The *Rodriguez* Case: Sticky Questions and Slippery Answers

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This comment addresses two issues raised by the *Rodriguez* case: the nature of Sue Rodriguez's request, and the way in which society should respond to it. While the Supreme Court was as one in seeing the claim she made as self-regarding, in fact, Ms Rodriguez sought not private freedom but public ratification of her decision, and assistance in its fulfilment. The question of how broadly a right to suicide must be construed has been opened by the Court, and therefore, the issue of the "slippery slope" must be addressed. The Supreme Court is clearly unequipped to deal with that issue, as is clear from the judgments. A political response is necessary.

Ce commentaire s'intéresse à deux aspects de l'affaire *Rodriguez*: la nature de la demande de Sue Rodriguez et la façon dont la société devrait y répondre. Bien que la Cour suprême ait reconnu que le problème auquel Madame Rodriguez faisait face ne concernait qu'elle personnellement, en fait, ce n'était pas la liberté de prendre sa décision en privé qu'elle recherchait, mais bien la reconnaissance publique de son droit de la prendre, et la possibilité d'obtenir de l'assistance dans son exécution. Étant donné que la Cour s'est demandée jusqu'à quel point la conception du suicide devait être élargie, il faut maintenant s'intéresser au problème de l'effet d'entraînement. Or, il appert que la Cour suprême n'est clairement pas bien équipée pour se questionner sur ce problème. Une réponse politique est donc requise.

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Introduction

In its decision in *Rodriguez* v. *Canada (A.G.)*,[1] the Supreme Court of Canada came within a whisker of transforming Canadian legal and medical practice regarding euthanasia and assisted suicide. Not only was the margin of decision — five to four — as close as could be, but in addition, the majority view presented by Mr. Justice Sopinka conceded nearly all of the building-blocks of which the dissenters, who favoured Rodriguez's legal claim, availed themselves.

Lost in the judgments, however, are two essential issues raised by the case. First, what was Sue Rodriguez actually requesting from the Court — as opposed to the issue that the Justices were actually deciding? Second, how should society reason about that actual request? In this brief comment, I will discuss both issues.

I. The Court's Question

The answer to any question depends upon the question posed. The *Rodriguez* case is commonly understood to pose the question of the legality of physician-assisted suicide, or more specifically, the constitutional question of whether the Canadian criminal prohibition on assisting suicide is contrary to the *Charter*.[2]

The State of Michigan, home to Dr. Jack Kevorkian, recently faced the same question, as the American Civil Liberties Union ("ACLU") challenged the constitutionality of a newly-minted law that prohibited physician-assisted suicide. How do we then understand the question posed by the Court in Michigan?

[1][1993] 3 S.C.R. 519, (*sub nom. Rodriguez* v. *British Columbia (A.G.)*) 107 D.L.R. (4th) 342 [hereinafter *Rodriguez* cited to S.C.R.].

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

Consider the titles of two recent discussions of the Michigan case. Is "the" question, as Yale Kamisar, a critic of the court action, argues, "Are Laws against Assisted Suicide Unconstitutional?"[3] Or is it rather, in the words of Robert Sadler, acting for the ACLU in this case, one of "The Constitution and Hastening Inevitable Death"?[4] While the ACLU would like to focus attention upon one kind of case, that of a person in a late stage of terminal illness, its opponents look to the broader issue of decriminalizing assisted suicide. To a large degree, the authors are correct in understanding that what stands between them is as much the question posed as the answer given. Sadler writes:

> The "right question," as regards the ACLU challenge to Michigan's ban on assisted suicide, is not, I would submit, whether there is a constitutional "right to assisted suicide" or a constitutional "right to die." Rather the right question, framed in the context of this particular constitutional challenge, is whether an absolute ban on the use of physician-prescribed medications by a terminally ill person to hasten that person's inevitable death, *if and when the person chooses to do so*, is an "undue burden" on the person's "liberty" interest protected by the Fourteenth Amendment's due process clause, and so is unconstitutional.[5]

These are the marks of the "slippery slope": the proponent of a change seeks to emphasize the limited nature of the question, while the opponent insists upon analyzing the broader implications of an answer. The identical rhetorical move can be found in the *Rodriguez* case. Justice Sopinka saw the case as posing a broad question, not restricted to the terminally ill. He stated:

> The result of the reasons of my colleagues is that all persons who by reason of disability are unable to commit suicide have a right under the *Canadian Charter of Rights and Freedoms* to be free from government interference in procuring the assistance of others to take their life.[6]

However, Madam Justice McLachlin insisted, to the contrary, on speaking of one specific disabled person who happens to be facing inevitable death. She writes:

> Our task was the much more modest one of determining whether, given the legislative scheme regulating suicide which Parliament has put in place, the denial to Sue Rodriguez of the ability to end her life is arbitrary and hence amounts to a limit on her security of the person which does not comport with the principles of fundamental justice.[7]

As the argument progresses between Justice Sopinka and the dissenting Justices (primarily Justice McLachlin and Chief Justice Lamer), other traditional hallmarks of the slippery slope argument can be discerned. Justice Sopinka maintained, *per contra* McLachlin J., that the principles of fundamental justice must take cognizance of a state interest — in effect, that the broad social implications of a decision can help to determine (or undermine) private assertions of right.[8] He cited with approval the conclusion of the Law Reform Com-

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[3](1993) 23:3 Hastings Center Rep. 32.
[4](1993) 23:5 Hastings Center Rep. 20.
[5]*Ibid.* at 20.
[6]*Supra* note 1 at 581.
[7]*Ibid.* at 628.
[8]*Ibid.* at 592-93.

mission of Canada, arguing that in the event of a legal reform permitting euthanasia or physician-assisted suicide, "there is no certainty that abuses can be prevented";[9] and, noting Dutch evidence suggesting that involuntary active euthanasia (which is not permitted by the guidelines) is being practised to an increasing degree, he stated that such a "worrisome trend supports the view that a relaxation of the absolute prohibition takes us down 'the slippery slope'."[10] The Chief Justice rejected such an argument as a legal matter:

> While I share a deep concern over the subtle and overt pressures that may be brought to bear on such persons if assisted suicide is decriminalized, even in limited circumstances, I do not think legislation that deprives a disadvantaged group of the right to equality can be justified solely on such speculative grounds, no matter how well intentioned. ... The truth is that we simply do not and cannot know the range of implications that allowing some form of assisted suicide will have for persons with physical disabilities. What we do know and cannot ignore is the anguish of those in the position of Ms. Rodriguez.[11]

Justice McLachlin dealt with the issue similarly, asserting that "Sue Rodriguez is asked to bear the burden of the chance that other people in other situations may act criminally to kill others or improperly sway them to suicide. She is asked to serve as a scapegoat."[12]

There is another unrecognized and more fundamental slippery slope issue that should have occupied the Court's attention. That is, how broad are Sue Rodriguez's claims, and to what have we committed by accepting them, thereby repudiating paragraph 241(*b*) of the *Criminal Code*? There is a conceptual or logical, as well as an empirical, version of the slippery slope argument. The Justices spoke of the empirical slippery slope. If assisted suicide is permitted under careful conditions (of free and informed consent and competence, for example), will society experience abuses as a result of such a reform, for example, with regard to persons of borderline competence who are brow-beaten into "requesting" that their doctors help kill them? The conceptual slippery slope instead asks, "By accepting the Rodriguez claim — or, what the Justices understood to be the Rodriguez claim — to what has society rationally committed itself, under logical canons of consistency?"

And here, there is troubling consistency within the Court. The case before them was brought by an individual who was, and remained, capable of suicide, and whose personal freedom of action was unimpaired by law.[13] Her claim was

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[9] *Ibid.* at 601.

[10] *Ibid.* at 603.

[11] *Ibid.* at 566.

[12] *Ibid.* at 621.

[13] This comment does not deal with another fundamental point of consistency amongst the Justices. They all held in common the view that Parliament had established a "right to suicide" when it amended the *Criminal Code* so that attempting suicide was no longer a crime. This is not obviously true. Kamisar (*supra* note 3) has noted that by far the more convincing reading of the American legislative history is that suicide was decriminalized in the strict sense — not "legalized", still less made the basis of further rights. By withdrawing the crime of attempted suicide from the books, the legislators were simply acknowledging that no useful purpose could be gained by continuing to prosecute for this act. None of the Justices in *Rodriguez* attempted any serious discussion of the legislative history surrounding the Canadian reform that resulted in the decriminalization of

not, then, self-regarding. Rather, what she desired was that a new form of cooperative action be legalized — one involving a decision and a "final act" on her part, and the construction of some suicide device on the part of doctors and others (technicians, bioengineers, *etc.*). The factual nature and background of Rodriguez's case, as well as the way in which her request involved not autonomy and private action but rather the legally-sanctioned social construction of death machines, is denied or obscured in all of the judgments. Sopinka J. writes:

> To impose medical treatment on one who refuses it constitutes battery, and our common law has recognized the right to demand that medical treatment which would extend life be withheld or withdrawn. In my view, these considerations lead to the conclusion that the prohibition in s. 241(*b*) deprives the appellant of autonomy over her person and causes her physical pain and psychological stress ...
>
> The complaint is that the legislation is over-inclusive because it does not exclude from the reach of the prohibition those in the situation of the appellant who are terminally ill, mentally competent, but cannot commit suicide on their own. ...
>
> The appellant asserts that ... to subject her to needless suffering in this manner is to rob her of her dignity.[14]

The basis of McLachlin J.'s judgment is that the law against assisted suicide denied Rodriguez a right (to commit suicide) that was available to others. She writes:

> It is argued that the denial to Sue Rodriguez of the capacity to treat her body in a way available to the physically abled is justified because to permit assisted suicide will open the doors, if not floodgates, to the killing of disabled persons who may not truly consent to death ... In short, it does not accord with the principles of fundamental justice that Sue Rodriguez be disallowed what is available to others ... It is also argued that Sue Rodriguez must be denied the right to treat her body as others are permitted to do because the state has an interest in absolutely forbidding anyone to help end the life of another.[15]

Other quotes that could be cited are otiose, for at a structural level McLachlin J.'s argument requires that one accept that Rodriguez is incapable of committing suicide, and that her co-optation of the legal and medical systems to the end of managing her death in the manner and at the time that she chooses is a private exercise of her own self-determination.

The Chief Justice's account was somewhat more careful and precise. He described his conclusion as follows:

> This provision [subsection 241(*b*)] has a discriminatory effect on persons who are or will become incapable of committing suicide themselves, even assuming that all the usual means are available to them, because due to an irrelevant personal characteristic such persons are subject to limitations on their ability to take fundamental decisions regarding their lives and persons that are not imposed on other members of Canadian society.[16]

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attempted suicide. I am skeptical that Parliament, in decriminalizing attempted suicide, contemplated the reconstruction of this decision, an acknowledgment of the limits of legal effectiveness, into a fertile source of further rights. I further believe that the burden was upon the Justices to demonstrate to the contrary; however, I will not pursue this issue further here.

[14] *Supra* note 1 at 588-92.

[15] *Ibid.* at 620-23.

[16] *Ibid.* at 557.

Structurally, since Lamer C.J. relied upon a claim of equality rights, he too was committed to arguing that the right to commit suicide in private without others interfering is equivalent to the right to arrange one's death with the assistance of medical personnel and with the knowledge and approval of the Canadian judiciary. The Chief Justice, however, recognized that this case did *not* concern one who was at the time incapable of committing suicide. Through some curious language ("all the usual means"), he indicated, as well, his awareness that the topic of the appeal was itself peculiar. Exactly how peculiar the question posed by Sue Rodriguez was will, however, require some exploration.

II. Sue Rodriguez's Question

Sue Rodriguez suffered from a motor neuron disease, amyotrophic lateral sclerosis ("ALS"), that progressively destroys the body's capacity for movement. The degeneration associated with ALS can proceed at varying rates, but generally the diagnosis is established years before the patient has approached a terminal phase.

I have met, as a consulting clinical ethicist, with a number of persons with ALS. A common and natural preoccupation of these discussions is not the present, but rather the future: not current choices, but what shall happen if and when. Of course, responses vary from patient to patient, as well as over time in the same patient. Some patients will, in discussion, fix upon some major hallmark event of the disease's advance (generally, permanent loss of the capacity for independent breathing) as being the point at which they wish to be kept comfortable rather than have their existence prolonged. There is, of course, another option. When told the diagnosis of ALS, the typical patient has the physical capacity to exercise the full range of suicidal acts. The range diminishes over time, and increasing assistance is required over time. For example, can the patient still get to the drugstore? If not, delivery of the drug is needed. Can the patient still open the bottle? Can he or she swallow the pills?

Some, of course, fight to the end: I vividly recall consultations regarding one patient who had in advance given her doctors *carte blanche* to attempt any experimental or nonvalidated treatment that might prolong her life in any way. The tragedy the health care staff faced in her case was that ultimately all capacity for motion is irretrievably lost, and with it, all prospect for communication. This woman, artificially ventilated for the duration of her last hospital admission, had begnn by writing notes, and progressed to mouthing her statements (with husband and nurses attempting to lip-read). For a period of time she could communicate by eye-blink; she soon was unable to do even that, though for a brief time thereafter she could slightly widen her eyes in response to questions.

ALS does not damage the intellect, however. This muted patient's awareness of her situation was evident daily. When told that the nurse had to suction her soon, a very uncomfortable procedure, this patient's eyes would fill, allowing gravity to express her grief. This is the macabre progression Ms Rodrignez faced, providing the backdrop against which her lawsuit seeking the right to assisted suicide must be understood.

There are a number of common ways in which people end their lives. People shoot themselves with guns, slit their wrists, jump from tall buildings, take poison or asphyxiate themselves. Some people do not care how they die, while others, for a variety of reasons, favour or insist upon a particular form of suicide. The choice of suicide method varies, as well, from culture to culture.

Many, if not most, suicide methods used in Canada assume some degree of cooperation, often unwitting, of others. Without gun manufacturers and distributors, nobody could choose to commit suicide by gunshot; without architects, nobody could leap from a skyscraper. Yet we do not consider these to be cases of assisted suicide. We do not prosecute the architect or gundealer for his role in such deaths, in spite of the fact that assisting suicide remains a criminal act in Canada. The factors which can come into play in determining that X assisted Y's suicide — the proximity of X's action to that of Y; X's knowledge of Y's situation and intention; X's own intention — rely upon socially conditioned judgments which are not themselves always clear. For example, one ethics consultation of mine began with a cancer patient's request for the phone number of the Hemlock Society, a group that furnishes information about suicide methods. Would the nurse whom he had asked have been assisting his suicide by giving him the phone number? By giving him a phone book? By telling him that there are phone books downstairs?

Sue Rodriguez had chosen to manage her dying process by killing herself, but she did not approach the Court to seek that right, since suicide had been legalized (or more precisely, decriminalized) decades before. At the time of the initiation of this litigation, and for a long time thereafter, Sue Rodriguez retained the capacity to kill herself, for example, by poisoning, though her debility had foreclosed other options. Yet as long as she retained this degree of capacity, she found life worth living and chose not to exercise her suicide option. Her specific desire was to have the assistance of a physician in installing a self-activated device which she could actuate at a time of her own choosing. I have seen no description of what specific device was contemplated. Would it require a motion of the finger? Would it be activated by eyeblink? By eyeball motion? Current technology permits any such arrangement, given sufficient ingenuity.

Sue Rodriguez wanted to kill herself, at a time of her choosing, in a manner of her choosing. She claimed this as a matter of right and the Justices seem to have all agreed with her on this crucial point: it is unjust to allow an able-bodied person to kill himself or herself and to deny a handicapped person assistance to achieve the same end. But the Justices all erred in finding equivalency between a private right to kill oneself, which only calls upon others not to interfere, thus literally asks them to do nothing, and the right Sue Rodriguez sought: the right to publicly ratify, in court, a new form of cooperative action bent upon inducing a certain person's death, at a certain time, and in a certain way. Moreover, this confusion of private and public realms implicates a further uncomfortable issue. A right has been established on behalf of persons who, by their handicap, are unable to kill themselves in a desired way, to seek whatever death-assistance is appropriate and receive judicial ratification thereof.

Imagine that an obese person wants to plunge to his death from Mount Everest. He knows of a mountaineer who would help him to do so. This mountaineer is prepared to act in spite of protests from the CMA (Canadian Mountaineering Association) that it is not the purpose of mountaineering to help clients engineer their deaths. However, the mountaineer will not perform this feat of assisting suicide unless the Supreme Court of Canada says this would not be a criminal act. Does it follow from the *Rodriguez* dissents that such a claim would succeed? Because of the argument the Chief Justice employed, just such an absurd conclusion does indeed seem to follow from his decision. Chief Justice Lamer explicitly stated:

> I prefer not to express any opinion on the position of persons suffering from less serious disabilities, whose physical condition may certainly complicate access to the usual means of committing suicide, but who if those means were available to them would be capable of doing so. I am not required to express any opinion on this situation and I prefer not to do so, in the absence of information to indicate that, as regards access to methods of suicide, persons with disabilities are in a radically different situation from the rest of the public.[17]

The last sentence seems to me to be disingenuous. If the Chief Justice lacked information on the fact that disabled persons do not have access to methods of suicide, such information is easily supplied. Beside the case of the rotund, noted above, we may include the lame (who need to be driven to the bridge from which they want to leap), the blind (who have no driver's license and thus cannot engineer a fatal car accident), paraplegics (who are unable to inflict gunshot wounds), and the socially disadvantaged (ex-cons unable to buy firearms). The statement is doubly disingenuous because the Chief Justice had already expressed his opinion, in the affirmative, on this question. He and the other dissenting Justices stated that a handicapped person's rights are violated by being legally denied assistance to kill himself or herself in the same way that any other Canadian might choose. That is exactly the right they affirmed on behalf of Sue Rodriguez.

The questions remain: If a person has a right to commit suicide,[18] how broadly should such a right be construed? Should it be allowed to include both the negative right of non-interference and the positive right to seek assistance (or perhaps even to have assistance provided); both quiescent acceptance and explicit judicial approval; both private action and public cooperation? What do we as a society mean by a right to suicide, and what consequences are we prepared to bear on behalf of that right? These are all questions of the slippery slope. As noted above, they were relied upon by Justice Sopinka in upholding the constitutionality of paragraph 241(*b*) and were rejected in the dissents. Note, however, that these arguments were not *refuted* by the dissenters, not disproven, not even empirically disputed, but rejected as a matter of legal relevance to a constitutional determination. In the next section I will illustrate that on this point the dissent is right. These questions of the slippery slope, that lie at the heart of

[17] *Ibid.* at 551-52.

[18] This is a view I do not personally believe has been established but have granted *arguendo*. See *supra* note 13 and accompanying text.

any dispute over assisted suicide, cannot be adequately addressed in any court other than one of public opinion.

III. The Slippery Slope: Considering the Social Impact of Approved Assisted Suicide and Euthanasia

In my understanding, rather than a single argument, the slippery slope reflects a complex of considerations regarding normative (legal, ethical or behavioural) social changes. How broadly were they intended at their initiation? How broadly will they be construed thereafter? What unintended, deleterious, ineluctable effects are they likely to have over time? Arguments from within this complex are cautionary, rather than apodictically certain, and are grounded in generalizations from numerous historical, psychological, sociological and biological observations.[19]

What specific slippery slope cautions might have been raised in the event that the *Rodriguez* case had been decided in her favour? Brock has argued convincingly that no important logical or ethical difference stands between physician-assisted suicide and euthanasia; legalizing one should logically entail legalizing the other.[20] Why the two might be thought equivalent is easily seen in reference to the Rodriguez request. Using complicated technology, involving the collaboration of physicians and technical personnel, she could have installed a machine that would have provided her with a lethal injection after a coded eye-blink; or, we could eliminate the middle-man (middle-machine) and have the physician perform the injection upon the same signal. With the near infinite flexibility of computer-driven machinery, it matters little whether a command is given to a person or a machine programmed by that person.

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[19] [N]ormative behavior — accepting norms, or acting in accordance with expressed or unexpressed norms — has consequences and develops its own momentum. Because there are limits to human predictive capacity and rationality, the congeries of slippery-slope arguments serve, not as a conclusive basis for rejecting change, but as a warning flag concerning the possible effects of change. Slippery-slope arguments are not apodictic, conclusively true, but rather more or less well grounded; and are always one among the many arguments that will need to be mounted concerning any given normative choice A (whether A be a policy or an action — the acceptance of a norm or action in accordance with a norm) by an individual, group, or society.

Slippery-slope arguments are comprised of or bolstered by numerous observations and generalizations. Socially, we note evidence of and experiments upon conformity and the effect of social pressure upon individual moral judgments; we note the phenomenon of immigrants, coming to a new land with their independent values, assimilating to the host culture. Biologically, we note phenomena such as desensitization: the organism adjusting its own reactions to accommodate its environment. We note further how this may form a positive feedback loop, since the organism's environment is partly self-generated. Psychologically, we note the phenomenon of cognitive dissonance and the normal reaction it evokes: discrepancies between a person's behavior and his or her beliefs are as likely to result in an alteration of belief as in a reform of behavior. Historically, in retrospectively examining regimes of horror and human degradation, we note that there were early, small, incremental steps taken by members and institutions of society that permitted the later holocaust to nakedly proceed (B. Freedman, "The Slippery-Slope Argument Reconstructed: Response to van der Burg" (1992) 3:4 J. Clinical Ethics 293 at 296-97).

[20] D. Brock, "Voluntary Active Euthanasia" (1992) 22:2 Hastings Center Rep. 10.

Nevertheless, rejecting Rodriguez's request, Sopinka J. disagreed by asserting that there remains a difference of agency between assisted suicide and euthanasia.[21] This fine difference between a person fulfilling a command and a person fabricating a device to fulfil the same command did not, however, trouble the dissenting Justices in *Rodriguez*, who were more inclined to concentrate upon the end rather than on its means; it is their views that must control our inquiry into the meaning that would have attached to upholding Rodriguez's claim. McLachlin J. writes:

> If the justification for helping someone to end life is established, I cannot accept that it matters whether the act is "passive" — the withdrawal of support necessary to sustain life — or "active" — the provision of a means to permit a person of sound mind to choose to end his or her life with dignity.[22]

The Chief Justice went one step further in recognizing the equivalency of the two:

> One of McEachern C.J.'s conditions is that the act of terminating the appellant's life be hers and not anyone else's. While I believe this to be appropriate in her current circumstances as a mechanism can be put in place allowing her to cause her own death with her limited physical capabilities, why should she be prevented the option of choosing suicide should her physical condition degenerate to the point where she is no longer even physically able to press a button or blow into a tube? Surely it is in such circumstances that assistance is required most. Given that Ms. Rodriguez has not requested such an order, however, I need not decide the issue at this time. Therefore, I prefer to leave it to be resolved at a later date.[23]

There can be, I think, no doubt as to how the Chief Justice will resolve the issue at that time. In Justice Cory's concurring dissent, his assertion of equivalency is clear as well. He could see no reason for distinguishing between choosing death by refusing life support equipment and choosing to "put an end to her life through the intermediary of another."[24] This, then, is the first slippery slope consequence: in spite of the fact that Rodriguez's case was framed and understood as an issue of physician-assisted suicide, had the dissent succeeded, physician-assisted euthanasia would quickly have followed.

There are a number of other slippery slope concerns, potentially consequent upon legalization of physician-assisted suicide. Yale Kamisar has noted studies concerning the inordinate toll that suicide takes on the young, particularly adolescents, and upon the mentally ill.[25] Very recent evidence confirms the fear that heightened social visibility concerning death-dealing volitional acts of the terminally ill leads to increased suicide of the mentally infirm. In an article entitled "Increase in Suicide by Asphyxiation in New York City after the Publication of *Final Exit*",[26] Peter Marzuk describes screening the records of all local suicides before and following the appearance of this best-selling suicide

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[21]Justice Sopinka writes that "the active participation by one individual in the death of another is intrinsically morally and legally wrong ..." (*supra* note 1 at 601).

[22]*Ibid.* at 624.

[23]*Ibid.* at 578-79.

[24]*Ibid.* at 631.

[25]*Supra* note 3 at 38ff and references cited therein.

[26](1993) 329:20 New England J. Med. 1508.

manual intended for use by the terminally ill. The book's recommended method of suicide, asphyxiation, was the cause of death in eight cases in the year preceding, and thirty-three cases in the year following the book's publication. In nine of those thirty-three cases, the book was found at the scene of the suicide. In a further six cases of suicide by poisoning, solid evidence of use of this book was also present. Of those fifteen cases, six had no evidence of physical illness and at least five had histories of psychiatric illness. The author concludes, "To many, euthanasia is distinct from suicide. We believe the line between the two is being blurred in the eyes of the public. Efforts to destigmatize euthanasia or even encourage it for some groups may have the untoward effect of promoting suicide in other groups ..."[27]

McLachlin J.'s dissent was restricted in scope to the terminally ill; the Chief Justice questioned such a restriction. In any event, the definition of "terminal illness" is an elastic matter, given to slippery slopes of its own. For example, last year's Washington State initiative to legalize "physician aid-in-dying" (assisted suicide and euthanasia) was to be restricted to the terminally ill. However, "I-119 would have expanded the state's definition of 'terminal condition' to include patients with as long as six months to live and also those who were not actually about to die, but in irreversible comas or persistent vegetative states."[28]

All of the dissenting judgments expressed concern about the possibility that illegitimate pressure to accede to suicide might be brought to bear. However, they failed to account for the fact that what actually counts as "illegitimate" pressure changes over time, as society becomes more accustomed to considering a willed death as a legitimate option. This slippery slope phenomenon is already evident in the Netherlands. John Keown describes a conversation with Dr. Herbert Cohen:

> One of Holland's leading practitioners of euthanasia told me that he would be put in a very difficult situation if a patient told him that he really felt a nuisance to his relatives because they wanted to enjoy his estate. Asked if he would rule out euthanasia in such a case, he replied: "I ... think in the end I wouldn't because that kind of influence — these children wanting the money now — is the same kind of power from the past that ... shaped us all. The same thing goes for religion ... education ... the kind of family he was raised in, all kinds of influences from the past that we can't put aside."[29]

Similar arguments can be made with respect to two other conditions stated by the dissenting Justices: that the request for euthanasia or assisted suicide be firm and unwavering, and that it be provided by a fully informed person of undoubted competence. These conditions are not self-interpreting. They are, moreover, in large degree, social constructions, often understood as relative to accepted or expected choices. What the slippery slope reminds us is that social expectations change over time, under pressure of the previous choice. At present, for example, asking to be killed is an odd choice and might trigger search-

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[27]*Ibid.* at 1510.

[28]R. Carson, "Washington's I-119" (1992) 22:2 Hastings Center Rep. 7 at 8.

[29]"On Regulating Death" (1992) 22:2 Hastings Center Rep. 39 at 41-42.

ing questions about competence. Over time, however, this rigour might well give way. It is not hard to envision a time when quite the reverse obtains, when an ill person who fails to ask to be killed is judged to be "in denial", and for that reason in need of therapy.

The same holds concerning the unwavering nature of the choice, something that is inevitably judged relative to the social acceptance of the choice in question. In this regard, it is interesting to compare one case of ambivalent euthanasia with a recent Supreme Court of Canada decision concerning ambivalent consent to medical treatment. The euthanasia case unfolded as follows:

> In February, Kevorkian assisted in the suicide of Hugh Gale, 70, an emphysema patient who may, at the last minute, have changed his mind. According to one version of the report that Kevorkian wrote, about 45 seconds after putting on the carbon-monoxide mask, Gale became flushed, agitated, saying "Take it off!" The mask was immediately replaced with oxygen, which helped calm him down. "The patient wanted to continue," the report states. "After about 20 minutes, with nasal oxygen continuing, the mask was replaced over his nose and mouth, and he again pulled the clip off the crimped tubing. In about 30 to 35 seconds he again flushed, became agitated with moderate hyperpnea [rapid or deep breathing]; and immediately after saying 'Take it off!' once again, he fell into unconsciousness. The mask was then left in place ... Heartbeat was undetectable about 3 minutes after last breath."[30]

This would not, at this time, satisfy the requirement that a request be unwavering; but would it not do so shortly after such requests became a commonly-accepted part of medical practice? Compare this situation with the Supreme Court of Canada decision regarding consent to medical treatment.[31] During an angiogram, the appellant, Mrs. Ciarlariello, began to spasm. After calming herself she said, "Enough, no more, stop the test." Her neurologist assessed her and assured her that five more minutes were required. The patient responded, "Please go ahead." The Court's opinion was that this consent was acceptable.

The juxtaposition of these two cases should, I think, be suggestive, for the consent provided by Mrs. Ciarlariello to her angiogram was no less ambivalent than that of Mr. Gale to euthanasia. At this moment, we are (rightly) outraged at the thought that a patient who has second thoughts might be put to death. Why? Because euthanasia is different from medical treatment. Yet if the dissenting Justices had their way, euthanasia would end up being seen by society as a form of medical treatment. At that point, the insistence that consent to euthanasia be firm and unwavering would dissolve, for, as Mrs. Ciarlariello's case demonstrates, the law will not insist upon such conditions for consent to medical treatment.

A great many other slippery slope considerations could be adduced. For my part, I do not propose that those discussed in this comment are decisive, but simply maintain that they must be considered. One who would discuss the kinds of normative changes that follow from the dissenting views in *Rodriguez* must, I think, admit their relevance; this is precisely what the argument is about. Yet

[30] N. Gibbs, "Death Giving" *[Canadian] Time* (31 May 1993) 44 at 48.
[31] *Ciarlariello* v. *Schacter*, [1993] 2 S.C.R. 119, 100 D.L.R. (4th) 609.

I believe the dissenters were correct in excluding these slippery slope concerns from their constitutional deliberations.

As *Charter* jurisprudence is constructed, once an infringement of a right has been demonstrated, the burden of proof is upon the State to demonstrate that the infringement has been legally "saved" under section 1, because the law in question is demonstrably justified in a free and democratic society. Can slippery slope arguments serve this role in judicial deliberations? Clearly not. First, courts are unequipped to gather, assess and weigh the complicated empirical evidence that needs to be brought to bear in such a discussion, as was evident in both Justice Sopinka's opinion and in the dissenting judgments. But there is a deeper, far more fundamental reason. Properly understood, slippery slope arguments cannot satisfy this requirement. They are cautionary in nature, providing reasons to pause, to reconsider, to temporize and to carefully weigh, but by their nature, they are not knock-down, conclusory points. A slippery slope consideration is, by definition, speculative, and so it cannot play the role of satisfying the burden of proof required. And yet — and the point must be repeated — it is agreed on all sides that slippery slope concerns are at the centre of any decision regarding change in the laws respecting euthanasia and assisted suicide.

What can be done to escape this jurisprudential dilemma? I believe the solution is simple. It is the solution proposed by Mr. Justice Sopinka, who had reached the right conclusion, albeit for the wrong reasons. The debate must proceed in the public arena, in particular, through the political process. In regard to those views in which no answer is provably right or wrong, in which expertise fails to reliably help, democracies rely upon one procedure: discuss, debate, propagandize — and then, vote.

There are a number of ancillary reasons I could provide to demonstrate why it is preferable that this issue be resolved in the political rather than in the judicial arena. For example, only in that way are interested parties given the time and opportunity to mobilize the resources needed to clarify the baffling factual questions raised. Above all, the unfortunate precedent of the abortion debate, in both Canada and the United States, should have served to teach all sides that a pre-emptive judicial resolution can leave a nation decades later with a festering moral wound damaging the body politic. This experience compares unfavourably with that of many European nations which achieved political, rather than judicial, closure on the abortion debate.

I would not, though, rest upon such counsels alone. How far along the path to euthanasia — for whom, with what safeguards, under what circumstances — is society prepared to walk? The Justices, particularly Justice Sopinka, gave their own estimates of this, but rather than estimate, it is far better to pose the question directly to society. What cost, in the form of abuse, is likely to accompany this path, and is the gain worth the price? These questions are at the heart of the debate. and a democratic nation has only one means of addressing them.