of dignity which have been applied to MAID often have their genesis in other topics and controversies.

This paper does not aim to tell a causal story about how or why a particular conception of dignity was embraced by a jurisdiction, to the exclusion of others. The question addressed here is the manner in which conceptions and their construction differ, not the reasons for the embrace of one conception over the other. The latter question is one properly

constitutes only the pressing of a button on the patient's behalf). PAS in turn can be distinguished from euthanasia, where a physician prepares and administers the lethal medication themselves — this requires no active assistance from the patient at the time of administration. I will use MAID as a blanket term, as the discussion generally concerns both PAS and euthanasia, but will use PAS and euthanasia only when the comment applies exclusively to one practice.

[3] See e.g. *Carter v Canada (Attorney General)*, 2015 SCC 5 [*Carter*] (finding a right to MAID); *Washington v Glucksberg*, 521 US 702 (1997) [*Glucksberg*] (not finding a right to MAID).

[4] For further exploration of the methodological and conceptual approach which aligns closest to what I am doing here, see e.g. Theunis Roux, "Comparative Public Law" in Paul Daly & Joe Tomlinson, eds, *Researching Public Law in Common Law Systems* (Cheltenham: Edward Elgar, 2023) 151 at 155–59.

investigated with socio-legal and political science methods, not the sort of contextualized, doctrinal argument offered here.[5]

A. DIGNITY: THE CONCEPT AND ITS CONCEPTIONS

It is not news that the concept of dignity is implemented differently across jurisdictions.[6] As a matter of moral theory, one may argue that dignity as a concept lacks any moral weight because it is incapable of precise definition.[7] But from a legal perspective, the idea that dignity may have different interpretations is not shocking. In the context of the *Universal Declaration of Human Rights* and the *United Nations Charter*, the term "dignity" was embraced because of its broad appeal.[8] It was meant to serve as "a placeholder to facilitate a practical agreement between representatives of opposing ideologies."[9] This is fitting in part because human dignity finds support in a diverse array of religious and philosophical traditions: among them the ancient Romans, Judeo-Christian theologians, Enlightenment philosophers, Hindu texts, and current-day secular moral philosophers.[10]

Adopting Ronald Dworkin's distinction between "concept" and "conception" helps differentiate between the idea of dignity and specific accounts of dignity.[11] In Dworkin's view, a legal principle of which many interpretations are possible may be considered a "concept."[12] A "conception," by contrast, denotes one specific interpretation of that legal principle.[13] In the context of constitutional interpretation, Dworkin suggests that legal principles are included by the drafters as a concept, amenable to different conceptions which vary over time, and between interpreters.[14] Applied to dignity as it appears in international law, the UDHR enshrines the concept of dignity, whereas different legal orders may utilize varying conceptions of dignity.[15] With regards to the role dignity plays in the context of MAID, what matters is not whether the concept of dignity is invoked at all, but which *conception* of dignity reigns.

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5 See e.g. *ibid* at 160–65. For a more fulsome picture of what socio-legal approaches to public law research constitutes, see generally Helen Carr & Ed Kirton Darling, "But Interrupting the Flow…Socio-Legal Approaches to Public Law" in Paul Daly & Joe Tomlinson, eds, *Researching Public Law in Common Law Systems* (Cheltenham: Edward Elgar, 2023) 251.

6 See e.g. Christopher McCrudden, "Human Dignity and Judicial Interpretation of Human Rights" (2008) 19:4 Eur J Intl L 655.

7 For critiques in this general vein, as well as other substantive critiques, see e.g. Ruth Macklin, "Dignity Is a Useless Concept" (2003) 327 Brit Med J 1419; Ruth Macklin, "Reflections on the Human Dignity Symposium: Is Dignity a Useless Concept?" (2004) 20:3 J Palliative Care 212; Jeff McMahan, "Human Dignity, Suicide, and Assisting Others to Die" in Sebastian Muders, ed, *Human Dignity and Assisted Death*, (New York: Oxford University Press, 2018) 13 [McMahan, "Human Dignity"].

8 *Universal Declaration of Human Rights*, UNGA, 3rd Sess, UN Doc A/810 (1948) GA Res 217A (III) [UDHR]; *UN Charter*, 26 June 1945, Can TS 1945 No 7, Preamble [*UN Charter*].

9 Doron Shulztiner & Guy E Carmi, "Human Dignity in National Constitutions: Functions, Promises and Dangers" (2014) 62:2 Am J Comp L 461 at 471–72. See also McCrudden, *supra* note 6 at 677–78.

10 Carozza, *supra* note 1 at 462.

11 Ronald Dworkin, *Taking Rights Seriously* (Cambridge, Mass: Harvard University Press, 1977) at 134.

12 *Ibid*.

13 *Ibid*.

14 *Ibid*.

15 UDHR, *supra* note 8, art I; *UN Charter*, *supra* note 8, Preamble.

The concept of dignity is the subject of rigorous study and debate with respect to MAID,[16] medical law and bioethics,[17] and generally in law and philosophy.[18] While more robust discussion on the nature of dignity can be found elsewhere, the focus of this paper is the construction and expression of conceptions of dignity in three unique jurisdictions within one particular topic. I will rely on a more general, legally focused definition of dignity to draw comparisons.

As the legal scholar Paolo Carozza asserts, the concept of dignity — as it appears in law — contains at least two premises: (1) "an ontological claim that all humans have equal and intrinsic moral worth;" and (2) "a normative principle that all human beings are entitled to have this … worth respected" and are bound to respect the worth of others.[19] Where parties invoke dignity, they are generally not arguing about whether someone has dignity, but rather what dignity *demands*.[20] Building on Carozza's account, we might think of dignity as eliciting two different (though not exclusive) concerns or responses: concern for autonomy, and concern for sanctity.[21]

Premise (1) of Carozza's definition invokes the intrinsic moral worth of the individual human being.[22] This may be thought of as the "sanctity" premise. Sanctity of life entails that each human life has intrinsic value regardless of the experiences or abilities that any individual possesses.[23] Sanctity is essential to the debate around MAID.[24] On a strong conception of the sanctity of human life, accepting the legitimacy of MAID wrongly assumes that there is a set of circumstances (for example, severe physical pain or terminal illness) which are so wretched as to render that life without intrinsic value.[25] Accordingly, an adherent to this conception of sanctity may argue that euthanasia serves as an ultimate insult to the value of human life.[26] But as is true for the concept of dignity, many

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16 See e.g. Sebastian Muders, ed, *Human Dignity and Assisted Death*, (New York: Oxford University Press, 2018); Kristen Loveland, "Death and its Dignities" (2016) 91 NYUL Rev 1279.

17 See e.g. Bjorn Hofmann, "The Death of Dignity Is Greatly Exaggerated: Reflections 15 Years After the Declaration of Dignity as a Useless Concept" (2020) 34:6 Bioethics 602; Rosalind Dixon & Martha Craven Nussbaum, "Abortion, Dignity and a Capabilities Approach" (2011) University of Chicago Law School, Working Paper No 345, online: [perma.cc/3UYX-PBFY]; Reva B Siegel, "Dignity and the Politics of Protection: Abortion Restrictions Under *Casey/Carhart*" (2008) 117 Yale LJ 1694.

18 See e.g. Luis Roberto Barroso, "Here, There, and Everywhere: Human Dignity in Contemporary Law and in the Transnational Discourse" (2012) 35 Boston College Int'l & Comp L Rev 331; Vicki C Jackson, "Constitutional Dialogue and Human Dignity: States and Transnational Constitutional Discourse" (2004) 65:1 Mont L Rev 15; Daniel P Sulmasy, "The Varieties of Human Dignity: A Logical and Conceptual Analysis" (2013) 16:4 Medicine, Health Care and Philosophy 937.

19 Carozza, *supra* note 1 at 460. This is embraced by McCrudden, *supra* note 6 at 679, and mirrored from a non-legal perspective by Sebastian Muders, "Autonomy and the Value of Life as Elements of Human Dignity" in Sebastian Muders, ed, *Human Dignity and Assisted Death*, (New York: Oxford University Press, 2018) 125 [Muders, "Autonomy"].

20 Carozza, *supra* note 1 at 460.

21 This dual focus account of dignity is acknowledged in Muders, "Autonomy", *supra* note 19, who ultimately argues for an account that combines the two concerns.

22 Carozza, *supra* note 1 at 460.

23 Jeff McMahan, *The Ethics of Killing: Problems at the Margins of Life* (New York: Oxford University Press, 2002) at 465 [McMahan, *The Ethics of Killing*]; John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation*, 2nd ed (New York: Cambridge University Press, 2018) at 38–40.

24 See generally Matthew P Previn, "Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life" (1996) 84:3 Geo LJ 589.

25 John Finnis, "A Philosophical Case Against Euthanasia" in John Keown, ed, *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (New York: Cambridge University Press, 1995) 23.

26 Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (New York: Alfred A Knopf, 1993) at 214 [Dworkin, *Life's Dominion*]. This is characteristic of the

conceptions of sanctity exist. For example, a more moderate conception of sanctity may hold that though each life is intrinsically valuable, MAID does not necessarily insult the value of human life.[27] Often, sanctity will be considered in contrast to, or in conflict with, the autonomy of an individual who wishes to end their life using MAID.

Premise (2) of Carozza's definition concerns respect for each individual's inherent dignity.[28] This invokes the Kantian argument that dignity entitles one to never be used simply as a means, but rather to be treated as an end in oneself.[29] This entails that one is given the opportunity to define one's own life and choices as one sees fit.[30] In turn, this may be seen as the foundation for respect for individual autonomy, especially in the context of medical treatment. A more relational account of dignity — which may still be concerned with autonomy — is often focused on the state's ability to create the appropriate conditions for people to realize their dignity, or to flourish.[31]

The discussion of MAID is predisposed to embracing the autonomy-focused account of dignity, in no small part because of the primacy of individual choice and consent in medical law.[32] With respect to any medical decision, including MAID, where one is focused on dignity's protection of autonomy, the question becomes whether it is ever possible to prevent someone from making a decision without infringing on their dignity. L. W. Sumner and others have proposed that there are two possible arguments from, or conceptions of dignity which are responsive to this question, and which may be applied to the issue of MAID.[33] On a "thick" conception of dignity, MAID is permissible not only because it is the patient's autonomous judgment, but also because it furthers the patient's interests in avoiding possible indignity at the end of life.[34] Other, "thin" conceptions of dignity, by contrast, entail that there are decisions which an individual can make for herself that nonetheless violates her own dignity.[35] As articulated by David Velleman, in ending her own life, the individual is placing her own subjective well-being over her value as a rational, autonomous individual.[36] MAID, or any other intentional ending of life, would on this view always be impermissible.[37]

Catholic religious tradition, as well as that of some Protestant sects: see e.g. Previn, *supra* note 24 at 595–96.

27 Dworkin, *Life's Dominion*, *supra* note 26 at 215–17; Previn, *supra* note 24 at 598–99; Keown, *supra* note 23 at 37, 49.

28 Carozza, *supra* note 1 at 460.

29 McCrudden, *supra* note 6 at 659–60.

30 *Ibid.*

31 Neomi Rao, "On the Use and Abuse of Dignity in Constitutional Law" (2008) 14:2 Colum J Eur L 201 at 219–22. This reflects McCrudden's account of dignity as employed in international human rights law, on which a third element of dignity includes that the state must exist for the benefit of the individual, not vice-versa (McCrudden, *supra* note 6 at 679). See also *ibid* at 699–701.

32 McCrudden, *supra* note 6 at 688–89.

33 LW Sumner, "Dignity Through Thick and Thin" in Sebastian Muders, ed, *Human Dignity and Assisted Death*, (New York: Oxford University Press, 2018) 49; Luke Gormally, "Two Competing Conceptions of Human Dignity" in Sebastian Muders, ed, *Human Dignity and Assisted Death*, (New York: Oxford University Press, 2017) 161 at 164–66; McMahan, *The Ethics of Killing*, *supra* note 23 at 473–85.

34 Sumner, *supra* note 33 at 55–59; Gormally, *supra* note 33 at 164–66.

35 J David Velleman, "A Right of Self-Termination?" (1999) 109:3 Ethics 606 at 614–17.

36 *Ibid* at 616.

37 Recall that one fundamental tenet of dignity is that each individual human has intrinsic and equal worth (Carozza, *supra* note 1 at 460). According to Sumner and McMahan, the problem with the "thin" account of dignity is that it in fact smuggles a conception of sanctity into its account of dignity (McMahan, "Human Dignity," *supra* note 7 at 21–23; McMahan, *The Ethics of Killing*, *supra* note 23 at 473–76; Sumner, *supra* note 33 at 53–55).

II. CURRENT MAID FRAMEWORKS

The three jurisdictions of concern in this paper took different approaches to the legalization of MAID. In turn, they vary drastically in the kind of options they offer patients. Moreover, all three jurisdictions have approached dignity in different ways. The following section will outline how their respective MAID systems came to be and will briefly address how dignity has been expressed and constructed therein.[38]

A. THE UNITED STATES

Before a case on PAS reached the US Supreme Court, the Court made clear that dignity was at the core of understanding the liberty interest contained in the due process clause of the Fourteenth Amendment to the US Constitution.[39] In cases concerning the withdrawal of life support, and the right to obtain an abortion, the Court described such decisions as "central to personal dignity,"[40] and stated that restricting such decisions "burdens the patient's liberty, dignity, and freedom."[41] In these early cases, the conception of dignity invoked was squarely based in autonomy, specifically the ability to make private personal decisions without government interference.[42] Importantly, this grounding of dignity in the Constitution's due process clause was dealt a blow by the 2022 US Supreme Court decision of *Dobbs v. Jackson Women's Health Organization*, which overturned the 1973 case of *Roe v. Wade* in which the US Supreme Court ruled that there was a constitutional right to obtain an abortion.[43] The Court in *Dobbs* questioned the entire method of constitutional interpretation on which *Roe*, and most recent substantive readings of the due process clause, rely.[44]

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38 Delaney Blakey, "A Comparative View of the Law, Ethics, and Policies Surrounding Medical Aid in Dying in the United States and Netherlands" (2020) 19:2 Wash U Global Studies L Rev 235; Joel Krinsky, "Embracing the End: A Comparative Analysis of Medical Aid in Dying in Canada and the United States" (2022) 48:1 Brook J Intl L 331.

39 US Const amend XIV, § 1 ("nor shall any State deprive any person of life, liberty, or property, without due process of law").

40 *Planned Parenthood of Southeastern Pennsylvania v Casey, Governor of Pennsylvania*, 505 US 833 at 851 (1992) [*Casey*].

41 *Cruzan v Director, Missouri Department of Health*, 497 US 261 at 288–90 (1990) (O'Connor J, concurring) [*Cruzan*]. See also *ibid* at 342, Stevens J, dissenting ("[t]he sanctity, and individual privacy, of the human body is obviously fundamental to liberty," citing *Washington v Harper*, 494 US 210 (1990) at 237, Stevens J, concurring in part and dissenting in part).

42 It is worth noting that in other American jurisprudence around abortion and reproduction, a conception of dignity focused on sanctity of life (of embryos and fetuses) has been advanced. See e.g. *Gonzales v Carhart*, 550 US 124 (2007) [*Gonzales*], which recognized in part that the *Partial Birth Abortion Ban Act* of 2003, 18 USC § 1531 "expresses respect for the dignity of human life" (*Gonzales*, *ibid* at 157). See also *James LePage v The Center for Reproductive Medicine, PC*, SC-2022-0515 at 7 (Ala Sup Ct 2024) in which the Alabama Supreme Court held that fertilized embryos (which it characterized as "extrauterine children") were persons for the purposes of private law wrongful death claims. In a concurrence, Chief Justice Parker noted that the opinion relied on a specific state constitutional provision affirming the "sanctity of unborn life" (*ibid* at 26) and also expanded on Christian justifications of sanctity (*ibid* at 33–38). For more far-reaching analysis of dignity in American constitutional law, see generally Maxine Goodman, "Human Dignity in Supreme Court Constitutional Jurisprudence" (2006) 84:3 Neb L Rev 740.

43 *Dobbs v Jackson Women's Health Organization*, 597 US 215 (2022) [*Dobbs*]; *Roe v Wade*, 410 US 113 (1973) [*Roe*]. Though the majority in *Dobbs* stressed that the ruling was unique to abortion (*Dobbs*, *ibid* at 63–66) the bulk of the ruling is critical of the entire analytic structure on which the constitutional right to privacy was founded (*ibid* at 45–56). Concurring in *Dobbs*, Justice Thomas argued that all substantive due process cases ought to be overturned (*ibid* at 7).

44 *Dobbs*, *ibid.*

The case of *Washington v. Glucksberg* reached the US Supreme Court in 1997, triggered by physicians who wished to offer their patients PAS.[45] The plaintiffs relied on the Fourteenth Amendment's due process clause, drawing on the statements around dignity cited in *Cruzan* and *Casey*.[46] Despite the explicit references to the Court's prior jurisprudence, the US Supreme Court held that a criminal prohibition against PAS did not violate the due process clause.[47] In so doing, the majority largely eschewed language of dignity, focusing instead on the history and tradition of the US, which lacked evidence of the legal practice of MAID.[48]

As a result of *Glucksberg*, federal constitutional law in the US is silent on the matter of PAS.[49] This void has been filled by litigation and legislative action in states. In most states where PAS is legal, statutes largely imitate the 1994 *Oregon Death with Dignity Act*, the nation's first statute legalizing PAS, which predated *Glucksberg*.[50] PAS is available in ten states, as well as Washington D.C. — a group of states comprising roughly 25 percent of the population of the US.[51] Though there are slight variations in the MAID statutes of American states, all require that patients be (1) adults, (2) terminally ill, (3) residents of the state, and (4) capable of medical decision-making.[52] Importantly, all MAID statutes in the US require that the patient take the life-ending prescription drug themselves.[53] From the 1990s onwards, attempts to legalize MAID in the US have been overwhelmingly focused on self-administered prescriptions.[54]

B. CANADA

MAID was first available to Canadians in Quebec, after the provincial legislature passed the *Act Respecting End-of-Life Care* in 2014.[55] As will be explored below, the Quebec medical establishment prompted legislative study of MAID, and triggered the creation of the Select Committee on Dying with Dignity, which lead to the drafting and

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45 *Glucksberg*, *supra* note 3 at 706.

46 *Ibid*; *Casey*, *supra* note 40; *Cruzan*, *supra* note 41.

47 *Glucksberg*, *supra* note 3 at 735.

48 *Ibid* at 727.

49 See e.g. John Dinan, "Rights and the Political Process: Physician-Assisted Suicide in the Aftermath of *Washington v Glucksberg*" (2001) 31:4 Publius 1.

50 *Oregon Death with Dignity Act*, Or Rev Stat §§ 127.800–.897 (2020).

51 Thaddeus Mason Pope, "Medical Aid in Dying: Key Variations Among US State Laws" (2020) 14:1 J Health & Life Sciences L 25 at 28–29 [Pope, "Medical Aid in Dying]. The states of Montana and North Carolina have non-statutory approaches to MAID. In those states, eligibility is limited to capable adults who are terminally ill, but all other requirements are determined solely with reference to the standard of care (*ibid* at 34–35). See also Death with Dignity, "In Your State" (30 March 2023), online: *Death with Dignity* [perma.cc/2ZYM-BLMF].

52 Pope, "Medical Aid in Dying," *supra* note 51 at 36. The final two requirements are somewhat variable, as states have different standards for what constitutes state residency, and different care standards for what constitutes capacity under state law (*ibid* at 37–39). Terminal illness is generally defined as an incurable and irreversible disease that has been medically diagnosed, and that in reasonable medical judgment will lead to death within six months (*ibid* at 55).

53 *Ibid* at 40. There is some variation to the requirements in state laws. In states where the legislation uses the word "ingest," entails that it must be administered through the gastro-intestinal tract, either orally or using a feeding tube (*ibid* at 44). Where this language is not present, patients may use intravenous administration, which is safer, faster, and avoids potential limits of a patient's body to metabolize the drug within the gastrointestinal tract (*ibid* at 45–46).

54 Thaddeus Mason Pope, "Legal History of Medical Aid in Dying: Physician Assisted Death in US Courts and Legislatures" (2018) 48:2 NML Rev 267 at 277–82 [Pope, "Legal History of Medical Aid in Dying"].

55 CQLR c S-32.0001 [*End-of-Life Care Act*].

adoption of the MAID law.[56] The 2014 Act allowed the provision of MAID to capable adults suffering from a serious and incurable illness, in a state of advanced irreversible decline, at the end of life.[57] Though this development was notable, and will be explored in sections below, the genesis and discussion of federal MAID policy has largely subsumed that of Quebec.[58]

Federally, MAID was prohibited until the 2015 Supreme Court case of *Carter v. Canada (Attorney General)*.[59] That case was the second constitutional challenge to an assisted death prohibition to reach the Supreme Court. In *Carter*, the plaintiffs alleged that the criminal prohibition against assisting one's suicide violated their rights under section 7 and section 15(1) of the *Charter of Rights and Freedoms*.[60] The Supreme Court held that the criminal prohibition was void, provided those seeking death were consenting individuals suffering from a "grievous and irremediable" condition causing enduring, intolerable suffering.[61] The Supreme Court's holding was based on section 7 rights to life, liberty, and security of the person, and not on the section 15(1) equality rights on which the plaintiffs also relied.[62]

In *Carter*, the focus of analysis was on the liberty and security of the person rights under section 7 of the *Charter* which are underlain by "a concern for the protection of individual autonomy and dignity."[63] The Supreme Court unanimously held that section 7 rights were infringed by the prohibition on PAS, largely because such a decision is foundational to one's own autonomy and dignity in the same way as other medical decisions.[64] Further, the Supreme Court recognized that the *Charter*'s protection of security of the person includes autonomy over one's bodily integrity "free from state interference."[65] In holding that section 7 was infringed by the prohibition on MAID, *Carter*

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[56] See generally Michelle Giroux, "Informing the Future of End-of-Life Care in Canada: Lessons from the Quebec Legislative Experience" (2016) 39:2 Dal LJ 431 at 435–36.

[57] *End-of-Life Care Act*, *supra* note 55, s 1.

[58] This is not to say that Quebec is irrelevant to the MAID discussion — Quebec in fact leads the development of MAID practice for the rest of the country (see Part III-C, below). Academic and public energy (especially to Anglophone ears) has been focused on the further-reaching federal policy. One could imagine that if Quebec was the only province to have MAID for a period of five years, more of this energy would have been directed at Quebec's MAID regime. Additionally, litigation which previously would have been launched against Quebec's MAID regime alone is now also launched against the federal MAID regime; the focus in such cases is not the *Quebec Charter of Human Rights and Freedoms* (CQLR, c-12), but the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*]. See generally the text accompanying note 76, below.

[59] *Carter*, *supra* note 3.

[60] *Ibid*; *Charter*, *supra* note 58, s 7 ("[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice)" and s 15(1) ("[e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability").

[61] *Carter*, *supra* note 3 at para 4.

[62] *Ibid* at para 48.

[63] *Ibid* para 64.

[64] *Ibid* at paras 64–69.

[65] *Ibid* at para 64, citing *R v Morgentaler*, 1988 CanLII 90 (SCC) [*Morgentaler*]. In *Morgentaler*, a plurality of the Supreme Court struck down prohibitions on abortion, holding that the prohibitions interfered with women's body and constituted an infringement on the security of the person (*ibid* at 79) (Dickson, CJ, in which Lamer J joined). Justices Beetz and Estey took the position that the impact on women was not justified by the governmental interest in the life of the fetus (*ibid* at 122). Justice Wilson, the final member of the plurality, focused on the impact of the abortion prohibition on women's liberty interests, and considered the concept of dignity at length: "The *Charter* and the right to individual liberty guaranteed under it are inextricably tied to the concept of human dignity.… [A]n aspect of the

built on the 1994 Supreme Court of Canada case of *Rodriguez v. British Columbia (Attorney General)*, in which a terminally ill plaintiff unsuccessfully challenged the prohibition on PAS.[66] In *Rodriguez*, the Supreme Court addressed arguments around differing conceptions of dignity. Justice Sopinka, for a narrow five-justice majority, asked whether a society "based upon respect for the intrinsic value of human life and on the inherent dignity of every human being" could also find a right to terminate one's own life, or if a secular conception of sanctity precluded such a right.[67] But sanctity and dignity, on the view of the majority, were broad enough to include consideration for quality of life: the deterioration, dependence, pain, and loss of dignity the appellant feared.[68] The prohibition thereby infringed on the appellant's section 7 right to security of the person.[69]

The plaintiff in *Rodriguez* was unsuccessful, however, because a slim majority of the Supreme Court held that the state's interest in protecting life and protecting the vulnerable was strong, and found that there was insufficient evidence that available safeguards could protect those interests while also allowing PAS.[70] In *Carter*, by contrast, the unanimous Supreme Court found that Canada did not prove that safeguards would be insufficient to prevent abuse without a blanket prohibition, and thus the section 7 infringement was unjustified, and the prohibition was invalidated.[71] The analyses in both cases were fundamentally concerned with balancing autonomy and sanctity.[72] In *Carter*, the Supreme Court did not find that sanctity was an irrelevant consideration, but instead that it was adequately protected, whereas autonomy was infringed upon by the prohibition on MAID.

In the wake of *Carter*, the federal government amended the *Criminal Code* to provide pathways to obtain MAID.[73] The initial scheme, which came into force in 2016, made subtle departures from the text of *Carter*. Though the statute included the Supreme Court's language limiting MAID to those who have a grievous and irremediable medical condition, it limited eligibility to capable persons 18 years and older.[74] The criteria also established a

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respect for human dignity on which the *Charter* is founded is the right to make fundamental personal decisions without interference from the state" (*ibid* at 164–66). For a broader account of dignity in Canadian jurisprudence, see generally R James Fyfe, "Dignity as Theory: Competing Conceptions of Human Dignity at the Supreme Court of Canada" (2008) 70 Sask L Rev 1.

66 *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519 [*Rodriguez*].

67 *Ibid* at 585, citing Dworkin, *Life's Dominion*, *supra* note 26. Dworkin did not explicitly embrace a view on which suicide was always impermissible but instead explored the scaffolding for such an argument on the grounds of a secular conception of sanctity (*ibid* at 214). See generally Dworkin, *Life's Dominion*, *ibid* at 71–84, 179–241.

68 *Rodriguez*, *supra* note 66 at 586–588, 595–596.

69 *Ibid* at 588–589.

70 *Ibid* at 590, 596–608. The majority rejected incorporating dignity as a principle of fundamental justice for the purposes of section 7 *Charter* analysis: "To state that 'respect for human dignity and autonomy' is a principle of fundamental justice, then, is essentially to state that the deprivation of the appellant's security of the person is contrary to principles of fundamental justice because it deprives her of security of the person. This interpretation would equate security of the person with a principle of fundamental justice and render the latter redundant" (*ibid* at 592).

71 *Carter*, *supra* note 3 at paras 99–121. It is worth noting here that the crucial analysis of safeguards in *Rodriguez* occurred under the principles of fundamental justice section of the section 7 argument (*Rodriguez*, *supra* note 66 at 596–608), whereas the discussion of safeguards in *Carter* was contained in the section 1 analysis (*Carter*, *supra* note 3 at paras 99–121).

72 The balancing of autonomy and sanctity is also core to Giroux's account of the development of MAID legislation in Quebec, which preceded *Carter* (Giroux, *supra* note 56 at 437–40).

73 *Ibid.* See generally Jocelyn Downie, "From Prohibition to Permission: The Winding Road of Medical Assistance in Dying in Canada" (2022) 34 HEC Forum 321.

74 *Criminal Code*, RSC 1985, c C-46, ss 241.2(1)(b), 241.2(2), as amended by *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, SC 2016, c 3.

narrow view of "grievous and irremediable" which included the limitation that natural death be "reasonably foreseeable."[75] The language of "reasonably foreseeable" in the federal act, and "end-of-life" in the Quebec act, was struck down by the Quebec Superior Court in 2019 — a decision which neither government appealed.[76]

After delays due to political developments and COVID-19, the federal government introduced the legislation which governs MAID in Canada today. Modifying the past framework, two tracks for eligibility exist: one for individuals with reasonably foreseeable deaths, and one for individuals with unforeseeable deaths.[77] The latter group is subject to a separate, more strenuous set of safeguards.[78] Mental illness has also been explicitly excluded as a "medical condition" to ground the use of MAID.[79] This exclusion is subject to a sunset clause, and will expire in March 2027 unless further extensions are sought by Parliament.[80]

In 2023, Quebec took yet another step ahead of the federal MAID framework, passing an act amending their existing MAID statutes. The revised law, with amendments in force as of 2024, permits a patient to make an advanced request for MAID if they are suffering from a serious and incurable illness leading to incapacity to give consent to care.[81] The patient must, while capable, describe the clinical manifestations of their illness that can be considered consent to MAID, which may only be administered if the patient has lost capacity and these manifestations remain present (among other requirements).[82] While the implementation of the revised scheme is in its early stages, the Quebec approach is now closely aligned to the MAID framework in the Netherlands, explored below.

C. THE NETHERLANDS

The legal condonation of MAID in the Netherlands arose from circumstances unlike those in Canada or the US. Euthanasia was formally illegal until the adoption of the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* in 2002.[83] But prior to 2002, physicians who provided euthanasia were not prosecuted regularly; when they were, they often received suspended sentences or probation.[84] It is difficult to decide

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75 *Ibid*, s 241.2(2)(d).

76 *Truchon c Procureur général du Canada*, 2019 QCCS 3792 at paras 734–36 [*Truchon*]. The invalidity of the relevant *Criminal Code* provision was delayed due to the dissolution of Parliament for an election (2020 QCCS 772), and then subsequently due to the COVID-19 pandemic (2020 QCCS 2019; 2020 QCCS 4388; 2021 QCCS 590).

77 *Criminal Code*, *supra* note 74, s 241.2 as amended by *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2021 c 2.

78 *Ibid*; Downie, *supra* note 73 at 341.

79 *Criminal Code*, *supra* note 74, s 241.2(2.1).

80 Bill C-62, *An Act to amend An Act to amend the Criminal Code (medical assistance in dying), No 2,* 1st Sess, 44th Parl, 2024, s 1 (assented to 29 February 2024) SC 2024, c 1. Parliament had previously extended the duration of the sunset clause in 2023 (Bill C-39, *An Act to amend An Act to amend the Criminal Code (medical assistance in dying)*, 1st Sess, 44th Parl, 2023 (assented to 9 March 2020), SC 2023, c 1).

81 *End-of-Life Care Act*, *supra* note 55, s 29.1.

82 *Ibid*, s 29.3.

83 *Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding* [*Termination of Life on Request and Assisted Suicide (Review Procedures) Act*], Stb 2001, 194 [*WTL Act*]. See translation: Netherlands, Regional Euthanasia Review Committees, *Euthanasia Code 2022* (Utrecht: Regionale Toetsingscommissies Euthanasie 2022) at 67 [*Euthanasia Code 2022*].

84 See generally John Griffiths, Alex Bood & Heleen Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998) at 43–86; Sjef Gevers, "Euthanasia: Law and Practice in the Netherlands" (1996) 52:2 British Medical Bulletin 326 [Gevers, "Euthanasia"]; Blakey, *supra*

when this period of permissiveness became the norm. Though cases of non-prosecution exist from the 1950s, a coherent working standard was not embraced until the early 1980s.[85] During this time, euthanasia would not be prosecuted where an explicit, voluntary request was made by a patient who was suffering unbearably.[86] Over time, developments in professional standards, as well as guidance from courts during rare prosecutions of physicians for euthanasia, contributed to further standards, such as a duty of the primary physician to consult a colleague.[87] Further developments in the mid–1990s expanded euthanasia to newborns who were suffering unbearably.[88]

Dignity played a less central role in the Dutch euthanasia cases than in Canadian and American jurisprudence. Where physicians were acquitted of euthanasia by Dutch courts, they relied largely on the argument appealing to a conflict of duties which existed for the physician: on one hand, an ethical duty to alleviate hopeless suffering, and on the other, a legal duty to preserve the patient's life.[89] In one such prosecution, a physician (who performed euthanasia on a 93-year-old woman at her repeated request) argued that he was confronted with a situation of *overmacht*.[90] The concept of *overmacht* absolves individuals of criminal liability if they are acting due to a force they could not be expected to resist, including a conflict of legal duties.[91] The Court of Appeals, Amsterdam, rejected the argument of *overmacht*, viewing the conflict as personal rather than legal.[92] The Supreme Court of the Netherlands ruled for the physician, directing that in the appraisal of *overmacht*, a court should consider whether reasonable medical opinion would conclude that a patient would lose their personal dignity without euthanasia (*ontluistering*).[93] Consequently, the Court in *Schoonheim* focused on the patient's ability to live with dignity, rather than the embrace of a particular conception of dignity by the law.[94]

note 38 at 245–48; Ybo Buruma, "Dutch Tolerance: On Drugs, Prostitution, and Euthanasia" (2007) 35:1 Crime & Justice 73 at 99–106.

85 Griffiths, Bood & Weyers, *supra* note 84 at 50–86; Gevers, "Euthanasia," *supra* note 84 at 327–29. Even this statement is a drastic oversimplification. It is nearly impossible to pinpoint the exact time where (from a practitioner's perspective) it was 'safe' to perform euthanasia without fear of prosecution. Regardless, the 1980s figure lands after the influential *Postma* case, the founding of the Dutch Association for Voluntary Euthanasia, and an influential 1975 report of the Dutch Medical Association (Griffiths, Bood & Weyers, *supra* note 84 at 52–54), and aligns with the formulation of a national prosecutorial policy on euthanasia in 1982 (*ibid* at 58–59) influential *Schoonheim* case in 1984 (*ibid* at 62), and a policy report from the Dutch Medical Association's Executive Board (*ibid* at 65–66).

86 Griffiths, Bood & Weyers, *supra* note 84 at 66–71.

87 *Ibid* at 71.

88 *Ibid* at 83–84. See also Eduard Verhagen & Pieter JJ Sauer, "The Groningen Protocol — Euthanasia in Severely Ill Newborns" (2005) 352:10 N Eng J Med 959.

89 Gevers, "Euthanasia," *supra* note 84 at 328; Griffiths, Bood & Weyers, *supra* note 84 at 62.

90 Supreme Court of the Netherlands, NJ 1985, No 106 [*Schoonheim*]. Refer to the translation from Griffiths, Bood & Weyers, *supra* note 84 at 322. This case is sometimes referred to in the literature as the *Alkmaar* case because it originated in the District Court at Alkmaar (*ibid*). See also Gevers, "Euthanasia," *supra* note 84 at 327; Blakey, *supra* note 38 at 245–46.

91 See commentary on *Schoonheim*, *supra* note 90: Griffiths, Bood & Weyers, *supra* note 84 at 326. Two types of *overmacht* exist in Dutch law, one which roughly accords with the common law concept of duress, and another which consists of a conflict of duties, which is referred to as necessity (*noodtoestand*) (*ibid*).

92 *Ibid*.

93 *Ibid* at 328.

94 *Ibid*.

When the *WTL Act* came into force in 2002, it codified much of the preceding case law and recommendations of commissions on the topic of euthanasia.[95] Patients, in order to be eligible for euthanasia, must have made a voluntary request, and be experiencing lasting and unbearable suffering to which no reasonable solution exists.[96] Unlike in Canada, there are explicit provisions allowing for euthanasia for minors 12–18 years old.[97] Further specifications have made euthanasia accessible for those with mental illnesses, and for those with dementia who wish to make advance requests for euthanasia.[98]

In 1998, just prior to the 2002 *WTL Act*, the Dutch government created the *Regionale Toetsingscommissies Euthanasie* [Euthanasia Review Committees] (RTE) which review all cases of euthanasia.[99] Dignity is frequently invoked in the RTE decisions.[100] In those decisions, as in *Schoonheim*, dignity is invoked as a subjective, quality of life concern.[101] Reflecting on these cases, dignity serves as a motivator for euthanasia, and as part of the standard for unbearable suffering.[102] This is particularly true for patients who craft advanced directives for euthanasia after being diagnosed with Alzheimer's Disease Dementia (AD).[103] The Netherlands, unlike Canada (with the recent exception of Quebec), allows for euthanasia to be performed with consent given by an advance directive.[104]

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95 *WTL Act*, *supra* note 83; Buruma, *supra* note 84 at 104; Blakey, *supra* note 38 at 247; Eva Constance Alida Asscher & Suzanne van de Vathorst, "First Prosecution of a Dutch Doctor Since the Euthanasia Act of 2002: What Does the Verdict Mean?" (2020) 46 J Medical Ethics 71 at 71.

96 *WTL Act*, *supra* note 83, c 2 s 2(1); *Euthanasia Code 2022*, *supra* note 83 at 68.

97 *WTL Act*, *supra* note 83 c 2 s 2(2–3); *Euthanasia Code 2022*, *supra* note 83 at 68.

98 *Euthanasia Code 2022*, *supra* note 83, at 38, 45–48.

99 GK Kimsma, "Death by Request in The Netherlands: Facts, the Legal Context and Effects on Physicians, Patients and Families" (2010) 13 Medicine Health Care & Philosophy 355 at 356–57.

100 The decisions of the RTE are available online, but only a small portion are available in English translations. Conducting a search for the phrase "dignity" in the English RTE database yielded 15 matching cases, which I draw on below. A search for "ontluistering" [dignity] in the Dutch RTE database yielded 107 matching cases, which are not included in my analysis other than those which were translated into English. All cases below are found on the publicly available RTE website. See Regionale Toetsingscommissies Euthanasie, "Home Page" (2023), online: [perma.cc/9D8E-ANJP].

101 *WTL Act*, *supra* note 83, c 2 s 2(1)(b); *Euthanasia Code 2022*, *supra* note 83 at 68. See e.g. Regionale Toetsingscommissies Euthanasie, 1 January 2014, *2014-12, General Practitioner*, *Neurological Disorder*s (Netherlands), online: [perma.cc/DYZ3-E2QN]; Regionale Toetsingscommissies Euthanasie, 1 January 2015, *2015-52, General Practitioner, Cardiovascular Disease, Voluntary and Well-Considered Request, Independent Assessment* (Netherlands), online: [perma.cc/D7X9-RVWD]. See also Cees Maris, *Tolerance: Experiments with Freedom in the Netherlands* (Cham, CH: Springer International, 2018) at 194.

102 The idea of a lack of dignity as motivating euthanasia is particularly resonant in the context of dementia, where the suffering involved may not always manifest as physical pain. See e.g. Dena S Davis, "Alzheimer Disease and Pre-Emptive Suicide" (2014) 40:8 J Med Ethics 40; Norman L Cantor, "On Avoiding Deep Dementia" (2018) 48:4 Hastings Center Report 15.

103 See e.g. Regionale Toetsingscommissies Euthanasie, 1 January 2015, *2015-107, General Practitioner, Dementia, Voluntary and Well-Considered Request, Unbearable Suffering Without Prospect of Improvement, No Reasonable Alternative* (Netherlands), online: [perma.cc/GX2R-883W]:

> For her, losing her dignity, losing contact with her loved ones, being dependent and being put away would be to suffer unbearably. She wanted to stay in her home as long as possible, where her husband would be her carer. If that were no longer possible, due to deteriorating mental and/or physical circumstances, then for her it would be time for a voluntary, self-determined and dignified end to her life.

Regionale Toetsingscommissies Euthanasie, 1 January 2018, *2018-123, Due Care Criteria Complied with* (Netherlands), online: [perma.cc/6UNF-FHNJ]; Regionale Toetsingscommissies Euthanasie, 1 January 2019, *2019-12, Due Care Criteria Not Complied with* (Netherlands), online: [perma.cc/2ZTX-U7Z3].

104 *Euthanasia Code 2022*, *supra* note 83 at 38. Canada provides for the use of an advance waiver of consent, which requires a specified date on which MAID may be administered notwithstanding the patient's lack of ability to consent (*Criminal Code*, *supra* note 74, s 241.2(3.2)). This applies largely to

Patients may specify that euthanasia should be performed when a certain set of clinical factors are present. These factors may include an unavoidable, irreversible loss of dignity.[105] As a result, cases often come before the RTE in which the presence or loss of dignity is in dispute.[106]

In one case, the RTE reviewed the provision of euthanasia to a man suffering from AD, who requested euthanasia by advance directive to be provided when he experienced "long-term terminal suffering" and "unavoidable loss of dignity."[107] The committee was concerned with whether the physician was able to deduce "loss of dignity" at the time that euthanasia was administered.[108] It found that the concern for dignity in the advance directive was centred on a fear of becoming aggressive and agitated, as well as a lack of ability to communicate, as the patient's AD progressed.[109] The RTE concluded that the loss of dignity was present and unimprovable — prior to his death, the patient was consistently agitated and aggressive, suffered from aphasia, and displayed no indications of enjoyment or pleasure.[110] The administration of euthanasia therefore accorded with the patient's advance directive and met the due care criteria set out in Dutch law.[111] This treatment of dignity in the RTE captures the patient-focused Dutch approach to dignity in MAID. In reaching its decision, the RTE relied on the patient's own conception of dignity, rather than crafting its own independent conception through which to evaluate the case.

III. FOUNDATIONAL DIFFERENCES

Jurisdictions differ in their approaches to MAID, and in the application of dignity therein. The remainder of this paper is concerned with exploring how conceptions of dignity have been constructed within existing legal structures and expressed by different actors in each constitutional system.

A. LEGISLATURES, THE JUDICIARY, AND FEDERALISM

In all three jurisdictions, the development of MAID policy and the expression of conceptions of dignity is reflected in legislative and judicial actions. These actions are shaped by the underlying structures of government. This section focuses on who decides, in order to understand which conception of dignity reigns. The Canadian experience is marked by strong federal judicial action followed by federal legislative developments — though Quebec enacted its own law before *Carter*. The US, by contrast, is coloured by inaction by both the federal and state judiciaries, resulting in fractured, polarized state-level development of MAID access. The Netherlands breaks both molds, and instead is

patients who wish to receive MAID, but who may lose consciousness before it is administered (for example, those at risk of slipping into a coma, or who are due to be given sedatives or painkillers which would preclude them from giving contemporary consent to MAID).

105 *Euthanasia Code 2022*, *supra* note 83 at 21–23.

106 Dignity was also relevant, albeit only incidentally, in the single case of prosecution brought against a physician in the Netherlands for performing MAID: see generally Asscher & van de Vathorst, *supra* note 95; Rechtbank Den Haag [District Court of the Hague], 11 September 2019, *ECLI:NL:RBDHA:2019:10650*, No 09/837356-18V (Netherlands).

107 Regionale Toetsingscommissies Euthanasie, 1 January 2019, *2019-119, Due Care Criteria Complied with* (Netherlands), online: [perma.cc/2FXM-LJNB].

108 *Ibid*.

109 *Ibid*.

110 *Ibid.*

111 *Ibid*.

defined by its unitary government structure, permissive judicial approach, and long inability of the legislature to regulate MAID.

In Canada, the judiciary is often centred as the key actor in the development of MAID policy: first by rejecting a right to MAID in *Rodriguez* and later reversing course in *Carter*.[112] But this narrative ignores the history of attempts at legislation on the issue. This especially ignores the legislative momentum in Quebec, which permitted MAID prior to *Carter* as the result of a lengthy deliberative and legislative process.[113] Federally, between *Rodriguez* and *Carter*, no fewer than six attempts to decriminalize MAID were made through private members bills. These bills were defeated in 1994, 2005, 2008, 2009, and 2014.[114] No bill reached a second reading in its respective chamber — that is to say, in the Canadian system, that the bill barely got out the door. In the face of this inaction, court challenges played an important role in doing what Parliament could not. In *Rodriguez*, *Carter*, and *Truchon*, plaintiffs who wished to end their lives with medical assistance sought constitutional exemptions to do so, in addition to seeking the invalidation of the MAID prohibition.[115] In both cases, the plaintiffs were backed by a small hoard of interveners supporting their cause (though opposing interveners also participated).[116] The Supreme Court's action on the issue of MAID, which broke legislative inaction, was prompted by a combination of individuals suffering from terminal illnesses and allied public interest groups who were willing to pursue (and fund) lengthy appellate litigation.

When the Supreme Court decided *Rodriguez* and *Carter*, it inserted its conception of dignity into the national conversation on MAID. On this conception, dignity demanded respect for the autonomy of individuals who wished to end their own lives.[117] Though the Supreme Court valued sanctity of life, it was not a value which precluded consenting adults from receiving MAID.[118] But the fact of court participation does not mean it imposed the language of dignity on legislators. Even at the early stages of legislative debate, competing conceptions of dignity were at the heart of the controversy. The sponsor of a 2005 Bill, which was entitled in part "*right to die with dignity*," focused her Bill on the importance of patient consent, and the interest in avoiding potential indignities at the end of life — a thick

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112 *Rodriguez*, *supra* note 66; *Carter*, *supra* note 3. See e.g. Keown, *supra* note 23 at 397–98.

113 Giroux, *supra* note 56.

114 "Bill C-215, An Act to amend the Criminal Code (aiding suicide)," 1st reading, *House of Commons Debates*, 35-1, No 94 (21 September 1994); "Bill C-407, An Act to amend the Criminal Code (right to die with dignity)," 1st reading, *House of Commons Debates*, 38-1, No 144 (31 October 2005) [Bill C-407 Debate]; "Bill C-562, An Act to amend the Criminal Code (right to die with dignity)," 1st reading, *House of Commons Debates*, 39-2, No 111 (12 June 2008); "Bill C-384, An Act to amend the Criminal Code (right to die with dignity)," 1st reading, *House of Commons* Debates, 40-2, No 89 (2 October 2009) at 5518 [Bill C-384 Debate]; "Bill C-581, An Act to amend the Criminal Code (physician-assisted death)" 1st reading, *House of Commons Debates*, 41-2, No 63 (27 March 2014); "Bill S-225, An Act to amend the Criminal Code (physician-assisted death), 1st reading, *Debates of the Senate*, 41-2, No 103 (4 December 2014) [Bill S-225 Debate]. The year 2014 is notable in that separate bills in the House of Commons and Senate were both defeated in the same year.

115 See e.g. *Carter v Canada (Attorney General)*, 2012 BCSC 886 at para 27; *Rodriguez*, *supra* note 66, Lamer J, dissenting (who would have granted Ms. Rodriguez a constitutional exemption to obtain MAID); *Truchon*, *supra* note 76 at paras 746–47. It should be noted that, having her *Charter* claim rejected by the Supreme Court, Ms. Rodriguez died with the assistance of a physician (who risked life in prison) on 12 February 1994. See generally *House of Commons Debates*, 36-1, No 27 (4 November 1997) at 1557–1561 (Svend Robinson). See also Downie, *supra* note 73 at 323.

116 *Rodriguez*, *supra* note 66; *Carter*, *supra* note 3.

117 *Carter*, *supra* note 3 at para 68.

118 *Ibid* at paras 63, 68.

conception of dignity.[119] The response of opponents of the Bill invoked a different conception of dignity, focused on sanctity arguments.[120] Despite the Supreme Court's holding in *Rodriguez*, the discussion on conceptions of dignity was far from settled.[121] If the treatment of identical issues before legislatures and courts is supposed to be a dialogue, it seems that Parliament was still talking about dignity after the Supreme Court believed it had ended the conversation.

Professor Jocelyn Downie, a Canadian legal scholar who worked on the legal team for the plaintiffs in *Carter*, has characterized the post-*Carter* period as the courts giving and Parliament taking away.[122] This model largely draws on the narrowing of eligibility from what the Supreme Court stated in *Carter* to the federal legislation in 2016.[123] For example, the requirement of "reasonable foreseeability" was struck down as contrary to the *Charter* in *Truchon*, which led to a revised framework.[124] But this model overstates the amount of direct conflict between the Supreme Court's judgment in *Carter* and the current efforts of legislators. Aside from the language of "reasonable foreseeability," Parliament has provided some method of advance consent for MAID, and is exploring MAID for mature minors, and those with mental illnesses as a sole underlying condition.[125] The process of addressing these subpopulations is slow, and some assert that their exclusion from MAID is in fact unconstitutional.[126] But crafting legislation on MAID for minors and the mentally ill is more challenging than legislation for the "paradigm" person accessing MAID

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[119] Bill C-407 Debate, *supra* note 114 at 9219–20 (Francine Lalonde). The Bill was introduced by a member of the Bloc Québécois and was opposed by the Liberal government: see *ibid* at 9221 (Hon Paul Macklin).

[120] *Ibid* at 9222–23 (Jason Kenney):

> This bill is premised on a radical misunderstanding of the dignity of the human person.… Properly conceived, human dignity is not a subjective sense of one's self worth, nor is it a reflection of one's worth in the eyes of society or the state.… [H]uman dignity, which is the basis of our civilizational belief in the sanctity of human life, is ontological, that is to say, an essential and inseparable characteristic of human personhood, of human existence.

It should be noted that the 2005 Bill was not the only time in which dignity was a central concern of legislative debate in the House of Commons after the introduction of a MAID statute: see e.g. Bill C-384 Debate, *supra* note 114 at 5519–20. See especially *ibid* at 5525 (Paul Szabo):("[t]he bill goes under the moniker of right to die with dignity, but the amendment to the Criminal Code would give a person the right to terminate a life before natural death. It would not give the right to die with dignity to someone. It would give the right of someone to take a life. That is a subtle difference…. All human life is dignified life." *Contra* Bill S-225 Debate, *supra* note 114 at 2611 (Hon Nancy Ruth).

[121] *Rodriguez*, *supra* note 66 at 586–88, 595–96.

[122] Downie, *supra* note 73 at 338; Jocelyn Downie & Jon Goud, "Four Years (and Counting) of Unconstitutional Barriers to MAID" (26 June 2020), online (blog): *Impact Ethics* [perma.cc/M7B5-MAMC]; Dying with Dignity Canada, "MAID and Mental Disorders" (9 March 2023), online: (video): *Dying with Dignity Canada* [perma.cc/4DG3-RWJQ].

[123] *Carter*, *supra* note 3; *Criminal Code*, *supra* note 74, s 241.2(2), as amended by *An Act to amend the Criminal Code and to make related amendments to other acts (medical assistance in dying)*, SC 2016, c 3, s 3; Downie, *supra* note 73 at 338.

[124] *Truchon*, *supra* note 76 at paras 511–87. That case was not the only case to challenge reasonable foreseeability as contrary to the *Charter*: see e.g. *Lamb v Canada (Attorney General)*, 2017 BCSC 1802, which did not reach the stage of a full trial by the time the Quebec Superior Court ruled in *Truchon*. See also Part II-B, above.

[125] See generally Parliament, *Medical Assistance in Dying and Mental Disorder as the Sole Underlying Condition: an Interim Report*: *Report of the Special Joint Committee on Medical Assistance in Dying* (22 June 2022) (Joint Chairs: Hon Marc Garneau & Hon Yonah Martin) [MAID Report I]; Parliament, *Medical Assistance in Dying in Canada: Choices for Canadians*: *Report of the Special Joint Committee on Medical Assistance in Dying* (15 February 2023) (Co-Chairs: Hon Marc Garneau & Hon Yonah Martin) [MAID Report II]; *Criminal Code*, *supra* note 74 s 241.2(3.2).

[126] Downie, *supra* note 73 at 345–46; Downie & Goud, *supra* note 122.

(someone with terminal cancer).[127] Considering the balancing function of section 1 of the *Charter*, the diligent (albeit slow) approach taken by the legislature is understandable, and does not necessarily fit with an 'adversarial' model.[128]

The development of MAID policy, and the application of dignity therein, has been a messy but co-operative endeavour between courts and the legislature in Canada. The process of arriving at the current status quo was therefore one of the courts and Parliament testing the balance of autonomy and sanctity of life. Neither conception of dignity was embraced to the exclusion of the other — rather, these two branches of government weighed the risks to these values against the legality of MAID.

The American story of dignity in the context of MAID is defined by originalism and absolutism. Proponents of originalism assert that constitutional rights must be interpreted as the drafters intended them; if you are arguing that the constitutional protection of dignity also includes the ability to obtain MAID, this must be reflected in the framers' conception of dignity.[129] Such an approach makes it difficult to argue that the right to MAID is constitutionally protected, when MAID was outlawed at the time that the relevant constitutional provision was drafted. The US' approach to constitutional disputes is also coloured by a certain rights absolutism, which makes compromise and the balancing of constitutional values more difficult than in the Canadian context. American courts tend to recognize fewer constitutional rights, but award them robust protection — making constitutional law a primarily interpretive exercise.[130] Canadian courts, by contrast, are quicker to recognize *Charter* rights, but more likely to find that government limits on those rights are justified, playing an adjudicative role.[131] As applied to PAS, this entails that recognizing a right to PAS in the American context — out of concern for autonomy — would foreclose to some degree the ability of governments to balance that right against other values, such as the sanctity of life.

These problems are exemplified in the US Supreme Court case of *Glucksberg*.[132] Where the plaintiffs in *Glucksberg* were successful at lower courts, the courts embraced a thick conception of dignity, including the right to PAS.[133] This approach was best captured by

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127 MAID Report I, *supra* note 125 at 17. According to the most recent report on MAID use in Canada, cancer is the most commonly cited underlying medical condition (65.6 percent of all cases), and a tiny minority of those accessing MAID had deaths which were not reasonably foreseeable (2.2 percent of all cases) (Health Canada, *Third Annual Report on Medical Assistance in Dying in Canada 2021* (Ottawa: Health Canada, July 2022) at 5).

128 See e.g. *Carter*, *supra* note 3 at paras 94–123; *R v Oakes*, 1986 CanLII 46 (SCC).

129 *Griswold v Connecticut*, 381 US 479 at 522 (1965), Black J, dissenting; *Roe*, *supra* note 43 at 171–76, Rehnquist J, dissenting; William H Rehnquist, "The Notion of a Living Constitution" (2006) 29:2 Harv JL & Pub Pol'y 401; *Dobbs*, *supra* note 43 at 36–37, Alito J.

130 Jamal Greene, "Rights as Trumps" (2018) 132:1 Harv L Rev 28 at 40–43, 62.

131 *Ibid* at 38–40; 58–59. See e.g. *Rodriguez*, *supra* note 66.

132 *Glucksberg*, *supra* note 3. It should be noted that *Glucksberg* had a companion case, *Vacco v Quill*, 521 US 793 (1997) [*Quill*]. *Quill* concerned a group of physicians who challenged a New York law which made it a crime to assist in a suicide. The question raised by *Quill*, however, was expressly limited to the Equal Protection Clause (US Const amend XIV, § 1, *supra* note 39) and did not contain a meaningful discussion of dignity (*Quill*, *supra* note 132). The US Supreme Court found that the prohibition on PAS was not unconstitutional on equal protection grounds (*ibid*). Taken together, the cases of *Glucksberg* and *Quill* mirror both arms of the argument made by the plaintiff in *Carter*, *supra* note 3.

133 *Compassion in Dying v State of Washington*, 79 F 3d 790 (9th Cir 1996) [*Compassion* 9th Cir II], rev'g 49 F 3d 586 (9th Cir 1995) [*Compassion* 9th Cir I], aff'g 850 F Supp 1454 (Dist Ct Wash 1994) [*Compassion* Dist Ct]. After the en banc hearing (*Compassion* 9th Cir II, *ibid*), the named party was changed. The case appeared before the US Supreme Court as *Washington v Glucksberg* (*Glucksberg*, *supra* note 3).

the trial judge, who found that the right to PAS was protected by the Fourteenth Amendment, stating:

> The liberty interest protected by the Fourteenth Amendment is the freedom to make choices according to one's individual conscience about those matters which are essential to personal autonomy and basic human dignity. There is no more profoundly personal decision, nor one which is closer to the heart of personal liberty, than the choice which a terminally ill person makes to end his or her suffering and hasten an inevitable death.[134]

Before a three-judge panel at the Court of Appeals for the Ninth Circuit, the trial judgment was overturned with scant mention of dignity.[135] Such a conception of dignity and autonomy (on the majority's logic) would entail that every adult, not simply the terminally ill, would have a right to PAS.[136] This reflects the absolutist tendencies within American constitutional disputes. On rehearing en banc, the Court of Appeals for the Ninth Circuit affirmed the District Court.[137]

The US Supreme Court reversed the Ninth Circuit's en banc decision. The majority in that case did not adjudicate between conceptions of dignity. Rather, it limited the scope of the due process clause by clarifying that it protects only rights which are deeply rooted in the history and tradition of the US.[138] Applying this originalist standard, and surveying some 700 years of Anglo-American legal tradition, Chief Justice Rehnquist found that PAS had been overwhelmingly rejected by legal tradition, and therefore was not protected by the due process clause.[139] In essence, the US Supreme Court decided that the conception of dignity that mattered was that of the framers of the Fourteenth Amendment. As a result of this strain of logic, any federal constitutional litigation asserting a right to PAS has failed.[140]

Judicial skepticism of PAS rights is not only a federal phenomenon — state courts have unanimously rejected claims that a constitutional right to PAS exists.[141] Unlike in Canada and the Netherlands, the individual states within the US have their own free-standing

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134 *Compassion* Dist Ct, *ibid* at 1461 [emphasis added]. At trial, Chief Judge Rothstein found that the right to assisted suicide was subject to an undue burden standard (*ibid* at 1462, citing *Casey*, *supra* note 40), and invalidated the law finding that the states' interests in preventing coerced suicides could be served by safeguards (*Compassion* Dist Ct, *ibid* at 1466). Of note, Chief Judge Rothstein also would have invalidated the law on grounds of equal protection under the Fourteenth Amendment (US Const amend XIV, § 1, *supra* note 39), finding that the state was preventing terminally ill people from hastening their death while allowing those on life support to end their lives (Compassion Dis Ct, *ibid* at 1467). In so doing she rejected the distinction between 'natural' and 'artificial' death: "Both patients may be terminally ill, suffering pain and *loss of dignity* and subjected to a more extended dying process without some medical intervention, be it removal of life support systems or the prescription of medication to be self-administered" [emphasis added] (*ibid*).

135 *Compassion* 9th Cir I, *supra* note 133. By contrast, Circuit Judge Wright centred dignity in his dissent, and would have held that a right "to die with dignity" was protected by the Constitution (*ibid* at 595).

136 *Ibid* at 590, Circuit Judge Noonan ("[t]he attempt to restrict such rights to the terminally ill is illusory. If such liberty exists in this context, as *Casey* asserted in the context of reproductive rights, every man and woman in the United States must enjoy it. The conclusion is a *reductio ad absurdum*" [citations omitted]). This reasoning exemplifies the absolutism of American constitutional rights discourse. Recognizing a right to PAS broadly speaking for all competent adults is only of concern if scrutiny of government action limiting those rights is so strict that it would preclude any action.

137 *Compassion* 9th Cir II, *supra* note 133 at 801–17.

138 *Glucksberg*, *supra* note 3 at 721.

139 *Ibid* at 723–28. At the time of the passing of the Fourteenth Amendment, most states criminalized assisting suicide. See generally Pope, "Legal History of Medical Aid in Dying," *supra* note 54 at 272.

140 Pope, "Legal History of Medical Aid in Dying," *supra* note 54 at 286–87.

141 *Ibid* at 269.

constitutions and criminal codes. As a result, in many states, litigants challenged state criminal prohibitions against PAS based on their state constitutions.[142] Often, state constitutional claims mirrored the liberty claims under *Glucksberg*, relying on state constitutional provisions which copied the language of the Fourteenth Amendment.[143] State courts are not necessarily bound to interpret similar provisions in the manner that federal courts have — at times, they may recognize broader protections.[144] But this possibility has not been realized with respect to PAS, even when the state courts rejected the historically focused method of the US Supreme Court in *Glucksberg*.[145] In other cases, the claims relied on state constitutional protections of privacy, but still found no right to PAS.[146]

Though language of dignity is sparse in state court cases post-*Glucksberg*, a notable exception is the case of *Baxter v. State of Montana*.[147] In that case, the plaintiff relied on the "dignity clause" in the Montana state constitution, as well as equal protection and privacy guarantees.[148] The trial judge relied on prior decisions regarding the dignity clause, including *Armstrong v. State*, where the Montana Supreme Court interpreted the clause as "demand[ing] that people have for themselves the moral right and moral responsibility to confront the most fundamental questions of life in general."[149] The trial judge also relied upon a law review article that argued that dignity "imagines human beings as intrinsically worthy of respect."[150] The trial judge held that the prohibition of PAS in Montana violated the state constitution.[151] On appeal, the Montana Supreme Court did not rule on the constitutional interpretation question, finding that there was no statute which prevented PAS for competent adults who administer the life-ending medication themselves.[152] As a result of *Baxter*, and in the absence of statute, MAID in Montana is now exclusively governed by the professional standard of care.[153]

No other state court would go further in its interpretation of liberty or dignity than the US Supreme Court did in *Glucksberg*. Legislation, therefore, has proven to be the only

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142 See generally Alan Meisel, "Physician-Assisted Suicide: A Common Law Roadmap for State Courts" (1997) 24:4 Fordham Urb LJ 817.

143 Pope, "Legal History of Medical Aid in Dying," *supra* note 54 at 288. See e.g. *Sampson v State*, 31 P 3d 88 at 98 (Alaska Sup Ct 2001) [*Sampson*]; *Myers v Schneiderman*, 85 NE 3d 57 (NY Ct App 2017) [*Myers*]; *Morris v Brandenburg*, 376 P 3d 836 (N Mex Sup Ct 2016) [*Morris*].

144 *Myers*, *supra* note 143 at 63; *Morris*, *supra* note 143 at paras 19–38.

145 *Kligler v Attorney General*, 491 Mass 38 at 58–74 (Mass Sup Jud Ct 2022), citing *Glucksberg*, *supra* note 3.

146 *Krischer v McIver*, 697 So 2d 97 (Fla Sup Ct 1997); *Sampson*, *supra* note 143.

147 354 Mont 234 (Mont Sup Ct 2009) [*Baxter* SC] aff'g in part 2008 No ADV-2007-787 (Mont Dist Ct, 5 December 2008) [*Baxter* Dist Ct].

148 *Baxter* SC, *supra* note 147; Mont Const art II, § 4 ("[t]he dignity of the human being is inviolable. No person shall be denied the equal protection of the laws").

149 1999 MT 261 at para 72 (Mont Sup Ct).

150 *Baxter* Dist Ct, *supra* note 147 at 14, citing Matthew O Clifford & Thomas P Huff, "Some Thoughts on the Meaning and Scope of the Montana Constitution's Dignity Clause with Possible Applications" (2000) 61:2 Mont L Rev 301. Other portions of that law review article had previously been cited with approval by the Montana Supreme Court in *Walker v State*, 2003 MT 134 at 81 (Mont Sup Ct).

151 *Baxter* Dist Ct, *ibid* at 16–19. The court found that there was no compelling state interest that could justify the prohibition, rejecting the rationales of the protection of life, protection of the vulnerable, and integrity of medical practice in the state (*ibid* at 19–23). In so doing, the court pointed to other jurisdictions which had narrowly tailored methods to ensure the state's goals without compromising the right of the individual to end their own lives (*ibid*).

152 *Baxter* SC, *supra* note 147 at paras 10–44.

153 Pope, "Legal History of Medical Aid in Dying," *supra* note 54 at 299. This is also the case in North Carolina, though not due to litigation (*ibid*).

viable path to MAID rights in the US.[154] In the US, ballot initiatives provided an early path for the legalization of MAID. Oregon's PAS law, passed in 1994, was passed by ballot initiative after two failed attempts in California and Washington.[155] A focus on autonomy played an important role in the success of the Oregon ballot initiative. Kathryn Tucker, an attorney involved for decades in the fight for MAID rights, attributed the Oregon breakthrough in part to a rejection of earlier language that referred to "mercy killing" and "suicide," and the adoption of the language of "physician-assisted suicide."[156] The state of Washington legalized PAS using a ballot initiative in 2008, with Colorado following suit in 2016.[157] Despite the success of ballot initiatives, the legislatures of states have passed the majority of PAS legislation since *Glucksberg*. This is true of Vermont (2013), California (2015), Washington, D.C. (2017), Hawai'i (2018), New Jersey (2019), Maine (2019), and New Mexico (2021).[158]

The ruling in *Glucksberg* made clear that MAID was not going to be resolved by the federal judiciary and provided impetus for the states to take action. After *Glucksberg*, the pace of change in more liberal states where MAID enjoyed broader public support accelerated (regardless of whether the bills were introduced by ballot initiative). Likewise, after *Glucksberg*, more conservative states moved quickly to enact legislation which clarified their opposition to MAID.[159] In the two years immediately following *Glucksberg*, Oklahoma and Virginia passed legislation which enabled a civil cause of action by which private parties could sue those who assisted in suicides.[160] In the same period of time, Michigan, Kansas, Arkansas, and Maryland strengthened their existing bans on PAS, or codified a common law prohibition.[161] These bans were often couched with the language of dignity, adopting a conception of dignity focused squarely on sanctity of human life, and rejecting a thick conception of dignity.

In effect, PAS legislation both accelerated and polarized post-*Glucksberg*. This phenomenon is not unique to the issue of MAID but rather is indicative of polarization on issues within the US generally.[162] Moreover, this response to *Glucksberg* is mirrored in the legal developments around abortion regulation in the US. State action in Mississippi and Texas prompted the US Supreme Court's reconsideration of abortion access; the reversal

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154 It is worth noting that some states did not wait until their own state-level judgments rejected MAID to pivot toward legislation. See generally Dinan, *supra* note 49 at 7–11.

155 Pope, "Legal History of Medical Aid in Dying," *supra* note 54 at 277.

156 Kathryn L Tucker, "In the Laboratory of the States: The Progress of *Glucksberg*'s Invitation to States to Address End-of-Life Choices" (2008) 106:8 Mich L Rev 1593 at 1595–96.

157 Pope, "Legal History of Medical Aid in Dying," *supra* note 54 at 280; Wash Stat tit RCW § 70.245; Col Stat tit CRS §§ 25-48-101 to 25-48-124.

158 Pope, "Legal History of Medical Aid in Dying," *supra* note 54 at 280; Vt Stat tit VSA §§ 5281–5293; Cal Stat tit HSC §§443–443.22; DC Stat tit DC Law § 21-182; HI Stat tit HRS § 327L; NJ Stat tit NJSA §§ 26:16-1 to 26:16-20; ME Rev Stat tit 22 §§ 2140-2140.13; NM Stat tit §§ 24-7C-1 to 24-7C-8.

159 Within two years of *Glucksberg*, 16 state legislatures considered MAID bills — half of which would have more thoroughly prohibited the practice, and half of which would have legalized it (Dinan, *supra* note 49 at 7).

160 Dinan, *supra* note 49 at 8; Va Stat § 8.01–622.1 (1998); Okla Stat tit 63 § 3141–50 (1998). This mirrors a civil cause of action passed in Texas during 2022, which introduced a civil cause of action by which any party could sue an individual for performing or assisting in the performance of an abortion after 6 weeks post-conception. See generally Whitney Arey et al, "A Preview of the Dangerous Future of Abortion Bans — Texas Senate Bill 8" (2022) 387:5 N Eng J Med 388.

161 Dinan, *supra* note 49 at 8–9.

162 Jacob M Grumbach, "From Backwaters to Major Policymakers: Policy Polarization in the States, 1970–2014" (2018) 16:2 Perspectives on Politics 416.

of *Roe* in *Dobbs* then prompted strict abortion restrictions in Republican-controlled states, while prompting strengthened protection in Democrat-controlled states.[163]

The interaction of the legislature and courts in the Netherlands is substantially more straightforward than in Canada or the US. Dutch courts exhibited leniency to physicians assisting in the deaths of their patients, clarifying the bounds of acceptable practice.[164] But the Dutch legislature did not enact meaningful legislation until 2002.[165] Perhaps most emblematic of the legislative failure to act are the reports and commissions which were requested or formed by the government or the legislature. These occurred in 1978, 1982, 1990, 1995, and 2000, and triggered responses or follow-up requests on the part of the Dutch government.[166]

To say that these reports were a cause of legislative delay, however, would not be entirely accurate. Rather, the cycle of reports and further study are a feature of a distinctly Dutch political culture of "depoliticizing" potentially controversial political issues.[167] In an effort to depoliticize the issue of MAID, the government engaged in a repetitive cycle of requesting input, revising legislation, and requesting further input. One of the many commissions studying MAID proposed a legislative revision of the underlying (and seldom-prosecuted) criminal provision in 1985.[168] A coalition government expressed openness to the revision, combined with a prior bill which was put on hold for the 1985 commission.[169] After seeking the advice of two different Councils, as well as the Committee of Procurators-General, the government submitted a revised bill for consideration.[170] That government fell before the bill faced a vote — the incoming government delayed once more to await the report of yet another commission on the topic of MAID.[171] This final commission concluded that the situation did not demand legislative

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163 *Roe*, *supra* note 43; *Dobbs*, *supra* note 43; Arey et al, *supra* note 160; Guttmacher Institute, "Interactive Map: US Abortion Policies and Access After Roe" (12 March 2025), online: [perma.cc/BKT9-FGYT].

164 See e.g. *Schoonheim*, *supra* note 90; Griffiths, Bood & Weyers, *supra* note 84 at 50–71; Gevers, "Euthanasia," *supra* note 84 at 327–29.

165 Griffiths, Bood & Weyers, *supra* note 84 at 71–88; Gevers, "Euthanasia," *supra* note 84; Blakey, *supra* note 38; Herbert Hendin, "The Dutch Experience: Euthanasia" (2002) 17:3 Issues L & Medicine 223; *WTL Act*, *supra* note 83.

166 Griffiths, Bood & Weyers, *supra* note 84 at 68–69, 76–77, 84–85; Kimsma, *supra* note 99 at 356–57; Sjef Gevers, "Selected Legislation and Jurisprudence: Evaluation of the Dutch Legislation on Euthanasia and Assisted Suicide" (2007) 14:4 Eur J Health L 369 at 369 [Gevers, "Selected Legislation"]; Agnes van der Heide et al, "End-of-Life Practices in the Netherlands under the Euthanasia Act" (2007) 356:19 New Eng J Med 1957.

167 Griffiths, Bood & Weyers, *supra* note 84 at 12–13, 86–88; Heleen Weyers, "The Legalization of Euthanasia in the Netherlands: Revolutionary Normality" in Stuart J Youngner & Gerrit K Kimsma, eds, *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (New York: Cambridge University Press, 2012) at 63–64 [Weyers, "The Legalization of Euthanasia"]. It also reflects a series of coalition governments, which changed from the centre left to centre right a number of times during the decades leading up to the passing of the *WTL Act*. See generally Adam McCann, *Assisted Dying in Europe: A Comparative Law and Governance Analysis of Four National and Two Supranational Systems* (PhD Thesis, University of Groningen, 2016) [unpublished] at 147–53.

168 Weyers, "The Legalization of Euthanasia," *supra* note 167 at 45; Griffiths, Bood & Weyers, *supra* note 84 at 70–72; Gevers, "Euthanasia," *supra* note 84 at 328.

169 Griffiths, Bood & Weyers, *supra* note 84 at 74.

170 *Ibid* at 75.

171 Weyers, "The Legalization of Euthanasia," *supra* note 167 at 50–51; Griffiths, Bood & Weyers, *supra* note 84 at 76–77.

action, giving the newly constituted government the opportunity to abandon any efforts at formalizing the MAID system.[172]

As a result of the general hesitancy to act on controversial issues, and reflecting a series of changing coalition governments, the Dutch legislature maintained a "legal vacuum," which forced courts and professional associations to craft acceptable guidance for physicians performing euthanasia.[173] Within this vacuum emerged the status quo understanding of the late 1980s and early 1990s, under which prosecution of euthanasia would be waived if physicians adhered to the guidelines provided by professional bodies and courts.

The legislative process was prompted in large part by the Royal Dutch Medical Association (KNMG) and the State Commission on Euthanasia, both of which desired the enactment of legislation to give physicians legal certainty.[174] By the time that the *WTL Act* was passed in 2001, the actions of courts and various advisory bodies had provided a robust foundation for the legislation itself, such that no controversial debate on the nature of euthanasia was necessary.[175] This represents successful depoliticization on the legislature's part — the hard and controversial work having been done elsewhere. The aims of Parliament in passing the *WTL Act* were to encourage legal certainty and establish a transparent system of evaluation, rather than to solve outstanding disputes on the bounds of MAID and on the nature of dignity.[176] At the point of legislative enactment, the *WTL Act* was not a major event in the Netherlands, but rather a codification of a longstanding practice.[177] The piecemeal, laissez-faire development of MAID entailed that neither the judiciary nor legislature were forced to confront the nature of dignity as explicitly as those actors were in Canada or the US. This resulted in the deferral of dignity to patients themselves being embraced in the Netherlands, rather than a legalistic conception being imposed by the courts or legislature.

B. CIVIL SOCIETY

Even where MAID policy has been the result of legislative and judicial decisions, civil society has played a role in constructing and expressing conceptions of dignity in each jurisdiction. Civil society organizations became parties to constitutional litigation, lobbied for legislative changes and ballot initiatives, and coloured public opinion. Where the judiciary and legislatures had not regulated MAID robustly — as in the Netherlands — these organizations played a key role not just in advancing the conversation around MAID, but also in establishing practice standards. The following section concerns two parts of civil society: physician organizations, which possess influence and sometimes legal control over the practice of MAID, and advocacy organizations, which advance their views in the public sphere but do not exercise control over the practice itself.

In all three jurisdictions, major medical associations and physicians' groups frequently turned toward the acceptance of MAID before or while the process of legalization took

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172 Griffiths, Bood & Weyers, *supra* note 84 at 78–80; Weyers, "The Legalization of Euthanasia," *supra* note 167 at 52.

173 McCann, *supra* note 167 at 147–53, 176; Griffiths, Bood & Weyers, *supra* note 84 at 87.

174 Maris, *supra* note 101 at 191.

175 Weyers, "The Legalization of Euthanasia," *supra* note 167 at 57.

176 Gevers, "Selected Legislation," *supra* note 166 at 374; van der Heide et al, *supra* note 166 at 1958.

177 Hendin, *supra* note 165 at 97.

place, advocating at times for their own conceptions of dignity. Beyond the medical profession, other civil society groups have also played key roles in advancing MAID legislation, and in imbuing national conversations with their own conceptions of dignity.

1. CANADIAN CIVIL SOCIETY

In Canada, medical organizations were deeply involved in advancing MAID. In 1993, the Canadian Medical Association (CMA) published a series of papers considering the issue of decriminalizing MAID.[178] This was quickly followed by the appointment of the Special Committee of the Senate of Canada to study legal, ethical, and social issues regarding euthanasia and PAS.[179] This committee represented large swathes of civil society and the medical community. At this early stage, dignity was a core concern of witnesses and the committee members in the subsequent report.[180] Concluding that PAS should not at that time be legalized, a majority of the committee stated that "[d]ignity exists when one faces the final stages of life with a feeling of self-worth and with the care, solicitude and compassion to which all human beings are entitled."[181] The committee also explicitly linked the notions of personal autonomy and dignity as providing a counterweight to concerns of the sanctity of life.[182]

Attitudes amongst the medical community shifted, first in Quebec and then in the broader medical community.[183] The Quebec College of Physicians Working Group on Clinical Ethics publicly stated their support for euthanasia in 2008 — a sentiment confirmed by the central College of Physicians body in 2009.[184] The Assembly of Quebec then commissioned a Select Committee on Dying with Dignity, which endorsed the legalization of MAID after studying end-of-life practices in European jurisdictions, and soliciting public input.[185] At the national level, the legalization of MAID was endorsed in 2011 by the Royal Society of Canada Expert Panel on End-of-Life Decision Making.[186]

Not only was there a shift in preferences around legalization, but the medical community appeared to be favouring a thicker conception of dignity. The Royal Society's final report addressed the concept of dignity and considered conceptions of dignity levied against the legalization of MAID. The final report concluded that most invocations of dignity against legalizing MAID cloak implicitly or explicitly theological concerns, making them inappropriate for legal and policy debate in a secular, multicultural society.[187] The Quebec working group addressed dignity in more favourable terms than the Royal

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178 Frederick H Lowy, Douglas M Sawyer & John R Williams, *Canadian Physicians and Euthanasia* (Ottawa: Canadian Medical Association, 1993).

179 Downie, *supra* note 73 at 323–25.

180 Senate, The Special Senate Committee on Euthanasia and Assisted Suicide, "*Of Life and Death – Final Report*," 35-1 (June 1995).

181 *Ibid* at ch 7.

182 *Ibid*.

183 Giroux, *supra* note 56 at 435–36.

184 *Ibid* at 435; Collège des Médecins du Québec, *Pour des soins appropriés au début, tout au long et en fin de vie*, Rapport du group de travail en éthique clinique (Quebec: CMQ, 2008) at 28–35.

185 Downie, *supra* note 73 at 326; Quebec, National Assembly, Select Committee on Dying with Dignity, *Dying with Dignity Report* (March 2012) at 76 [*Dying with Dignity Report*]; Giroux, *supra* note 56 at 436.

186 Royal Society of Canada, *End of Life Decision Making* (Ottawa: Royal Society of Canada, 2011) [RSC Report].

187 *Ibid* at 56.

Society of Canada, but concluded that a "subjective" account of dignity, on which patients had the autonomy to decide what dignity entailed for them, was preferable.[188]

The change in perspectives between *Rodriguez* and *Carter* is well reflected in the positions that advocacy groups took in litigation. During *Carter*, the CMA took the neutral position that "the decision as to the lawfulness of the current prohibition on medical aid in dying is for patients and their elected representatives as lawmakers to determine, not physicians," abandoning their participation in the conversation of MAID and dignity.[189] By this time, other civil society groups outside of the medical community took up the arguments that medical organizations had been making for years.[190]

Canadian civil society was not united in its support for MAID. But much of the civil society resistance to the legalization of MAID came from religious organizations. This was true in *Carter*, where three Christian medical associations intervened before the Supreme Court, along with several non-medical religious groups.[191] These parties argued that legalizing MAID would negatively affect the understanding of human life as intrinsically valuable, and that dignity was not furthered by the ending of life, but rather by palliative care.[192]

2. AMERICAN CIVIL SOCIETY

In the US, unlike Canada, opposition to MAID is shared by both mainstream medical associations and religious physician associations. The American Medical Association (AMA) opposed the first ballot initiative to legalize MAID.[193] Some 30 years later, the AMA's *Code of Medical Ethics* (AMA Code) states that "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer," while acknowledging that some physicians may have deeply held beliefs in support of the practice.[194] The AMA Code takes the same stance toward euthanasia, without the caveat regarding beliefs.[195] Beyond the AMA, a recent review of all 150 secular American medical societies revealed that none overtly supported MAID.[196] This opposition is bolstered by religious medical associations,

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188 *Dying with Dignity Report*, *supra* note 185 at 64.

189 *Carter*, *supra* note 3 (Factum, Intervener (Canadian Medical Association) at para 17).

190 *Ibid* (Factum, Intervener (Canadian Civil Liberties Association) at paras 4–18); *ibid* (Factum, Intervener (Canadian Unitarian Council) at paras 19–27).

191 *Carter*, *ibid* at para 130.

192 *Ibid* (Factum, Intervener (Catholic Health Alliance of Canada) at paras 5–12); *ibid* (Factum, Intervener (Christian Medical and Dental Society of Canada & the Canadian Federation of Catholic Physicians' Societies) at paras 5–6); *ibid* (Factum, Intervener (Euthanasia Prevention Coalition and Euthanasia Prevention Coalition British Columbia) at paras 9–13); *ibid* (Factum, Intervener (Christian Legal Fellowship) at paras 3–9).

193 Ian Dowbiggin, "From Sander to Schiavo: Morality, Partisan Politics, and America's Culture War over Euthanasia, 1950–2010" (2013) 25:1 J Pol'y History 12 at 29.

194 American Medical Association, Code of Medical Ethics, (Washington, DC: AMA, 2023) at 5.7, 1.1.7 [AMA Code].

195 *Ibid* at 5.8.

196 Joseph G Barsness et al, "US Medical and Surgical Society Position Statements on Physician-Assisted Suicide and Euthanasia: A Review" (2020) 21:111 BMC Medical Ethics 1. The study included only secular medical societies and conducted the review by consulting the position statements of all medical societies which have a seat within the AMA house of delegates (*ibid* at 2). Only 12 societies had position statements on MAID, of the available statements, 45 percent opposed PAS, and 67 percent opposed euthanasia — the remaining position statements either took an explicitly neutral position, or did not acknowledge a position at all (*ibid* at 3).

which advocate explicitly for the sanctity of life.[197] Though associations are united against legalization, a majority of individual American physicians (60 percent) support the legalization of PAS.[198] This population, evidently, is not large enough to trigger a policy shift within the American medical establishment.

Beyond physician associations, the US has a particularly robust set of advocacy groups which campaign against an autonomy-focused, thick conception of dignity. Foremost amongst these groups are churches, some of which engaged with the MAID debate directly from the passing of the first American PAS bill in 1994.[199] Though some are focused wholly on MAID, non-church groups are often multi-issue organizations, campaigning against abortion, the termination of life-sustaining care, and gender-affirming care for transgender patients.[200]

In the face of resistance and indifference from the medical communities and religious groups, other civil society groups have been essential to the legalization of MAID in the US. Through the twentieth century, efforts to legalize euthanasia were championed by the Euthanasia Society of America.[201] The organization was focused on legalizing so-called "mercy killings" — euthanasia consented to by the family of a dying patient, rather than the patient themselves.[202] But many legislative efforts in the early twentieth century incorporated involuntary euthanasia, toward eugenic ends.[203] In addition, the perversion of the term "euthanasia" under the Nazi Party during the Second World War slowed the advancement of the euthanasia movement in the US.[204] In the immediate post-war period, advocacy organizations shifted to focus on patient autonomy and end-of-life planning.[205] In part, this was an effort to avoid the conflation of their mission with eugenics.[206]

After this shift, those still focused on advancing MAID were left to revitalize the advocacy community. The 1990s saw the establishment of several state and federal organizations focused on MAID, many of whom incorporated "dignity" into their name.[207] These advocacy organizations founded in the 1990s have been essential to the advancement

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197 See e.g. Christian Medical & Dental Associations, "Physician-Assisted Suicide and Euthanasia" (2023), online: [perma.cc/BA55-HD7C]; Catholic Medical Association, Press Release, "Catholic Medical Association Speaks out Against Fellow Medical Organization's Decision to Take a 'Neutral Stance' on Physician-Assisted Suicide" (17 October 2018), online: [perma.cc/FWA4-KH2Y].

198 Peter T Hetzler III et al, "A Report of Physicians' Beliefs About Physician-Assisted Suicide: A National Study" (2019) 92:4 Yale J Biology & Medicine 575. Only a small proportion of those in favour of legalization (13 percent) would perform PAS themselves (*ibid* at 579).

199 Dowbiggin, *supra* note 193 at 30.

200 See e.g. Terri Schiavo Life & Hope Network, "About" (2023), online: [perma.cc/27MS-M4JN] (a single-issue anti-MAID group). For groups which campaign on many issues, see e.g. National Center for Life and Liberty (2023), online: [perma.cc/PWX7-47V4]; National Right to Life, "Assisted Suicide & Euthanasia" (2024), online: [perma.cc/F4ZK-HM5Z].

201 MaryKatherine A Brueck & Daniel P Sulmasy, "The Genealogy of Death: A Chronology of U.S. Organizations Promoting Euthanasia and Assisted Suicide" (2018) 17:5 Palliative & Supportive Care 604 at 604.

202 Shai J Lavi, *The Modern Art of Dying: A History of Euthanasia in the United States* (New York: Princeton University Press, 2005) at 144–45, 152–57; Brueck & Sulmasy, *supra* note 201 at 604 ("mercy deaths").

203 Lavi, *supra* note 202 at 107–10.

204 Brueck & Sulmasy, *supra* note 201 at 604; Lavi, *supra* note 202 at 121–24; Michael A Grodin, Erin L Miller & Johnathan I Kelly, "The Nazi Physicians as Leaders in Eugenics and 'Euthanasia': Lessons for Today" (2018) 108:1 Am J Pub Health 53.

205 Brueck & Sulmasy, *supra* note 201 at 605.

206 *Ibid*.

207 *Ibid* at 606.

of PAS legislation.[208] The two largest MAID advocacy groups in the US — Death With Dignity and Compassion & Choices — have been at the heart of most successful PAS legislation: drafting bills, engaging in public advocacy, and litigating.[209]

The influence and impact of MAID advocacy is affected by MAID's status as a state-level issue. In liberal states, where MAID legislation has passed, the conversation was in effect dominated by pro-MAID organizations which have advocated a secular conception of dignity focused on autonomy. In conservative states where MAID legislation has failed, or where prohibitions on MAID have been strengthened, the discussion was dominated by conservative, often religious groups, pushing a conception of dignity that focused on sanctity. This is consistent with wider trends of state-level polarization, addressed explicitly in Part III-C, below.

3. DUTCH CIVIL SOCIETY

In the Netherlands, the legislature essentially delegated the governance of MAID to medical professionals instead of legislating.[210] Dutch physician associations and health authorities therefore wielded great influence over the shape of MAID policy. Such deference is not an anomaly in the Netherlands, where physicians enjoy a great deal of public trust.[211]

Despite their later role, the Dutch medical community was initially opposed to legal euthanasia. The KNMG and Dutch Health Council took a position against active euthanasia in the early 1970s, though they accepted the withdrawal of life-sustaining care.[212] The independent, pro-life group the Dutch Association of Physicians (NAV) advocated for sanctity of life principles, endorsing a ban on euthanasia and the withdrawal of life-sustaining care.[213] Prompted by two criminal cases acknowledging the practice of euthanasia in the Netherlands, the KNMG in 1984 took the position that euthanasia was

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208 *Ibid* at 607.

209 Death with Dignity, "Our History" (2023), online: [perma.cc/V37P-CZLZ]; Compassion & Choices, "Medical Aid-in-Dying Campaign Progress" (2025), online: [perma.cc/U7XP-DHN2]; Compassion & Choices, "Legal Advocacy" (2025), online: [perma.cc/4XGW-DVAM]; Brueck & Sulmasy, *supra* note 201 at 606–07; Dowbiggin, *supra* note 193 at 29–32. For a more fulsome account of how American MAID advocates have embraced "dignity" in their advocacy, and other conceptual shifts, see generally Yvonne Lindgren, "From Rights to Dignity: Drawing Lessons from Aid in Dying and Reproductive Rights" (2016) 5:3 Utah L Rev 779 at 790–92, 795–805.

210 Griffiths, Bood & Weyers, *supra* note 84 at 91; Esther Pans, "The Normative Context of the Dutch Euthanasia Law" in Stuart J Youngner & Gerrit K Kimsma, eds, *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (New York: Cambridge University Press, 2012) 69 at 72–74.

211 See generally Margo Trappenburg & Hans Oversloot, "The Dutch Social Fabric: Health Care, Trust, and Solidarity" in Stuart J Youngner & Gerrit K Kimsma, eds, *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (New York: Cambridge University Press, 2012) 99 at 99. Various scholars have argued that trust in Dutch physicians on the issue of MAID was grounded, at least in part, on their actions during Nazi occupation, when many members of the medical profession risked imprisonment and death resisting occupying Nazi orders to involuntarily euthanize patients: see e.g. Jennifer M Scherer & Rita J Simon, *Euthanasia and the Right to Die: A Comparative View* (Lanham: Rowman & Littlefield Publishers, 1999) at 55. It was the position of the KNMG and the Dutch Health Council on life-sustaining care that motivated the founding of the Dutch Association of Physicians (Weyers, "The Legalization of Euthanasia," *supra* note 167 at 39). See also James C Kennedy, "The Lateness of the Dutch Euthanasia Debate and Its Consequences" in Stuart J Youngner & Gerrit K Kimsma, eds, *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (New York: Cambridge University Press, 2012) 3.

212 Weyers, "The Legalization of Euthanasia," *supra* note 167 at 39.

213 *Ibid*.

already a "fact of life."[214] Rather than attempting to crack down on an illegal practice, the KNMG drafted due care criteria for the performance of euthanasia — a permissive reaction explored further in III-C, below.[215] These criteria remain at the core of current regulations in the Netherlands.

Because of the deference given to the Dutch medical establishment, their internal ethical considerations had the most import before the passing of the *WTL Act* in 2001. The conception of dignity agreed upon within the Dutch medical establishment was squarely focused on patient autonomy — a principle long embraced by the Dutch medical community.[216] The Dutch Health Council, which authored influential reports on MAID before legalization, viewed autonomy as an implicit principle of the law, which protected the individual from the state's protection where it was unwanted.[217] This principle of autonomy was not limited by the concept of dignity recognized in Dutch constitutional law.[218] Rather, Dutch ethicists embraced a thick conception of dignity, entitling individuals the autonomy to decide the shape of their own life.[219] This conception mirrors the open definition of "unbearable suffering" in the *WTL Act*, which in practice refers not to what sort of suffering is objectively unbearable, but rather what is unbearable to that patient in particular.[220] In effect, it is the autonomy of the patient which legitimizes the claim that they are suffering indignity, and it is this judgment on which physicians take action by performing MAID when requested.

Despite the deference given to Dutch physicians, civil society was still involved in the discussion. In particular, the Dutch Association for Voluntary Euthanasia (NVVE), founded in 1973, pushed for the formal legalization of MAID as physician groups were tasked with governing its practice.[221] On the other hand, resistance was posed by religious groups, led by the NAV, strict Calvinist churches, and the Roman Catholic Church.[222] These groups tended to characterize the practice of euthanasia as an attack on the dignity of the person, and an affront to the sanctity of life.[223] But these movements never attracted wide public attention.[224]

C. RELIGION, PUBLIC OPINION, AND TOLERANCE

Beyond the interactions of legislatures, the judiciary, and civil society, each jurisdiction's development of MAID and conception of dignity embraced therein is reflective of political dynamics, public opinion, and religion. Though all of these dynamics have been at play throughout the preceding sections, in the following section they will be

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214 *Ibid* at 42.
215 *Ibid* at 42–43.
216 Griffiths, Bood & Weyers, *supra* note 84 at 169.
217 *Ibid*.
218 *Ibid* at 169–72.
219 *Ibid*.
220 Pans, *supra* note 210 at 72, 78.
221 Griffiths, Bood & Weyers, *supra* note 84 at 53, 55–57, 77; Heleen Weyers, "Dutch Social Groups on Euthanasia: The Political Spectrum on Ending Life on Request" in Stuart J Youngner & Gerrit K Kimsma, eds, *Physician-Assisted Death in Perspective: Assessing the Dutch Experience* (New York: Cambridge University Press, 2012) 82 at 85–86 [Weyers, "Dutch Social Groups"].
222 Griffiths, Bood & Weyers, *supra* note 84 at 53; Weyers, "Dutch Social Groups," *supra* note 221 at 87.
223 Weyers, "Dutch Social Groups," *supra* note 221 at 87.
224 Griffiths, Bood & Weyers, *supra* note 84 at 53. In part, this is because anti-euthanasia religious groups did not campaign actively. For instance, after the release of yet another influential government report on euthanasia in 1991, no Dutch church organization issued a position statement on the matter (Weyers, "Dutch Social Groups," *supra* note 221 at 89).

addressed explicitly. Religion is important to the discussion around MAID for two reasons. First, religion provides much of the language around dignity itself and especially bolsters sanctity of life arguments on which many of the advocacy groups mentioned previously rely. Second, religion can be an important predictor of support for MAID generally — but that trend itself varies between jurisdictions.

All three jurisdictions have Christian majorities, sizable agnostic/atheist/unaffiliated minorities, and a cluster of smaller minority faiths (such as Islam, Judaism, Hinduism, and Sikhism). Considering the similarity — both in population and in Christian teachings on MAID — one may expect a similar approach to MAID policy. One might also expect the invocation of a Christian conception of dignity, focusing on sanctity of life at the expense of individual autonomy.[225] But this is not the case. The differences in approach are reflected in the history and religious practice of each jurisdiction: the Netherlands has a robust history of tolerance, arising from compromise between religious sects; the US is beset by polarization and overrepresentation of religious and conservative politicians; and Canada is coloured by secularism as well as Quebec's laïcité.

The Dutch propensity toward tolerance sets it apart from both the US and Canada. Tolerance as a political phenomenon in the Netherlands dates back at least until the sixteenth century, when various minority religious groups fled there from wars of religious persecution.[226] In that time, the Netherlands served as a safe haven for Jews, Catholics, and French Protestant Huguenots.[227] It was also one of the few western European countries which did not engage in the torture and killing of women accused of "witchcraft" during the seventeenth century.[228] The Netherlands' modern propensity for tolerance was also affected by pragmatic, political concerns. From the turn of the twentieth century and well after the Second World War, Dutch society saw the rise of *verzuiling* (pillarization): the segregation of society into many different segments, each with their own institutions and ideology.[229] As a result, the political elites in the Netherlands adopted a pragmatic approach to political decision-making — compromises were essential to any progress, since no social group enjoyed majority dominance.[230] As religion became less of a stark dividing line within society, the concept of tolerance was instead applied to political views and partisan divides.[231]

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[225] See e.g. Keown, *supra* note 23 at 38:

> The [Judeo-Christian] doctrine of the sanctity of life holds that human life is created in the image of God and is, therefore, possessed of an intrinsic dignity which entitles it to protection from unjust attack. Even without that theological underpinning, the idea that human life possesses an intrinsic dignity grounds the principle that one must never intentionally kill an innocent human being. The 'right to life' is essentially a right not to be intentionally killed [footnotes omitted].

This is in contrast to a secular account of the sanctity of human life, which would find dignity in "that radical capacity, inherent in human nature, which normally results in the development of rational abilities, such as understanding and choice" (*ibid*).

[226] Titia HC Bueller, "The Historical and Religious Framework for Euthanasia in the Netherlands" in Robert I Misbin, ed, *Euthanasia: The Good of the Patient, the Good of Society* (Frederick, Maryland: University Publishing Group, 1992) 183 at 183–84; Buruma, *supra* note 84 at 76.

[227] Buruma, *supra* note 84 at 76–80.

[228] *Ibid* at 77.

[229] James C Kennedy, *A Concise History of the Netherlands* (London: Cambridge University Press, 2017) at 393–96; Buruma, *supra* note 84 at 78–79; Griffiths, Bood & Weyers, *supra* note 84 at 11.

[230] Griffiths, Bood & Weyers, *supra* note 84 at 11–12.

[231] Buruma, *supra* note 84 at 80.

Reflecting this history, the euthanasia argument in the Netherlands is characteristically "Dutch."[232] Parties with divergent views engage freely in debate on foundational issues. Such tolerance provides more freedom for each individual to discern what 'dignity' means to them. This also provides context for the support for the legalization of MAID amongst broad swathes of the population; in the most recent available poll (from 2016), 88 percent of the Dutch public supported the *WTL Act.*[233]

In contrast to the example set by the Netherlands, the US' development of MAID policy displays polarization between two factions.[234] As explored above, the structure of the American court system foreclosed a federal constitutional solution to the matter of MAID. By default, this leaves the issue to the states. The jurisdictions where MAID has been legalized in the US are overwhelmingly liberal and Democrat-leaning. In the most recent Gallup poll on the issue, a healthy majority of Americans (72 percent) believe that euthanasia should be legalized.[235] But the sentiment toward euthanasia varies by political affiliation. While 62 percent of self-identified Republicans support euthanasia, this drops to 54 percent of self-identified conservatives.[236] By contrast, euthanasia is supported by 80 percent of self-identified Democrats and 89 percent of self-identified liberals.[237] Support drops most notably in respondents who attend Church weekly — with only 37 percent of these individuals supporting euthanasia.[238]

The absence of any suggestion of federal legislative action on PAS is emblematic of a system in which conservative, rural, and religious voters are overrepresented.[239] Religious overrepresentation is particularly relevant, considering the strong religious undertones present in conceptions of dignity. A review of the 117th Congress (sworn in after the 2020 federal election) found that Christians composed 88 percent of Congress, despite making up only 65 percent of the American population.[240] Most strikingly, 99 percent of Republicans in Congress identify as Christians.[241] Only one member of Congress reported being "unaffiliated," despite 26 percent of the American population identifying as such.[242] Moreover, polarization and overrepresentation also entails that issues are ceded to the states, where polarization of a different kind exists. Delegation to the states has resulted in more extreme policy shifts, to both the left and right, on a variety of issues over the past

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232 Weyers, "The Legalization of Euthanasia," *supra* note 167 at 63.

233 Kirsten Evenblij et al, "Public and Physicians' Support for Euthanasia in People Suffering From Psychiatric Disorders: A Cross-Sectional Survey Study" (2019) 20:62 BMC Medical Ethics at 2.

234 This also mirrors the American polarization around abortion: see e.g. Michael Hout, Stuart Perrett, & Sarah K Cowan, "Stasis and Sorting of Americans' Abortion Opinions: Political Polarization Added to Religious and Other Differences" (2022) 8 Socius.

235 Megan Brenan, "Americans' Strong Support for Euthanasia Persists," *Gallup* (31 May 2018) online: [perma.cc/F2J9-6RE9].

236 *Ibid*.

237 *Ibid.*

238 *Ibid*.

239 See e.g. John D Griffin, "Senate Apportionment as a Source of Political Inequality," (2006) 31:3 Legislative Studies Q 405.

240 Aleksandra Sandstrom, *Faith on the Hill: The Religious Composition of the 117th Congress* (Washington, DC: Pew Research Center, 2021) at 4. This overrepresentation was true of both Catholics and Protestants (*ibid*).

241 *Ibid* at 10.

242 *Ibid*. This may reflect a general American suspicion of atheists, especially in the political sphere: see e.g. Casey Cep, "Why are Americans Still Uncomfortable with Atheism?", *The New Yorker* (22 October 2018), online: [perma.cc/GY6R-95WV].

several decades.[243] Any advances in federal MAID policy would have to overcome these deeply engrained facts of the American political system.

Canada also has a large number of Christians: 63.2 percent of the population identified as Christian in the most recent census, roughly half of whom were Catholic.[244] But in Canada, unlike the US, religiosity is not a good predictor of whether an individual will support MAID. In a 2020 poll, 86 percent of Catholics and 79 percent of Protestants supported MAID, comparable to 86 percent support among the general Canadian population.[245] Similarly, there is no extreme variation between political parties. Self-identified members of all three major parties supported the Supreme Court's decision in *Carter*: 88 percent of the left-leaning NDP, 87 percent of the centre-left Liberals, and 82 percent of the centre-right Conservatives.[246] In contrast to the example of the US, this national attitude toward MAID is not affected by devolution into a provincial matter (with the exception of Quebec), or by substantial conservative, rural, or religious overrepresentation in government.[247] Canada also has a history of tolerance, multiculturalism and secularism which may reflect more amenability to compromise on social issues in a similar manner as the Netherlands.[248]

The exception to the otherwise federal story of the advancement of MAID in Canada is Quebec, which legalized MAID through legislation one year before *Carter*. But this is not indicative of American-style polarization. Rather, Quebec has a special relationship to religion and secularism. Roughly 40 percent of Quebeckers identified as possessing a religious affiliation, while reporting that their religious beliefs were "not very important" or "not important at all" to how they live their lives.[249] Despite being Canada's most Catholic province, Quebec has also become one of Canada's most secular. Quebec's secularization has roots in the Quiet Revolution, a movement in the 1960s after which the place of Catholicism in provincial government was drastically reduced.[250] The province is now marked by an attachment to the identity of Catholicism more than to its religious tenets, and has explicitly embraced a distinct conception of laïcité.[251] Moreover, Quebec's early advancement of MAID is not out of character for the province, which has proactively addressed controversial issues which its Catholic populace would not be expected to

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243 Grumbach, *supra* note 162.

244 Statistics Canada, *Religiosity in Canada and its evolution from 1985 to 2019*, by Louis Cornelissen, in *Insights on Canadian Society*, Catalogue No 75-006-X (Ottawa: Statistics Canada, 2021) [Statistics Canada].

245 Ipsos, Press Release, "Large Majority (86%) of Canadians Support (50% Strongly/36% Somewhat) Supreme Court of Canada Decision about Medical Assistance in Dying" (6 February 2020), online: [perma.cc/5GBL-EA7X] [Ipsos]. The poll specifically asked whether respondents supported MAID subject to the limitations stated by the court in *Carter*.

246 Ipsos, *ibid*.

247 *Ibid*. See e.g. Henry Milner, "The Case for Proportional Representation in Canada" in Henry Milner, ed, *Making Every Vote Count: Reassessing Canada's Electoral System* (Peterborough: Broadview Press, 2004) 37 at 38–40. This is not to say that these factors do not exist generally in Canada, but rather that these factors do not manifest themselves in the Canadian MAID debate.

248 See generally Brian Clarke & Stuart Macdonald, *Leaving Christianity: Changing Allegiances in Canada Since 1945* (Montreal: McGill-Queen's University Press, 2017) at 232–245.

249 Statistics Canada, *supra* note 244 at 11.

250 Jean-François Nault & E-Marin Meunier, "Is Quebec Still a Catholically Distinct Society within Canada? An Examination of Catholic Affiliation and Mass Attendance" (2017) 46:2 Studies in Religion 230.

251 *Ibid* at 241–42; *An Act Respecting the Laicity of the State*, CQLR c L-0.3. See also Jean-François Laniel, "La moitié religieuse de la laïcité Québécoise. Vers une sociologie complexifiée de la sécularisation" in Jean-Philippe Perreault & Jean-François Laniel, eds, *La laïcité du Québec au miroir de sa religiosité* (Montreal: University of Laval Press, 2021) 115.

support: namely, abortion and same-sex marriage.[252] As a result, the population of Quebec is particularly well placed to eschew a more Christian-influenced conception of dignity, at least as it is reflected in public policy.

IV. CONCLUSION

This paper is not meant to resolve any disputes about the proper application of dignity to the law of MAID in different jurisdictions. Nor is it meant to offer a full causal story of what factors were determinative in the adoption of one conception of dignity or the other. Rather, it explores differing conceptions of dignity, addressing how they have been constructed and expressed. The American picture of dignity is constructed through the unique interpretive theory of originalism, on which the federal judiciary sent the issue of MAID to the state legislatures and thereby to the polarized court of public opinion. Canada's conception of dignity, in contrast, was shaped by a pragmatic, balancing model of constitutional adjudication, and in part triggered by the actions of civil society and individual litigants who advocated for a "thick," autonomy-focused conception of dignity. The Netherlands, reflecting its long history of compromise and tolerance, effectively allowed the practice of MAID to respond to the dignitary concerns of individual patients — it was this conception which dominated once euthanasia was finally legislated.

What is common in all three jurisdictions is that the conception of dignity which governs MAID policy is not invented by any one constitutional actor or level of government. Just as it takes multiple actors and pathways to legalize a practice like MAID, it takes multiple actors and strategies to engrain a particular conception of dignity in dying.[253] Even in the Netherlands, where the medical community was largely free to define the practice of euthanasia for themselves, dignity was not simply a ground-up endeavour — its consideration was demanded by the nation's top court.[254] Though the Supreme Court considered the conflict between autonomy and sanctity in its ruling, it was the legislature and those contributing their opinion to it which determined the full picture of dignity as it now applies to the Canadian MAID framework. The US, despite its polarized and localized approach to MAID, arrived at its current state due to federal courts, state legislatures, and national-level advocacy organizations. In this comparative story of dignity in dying, there is no implementation of a conception of dignity by fiat of one actor.

It is perhaps tempting to conclude that dignity as a concept is subject to sufficient manipulation and variation that it must be rejected as a universal moral principle.[255] But dignity can serve as a unifying goal, regardless of what interpretation of dignity governs in each jurisdiction.[256] The international embrace of dignity was meant to establish a common goal, regardless of how individual nations pursued it.[257] To criticize the application of dignity in a given jurisdiction as flimsy or politically motivated risks implying that a pure concept of dignity exists. To the contrary, every conception of dignity is subject to change and utilization by groups with different goals and beliefs. Focusing on the constituent parts

252 Downie, *supra* note 73 at 326.

253 This mirrors the "hydraulic process" account, in that the conception of dignity is shaped by a wide variety of actors who pursue various paths toward influencing the result of a constitutional dispute or claim: see generally Athanasios Psygkas, "The Hydraulics of Constitutional Claims: Multiplicity of Actors in Constitutional Interpretation" (2019) 69:2 UTLJ 211 at 213–14.

254 *Schoonheim*, *supra* note 90.

255 See e.g. McMahan, "Human Dignity", *supra* note 7.

256 See e.g. Carozza, *supra* note 1 at 466–68.

257 Shulztiner & Carmi, *supra* note 9 at 471–72; McCrudden, *supra* note 6 at 677–78.

of particular conceptions, and the beliefs of the groups invoking dignity, would perhaps provide clarity within MAID discussion.[258] At minimum, a deeper understanding can help make sense of how parties can invoke dignity while coming to entirely different conclusions about what it demands.

[258] This in some way mirrors the conclusions of the Royal Society of Canada with regards to focusing on the constituent parts of dignity as a concept (see e.g. RSC Report, *supra* note 186); and the conclusion of McCrudden, *supra* note 6 at 712–22 with regards to the utility of dignity as an international legal norm.