

POLITICS OF END-OF-LIFE CARE: ACTIVE EUTHANASIA

by

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Submitted in partial fulfilment of the requirements
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DALHOUSIE UNIVERSITY

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DEDICATION PAGE

Dedicated to my family, without their love and support I would not be who I am today. I owe my deepest gratitude, love and respect to all of you. I love you all so much.

Dedicated to the terminal patients who are suffering on a daily basis in pain and with each passing day are losing their autonomy and dignity; I hope you will have the option to live and end your life in a manner you deem dignified.

TABLE OF CONTENTS

LIST OF FIGURES.....	x
ABSTRACT.....	xi
LIST OF ABBREVIATIONS USED.....	xii
GLOSSARY.....	xv
ACKNOWLEDGEMENTS.....	xvii
CHAPTER 1 INTRODUCTION.....	1
1.1 Research Question.....	2
1.2 Objectives.....	6
1.3 Situating Euthanasia: Philosophical, Medical and Legal Perspectives.....	7
1.3.1 Philosophical Arguments.....	7
1.3.2 Medical Arguments.....	10
1.3.3 Legal Arguments.....	12
1.4 Chapter Breakdown.....	18
1.5 Conclusion.....	20
CHAPTER 2 MAPPING THE LITERATURE.....	21
2.1 Public Policy and EOLC: Active Euthanasia.....	21
2.1.1 The Special Committee of the Canadian Senate.....	22
2.1.2 The House of Lords Select Committee.....	23
2.1.3 The New York Task Force.....	24
2.2 The Facts on AE and PAD (Netherlands, Washington and Oregon)	25
2.3 Political Parties and EOLC: Active Euthanasia.....	27
2.4 Canadian Institutions and EOLC: Active Euthanasia.....	27
2.5 CMA, The Colleges of Physicians and Surgeons.....	28
2.5.1 Collège des Médecins du Québec.....	28
2.6 Medical Schools.....	29
2.7 Missing from the Literature.....	31
2.8 Conclusion.....	31

CHAPTER 3 METHODOLOGY	33
3.1 Comparing and Contrasting	33
3.2 Comparative Politics.....	33
3.3 Theoretical Frameworks.....	34
3.3.1 Pressure Group Politics.....	34
3.3.2 Constructivist Approach.....	35
3.3.3 Rational Choice Approach.....	35
3.3.4 Institutionalism and Structuralism.....	37
3.4 Conclusion.....	37
CHAPTER 4 POLITICAL PRESSURE GROUP APPROACH TO ACTIVE EUTHANASIA.....	39
4.1 What are Pressure Groups?.....	39
4.2 Pressure Groups and the Policy Process.....	41
4.3 Pressure Groups: Active Euthanasia.....	42
4.3.1 Interest Promotion.....	43
4.3.2 Communications.....	43
4.3.3 Legitimizing.....	43
4.4 Pressure Groups in Action.....	44
4.5 Integrated Pressure Groups Active Euthanasia Context.....	45
4.5.1 CMA and the Colleges of Physicians and Surgeons....	45
4.6 Peripheral Pressure Groups Active Euthanasia Context.....	45
4.6.1 The Euthanasia Prevention Coalition.....	46
4.6.2 The Council of Canadians with Disabilities (CCD)....	47
4.6.3 Citizens United Resisting Euthanasia.....	47
4.6.4 Patients' Rights Council.....	48
4.6.5 The Farwell Foundation.....	49
4.6.6 The B.C. Civil Liberties Association.....	49
4.6.7 Compassion & Choices.....	51
4.6.8 Euthanasia Research and Guidance Organization.....	52
4.7 The Influence of Pressure Groups.....	52

4.8	Conclusion.....	57
CHAPTER 5 THE CONSTRUCTIVIST APPROACH TO ACTIVE EUTHANASIA.....		
5.1	The Constructivist Approach.....	59
5.2	Government Policies' Influence on Curriculum.....	61
5.3	The Hippocratic/Physicians' Oath.....	62
5.3.1	The Influence of the Oath.....	64
5.4	The Medical Associations' Influence on Medical Students and Physicians.....	65
5.4.1	The USAMA.....	65
5.4.2	The WSMA.....	66
5.4.3	The US OMA and MMA.....	66
5.4.4	The CMA.....	66
5.4.5	The College of Physicians and Surgeons.....	68
5.4.6	The Influence of Medical Associations and Colleges of Physicians and Surgeons.....	68
5.5	Medical Schools and Curriculum.....	70
5.6	Physicians and Medical Students: Active Euthanasia.....	73
5.6.1	Medical Schools in the USA and the UK.....	74
5.6.2	Medical Schools in Germany.....	75
5.6.3	Medical Schools in Canada.....	77
5.7	The Influence of Medical Schools on AE and PAD.....	78
5.8	Constructivism and Society.....	79
5.9	Conclusion.....	80
CHAPTER 6 THE RATIONAL CHOICE APPROACH TO ACTIVE EUTHANASIA.....		
6.1	Empirical Evidence.....	82
6.2	Rational Choice Definitions.....	84
6.3	The Consequences for Physicians in Canada.....	85
6.3.1	Legal Offences.....	85
6.3.2	Medical Associations and Colleges of Physicians and Surgeons: Offences.....	87

6.3.3	Colleges of Physicians.....	88
6.4	Legal Cases in Canada.....	89
6.4.1	The Influence of Canadian Court Cases.....	91
6.5	Influence of the Criminal Code and Provincial Colleges of Physicians and Surgeons.....	91
6.6	Conclusion.....	93
CHAPTER 7 INSTITUTIONALISM AND STRUCTURALISM APPROACH TO ACTIVE EUTHANASIA.....		95
7.1	Institutionalism and Structuralism Definitions.....	95
7.1.1	Institution.....	95
7.1.2	Formal and Informal Institutions.....	96
7.1.3	New Institutionalism.....	97
7.1.4	Political Institutions.....	97
7.1.5	Structuralism.....	98
7.2	Institutionalism and Active Euthanasia.....	98
7.2.1	Oregon: the Ballot Box and the Courts.....	99
7.2.2	Washington: the Ballot Box and the Courts.....	101
7.2.3	Montana: Court Case.....	102
7.2.4	Netherlands: The Court and Society.....	102
7.2.5	Switzerland: The Legislature.....	104
7.2.6	Canada: The Legislature and the Courts.....	105
7.3	Federalism.....	107
7.3.1	Public Healthcare System vs. Private Healthcare.....	107
7.4	Political Parties and EOLC: Active Euthanasia.....	109
7.4.1	The Conservative Party of Canada.....	109
7.4.2	The New Democratic Party.....	110
7.4.3	The Liberal Party.....	111
7.4.4	The Bloc Quebecois.....	111
7.4.5	Party Discipline.....	112
7.4.6	Political Parties' Refusal to Support AE.....	113

7.4.7	Quebec’s Role.....	116
7.4.8	Federal Laws vs. State Laws.....	117
7.4.9	Canadian Criminal Code.....	118
7.4.10	The Judiciary.....	119
7.5	Conclusion.....	121
CHAPTER 8 CONCLUSION.....		123
8.1	Discursive Institutionalism.....	125
APPENDIX 1-1	Declaration of Geneva 1948.....	138
APPENDIX 1-2	Canadian Criminal Code.....	139
APPENDIX 1-3	Private Members Bill C-384.....	142
APPENDIX 1-4	Canadian Charter of Rights and Freedoms.....	144
APPENDIX 5-1	Hippocratic Oath.....	145
APPENDIX 5-2	UWO Curriculum.....	148
APPENDIX 5-3	UK Suicide Act 1961.....	149
APPENDIX 6-1	Medicine Act, 1991 Professional Misconduct.....	150
APPENDIX 7-1	Oregon Death with Dignity.....	152
APPENDIX 7-2	Washington’s Death with Dignity Act.....	163
APPENDIX 7-3	Recommendations for Canada.....	175
Reference List.....		179

LIST OF FIGURES

Figure 4-1 C&C lobbying expenditures between 2006-2011	130
Figure 4-2 I-1000: Assisted Suicide.....	131
Figure 4- 3 – Massachusetts 2012 Pro and Con Question 2 Committees.....	132
Figure 5-1 – Study conducted by DuBois and Burkemper.....	133
Figure 5-2&3 – DeLeo et al’s Study.....	135
Figure 5-4 – Dickinson and Field Study.....	136

ABSTRACT

With new medical advances in technology, there has been a push from the legal, medical and political communities to re-examine the policies of end-of-life-care. End-of-life-care (EOLC) is a term that refers to not only a patient's final hours of life, but also the medical care of individuals with terminal illnesses or conditions that have become advanced and incurable. For the purpose of this paper, I will be referring to physician-assisted death and active euthanasia as forms of end-of-care. The *Politics of End-of-Life-Care: Active Euthanasia and Physician-assisted Death* examines the political disjuncture between the evidence presented in favour of active euthanasia (AE), physician-assisted death (PAD) and the current practice of refusing to grant AE and PAD legal status in Canada. It will examine the political dynamics underlying the disjuncture using political pressure groups, constructivism, rational choice, institutionalism and structuralism. There is empirical evidence that demonstrates support for the legalization of AE and PAD. Sixty-seven percent of Canadians support AE /PAD and 80 percent support allowing physicians to assist in AE and PAD (Angus Reid 2012). However, Parliament has not legalized AE/PAD and the CMA has not sanctioned AE /PAD. The two sides of the debate have clearly communicated their arguments. The arguments on each side are strong and have merit. Conversely, the arguments against AE and PAD appear to hold more weight with institutions than with the public. This thesis examines a number of different reasons for why AE/PAD remains illegal in Canada despite society's widespread support for AE/PAD. The results of the research found no one method explains the disjuncture between the evidence presented in favour of active euthanasia and the current practice of refusing to grant it legal status. However, discursive institutionalism does help elites to generate and communicate the discourse of AE and PAD. It also explains how discourse can also occur from the bottom which results in a new discourse. For example, physicians, politicians, and the public who have deviated from the accepted discourse on AE and PAD can help to create a new discourse regarding AE and PAD policies.

LIST OF ABBREVIATIONS USED

AE- Active Euthanasia

AMA – Alberta Medical Association

AIDS – Acquired Immunodeficiency Syndrome

BC – British Columbia

BCCLA – British Columbia Civil Liberties Association

BCMA – British Columbia Medical Association

BMA – British Medical Association

C&C – Compassion & Choice

CHN - Compassionate Healthcare Network

CMA – Canadian Medical Association

CMQ – Collège des médecins du Québec

CPSNS – College of Physicians and Surgeons in Nova Scotia

CSA – Controlled Substance Act

CURE – Citizens United Resisting Euthanasia

DWD – Dying With Dignity

EOLC – End-of-life-Care

EPC - Euthanasia Prevention Coalition

ERGO – Euthanasia Research & Guidance Organization

FMSQ – Federation of Quebec medical Specialists

GMA – Good Medical Council

GP – General Practitioner

HIV – Human Immunodeficiency Virus

IVAE – Involuntary Active Euthanasia

MMA – Montana Medical Association

MP – Member of Parliament

NDP – New Democratic Party

NHS – National Health Services

NSCPS – Nova Scotia College of Physicians and Surgeons

NVAE - Non-voluntary Active Euthanasia

OMA – Ontario Medical Association

PAD – Physicians Aid-in-Dying; it is the same as PAS - Physician-Assisted Suicide

POA – Power of Attorney

PTR – Patients Rights Council

QCPS – Quebec College of Physicians and Surgeons

QMA –Quebec Medical Association

RAT – Rational Action Theory

RCT – Rational Choice Theory

RDSC – Right to Die Society of Canada

SMA – Saskatchewan Medical Association

UK – United Kingdom

UME – Undergraduate Medical Education

USA/ US – United States of America/ United States

USAMA – United States American Medical Association

USOMA – United States Oregon Medical Association

UWO – University of Western Ontario

VAE - Voluntary Active Euthanasia

VPE - Voluntary Passive Euthanasia

WMA – World Medical Association

WSMA – Washington State Medical Association

GLOSSARY

Active Euthanasia: for the purpose of the thesis will refer to voluntary and non-voluntary active euthanasia.

Constructivism – refers to the concept that each learner constructs knowledge for individuals and society to create meaning as they gain knowledge regarding a particular field of study.

End-of-life-care - refers to medical care to patients in the final hours or days of their lives, and more broadly, medical care of all patients with a terminal illness or terminal condition that has become advanced, progressive and incurable.

Euthanasia: is an act or omission of an act, undertaken by one person, for the purpose of the thesis a physician with the motive of relieving another person's suffering with the knowledge that the act or omission of an act will end the life of the patient (Manning 1).

Institutionalism – is a process by which structures and norms become established as authoritative guidelines for social behaviour. It examines how elements of social norms are created, adopted and adapted over time; and how they fall into decline and become neglected.

Involuntary-voluntary Active Euthanasia [IVAE]: a physician intentionally administers a lethal dose of medication to patients with the intent to cause death. This occurs without the informed consent and against the wishes of the patient and the legal guardian (Manning 3).

Non-voluntary Active Euthanasia [NVAE]: a physician administers a lethal dose of medication to patient without being aware of the patient's wishes. The patient does not give consent because it cannot be obtained from the patient for a variety of reasons including unconsciousness. However, the legal guardian can give consent to the physician (Cutler and Demy 25).

Palliative Care – is an area of healthcare, which focuses on relieving and preventing the suffering of patients. Palliative care caters to patients in all disease stages.

Physician Assisted Death/Physician-assisted Suicide – physician assists patients to bring about their own death. Physicians may assist by providing patients with the means to end their patients to end their life. It differs from *active euthanasia* where the physician ends the patient's life with their consent or the consent from their POA.

Power of Attorney – written authorization from an individual (grantor) that give permission to another individual to represent or act on his or her behalf if they are unable to act on their own. The POA becomes involved in the decision making when the individual becomes incapacitated and unable to give consent due to physical or mental illness. The POA concerning healthcare gives the POA the authority to terminate care and

life support. The grantor can restrict or amend the scope the POA has in the decision-making.

Pressure Groups – refers to an action of groups that extorts pressure to obtain decisions from government that the government would not have been inclined to make without the pressure from the groups.

Rational Action Theory – implies a conscious social actor engaging in deliberate calculative strategies that are shaped by rewards and punishments that are encountered. Individuals take actions that will lead to rewards and avoid actions that could lead to punishments.

Rational Choice Theory – the individual act as if to balance the costs against the benefits to arrive at an action that maximizes personal advantage. It does not address the role of an individual's sense of morals or ethics in their decision-making. The actors are only concerned with the benefits and consequences of their actions.

Sedation (Terminal) – is a palliative practice of relieving distress in a terminally ill person in the last days of a dying patient. It requires continuous intravenous or subcutaneous infusion of a sedative drug. Terminal sedation is the option of last resort for patients whose symptoms cannot be controlled by other means.

Special Publics: are unique or distinctive groups with which an organization needs to communicate. Special public groups may be minority publics (Hendrix and Hayes 334).

Structuralism – is a theoretical paradigm that highlights the elements of culture in terms of their relationship to a larger, overarching system or "structure".

Voluntary Active Euthanasia [VAE]: an act performed by a physician at the request of the patient. The physician intentionally administers a lethal dose of medication to cause the patient's death. To request this action the patient must be fully informed and aware of the consequences in order to give consent (McDougall et al. 2).

Voluntary Passive Euthanasia [VPE]: occurs when a physician withholds or withdraws medical treatment at the request of the patient or legal guardian thereby allowing the patient to die, the medical treatments include CPR, respirators or the provision of nutrients through a tube (Yount 4).

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CHAPTER 1 INTRODUCTION

On June 15, 2012, the B.C. Supreme Court ruled that the right to die with dignity is protected by the Charter of Rights and Freedoms *Carter et al. v. Attorney General of Canada* seeks to allow seriously and incurably ill, mentally competent adults the right to receive medical assistance to hasten death under certain specific safeguards. The lawsuit claims that *Criminal Code* provisions against PAD are unconstitutional because they deny individuals the right to have control over choices to their healthcare and restrict physicians from being able to perform such practices. The judgment gave Parliament one year to draft new legislation on PAD. The Court has also granted plaintiff Gloria Taylor a constitutional exemption to seek PAD. On July 13th, 2012, the federal government announced that it would be appealing the judgment. The hearings resumed on March 4th, 2013 in the BC Court of Appeals. This decision could influence further cases on AE and PAD in Canada. If upheld by the BC Court of Appeals it will influence the laws of Canada, policies of the medical community, curriculum in medical schools and the treatment options provided to terminally ill patients at the end of life.

In Canada, as in many western nations, there is panoply of cogent and persuasive arguments in support of active euthanasia as a component of end-of-life care (EOLC). Philosophers, policy analysts and practitioners have all presented compelling arguments for voluntary and involuntary euthanasia as part of the care provided both for patients in their final hours, and for individuals with terminal illnesses or conditions that have become advanced and incurable such as, Lou Gehrig's disease, AIDS and cancers. Curiously, however, active euthanasia steadfastly remains outside of the law in Canada. This thesis examines the political dynamics underlying the disjuncture between the evidence presented in favour of active euthanasia, physician-assisted suicide and the current practice of refusing to grant them legal status.

New medical advances in life prolonging technology are allowing people to live longer. According to current policy, the only acceptable measures that allow individuals to die include taking them off the lifesaving technology including respirators and by

removing feeding tubes. In Canada, any competent person has the right to refuse treatment or to request treatment be discontinued. In *Rodriguez v. British Columbia (Attorney General)*, ([1993] 3 S.C.R. 519), Justice Sopinka argued to the effect that there is a common law in Canada giving individuals the right to refuse potential life-sustaining treatment:

That there is a right to choose how one's body will be dealt with, even in the context of beneficial medical treatment, has long been recognized by the common law. 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....

Canadian courts have recognized a common law right of patients to refuse consent to medical treatment, or to demand that treatment, once commenced, be withdrawn or discontinued (*Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119). This right has been specifically recognized to exist even if the withdrawal from or refusal of treatment may result in death (*Nancy B. v. Hôtel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. S.C.); and *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.)....

Whether or not one agrees that the active vs. passive distinction is maintainable, however, the fact remains that under our common law, the physician has no choice but to accept the patient's instructions to discontinue treatment. To continue to treat the patient when the patient has withdrawn consent to that treatment constitutes battery (*Ciarlariello and Nancy B.*, supra).... ([1993] 3 S.C.R. 519)

The right of a patient to accept or refuse medical treatments has not translated to a terminally ill patient's right to discontinue lifesaving treatment and request AE or PAD. If patients refuse lifesaving treatment, they have accepted that the consequence of this action is death. Therefore, it is not difficult to argue that if a person is terminally ill and has accepted death they may prefer AE or PAD instead of sedation as an alternative to pain management. Patients who have withdrawn from lifesaving treatments or procedures by a power of attorney are likely to have a prolonged and possibly painful death. If the patient's power of attorney requested active euthanasia for the patient, it is only likely to hasten the patient's death without causing the patient undue pain and suffering.

1.1 Research Question

In this thesis, I will argue that there is a disjuncture between the evidence presented in favour of active euthanasia, PAD and the current practice of refusing to

grant them legal status. This thesis examines the political disjuncture between the evidence presented in favour of active AE, PAD and the current practice of refusing to grant them legal status in Canada. It will examine the political dynamics underlying the disjuncture using various methodological approaches: pressure group politics, the constructivist approach, rational choice theory approach and the institutionalism and structuralism approach. The thesis will explain how each approach contributes to the understanding of the political dynamics underlying AE and PAD and their limitations.

In Canada, there are inconsistencies with the EOLC laws regarding the withholding and withdrawing of lifesaving treatments and AE/PAD. For instance, the withholding and withdrawing of lifesaving treatment are legal in Canada even though it results in the patient's death. However, active euthanasia and physician-assisted death remain illegal even though the result is the same as withholding and withdrawing life prolonging treatment for the patient. Active euthanasia and PAD only hasten the death of the patient once the patient or power of attorney decide to withhold or withdraw lifesaving treatment. A 2010 Angus Reid survey found that 67 percent of Canadian respondents favoured AE; however, it remains illegal in Canada (Angus Reid, 2012). The 2012 Angus Reid survey on AE and PAD found 80 per cent of respondents in Canada support allowing a doctor, at the request of a competent, informed, terminally ill patient, to assist the patient in ending their life (Angus Reid, 2012). Yet medical associations, such as the CMA do not support AE or PAD. The evidence in support of AE and PAD has not persuaded federal government or Parliament to legalize AE and PAD.

A CMA survey found that only 20 percent of physicians would be willing to participate in AE (Sullivan P., 2013). The responses to the survey do highlight disconnects between physicians unwilling to perform PAD or AE and their stance on legalizing physician-assisted death. Forty-four percent of respondents stated that they would refuse to perform PAD while forty-four percent said they would not perform active euthanasia. About 40 percent of respondents were unsure or did not answer. The physicians surveyed gave similar responses to the questions regarding active euthanasia (Sullivan, P., 2013). Canadian law also has disconnect between withholding and

withdrawing lifesaving/life prolonging treatment and the use of a noxious substance that only serve to hasten death in the medical community. Fifty-nine percent of physicians surveyed have withheld lifesaving/sustaining treatments that led to the death of patients (Sullivan, P., 2013). Under Canadian law, it is legal to withhold and withdraw treatment of patient under specified circumstances. The CMA's policies also allows for the withholding and withdrawing of lifesaving/life prolonging treatment.

It is likely these disconnects occur due in part to the CMA's policy and view of AE and PAD and the education they received concerning various EOLC treatments. This is especially important because the data has remained unchanged since the 1993 survey (Sullivan, P., 2013). The CMA and the Canadian government support the withholding or withdrawing of lifesaving/ sustaining treatments but not AE or physician-assisted death. In addition, it is difficult to determine their responses in order to provide a better picture of Canadian physicians and their views on active euthanasia and physician-assisted death.

In Canada, it is illegal for a physician to assist in the death of a patient. Physicians, by law, cannot administer fatal doses of medication such as morphine to terminal patients regardless of consent. The Canadian *Criminal Code* prohibits voluntary and involuntary active euthanasia under section 14: “[n]o person is entitled to consent to have death inflicted on him, [moreover], such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given

Although active euthanasia remains illegal in Canada 67 percent of Canadian respondents in a 2010 Angus Reid survey were in favour of legalizing VAE. The survey used a sample of 1,003 ,in the same survey 76 percent of respondents believe legalizing VAE would establish clear guidelines for physicians dealing with EOLC decisions (Angus Reid, 2012). The 2012 Angus Reid survey found 80 per cent of respondents in Canada support allowing a doctor, at the request of a competent, informed, terminally ill patient, to assist the patient in ending their life. Two-thirds (66%) of Canadians thought legalizing VAE would not send the message that it would make life less valuable. The

survey also found that 41 percent of respondents stated that physicians who assist patients in euthanasia should be free from prosecution (Schuklenk et al., 2011, p. 23). A 2007 study conducted by Wilson of 238 terminal cancers patients in palliative care found that 62.8 percent of respondents supported the legalization of active euthanasia and 10 percent could foresee themselves making the request, while 6 percent of patients reported that they would actually make the request (Schuklenk et al., 2011, p. 25). Independent data on Canadian physicians and their support of the legalization of AE and PAD is scarce; however, some information was gathered. The reason why the information is scarce is that many physicians unwilling to support AE or PAD for fear of backlash within the medical community and from patients. Seventy-five percent of Quebec medical specialists are in favour of AE as long as strict guidelines were in place (Schuklenk, 2012).

The data gathered from the United States provides further empirical evidence that there is great support internationally for the legalization of active euthanasia and physician-assisted dying. A Gallup survey found 58 percent of Americans support doctor assisted suicide for patients with terminal conditions. There appears to be a conflict in values when “suicide” is mentioned and when it is not mentioned. When asked if physicians should be allowed to end the life of a patient who is suffering from a terminal illness and wants to die, 75% of Americans said “yes” (Moore, 2005). In a literature review study conducted by Dickinson et al. 13 of the 39 articles asked, “Should PAD be legalized?” The response ranged from 31 to 71 percent agreeing to the legalization of PAD (Dickinson et al., 2005, p. 45). In five of the articles, the responses ranged between 35 to 71 percent of physicians favouring the legalization of VAE (Dickinson et al., 2005, 46).

Although there is empirical evidence that demonstrates there is support for legalization of active euthanasia and PAD in Canada, the government has not taken steps to legalize AE and PAD. The two sides of the debate have clearly outlined their positions and arguments. The arguments on each side have merit and are strong. However, the arguments against active euthanasia seem to hold more weight than the arguments for AE and PAD. The question the thesis wants to answer is why there seems to be an

institutional bias in maintaining the status of AE and PAD when a majority of society wishes to change the present laws and practices of the medical community and legalize active euthanasia and physician-assisted suicide.

1.2 Objectives

This thesis examines a number of different possible explanations for why active Euthanasia and PAD remain illegal despite the widespread public support and some support from physicians. In the first place, I examine whether the political influence of specific interest groups upon policy-makers plays a key role. In the second place, I ask whether specific structural or institutional variables can explain why active euthanasia is suppressed as a viable policy option. In the third place, I investigate the extent to which the training of physicians is a key variable in explaining the refusal to sanction active euthanasia.

Palliative care is the standard of care for the dying but it does not address patient suffering from persistent and intolerable pain. In the debate regarding the acceptability of euthanasia, voluntary passive euthanasia – the withholding and withdrawing of treatment is considered morally permissible according to the CMA under certain circumstances while AE is not (Gorman, 1999, p.857). The reason withholding and withdrawing of lifesaving/life prolonging treatments are morally permissible is that they do not involve a physician administering a lethal dose of medication. It does not involve actively causing a patient's death. Active euthanasia is the last resort in palliative care treatment.

This thesis will not be researching the politics and practice of voluntary and non-voluntary passive euthanasia, nor will it concentrate on the politics of withholding and withdrawing of care. The research is not advocating involuntary active or passive euthanasia. The thesis will not advocate for euthanizing individuals based on mental or physical disabilities nor will it be advocating active euthanasia for the elderly on the bases of their age. The thesis will also not be advocating for individuals other than a licensed physician to perform active euthanasia on a patient.

1.3 Situating Euthanasia: Philosophical, Medical, and Legal Perspectives

The Canadian *Criminal Code*, decisions of the Supreme Court of Canada and the CMA considers voluntary active euthanasia as improper medical treatments. Current scholarly debates encompass three broad categories that are often overlapping each other the philosophical argument, the medical arguments and the legal arguments. While there is much literature on these three perspectives, there is a gap in the literature when it comes to political analysis

1.3.1 Philosophical Arguments

The autonomy argument argues for the right of an informed and rational individual to have control over their body and to make medical decisions (Manning, 1998, p. 26). The autonomy argument focuses on an individual's right to determine as much as possible their medical treatment. Proponents of the autonomy argument, argue that active euthanasia for terminal patients should be a treatment option. According to proponents such as Ronald Dworkin, competent patients should be permitted to arrange their deaths. The ending of a patient's life occurs with the assistance of a physician who is willing to participate in active euthanasia (Dworkin, 1994, p.190; Battin, 2005, p. 20).

The autonomy principle is crucial to individuals who believe that they have the right to make central decisions regarding their EOLC as long as their decision is rational (Dworkin, 1994, p.190). The opponents of voluntary active euthanasia object to the autonomy argument on the grounds that true autonomy is rare and choices for the most part are socially formed (Battin, 2005, p.20).

Autonomous choice involves respect for rational-self-governance (Battin, 2005, p. 21). Some have argued that individuals cannot make informed decisions when an individual has lost their objectivity due to the stress of their illness, depression and other factors such as outside pressure from family, coercion and manipulation (Gorsuch, 2006, p. 86-87). According to Dan Callahan (1997), the argument of autonomy and self-determination by supporters of VAE has run amuck (p. 415). Opponents of active euthanasia argue that there is limit to the freedom of choice patients. Patients can be

pressured into active euthanasia for socioeconomic reasons by the physicians and by their family (Manning, 1998, p.31). However, proponents can argue that with proper safeguards in place, including counselling, it can help to protect patients from outside pressure.

Opponents of the autonomy argument argue that terminal patients cannot impose on a physician to take an immoral action, such as voluntary active euthanasia. They believe that actively ending a life is murder and therefore physicians cannot actively end patients' lives even if a patient has given consent (Battin, 2005, p. 20; Callahan, 1997, p. 410). According to Brock, if physicians do not believe it is their duty to practice VAE, they can abstain from the practice without any putative measures put on them. However, physicians should be obligated to refer their patients to physicians who are willing to practice VAE and see it as part of EOLC (Brock, 1997, p.407).

Proponents of voluntary active euthanasia argue that it will improve a terminal ill patient's quality of life. They argue that if physicians are unable to relieve a patient's suffering in ways that are acceptable to the patient, VAE could be their only choice. If a patient wishes to have a lethal dose of medication injected by a physician it should be their right to do so (Battin, 2005, p.29). Callahan argues that there is no objective way of measuring claims of suffering. Three people can have the same condition but only one patient may find it unbearable and request VAE. Because it is difficult to measure suffering, according to Callahan it is even more difficult to determine the value of a patient's statement that their life is no longer worth living (1997, p.411). Proponents of VAE would argue that it is the patient's decision and their opinion that matters.

In the context of end-to-life medical care, society must respect a terminally ill patient's right to choose their treatment option. The treatment options may include therapeutic and palliative care, life-prolonging treatment if it is desired but it could also mean active euthanasia (Battin, 2005, pp.20-21). In accordance with respect to autonomy and John Stuart Mill's, harm principle, society should not interfere in an agreed upon course of treatment between a patient and their physician unless harm is being caused.

John Stuart Mill's harm principle states that individuals have the right to exercise self-control over themselves and their bodies and minds as long as it does not cause harm to another individual. The only instance a power, such as the government, can exercise limitations over individuals, against their will, is to prevent harm from coming to others (Gorsuch, 2006, p. 89). The harm principle allows individuals the freedom they want to pursue their views of the good life. This freedom under the harm principle limits the freedom individuals have only when their actions could cause an unwilling individual to be harmed. Thus, their rights end when it impedes on the rights of others (Gorsuch, 2005, p. 90). However if a competent and rational individual who is terminally ill decides to end their life with the help of a willing physician then it should be their right to do so. Their action will not violate or impede on another person's rights.

According to Dworkin (1994), individuals oppose active euthanasia because they think even when people have chosen to die; it is nevertheless bad for them to die (p.193). Dworkin (1994) argues that it is not right for society to deny an individual their autonomy based on individual beliefs about life and death (p.193). Proponents of active euthanasia argue that just because pain can be managed it may not be in the patient's best interest to do so (Battin, 2005, p. 29). Terminal patients should not suffer or be sedated in order to prolong their lives; rather, society should focus on quality of life over quantity. When medication cannot control pain, opponents promote the use of sedation to alleviate pain. The argument against complete sedation is that it would render patients unable to communicate their wishes (Battin, 2005, p.29). Proponents of EOLC would argue that this type of medical treatment is arguably the equivalent of being dead.

The religious and spiritual argument opposing active euthanasia as way of alleviating pain and suffering is based on the belief that the experience would lead to spiritual growth. They argue pain and suffering could be a valuable experience to the patient (Battin, 2005, p.29). The argument proponents of active euthanasia forward to counter the spiritual and religious growth argument, is that there is no guarantee that a terminal patient will have a positive transformative experience from the pain and suffering (Battin, 2005, p.29). Another argument against the religious and spiritual is that

an individual's religion and religious beliefs should not hinder a person's right to die as they deem fit nor should they influence laws. If individuals do not agree with active euthanasia for spiritual, religious or moral reasons then they do not have to use it as an EOLC treatment option but they should not deny others active euthanasia as a form of EOLC treatment.

1.3.2 Medical Arguments

Opponents to AE have often argued that the nature of the medical profession prohibits physicians from actively ending their patient's life. In accordance with the Hippocratic /Physicians' Oath, physicians cannot kill or hasten a patient's death (Manning, 1998, p.79). Proponents argue that due to past modifications that allow for new practices it is possible for a new amendment to include voluntary active euthanasia (Battin, 2005, p.24). Physicians can argue that by aiding their patient, who has made their choice freely without coercion, they are doing their duty under the Physicians' Oath by doing what is in the best interest of the patient. Physicians can argue that in order to "maintain the utmost respect for human life" (Declaration of Geneva, 1948) (**See Appendix 1-1**) they must be allowed to assist terminally ill patients who are suffering and do not have a quality of life.

Opponents of active euthanasia argue that due to the medical advances in pain management by hospices and other end-of-life treatment facilities it is possible for physicians to treat all pain and it is possible to relieve most of the suffering endured by terminally ill patients (Battin, 2005, p.29). Proponents counter this argument by arguing 'virtually all' is not 'all' and there would still be terminally ill patients that cannot be treated for their pain and suffering. Active euthanasia opponents have argued that patients would not want to end their lives if adequate pain control medications were available to everyone and if adequate palliative care facilities were available to everyone in need of such facilities (Downie, 2004, p.103). Empirical data has shown that uncontrolled pain and a lack of access to palliative care facilities is not the most common or only reason for requests for active euthanasia (Downie, 2004, p.103). That is not to say that access to adequate pain medication and palliative care facilities may only reduce the number of

requests for physician-assisted death or voluntary active euthanasia but they will not eliminate the requests (Downie, 2004, p.103).

Adequate pain control and palliative care is unavailable to many people and will remain unavailable for the near future (Downie, 2004, p.103). Even if the Canadian government were to make access to pain medication and palliative care universal, not all pain can be controlled and still provide a patient with the quality of life the patient would want and palliative care may not be able to relieve a patient's suffering. Therefore, if terminal patients want to avoid the pain and suffering the need for active euthanasia is still present (Battin, 2005, p.29). The opponents to the argument have countered that complete sedation can be used to alleviate a patient's pain when it can no longer be controlled. Proponents argue against complete sedation because it would mean that the patient would not be conscious. Complete sedation renders a patient unable to communicate or be aware of their surroundings. This type of existence is arguably the equivalent of being dead (Battin, 2005, p. 29).

The slippery slope argument opposing voluntary active euthanasia has two parts: the logical slippery slope argument and the empirical slippery slope argument. The proponents of the logical slippery slope argument argue that if we allow this [active euthanasia] then we have no rational grounds for not allowing that [IVAE] (Manning, 1998, p. 61; Downie 2004 107). It argues that society does not have the ability to determine acceptable and unacceptable practices. Proponents of active euthanasia, argue that society can avoid the slippery slope as long as hospital administration and staff, government, and law enforcement agencies retain tight control on the criteria that would need to be in place. The government legislation would also need to be tightly controlled and worded (Downie, 2004, p.107).The empirical slippery slope argument states, "once certain practices are accepted, people shall in fact go on to accept other practices..." (Downie, 2004 p.107). Supporters of active euthanasia argue that in Canada there is no direct empirical data regarding the fact, Canadians would accept other involuntary active euthanasia (Battin, 2005, p.24). Canada overturned the use of the death penalty which can be argued was a form of IVAE. By doing so Canada showed it would not accept certain

practices such as having the government take the life of an individual against their wishes.

According to Dworkin (1994), opponents of euthanasia argue that if euthanasia were legal it would lead to the IVAE of patients (p.190). However, proponents argue that laws can be enacted that would minimize IVAE from occurring by ensuring only competent patients and legal guardians can make the decision along with the physician (Dworkin,, 1994, p.190). The possible safeguards Dan Brock outlines for active euthanasia include: informing patients or legal guardians about the patient's conditions, possible treatments, and to ensure that all reasonable medical means to improve the patient's quality of life have been exhausted (Brock, 1997, p.407). Secondly, in order to protect against the overuse of AE and PAD only physicians should perform euthanasia on terminal patients. It also limits the number of people given authority to perform active euthanasia in order to hold physicians accountable concerning their exercise of AE. The training and professional norms physicians have allows for some assurance that they will perform their duties honorably and responsibly (Brock, 1997, p.407).

1.3.3 Legal Arguments

There are legal arguments surrounding the debate of voluntary active euthanasia. The Canadian *Criminal Code* prohibits voluntary active euthanasia under section 14, which states, "No person is entitled to consent to have death inflicted on him and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given." If a physician, at the request of the patient, gave the patient a lethal dose of medication the physician would be criminally liable under section 14 of the Canadian *Criminal Code* and subjected to criminal prosecution (See **Appendix 1-2**).

Depending on the circumstances, the Crown may use other provisions of the *Criminal Code* to prosecute physicians. The Crown can charge physicians who end the lives of patients, at the request of the patients with homicide under section 222: (1) "A person commits homicide when, directly or indirectly, by any means, he causes the death

of a human being”. Sections 222 subsection 5, of the *Criminal Code* states: “A person commits culpable homicide when he causes the death of a human being, (a) by means of an unlawful act; [...]; (d) by wilfully frightening that human being, in the case of a child or sick person.” The two subsections seem to apply more to voluntary active euthanasia. It is illegal for a physician to give a patient a lethal dose of medication to end their life regardless if they asked for it. Therefore, by doing so is an unlawful act. The Crown could also argue that by counselling a patient on voluntary active euthanasia in connection to their terminal and debilitating conditions, the physician had wilfully frightened the patient. There are several provisions fall under homicide and murder as well as provisions for various assaults involving bodily harm (Tiedemann and Valiquet, 2008, p. 4).

In theory, due to the nature of AE physicians could be prosecuted for first-degree murder because the intent of the act was to cause death. The law regarding any form of euthanasia, including VAE is influenced by certain criteria: the intent is to relieve an individual’s pain and suffering; the unpredictable attitude of juries; and the technical difficulties in proving the exact cause of death when a person is dying and taking a considerable amount of pain medication. The charges in Canada under the *Criminal de* can range from administering a lethal dosage of medication, to manslaughter and to murder (Tiedemann and Valiquet, 2008, p. 5).

According to the Canadian *Criminal Code*, it is illegal to counsel to another person to end his or her life. Physicians in violation of this law are subjected to prosecution. A physician cannot aid and abet a patient to commit suicide by giving them information on how to do it, where they could get the necessary materials do commit suicide and cannot give them the lethal dosage to achieve their goal of ending their life. If physicians were to do so then he or she may be prosecuted and a prison term of fourteen years. Sue Rodriguez challenged the constitutionality of section 241 under the Canadian *Charter of Rights and Freedoms* in 1992 in the British Columbia Supreme Court. The BC Supreme Court ruled against Rodriguez and the Supreme Court of Canada upheld the decision of the lower courts (Tiedemann and Valiquet, 2008, p. 6). Proponents have

argued that the changes to the law can accommodate the practice of voluntary active euthanasia. The Honourable Francine Lalonde introduced Bill C-384: An Act to amend the Criminal Code (right to die with dignity) in a Private Members Bill in the House of Commons in May 2009. Bill C – 384 was a Private Members Bill that failed to become law in the Canadian House of Commons. It would have given physicians the right help end the lives of patients who wished to die if the patients were lucid and gave voluntary consent and were suffering physical or mental pain and/or are terminally ill. Bill C – 384 could have been enactment to amend the *Criminal Code*. It would have allowed physicians that ability to, subject to criteria, end the life an individual who is experiencing severe physical and mental pain from a terminal illness to die with dignity once the person has expressed their free and informed consent to end their life (Bill C-384, 2009) (See **Appendix 1-3**)

The Supreme Court of Canada has also added to the debate of voluntary active euthanasia during the Sue Rodriguez case, involving physician-assisted death. This case is important to those on both sides of the debate regarding euthanasia as a form of medical treatment. Rodriguez argued that by not allowing her to die by a lethal dose of medication that would be given to her in some capacity by a physician, violated sections 7, 12 and 15 of the Canadian *Charter of Rights and Freedoms*. Although Rodriguez lost her case in a 5 to 4 decision, the judges dissenting added to the debate along with the Courts majority (See **Appendix 1-4**).

Justice Sopinka wrote for the majority with La Forest, Gonthier, Iacobucci and Major JJ., concurring with the decision. Justice Sopinka found that section 241 of the Canadian *Criminal Code* did not violate section 7 of the Canadian *Charter of Rights and Freedoms*. He first examined whether the prohibition on ending one's life was connected to the right to security of the person. Justice Sopinka found that the sanctity of life has historically not included the freedom of choice to participate in ending one's own life or participating in ending another person's life. He also argued that there has not been a new consensus in society "opposing the right of the state to regulate the involvement of others in exercising power over individuals ending their lives" ([1993]3 S.C.R. 519). Justice McLachlin

pointed out section safeguards the rights of individuals from government interference. There is nothing written in section 7 of the Charter that would imply it is utilized to protect society ([1993]3 S.C.R. 519).

Justice McLachlin dissented on the grounds that section 241 (b) of the *Criminal Code* violated section 7 of the Charter: “I see this rather as a case about the manner in which the state may limit the right of a person to make decisions about her body under s.7 of the Charter. I prefer to base my analysis on that ground” ([1993]3 S.C.R. 519). Section 7 of the Charter protects the right of every individual to make decisions regarding their body. Section 7 safeguards against government interference. The security of the person gives individuals an element of “personal autonomy, protecting the dignity and privacy of individuals with respect to decisions concerning their own body ([1993]3 S.C.R. 519). Security of the person is an important part of the human persona because it provides individuals with the dignity and respect that individuals should have and the autonomy to decide what is the best decision for their body. Justice Sopinka found that the prohibition on physician-assisted death does prevent Sue Rodriguez from having assistance in committing suicide but the prohibition on AE and PAD did not violate the principles of fundamental justice. He concluded that the laws prohibiting AE and PAD reflect the fundamental values of society and therefore these laws could not be in violation of fundamental justice.

Justice McLachlin concluded that the law violates the principles of fundamental justice under section 7. In order to decipher if a law is arbitrary under section 7 one must first focus on how it infringes a person’s “protected interests in a way that it cannot be justified” with regards to the objective ([1993] 3 S.C.R. 519). The principles of fundamental justice require each person to be considered individually and be treated fairly by the law. Justice McLachlin stated that section 241 (b) is not in accordance with the principles of fundamental justice. Sue Rodriguez should be able to use what is available to others even if another person with her consent has to assist her and not be denied this right because of the possibility that someone may abuse it in the future ([1993] 3 S.C.R. 519).

Justice Sopinka disagreed with the argument made by Rodriguez that section 241(b) violated section 12. Sue Rodriguez and other Canadians who have chronic and debilitating conditions that causes physical pain and suffering to the patient. People suffer from illnesses such as ALS suffer in extreme pain and end up dying as a result of choking, suffocation, or pneumonia caused aspiration of food or secretion. They also become completely dependent upon machines to perform their bodily functions. Sopinka argues that it comes down to the meaning of the word treatment; the treatment caused by the disease or the treatment caused by the state. If by treatment, it means the treatment caused by the disease there may not be a violation (3 S.C.R. 519). Sopinka came to the decision that “to hold that the criminal prohibition in section 241(b), without the appellant being in any way subjected to the state administrative or justice system, fall within the bounds of s. 12 stretches the ordinary meaning of being “subjected to...treatment” by the state” (3 S.C.R. 519).

If it means treatment from the government due to section 241 (b) of the *Criminal Code* then one can argue that section 241(b) infringes on the rights set out in section 12. It can be argued that due to the government treatment under the *Criminal Code* the laws that are in place allow terminally ill people to suffer in severe physical and mental pain until they die a “natural” death. It can also be argued that section 241(b) would not be saved under section 1 because the law is not “demonstrably justified”. It is not justifiable to allow patients to suffer because of sections 222 and 241 of the *Criminal Code* when amendments to these sections of the *Criminal Code* could be made giving physicians the ability to assist their patients who have clearly and of their own free will expressed their intent to end their life. The amendment could include the safeguards and criteria needed to decrease the risk of the “slippery slope”. If the proper criteria and safeguards were in place there would not be a real need for physicians to perform AE and PAD illegally.

Chief Justice Lamer wrote a dissenting judgment in favour of Sue Rodriguez. The Chief Justice found that section 241 (b) of the *Criminal Code* violates section 15 of the

Charter. The Chief Justice concluded that a person unable to end their own lives under the law because they do not have access to assistance and it is therefore a disadvantage to the application of section 15 (1). Chief Justice Lamer also concluded that section 241 (b) was discriminatory against people who are or will be incapable of ending their own lives because they are subjected to limitations on their ability to take fundamental decisions regarding their lives that are not imposed on other members within Canadian society (3 S.C.R. 519). Chief Justice Lamer concluded that the objective of section 241(b) of the *Criminal Code* satisfies the first branch of section 1 – validity of the legislative objectives. The provisions are there to protect the vulnerable from coercion when deciding to end their lives and the underlying legislative purpose of s. 241(b) is to preserve life (3 S.C.R. 519). However, section 241(b) does create limitations and regulates the control an individual may exercise over the timing and circumstances of their death. Chief Justice is satisfied that Section 241(b) cannot survive the minimal impairment component of the proportionality test in section 1 and infringes on section 15 because although the law is meant to protect vulnerable people it impedes the access of non-vulnerable people (3 S.C.R. 519).

Justice McLachlin disagreed with Sopinka J. argument that “active participation by one individual in the death of another is intrinsically, morally, and legally wrong.” Justice McLachlin argued that the law involving an individual’s participation of ending an individual’s life is inconsistent. Justice McLachlin noted, “Parliament has not exhibited a consistent intention to criminalize acts which cause the death of another” (3 S.C.R. 519). In Canada, individuals are not criminally liable when their omissions contribute to a person’s death. Individuals who are under legal obligation to provide the “necessities of life” are not subjected to criminal punishment under the *Criminal Code* where a violation of this obligation results in death. Individuals who have killed in self-defence are not criminally liable. The law in Canada has recognized there are valid justifications for causing a person to die and that performs AE or PAD would not be in violation of the *Criminal Code* (3 S.C.R. 519). Justice McLachlin argued that because Canadian law is inconsistent regarding criminal actions that cause the death of an individual there is room in Canadian law to allow AE and PAD.

In most health care matters, with the exception of AE, patients are able to make informed decisions regarding their medical treatments. Patients have the right to autonomy in making crucial decisions regarding their health care choices. Once informed of their medical status they have the right to accept or to refuse medical treatments. Parents and power of attorneys are able to make medical decisions for children and those who are unable to make the choice for themselves. Parents and POAs serve as medical proxies for patients who are incapacitated. Proponents see active euthanasia as another medical treatment option. Like other medical procedures and treatments, physicians would have the ability to abstain from performing AE or PAD. They would however be obligated to refer their patients to physicians who are willing to perform such treatments.

1.4 Chapter Breakdown

Chapter 2 is vital because it provides important background information to the arguments that I will be making in the thesis. It provides information on the arguments that academics have made in support of and in opposition to the legalization of AE and PAD. Chapter 2 also provides important information regarding the decisions made by the Canadian judiciary regarding AE and PAD. The judiciary is an important institution for Canadians seeking to legalize AE and PAD. The Canadian judiciary has heard judicial cases concerning AE and PAD, i.e. the *Rodriguez Case* and the *Carter Case*. The decisions made by the judiciary, unless specified, become Canadian laws and Canadians have used the judiciary to legalize AE and PAD. Chapter 2 examines the published literature from government sources in Canada and outside of Canada on legalizing AE and PAD as EOLC treatments. It examines what task forces and committees have concluded regarding AE and PAD as public policy. These task forces and committees have been influential in shaping policies on AE and PAD. The Chapter 2 looks at the positions of the Conservative Party, NDP, Liberal Party and Bloc Quebecois. It is important to examine the voting history and policy statements made by the political parties because they are the ones that pass laws. Therefore, the only way to gauge whether or not Parliament may legalize AE and PAD is to know the position of political parties.

Chapter 3 explains the methodologies and theoretical frameworks used to explain

why AE and PAD are not acceptable legitimate medical treatments. It provides a methodological and theoretical breakdown for the thesis. I will compare and contrast the various theoretical frameworks in order to determine which frameworks would best explain the institutional bias in maintain the status quo when a majority of society supports the legalization of AE and PAD. I will use comparative politics to compare Canada's political and institutional structures to different countries in order to determine if political and institutional structures have an impact on the legalization of AE and PAD. Pressure group politics examines how pressure groups influence EOLC policies in Canada and the US. It will also examine their influence on the public's view regarding AE and PAD. The constructivist approach examines how physicians are influenced by their education and how their views on AE and PAD are influenced by their education. It also explores how the CMA and Canadian law constructs physicians' views on AE and PAD. The rational choice approach will examine why physicians believe it is not in their best interest to participate in AE and PAS. Institutionalism and structuralism will examine the impact the *Criminal Code* and the provinces' responsibility in administering the Code has on the legalizing on AE and PAD. The Chapter will examine the impact of federal law versus state law may have on passing AE and PAD legislation. Chapter 3 will examine the influence of party discipline on legalizing AE and PAD.

Chapter 4 on "Pressure Group Politics" explains the influence pressure groups have on influencing EOLC. This chapter provides a definition of pressure politics and identifies the pressure groups that are involved in advocating for and against active euthanasia. Chapter 4 examines the pressure that groups and organizations put on politicians, the District Health authorities, physicians, etc. and how they do it. Chapter 5 "Constructivist Approach" looks at how doctors are educated may influence their beliefs on the practices of active euthanasia policies. Chapter 5 examines how the Hippocratic Oath, the CMA, and WHO influences and shapes a physician's ideas and norms. It also examines how the ideas and norms of society influence physicians.

Chapter 6 on "Rational Choice Approach" looks at the role and behaviour of physicians. It provides explanations why physicians who support active euthanasia are

not are performing it. Chapter 6 also explains why physicians believe it is not in their best interest to perform AE and PAD. It also provides a definition of Rational Choice. Chapter 7 examines how Canadian institutions and structures influence the politics of EOLC. It examines the influence that the structure of the Canadian healthcare system can have on EOLC by looking at the difference between private and public healthcare systems.

1.5 Conclusion

The this thesis will reach will be that one theory cannot explain the disjuncture between the evidence presented in favour of active euthanasia/PAD and the current practice of refusing to grant AE and PAD legal status in Canada. In Canada peripheral pressure groups do not participate in policymaking, therefore the influence they may have will be indirect and minimum unlike integrated groups such as the CMA. Political strategizing is an explanation for the outcome of government policies. The Conservative Party does not support AE due to the political ideology of their base and the other political parties (with exception of the BQ) have not taken a stance for various political reasons that are explained in Chapter 7.

The constructivist approach will explain how an individual's education and experiences shape their views on AE and PAD. Rational choice will explain that although a physician may support active euthanasia they may be unwilling to participate in AE and PAD because they believe it would not be in their best interest. Intuitionism and structuralism will conclude that Canada's degree of federalism may be a factor to why the Canadian Parliament has not legalized AE. The states in the US have the ability to change their laws without interference from the federal government. Canadian provinces cannot change their laws like the US because the *Criminal Code* is a federal statute. Therefore, one explanation does not explain the various dynamics at play but together the theories will be able to provide a clear picture of the politics underlying AE and PAD. Discursive institutionalism will explain how the status quo and a discourse can develop.

CHAPTER 2 MAPPING THE LITERATURE

Chapter 2 is vital because it provides important background information to the arguments that I will be making in the thesis. It provides information on the arguments that academics have made in support of and in opposition to the legalization of AE and PAD. Chapter 2 also provides vital information regarding the decisions made by the Canadian judiciary regarding AE and PAD. The judiciary is an important institution for Canadians seeking to legalize AE and PAD. The Canadian judiciary has heard judicial cases concerning AE and PAD, i.e. the *Rodriguez Case* and the *Carter Case*. The decisions made by the judiciary, unless specified, become Canadian laws and Canadians have used the judiciary to legalize AE and PAD. Chapter 2 examines the published literature from government sources in Canada and outside of Canada on legalizing AE and PAD as EOLC treatments. It examines what task forces and committees have concluded regarding AE and PAD as public policy.

The Chapter 2 looks at the positions of the Conservative Party, NDP, Liberal Party and Bloc Quebecois. It is important to examine the views of political parties because they are the ones that pass the laws. It will also examine the medical arguments put forward by physicians, the Canadian Medical Association and Quebec's College of Physicians regarding the responsibilities of physicians to their patients regarding active euthanasia. Therefore, the only way to gauge whether or not Parliament may legalize AE and PAD is to know the position of political parties. The Chapter will also discuss the education medical student receive in medical schools concerning AE and PAD. Examining the education medical students receive regarding AE and PAD is important because the way students are educated helps to construct their views on the role of a physician regarding AE and PAD.

2.1 Public Policy and EOLC: Active Euthanasia

Public policy is generally the principles that guide the actions taken by the government or Parliament in a manner consistent with law and institutional conduct. It is a governmental body or its representatives that convey a system of regulatory

measures and laws concerning a given topic such as active euthanasia and PAD. Public policies are entrenched in constitutions, legislative acts and judicial decisions.

2.1.1 The Special Committee of the Canadian Senate¹

The Committee's objective was "to examine and report on the legal, social, and ethical issues relating to [AE] and [PAD]" (Keown, 2002, p.185). The Committee collected written and oral evidence on active euthanasia and physician-assisted death. It held a videoconference with numerous Dutch legal and medical experts in October 1994. In May 1995, the Committee's report recommended that Parliament make no amendments to Canadian laws to allow AE and PAD (Keown, 2002, p.185).

A majority of the Committee opposed PAD and AE because of the concern with "maintaining the fundamental social value of respect for life" (Keown, 2002, p.185). The Committee stated the legalization of AE and PAD could result in abuses specifically with respect to the most vulnerable members of society. The Special Committee noted, "The Netherlands experience illustrates that the guidelines are not always followed" (Keown, 2002, p.185). The Committee believed that because a second person was directly involved in AE, the adequate safeguards could not be established to ensure the patient's consent was voluntarily given. Some members of the committee believed that although there maybe patients who "could not be dealt with adequately by palliative care it was not sufficient to justify legalizing [AE and PAD] because it could not create serious risks for the most vulnerable and through the fundamental value of life" (Keown, 2002, p.186).

There was a minority on the Committee that favoured the legalization of PAD and AE. The reason cited for their support is that patients with debilitating and terminal illnesses are often in extreme pain, and physicians are unable to alleviate a patient's pain. The minority also argued that to deny patients the right to die means the loss of the patient's autonomy is another reason to legalize AE and PAD (Keown, 2002, p.186). The minority argue that the drugs used for terminal sedation to alleviate pain often

¹ The Committee included nine senators and chaired by Senator Joan Neiman, QC. The Committee was established in 1993 and the Committee's report came out in 1994

hastens death is in a way similar to AE and physician-assisted death. Patients and their power of attorney (POA) are able to request the withdrawing or withholding life-sustaining treatments justifies permitting AE and PAD because the result for the patient is the same regardless of the way in which they die (Keown, 2002, p.187).

The Special Committee of the Canadian Senate concluded that the arguments in support of active euthanasia and physician-assisted death do not outweigh the arguments in support of the status quo. The Committee believed the legalization of AE and PAD would result in abuses to the most vulnerable members of society. The Special Committee argued that the Canadian government should maintain the status quo in order to preserve the fundamental value of life.

2.1.2 The House of Lords Select Committee²

The House of Lords Select Committee in the UK appointed an expert Select Committee to address the issues presented in the Bland Case³. Between 1993 and 1994, the Select Committee received ample evidence. It examined witnesses supporting and opposing reforms to EOLC. The Committee's 1994 report the Select Committee unanimously recommended that the UK law should remain intact regarding VAE and PAD (Keown, 2002, p.184). The Select Committee stated there was insufficient evidence to justify prohibiting the practice of VAE and PAD. It stated the prohibition is the basis of law; the Select Committee embodies the belief that all are equal. However, the Select Committee did not want the protection of society to diminish (Keown, 2002, p.184). In order to protect society the Select Committee recommended keeping the status quo and not allowing the practice of AE and PAD.

The Select Committee noted there are individual cases in which AE and PAD may seem to be appropriate medical treatments. However, the Committee believes individual cases cannot logically establish the foundation of a policy that could have serious extensive repercussions (Keown 184). The Select Committee argued that an

² The House of Lords Select Committee was established in 1993.

³ Anthony Bland suffered from severe brain damage. He was left in a persistent vegetated state. With the support of his family he applied to the courts to allow him to die with dignity. In 1995 he became the first patient in England to be allowed to die through assisted death.

individual's death affects the lives of others in ways that are unpredictable. The Committee further stated that the issue of AE and PAD is one in which the individual is unable to be separated from the interest of society (Keown 184). The Select Committee argued "We do not think it possible to set secure limits on 'voluntary euthanasia' (Keown, 2002, p.184).

The main arguments of the House of Lords Select Committee reflect the arguments made by the Special Committee of the Canadian Senate. The Select Committee argued that by legalizing AE and PAD it would leave society unprotected from any abuses that may occur. It also argued that society has a valuable interest in each individual and to legalize AE and PAD would weaken the value of human life. The Committee also did not believe it would be possible to set limits on AE, PAD to ensure human life is valued, and ensure the protection of the vulnerable members of society.

2.1.3 The New York Task Force⁴

The New York Task Force consisted of twenty-four members whose expertise included medicine, nursing, law, philosophy, and theology turned their attention to VAE and PAD in order to inform the growing public debate (Keown, 2002, p.187). Some of its members regarded VAE and PAD as inherently wrong, as violating the prohibition on ending the life of patients felt that VAE and PAD violates the values fundamental to the practice of medicine and the doctor-patient relationship (Keown, 2002, p.187). Others on the task force disagreed and felt that providing a quick death for patients respects a patient's autonomy and demonstrates care and commitment by physicians. However, the twenty-four member panel all agreed that legalizing VAE and PAD was "unwise and dangerous public policy" (Keown, 2002, p.187).

The task force concluded that it would be dangerous to legalize active euthanasia and PAD because there are some patients who have undiagnosed or untreated mental illness. Many individuals, who consider death, including the terminally ill, suffer from treatable mental disorders (New York Task Force, 1994). According to the task force,

⁴ The New York Task Force was appointed by Governor Mario Cuomo in 1985 to make recommendations on public policy aspects of issues raised by medical advances.

physicians consistently fail to diagnose and treat these disorders, principally among patients at the end of life. They also stated AE should remain illegal because physicians improperly managed physical symptoms, pay insufficient attention to the suffering and fears of dying patients. They argue that socially marginalized groups are vulnerable and it would lead devaluation of the lives of the disabled (New York Task Force, 1994).

The task force does not consider the possibility that individuals with mental illness are capable of making their own medical decisions. Most individuals with a mental illness are capable of choosing to be medicated and/or other means of treatment. If we allow individuals with mental illness to make these decisions, with certain exceptions, then they should also be able to choose how they die if they become terminally ill. It is important to remember that being terminally ill is the main component to active euthanasia or PAD therefore nobody regardless of their mental state would be considered a candidate unless they were terminally ill.

The task force concluded that patients may believe that active euthanasia and PAD is the only solution to the “profound existential suffering, feelings of abandonment, or fears about the process of dying” (New York Task Force, 1994). Despite the fact that psychological, spiritual and social support and comprehensive hospice services can often address these concerns, many individuals do not receive hospice services. Patients are likely to seek physician-assisted death or active euthanasia because physicians have not adequately addressed their suffering and fear of dying.

2.2. The Facts on AE and PAD (Netherlands, Washington and Oregon)

It is true that patients may perceive active euthanasia and PAD as a last resort in ending their pain and suffering but it does not mean AE and PAD should not be an option. If hospice care does not provide patients with the quality of life they want then patients should have the right to decide when their life is over. Patients should have the right to end their life in the most humane way possible. In places where it is legal to perform AE or PAD the number of deaths, involving AE and PAD do not reflect the

concerns or theories of the task forces and committees.

In 1995, before the Netherlands legalized active euthanasia, 2.3% of all deaths were by active euthanasia. In 2001, after the legalization of AE, 2.2% of all deaths were by active euthanasia (Gorsuch, 2006, p.108). These numbers show that legalization of VAE does not necessarily mean there will be drastic increases in the number of people seeking it or dying because of it as opponents have suggested. In the State of Oregon from 1998-2009, 88 percent of requests came from patients in hospice. The New York State Task Force argues that no matter how carefully the government designs guidelines to AE and PAD it will marginalize vulnerable peoples of society. They argued that the practice would apply through the “prism of social inequality and bias that characterizes the delivery of services in all segments of our society” (New York Task Force, 1994). According to the task force, PAD and active euthanasia will “pose the greatest risk to the poor, elderly, isolated, members of minority groups, or those who lack access to good medical care” (New York Task Force, 1994).

Again, it is important to reiterate that active euthanasia/PAD is for the terminally ill. Physicians require the consent of the patient or the patient’s power of attorney. In Oregon and Washington, patients that request active euthanasia or PAD are predominately male. In Oregon and Washington between 1998 and 2009, males made up 53 percent and 55 percent of requests respectively. The ages ranged from 25-96. Ninety-eight percent of patients requesting active euthanasia/PAD were white (Starks, 2010 p.7). Therefore, according to this study, females and racial minorities are not the ones that are requesting AE and PAD or nor are they being targeted because they are part of minority group.

The task force also claimed that active euthanasia PAD is far less expensive than palliative care at the end of life and therefore used as a cost effective treatment rather than the appropriate medical treatment, which is more expensive. However, in Starks (2010) research only 3 percent in Oregon and 2 percent in Washington stated financial considerations as a reason or part of the reason for choosing active euthanasia and PAD (p.10). In the Canadian context, it is more about patients in the last six months of life,

which is considerably high. In Canada, about 25 per cent of all health care costs are devoted to caring for patients in their last year of life. (Priest, 2012). Professor Fassbender's research demonstrates it costs the health care system around \$39,947 to treat a patient with organ failure near the end of life, \$36,652 for a terminal illness. Approximately 70 percent of Canadians die in hospital, including some in high-tech intensive-care beds, which cost about \$1-million a year to operate (Priest, 2012).

The task force also argued that it was impossible to develop effective regulation. The task force claimed that the clinical safeguards proposed to prevent abuse and errors are unlikely to be realized. Furthermore, the private nature of EOLC decisions would undermine efforts to monitor physicians' behavior to prevent mistake and abuse. It is a possibility that abuses can happen but euthanasia is rare in places where it is legalized. In Oregon PAD makes up 1.5 percent of all deaths and in Washington it makes up 0.08 percent (Starks, 2010, p. 7). Silent euthanasia, euthanasia that occurs in areas where it remains illegal, is more likely to account for more deaths and more abuses.

2.3 Political Parties and EOLC: Active Euthanasia

In politics, active euthanasia is a hot button for political parties and politicians. Due to the sensitive nature of active euthanasia, politicians do not want to debate the issue for fear of angering voters. In 2011 according to the *Globe and Mail* the Conservative Party of Canada, the New Democratic Party of Canada, the Liberal Party of Canada and the Bloc Quebecois have refused to comment on active euthanasia. University of Toronto law professor Bernard Dickens stated it should not be a surprise that most politicians avoid the active euthanasia topic because there is limited political capital for political parties to gain (Anderson and Paperny, 2011). Politicians and political parties are unlikely to sway voters to their parties by taking a position of AE and PAD. Active euthanasia is a topic that political parties fear may alienate their base depending on the stance they take.

2.4 Canadian Institutions and Active Euthanasia

This section examines how Canadian institutions can hinder the legalization of

AE and PAD and how they can help. The section will examine the efforts made by BQ MP Francine Lalonde to amend the *Criminal Code* in an effort to legalize PAD/AE. It will also examine the judiciary's role in legalizing AE and PAD. This section will examine the successful Gloria Taylor case. Chapter 7 will discuss these issues in further details.

2.5 CMA, The Colleges of Physicians and Surgeons

The CMA, the Royal College of Physicians and Surgeons and their provincial counterparts are influential in providing government policy-makers with informed and critical analysis on a wide range of issues and trends that affect Canada's health system including AE and PAD. The CMA and the colleges are in favour of maintaining the illegal status of AE and PAD.

2.5.1 Collège des Médecins du Québec

The CMQ studied the issues surrounding active euthanasia for three years before announcing in 2009 that it supports AE and PAD as medical treatment. The CMQ stated that it supports the decisions made by patients and their physicians regarding AE and PAD. According to the CMQ's press release, it will support physicians who perform AE or PAD when death is imminent and inevitable (Labranche, 2009). The CMQ stated neither surveys, nor attorneys, nor can politicians advise physicians and patients facing end-of-life. The CMQ believes only physicians and their patients can decide, "The appropriate pain control that respects the ethical obligation of physicians not to preserve life at any cost" (Labranche, 2009). The CMQ further stated, "When the death of a patient appears to be inevitable, to act so that it occurs with dignity and to ensure...the patient obtains the appropriate support and relief" (Labranche, 2009).

Dr. Yves Lamontagne⁵ stated there is a need for society to get beyond the logic of the current legislation. Dr. Lamontagne believes there is a "need to move toward an appropriate care and adopt the legislative framework accordingly...it allows us to reassure patients, physicians and society that the care provided at the end of an

⁵ President and Chief Executive Officers of the Collège des Médecins du Québec

individual's life will be as appropriate support and relief" (Labranche, 2009).

According to the Collège des Médecins du Québec, Canadian law concerning AE and PAD "does not reflect the clinical reality of patients and their doctor and restricts the development of appropriate [EOLC] (Labranche, 2009). The new legislation should define the procedure for arriving at a decision whereby the patient, their family, and the physician can voice their opinions and can obtain the assistance needed to make a decision that is satisfactory to each party concerned. Dr. Robert⁶ states that the CMQ believes "a new sensitivity is clearly evident among doctors and the public that is increasingly pluralistic", (Labranche, 2009). According to Dr. Robert, there is a new inclination to acknowledge that there are certain exceptional circumstances where euthanasia is considered by the patient and their physician to be the proper medical treatment to ensure the patient receives appropriate and quality care at the end of life (Labranche, 2009).

2.6 Medical Schools

Due to a lack of research on AE and PAD in Canadian medical schools' and the influence it has on students, this thesis used data from the US and the UK. According to research conducted by Meier et al in 1997, the curriculum at medical schools in the United States and residency programs contain inadequate formal courses on death and dying. The result of inadequate formal training has resulted in inadequate professional knowledge of palliative medicine (Meier et al, 1997, p. 225). Dr. Boudreau stated, "[I]t is widely recognized that clinical educators contribute more to students' development than the acquisition of new knowledge and skills; they transmit values and participate in the forging of professional identities" (p.79). Clinical educators instill, insinuate, and instantiate in their students a method of seeing, thinking, acting, and being in the clinical world. The socialization and formative process undergone by students is powerful and pervasive. It inevitably leads to conflict of the hearts and minds of students (Boudreau, 2011, pp. 79-80).

⁶ Dr. Yves Robert, Secretary of the Collège.

If Bill C-384 in 2010 was enacted it would have legalized active euthanasia. According to Boudreau whether or not it is considered part of the formal medical school education, the topic of active euthanasia has become a relevant feature of the ecology of medical schools. This is due to its multi-definitions, clinical correlations, scope, access, moral dimensions and political overtones (Boudreau, 2011, p.80). Professor Daren Heyland at Queen's University and a clinical care physician at Kingston General stated, "It's not something I support or endorse" (Anderson and Paperny, 2011).

A study conducted by Dickinson and Field (2002) with the objective to determine how broadly end-of-life issues are responsible in the undergraduate medical school curricula of the United Kingdom and the United States. Their mailed survey yield response rates of 100 percent in the UK and 92 percent in the USA. Every school that responded offered exposure to dying, death, and bereavement courses but one in the UK. Most schools addressed the topic of palliative care. In the UK, 96 percent of medical schools offered hospice involvement as part of the curriculum but only 50 percent of US medical schools offered their students the chance to experience a hospice (Dickinson and Field, 2002, p.181).

In the UK, medical schools according to the study used a greater variety of teaching methods in their courses on dying, death and bereavement. The most popular methods in both countries were the seminar and small discussions. In the UK, 96 percent of the courses use these techniques and 84 percent of schools in the US apply these techniques (Dickinson and Field, 2002, p.183). In the US 69 percent of medical schools use clinical case methods while 96 percent of medical schools in the UK also apply it. The least popular teaching method applied in the UK and the US were stimulated patients; other teaching methods that were used in the UK more frequently than in the US included role playing, hospice visits, and videos or films (Dickinson and Field 183). In the UK 89 percent, medical schools include euthanasia in the curriculum. In the United States, only 46 percent of medical schools include euthanasia in the curriculum (Dickinson and Field, 2002, p.184). At present there are no statistics for Canada.

2.7 Missing from the Literature

The deficiency with the current state of knowledge on end-of-life cares is its lack of understanding of the politics behind EOLC (such as why certain policies are successful and why other policies are not). Although the literature has touched on some of the politics of EOLC, the literature has not researched effect and impact of various interest groups that fund political campaigns and organizations associated with EOLC. It has not addressed the impact the policies of the CMA, the provincial colleges of physicians and surgeons and medical schools and their ability to influence and constrain medical students, physicians and patients concerning performing AE and PAD.

The research into the politics of EOLC as it pertains to active euthanasia will bring new knowledge to the debate. It will present new understandings of the politics of EOLC. It will provide knowledge of how pressure groups work to influence society and politicians. The research will offer a deeper understanding of how the political structures and institutions such as the healthcare system influence the decisions regarding active euthanasia. The research will also explain the impact medical school and the CMA have on socializing physicians and shaping their beliefs regarding active euthanasia. In order to understand why active euthanasia is illegal in Canada it is important to understand the different politics behind EOLC.

2.8 Conclusion

End-of-life issues including active euthanasia are not given high importance in medical schools. The literature does not discuss the politics behind the decisions as to why some medical schools or countries put an emphasis on EOLC as it pertains to active euthanasia and others do not. The literature does not provide explanations for why if end-of-life treatment is an important part of a physician's work, is it not given significant importance in medical schools.

The literature does not discuss but it does hint to the gap in the literature. Why are the advocates for active euthanasia falling on the deaf ears of political parties and MPs and why is the government attempting to suppress these voices in Court? Do pressure

groups influence EOLC policies? Does the education of physicians influence their beliefs on the practices of active euthanasia? Why do physicians who support AE and PAD refuse to practice them as EOLC treatment options and why do many remain silent? Lastly, the literature does not discuss the influence of Canadian institutions and structures on the politics of EOLC.

CHAPTER 3 METHODOLOGY

To explain the political dynamics underlying AE and PAD I will be using several theoretical frameworks. Pressure group politics will examine the relevant pressure groups and their influence politicians and policy makers. The constructivist approach examines how a physician's education, the CMA and their oath influence them. Rational choice will examine how the goal of maximizing benefits while minimizing the costs influences physicians. Institutionalism and structuralism examines the influences of the healthcare systems, systems of governing, the *Criminal Code*, and party discipline have on government decisions regarding the legal statuses of AE and PAD.

3.1 Comparing and Contrasting

For the purpose of the thesis, I am comparing and contrasting the policies of different countries have regarding active euthanasia and PAD as forms of end-of-life medical treatment. It will compare and contrast the influence pressure groups have on the policies in the United States and Canada. I am comparing and contrasting the EOLC education physicians receive in Canada and in other countries. It examines the influence education has on a medical student's and a physician's opinion of AE and PAD. The research compares and contrasts the political systems of various countries to determine if it matters that country has a strong or weak federalism in order to legalize AE and PAD. I am examining the cultural similarities and difference between Canadian, UK and the Netherlands.

3.2 Comparative Politics

For the purpose of the thesis, I am comparing how pressures groups work in Canada and in the US. For example does providing public financing to political parties rather than dependence on private funding influence the impact pressure groups have on political parties. It is comparing the healthcare systems of various countries such as the USA, the Netherlands and Canada in order to determine if healthcare systems are influential to the legalization of AE and PAD. The research examines the impact that a

public healthcare could have on implementing AE and PAD. For example, does having a public rather than a private healthcare system affect the policies governing AE and PAD? It will examine if it is easier to legalize PAD and AE in a country that has a private healthcare system.

3.3 Theoretical Frameworks

3.3.1 Pressure Group Politics

Pressure group politics is a traditional form of political analysis. Pressure group politics examines how groups of people seek to exert pressure on legislators, public opinion, etc., in order to promote their own ideas or welfare. I am using pressure group politics to help identify relevant actors and groups of interest and how do they use their power to influence policies. For the purpose of the thesis, it looks at the different types of pressure groups and organizations that influence politicians and policy makers from the United States and Canada. Pressure group politics examines how pressure groups influence end-of-life treatment in Canada. To explain the influence of pressure groups on EOLC policies and public opinion I am applying inductive reasoning. Because studies of pressure groups by academics such as Pross (1992) have not been applied specifically to EOLC the thesis applied Pross's work on pressure groups to EOLC.

The thesis uses the information provided by Pross regarding pressure group politics in order to explain how pressure groups influence EOLC policies. I will also track the activities (funding of political campaigns, distribute information, lend support to court cases, etc.) of various pressure groups in Canada and the United States in order to examine the influence they may have on politicians. The thesis also examines the influence pressure groups have on public opinion by examining opinion polls and studies. It looks at Canadian pressure groups and USA groups.

The thesis is using the information provided on the groups' websites to gain information on these groups. The websites are useful tools to explain how the groups influence policy decisions and public opinion. These groups use their websites to provide information regarding campaigns, provide literature and provide information on current legal cases and government legislation. The websites also provides an

opportunity for individuals to donate to the group(s) they support. I am also using Elections Canada and Open Secrets to track campaign contributions made by these groups.

3.3.2 Constructivist Approach

Constructivism is an alternate explanatory factor to the utilization of pressure groups. Constructivism argues that humans generate knowledge and meaning from an interaction between their experiences and their ideas. I am using the constructivist approach to study the norms of society in order to determine the behavior of physicians. For example, how they are educated influences their behavior. Medical schools teach physicians to keep people alive, not end their patients' lives.

The thesis looks at the way doctors are educated may influence their beliefs on the practices of active euthanasia and PAD policies. It explores the message medical students receive on active euthanasia from medical schools and from the Canadian Medical Association, the influence the Hippocratic/Physicians Oath has in socializing physicians in either accepting or rejecting active euthanasia as a form of EOLC. It examines the curriculum in medical schools where active euthanasia is accepted and where it was not part of the curriculum in order to determine the influence medical schools have on socializing medical students.

3.3.3 Rational Choice Approach

The rational choice approach is an alternate explanatory factor to the utilization of pressure groups. Rational choice theory is the concept that individuals act as if they are balancing costs against the benefits in order to arrive at an action that would minimize the backlash. For example, a patient requests active euthanasia from their physician. However, AE is illegal in Canada. The physician would then have to decide if the punishment they may receive if caught outweighs ending the suffering of their patient. It is rational for a physician to deny the request because the cost to them would be too high. Because people always try to maximize their interests, they are unlikely to act against their interests. The questions I want to answer is why are physicians who

support AE and PAD not performing these EOLC treatments and what is the explanation for physicians who have in fact performed AE or PAD. Physicians learn in medical schools that their job is to save lives not end them. Physicians are aware that there are patients who are suffering and the pain medication is unable to alleviate their pain. The only treatment option patients have left is permanent sedation. The education medical students receive is influenced by the Physicians Oath, by the CMA, and provincial college of physicians in each province. The *Criminal Code's* stance on AE and PAD is reinforced in medical schools. Medical schools teach students that if they administer a lethal dose of medicine to the patients risks criminal charges for violating the *Criminal Code*.

In Canada physicians could face criminal charges and be sent to prison for performing AE and PAD. Therefore if physicians knew that society would react negatively to their involvement in active euthanasia they would choose not to do it due to the possibility of losing their license to practice and a possible prison sentence regardless of their belief that such a strategy is in fact a superior form of health policy compared to the status quo. In the case of terminal patients, the physicians are not saving lives but using machines and invasive treatments to prolong a patient's life. They are also using medications to alleviate any pain and suffering (these medications often become inadequate). If physicians were to perform AE and PAD they would be helping to hasten the deaths of terminal patients, not taking a life that can be saved. For example, an individual with AIDS is a terminal patient. Because there no cure for AIDS, it is only a matter of when not if a patient will die. Therefore, the physician is only hastening the inevitable death of that patient. Physicians can argue that they support AE when death is inevitable for patients and the patients have chosen AE/PAD as their EOLC treatment. However not many physicians are willing to support the legalization of AE and PAD publically for fear of negative backlash. Nevertheless, there is an argument that part of the rational choice theory that may explain why some physicians are willing to perform active euthanasia and PAD at a patient's request.

3.3.4 Institutionalism and Structuralism

Institutionalism is an approach in which structures and norms establish authoritative guidelines for social behavior. The thesis uses institutionalism to examine how the Canadian healthcare system affects policies on active euthanasia. The research examines the impact of that a public healthcare system could have on implementing AE or PAD. For example, does having a public rather than private health care system affect the policies governing AE and PAD? Is it easier to legalize PAD and AE in country that has a private system? The chapter examines the healthcare systems of various countries such as the USA, the Netherlands and Canada in order to determine if healthcare systems are influential.

The chapter also examines impact the federal *Criminal Code* (and the provinces' responsibility in administer it) may have on the legalization of AE and PAD. The research also examines the role of the Canadian *Criminal Code* as an obstacle to AE and PAD. However, the *Criminal Code* is capable of being re-written to accommodate the legalization of AE and PAD. For example, because the *Criminal Code* governs the laws of every province and territory does this make it easier or harder to change the laws on AE and PAD? Alternatively, would it be easier to change the laws if the provinces had more power over laws as the states in the US have. The thesis examines federal laws vs. state laws by looking at the differences in Canada and the US.

Finally, this chapter examines the influence of party discipline and the MPs' responsibility to their constituencies may have on the legalization of AE and PAD. For example, in Canada party discipline (whether directly or indirectly) is strong, meaning even if a free vote occurs many MPs may still fall in line with the leader. However, in the USA party discipline is weak thus allowing representatives more freedom to vote with or against their party. The question is whether hard or soft party discipline is an obstacle to legalizing AE or PAD.

3.4 Conclusion

In conclusion, I am employing inductive reasoning to develop an explanation for

why AE and PAD are not accepted methods of medical treatment. Inductive reasoning helps to evaluate the evidence provided for the various theories this thesis has put forward in order to arrive at the strongest logical conclusion(s). The thesis applies comparative politics to examine the policies of various countries have involving active euthanasia and physician-assisted death as forms of EOLC medical treatments. Comparative politics compares the influence of various pressure groups in Canada and the USA on policies. For example, does providing public financing to political parties rather than dependence on private funding influence the impact pressure groups have on political parties. Comparative politics compares the influence different healthcare systems may have on informing public policies.

The thesis compares and contrasts the various theoretical frameworks to determine the best explanation(s) as to why governments, specifically Canada, refuse to sanction AE and PAD in Canada. The thesis applies pressure groups politics to provide a political analysis of how various pressure groups seek to exert pressure on legislators, public opinion, etc. This analysis helps to identify relevant actors and groups.

The thesis applies the constructivist approach to study how the norms of society determine the behavior of physicians. It explores the message medical students receive concerning AE and PAD from various parts of the medical community. The thesis applies the rational choice approach in order to explain why physicians who support AE and PAD are unwilling perform them or voice their opinions on them. Institutionalism and structuralism examine how various Canadian institutions affect public policies on AE and PAD.

CHAPTER 4 POLITICAL PRESSURE GROUP APPROACH TO ACTIVE EUTHANASIA

Pressure group politics is a traditional form of politics. Chapter Four examines how groups of people seek to exert pressure on legislators, public opinion, etc., in order to promote their own ideas or welfare. This chapter on pressure groups will help identify the relevant actors and groups of interest and how do they use their power to influence policies on active euthanasia. It will look at the different types of pressure groups and organizations that influence politicians and policy makers from the United States and Canada. It looks at how pressure groups influence end-of-life treatment in Canada. Studies of pressure groups by academics such as Pross (1992) have not been applied specifically to EOLC. This chapter examines the analytical framework provided by Pross regarding pressure group politics in order to explain how pressure groups have been used to influence EOLC policies on active euthanasia.

The chapter will track the activities (funding of political campaigns, distribute information, lend support to court cases, etc.) of various pressure groups in Canada and the United States in order to examine the influence they may have on politicians and on the judiciary. The thesis will also examine the influence pressure groups have on public opinion by examining opinion polls and studies. The Canadian based pressure groups the chapter looks at include Euthanasia Prevention Coalition, Council of Canadians with Disabilities Compassionate Healthcare Network and Canada Dying with Dignity. The United States based pressure groups the chapter looks at includes the Patients' Rights Council, Citizens United Resisting Euthanasia, Compassion & Choice, and Hemlock Society USA/Final Exit. Finally, this chapter will identify the theoretical weaknesses of this approach when applied to EOLC in Canada.

4.1 What are Pressure Groups?

The term 'pressure groups' refers to actions by groups that exert pressure on politicians to obtain decisions from government that they would not have been inclined to make or to ensure they maintain their support for a particular view. The relationship between government and pressure groups is often adversarial. Some would argue that

pressure groups do not help governments by providing advice or expertise but those groups pressure government to adopt policies against the government's will. Others would argue that the relationship between government and pressure groups is one of cooperation (Montpetit, 2009, p. 265). Pressure groups are organizations whose members act together to influence public policy to promote their common interest. The main characteristic of a pressure group according to Pross is that pressure groups try to persuade governments to pursue the policies they are advocating (p.3). According to Montpetit (2009), interest groups (pressure groups) are "organizations created to facilitate the collective action of members who share interests or ideas, with the objective of making a contribution to governance, without seeking public office" (p.266). Pressure groups that are in favour or against the legalization of active euthanasia are advocacy groups. An advocacy group's key action is to advocate in favour of their ideas and beliefs regarding a particular government policy. These pressure groups do not exclusively focus on government. Pressure groups try to convince society about the legitimacy of their ideas in order to pursue everyone that their ideas are valid (Montpetit, 2009, p. 265).

The persuasion by pressure groups takes on many forms; most are intended to extract political pressure. Most pressure groups expect that the force of logical and well-prepared arguments will be sufficient to convince governments to adopt their proposals. When the arguments fail, many pressure groups attempt to use the public and public opinion to persuade governments to adopt the policies of pressure groups (Pross, 1992, p. 3). Pressure groups often try to influence judicial decisions. In cases involving active euthanasia as a form of EOLC, pressure groups have sought and gained access to the judicial proceedings as interveners (Pross, 1992, p. 3, Smith, 2008, p.179-80). The Charter has allowed new opportunities for litigation; the most common challenges occur in the area of criminal law (Smith, 2008, p.180). In order for pressure groups to be persuasive, they must be persistent, have extensive knowledge of substance issues and policy processes and have the financial resources necessary to communicate with the public and with government (Pross, 1992, p. 3). In order to have an impact the activities of pressure groups must have continuity with their message and organization (Pross,

1992, p.3).

4.2 Pressure Groups and the Policy Process

Society allows specialized publics to govern decision-making in sectors of policy where they have competence. These specialized groups interfere when large concerns take precedence when systemic or technological change requires intervention, or when conflict within the special public spills over into the larger political arena (Pross, 1992, pp.118-119). Due to globalization and the ability to mobilize within Canada and outside the country, public policy is subjected to pressures from outside Canada. Canadian groups have the ability to interfere in policy debates in other countries. The advance in technology allows Canada to form alliances with groups outside Canada that have similar policy goals (Smith, 2008, p.181).

There are two terms commonly used to describe the specialized publics: policy communities and networks. A policy community is part of the political system that has acquired a dominant voice in determining government decisions in a field of public activity (Pross, 1992, p.119). Society and the public authorities commonly permit the policy community to create public policy in a particular field. Political communities are populated by government agencies, pressure groups, media, people and individuals, including academics, who have an interest in a particular policy field (such as active euthanasia) and attempt to influence the outcome. Networks are “the relationships that develop among a set of actors around a policy issue of importance to the policy community” (Pross, 1992, p.119).

Policy communities and networks are strongly related but they have significantly different aspects of the policy process. According to Pross, a policy field draws together a community; the policies and policy issues then activates the networks. The key distinction between a policy community and a network rests in the fact that the community exists because a policy field exists. A network exists because those in the field share an approach to a policy (Pross, 1992, p.119). The members of a policy community have in common an involvement, invested interest, intellectual attachment

or commitment to a view of public interest in a particular field such as EOLC and active euthanasia. Their involvement in the political community does not mean their approach to the policy is the same and may often disagree. Networks tend to be composed of like-minded individuals (Pross, 1992, p. 119). Debates over policy issues help to identify groups and individuals who share common values and perceptions about which policies to adopt and which to reject. A network's characteristics have the tendency to attract involvement from actors having an immediate stake in an issue such as active euthanasia that helps to conceptualize what occurs when an issue affects those who are not normally a part of a policy community. Networks tend to be open-ended, members and stakeholders may 'tune in' or leave as issues emerge and their concerns are awakened and resolved (Pross, 1992, p.120).

There are two types of pressure groups: integrated pressure groups and peripheral pressure groups. Integrated pressure groups are those groups that are involved in providing government with informed and critical analysis on a wide range of healthcare issues. Because the CMA, the Royal College of Physicians, Surgeons and their provincial counterparts represent physicians working in Canada public healthcare system they are integrated pressure groups. They work within the government to promote their values and interests. Peripheral pressure groups are the groups that work outside government. These groups have no direct influence on policy-makers nor do they represent the medical community.

4.3 Pressure Groups: Active Euthanasia

According to Pross, comparative studies of pressure group systems suggest that there are significant variations in pressure groups politics from country to country. These significant differences are possibly rooted in the different political systems of these countries. Pressure groups must work within the laws of the country they are operating in and adopt its particular characteristics. However, the goals of a pressure group are the same. Pressure groups perform one significant function – to promote the interest of the stakeholders (Pross, 1992, p.130). There are four other functions pressure groups serve in influencing Canadian policies.

4.3.1 Interest Promotion

Pressure groups seek to “influence public policy in order to promote their common interest” (Pross, 1992, p.130). The pressure groups draw together individuals who have common interests; the groups agree on which interests they do have in common and the best way these interests can be best served. Pressure groups enable these individuals to express their interests to government in a way they hope will influence public policy in their favour. In order to promote the interests of its members pressure groups use interest aggregation and interest articulation (Pross, 1992, p.130-31).

4.3.2 Communications

Public officials encourage pressure groups to act as the main conduit between themselves and pressure group members. It promotes a dialogue and because they have found that interest organizations frequently offer the most effective means of reaching special publics (Pross, 1992, p. 132) such as terminal patients that wish to participate in active euthanasia. Pressure groups can facilitate communication within government by carrying messages between agencies, cutting across the barriers that separate levels in the administrative hierarchy or divide the political and administrative worlds (Pross, 1992, p.132). The multi-directional flow of messages allow pressure groups to respond effectively to its environment, influence that environment, or attempt to create within it an element of order and stability (Pross, 1992, p.134).

4.3.3 Legitimizing

Pressure groups are legitimized when they acknowledge and the support the work of a particular individual, institution, or policy and use their influence with the community to extend that support (Pross, 1992, p.135). Legitimacy guarantees pressure groups a measure of influence over policy decisions that concern pressure groups (Pross, 1992, p.136). For example, pro-euthanasia groups and anti-euthanasia groups vie for the attention of governments regarding bills on euthanasia. The relationship between pressure groups (such as the pro and anti-euthanasia) and government help to keep government aware of the changes within the social system and thereby promoting general political

stability (Pross, 1992, p.136).

4.4 Pressure Groups in Action

Pressure groups often use debates and public forums to persuade politicians and society to support their cause. Pressure groups present briefs to royal commissions, parliamentary committees, tribunals and officials. They use legal arguments to dispute or support the legitimacy of government policy (Pross, 1992, p.140). Pressure groups use placards, the arts such as theatre, film, music, etc. to express the groups' opinions about government and aimed indirectly at government (Pross, 1992, p.140). Pressure groups often use threats and promises in the political debate. Demonstrators use the political process to influence politicians by threatening to vote against the parties that do not support their views on policies. Pressure groups commonly use the threat of publicity as a powerful incentive for reducing the inflexibility of groups and officials who prefer the status quo. Groups that wish to maintain the status quo (Pross, 1992, p.140) also use this tactic.

According to Smith (2008) when groups seek to influence politicians and the outcome of elections, and bill in the HOC, they use the media to draw public attention to the group's views. In the case of AE and PAD supporters and opponents attempt to capture the media's attention as a way to pressure politicians and MPs (p.180). Media such as television tends to focus on dramatic conflicts within a short period; the successful groups are usually the ones that can capture the audience's attention in a 10-second sound bite (Smith, 2008, p.180).

Pressure groups with extensive resources that are sure their views carry weight in policy circles the tactics of traditional lobbying are ideal (Pross, 1992, p.141). They can afford to give the best "power parties in Ottawa where the Cabinet Ministers and deputy ministers mingle with captains of industry" (Pross, 1992, p.141). These pressure groups can afford professional preparations of briefs and other documents and can afford the cost of litigation or appearances before regulatory bodies. Pressure groups that have sources of revenue can pay for campaigns of mass persuasion. For pressure groups that

do not have access to the policy process it is difficult to obtain because, they may not understand the bureaucratic ways of policy-makers (Pross, 1992, p.141)

4.5 Integrated Pressure Groups Active Euthanasia Context

This section looks at the influence of the CMA and Collège des Médecins du Québec on EOLC. It also examines the influence of medical schools and the education medical students receive regarding EOLC. According the literature there are many medical professors who lack knowledge in palliative medicine. This lack of knowledge reinforces the prevailing trend against recognizing and attending to the needs of terminal patients (Meier et al, 1997, p. 226).

4.5.1 CMA and the Colleges of Physicians and Surgeons

The Canadian Medical Association (CMA) is opposed to the legalization of active euthanasia. One of the reasons cited for their opposition is because the various proposals on dying with dignity, for example, the report from the Royal Canadian Society have put physicians in charge of deciding of who is of sound mind to make the decision to die. The physicians are then responsible for perform that death makes physicians uncomfortable (Anderson and Paperny, 2011). The Royal College of Physicians and Surgeons provides government policymakers with informed and critical analysis on issues that affect our health system, including AE and PAD.

The CMA and the colleges, especially the Royal Colleges are able to influence policymakers because they are involved in the policy process. They submit briefs to parliamentary committees, representatives from CMA and Royal College also appear before committees to provide critical input on subjects regarding healthcare. Their input and information is considered more creditable than pressure groups on the periphery. This is because they are considered experts because of their medical experience.

4.6 Peripheral Pressure Groups Active Euthanasia Context

There are some issues, such as active euthanasia, that are deemed too important to the country to be left in the hands of a small number of government agencies and their

associated interests. These issues have to be resolved by the political leadership after a full debate in the media, in Parliament, and at intergovernmental meetings (Pross, 1992, p.165). When influencing public opinion pressure groups have one of two ends in view: 1) pressure groups try to use a stimulated public to dictate a specific decision and 2) through public education, pressure groups try to create an environment of ideas and attitudes that will encourage policy makers to take a certain action (Pross, 1992, p.166). Pressure groups like the pro-euthanasia and anti-euthanasia pressure groups influence public opinion through advertisements, direct lobbying, obtain media attention and using Parliament. Several different pressure groups in Canada and in the USA are for and against active euthanasia as a form of EOLC. These groups are using the aforementioned tactics to influence Parliament, the judiciary and public opinion.

4.6.1 The Euthanasia Prevention Coalition

The Euthanasia Prevention Coalition (EPC) is a Canadian pressure group that works to prevent the legalization of active euthanasia. The purpose of the EPC is to preserve and enforce the legal prohibitions and ethical guidelines prohibiting the use of active euthanasia as an EOLC treatment and to increase the public's awareness of hospice and palliative care. The goal of the EPC is to educate the public on harm and risks associated with promotion of euthanasia and assisted death with pamphlets, information seminars, media campaigns and research articles (EPC, 2013). The EPC also co-ordinates and disseminate research and information on issues related to active euthanasia and assisted death. The EPC also represents the vulnerable and where appropriate advocates before the courts on issues related to active euthanasia and assisted death (EPC, 2013). The EPC presents a united voice against the legalization of AE and PAD to government and other organization and institution such as the courts. The EPC intervened in the *Carter Case* in B.C., which sought to legalize active euthanasia in Canada. In response to Justice Lynn Smith's ruling in the *Carter Case* in British Columbia, the EPC has set up a letter writing campaign. The EPC is urging members to contact their MPs to urge them to oppose active euthanasia and assisted death. The EPC urged its members to write letters to the media (EPC Admin, 2012).

The EPC of British Columbia has even tried to influence government policies outside Canada by giving \$1000 in opposition to the Washington Death with Dignity Act (I-1000). Alex Schadenberg of the EPC gave \$200 in opposition to I-1000 (Follow the Money - EPC, 2008). However, the electorate approved measure I-1000 approved in the 4 November 2008 general election.

4.6.2 The Council of Canadians with Disabilities (CCD)

The CCD opposes changes to the criminal that would legalize active euthanasia through act of Parliament or judicial decision (CCD, 2013). In a policy statement passed by the CCD National Council of Representatives on 8 June 1996, the CCD opposes government action to decriminalize assisted death because of the serious potential for abuse and the negative image of people with disabilities that it portray if people with disabilities were killed with state sanction (CCD, 2013). On 16 June 2010, two CCD representatives, Rhonda Wiebe, Co-chair of CCD's Ending of Life Ethics Committee, and Jim Derksen, a Committee Member, appeared before the Ad Hoc Committee on Palliative and Compassionate Care to present CCD's brief *Canadians with Disabilities We Are Not Dead Yet*. Ms. Wiebe and Mr. Derksen, in their appearance before the Committee explained, how active euthanasia puts those with disabilities in harm's way (CCD, 2010). In June 2009, the CCD released a press statement stating, “everyone who supports disability rights should oppose Bill C-384” (CCD, 2009).

4.6.3 Citizens United Resisting Euthanasia

The Citizens United Resisting Euthanasia (CURE) is a USA based grassroots network of patient advocacy groups ranging from professional politicians and religious leaders that advocate against the legalization of active euthanasia and PAD. The CURE provides educational materials that seek to alert the public of the growing danger of active euthanasia. CURE defends patients against euthanasia through a broad range of print, online media, radio and television (CURE, 2005).

It is difficult for CURE to advocate the dangers of AE and PAD on behalf of terminal patients because there are terminal patients who support AE and PAD. A USA

study of 100 terminal cancer patients found that 69 percent of the patients supported AE and PAD (Saurez-Almazor, 2002, p. 2134). The support of terminal patients for active euthanasia and PAD makes it hard for advocacy groups like to CURE to advocate effectively against the legalization of AE and PAS. By advocating against active euthanasia and physician-assisted suicide, they are alienating a demographic of terminal patients who support AE and PAD.

4.6.4 Patients' Rights Council

The Patients' Rights Council (PRC) is a United States based pressure group committed to ensuring active euthanasia and PAD remain a criminal offence, in addition they fight to criminalize active euthanasia or assisted death in states where they are legal. The PRC provides information to the public regarding active euthanasia as part of end-of-life treatment. The PRC builds and maintains strong networks with individuals and other pressure groups in order to influence policy and news coverage (PRC, 2013). It provides assistance and training as to the most effective ways to address audiences on active euthanasia. Individuals and organizations that network with PRC share a common concern regarding active euthanasia and PAD (PRC, 2013).

The PRC provides individuals with the educational research and materials. These materials include journal articles, books, etc. The PRC library's contains the most extensive and up-to-date collection of books, periodicals, newspapers professional journal articles dedicated to active euthanasia and end-of-life decisions (PRC, 2013). Spokespersons for the PRC appear at conferences on news programs, etc. They primarily work with policy-makers and journalists to influence the judiciary, governments, and public opinion (PRC, 2013). In return for media attention, the PRC provides the media with information on failure stories on euthanasia and investigative reports. The Patients' Rights Council assists attorneys and those involved in field of bioethics. PRC has developed a network of attorneys willing to devote time to maintaining the status quo (PRC, 2013).

However, it is difficult for the Patients' Rights Council to argue against AE and PAD because patients are requesting the legalization of AE and PAD. It is also difficult

for the PRC to gain support for AE when patients support active euthanasia. In Canada Sue Rodriguez and Gloria Taylor are two patients who requested the legalization of active euthanasia and physician-assisted suicide. According to the Angus Reid (2012) survey two-thirds (66%) of Canadians thought VAE would not send the message that the lives of patients and the disabled were meaningless and not worth living. Out of 238 terminal patients, 62.8 percent would consider requesting active euthanasia. Six percent of patients said they would actually request active euthanasia.

4.6.5 The Farewell Foundation

The Farewell Foundation is an organization that supports the legalization of euthanasia. The Farewell Foundation believes that individuals have the right to make decisions regarding their bodies. The foundation believes individuals should have the right to receive assistance to end their lives. The Farewell Foundation is challenging the constitutional legitimacy of s. 241 (b) of the Criminal Code.

The Farewell Foundation launched a lawsuit on behalf of four anonymous people who want help ending their lives in 2011, arguing the Criminal Code section dealing with assisted death violates the Charter of Rights and Freedoms. B.C. Supreme Court Justice Lynn Smith ruled the group does not have standing because the plaintiffs were anonymous, but she recommended the Farewell Foundation apply to intervene in the *Carter* case that was about the head to trial (“Farewell Foundation,” 2011). The Farewell Foundation, one of several groups intervening in the case in support of the applicants, argues that the Swiss system should be adopted in Canada (Hume, Dec. 2011). In August 2012, Justice Smith ruled that the sections of the *Criminal Code* that banned AE and PAD were unconstitutional.

4.6.6 The B.C. Civil Liberties Association

The B.C. Civil Liberties Association (BCCLA) is a Canadian pressure group in British Columbia. The Law Foundation of B.C and private citizens fund the British Columbia Civil Liberties Association. Their mandate is to preserve, defend, maintain and extend civil liberties and human rights in Canada. The BCCLA achieves their

mandate through their Advocacy in Action, Public Policy, Community Education and Justice Programs (BCCLA 2013). The BCCLA is an autonomous, non-partisan charitable society. The BCCLA strives to work cooperatively with other groups on common causes (BCCLA, 2013).

The BCCLA Community Education Program informs citizens and educates them on EOLC and active euthanasia. The BCCLA provides free publications and leaflets on a range of topics. The publications include the Privacy Handbook, Rights Talk, The Arrest Handbook, Police Complaints, Drug Testing in the Workplace, and the Citizenship Handbook offered in various languages to engage immigrants and students (BCCLA, 2013). The B.C. Civil Liberties Association Speakers Bureau in which their staff and board members talk to students and community groups and they hold public events about civil liberties and human rights (BCCLA, 2013). The BCCLA Advocacy in Action Program provides direct assistance to individuals who request information or have complaints about civil liberties violations by government agencies, employers, and other organizations (BCCLA, 2013).

In their Public Policy Program, the BCCLA has developed over 200 policy briefs, which serve as the principled cornerstones for our work. They meet with government and private sector officials to persuade them to change laws or policies that infringe on civil liberties and to develop new laws and policies that protect fundamental rights and freedoms (BCCLA, 2013). The BCCLA uses their Justice Program to challenge laws in the courts and over the years, they have attracted the resources and pro bono legal talents to be successful at this (BCCLA, 2013).

In 1994, the BCCLA argued that the complete ban in Canada on PAD and active voluntary euthanasia is not morally defensible. According to the BCCLA there is a strong prima facie case for allowing persons who are facing intractable pain or indignities in the final stages of their lives to determine for themselves when life is no longer worth living, and, where necessary, receive assistance in ending their lives. The BCCLA argues that their prima facie case is constructed from the principles of liberty, autonomy and equality; from the value of preventing unnecessary suffering and

preserving the dignity of the individual; and from the inconsistency between legally allowing suicide and passive voluntary euthanasia while denying legal space to assisted death and active voluntary euthanasia (BCCLA, 1994).

The B.C. Civil Liberties Association is leading the charge against laws that make PAD of incurably ill people to die with dignity a crime (Sullivan, S., 2011). In 2011, BCCLA launched a lawsuit aimed at overturning Canada's laws affecting people's right to die. Gloria Taylor joined the lawsuit in June 2011 (“B.C. Woman joins,” 2011). The BCCLA was instrumental in challenging the criminalization of AE and PAD. The court dismissed the lawsuit because the plaintiffs were anonymous; however, Gloria Taylor and Lee Carter⁷ filed a separate lawsuit. Their lawsuit requested the legalization of PAD. In August 2012, the B.C. Supreme Court declared Canada's euthanasia laws unconstitutional.

4.6.7 Compassion & Choices

Compassion and Choices (C&C) is a USA based non-profit organization that advocates for the improvement and expansion of the choices of treatment available to patients at the end-of-life. The C&C organization dedicates itself to legal and legislative initiatives to secure comprehensive and compassionate options at the end-of-life (C&C, 2013). The team of C&C litigators and legislators experts fight bills that force dying patients to endure futile invasive treatment set enforceability standards for advance directives. The organization monitors legislative and policy initiatives for EOLC (C&C, 2013).

Compassion & Choices involves itself in court cases such as *Bergman v Chin* which established that the under treatment of pain is a form of elder abuse; *Furlong vs. Catholic Healthcare West* sought to demonstrate an obligation to follow the wishes of patients regarding CPR and ICU care at the end-of-life (C&C, n.d). Compassion and Choices coalitions work to forward legislation that strengthen advance directives.

⁷ Lee Carter escorted her mother to Switzerland, where a physician-assisted in ending her mother's life, at the request of the mother.

In 2009, the Montana Supreme Court decision, which affirmed the principle that end-of-life medical choices are private between patients and their doctors. The judicial decision enables terminally ill adults to request a noxious substance that would allow the patient to have a peaceful death. Montana Sen. Greg Hinkle introduced Bill SB 116 on behalf of groups and individuals that would overturn the court ruling and eliminate end-of-life choice for Montanans (C&C, n.d.). In February 2011, the Montana Senate Judiciary Committee voted 7 to 5 to maintain the Montana Supreme Court's Baxter ruling (C&C, n.d.).

Compassion & Choices lobbying expenditures from 2006 to 2012 was \$420,000. In 2011, the C&C's lobbying expenditures totaled \$20,000 (Open Secrets, 2011) (**Figure 4-1**). Its Washington Initiative PAC spent \$627, 625 (Follow the Money, 2008, Table 1) (**Figures 4- 2**). Washington is the second state to Legalize aid-in-dying. The Yes on I-000 Campaign has moved patient's rights forward. The Oregon legislation demonstrates aid-in-dying law benefits all at end of life. It provides comfort and control to the terminally ill and ends violent deaths. On November 4, 2008, Washington voters approved I-1000 59% to 41% (C&C, n.d.).

4.6.8 Euthanasia Research and Guidance Organization

The Euthanasia Research & Guidance Organization (ERGO) is a non-profit educational corporation based in Oregon, USA. It provides quality to research euthanasia for individuals who are terminally ill and wish to end their suffering. The ERGO considers active euthanasia as an appropriate EOLC treatment (ERGO, 2010). The ERGO conducts opinion polls, develops and publishes ethical, psychological, and legal guidelines for patients and physicians. The organization supplies literature to, and does research for, other right-to-die groups worldwide (ERGO, 2010).

4.7 The Influence of Pressure Groups

Pressure groups do not seem to have a significant influence over government policy concerning active euthanasia and physician-assisted death. Pluralism is a significant reason why pressure groups do not have a significant influence on

government policy regarding active euthanasia and physician-assisted death. Pluralism is the understanding that pressure groups operate in competition with one another and play a key role in the political system; they do this by acting as a counterweight to undue concentrations of power (Montpetit, 2009, p. 277).

Pressure groups that are in favour of the legalization of active euthanasia and pressure groups that oppose active euthanasia have access to pro and anti-active euthanasia networks. These pressure groups are often open and individuals can enter and exit easily (Montpetit, 2009, p. 277). Because of the large number of groups in favour of active euthanasia and groups opposed to AE and PAD, they can often voice a wide range of policy preference. This contributes to the autonomy of government officials in decision-making. Governments when managing large networks are free to make policies that best suit the government's agenda rather than one that best suits the pressure groups (Montpetit, 2009, p. 277).

Pluralist networks of pro and anti-active euthanasia networks distribute expertise equally between the state and pressure groups. Therefore, networks that support and oppose the legalization of active euthanasia can provide reasonable arguments to explain their dissatisfaction with a policy encourages an adversarial debate. These networks are often constrained by the number of groups in the network (Montpetit, 2009, p.277). Because of this constraint, these groups often invest just enough to make their policy preferences credible, but not enough to influence policy-makers and Parliament. The groups that support and oppose active euthanasia in pluralist networks often advocate and lobby rather than participate in policy-making (Montpetit, 2009, p. 278). The influence of pressure groups on policy-making is minimized when they are not when they are not directly involved in the process.

There is a difference between how pressure groups function in Canada and in the United States. This could be due in part to the differing political cultures. According to Alexander, Canada has a more egalitarian approach, providing public financing and individual donations in order to achieve a "level playing field" by imposing expenditure ceilings on candidate, party and even interest group spending (Alexander, 2005, p. 91).

The United States has a more libertarian or free speech approach, with dependence upon private financing through more generous contribution limits from individual, political action committee and political party sources. In the USA, spending limits are enacted only in presidential campaigns and are acceptable only when candidates voluntarily agree to them as a condition of their acceptance of public financing (Alexander, 2005, p. 91).

The US political culture values individual liberty, whereas the Canadian cultural values focus upon equality and good governance. American political parties are relatively weak, allowing individual candidates to define their own political agendas and to raise their own funds by amass their own financial coalition (Wilcox, 2005, p.123). Individuals are limited in the amount that they can give to candidates for federal office, the amounts that they can give to political parties and the political committees associated with interest groups. Parties and interest groups are also limited in the amounts that they can give to candidates, to political committees' association with interest groups (PACs), or to party committees. The US banned corporations and labor unions from direct contributions of treasury funds to candidates. However, they can form PACs and raise money from their members to donate to federal candidates and committees (Wilcox, 2005, p.124). Because candidates receive money from interest groups (and depend on these groups for financial support), they become indebted to these groups. The criticism of the USA is that money and those who finance the campaigns determine public policies. They candidates feel indebted to their financiers and therefore are willing to vote the way in which the interest group or PAC want them to.

Canada does not appear to have this problem with interest groups. In Canada, political parties are strong, meaning that candidates must promote the views of the party. As of 2007, Canadian political parties can only acquire campaign funds through individual donations and per-vote subsidies (Alexander, 2005, p.105). Interest groups are more entrenched in the American elections than they are in Canadian ones. Interest groups cannot donate money to political parties or candidates and they are limited to the amount of money they can spend on advertisements nationwide. For the 2006 election,

each registered group could spend up to \$172,050, on election advertising nationwide. Of this, an interest group could not spend more than \$3,441 in a single electoral district (Elections Canada, 2006).

Pressure groups often direct their lobbying to Cabinet Ministers, especially the minister in charge of their particular portfolio (Gatner, 1980, p.35). The EPC's letter writing campaign is focused on Members of Parliament, specifically to the most honourable Rob Nicholson, the Minister of Justice. Because of Nicholson's position as Minister of Justice the EPC and other anti-euthanasia and pro-euthanasia groups believe that he has the ability to influence the Prime Minister. With the permission of the Prime Minister, Rob Nicholson would then be able to appeal court decisions that legalize AE and PAD in order to persuade the higher courts to overturn the decisions made by the lower courts. In matters such as amendments to the *Criminal Code*, concerning social issues such as active euthanasia and physician-assisted suicide, pressure groups direct their efforts toward individual MPs. Pressure groups become more active when a free vote occurs in Parliament (Gatner, 1980, p. 35). According to individual MPs, pressure groups mistakenly think that if a significant number of backbencher MPs to support their policies on AE and PAD through their efforts in caucus, they could ensure that that Minister of Justice and the policy of government fall in line with the pressure group's policy (Gatner 35). Members of Parliament may only help further a pressure groups' agenda if it coincides with their own, their constituents and those of political party. Political parties like MPs are more willing to listen to pressure groups when their ideology coincides (Gatner, 1980, p35). The Conservative Party of Canada has publically supported that status quo on AE and PAS policies. Therefore, the Conservative Party is less willing to listen to pro-euthanasia but be more willing to listen to anti-euthanasia groups.

In recent years, pressure groups opposing the legalization of AE and PAD have lost the public's support of the status-quo. In 2010, sixty-seven percent of Canadians were in favour of VAE. Despite anti-active euthanasia groups' use of advertisements, conferences, newspaper, magazine articles and television news media segments over

sixty percent of the Canadian population agree with legalizing active euthanasia.

Anti-active euthanasia groups have failed to create an environment that would encourage policy-makers and the judicial system to continue its support of the status quo. In Washington, Oregon⁸, and Montana⁹ PAD is legal. The electorate in Washington approved measure I-1000 in the 4 November 2008 general election. Initiative 1000 of 2008 established the state of Washington's *Death with Dignity Act*. In Canada, Justice Lynn Smith ruled in August 2012 that the ban on assisted-death was unconstitutional. However, pressure groups can only intervene in court cases and provide funding for the legal bills. These groups have no power within the courts.

In recent years, pressure groups supporting the legalization of AE and PAD have to gain the public's support because of their stance on the legalization of AE and PAD. The public has shown its support for pro AE and PAD groups through opinion polls and through ballot measures. Despite anti-active euthanasia groups, use of advertisements, conferences, newspaper and magazine articles and television news media segments the pro-active euthanasia groups helped to influence about 67 percent of the Canadian population to support the legalizing active euthanasia and physician-assisted suicide.

The United States Washington's 2008, I-1000 and Massachusetts' 2012 ballot measure Question 2¹⁰ indicate that pressure groups support assisted death are more likely to receive contributions from individuals than pressure groups opposing assisted death. Nevertheless, pressure groups opposing assisted death were able to receive more financial support from institutions than pressure groups supporting assisted death. Pro I-1000 committees¹¹ received support from 13, 212 individuals while the committees¹² against assisted suicide received financial support from 5,197 individuals. Pro I-1000 committees received financial support from 54 institutions while committees against

⁸ Measure 16 of 1994 established the U.S. state of Oregon's Death with Dignity Act

⁹ *Baxter v. Montana* was a Montana Supreme Court case, argued on September 2, 2009, and decided on December 31, 2009. On Dec. 31, 2009, the Montana Supreme Court ruled in favor of Baxter, thus legalizing PAS.

¹⁰ The ballot measure that could legalize assisted suicide in the State of Massachusetts

¹¹ Pro Ballot Measure Committees: Yes on I-1000 and the Compassion and Choice Group (Follow The Money "I-1000")

¹² Con Ballot Measure Committee: Coalition Against Assisted Suicide (Follow The Money "I-1000")

Pro I-1000 received financial support from 263 institutions (Follow the Money, 2008). Pro Question 2 committees¹³ received financial support from 714 individuals and the opposing Question 2 committees¹⁴ received financial support from only 42 individuals. Pro Question 2 committees only received financial support from eight institutions while opposing committees received financial support from 43 institutions (Follow the Money, 2012). (**Figure 4-3**)

The information provided from indicates that pro AE pressure groups are more successful in gaining the financial and electorate support from individuals. A majority of individuals see active euthanasia as a personal choice for physicians and patients. Many individuals perceive active euthanasia as an appropriate medical treatment at the end-of-life and option they would like to have if they develop a terminal illness. However, opposing AE pressure groups are more likely to receive the financial support of institutions. Many institutions such as medical associations, religious institutions, government institutions and agencies and political parties oppose AE based on professional ethics (i.e. Physicians Oath), religious doctrine (i.e. the Bible), government policies and ideology of political parties (i.e. pro-life policies and pro-life ideology). These groups do not consider the autonomy of the individual; many only think of the ramifications AE would have on their institutions.

4.8 Conclusion

The theory of pressure groups does not explain how they could have a strong influence on government when they are not involved in the policy making process. Particularly, because of the constraints on the two sides of the debate it makes it easy for government officials to have autonomy over decision-making, thereby making the policies that want to make and not the policies pressure groups want them to make. In Canada, the policy states that AE and PAD are criminal offences according the *Criminal Code*. Pressure groups on either side of the debate try to influence society

¹³ Dignity 2012 and Massachusetts' Compassion and Choice (Follow The Money "Question 2")

¹⁴ CMIE Against Physician Assisted Suicide, Massachusetts Alliance Against Doctor Prescribed Suicide and Second Thoughts People with Disabilities Opposing the legalization of Assisted Suicide Follow (The Money "Question 2")

however because they do not participate in policy-making they have little influence. Since pressure groups have limited influence on government because they do not participate in policy-making, pressure group politics does not fully explain the political dynamics of AE and PAD. Because pressure groups do not explain the disjuncture between the evidence presented in favour of AE, PAD and the practice of refusing to grant it legal status it is important to look at other possible dynamics.

CHAPTER 5 THE CONSTRUCTIVIST APPROACH TO ACTIVE EUTHANASIA

Constructivism is another approach that may help us understand why AE and PAD remain illegal despite public support for it. This approach argues that humans generate knowledge and meaning from an interaction between their experiences and their ideas. First, Chapter 5 examines the influence government policies have in constructing the societal norms and how the policies of the medical community construct the norms of the medical profession. The chapter also shows how the policies of government and the medical community are interwoven and influence each other. The chapter uses the constructivist approach to study the norms of the medical profession in order to determine the behaviour of physicians. It examines the messages medical students receive on active euthanasia from medical schools, the Canadian Medical Association, and the influence the Hippocratic /Physicians Oath has on the medical community in socializing physicians in either accepting or rejecting active euthanasia as a form of EOLC. Chapter Five looks at the curriculum in medical schools where active euthanasia is accepted and where it is not.

This chapter focuses on the American Medical Association, Washington State Medical association, Oregon Medical Association and the Montana Medical Association due to their stances on AE and PAD and state laws. The chapter uses studies from the US and the UK due to the lack of studies done on AE and PAD curriculum in Canadian medical schools. However, the thesis infers that the evidence from UK medical schools and US medical schools could be reflected in Canadian medical schools if more in-depth studies were done.

5.1 The Constructivist Approach

Constructivism refers to the idea that each learner constructs knowledge from individuals and society to create meaning as they gain knowledge regarding a field of study (Hein, 1991) Von Glaserfeld stated, "...from the constructivist perspective, learning is not a stimulus response phenomenon. It requires self-regulation and the

building of conceptual structures through reflection and abstraction.” (p.14). According to Von Glaserfeld, we construct knowledge through experiences regardless of the reality. Meaning perception is reality. To rely on this type of knowledge construction can be problematic because our experiences of situations may differ from the reality of the situation.

Fosnot (1996) believes behaviors or skills are not the goal of instruction but rather the concept of development and deep understandings are the focal points (p.10). If Canadian professors teach medical students that the law, medical associations and provincial colleges of physicians and surgeons do not accept AE or PAD then medical students may be less likely to support AE and PAD. By teaching medical students that AE and PAD are unethical professors continue to reinforce to students that the practices wrong. However, if a professor offered a more balanced approach to teaching AE and PAD medical students would be able to make a better-informed decision concerning their views on AE and PAD. Professors can discuss the merits of legalizing AE and PAD with medical students. This may influence students to support the legalization of AE and PAD or not but their decision would be a more well informed one. Nonetheless, students may not be willing to perform AE and PAD because social norms (*Criminal Code* and medical associations) have deemed these practices unacceptable. Even though medical students maybe unwilling to perform AE and PAD, they are being taught by professors that AE and PAD do have their merits may leave medical students more open to the subject of legalization. Central to the constructivist approach is its conception of learning.

Constructivist learning suggests that individuals create their own new understanding based upon the interaction of what they previously knew and the phenomena or idea with which they come into contact (Richardson, 1997, p.3). People learn through experience and develop ideas concerning ethical and unethical practices from what they experience and what they are taught. Constructivism aides in understanding why some physicians accept active euthanasia as an adequate alternative to the withholding and withdrawing of life sustaining treatment and sedation and why

others reject it. It also explains why some physicians agree with the concept of active euthanasia because of their experience with the suffering and decreased quality of life patients will have; they refuse to participate due to their views constructed by the medical community.

The educational philosophy of constructivism states that learners construct their own knowledge. The knowledge gained by the learners becomes as unique as they are. Thereby constructivism enforces the idea that our experiences and education help to construct not only a physician's views on active euthanasia but also their response to participating in the act. Constructivism may also explain why a physician's views on active euthanasia and their response to practicing AE may be contradictory.

5.2 Government Policies' Influence on Curriculum

Government policies indirectly influence the curriculum in medical schools, hospital policies, and medical student and a physician's stance or willingness to perform active euthanasia and physician-assisted death. The Canadian government, a majority of US states, and Germany have criminalized active euthanasia and physician-assisted death. Medical schools cannot teach students that active euthanasia and PAD are legitimate medical treatments in Canada because of their illegal status.

The state constructs laws making certain practices illegal, i.e. active euthanasia and PAD. Medical schools teach students that AE and PAD are illegal in Canada in accordance with the Canadian *Criminal Code* and the Supreme Court of Canada. These decisions from Parliament and the judiciary reinforce the concept that AE and PAD are wrong. However because physicians are self-regulatory they are able to directly influence medical students. The curriculum in medical schools can debate the merits of AE and PAD but are unable to authorize the practices of AE and physician-assisted death. By debating their medical students have the opportunity to discuss the pros and cons of legalizing AE and PAD and its impact it has on their role as physicians. A UWO study indicated that 63 percent of medical students that respondent were unwilling to participate in PAD. According to the study, the fourth year students were less willing to

participate in PAD. Only 17 percent of fourth year students were willing to participate in PAD while 51 percent of first year students were willing to participate in PAD (Gabel et al, 2005, p.124). This study indicates that there is a link between education and the willingness of medical students to participate in AE and PAD.

Sections 14 and 241 and the Supreme Court decisions have reinforced the ethical policies of the CMA, provincial medical associations, and provincial colleges of physicians. The CMA, provincial medical associations, and the provincial colleges of physicians have also endorsed the concept that active euthanasia is an illegal and unethical medical practice. The medical associations and the *Criminal Code* influence the teachings of professors at medical schools. Although a professor may support AE and PAD and teach their merits in the classroom, they still must make it clear to students that the current law deems AE and PAD an illegal practice.

By ignoring, the concept of AE and PAD as an alternative medical treatment or by teaching students that they are unethical treatments medical schools could make it difficult for some physicians to accept AE and PAD as legitimate medical treatments. It also makes it difficult to convince other healthcare professionals to change their stance on AE and physician-assisted death. If professors teach active euthanasia and physician-assisted death by debating the merits of AE and PAD, it may lead to a more productive discussion on AE and PAD. It would allow students to express their opinions on the topic and even allow them to construct their own views on AE and PAD.

5.3 The Hippocratic/Physicians' Oath

The Hippocratic Oath is one of the oldest binding documents in history (**Appendix 5-1**). The Oath has changed various times over the years to incorporate “new” medical practices. Although there have been changes to the Oath the main ethical principles of the Oath remained. Today, most graduating medical students swear to uphold the ethical principles. However, they use a modernized version of the Oath. In 1928, only 24 percent of medical schools in the US administered the Oath. Today, nearly 100 percent of medical schools administer it (Tyson, 2001). By administering of

the Oath, medical schools reinforce the ethical principles of medical associations, and colleges of physicians and surgeons.

The Hippocratic Oath does mention the usage of drugs by physicians. The Hippocratic Oath states, “I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect”. There are scholars that see it as renouncing physicians’ involvement in executions. It is important to point out that physicians are involved in euthanasia when they participate in state executions. Therefore, physicians who participate in executions are in violation of the Hippocratic Oath (Miles, 2004, p. 66-67). The interpretation of the passage denouncing the use of drugs to induce death has several different scenarios.

The World Medical Association adopted the Physician’s Oath in 1968. This Oath appears to be a response to the atrocities committed by doctors in Nazi Germany (“Declaration of Geneva”, 1948). Notably, the Physician’s Oath requires physicians to “maintain the utmost respect for human life; even under threat...not use [their] medical knowledge contrary to the laws of humanity”. However, this section of the Oath relates to the concept that physicians cannot use their medical knowledge to participate in the murder of individuals or to cause harm to individuals through experiments. The medical community has interpreted the Oath to mean physicians should never take part using their medical knowledge to cause someone’s death in practice there have been narrower interpretations. Physicians, commonly in the USA participate in the executions of prisoners. Using the broad interpretation of the Declaration of Geneva, physicians who participate in executions are in violation of the Declaration. Therefore, a physician participating in executions is contradictory to their code of ethics. However, if narrowly interpreted the section could suggest that as long as physicians use their knowledge within the law it is acceptable even though practices such as the death penalty are deemed unacceptable in other elements of society.

The structure of the Oath implies that the form of medical ethics ought to include principles and issues that address the societal and clinical roles of the physician (Miles,

2004, p.180). Past versions of the Oath prohibited physicians from performing surgeries, abortions and from receiving fees for teaching medicine. The Oath is not absolute and modifications to the Oath can occur as medical ethics change. Therefore, the Oath can include active euthanasia as another end-of-life option. The Oath in all its forms does stress the importance of human life and the physicians' responsibility to maintain life. However, physicians do not always maintain life under specific conditions.

5.3.1 The Influence of the Oath

According to Antiel et al (2011), most physicians take part in a medical school oath ceremony, but only a small number of students and physicians believe that the rite of passage has strongly shaped their sense of professionalism (p. 469). In 2009, almost 80% of 1,032 practicing physicians surveyed stated they took part in a medical school oath ceremony using the original or modified versions of the Hippocratic Oath or the Declaration of Geneva, also known as the Physicians Oath (O'Reilly. 2011). Conversely, only 26% of physicians surveyed said the Oath significantly influenced their practice of medicine or provided moral guidance in their medical careers (Antiel et al, 2011, p. 470). It is important to note that although physicians may not feel that the Oath significantly influences them, it is possible that it does influence them indirectly because it influences the codes and ethics of medical associations, colleges of physicians and surgeons, of which they are members. A majority of institutions have interpreted sections of the Oath as being opposed to physicians performing AE and PAD. The Oath influences the ethics and codes of medical associations and colleges of physicians and surgeons, and they in turn may influence the behaviour of physicians.

In the US, only 1 in 4 practicing physicians acknowledged a strong influence of the Oath on their practice of medicine. Nonetheless, 100% of medical students take the Oath. The Oath influences medical students and physicians indirectly through its influence of the ethical codes of medical associations and colleges of physicians and surgeons (Antiel et al., 2011, p. 470). The moral teachings and the specific traditions of physicians and medical students are influenced by the Oath. Physicians may not

recognize the importance the Oath has on their belief system but it influences what they are taught in medical school. The Oath does have influence over the ethical codes of the medical associations, the WHO and the curriculum at medical schools. Therefore, it is likely that if the Oath does not influence Canadian medical students and physicians directly it has an indirect influence. The ideas that are in the Oath are embedded in the policies of the CMA and the colleges of physicians and surgeons. The CMA and the provincial colleges have refused to recognize AE and PAD as legitimate EOLC treatments because, according to their policies, run contradictory to the role of physicians.

5.4 The Medical Associations' Influence on Medical Students and Physicians

The Hippocratic and Physicians Oath have influenced the medical associations' values and norms. Most medical associations cite active euthanasia as not being an appropriate role of physicians as healers. According to these associations, a physician's job is to save lives and heal patients, not end their lives. Because a majority of physicians are members of medical associations, they have the ability to influence their members. By influencing physicians, medical associations are able to influence medical students who are most likely a part of the medical association. Physicians who teach in medical schools are most likely a part of a medical association. Through influencing the physicians, the medical associations are able to influence the curriculum in the medical schools where their members teach medical students.

5.4.1 The USAMA

According to the US American Medical Association (USAMA) even if some patients are in extreme duress, such as those suffering from a terminal, painful and debilitating illnesses may come to decide that death is preferable to life AE and PAD are not an appropriate practices. However, if the USAMA permitted physicians to engage in euthanasia it would eventually cause more harm than good (AMA, 2001). The USAMA considers euthanasia fundamentally incompatible with the physician's role as healer (a physician is expected to save lives not end them). The practice of AE

and PAD would be difficult or impossible to control, and would pose serious societal risks (AMA, 2001). The USAMA stance on active euthanasia reflects the Hippocratic and Physician's Oath.

5.4.2 The WSMA

The Washington State Medical Association (WSMA) delivers strong advocacy that is patient focused and physician driven. The WSMA (1984) states, “[a] physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient”. According to Washington State law, assisted dying is legal and physicians are required to respect it. However, the official position of the WSMA is that the Washington State Medical Association opposes Initiative-1000, the measure to legalize physician-assisted death in Washington State (WSMA, 2012, p.21). The WSMA believes that PAD is incompatible with the role of physicians as healers the law in Washington State does allow physicians to participate in PAD if they wish to participate in Physician-assisted death.

5.4.3 The US OMA and MMA

The US Oregon Medical Association (US OMA) serves and supports physicians in their efforts to improve the health of patients (The OMA 2011). The US OMA established a handbook with clear guidelines for physicians. This handbook provides support for physicians willing to participate in PAD and for physicians unwilling to do so. By providing a handbook the US OMA makes it acceptable to participate in PAD however, the association does make it clear that physicians should take into account hospital policies before participating in PAD (The OMA, 2011). Physician-assisted death was legalized in a 4-2 decision issued Dec. 2009. The Montana Medical Association (MMA) does not have policy on physician-assisted death as of January 2009 (O'Reily, 2010). Therefore, physicians are able to perform active euthanasia and physician-assisted death without breaching the ethical standards of the MMA.

5.4.4 The CMA

The Canadian Medical Association's Code of Ethics requires a high standard of

behaviour of physicians than the criminal law in Canada. The CMA makes their policy on active euthanasia and assisted death clear. Canadian physicians should not participate in euthanasia or assisted death (CMA, 2007). The CMA does not support euthanasia or assisted death. It urges its members to uphold the principles of palliative care (CMA, 2007). The CMA has advocated in opposition to *Bill C – 384 (an Act to amend the Criminal Code)*. The CMA delivered a letter to all 308 members of Parliament stating their opposition to active euthanasia and assisted death. In the letter, the CMA urged members to vote down Bill C – 384 and uphold the principles of palliative care by enhancing access to palliative care and suicide prevention programs (Sullivan, P., 2009).

The influence of the CMA can be measured by looking at the policies of the provincial medical associations and the provincial colleges of physicians and surgeons. For example, the British Columbia Medical Association (BCMA) is bound by the codes and ethics established by the CMA. This includes the CMA's position on active euthanasia and PAD. The BCMA represents over 11 000 (approximately 95%) practicing physicians in British Columbia (BCMA, 2013). Because it represents 95 percent of practicing physicians it has the ability to influence these physicians into thinking AE and PAD are unethical medical treatments. These physicians also have the ability to influence medical students into believing PAD and AE are wrong. The Alberta Medical Association (AMA) is a provincial division of the CMA. The AMA represents about 95% of Alberta's practicing physicians as well as resident physicians and medical students who are bound by the codes and ethics of the CMA (AMA, 2012). The SMA (Saskatchewan Medical Association) represents 90 percent of Saskatchewan's physicians and represents a majority of medical students and residents. The SMA is a provincial division of the Canadian Medical Association and therefore bound by its codes (SMA, 2009). The CMA promotes their belief that AE and PAD are wrong and unethical to the physicians that are members of the associations. The physicians that are convinced AE and PAD go against the role of physicians have the ability to influence medical students of the same thing.

There is a significant difference between the Canadian medical associations and the American medical associations. In Canada, these associations are divisions of the CMA and are subjected to the codes and ethics of the CMA. In the USA, medical associations are not subjected to the AMA. The medical associations in the US appear to have the autonomy to be independent from the AMA. This allows state medical associations such as the OMA to introduce ethics and codes that are pro AE and PAD. The medical associations continued to support of the status quo may isolate physicians who believe AE and PAD are legitimate treatments. This may result in physicians not performing AE and PAD where it is legal to do so or prevent them from taking a stance in favour of AE and PAD as EOLC treatments in places such as Canada. The CMA does not allow provincial associations to have the same autonomy as the US. Canadian provincial associations appear to be unable to change their codes of ethics in order to accept AE and PAD as ethical treatments.

5.4.5 The College of Physicians and Surgeons

The College of Physicians and Surgeons in Nova Scotia (CPSNS) like other colleges in Canada endorse the CMA's Policies in euthanasia and assisted death .The CPNS represents a total of 2451 physicians and surgeons in Nova Scotia as of 31 December 2011 (CPNS, 2011). The CPNS expects their physicians to follow the ethical guidelines and policies of the College and the CMA. The failure to uphold the ethical standards of the College could result in punishment by the provincial colleges' disciplinary committees. The punishments include suspended license for an unspecified time and the revocation of a physician's license. The exception is in Quebec. The Quebec College of Physicians and Surgeons (QCPS), has endorsed active euthanasia and PAD (Perreux, 2010).

5.4.6 The Influence of Medical Associations and Colleges of Physicians and Surgeons

The USAMA's and the CMA's objections to the legalization of AE and PAD can make it difficult for physicians to perform active euthanasia and physician-assisted suicide or to support them. If the government were to legalize AE and PAD and the

CMA and USAMA 's lack of support for physicians who are willing to perform AE and PAD as EOLC treatment may make the physicians uncomfortable and unwilling because they may still considered these acts wrong and in violation of their roles as physicians. The lack of support physicians may receive can further reinforce the concept that the legalization of AE and PAD would not be in accordance to CMA policies. If the CMA stance remains stagnate, like the WSMA's policy on PAD it can have adverse effects on the physicians willing to participate in AE and PAD or even promote it as an alternative.

Physicians in Washington can legally assist in a patient's death, however the WSMA continues to hold the policy that PAD is incompatible with the role of physicians. The lack of support from the WSMA may cause problems for physicians willing to perform PAD. Therefore, physicians may be less willing to perform PAD because the medical association of which they are a part of considers it wrong. The WSMA may refuse to support physicians in legal matters such as performing PAD when it is in violation of hospitable policy or from the scrutiny of a patient's family that may include a lawsuit. The support of the medical association is important to physicians because it allows physicians to perform PAD as an EOLC treatment without feeling that they are violating the Physicians Oath and the ethics and codes of the medical community, as the WSMA believes. The support of the CMA and other medical associations for the legalization of AE and PAD would indicate to physicians that it is an ethical treatment and does not go against their role as physicians. In Canada, the CMA and the provincial medical associations have the ability to expel physicians if they violate one of the association's policies. The benefits the CMA could provide physicians if they support AE and PAD include public support and legal support if needed. Therefore, the support of the medical community would reinforce the CMA's approval of AE and PAD.

The USOMA supports of the legalization PAD and supports physicians who are willing and unwilling to perform PAD. This support makes it easier for physicians to perform and not to perform this type of EOLC treatmentnt. To make it easier for

physicians the US OMA has created a safe environment for physicians by writing a handbook for physicians that provide support for physicians willing and unwilling to perform PAD. The USOMA will not punish physicians for performing PAD. This allows physicians not to feel rejected from the medical community for participating in an action it has deemed wrong. Instead, it reinforces for physicians in Oregon that PAD is an acceptable treatment, which allows physicians to participate in PAD without fearing negative consequences or believing they are doing something wrong.

The Quebec College of Physicians (CMQ) and the Federation of Quebec Medical Specialists (FMSQ) support the legalization of active euthanasia. They have contended that terminal sedation is a form of euthanasia. Therefore, by continually sedating patients, physicians are not improving a dying patient's quality of life. A majority of Quebec specialists favour legalizing active euthanasia. Of the 2,025 Quebec medical specialists that responded to a survey, 75 percent said to be in favour of AE, as long as strict guidelines were in place ("Quebec Specialists," 2009). Quebec physicians are more willing to support the legalization of active euthanasia publically because the CMQ and FMSQ support the legalization of AE. The support of the CMQ and FSMQ is important because they represent the interests of physicians and are the ones to determine unethical practices and makes it easier for physicians to support active euthanasia and physician-assisted death.

5.5 Medical Schools and Curriculum

Most medical schools in the US (58%) state they teach ethics as one component of a larger required course. Ethics might receive 20 or more formal classroom hours or no formal time. There is little known about the contents of required formal ethic components. It is difficult to evaluate the strengths and weaknesses of medical school curriculum regarding ethics (DuBois and Burkemper, 2002, p. 433). In the study conducted by DuBois and Burkemper of US medical schools, they requested course syllabi from each school. Each school required an ethical component in a four-year curriculum. Eighty-seven (72%) schools responded. According to the respondents 74 percent claimed to require a formal ethics course and 84 percent provided their ethics

course syllabi (DuBois and Burkemper, 2002, pp. 432-433).

DuBois and Burkemper's study found that only two course objectives were found in more than half of the courses: (1) to familiarize students with medical ethical topics (77%) and second to develop ethical reasoning and problem-solving skills (64%) (DuBois and Burkemper, 2002, pp.433). The four teaching methods used to teach ethics in medical schools include: (1) discussion/debates (84%), (2) readings (83%), (3) writing exercises (64%) and (4) lectures (64%) (DuBois and Burkemper, 2002, p. 433). The two methods used in a majority of medical schools that required ethics components: class participation (90%) and examinations (64%) (DuBois and Burkemper, 2002, p.433). In only 67 percent of schools that responded the quality of life, futility, and provision of treatment. Sixty-six percent of medical schools taught students about death and dying and 60 percent of medical schools included euthanasia and PAD in their course content (DuBois and Burkemper, 2002, pp. 434-435) (**Figure 5-1**).

According to the study conducted by Weber et al,¹⁵ only 5 to 10 percent of students declared a high level of confidence in dealing with palliative care issues. However, 50 percent of medical students approached pain management with confidence, meaning that another 50 percent were less confident (Weber et al., 2011, p.2). According to the study, only 55 percent of all students could correctly identify the definition of euthanasia (Weber et al, 2011, p. 4). It could be interfered that because forty-five percent of students were unable to correctly define euthanasia these students are not being adequately educated in EOLC matters. The study conducted by DeLeo et al¹⁶ indicated that a high proportion of students were interested in education topics that involved quality of life and quality of death topics. The survey found that 76.8 percent of medical students, supported by 66 percent of undergraduate respondents, favoured

¹⁵ The study conducted by Weber et al was a composite three-step questionnaire conducted during the final year of medical school two German Universities. Out of 318 enrolled students, 101 medical students responded (Weber et al 1).

¹⁶ DeLeo et al conducted semi-structured interviews on a sample of medical school coordinators, medical school students, and general practitioners in Australia. Three-hundred and seventy-three students completed the survey from 15 medical schools (DeLeo 10)

the study of different types of euthanasia and PAD. DeLeo et al's study also found that 88.8 percent of students supported the idea of having physicians involved in discussions regarding end-of-life issues and 50% of students agreed they physicians should actively participate in life ending decisions (DeLeo et al., 2012, p.13) (**Figure 5- 2&3**).

The majority of medical students expressed an interest in learning about the quality of life and quality of death, euthanasia and right to die issues and different types of euthanasia and PAD are likely to be aware of the importance of acquiring knowledge and skills in euthanasia and EOLC issues (DeLeo et al 15). Half of the participants agreed with the teaching of euthanasia in medical schools. A third of the participants neither agreed nor disagreed (neutral). The reason a third of participants stayed neutral could be due in part to the lack of EOLC education. This lack of education makes them unable to form an opinion. The rest of the participants did not think physicians should be involved in life ending decisions (DeLeo et al., 2012, p.15). The belief that physicians should not be involved in life ending decisions demonstrates the lack of EOLC education medical students receive. Physicians are involved in life ending decisions on a daily basis. The most contact patients have with physicians is at the end of life. Seventy percent of people die in hospital and about 25 percent of all healthcare costs are allocated to caring for patients in the final year of life (Priest, 2012)

Due to the lack of academic studies done on Canadian medical students' education regarding EOLC there is a need to examine the studies from other countries that have similar experiences with AE and PAD. Because physicians in Canada, Britain and the USA are part of the medical community, it is likely that Canadian medical students receive similar education in medical schools as their counterparts and are more likely to form similar opinions. It is possible that Canadian medical students like their counterparts in the US and in the UK begin their medical education believing AE or PAD should be legal and willing to perform these acts as EOLC treatment. However as their education continues although their views on AE and PAD have not changed their willingness to perform such acts has. In Canada as in the UK, the US and Australia physicians may become less willing to perform AE and PAD because of their illegal

status and the punishments they could receive for performing them.

At the University of Western Ontario (UWO) from January 2011 to April 2011, Dr. J Niskor taught a medical ethics course¹⁷ that included PAD and AE. The course was a credited that ran six weeks for two hours per week. In week five, the course dealt with End of Life Ethics. The class dealt with issues regarding physicians' roles and obligations as a physician to the patient regarding end of life decisions (UWO, 2011, p.30). The objective of the course is to understand the moral issues in physician-assisted death. Week 5 discusses the social issues surrounding euthanasia and the physician's obligation to the patient, to society, to the patient's family and to themselves. It also discusses the pros and cons of legalizing AE and PAD. This class is supposed to help students develop an understanding that would allow physicians to counsel a patient requesting euthanasia. It discusses a physician's obligation to persons (patient or POA) making end of life decisions (UWO, 2011, p.30) (**Appendix 5-2**). The course only spent one week on the ethics of AE and PAD. For students to grasp the complexities of the PAD and AE debate medical professors need to spend more than two hours on the subject. These professors could spend two-hours alone discussing the complexities and ethics of just PAD. Although six weeks is relatively substantial of time to spend on EOLC, these types of courses do not allow medical students to experience palliative and hospice care or interact with terminal patients.

5.6 Physicians and Medical Students: Active Euthanasia

Most medical students often cite their reason for entering medicine as wanting to cure or help patients. The reality of medicine is that the majority of patients are those with chronic progressive illnesses for whom no cure is possible. Because patients with chronic or terminal illnesses occupy over 90 percent of hospital beds it is important for students to be educated in EOLC (Lloyd-Williams and Dogra, (2004, p.31).

5.6.1 Medical Schools in the USA and the UK

Active euthanasia is a criminal offence in all states in the USA. However,

¹⁷ The class was titled *Medical Ethics Through Film*

physician assisted dying (PAD) is legal in the states of Washington, Oregon and Montana. The criminal law in the United States however varies from state to state; therefore medical school curriculum may also vary from state to state depending on the law of the state.

The curriculum at medical schools in the United States and residency programs contain inadequate formal courses on death and dying. The result of inadequate formal training has resulted in inadequate professional knowledge of palliative medicine (Meier et al, 1997, p.225). According to Dr. Boudreau (2011), “it is widely recognized that clinical educators contribute more to students’ development than the acquisition of new knowledge and skills; they transmit values and participate in the forging of professional identities” (p.79). The socialization and formative process undergone by students is powerful and pervasive.

The study conducted by Dickinson and Field (2002) was determined that the undergraduate medical schools in the USA and UK the schools that responded offered exposure to dying, death and bereavement courses except for one school in the UK. Most schools addressed the topic of palliative care. In 96 percent of UK medical schools hospice involvement was part of the curriculum but it only 50 percent of US medical schools offered it as part of the curriculum (Dickinson and Field, 2002, p.181).

In the United Kingdom, suicide was decriminalized according to section 1 of the Death Act 1961. Section 2 of the Act states it is a criminal offence to be compliant in another individual’s death (**Appendix 5-3**). The most popular methods in both countries were the seminar and small discussions. In the UK, 96 percent of the courses use these techniques and 84 percent of schools in the US apply these techniques. In the US 69 percent of medical schools use clinical case methods while 96 percent of medical schools in the UK also apply it (Dickinson and Field, 2002, p.182). UK medical students appear to be receiving a better education in EOLC than those in the US. However, because seminar and discussion are the most popular students are only discussing EOLC in the abstract. They do not have an emotional connection to patients

who are suffering and unaware of the realities dying patients endure (except for any person experiences the students may have).

The least popular teaching method applied in the UK and the US was simulated patients. In health care, a simulated patient is an individual trained to act as a real patient in order to simulate a set of symptoms or problems. Other teaching methods that were used in the UK more frequently than in the US included role-playing, hospice visits and videos or films (Dickinson and Field, 2002, p.183) (**Figure 5-4**). The lack of hands on experience fails to give medical students a more rounded education. Through their experiences with the dying, they would have been able to construct, their own views on AE and PAD not just internalize what professors, medical associations and the laws have said on the issue. Euthanasia appeared more often in the United Kingdom's medical schools (89 percent) curriculum. In the United States, 46 percent of medical schools included euthanasia in their curriculum (Dickinson and Field, 2002, p.184).

5.6.2 Medical Schools in Germany

In Germany, suicide and assistance of suicide are not criminal offences. In Germany, there is a legal duty for doctors to assist in cases of accidents and in situations where the patients are in need of professional health care. In Germany death in the absence of contrary evidence, is ruled an accident thereby creating a legal duty for physicians to try to save the patient's life (Schildmann et al, 2006, p.31). The German Medical association in 1998 rejected PAD as unethical (Schildmann et al, 2006, p.31). A German survey of members of the German Association of Palliative Medicine demonstrated that a positive attitude toward active euthanasia is highly dependent on professional experience, knowledge in ethics, and palliative medicine. The studies of undergraduate medical students have shown relatively high rates of acceptance of active euthanasia (Clemens et al, 2008, p.539).

In a survey conducted by Schildmann et al¹⁸ (2006) at the Charité University

¹⁸ The study conducted by Schildmann et al included all fifth year medical students from the University. They conducted their study from October 2002 until February 2003. The survey-questionnaire was distributed to half of the 204 medical students. Only 85 out of 102 medical students completed the survey (Schildmann et al 32 -33).

Medicine Berlin 16.5 percent reported a patient has asked them about assisted death while 70 percent indicated they had no such experience (p. 33). At University 1 (U1) 21.2 percent and 37.2 percent of respondents in University 2 (U2) answered that they would perform active euthanasia on the grounds it was legal (Clemens et al, 2008, p.541). When given the choice of “not sure” most medical students answered not sure. In the Schildmann et al study 25.9 percent of respondents agreed that prescribing drugs for the purpose of a patient’s death is never ethically justified (Schildmann et al, 2006, p.34).

According to Schildmann et al, twenty-one participants indicated they would prescribe medication to assist death (Schildmann et al, 2006, p.34). At U1 39.8 percent students and 52.6 percent of all U2 students cited a dignified death as their reason for supporting active euthanasia. At the U1 37.2 percent and 48.7 percent of medical students cited ‘respect for the patients’ as their reason for supporting active euthanasia. Fifteen percent of medical students at U1 cited this as their reason while 29.5 percent of medical students at U2 refer to the patient’s belief in their lack of quality of life as their reason to support active euthanasia (Clemens et al, 2008, p.542).

A significant percentage of German medicals students believe that if AE was legalized it would be misused. At U1 72.6 percent and 78.2 percent of medical students at U2 answered that if legalized active euthanasia would be misused. Due German physicians practicing NVAE in the Holocaust, it is understandable that physicians believe AE would be misused. The medical students expressed their concerns that they have not been appropriately prepared in the care of dying patients. An alarming 12.2 percent of medical students at U1 felt they had been adequately prepared while only 7.1 percent at U2 stated they have been adequately prepared and educated in the care of dying patients (Clemens et al, 2008, p. 542). The study conducted by Ostgathe et al¹⁹, found that the overall self-estimation of students regarding EOLC was low and the overall knowledge of students was low. According to Ostgathe et al, only 60 percent of

¹⁹ A cross sectional, questionnaire based survey at the medical school of Bonn. First, third, and fifth year students had to grade their knowledge and skills in items concerning palliative medicine. The return rate was 78 percent. The research was conducted in 2003.

the questions students received at the end of training were correctly answered (Ostgathe, 2007, pp.155-156). Because medical students expressed their concerns that they have not been appropriately in the care of dying patients and their overall knowledge on EOLC was low, it is difficult to determine what the students' opinions on AE and PAD would be if students were educated more efficiently on EOLC.

5.6.3 Medical Schools in Canada

A study conducted by Gabel et al.²⁰ at the UWO indicated that 63 percent of respondents were unwilling to participate in PAD as a physician. According to the study, only 17 percent of fourth year students were willing to participate in PAD while 51 percent of first year students were willing to participate in PAD (Gabel et al., 2005, p.124). However seventy-seven (64%) of respondents stated that they supported the notion of PAD as an option but were less willing to participate.

It is possible that the more education medical students receive regarding the role of physicians the more unlikely they are to participate in PAD or AE. It is important to note that there is a difference being willing to participate in AE and PAD and supporting AE and PAD. More medical students support the idea of PAD over the course of their medical education but become unwilling to participate in PAD and AE. Twenty-six (74%) respondents became in favour while nine respondents became opposed to PAD over the course of their medical education (Gabel et al., 2005, p.124). However fourth year medical students were significantly less willing to participate in PAD compared to first year students. This suggests that more educated students are the less willing they are to participate as physicians in PAD even if they personally support PAD (Gabel et al., 2005, p.124).

²⁰ The survey was administered to first and fourth year medical students at the University of Western Ontario (UWO) in Canada. The survey was administered in March 2004 to 236 medical students. The response rate was 34 percent (72 students) in first year and 52 students (51%) in fourth year (Gabel et al 122-123).

5.7 The Influence of Medical Schools on AE and PAD

The studies have indicated that medical students and physicians with a strong foundation in the principles of medical ethics and knowledge regarding alternative approaches to end of life issues correlates with a low approval of participating in active euthanasia and physician-assisted death (Clemens et al., 2008, p.545). Low approval ratings for AE by medical students may occur because medical schools teach students that it is unethical to perform AE and PAD. Colleges for physicians and surgeons may punish physicians for violating their ethical codes making medical students and physicians to become less willing to support or perform AE and PAD.

The laws against AE and PAD reinforce to students the norms and values of society. The norms and values of society do not include physicians performing active euthanasia and physician-assisted death, at least according to the laws of the country and not the views of society. However, a majority of society supports the legalization of AE and PAD. Nevertheless, the laws have an impact on physicians because they help to reinforce the values and norms of medical associations and colleges of physicians and surgeons have interpreted in the Hippocratic and Physicians Oath.

The studies also indicate that if palliative medical training were compulsory it could have an impact on the attitudes future medical students and physicians have pertaining to end-of-life issues. The medical schools that did include compulsory training in palliative medicine that included AE and PAD implied a high acceptance of supporting legislation that would legalize active euthanasia as a course of medical treatment for themselves and a willingness to perform it at their patient's request (Clemens et al., 2008, p.545). This could indicate the more educated students are regarding the pain and suffering patients go through tend to be supportive of the legalization of AE and PAD. The various studies found that students who had experience with dying patients were more decisive with respect to whether they would be willing to participate in PAD. According to Schildmann et al, a medical student or a physician's personal experience with the caring for dying patients or family members can influence position on PAD. It is possible that the emotional involvement,

experiences and personal reflections associated with EOLC will lead medical students to form a stronger position on PAD as a course of treatment (Schildmann et al., 2006, p.35).

Therefore, if taught primarily that AE and PAD are unethical EOLC practices medical students and physicians are unlikely to accept these options as proper medical procedures without proper knowledge and experience with terminal patients. As physicians become aware of the indignities terminal patients endure they may be more likely to support AE and PAD. Through experience with terminal patients, individuals realize inadequacy of palliative care can cause individuals to change their opinions on AE and PAD and construct a new understanding of what they consider appropriate treatments. Subsequently if these physicians teach at medical schools, write article, etc., they may provide medical students and other physicians a new perspective or even validate their view on AE and PAD.

5.8 Constructivism and Society

It is important to look at cultural and historical differences between jurisdictions. Canada, Britain and the USA do not have history with euthanasia that Germany does. In Nazi Germany, NVAE was legal. The physicians in Nazi Germany euthanatized individuals who were not terminally ill nor wished to end their lives but were non-voluntarily euthanized because they were of religious, cultural, ethnic and political backgrounds deemed undesirable. Therefore, it is not surprising that people in Germany including the state would be hesitant to legalize AE and PAD.

The United States claims to be a country based on individualism, therefore one would expect the US to accept AE and PAD as an individual's choice. However, the US has a history of mistrust regarding authority, especially the state. Therefore, the public may be wary of legalizing AE and PAD for fear that it will be misused, creating distrust between physicians and patient. Canada does not have a historical mistrust of the state. Canadians see the state as benign and look to the state to protect their rights (the Charter) and provide the necessities (healthcare, employment insurance, etc.). Some

states in the US have legalized PAD. Washington is a socially liberal state due to its legalization of PAD, same-sex marriage and cannabis. Oregon legalized PAD in 1994. It is a socially and politically liberal state. The last Republican governor served from 1979-1987 (National Governors Association, 2011). Chapter Seven explains the various ways these states legalized PAD. Due to Canada's strong federalism, provinces cannot individually legalize AE and PAD like America states. Chapter Seven will explain the differences between federal laws and state laws.

Even through there is a separation of church and state in the US there is a culture of religious identity. According to Brooks, religion influences individuals in the US more than in Canada and Britain (Brooks, 2009, p.67). According to Brooks (2009), Canada has more in common with western European countries than with the United States (66). Canada is a more secular society than the US. Secularism has allows more individuals to break from the beliefs of religious organizations to form their own beliefs on right or wrong, including their views on AE and PAD. In the Netherlands 40 percent of the population claims no religious affiliation (Palmer, 2011). It is possible that secularization and the break from religious organizations maybe contacted with the legalization of AE. Secularism has created an increase in social, cultural and political influence of elites whose expertise is not based on religion (Brooks, 2009, p.65). In 2000, only 30 percent of Canadians reported religion was important to in their life, 15 percent in Britain agreed and in the USA 57 percent of people agreed with this statement (Brooks, 2009, 67).

5.9 Conclusion

Government laws reinforce the norms and values of society, the ethical principles interpreted in the Hippocratic and Physicians Oath and the policies of the medical associations. In various studies, most physicians and medical students are favour active euthanasia but are less willing to participate in it. The studies have shown that more the indoctrinated physicians are into the norms and values of the medical community and the existing laws of society the less willing they are to participate because they taught PAD and AE is unethical. The medical schools that did include compulsory EOLC education indicated a high acceptance of supporting legislation that would legalize

active euthanasia as a course of medical treatment for themselves and a willingness to perform it at their patient's request than schools that only discuss it (Clemens et al., 2008, p.545). The studies indicate that emotional involvement, experiences and personal reflections associated with the terminally ill will lead medical students to form a stronger position on PAD as a course of treatment (Schildmann et al., 2006, p.35).

The number of physicians supporting AE and PAD but are unwilling to practice or voice their opinions could indicate that the social construction of laws such as the *Criminal Code* and policies of the medical community influence the behavior of physicians. Nevertheless, the support from the majority society helps to create new norms and values of society that the medical community and government have not acknowledged. Thus constructivism does not adequately explain the disjuncture between a majority of society, a number of physicians supporting the legalization of AE and PAD and the government's and the majority medical community's refusal to accept them as appropriate EOLC options.

CHAPTER 6 THE RATIONAL CHOICE APPROACH TO ACTIVE EUTHANASIA

The rational choice approach is an alternate explanatory factor to the utilization of pressure groups. Rational choice theory states that individuals act as if they are weighing the costs of an action against the benefits of taking a particular in order to arrive at an action that would minimize the backlash they may receive from a particular action. In other words, people will always try to maximize their interests while minimizing their costs. The question this chapter wants to answer is why physicians who support active euthanasia are not practicing it or publically supporting the legalization of active euthanasia and physician-assisted suicide.

According to the CMA and Colleges of Physicians and Surgeons, a physician's job is to save lives, not end them. The Physicians Oath, the CMA in Canada and provincial colleges of physicians in each province influence the education physicians receive in medical school. Because of their education, physicians are aware that if a terminally ill patient or their POA request PAD or AE there are legal and professional consequences to physicians if they honour the patient's request. In Canada the physician could face criminal charges and be sent to prison. Therefore if physicians knew that society would react negatively to their involvement in AE they would choose not to do it due to the possibility of losing their license to practice and a possible prison sentence despite their belief that such a strategy is in fact a superior form of health policy compared to the status quo. Chapter Six examines how rational choice is a possible explanation of why physicians are unwilling to participate in active euthanasia and physician-assisted dying.

6.1 Empirical Evidence

Because active euthanasia and physician-assisted death is such a dividing issue in Canada, most physicians are unwilling to express publically their support for AE and

PAD. In Canada, the CMQ²¹ and the FMSQ²² support the legalization of active euthanasia. They have also argued that terminal sedation is a form of euthanasia. A majority of Quebec specialists favour legalizing active euthanasia. Of the 2,025 Quebec medical specialists that responded to a survey, 75 percent said to be in favour of AE, as long as strict guidelines were in place (“Quebec Specialists Support,” 2009).

A Washington State study led by Jonathan Cohen and a number of academics²³ found that fifty-four percent of responding physicians thought AE should be legal in particular situations. Thirty-three percent of respondents said they would be willing to perform AE (Cohen, 1992, p.91). An American study led by Emanuel et al²⁴ found that of the 3,299 oncologists twenty-five percent supported PAD for terminal patients and 6.5 percent supported AE. Fifteen percent of respondents stated they would be willing to perform PAD and 2.0 percent said they would perform active euthanasia (Emanuel et al., 2000, p.529). According to the study, 10.8 percent of respondents performed PAD during their career and 3.7 percent reported performing AE (Emanuel et al., 2000, p.529).

In a study led by Professor Clive Seale²⁵, 4000 British physicians participated in the survey. The study found one in three physicians believed doctors should be allowed to help their patients to die. The study also found that in one in 200 deaths a physician has intentionally used drugs to hasten a patient’s death, a majority of whom had 24 hours to live (Devlin, 2009). It is highly likely that Canadian physicians have also used drugs to hasten a patient’s death under the guise of trying to alleviate a patient’s pain.

There is empirical evidence that does demonstrate that there are physicians who support the legalization of active euthanasia and physician-assisted death and are willing to perform them as medical treatments. In Canada, according to one study,

²¹ CMQ is the Quebec College of Physicians

²² FMSQ is the Federation of Quebec medical Specialists

²³ Cohen et al’s study was done by sending questionnaires to 1355 physicians and 938 responded.

²⁴ 3299 oncologists in the U.S. participated in the study. All participants were members of the American Society of Clinical Oncology in the U.S.

²⁵ Professor Clive teaches at Centre for Health Sciences at Queen Mary University in London.

seventy-five percent of Quebec physicians who specialize in EOLC favour AE and physician-assisted death (“Quebec Specialists Support,” 2009). This chapter examines if rational choice a potential reason why physicians who support AE and PAD and would perform AE and PAD as medical treatments do not participate in these practices?

6.2 Rational Choice Definitions

Rational choice theory (RCT) or rational action theory (RAT) is the framework for understanding and formally modeling social behaviour. Within the rational choice theory, there is a specific definition of ‘rationality’. A rational action generally implies a conscious social actor engaging in deliberate calculative strategies. Human behaviour is shaped by the rewards and punishments that individuals encountered. Individuals take actions that lead to rewards and they avoid actions that could lead to punishment (Scott, 2000, p.129). Through RCT and RAT, individuals are conditioned to balance costs against benefits to arrive at an action that maximizes personal advantage. For example rational choice may involve deciding to cheat on a test, buy a new dress, or for a physician to participate in AE. Rational choice looks at the costs of doing an activity and an individual reflects on the chances of being punished. (Monroe, 1991, p.77)

The rational actor is an individual whose behaviour comes from an individual’s self-interest. The individual is credited with extensive and clear knowledge of the environment, a well-organized and stable system preference and computational skills that allow the actor to calculate the best choice of alternatives available to her (Monroe, 1991, p.78). The RAT does not contain discussions about the nature of actors’ particular preferences. The RAT assumes actors choose the alternatives with the highest expected utility. Each choice is measured by the probability that the outcome will ensure the alternative option in question is chosen (Monroe 78-79, Simon 296). The RAT ignores the limitations that are inherent within the actor; it only considered the constraints that arise from the external situation (Monroe, 1991, p.79).

Laws, rules or administrative regulations forbid behaviour such as active euthanasia and PAD by physicians and carry penalties. The decision to violate the

norms appear to be instilled with the intent to do a cost-benefit analysis and to some forethought about the harmful consequences of such actions (Vaughn, 1998, p.24). Within the RAT and RCT, punishment is considered an important tool for social control. Rational actors include the cost and benefits to them in their calculations before choosing an action. If the cost outweighs the benefits individuals can be deterred from participating in a particular action. The legal and administrative apparatus for the social control of organizations utilizes diverse approaches (Vaughn, 1998, p.24).

The rational choice theory begins with the assumption that actors know what they want and can choose what they want. The individual is required to choose the best from among several goals and failing to attract and to choose the second best (Riker et al. 1995, p.24). Rational choice theory has roots in utilitarian theories that claim rational actions of individuals that are based on continuous calculations of opportunities, the costs and the maximization of utilities and gains (Neteda, 2010, p.57).

6.3 The Consequences for Physicians in Canada

In a medical context, physicians who practice AE risk being charged and found guilty of numerous criminal offences under the *Criminal Code*. In Canada, there are a number of criminal cases regarding active euthanasia. Physicians who practice AE also face professional consequences. Those charged with active euthanasia risk the suspension or revocation of their license to practice medicine.

6.3.1 Legal Offences

As previously stated the *Criminal Code* forbids the practice of active euthanasia. Physicians who practice AE in Canada can be prosecuted under section 14 of the *Criminal Code*, which criminalizes anyone, including physicians inflicts death upon an individual even if consent is given. Under s.14 if a physician upon a patient's requests gives a patient a lethal injection they would be criminally liable. Depending on the circumstances, other provisions can come into play. The provisions under which physicians may find themselves charged with include section 215, which states that it is a physician's, legal duty to provide individuals in their care the necessities of life.

Section 215 states that anyone under section 215(3) who commits an offence under s.215 is guilty of an indictable offence and liable to imprisonment for a term not exceeding five years. The Court could find a physician guilty of an offence punishable on a summary conviction and liable to imprisonment for a term not exceeding eighteen months. In the medical context, this could mean the failure of a physician to provide acceptable medical treatment to sustain life (See **Appendix 1-2**).

Under s. 219, physicians face charges of criminal negligence if they do anything or omit to do anything in their duty that shows wanton and reckless disregard for the lives of their patients. Physicians under section 220 can be charged with criminal negligence causing death. Section 220 is an indictable offence when a physician through medical negligence causing death. Physicians found guilty could receive imprisonment for life. Under the Canadian *Criminal Code*, physicians can be charged with criminal negligence causing bodily harm under section 221. In the medical context, under s. 221 physicians who the court deems negligent of causing bodily harm to their patient by use of active euthanasia are guilty of an indictable offence and liable for a term not exceeding 10 years imprisonment (See **Appendix 1-2**)

Under the Canadian *Criminal Code*, physicians can be charged with homicide if they participate in active euthanasia and murder under s. 229. There are different classifications of murder physicians can be charged under if they participate in active euthanasia under s. 231. Murder in the first degree is a murder that is planned and deliberate act. Second-degree murder is any murder that not classified as first-degree murder (See **Appendix 1-2**). Under section 235 (1) everyone, including physicians, who commits first-degree murder or second degree, is guilty of an indictable offence could be sentenced to a maximum sentence of life imprisonment. Under section 236 of the Criminal Code individuals, including physicians, who commits manslaughter, is guilty of an indictable offence and liable to face imprisonment for life or a term of four years (See **Appendix 1-2**). Physicians under s. 241, who counsel a person to commit suicide, aid, or abet a person to commit suicide whether death ensues or not is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years

(See **Appendix 1-2**).

6.3.2 Medical Associations and Colleges of Physicians and Surgeons: Offences

Euthanasia whether or not consent was given and regardless of whether a physician or someone else carried it out, or whether it was voluntary, non-voluntary or involuntary is culpable homicide. Canadian courts have issued lenient sentences in cases where family caregivers are unable to alleviate severe suffering without any personal gain, took the life of a loved one. Society and the law hold professionals to higher standards to act within the law (Kotalik, n.d., 5.2). Medical associations and colleges advise physicians not to perform active euthanasia/assisted death through regulatory sanctions, regardless of their personal convictions (Kotalik, n.d., 5.2).

The Canadian Medical Association (2004) outlines the standards of ethical behaviour expected of Canadian physicians; it has also developed and approved the Code of Ethics as a guide for physicians. Its sources are the traditional codes of medical ethics such as the Hippocratic Oath, as well as developments in human rights and recent bioethical debate. Legislation and court decisions may also influence medical ethics. Physicians, according to the CMA must be aware of the legal and regulatory requirements for medical practice in their jurisdiction (CMA, 2004).

The Code is based on the fundamental ethical principles of medicine of the Hippocratic/Physicians Oath. The CMA interprets these principles with respect to the responsibilities of physicians to individual patients, family and significant others, colleagues, other health professionals and society. Specific ethical issues such as abortion, transplantation and euthanasia are not mentioned (CMA, 2004). The CMA does not support euthanasia or assisted death as previously stated. Physicians may experience tension between the different ethical principles, between the ethical and legal or regulatory requirements or between their own ethical convictions and the demands of other parties.

6.3.3 Colleges of Physicians

According to British Columbia's College of Physicians and Surgeons *Medical Practitioners Act*²⁶ section 50 (1) a physician convicted of an indictable offence by a court in British Columbia or elsewhere is not entitled to be registered. The council may erase the physician's name from the register. Under subsection 2, the council may permit a physician convicted of an indictable offence to become or remain a member of the college. The council can also reinstate an expelled member. The Ontario *Medicine Act 1991* sets regulations and standards expected of physicians to maintain (**Appendix 6-1**). Section 1 of the Act, sets out the professional conduct of health care professionals that physicians are expected to uphold. Subsection 2 states that a failure to maintain the standard of practice of the profession is a violation of the Act. Subsection 6 states that it is unprofessional for physicians to prescribe or dispense drugs for an improper purpose. Physicians who are prescribing or dispensing drugs to a patient for the purpose of active euthanasia/physician-assisted death are in violation of the Act and can be punished.

Subsection 16 states that it is professional misconduct for a physician to falsify records relating to a college member's practice. Therefore, the College can punish physicians who participate in AE and PAD where it remains illegal in accordance to subsection 16 of the Act. Physicians may not include the amount of drugs or the drugs used to treat a patient with chronic pain. However, physicians could state the cause of the death as being a part of their illness. Subsection 28 of the Act states that it is unprofessional for physicians to breach a federal, provincial or territorial law, a municipal bylaw or public hospital policy. In the case of practicing active euthanasia and PAD, physicians would be breaking federal laws if PAD and AE were illegal. Subsection 34 of the Act states the physicians can be disciplined with conduct unbecoming a physician. The CMA and the *Criminal Code* do not support AE and therefore, it would be unprofessional conduct to participate in active euthanasia and PAD.

²⁶ On June 1, 2009, the Medical Practitioners Act was repealed and the College of Physicians and Surgeons of BC transitioned under the Health Professions Act.

Physicians charged with a crime and/or found guilty by the Court will face the College's disciplinary committee. Physicians, if found guilty by the disciplinary committee, may be punished by having their medical licence suspended. The College may also revoke a physician's medical licence. The code of conduct set out by the British Columbia and Ontario medical acts are similar to the medical acts and professional misconduct acts set out by the other provinces and provincial colleges.

6.4 Legal Cases in Canada

Ms. A in October 1991, had lung cancer and was using a respirator at the former St. Mary's Hospital in Timmins Ontario. Ms. A informed her family members that she wanted to remove her breathing tube and requested the end of her suffering (Gorman, 1999, p.857). Ms. A.'s family supported her decision and conveyed it to Dr. de la Rocha. In accordance with standard medical practices, he removed Ms. A's breathing tube and administered 40 mg of morphine in 3 doses to ensure that she did not experience a feeling of suffocation. Dr. de la Rocha broke with standard ethical practice by administering potassium chloride, causing her heart to stop (Gorman, 1999, p.857). Even though the patient was going to die after the breathing tube physicians removed regardless of the potassium chloride injection the Crown, charged Dr. de la Rocha with administering a noxious substance.

In April 1993, Dr. de la Rocha was convicted in criminal court of administering a noxious substance. He received a suspended sentence and 3 years' probation. In April 1995, the Discipline Committee of the College of Physicians and Surgeons of Ontario charged him with professional misconduct because of his court conviction. Dr. de la Rocha was also charged with the failure to maintain the standard of practice by the Discipline Committee. He pleaded guilty to the first charge and the college did not proceed with the second. Dr. de la Rocha received the penalty of a 90-day licence suspension that would be lifted if he wrote a guideline on withdrawing life support from terminally ill patients.

On 6 May 1997, in Halifax NS, Dr. Nancy Morrison was charged with first-

degree murder in the death of a terminally ill cancer patient. Mr. Mills had cancer of the esophagus, which required removing the esophagus and repairing the gap by repositioning the stomach. All possible methods of treatment were unsuccessful and by 9 November 1996, Mr. Mills had no hope of recovery. The family a physician agreed by all that active life support would be discontinued (Tiedemann and Valiquet, 2008, p.9). When Mr. Mills' life-support was discontinued, the physicians administered pain control medication and increased several times. According to witnesses, Mr. Mills remained in substantial distress and pain and the level of drugs given to Mr. Mills was in the lethal range. Dr. Morrison administered nitroglycerine, then potassium chloride by a syringe. The potassium chloride was used to stop Mr. Mills' heart (Tiedemann and Valiquet, 2008, p.9). Judge Randall found that a "jury properly instructed could not convict the accused of the offence charged, any included offence or any other offence and therefore, she is hereby discharged" (Tiedemann and Valiquet, 2008, p.9). The judge said that Mr. Mills could have died from the enormous amount of pain killers received or because the intravenous line delivering the various drugs to Mr. Mills was not working or from natural causes (Tiedemann and Valiquet, 2008, p.9).

Dr. Nancy Morrison received a reprimand by the NSCPS. The college publically declared that Dr. Morrison's actions were "inappropriate and outside the bounds of acceptable medical practice" ("Nancy Morrison...", 2000) because she had used a lethal dose of drugs that lacked pain-killing proprieties. By accepting the reprimand from the NSCPS, Dr. Morrison avoided a long expensive fight with the College of Physicians and Surgeons ("Nancy Morrison...", 2000).

In 1998, Doctor Maurice Genereux pled guilty on two accounts of adding and abetting a patient to commit death after prescribing a lethal dose of drugs to two HIV positive patients that were not terminal at the time because they had not developed AIDS (Nicol et al., 2010, p.8). The patients were considered depressed and Dr. Genereux was aware they would use the drugs to end their lives. The doctor was found guilty and sentenced to two years less one day and three years' probation. Dr. Genereux lost his licence to practice medicine (Nicol et al., 2010, p. 8).

In June 2007, a British Columbia court sentenced Dr. Ramesh Kumar Sharma, a general practitioner, for aiding in the death of Ruth Wolfe. Ruth Wolfe, a 93 year-old woman suffering from heart problems requested the aid of Dr. Sharma. Dr. Sharma prescribed Wolfe a deadly dose of drugs. The British Columbia Court imposed a conditional sentence of two years less a day to be served in the community. Dr. Sharma's licence was revoked by British Columbia's College of Physicians (Nicol et al., 2010, p.10).

6.4.1 The Influence of Canadian Court Cases

In Canada, the judicial system may charge physicians under various sections of the Criminal Code ranging from providing patients with a lethal injection to homicide. Physicians can receive various punishments ranging from probation and community service to life imprisonment. For example, under s. 215 if a physician is guilty of not providing individuals with necessities to sustain life then under s.215 (3) they are liable to a maximum of five years imprisonment. Under section 231(1), the courts could sentence physicians to a maximum of life imprisonment. Therefore, if physicians knew the courts would react negatively to their involvement in active euthanasia they may choose not to do it especially if it would have adverse effects for them.

According to the rational choice theory, it is not in a physician's best interest to perform AE and PAD because of the legal consequences. RCT states that the actions taken by physicians should lead to rewards and avoid punishments. Logically physicians want to avoid criminal acts in order to avoid punishment by the judicial system. To avoid punishment by the judiciary most physicians do not participate in active euthanasia and physician-assisted death.

6.5 Influence of the Criminal Code and the Provincial Colleges of Physicians and Surgeons

The provincial colleges of physicians and surgeons ability to suspend a physician's medical licence can have consequences for physicians even when the licence is reinstated. A physician may find it difficult to get positions at hospitals if the

suspension is on their record. The disciplinary committee can revoke a physician's medical licence. The revocation of a physician's medical licence could effectively end the career of the physician if he or she is unable to have it restored. If the licence is restored it may be restored with conditions attached; this is also related to suspended medical licence. The physician may need another physician to sign off on prescriptions. The physician may be unable to administer specific drugs that can hasten death. The physician may have to consult with another physician within a specific time-period (i.e. 72 hours) before taking on a new patient (Downie, 2000, p.214)²⁷. These constraints can make it difficult for physicians treat their patients effectively. They would have to get another physician to sign off on prescriptions they prescribe for patients. They would have to get another physician to administer medications to their patients. A physician would need to receive the approval of a colleague before they could take on a new patient. These conditions create an environment where his or her colleagues are regulating the physician and the physician is no longer an independent practitioner.

Dr. Sharon Cohen²⁸ states that many Canadian physicians are torn between the threat of imprisonment and the instinct to help patients pleading for relief. Because of this, Cohen believes physicians are unwilling to come forward to attest to cases where they broke the law but "physician-assisted death is happening all the time" (Cribb, 2012). According to Cohen, one in five of the 24 physicians interviewed said they have or know of physicians who have provided forms of PAD to terminal patients requesting relief (Cribb, 2012). In Cohen's opinion, the reason physicians are unwilling to acknowledge participating in AE or PAD is that physicians are fearful for their reputations, their medical licenses and the hostility of those who disagree (Cribb, 2012) Physicians may also worry about the types of punishments they may receive. According to the law and previous cases, physicians can receive anything from a dismissal of charges, probation to life in prison. Due to the uncertainty of the charges and punishments by the judiciary, physicians who perform active euthanasia and physician-assisted death are playing Russian roulette with their careers, professional reputations

²⁷ In 1992 a Quebec physician used potassium-chloride to perform AE at the patient's request. The CPMQ put these restrictions on the physician.

²⁸ A behavioral neurologist and Medical Director of the Toronto Memory Program

and their lives, especially if found guilty of violating the *Criminal Code*. According to Cohen, physicians also worry about how the public, their patients and colleagues view them. They become apprehensive that they may not have the opportunity to defend their decisions (Cribb, 2012). Therefore, many physicians believe that the rational choice is not to participate in active euthanasia and physician-assisted death. However, Dr. Cohen did state that she and many of her colleagues would perform PAD if the law did not prevent them from complying with the request of patients.

Although hospice care is another option for the terminally ill, in Canada only 16 percent to 30 percent of Canadians who are dying currently have access to or receive hospice palliative and other EOLC services depending on where they live in Canada. Canada is unable to provide important hospice palliative care services to over 70 percent of those dying in Canada. The 2000 Senate Report “Quality End-of-Life Care: The Right of Every Canadian” found that approximately only 15 percent of Canadians who require hospice palliative care services have access to these specialized services (CHPCA, 2012, 1). Patients who cannot receive palliative care have to look into alternatives such as homecare and hospitals. Even palliative care centres are unable to adequately relieve the pain some patients are in or they have terminal sedated the patients, which can be seen as another form of euthanasia.

The empirical data shows that terminal sedation does not eliminate suffering of all patients, and suggests that many patients receiving terminal sedation continue to suffer unbearably without presenting noticeable signs and symptoms of suffering (Kon, 2011, p.42). The evidence is clear that terminal sedation does not prevent the need for AE and PAD. Many support PAD and AE because for some patients they are the only options that guarantee relief of unbearable suffering. Active euthanasia and physician-assisted death may be the treatment of last resort and therefore considered medically indicated (Kon, 2011, p.42).

6.6 Conclusion

According to the rational choice theory, it is not in a physician’s best interest to

perform AE and PAD because of the legal consequences. RCT states that the actions taken by physicians should lead to rewards and avoid punishments. In Canada, physicians who perform AE and PAD are criminally liable under various sections of the Criminal Code and subjected to imprisonment. Logically physicians want to avoid Criminal Acts in order to avoid punishment by the judicial system. To avoid punishment by the judiciary most physicians do not participate in active euthanasia and physician-assisted death. Physicians also want to avoid punishment by the provincial colleges of physicians and surgeons. By performing active euthanasia and physician-assisted deaths, physicians risk their medical licence. Because the colleges have the ability to suspend or revoke medical licences due to unethical practices physicians who perform AE and PAD are at a greater risk of punishment.

Rational choice theory does not entirely explain the disjuncture between public support for AE and PAD and institutional biases that want to maintain the status quo. However, rational choice theory does provide a plausible reason for why physicians refuse to perform AE or PAD. The theory does not explain why there are physicians willing to perform AE and PAD despite the consequences if they are caught performing AE and PAD. Rational choice theory assumes that every physician is only doing what is in his or her best interest. It does not take into account physicians who are more concerned with the needs of their patients than any punishment they may receive for participating in AE and PAD. Rational choice theory does not explain the institutional and structural factors that may impede or facilitate the legalization of AE and PAD. It can only explain an individual's response to the social norms and rules that institutions have established.

CHAPTER 7 INSTITUTIONALISM AND STRUCTURALISM APPROACH TO ACTIVE EUTHANASIA

Institutionalism is a process by which structures and norms establish authoritative guidelines for social behaviour. It examines how society creates, adopts and adapts social norms. Institutionalism also examines how social norms fall into decline and become neglected. Chapter Seven uses institutionalism to examine how the Canadian healthcare system affects policies on active euthanasia. The chapter examines the impact the public and private healthcare systems have on the legalization and administration of AE and PAD. It will explore the possibility that Canada cannot implement active euthanasia because of how the public system is shaped. The federal government transfers healthcare payments to the provinces and by doing so, they become involved in for healthcare policies.

The provinces are in charge of administering healthcare within the provinces, thereby making provincial governments accountable to society. Politicians may not want to legalize active euthanasia because they are accountable to their constituents including those who do not support active euthanasia. The chapter will compare and contrast the Canadian healthcare system to other system such as the system in the United States (Washington and Oregon), and Netherlands. It examines the impact of decentralization has had on active euthanasia policies, for example state laws vs. federal laws. Chapter Seven will also examine the role of the Canadian *Criminal Code* as an obstacle to active euthanasia regarding how it stands at present. However, it is possible to re-write the *Criminal Code* to legalize active euthanasia.

7.1 Institutionalism and Structuralism Definitions

7.1.1 Institution

An institution is any structure or mechanism of social order and collaboration governing the behavior of individuals within a community. They are identified with a social purpose and durability, transcending individual lives and intention by enforcing rules that govern cooperative human behavior (Stanford Encyclopedia: Social Institution). Institutions are also a central concern for law, the formal mechanism for

political rule making and enforcement.

The term "institution" commonly applies to customs and behavior models important to a society. It also applies to formal organizations of government and public services. As structures and mechanisms of the social order among humans, institutions are one of the main objects of study in the social sciences, such as political science, anthropology, economics and sociology (Durkheim, 1982, p.45). Diermeier and Kiehl (2003) describe political institutionalism as a set of contextual features in a collective choice setting that defines constraints on, and opportunities for individual behaviour in the setting (p.125).

7.1.2 Formal and Informal Institutions

There is an important distinction between formal and informal institutions. One common distinction between formal and informal institutions is that formal institutions are state-societal. According to the state-societal approach 'formal institutions refer to state bodies such as courts, legislatures, bureaucracies, and state enforced rules such as constitutions, laws and regulations. Informal institutions encompass civic, religious, kinship and other societal rules and organizations (Helmke and Levitsky, 2003). The state-societal approach fails to account for a variety of informal institutions. This includes the informal rules that govern the behaviours within state institutions. The informal rules are the rules that govern non-state organizations such as religious orders, political parties and interest groups (Helmke and Levitsky, 2003). The second distinction between formal and informal institutions centers on the location of rule enforcement. Informal institutions or norms are self-enforcing institutions. In contrast, a third party, i.e. the state (Helmke and Levitsky, 2003), enforces formal rules.

A third approach defines formal institutions as establishing codified rules. Formal institutions are established and they communicate through channels that are widely accepted as being official (Helmke and Levitsky, 2003). Informal institutions are socially shared rules that are usually unwritten, created, communicated and enforced outside officially sanctioned channels (Helmke and Levitsky, 2003).

7.1.3 New Institutionalism

Neo-institutionalism recognizes that institutions operate in an environment consisting of other institutions. It deemphasizes the dependence of policy on society in favour of an interdependent relationship between relatively autonomous social and political institutions (March and Olsen, 1984, p.738). New institutionalism discusses the pervasive influence of institutions on human behaviour through the rules, norms and other frameworks. New institutionalism insists on a more autonomous role for political institutions. Society can affect the state and the state can affect society. The bureaucratic agencies, the legislative committee and the appellate court are areas for contending social forces, and they are collections of standard operating procedures and structures that define and defend interests (March and Olsen, 1984, p.738).

Previous theories held that institutions could influence individuals to act in one of two ways. Institutions can cause individuals within institutions to maximize benefits similar to rational choice theory or to act out of duty or an awareness of what one is “supposed to do” (Koelble, 1995, p. 232). New institutionalism has provided an important contribution to the cognitive approach. Instead of individuals acting under rules based on obligations, they are acting based on conceptions. Sociological institutionalism (a form of new institutionalism) is concerned with “the way in which institutions create meaning for individuals, providing important theoretical building blocks for normative institutionalism within political science” (Lowndes, 1997, p,65). Individuals make certain choices or perform actions not out of fear of punishment or attempt to conform to socially constructed values and norms, or because an action is appropriate or they feel obligated. Instead, the cognitive component of new institutionalism proposes that individuals make particular choices because they cannot conceive of alternate options. For example, if a patient is dying and there is no alternative course of lifesaving treatment the physician and patient may feel AE and PAD are the only options.

7.1.4 Political Institutions

According to March and Olsen political institutions can be treated as political

actors the same way individuals are treated as political actors (March and Olsen, 1984, p.472). Institutionalism emphasizes the part played by institutional structures imposing elements of order. The traditional political theory involved considerable attention shaped by political contracts and reflected in constitutions, laws, or by a community of moral obligations (March and Olsen, 1984, p.473). Reason is recognized in ideas of rationality and intentional action and it finds institutional expression in the hierarchical organization of means and ends (March and Olsen, 1997, p.473). Competition and coercion are recognized in ideas of conflict of interest, power and bargaining. Institutional expression is expressed in elections and policymaking (March and Olsen, 1997, p.473).

New institutionalism has certain deconstructionist elements and it is sure to focus on the multiplicity and complexity of the goals (Peters, 2005, p.3). Within new institutionalism, most rational choice assumptions tend to divorce political life from its cultural and socioeconomic roots. Political life then becomes only compilation of autonomous choices by the relevant political actors (Peters 9). Behavioral political science has included social influence more explicitly; however, it still looks at the individual as an autonomous actor (Peters, 2005, p.9).

7.1.5 Structuralism

Structuralism is a theoretical paradigm that highlights the elements of culture in terms of their relationship to a larger, overarching system or "structure". Philosopher Simon Blackburn (2005) describes structuralism as "the belief that phenomena of human life are not intelligible except through their interrelations. These relations constitute a structure, and behind local variations in the surface phenomena there are constant laws of abstract culture" (p. 353).

7.2 Institutionalism and Active Euthanasia

This section will compare the institutional responses and experiences of various countries to Canada to show that the difficulties in legalizing AE and PAD are not unique to Canada. The discussion is important because it examines how other countries and

American states have been successful in legalizing AE and PAD. The factors that led to the legalization of AE and PAD for other regions could be utilized in Canada. The comparative discussion allows us to examine if a country's healthcare system or commitment to federalism are important factors to legalizing AE and PAD. By comparing the UK, the US and the Netherlands' healthcare systems and commitment to federalism to Canada, we can determine if either factor is important to legalizing AE and PAD.

The British House of Lords provided a collection of institutional views on active euthanasia. Members of the Lords, served as the ultimate appellate court in the 1993 Bland Case. In the Bland Case, the Members of the Lords had to determine the distinction between killing and letting die (Sommerville, 1996, p. 310). The Bland Case was concerned with deciphering whether the withdrawal of nutrition from an incapacitated individual resulting in the patient's death constituted a lawful act. The Lords determined that the withdrawal of artificial feeding was an omission, a failure to act, a "letting die" but would not amount to a homicide (Sommerville, 1996, p.310). Lord Browne-Wilkinson however, summed up an apparent anomaly germane to the case: How can it be lawful to allow a patient to die slowly, although painlessly over a period of weeks from lack of food but unlawful to generate the patient's instant death by a lethal injection?

7.2.1 Oregon: the Ballot Box and the Courts

In the United States, Oregon was the first state to legalize physician-assisted death. In the State of Oregon, ballot measure 16 in 1994 established the *Oregon Death with Dignity Act* ("Death with Dignity Act", 2012, p.1) (**Appendix 7-1**). The Act legalized physician-assisted death; however, the Act provided certain restrictions. The *Oregon Death with Dignity Act* ballot measure was approved in 8 November 1994 general election. Fifty-one percent of the electorate voted in favour of physician-assisted dying and 49 percent of the electorate opposed the measure to legalize physician-assisted dying ("Death with Dignity Act", 2012, p.1). The *Oregon Death with Dignity Act* was immediately in the Federal District Court; delaying the implementation

of the Act for three years as the case made its way through the Federal courts. In 1997, the United States Supreme Court declined to re-examine the case or appeal it (Lunge et al., 2004). While the litigation regarding the appeal was in progress; the Oregon legislature approved the legislation to permit the electorate to vote to repeal the *Death with Dignity Act*. Sixty percent of voters defeated the repeal ballot while 40 percent of voters supported it (Lunge et al., 2004).

In 1997, after the implementation of the law the Federal Department of Justice challenged the compliance with the Act. The Department of Justice issued a directive calling for the prosecution of health care professionals who participate in assisted-death. The Federal Department of Justice challenge was unsuccessful (Lunge et al., 2004).

Members of the United States Congress suggested that physicians in Oregon who participate in active euthanasia/physicians-assisted death under the Oregon *Death with Dignity Act* would be in violation of the Federal *Controlled Substance Act (CSA)* (Lunge et al., 2004). Then Attorney General Janet Reno in June 1998 announced that the Department of Justice would not prosecute physicians who complied with the laws of Oregon. She further stated that the CSA does not support banning the use of legitimate drugs for approved medical purpose. In late 1998, a congressional introduction of the 105th Congress known as the *Lethal Drug Abuse Prevention Act* it proposed to block the use of controlled substances in physician-assisted death or mercy killing (Lunge et al., 2004). The Bill was unsuccessful in the 105th Congress and was revised and resubmitted to the 106th Congress but it also failed (Lunge et al., 2004)

In November 2001, Attorney General John Ashcroft issued a ruling reversing the position of his predecessor Attorney General Janet Reno. Ashcroft ordered the Justice Department to pursue action under the CSA against physicians and pharmacists who prescribed, filled, or dispensed drugs under the Death with Dignity guidelines (dubbed the Ashcroft Directive) (Lunge et al.). The state of Oregon instantly filed a suit seeking to instruct the federal government from imposing the Ashcroft Directive on physicians and pharmacists. The federal district court ruled in favor of Oregon, and the Justice

Department replied by appealing to the Ninth Circuit (Lunge et al., 2004).

On 6 May 2004, the Ninth Circuit affirmed previous decisions of the lower court's decision. This is because Ashcroft exceeded his authority; Congress intended for the CSA to deal with problems related to drug abuse and addiction. The courts concluded that the CSA's mandate does not perceive physician-assisted death to be a form of drug abuse that Congress intended to cover (Lunge et al., 2004). The CSA did not give the Attorney General the authority to exercise over an area of law that is traditionally reserved for the state to have authority over. The Justice Department on 9 November 2004 appealed the decision to the Supreme Court (Lunge et al., 2004). The Supreme Court heard argumentation in October 2003 regarding the *Gonzales v. Oregon* case. The Supreme Court ruled in 2006 that the Attorney General could not enforce the federal CSA against physicians in Oregon because the CSA did not give him the authority to exercise control over an area of law reserved for state authority. The court held the Ashcroft Directive violated the clear language and intent of the CSA by not reflecting the standards and requirements of the federal statute (Lunge et al., 2004).

On November 9, 2004, the Federal Justice Department appealed the decision to the United States Supreme Court (Lunge et al., 2004). In January 2006, the Bush administration advocated for the criminal prosecution of doctors for aiding in the deaths terminally ill patients. The Supreme Court upheld Oregon's PAD law. In a 6-3 vote, the majority said a federal drug law does not override the 1997 Oregon law (Lewin, 2006)

7.2.2 Washington: the Ballot Box and the Courts

In 1991, Washington State voters defeated Initiative 119. The measure would have permitted doctors to provide euthanasia by lethal injection or assisted death by a prescription for an intentional lethal overdose of drugs by a vote of 54 to 46 percent (PRC, n.d.). The Washington State legislature made three attempts to transform assisted death, which was a crime in Washington, into a medical treatment. The three attempts failed to gain support in the Washington State Legislature (PRC, n.d).

Washington's 2008 Initiative²⁹ 1000 (I-1000) established the state of Washington's *Death with Dignity Act*. The Act legalized physician-assisted death with certain restrictions that are laid out in the Act (Ch. 70 2445 RCW) (**Appendix 7-2**). Initiative 1000 received the support of the electorate on 4 November 2008 general election. The electorate voted 57.82 percent in favour of legalizing physician-assisted death while 42.18 percent of the electorate voted against the initiative (Starks, 2010, p.3). The legislature accepted Washington's *Death with Dignity Act* into law following the plebiscite.

7.2.3 Montana: Court Case

On 5 December 2008 the State District Court Judge, Judge Dorothy McCarter ruled in favour of a terminally ill Montana resident who had filed a lawsuit with the assistance of Compassion and Choices (Gouras, 2009). The ruling states that competent terminally ill patient has the right to self-administer lethal dose of medication. Physicians who prescribe such medications will not face legal punishment (Gouras, 2009). On 31 December 2009, the Montana Supreme Court delivered its verdict in the *Baxter v. Montana* case (Johnson, 2009). The Court also held that there was "nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy" (C&C, 2012).

7.2.4 Netherlands: The Court and Society

The Debate in the Netherlands regarding active euthanasia and assisted death began in 1973, with the "Postma Case". The case concerned a physician who facilitated the death of her mother following repeated explicit requests for euthanasia (Rietjens et al., p.272). The court convicted the physician of performing active euthanasia. However, the court's judgment set out criteria for active euthanasia, the criteria included when a physician could aid in ending the life of a patient who did not wish to live. The criteria regarding active euthanasia was formalized in a number of court cases in the 1980s (Rietjens et al., 2009, pp.272-273). In 1980, the Committee of Attorneys

²⁹ An initiative is a means by which a petition signed by a certain minimum number of registered voters can force a public vote (plebiscite).

General took an interest in physician's end-of-life decisions in order to achieve a uniform policy (Rietjens et al., 2009, p. 273).

The Supreme Court ruled on a 1984 case regarding a patient named Sclinanheim³⁰; it was the first case introduced in the Dutch Supreme Court after the new uniform policy was established. The Court ruled that the physician on Sclinanheim's case acted out of "necessity" and had the duty to relieve suffering and to do no harm. The court acquitted the physician of any wrongdoing (Rietjens et al., 2009, p.273). The Dutch physician relieved the suffering of the patient as is required of physicians in accordance with the Hippocratic/Physicians Oath. The physician also upheld the principle of "first do no harm" in accordance with the Oath.

The Royal Dutch Medical Association undertook important steps towards formal social control of euthanasia in the 1980s. The Dutch Medical Association supported the legalization of euthanasia and the association called for the elimination of barriers for physicians who intended to report their acts regarding active euthanasia/physician-assisted death (Rietjens et al., 2009, p. 273). The Royal Dutch Medical Association supports active euthanasia/PAD only if physicians perform it. The Medical Association encourages physicians to report their cases in order to influence the development of the due care criteria (Rietjens et al., 2009, p.273).

There are elements of the Dutch healthcare system that play significant roles in the process of legalization of active euthanasia/PAD. The Dutch healthcare system has important attributes that shaped a context of safeguards that enable legalization of active euthanasia/PAD (Rietjens et al 274). The social policies in the Netherlands have given broad support for equity in sharing financial burdens. Virtually every citizen in the Netherlands is covered by health insurance and healthcare is freely accessible and affordable (Rietjens et al., 2009, p.274).

The structure of the Dutch healthcare system is unique. General practitioners in

³⁰ 95-year-old patient with numerous health problems who received AE.

many instances provide health care at home; 65 percent of the people who die of cancer died at home (Rietjens et al., 2009, p.274). Most citizens in the Netherlands have a general practitioner with whom they often have an established and personal relationship. Because virtually all Netherlands citizens have access to GPs it might enable a general practitioner to better judge whether a patient fulfills the first three patient-related criteria of due care for active euthanasia/PAD (Rietjens et al., 2009, p.274).

The Netherlands is a climate that welcomes and discusses new views and ideas such as those on active euthanasia and PAD. In the Netherlands political culture is a general conviction that it is better to guide social development (Rietjens et al., 2009, p.274). The legalization of active euthanasia/PAD may result from individualism, diminished taboos about death, and to the recognition that prolonging life is not necessarily the appropriate focus of medical treatment (Rietjens et al., 2009, p.274).

7.2.5 Switzerland: The Legislature

In 1918 the Swiss Federal Government stated that under the first penal code “in modern penal law, suicide is not a crime...Aiding and abetting suicide can themselves be inspired by altruistic motives. This is why the project incriminates them only if the author has been moved by selfish reasons” (Hurst and Mauron, 2003, p.271). Article 115 of the Swiss penal code only considers assisted death a crime if the motives are selfish. In most cases, the acceptability of altruistic assisted death cannot override a physician’s duty to save a life. Article 115 of the Swiss penal code does not require the involvement of a physician. It also does not require a patient to be terminally ill (Hurst and Mauron, 2003, p.271).

Although the Swiss law allows for active euthanasia/assisted death the Swiss Academy of Medical Sciences states in its ethical recommendations that assisted death is “not a part of a physician’s activity” (Hurst and Mauron, 2003, p.272). A 2002 joint statement by the Swiss Medical Association and the Swiss Nurses Association stated physicians should not assist death. The statement from the Swiss Academy of Medical

Science has positioned assisted death outside the scope of professional oversight and they refer to physicians as citizens, to the law. This allows physicians to be able to act in the same manner as other citizens and perform altruistic assisted-death (Hurst and Mauron, 2003, p. 272). Although it is legal, many physicians oppose assisted death and active euthanasia. Many hospitals have banned the performing of assisted death on their premises. In 2001, the Swiss Parliament rejected a bill that would have forbidden physicians from assisting in death (Hurst and Mauron, 2003, p.272). In Switzerland, assisted death remains legal because of the support from the Swiss Parliament.

7.2.6 Canada: The Legislature and the Courts

In Canada, there have been several initiatives in recent years that have reopened the debate on active euthanasia/PAD. Over the Past twenty years, there have been several court cases regarding active euthanasia/PAD and there have been different bills introduced in the House of Commons. The most prominent case opposing the section 241(b) of the Criminal Code was the Sue Rodriguez case. The Supreme Court of Canada split 5-4 to uphold this section of the Criminal Code.

Member of Parliament, Francis Lalonde introduced private members bill C-407 on June 2005. Had Bill C-207 passed it would have legalized physician-assisted death/active euthanasia in Canada. The bill failed to gain the support of the House of Commons. The elections in 2006 and 2008 killed Lalonde's attempts to legalize active euthanasia. On 13 May 2009, Lalonde introduced another Bill C 384 that would legalize active euthanasia. The House of Commons debated the Bill and it died on 21 April 2010 in its second reading in the House of Commons. The vote to advance Bill C384 to the Justice and Human Rights Committee failed in a 59 to 228 vote ("Vote no. 36", 2010). Bill C-384 was the last bill presented to the House of Commons at present.

Gloria Taylor has brought the most recent legal case on euthanasia in Canada forward. She is a 63-year-old woman with ALS, or Lou Gehrig's disease. Taylor's took the case to the B.C. Supreme Court to argue against the laws within the Criminal Code to aid seriously ill people end their lives (Drews, 2011). British Columbia's Supreme

Court stated the section of the Criminal Code that prohibits physician-assisted death invalid. Madame Justice Lynn Smith claimed that the *Criminal Code* provisions are “unjustifiably infringes the equality right” (Dhillon, 2012). A spokesperson for the federal government stated that the Minister of Justice needed time to read the extensive ruling of the court’s decision but they would be reviewing the judgment. Madame Justice Smith’s ruling gave Parliament one year “to take whatever it sees fit to draft and consider legislation” (Dhillon, 2012).

Justice Smith stated that the *Criminal Code* provisions also infringed upon the other plaintiffs in the case formally known as *Carter v British Columbia (Attorney General)*. Lee Carter travelled with her mother, Kay to a clinic in Switzerland in 2010 to end her life. Kay suffered from spinal stenosis, which confined her to a wheelchair; the physicians told her that she would soon be unable to move. Justice Smith stated the law infringed upon the right to life, liberty, and security of the person, i.e. s. 7 of the *Charter* (Dhillon, 2012) Justice Smith acknowledged, “[the] evidence shows that risks exist, but they can be very largely avoided through carefully-designed, well-monitored safeguards” (Dhillon, 2012). She also stated that the legislation that prevents physician-assisted death is “outside the bounds of constitutionality” (Dhillon, 2012).

The position of the federal government according to the Department of Justice lawyer is that assisted death should remain criminalized because it would go against the basic societal values, as well as the will of Parliament. Nygard stated that there is no reason to think the Supreme Court of Canada would feel any differently from the federal government (Dhillon, 2012). Nygard further engrained this belief by stating, Parliament has considered and rejected proposed changes to the Criminal Code since 1982. It has also heard nine private members’ bills regarding active euthanasia/PAD. Three bills have failed to gain support and the House debated six cases but each case failed to gain the majority’s support (Dhillon, 2012).

The federal governments in the past and current governments and the House of Commons have refused to legalize physician-assisted death/active euthanasia. They

have voted against every bill regarding active euthanasia and have become actively involved in the court cases. In the British Columbia case involving Gloria Taylor, the federal government expressed to the Court that the government does not support the legalization of physician-assisted death. The House of Commons as recently as April 2010 voted against making changes to the *Criminal Code* regarding active euthanasia/PAD (Dhillon, 2012). (See **Appendix 7-3** for further recommendations)

7.3 Federalism

7.3.1 Public Healthcare System vs. Private Healthcare

The National Health Service (NHS) is the publicly funded healthcare system in England. The NHS is a single-payer healthcare system. The funding of the NHS comes through the general taxation system. The NHS provides healthcare to any legal resident of England and the UK. Most services are free at the point of use for all such people. In practice, "free at the point of use," means that anyone legitimately fully registered with the system including UK citizens and legal immigrants, can access the full extent of critical and non-critical medical care without any out-of-pocket expenses of any kind.

Canada delivers healthcare through a publicly funded health care system. Canada's health care system is mostly free at the point of use; private bodies provide most services. The government guarantees the quality of care through federal standards. Canada's health care system is provincially based medical care systems. The provinces are in charge of administering health care. In each province, physicians handle their insurance claim against the provincial insurer. Patients who access health care are not involved in billing and reclaiming money. Private insurance is only a minimal part of the overall health care system.

Netherlands finances its healthcare through a dual system that came into effect in 2006. Hospitals in the Netherlands are mostly privately run and not for profit as are the insurance companies. Most insurance packages allow patients to choose where they want to be treated. To help patients to choose, the government gathers and discloses information about provider performance. A state-controlled mandatory insurance covers

long-term treatments, especially those that involve semi-permanent hospitalization and disability costs such as wheelchairs. A required insurance package is available to all citizens at affordable cost without insurance companies needing to assess the risks of the insured. Indeed, health insurers are now willing to take on high risk individuals because they receive compensation for the higher risks.

In the USA, the private sector mainly owns and operates health care. Physicians and hospitals are funded by payments from patients and insurance plans in return for services rendered (fee-for-service or FFS). Fee-for-service is a payment model where the patient pays for the services individually. In health care, it gives an incentive for physicians to provide more treatments (including unnecessary ones) because payment is dependent on the quantity of care rather than quality of care. In some cases, it may be in the physician's best economic interest to keep a patient alive for as long as possible regardless of their pain and suffering. Because physicians are paid by the quantity of treatments they provide patients, they will receive larger paychecks if patients are unable to request PAD and AE. Therefore, for some physicians the fact that AE and PAD remain illegal in most states is economically beneficial to them.

However, due to the differences in healthcare systems in the four countries it seems unlikely that the countries' health care structures can explain the legalization of AE and PAD in the Netherlands and in three US states. Canada and the UK systems are similar because they have a single payer system but have not legalized AE or PAD. The Netherlands system is a dual-payer system not based on profits while the USA is mainly a system based on fees for services. The structure of private versus public health care systems does not appear to have an effect on the legalization of PAD and AE.

As previously stated, legalizing AE and PAD would help save the provincial governments a significant amount of money every year. The importance of cost-savings to government is not relevant to the Canada's federal government as it is in the USA. In Canada, the provinces administer healthcare and are burden with the financial costs. The federal government is responsible for the laws criminalizing AE and PAD. If AE

and PAD were legalized in Canada, the provincial provinces would benefit financially because they would not have to spend millions of dollars to keep a terminal patient alive and they would not have to spend money on prosecuting physicians who performed AE and PAD. However, because the Canadian government is not spending the money on healthcare they are not concerned with the cost to the provinces. Because the Canadian government is not incurring the costs, they are not motivated by cost-savings to change laws concerning EOLC.

7.4 Political Parties and EOLC: Active Euthanasia

In politics, active euthanasia is a hot button for political parties and politicians. Due to the sensitive nature of active euthanasia, politicians do not want to debate the issue for fear of alienating potential voters. In 2011 according to the *Globe and Mail* the Conservative Party of Canada, the New Democratic Party of Canada, the Liberal Party of Canada and the Bloc Quebecois have refused to comment on active euthanasia. University of Toronto law professor Bernard Dickens stated it should not be a surprise that most politicians avoid the active euthanasia topic because there is limited political capital for political parties to gain (Anderson and Paperny, 2011). Politicians and political parties are unlikely to sway voters to their parties by taking a position of AE and PAD. Active euthanasia is a topic that political parties fear may alienate their base depending on the stance they take.

7.4.1 The Conservative Party of Canada

The Conservative Party of Canada has stated that they have no plans to reopen the debate on active euthanasia and physician-assisted dying based in Parliaments past rejection of legislation aimed at legalization AE and PAD. However, the Conservative Party has been actively involved in court cases regarding active euthanasia and physician-assisted dying.

The Canadian Parliament has remained almost silent on the debate. Justice Minister Rob Nicholson, a Conservative MP stated, “We have no plans to purpose any reforms to this area” (Andrea and Paperny, 2011). Nicholson has also stated,

“Parliament passed judgment on [active euthanasia]...The question of euthanasia was rejected within Parliament, just within the last year” (Baily, 2011).

The Conservative Party of Canada voted against bill C-384 introduced in 2010 with the exception of two party members (“Vote no. 34”, 2010). The Conservative Party of Canada acting on behalf of the government also became involved in the Gloria Taylor case in B.C.³¹ The Canadian government requested an appeal to British Columbia’s Court of Appeals to suspend Taylor’s right to die. The B.C.’s Court of Appeals refused to appeal B.C.’s Supreme Court ruling.

7.4.2 The New Democratic Party

The New Democratic Party has not taken a stance either way on active euthanasia and physician-assisted dying. The NDP believes active euthanasia and PAD is an individual matter and not a party matter. NDP member Jack Hains stated, “We don’t want to go down that road” (Andrea and Paperny, 2011). The NDP has also stated that it does not “as a party, support euthanasia...that this is a matter of individual conscience” (Gurney, 2012). The NDP allows its MPs and party members to vote their own with their conscience or with the wishes of their constituents. By allowing members to vote with their conscience, it allows MPs who do not support active euthanasia to vote against any bill seeking to legalize it. The NDPs’ refusal to take a hard stance on AE makes it difficult for right-to-die supporters to gain national support from a national political party in Parliament (not including the BQ).

In 2010, the NDP caucus split on C-384 “*An Act to Amend the Criminal Code (Right to Die with Dignity)*”. Five NDP members supported C-384. Thirty members were against the bill (Tuns, 2011) mainly due to concerns over the wording and not out of principle opposition to active euthanasia (“The 2011 election,” 2011). It is possible that

³¹ Gloria Taylor suffers from the degenerative Lou Gehrig’s disease. The British Columbia Supreme Court granted Taylor the right to active euthanasia. At present she is the only Canadian allowed to be euthanatized by another Individual. Gloria Taylor died suddenly of natural causes, therefore the ruling was never acted upon.

more NDP members would support a new bill with more concise and detailed wording.

7.4.3 The Liberal Party

Eight Liberal Members of Parliament supported C-384, 59 Liberal MPs voted against the bill and 10 party members abstained from voting in favour of the bill C384 (“Vote no. 34”, 2010). The Liberals have not come out against or in support of active euthanasia; however the Young Liberals have taken a stance. The lack of support of active euthanasia from the Liberal Party makes it challenging to gain a majority of support from Parliament for its legalization.

The Young Liberals of Canada (Manitoba) declared their support for active euthanasia. The Young Liberals of Canada (Manitoba) declared that Canadians have the rights and freedom of the individual and believe that chronically ill people have the right to decide when they die at their 2012 Convention. The Young Liberals of Canada (Manitoba) support the legalization of active euthanasia with certain restrictions and provisions. They support the rights of the immediate family to determine whether it is timely for a patient with a chronic illness to end their life provided they have mental capacity for such a decision (Liberal Biennial 2012).

They support the rights of the individual or immediate family to pursue the option of active euthanasia. They need to obtain two separate medical opinions that AE and PAD are obtained that it is a viable option given the quality of life of said patient. Patients and family member could pursue the option of active euthanasia only if a government-funded hospital has the capacity to provide said procedure in a humane and painless way (Liberal Biennial Convention, 2012). The Young Liberals’ support of active euthanasia is important because they may be able to influence the Liberal Party of Canada to change their position on the issue. The Young Liberals’ stance may influence wings of other parties, i.e., the NDP youth wing to take a stance.

7.4.4 The Bloc Quebecois

The Bloc Quebecois has supported active euthanasia and physician-assisted suicide in Parliament. However, due to the BQs’ drop in popularity in Quebec in the

2011 federal election the support for the legalization of AE and PAD may have decreased. The Bloc Quebecois supported the Bill C-384 43 to two and three party members abstained from voting. A Bloc Quebecois MP, Francine Lalonde introduced the bill as a private members bill in 2010 (“Vote no.34,” 2010). In 2006, the Bloc Quebecois wrote a letter to Alex Schadenberg, executive director of the Euthanasia Prevention Coalition, party spokesperson Nadine Charbonneau stated clearly the Bloc’s position.

In our view, however, everyone has the right to make decisions about the health care they want to receive, and to expect that their decisions about their own body will be carried out. People should be able to choose freely to die if it is clear to them that they no longer have any quality of life and that their suffering has become intolerable [...] We have a moral obligation to respect the preferences of such people, in such circumstances, as to when and how they wish to die (Charbonneau, 2006).

The Bloc Quebecois has taken a hard stance in support of active euthanasia, however because the BQ only represents Quebec interests the party is unlikely to influence a majority of MPs needed to make AE legal.

7.4.5 Party Discipline

Another difference in the institutional structures of Canada and the US is that compared to the United States Canada has strong party discipline. Party discipline occurs mainly in Westminster (Parliamentary system) systems. Political parties use party discipline in order to get its members to support the policies of their leadership and over the legislature. Party discipline is crucial to voting on bills in the legislature; if the governing party is not a cohesive unit that government becomes weak and can fall in a confidence vote as long as the party discipline is strong within the opposition parties. Party leaders have the power to expel members who violate the party line and side with an opposing party. Because party discipline has become engrained in the mindset of party members it is often practiced when a “free vote” (MPs are free to vote with their conscious rather than party without formal discipline).

During a free vote, many MPs continue to vote along party lines for various

reasons including informal retribution. Five NDP members supported C-384, 30 members were against the bill mainly due to concerns over the wording and not out of principle opposition to active euthanasia, eight Liberal Members of Parliament supported C-384, 59 Liberal MPs voted against the bill and 10 party members' abstained from voting in favour of the bill C384. The Bloc Quebecois supported the Bill C-384 43 to two, and three party members abstained from voting. The Conservative Party of Canada voted against bill C-384 introduced in 2010 with the exception of two party members ("Vote no. 34", 2010). Therefore, MPs can also vote as a party or a bloc of parties to legalize active euthanasia or to maintain the status quo.

In the United States, party discipline is weak within the two main political parties. This allows member freedom to vote based on their constituencies and political ideology and not the party's. Members of a particular party do have a freedom of movement and vote without retribution from the party such as expulsion. Therefore, in the US, weak party discipline allows republican politicians vote against their party's platform while Democrats are able to vote against their party's platform also. By having this freedom of movement, it may be easier to recruit politicians to vote on the legislation. However due to the lack of party discipline it is more difficult to get the entire party to vote as a bloc to defeat or accept a PAD bill.

To reiterate in a Westminster system MPs are answerable to the party leaders and through informal (party discipline) institutional structures. Therefore, if the party does not support legalizing AE and PAD it is most likely that party members will not vote to legalize AE and PAD. The US political parties have weak party discipline that allows party members to cast their votes more freely for or against a particular bill regardless of their party's position.

7.4.6 Political Parties' Refusal to Support AE

Chantal Herbert (2011) argues that politicians and political parties refuse to support the legalization of AE because they are unable to divorce the emotions and

personal beliefs (i.e. religious, morals, etc.) from the debate. Although one cannot divorce emotions from the debate, it is a disservice to Canadians to debate AE and PAD based on fear tactics and fictitious information. By debating based on emotions and fear tactics without regard to the facts political parties and MPs are making decisions based on fictitious information rather than on the facts. Members of Parliament who opposed Bill C-384 often cited protecting vulnerable people from physicians and their families as their reasons for not supporting the C-384.

Liberal MP Judy Sgro stated her constituents opposed C-384 because “assisted suicide and euthanasia pose a threat to societies most vulnerable and that the bill would allow any medical practitioner to assist in death.” (Open Parliament, 2011, p.2). Conservative MP Gary Breitkreuz stated “...petitioners say that legalized euthanasia speaks of a culture of death, of giving someone else the right to kill another and is not about compassion, dignity, love or care, but is deliberate killing” (Open Parliament, 2011, p.3). The information from the Netherlands found AE makes up only 2.2% of all deaths (Gorsuch, 2005, p.108). Ninety-eight percent of patients requesting AE or PAD in Washington and Oregon were white males (Starks, 2010, p.7). The facts show that vulnerable people are not targets because they are vulnerable persons. Countries and states that have legalized AE or PAD do not have high rates of AE and PAD.

Active euthanasia and PAD are value laden issues however, this choice like other medical choices, i.e. abortion, the withdrawing and withholding of treatment should be treated as a private matter between patient, physician and if necessary a POA. If MPs were to debate based on the facts Parliament would have a more intellectual and comprehensible debate regarding active euthanasia and physician-assisted suicide. The debate could result in Parliament creating a more coherent AE/PAD laws and regulations. These tactics are not isolated to the HOC. They are also in the public’s debate on active euthanasia. Politicians, pressure groups and the public must remove the fear tactics and fictitious information from the debate in order to have a comprehensive debate.

In May 2011, the Conservative Party of Canada formed a majority government making it more unlikely that Parliament will legalize AE and PAD without the courts intervention because the Conservative Party will not voluntarily introduce AE in the House of Commons again. Preston Manning, former leader of the Reform Party, stated that because the Conservative Party has formed a majority government, many Canadians share the Conservative Party's values. Therefore, if the courts side against conservative values they are siding not only against the government, but also against values that are important to Canadian society (Sniderman, 2012) Sniderman points out that Manning's assumption was weak because a majority of Canadian society does support PAD and AE thereby bringing the court in line with Canadian societies values (Sniderman, 2012). Because over 60 percent of Canadians support AE, Parliament has sided against majority of Canadian values. Preston Manning's comment is also misleading. In the Canadian election of 2 May 2012, only 61.4 percent of eligible voters actually cast a ballot. The Conservative Party received 39.6 percent of the vote. Therefore, not the entire electorate that shares the values of the Conservative Party ("Voter Turnout," 2011).

As previously stated, over 60 percent of the population are in favour of legalizing active euthanasia which means there may be political capital to gain by politicians supporting active euthanasia as a form of EOLC. However, there is a possibility that votes gained for supporting active euthanasia may only supplement the votes that are lost due to a party's support. Politicians also fear they may lose funding from their supporters. If political parties lose funding, they lose the ability to fund campaigns. Most Conservative Party members are against the legalization of AE and PAD. It still does not explain why the NDP and the Liberal Party have been reluctant to take a solid position on the issue if 67 percent of Canadians support active euthanasia. It also does not explain why the opposition parties did not vote for legalizing active euthanasia in 2010. Although they may have received some backlash, they could conceivably win the support of a majority of those Canadians not supporting Conservative policies.

Politicians have stated their reasons for maintaining the criminalization of AE and PAD was because they are protecting the vulnerable and fear of abuse from physicians,

families and health agents wanting to clear beds and cut medical costs. However, places such as the Netherlands, Washington and Oregon have not reported such incidences have occurred. There have not been significant increases in the use of PAD and AE as an EOLC treatment in these areas. The reason that politicians are also unwilling to support AE and PAD may be due to party loyalty, religious views and personal beliefs. Although active euthanasia and PAD are free votes, MPs may continue to vote along party lines.

The Conservative government has shown that it is prepared to fight to ensure AE and PAD remains illegal through its lack of support for bills that sought to legalize AE and PAD. The reluctance of the government and Parliament to address AE and PAD the issue is the reason it has ended up in the courts again. However, the Conservative government has also intervened in court cases regarding active euthanasia and physician-assisted death in order to maintain the status quo. The Conservative government has also tried to appeal a court's decision that deemed the sections of the *Code* that criminalized AE and PAD as unconstitutional.

7.4.7 Quebec's Role

Quebec has been the leading vehicle for change in Canada. It was instrumental in decriminalizing abortion in Canada. In Quebec, a majority of physicians specializing in EOLC support the legalization of AE and PAD and are willing to aid a person in dying with dignity. The Quebec government announced that it would proceed with aimed at allowing physicians to aid terminally ill patients end their lives. However, the Conservative government has continued to fight against the legalization of AE and PAD. Therefore, Quebec may not able do for EOLC what it did for abortion. The federal government is no longer really courting Quebec as it did in the 1980s and 90s when there was a real threat of Quebec separation. The federal government does not feel it needs to do favours for Quebec in order to keep Quebec from threatening to separate from Canada. Although a majority of Canadians support AE and PAD the Conservatives remain unsupportive. The Conservatives are more concerned with keeping their base happy this means keeping the social conservative fraction of the party happy. This means

defending the status quo on the AE and PAD. The other political parties are not using EOLC as a cleavage issue for many possible reasons. End-of-life-care and other social issues take a backseat to economic issues, elite party members may be divided on the issue or they may not consider it an issue that would motivate voters or bring them new supporters.

7.4.8 Federal Laws vs. State Laws

There are institutional structural differences that may partially explain why active euthanasia has been legalized in three states in the USA but not in Canada. First Canada's *Criminal Code* is unitary. The laws within the *Criminal Code* apply to every province and territory and do not change regardless. However, because the provinces are in charge of administering the law, the judiciary has discretion within the law to determine punishment. Section 91 (27) of the *Constitution Act, 1867* establishes the sole jurisdiction of Parliament over criminal law in Canada. In the United States, the federal government does not have jurisdiction over particular state penal code laws. The US Supreme Court has determined that the federal government cannot interfere in state matters such as physician-assisted death and active euthanasia.

By allowing the states to have control over issues such as legalizing assisted-death and active euthanasia than it is only that state that has legalized it, not the entire country. In Canada, socially conservative MPs are less likely to vote for PAD and active euthanasia. However, because the states in the US have jurisdiction of these laws, socially liberal states can legalize AE and PAD without needing approval from the federal government. In Canada, provinces are unable to change the laws that govern AE and PAD because the *Criminal Code* applies to every province. The support of Parliament is needed in order to legalize active euthanasia and physician-assisted suicide. Judicial systems in Canada can also legalize AE and PAD. Therefore, the provinces cannot unilaterally change their laws to allow AE and PAD without changing the laws of Canada.

However, the Netherlands government structure is similar to Canada in that it is a parliamentary, representative democracy and a constitutional monarchy but it differs in

that it is a decentralized unitary state. When euthanasia was legalized in 2002, it was legalized for every region of the Netherlands. The law applied for the Netherlands as a whole much like Canada. It would also make sense that it should be simpler to change federal laws than to change various state laws individually to create a cohesive law for a country. Although it may be easy to change federal laws than individual state laws American states have the ability change their laws without interference from federal government. If one American state wanted to legalize AE and PAD while the rest of the states refused then the state could change its law regardless of federal state, however a Canadian province cannot change its laws to legalize AE and PAD. Canadian provinces can decide how they are going to prosecute cases involving AE and PAD.

It is possible that Canada not legalizing AE or PAD is based on its degree of federalism. The *Criminal Code* applies to all provinces and territories and no one province or territory can make a change to the Code unlike the USA. Only Parliament can make changes to the *Criminal Code*. Therefore, a majority of Parliament would have to agree to legalize AE and PAD. However, the Netherland has a similar system to Canada and it has legalized AE and PAD. On the other hand, the Netherlands' political and social culture may be more of a factor than federalism.

7.4.9 Canadian Criminal Code

As previously stated the Canadian *Criminal Code* prohibits both active euthanasia and physician-assisted death and Francine Lalonde MP introduced a private members bill that if passed would change the Canadian *Criminal Code*. The Private Member's Bill failed in the 40th Parliament, 3rd Session on 21 April 2010. The vote on Bill C – 384 “An Act to amend the Criminal Code (right to die with dignity) was 59 for the Bill C-384 and 228 against. Although it failed in Parliament, it is a good example of how Canada could amend the *Criminal Code* if physician-assisted death became legal in Canada. It is important to reiterate the point that there is no real support across party lines for AE and PAD. It is not surprising that the Conservatives refuse to support its legalization. What is slightly more notable is that no other parties, with the exception of the BQ, are interested in making this an issue or party platform. Chapter 7 will discuss

these issues in further details.

The amendment would have exempted physicians from criminal charges under section 14 and therefore, under s.14 physicians could have participated in physician-assisted death and/or voluntary active euthanasia due to the addition of new subsections of the *Criminal Code*, 222(7) and 241(2). The second amendment would have been to section 222 of the *Criminal Code*. The amendments to section 222 would have allowed physicians to participate legally in physician-assisted death. It also laid out criteria that physicians must follow in order for the act to be legal. The safeguards would have ensured that a patient could change their minds within ten days and to guarantee that the diagnoses was correct and to ensure it is what the patient wishes to do. The safeguards would have also ensured abuses did not occur.

The third amendment would have been to section 241 of the *Criminal Code*. Under the present section 241, it is illegal for anyone to counsel a person to commit death or to aid or abet a person to commit death. The amendment to section 241 included two additional subsections 241(2) and 241(3). Under the proposed amendments, it would have been legal for physicians to counsel their patients on their options. The options also included physician-assisted death.

7.4.10 The Judiciary

Due to Parliament's failure to legalize PAD and active euthanasia, individuals and groups are going to the courts for a judicial decision. In June 2012, the B.C. Supreme Court granted Gloria Taylor the right to die. The Conservative Government has tried to intervene in court cases involving AE and PAD. The government has also challenged the court's decisions on AE and PAD.

In the Gloria Taylor case, a lawyer for the federal Department of Justice challenged the credentials of Marcia Angell, former editor of the *New England Journal of Medicine*, in the Supreme Court of British Columbia. The lawyer for the federal Department of Justice tried to prevent the entering of Angell's affidavit a case before the Supreme Court of B.C. concerning PAD (Hume, Nov.2011). The federal

government argued to the Court that Angell should not be an expert witness because she is an advocate for euthanasia and because her experience and training does not involve original research (Hume, Nov. 2011).

Shelia Tucker, one of a team of lawyers representing a group trying to change the euthanasia laws said that Dr. Angell is a prominent medical ethicist and her “expertise was recognized by Harvard Medical School when they employed her to teach their own doctors medical ethics” (Hume, Nov. 2011). Tucker also stated that as an editor of the New England Journal of Medicine Angell kept up to date regarding a wide range of medical issues and therefore could offer the Court a broad perspective (Hume, 2011). Tucker also argued that Dr. Angell’s views on euthanasia formed over a period of time and having researched it thoroughly she would therefore not be representing arguments but offering views formed after deep reflection (Hume, Nov. 2011). Angell did serve as an expert witness in the case.

This is one example of how the Conservative Government is actively ensuring that PAD and AE do not become legal. The government has gone as far as to object to witnesses that may debunk their arguments for maintaining the status quo. It also shows that politics is not divorced from the judiciary. The judiciary is a political institution, subjected to the same strategic pressure from political/pressure groups as other political institutions (Sniderman, 2012).

In December 2011, Justice Smith, while presiding over a case brought before the Court by the Civil Liberties Association and a group that wanted to legalize PAD, asked how can the government state that it does not condone the taking of a human life but it sends men and women to war. This prompted Department of Justice lawyer Dornaree Nygard to claim that war is a separate issue because it does not fall under the *Criminal Code*. Nygard has also argued that the government regards life as sacrosanct and therefore, active euthanasia and PAD can never be justified. However, the government cannot regard life as being sacrosanct when provisions in the law allow people to kill in self-defence, commit/attempt suicide and as Justice Smith mentioned participate in war.

In June 2012, the British Columbia's Supreme Court has declared a section of the Criminal Code that prohibits physician-assisted death unconstitutional. The federal government commenced an appeal and requested the Appeal Court to overturn Ms. Taylor's exemption, but Justice Jo-Ann Prowse rejected the appeal and the request to overturn the exemption. In a written decision, Justice Prowse says rescinding "Ms. Taylor's exemption would cause irreparable harm to Ms. Taylor which outweighs the federal government's interests" ("Court upholds B.C woman's exemption", 2012).

7.5 Conclusion

Initiatives to legalize active euthanasia/PAD through the ballot box have also had some success and failures. However, the results from a plebiscite are more likely to become law because a majority of Canadians favour euthanasia and are unafraid of the political backlash that may occur. Court cases are also having success in the legalization of active euthanasia/ PAD whether it is the court giving a physician a light sentence, courts upholding state law in the USA, or Charter rights in Canada.

A possible reason for Canada not legalizing AE or PAD is its form of federalism. The *Criminal Code* applies to all provinces and territories and no one province or territory can make a change to the Code. Only Parliament can make changes to the *Criminal Code*. Therefore, a majority of Parliament would have to agree to legalize AE and PAD. The majority government under Prime Minister Stephen Harper's conservative government makes their legalization less likely. It has voted to maintain the status quo on several occasions and has intervened in judicial cases involving AE and PAD opposing their legalization.

There appears to be no difference between private and public healthcare systems regarding the legalization of AE and PAD because various countries and USA states that have legalized AE or PAD are the different healthcare systems. The healthcare systems are from private to public healthcare.

In Canada, bills on AE and PAD that come from a MP are more likely to fail in its first or second reading because most MPs are unwilling to support the legalization of active euthanasia and physician-assisted death. Party discipline may be a factor. MPs may follow the party line on AE and PAD for fear of informal retribution by the party. Although it may be a free vote, many party members like to vote with the party leader.

Nevertheless, institutional structural factors do not fully explain the political dynamics underlying the disjuncture between the evidence presented in favour of active euthanasia and physician-assisted suicide, and the current practice of refusing to grant them legal status. Governments, political system i.e. federalism, criminal/penal code, the judiciary and plebiscites are important institutional factors in explaining the disjuncture. It helps to explain the complexities of getting bills to pass into law and the complications that can occur from strong party discipline. However, it does not explain why MPs when they have had the chances refuse to legalize AE and PAD when 67 percent of Canadians support AE and PAD. If a majority of Canadians support AE and PAD why are the parties voting against the wishes of 67 percent of the electorate in favour of the 33 percent that oppose AE and PAD. It does not explain why parties, especially the NDP or the Liberal Party do not make AE and PAD part of their party platform when there is electoral support to be gained for supporting AE and PAD.

CHAPTER 8 CONCLUSION

In this thesis, I have argued that there is a disjuncture between public support for the legalization of AE and PAD and maintaining the current practice of refusing to grant these practices legal status in Canada. First, I argued that pressure groups might be influential in maintaining the status quo by influencing policy-makers. The research found that pressure groups do not have any influence on policy-makers because they are not directly involved in policymaking. Any influence pressure groups have on MPs is significant because they are not allowed to donate to political parties or candidates. This means that MPs are not in their debt and do not owe them any favours. Pressure groups appear to have some influence on public opinion through their use of the media but have no real influence on policymaking.

Second, I argued that the constructivist approach was useful in explaining how physicians formed their opinions on AE and PAD. I argued that a physician's education, emotional involvement, experiences, and personal reflections help them form a stronger position whether they support or oppose AR and PAD as a course of medical treatment. However, the limitations of approach is that it does not explain the disjuncture between the support for AE and PAD in society and in the medical community and the government and the elites in the medical community's refusal to accept AE and PAD as appropriate EOLC treatment options. Therefore, Canadian law and medical policies do not reflect a majority of society's values regarding AE and PAD.

Third, I argued that the rational choice approach was in explaining that although a physician may support active euthanasia they may refuse to perform AE and PAD because it would not be in their best interest to do it. The limitations of this approach are that it does not take into account the physicians who go against their own interests and perform AE and PAD. Rational choice can explain a many physicians would act in accordance to institutional laws and policies but it cannot explain the disjuncture between public support for AE and PAD and institutional biases that want to maintain the status quo.

Fourth, I argued that the intuitionism and the structuralism approach helps explain how Canada's degree of federalism may be a factor in understanding why the Canadian Parliament has not legalized AE. For example, state laws vs. federal laws, strong party discipline vs. weak party discipline these appear be factors in the legalization of AE and PAD. However, institutionalism and structuralism do not explain how a majority of Canadians formed their opinion on AE and PAD that is contradictory to the Canadian laws or how physicians who support AE and PAD have come to form their opinions contradictory to the policies of the CMA and colleges of physicians and surgeons. It also does not explain why some physicians choose to perform AE and PAD even though they are illegal.

I concluded that the aforementioned approaches do not fully explain the lack of institutional change, even though public opinion has changed in regards to legalizing AE and PAD as EOLC medical treatments. These approaches do not explain why some physicians perform AE and PAD and why the courts are beginning to legalize AE and PAD, thereby deviating from the accept discourse and helping to create a new discourse. However, there is a debate in the literature between rational choice, historical institutionalism and constructionist (discursive) institutionalism. The main critique of rational choice and historical institutionalism by constructivist institutionalism is that the established positions are unable to explain intuitional change or lack of institutional change "largely because the agents in question are said to be highly constrained by their institutional environments" (Bell, 2011, p,883). Mark Blyth argues that rational choice and historical institutionalisms tend to use ideas as "fillers" or supporting hypotheses and are only important when they are congruent with pre-existing institutions or a national political culture. According to Blyth, neither approach provides adequate weight "to ideas as explanatory factors in their own right" (Bell, 2011, p.887). Blyth argues that institutional change only makes sense when referencing the ideas that inform an agent's reactions to moments of indecisiveness. Ideas provide substance to interests and determine the form and content of new institutions that comes from such moments (Bell, 2011, p.887).

8.1 Discursive Institutionalism

Discursive institutionalism does help to explain the deviation from the accepted discourse. It also explains how that deviation of ideas helps to create a new discourse. I intend to examine the debate in the literature between rational choice, historical institutionalism and discursive institutionalism in order to provide a better explanation for why there is a disjuncture between the evidence in support for AE and PAD and current practice of refusing to grant AE and PAD legal status.

The constructivist approach explains how the norms and values of institutions influence the behaviours of politicians and physicians but it does not explain how elements of social norms are created, adopted and adapted. Institutionalism helps to explain how elements of norms and values are adopted but it does not explain how society values change while institutional norms stay the same.

Discursive institutionalism offers insight into the role of ideas and discourse in politics. Ideas according to Schmidt are the substantive content of the discourse. Ideas according to constructivists “exist on three levels – policies, programs, and philosophies... it can be categorized into two types, cognitive and normative” (Schmidt, 2008, p.303). Discourse is the interactive process of conveying ideas that form “the coordinative discourse among policy actors and the communicative discourse between political actors and the public” (Schmidt, 2008, p.303). Discourse indicates the ideas represented by discourse helps to explain the interactive process by which actors convey ideas that various agents carry out in different spheres (Schmidt, 2008, p.309). The discursive process helps to explain why some ideas succeed while other ideas fail because of the method in which they are projected, to whom, and to where. The discourse needs to be about evaluating its success or failures in promoting ideas (Schmidt, 2008, p.309).

Bell argues that historical institutionalism is compatible with significant constructivist insights because it “offers a solution to a longstanding problem with constructivism” (Bell, 2011, p.88) by offering a more rounded account of agency.

Constructivism's strength lies in insisting, "...ideas and inter-subjectivity meanings inform and shape the interests and choices of agents" (Bell, 2011, p.883).

The movement of discourse and ideas of discursive interaction often occurs from the top down through the interaction policy elites generate. The political elites then communicate their ideas to the public (Schmidt, 2008, p.311). These elites often entwine the coordinative and communicative discourses into a master discourse that presents a seemingly logical political program. The elites then frame the issues for the media to be transmitted the public in order to shape public opinion by establishing the terms of the discourse (Schmidt, 2008, p.311). The elites communicate their ideas on AE and PAS to the public through carefully formed and shaped discourse. The goal of the political elites in Canada has been to ensure the criminalization of active euthanasia and PAD remains the law. Most of the medical community elites carefully form and shape the discourse not for the public but for medical students and physicians. The medical community elite through such avenues as medical schools frame the curriculum to persuade students and physicians from supporting AE and PAD as legitimate EOLC treatments by establishing their terms of the discourse.

The movement of discourse and ideas can move from the bottom up through discursive interactions of social activists, grassroots organizations, etc (Schmidt, 2008, p.311). In the case of AE, grassroots organizations and individuals are generating the ideas and discourse that are influencing the public and hopefully the political elites in order to evoke legal change. In Canada, they use the media to shape and form the discourse; they also use political institutions such as the courts when they fail to influence government. For example, pro AE groups are using their political power and the political institutions at their disposal (i.e. the courts) and the use of media to frame the discourse and provide new ideas for the public. These groups hope to continue to gain the support of the public for legalizing AE and PAD. Individuals bring the discourse of AE and PAD into the courts in order to influence political institutions to change the laws criminalizing AE and physician-assisted death.

Under rational choice and historical institutionalism, actors face rule based constraints provided by the institutional environment, which influences their behaviour. Actors within institutions conform to the rules established by the institutions. Following this logic, if every actor follows the rules once established the actors who deviate from the rules of institutions are explained (Schmidt, 2008, p.314). Schmidt argues that rational choice and historical institutionalism treats actors as “unthinking” actors who are in an important sense not agents at all, because they are only following the rules institutions establish. The subordination of agency to the structures (rules) is the key problem for rational choice and historical institutionalism and it is why new institutionalism has turned to ideas and discourse in recent years (Schmidt, 2008, p.314).

Discursive institutionalism treats institutions as a given and as contingent. The rules of the institutions can change depending on the circumstances of the internal actors. Institutions are internal to the actors, serving as structures that “constrain actors and as constructs created and changed by those actors” (Schmidt, 2008, p. 314). Action in these institutions is not the product of agents rationally calculated, path-dependent, or norm-appropriate rule following. Agents create and maintain institutions by using “background ideational abilities” (Schmidt, 2008, p.314). Background ideational abilities strengthen agents’ ability to make sense of and provide a “given meaning context, that is, in terms of the ideational rules and “rationality” of that setting” (Schmidt, 2008, p.314). However, institutional action can also be “predicated by foreground discursive abilities, through which agents may change (or maintain) their institutions” (Schmidt, 2008, p.314). The discursive abilities represent the logic of communication, which facilitates agents to think, speak and act outside their institutions even as they are inside them, to examine the institutional rules of the institution even as they use them, and to influence one another to modify those institutions or to maintain them. Because of its ability to communicate ideas and discourse in a logical manner, discursive interaction is more equipped to explain institutional and continuity than rational choice and historical institutionalism (Schmidt, 2008, p.314).

Discursive institutionalism helps to explain how physicians who support AE and

PAD are able to influence the medical community in supporting the legalization and the participation of physicians of active euthanasia and physicians-assisted suicide. It explains that because physicians are thinking actors they are able to change the discourse within the medical community. The ideas these physicians present to the medical community may facilitate the medical community to be more accepting and supportive of physicians who support AE and PAD as EOLC treatment. Discursive interaction also explains why the courts have taken the step forward to legalize AE and PAD despite previous court rulings that maintained their criminalization. The judges as thinking actors are able to interpret the laws that that are more in line with their own views and the public's view and are more favourable to the practice of physicians-assisted suicide and active euthanasia. These changes within the judicial system create a new discourse within the institutions. Discursive institutionalism allows for members of political parties to change the discourse within the party with new ideas.

Discursive interaction can be complementary to rational choice and historical institutionalism. Institutions where rational choice incentive based or historical institutionalism established patterns to frame the discourse and define contexts within which repertoires are more or less acceptable ideas and discursive institutions develop. The institutions can provide background information for what one expects due to structural constraints as opposed to the unexpected, which maybe better explained by discursive interactions (Schmidt, 2008, p.314). It accounts for "unique events by references to individuals' ideas and discourses" (Schmidt, 2008, p. 314) and the unexpected which maybe the expected when analysis is based on a set of identical rules and discursive regularities following a logic of path dependence or cultural norms following a logic of appropriateness. The norms are inter-subjective and discursively constructed that can be understood across cultures even when they are not shared (Schmidt, 2008, p. 321).

There has been a change in the discourse within a majority of the public who accept the legalization of active euthanasia and physician-assisted suicide. Justice Smith in British Columbia has begun to change Canada's legal intuitional discourse on AE and

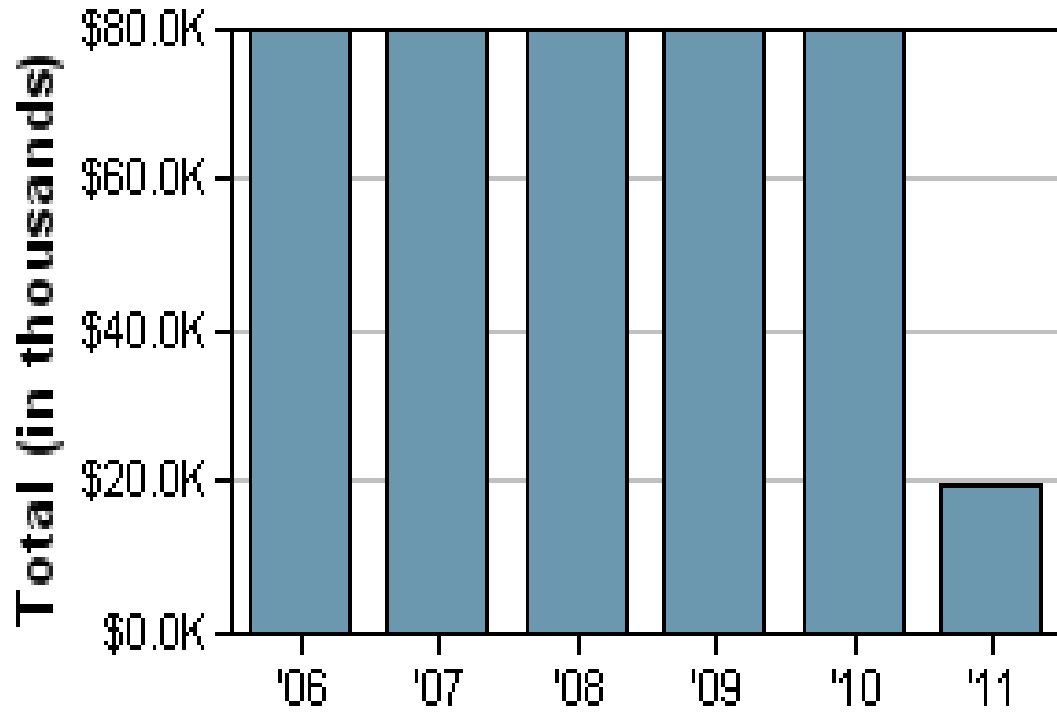
PAD when she ruled that the laws banning assisted suicide were unconstitutional and gave Parliament one year to amend the *Criminal Code*. It helps to explain why some physicians perform AE or PAD or who have lobbied for the sanctioning of these practices. These physicians believe that it is part of their duty to ease the pain and suffering of patients when terminal patients request AE or PAD. By publicizing their views, physicians help to frame a new discourse within the medical community, government and the public in hopes of influencing change to the status quo.

Because political reality is immense and complex, no one methodological approach is able to explain political issues and agencies responses sufficiently to those issues. When examining the legalization of active euthanasia and physician-assisted suicide there are various pieces of this complex puzzle to account for, such as the public, government and political parties, the judicial system, physicians, elites within the medical community that establishes policies and the viewpoint of patients. Each method provides a different piece of this political reality at different levels of abstraction with different objects and logics of explanation. Because of this discursive institutionalism can treat the results of the other approaches as background information (Schmidt, 2008, p.322). However, it does help to provide a more accurate representation of the politics AE and PAD. Discursive institutionalism helps to explain why there is deviation from the accepted discourse and how the deviation of ideas helps to create a new discourse.

One can argue that there is no need to develop a new discourse because there has been some progress concerning EOLC. For example, Quebec's government has supported legislation to legalize PAD and the Carter et al. v. A.G. Canada recent decision. However, there is no uniformity in the laws on EOLC in Canada and physicians can be prosecuted if caught and punished under various laws in the *Criminal Code* and by the provincial colleges of physicians and surgeons. Patients do not have the autonomy to receive AE/PAD without the possibility of prosecution or punishment. Therefore, the initial concerns in this thesis are not overstated. Due to society's favourable views on legalizing AE and PAD, court challenges and Quebec's stance on PAD, it is important for the Parliament and political parties to address EOLC issues.

FIGURE 4-1 C&C Lobbying Expenditures

United States, 2011³²
Lobbying Totals, 2006-2011



³² Retrieved from <http://www.opensecrets.org/lobby/clientsum.php?id=D000044766>

FIGURE 4-2 I-1000: Assisted Suicide

Washington State, US, 2008³³

TABLE 1: Ballot Measure Committees Ballot Committee

Pro Ballot Committees

	Records	Total
YES ON I 1000	13859	\$4,902,811
COMPASSION & CHOICES WASHINGTON INITIATIVE PAC	13	\$627,625
	Pro Total:	\$5,530,436

Con Ballot Committees

COALITION AGAINST ASSISTED SUICIDE	5602	\$1,678,796
	Con Total:	\$1,678,796
	Overall Total:	\$7,209,232

³³ Retrieved from <http://www.followthemoney.org/database/StateGlance/ballot.phtml?m=443>

FIGURE 4-3 Massachusetts 2012 Pro and Con Question 2 Committees

Massachusetts, US, 2012 ³⁴

TABLE 1: Ballot Measure Committees Ballot Committee

Pro Ballot Committees	Records	Total
DIGNITY 2012	764	\$564,071
MASSACHUSETTS COMPASSION & CHOICES DIGNITY 2012	25	\$53,049
	Pro Total:	\$617,120
Con Ballot Committees		
CMTE AGAINST PHYSICIAN ASSISTED SUICIDE	52	\$737,898
MASSACHUSETTS ALLIANCE AGAINST DOCTOR PRESCRIBED SUICIDE - NO ON 2	36	\$109,886
SECOND THOUGHTS PEOPLE WITH DISABILITIES OPPOSING THE LEGALIZATION OF ASSISTED SUICIDE	7	\$15,350
LIFE WITH DIGNITY - NO ON 2	0	\$0
CHOICE IS AN ILLUSION DBA MASSACHUSETTS AGAINST ASSISTED SUICIDE	0	\$0
	Con Total:	\$863,134
	Overall Total:	\$1,480,255

³⁴ Retrieved from <http://followthemoney.org/database/StateGlance/ballot.phtml?m=1008>

FIGURE 5-1 Study Conducted By Dubois and Burkemper³⁵

**Table 1
Rank Orders of Course Objectives, Teaching Methods, and Methods of Assessing
Students of Required, Formal Ethics Courses from the Syllabi of 58 U.S. Medical
Schools**

Rank	Component	% of medical Schools
Course Objective		
1	Familiarize with medical ethical topics (e.g. informed consent, truth-telling, futility)	77.6
2	Develop ethical reasoning/ethical problem-solving skills	63.8
3	Learn normative theories/ethical frameworks	34.5
4	Learn about law and medicine	32.8
5	Promote medical virtues/interiorization of professional Values	29.3
6	Personal value clarification	22.4
7	Foster communication skills	20.7
8	Know ethics literature	12.1
9/10	Engage codes and compliance issues	10.3
9/10	Provide ethically-relevant educational experiences (or growth opportunities, e.g., watch a film meant to foster empathy)	10.3
Teaching Method		
1	Discussion/debates	84.5
2	Readings	82.8
3 /4	Writing exercises	63.8
3 /4	Lectures	63.8
5	Multi-media presentations (e.g. films)	29.3
6	Role playing/standardized patients	20.7
7	Clinical rounds/field visits	19.0
8	Computer exercises	10.3
Method of assessing		

³⁵ Retrieved from DuBois, James and Jill Burkemper. (2002) Ethics Education in US Medical Schools: A study of Syllabi. *Academic Medicine*, Vol. 77(5), 432-57. Retrieved From <http://www.ncbi.nlm.nih.gov/pubmed/12010705>

Students

1	Class participation	89.6
2	Examination	64.6
3	Papers	45.8
4	Case analysis	43.8
5	Disposition and reactions to others	10.4
6	Journals	4.2

*Percentages pertain to those 48 of 58 syllabi from schools that reported that their courses were graded. Those that did not grade (18%) did not assess students' performances.

FIGURE 5-2 DeLeo Et al.'s Study³⁶

Figure 2

Table 1. Participants' composition: gender and mean age of students by year

Undergraduate year level	Male n (%)		Female n (%)		Total student response rate (%)	Mean age	
First Year	74	44%	95	56%	169 73%	25.5	
Second Year	68	45%	82	55%	150	86%	25.47
Third Year	8	40%	12	60%	20	80%	27.5
Fourth Year	16	46%	18	54%	34	85%	28.41
Total	166	-	207	-	373	-	-

³⁶ Retrieved from DeLeo, Diego, J. Hawgood, and N, Ide. (19 Mar. 2012). Do we need education on right-to-die issues? Medical perspectives from Australia. *Asia-Pacific Psychiatry*, Vol. 4(1), pp. 10-19. Retrieved from DOI: 10.1111/j.1758-5872.2011.00174.x

FIGURE 5-3 Dickinson and Field Study³⁷

Table 4. End-of-life topics covered in the curriculum

	UK * (%)	US ** (%)
Attitudes toward death and dying	24 (100)	90 (80)
Communication with dying patients	21 (89)	97 (87)
Communication with family members of dying patients	23 (96)	85 (76)
Grief and bereavement	22 (92)	81 (72)
Social contexts of dying	21 (89)	71 (63)
Psychological aspects of dying	22 (92)	80 (71)
Religious and cultural aspects of dying	16 (67)	74 (66)
The experience of dying	19 (79)	68 (61)
Analgesics for chronic pain	23 (96)	87 (78)
Analgesics for cancer pain	23 (96)	83 (74)
Symptom relief in advanced terminal disease	24 (100)	74 (66)
End-of-life hydration	16 (67)	55 (49)
End-of-life nutrition	14 (58)	57 (51)
Other physical therapy	8 (33)	5 (4)
Neonatal issues	8 (33)	29 (26)
Relating to patients with AIDS	9 (37)	58 (52)
Euthanasia	21 (89)	51 (46)
Advance directives	18 (75)	91 (81)

³⁷ Retrieved from Dickinson, George E., and David Field. (2002). Teaching end-of-life issue: current status in the United Kingdom and United States Medical Schools. *American Journal of Hospice and Palliative Medicine*, Vol. 19 (3), 181-86. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/12026041>

Death certificates
* N = 12; ** N = 112

20 (83)

29 (26)

APPENDIX 1-1 Declaration of Geneva 1948 ³⁸

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968 and the 35th World Medical Assembly, Venice, Italy, October 1983 and the 46th WMA General Assembly, Stockholm, Sweden, September 1994 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005 and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006

AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to consecrate my life to the service of humanity;

I WILL GIVE to my teachers the respect and gratitude that is their due;

I WILL PRACTISE my profession with conscience and dignity;

THE HEALTH OF MY PATIENT will be my first consideration;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL MAINTAIN by all the means in my power, the honour and the noble traditions of the medical profession;

MY COLLEAGUES will be my sisters and brothers;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely and upon my honour

³⁸ Retrieved From World Medical Association. Declaration of Geneva 1948.
<http://www.wma.net/en/30publications/10policies/g1/index.html>

APPENDIX 1-2 Canadian Criminal Code

Criminal Code

R.S.C., 1985, c. C-46

Consent to Death

14. No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

Duties Tending to Preservation of Life

Duty of persons to provide necessities

215. (1) Every one is under a legal duty

- (a) as a parent, foster parent, guardian or head of a family, to provide necessities of life for a child under the age of sixteen years;
- (b) to provide necessities of life to their spouse or common-law partner; and
- (c) to provide necessities of life to a person under his charge if that person
 - (i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and
 - (ii) is unable to provide himself with necessities of life.

Offence

(2) Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies on him, to perform that duty, if

- (a) with respect to a duty imposed by paragraph (1)(a) or (b),
 - (i) the person to whom the duty is owed is in destitute or necessitous circumstances, or
 - (ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently; or
- (b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

Punishment

(3) Every one who commits an offence under subsection (2)

- (a) is guilty of an indictable offence and liable to imprisonment for a term not exceeding five years; or
- (b) is guilty of an offence punishable on summary conviction and liable to imprisonment for a term not exceeding eighteen months.

Criminal negligence

219. (1) Every one is criminally negligent who

- (a) in doing anything, or
 - (b) in omitting to do anything that it is his duty to do,
- shows wanton or reckless disregard for the lives or safety of other persons.

Definition of "duty"

(2) For the purposes of this section, "duty" means a duty imposed by law.

Causing death by criminal negligence

220. Every person who by criminal negligence causes death to another person is guilty of an indictable offence and liable

- (a) where a firearm is used in the commission of the offence, to imprisonment for life and to a minimum punishment of imprisonment for a term of four years; and
- (b) in any other case, to imprisonment for life.

Causing bodily harm by criminal negligence

221. Every one who by criminal negligence causes bodily harm to another person is guilty of an indictable offence and liable to imprisonment for a term not exceeding ten years.

Homicide

222. (1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.

Kinds of homicide

(2) Homicide is culpable or not culpable.

Non culpable homicide

(3) Homicide that is not culpable is not an offence.

Culpable homicide

(4) Culpable homicide is murder or manslaughter or infanticide.

(5) A person commits culpable homicide when he causes the death of a human being,

(a) by means of an unlawful act;

(b) by criminal negligence;

(c) by causing that human being, by threats or fear of violence or by deception, to do anything that causes his death; or

(d) by wilfully frightening that human being, in the case of a child or sick person.

Murder

229. Culpable homicide is murder

(a) where the person who causes the death of a human being

(i) means to cause his death, or

(ii) means to cause him bodily harm that he knows is likely to cause his death, and is reckless whether death ensues or not;

(b) where a person, meaning to cause death to a human being or meaning to cause him bodily harm that he knows is likely to cause his death, and being reckless whether death ensues or not, by accident or mistake causes death to another human being, notwithstanding that he does not mean to cause death or bodily harm to that human being; or

(c) where a person, for an unlawful object, does anything that he knows or ought to know is likely to cause death, and thereby causes death to a human being, notwithstanding that he desires to effect his object without causing death or bodily harm to any human being.

Murder in commission of offences

231. (1) Murder is first degree murder or second degree murder.

Planned and deliberate murder

(2) Murder is first degree murder when it is planned and deliberate.

235. (1) Every one who commits first degree murder or second degree murder is guilty of an indictable offence and shall be sentenced to imprisonment for life.

Minimum punishment

(2) For the purposes of Part XXIII, the sentence of imprisonment for life prescribed by this section is a minimum punishment.

Suicide

Counselling or aiding suicide

241. Every one who

(a) counsels a person to commit suicide, or

(b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

APPENDIX 1-3 Private Members Bill C-384³⁹

2nd Session, 40th Parliament,
57-58 Elizabeth II, 2009
HOUSE OF COMMONS OF CANADA

BILL C-384

An Act to amend the Criminal Code (right to die with dignity)

R.S., c. C-46

Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

1. Section 14 of the *Criminal Code* is replaced by the following:

Consent to death

14. Subject to subsections 222(7) and 241(2), no person is entitled to consent to have death inflicted on him or her, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

2. Section 222 of the Act is amended by adding the following after subsection (6):

Exception

(7) Despite anything in this section, a medical practitioner does not commit homicide within the meaning of this Act by reason only that he or she aids a person to die with dignity, if

(a) the person

(i) is at least eighteen years of age,

(ii) either

(A) continues, after trying or expressly refusing the appropriate treatments available, to experience severe physical or mental pain without any prospect of relief, or

(B) suffers from a terminal illness,

(iii) has provided a medical practitioner, while appearing to be lucid, with two written requests more than 10 days apart expressly stating the person's free and informed consent to opt to die, and

(iv) has designated in writing, with free and informed consent, before two witnesses with no personal interest in the death of the person, another person to act on his or her behalf with any medical practitioner when the person does not appear to be lucid; and

(b) the medical practitioner

(i) has requested and received written confirmation of the diagnosis from another medical practitioner with no personal interest in the death of the person,

(ii) has no reasonable grounds to believe that the written requests referred to in subparagraph (a)(iii) were made under duress or while the person was not lucid,

(iii) has informed the person of the consequences of his or her requests and of the alternatives available to him or her,

(iv) acts in the manner indicated by the person, it being understood that the person may, at any time, revoke the requests made under subparagraph (a)(iii), and

(v) provides the coroner with a copy of the confirmation referred to in subparagraph (i).
Definition of “medical practitioner”

(8) For the purposes of subsection (7), “medical practitioner” means a person duly qualified by provincial law to practice medicine.

3. Section 241 of the Act is renumbered as subsection 241(1) and is amended by adding the following:

Exception

(2) A medical practitioner is not guilty of an offence under this Act by reason only that he or she aids a person to commit suicide with dignity, if

(a) the person who commits suicide meets the conditions set out in paragraph 222(7)(a); and

(b) the medical practitioner meets the conditions set out in paragraph 222(7)(b).

Definition of “medical practitioner”

(3) For the purposes of paragraph (2), “medical practitioner” means a person duly qualified by provincial law to practice medicine.

Published under authority of the Speaker of the House of Commons

APPENDIX 1-4 Canadian Charter of Rights and Freedoms

CONSTITUTION ACT, 1982

1982, c. 11 (U.K.), Schedule B

PART I

CANADIAN CHARTER OF RIGHTS AND FREEDOMS

Whereas Canada is founded upon principles that recognize the supremacy of God and the rule of law:

GUARANTEE OF RIGHTS AND FREEDOMS

1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

LEGAL RIGHTS

Life, liberty and security of person

7. Everyone 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.

Treatment or punishment

12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

EQUALITY RIGHTS

Equality before and under law and equal protection and benefit of law

15. (1) Every 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.

APPENDIX 5-1 Hippocratic Oath

Hippocratic Oath: Classical Version⁴⁰

I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

⁴⁰ Peter Tyson. *The Hippocratic Oath Today*. <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>

—Translation from the Greek by Ludwig Edelstein. From *The Hippocratic Oath: Text, Translation, and Interpretation*, by Ludwig Edelstein. Baltimore: Johns Hopkins Press, 1943.

Hippocratic Oath: Modern Version⁴¹

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

⁴¹ Peter Tyson.(2001) The Hippocratic Oath Today. *PBS Nova* . Retrieved from <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>

—Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today.

MEDICAL ETHICS THROUGH FILM

Coordinator: Dr. J. Nisker

Credit: 12 hours.

This selective uses film to further your training in Medical Ethics and Humanities and provide you films to use as tools to educate others when you are residents and clinicians (at grand rounds) and if you become teachers in hospitals or in medical schools. Students will be required to view (independently or in groups) at least half of the designated films and be prepared to discuss the ethical issues surfaced in each film in general and how they relate to the particular topic of the week. Evaluation will be based exclusively on a very short description of an ethical issue encountered during your clinical clerkship or 4th year electives, as informed by one of the films.

5. End of Life Ethics – Mar. 3/11

Potential Films:

- *Million Dollar Baby** - Clint Eastwood, Director
- *The Sea Inside** - Alejandro Amenábar, Director
- *Whose Life Is It Anyway?* – John Badham, Director
- *The Barbarian Invasions** - Denys Arcand, Director
- *The English Patient** - Anthony Minghella, Director
- *Philadelphia** - Jonathan Demme, Director
- *When Did You Last See Your Father?* – Anand Tucker, Director
- *Away From Her* - Sarah Polley, Director
- *Death of Mr. Lazarescu* - Cristi Puiu, Director
- Your choices

Issues:

- Physician roles and obligation during end of life decisions

Objectives:

- To understand the moral issues in physician assisted suicide o Societal issues
o Physician obligation - to the patient, to society, to family, to themselves
- To understand the ethical underpinnings that might help inform the pros and cons of the current Canadian euthanasia debate
- To develop the understanding that would allow the physician to counsel a patient requesting euthanasia
- To understand a physician's obligation to persons making end of life decisions

* Academy Award winner for best picture or best foreign film

⁴² UWO. (2010-2011).Year 4 MEDS 2011 Transition Handbook 2010-2011. University of Western Ontario: Schulich Medicine and Dentistry. Retrieved from <http://www.schulich.uwo.ca/medicine/undergraduate/year4/files/Year3and4/TransitionHandbook.pdf>

APPENDIX 5-3 UK Suicide Act 1961



Suicide Act 1961

1961 CHAPTER 60 9 and 10 Eliz 2⁴³

An Act to amend the law of England and Wales relating to suicide, and for purposes connected therewith.

[3rd August 1961]

1 Suicide to cease to be a crime.

The rule of law whereby it is a crime for a person to commit suicide is hereby abrogated.

2 Criminal liability for complicity in another's suicide.

(1) A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years.

(2) If on the trial of an indictment for murder or manslaughter it is proved that the accused aided, abetted, counselled or procured the suicide of the person in question, the jury may find him guilty of that offence.

(3) The enactments mentioned in the first column of the First Schedule to this Act shall have effect subject to the amendments provided for in the second column (which preserve in relation to offences under this section the previous operation of those enactments in relation to murder or manslaughter).

(4) **F**1no proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions.

⁴³ Retrieved from <http://www.legislation.gov.uk/ukpga/Eliz2/9-10/60>

APPENDIX 6-1 Medicine Act, 1991 Professional Misconduct⁴⁴

Medicine Act, 1991 Loi de 1991 sur les médecins

ONTARIO REGULATION 856/93 PROFESSIONAL MISCONDUCT

Last amendment: O. Reg. 450/10.

This Regulation is made in English only.

1. (1) The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:

1. Contravening a term, condition or limitation on the member's certificate of registration.
2. Failing to maintain the standard of practice of the profession.
6. Prescribing, dispensing or selling drugs for an improper purpose.
16. Falsifying a record relating to the member's practice.
28. Contravening a federal, provincial or territorial law, a municipal by-law or a by-law or rule of a public hospital if,
 - i. the purpose of the law, by-law or rule is to protect public health, or
 - ii. the contravention is relevant to the member's suitability to practise.
34. Conduct unbecoming a physician. O. Reg. 856/93, s. 1 (1); O. Reg. 857/93, s. 1 (1); O. Reg. 115/94, s. 1; O. Reg. 53/95, s. 1; O. Reg. 450/10, s. 1.

(2) Despite paragraph 10 of subsection (1), it is not professional misconduct for a member to give information about a patient, including access to the patient's records,

- (a) to a practitioner of a health profession for the purpose of providing care to the patient; or
- (b) to a person for the purpose of research or health administration or planning if the member reasonably believes that the person will take reasonable steps to protect the identity of the patient. O. Reg. 856/93, s. 1 (2).

(2.1) Paragraphs 23, 23.1 and 23.2 of subsection (1) do not apply in a case where a member charges a fee to a third party for a third party service under the *Health Insurance Act*. O. Reg. 857/93, s. 1 (2).

⁴⁴Retrieved from https://www.e-laws.gov.on.ca/.../elaws_statutes_91m30_e.doc

(3) A member shall be deemed to have committed an act of professional misconduct if the governing body of a health profession in a jurisdiction other than Ontario has made a finding of incompetence or professional misconduct or a similar finding against the member, and the finding is based on facts which would, in the opinion of the College, be grounds for a finding of incompetence as defined in section 52 of the Code or would be an act of professional misconduct as defined in subsection (1). O. Reg. 856/93, s. 1 (3).

(4) A member shall be deemed to have committed an act of professional misconduct if,

- (a) the governing body of a health profession in a jurisdiction other than Ontario has provided records to the College evidencing that an allegation of professional misconduct or incompetence or a similar allegation has been made against the member and he or she has entered into an agreement or compromise with the governing body in order to settle the matter without a finding of misconduct or incompetence or a similar finding being made;
- (b) the College is satisfied that the records are authentic, accurate and complete; and
- (c) the act or omission that is the subject of the allegation would, in the opinion of the College, be an act of professional misconduct as defined in subsection (1), or would constitute incompetence as defined in section 52 of the Code. O. Reg. 856/93, s. 1 (4).

2. Omitted (provides for coming into force of provisions of this Regulation). O. Reg. 856/93, s.

APPENDIX 7-1 Oregon Death With Dignity

THE OREGON DEATH WITH DIGNITY ACT⁴⁵ OREGON REVISED STATUTES

(General Provisions)
(Section 1)

Note: The division headings, subdivision headings and leadlines for 127.800 to 127.890, 127.895 and 127.897 were enacted as part of Ballot Measure 16 (1994) and were not provided by Legislative Counsel.

127.800 §1.01. Definitions. The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings:

- (1) "Adult" means an individual who is 18 years of age or older.
- (2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
- (3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
- (4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
- (5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
- (6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.
- (7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
 - (a) His or her medical diagnosis;
 - (b) His or her prognosis;

⁴⁵ Retrieved from <http://library.state.or.us/repository/2012/201209260807593/index.pdf>

- (c) The potential risks associated with taking the medication to be prescribed;
- (d) The probable result of taking the medication to be prescribed; and
- (e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 §1.01; 1999 c.423 §1]

(Written Request for Medication to End One's Life in a Humane and Dignified Manner)

(Section 2)

127.805 §2.01. Who may initiate a written request for medication. (1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 to 127.897.

(2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability. [1995 c.3 §2.01; 1999 c.423 §2]

127.810 §2.02. Form of the written request. (1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

- (a) A relative of the patient by blood, marriage or adoption;
- (b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or
- (c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Services by rule. [1995 c.3 §2.02]

(Safeguards)

(Section 3)

127.815 §3.01. Attending physician responsibilities. (1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;

(b) Request that the patient demonstrate Oregon residency pursuant to ORS 127.860;

(c) To ensure that the patient is making an informed decision, inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking the medication to be prescribed;

(D) The probable result of taking the medication to be prescribed; and

(E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;

(d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(e) Refer the patient for counseling if appropriate pursuant to ORS 127.825;

(f) Recommend that the patient notify next of kin;

(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place;

(h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to ORS 127.840;

- (i) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;
- (j) Fulfill the medical record documentation requirements of ORS 127.855;
- (k) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and
- (L)(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or
- (B) With the patient's written consent:
 - (i) Contact a pharmacist and inform the pharmacist of the prescription; and
 - (ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.
- (2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate. [1995 c.3 §3.01; 1999 c.423 §3]

127.820 §3.02. Consulting physician confirmation. Before a patient is qualified under ORS 127.800 to 127.897, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision. [1995 c.3 §3.02]

127.825 §3.03. Counseling referral. If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. [1995 c.3 §3.03; 1999 c.423 §4]

127.830 §3.04. Informed decision. No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in ORS 127.800 (7). Immediately prior to writing a prescription for medication under ORS 127.800 to 127.897, the attending physician shall verify that the patient is making an informed decision. [1995 c.3 §3.04]

127.835 §3.05. Family notification. The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason. [1995 c.3 §3.05; 1999 c.423 §6]

127.840 §3.06. Written and oral requests. In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request. [1995 c.3 §3.06]

127.845 §3.07. Right to rescind request. A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request.[1995 c.3 §3.07]

127.850 §3.08. Waiting periods. No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under ORS 127.800 to 127.897. [1995 c.3 §3.08]

127.855 §3.09. Medical record documentation requirements. The following shall be documented or filed in the patient's medical record:

- (1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;
- (2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;
- (3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;
- (4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;
- (5) A report of the outcome and determinations made during counseling, if performed;
- (6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to ORS 127.840; and
- (7) A note by the attending physician indicating that all requirements under ORS

127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed. [1995 c.3 §3.09]

127.860 §3.10. Residency requirement. Only requests made by Oregon residents under ORS 127.800 to 127.897 shall be granted. Factors demonstrating Oregon residency include but are not limited to:

- (1) Possession of an Oregon driver license;
- (2) Registration to vote in Oregon;
- (3) Evidence that the person owns or leases property in Oregon; or
- (4) Filing of an Oregon tax return for the most recent tax year. [1995 c.3 §3.10; 1999 c.423 §8]

127.865 §3.11. Reporting requirements. (1)(a) The Department of Human Services shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897.

(b) The department shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the department.

(2) The department shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public.

(3) The department shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 §3.11; 1999 c.423 §9; 2001 c.104 §40]

127.870 §3.12. Effect on construction of wills, contracts and statutes. (1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 §3.12]

127.875 §3.13. Insurance or annuity policies. The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither

shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 §3.13]

127.880 §3.14. Construction of Act. Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 §3.14]

(Immunities and Liabilities)

(Section 4)

127.885 §4.01. Immunities; basis for prohibiting health care provider from participation; notification; permissible sanctions. Except as provided in ORS 127.890:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(5)(a) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in ORS 127.800 to 127.897 on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's policy regarding participating in ORS 127.800 to 127.897. Nothing in this paragraph prevents a health care provider from providing

health care services to a patient that do not constitute participation in ORS 127.800 to 127.897.

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

(A) Loss of privileges, loss of membership or other sanction provided pursuant to the medical staff bylaws, policies and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in ORS 127.800 to 127.897 while on the health care facility premises, as defined in ORS 442.015, of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(B) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in ORS 127.800 to 127.897 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(C) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in ORS 127.800 to 127.897 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subparagraph shall be construed to prevent:

(i) A health care provider from participating in ORS 127.800 to 127.897 while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(ii) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

(A) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the provider's participation in ORS 127.800 to 127.897 of the sanctioning health care provider's policy about

participation in activities covered by ORS 127.800 to 127.897.

(B) "Participate in ORS 127.800 to 127.897" means to perform the duties of an attending physician pursuant to ORS 127.815, the consulting physician function pursuant to ORS 127.820 or the counseling function pursuant to ORS 127.825. "Participate in ORS 127.800 to 127.897" does not include:

(i) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(ii) Providing information about the Oregon Death with Dignity Act to a patient upon the request of the patient;

(iii) Providing a patient, upon the request of the patient, with a referral to another physician; or

(iv) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(6) Suspension or termination of staff membership or privileges under subsection (5) of this section is not reportable under ORS 441.820. Action taken pursuant to ORS 127.810, 127.815, 127.820 or 127.825 shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (2) or (3).

(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community. [1995 c.3 §4.01; 1999 c.423 §10]

Note: As originally enacted by the people, the headline to section 4.01 read "Immunities." The remainder of the headline was added by editorial action.

127.890 §4.02. Liabilities. (1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

(3) Nothing in ORS 127.800 to 127.897 limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in ORS 127.800 to 127.897 do not preclude criminal penalties

applicable under other law for conduct which is inconsistent with the provisions of ORS 127.800 to 127.897. [1995 c.3 §4.02]

127.892 Claims by governmental entity for costs incurred. Any governmental entity that incurs costs resulting from a person terminating his or her life pursuant to the provisions of ORS 127.800 to 127.897 in a public place shall have a claim against the estate of the person to recover such costs and reasonable attorney fees related to enforcing the claim. [1999 c.423 §5a]

(Severability)

(Section 5)

127.895 §5.01. Severability. Any section of ORS 127.800 to 127.897 being held invalid as to any person or circumstance shall not affect the application of any other section of ORS 127.800 to 127.897 which can be given full effect without the invalid section or application. [1995 c.3 §5.01]

(Form of the Request)

(Section 6)

127.897 §6.01. Form of the request. A request for a medication as authorized by ORS 127.800 to 127.897 shall be in substantially the following form:

REQUEST FOR MEDICATION
TO END MY LIFE IN A HUMANE
AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.
I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician. I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control. I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the

medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

- (a) Is personally known to us or has provided proof of identity;
- (b) Signed this request in our presence;
- (c) Appears to be of sound mind and not under duress, fraud or undue influence;
- (d) Is not a patient for whom either of us is attending physician.

_____ Witness 1/Date

_____ Witness 2/Date

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

[1995 c.3 §6.01; 1999 c.423 §11]

PENALTIES

127.990: [Formerly part of 97.990; repealed by 1993 c.767 §29]

127.995 Penalties. (1) It shall be a Class A felony for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument or any other evidence or document reflecting the principal's desires and interests, with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration which hastens the death of the principal.

(2) Except as provided in subsection (1) of this section, it shall be a Class A misdemeanor for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal's desires and interests with the intent or effect of affecting a health care decision. [Formerly 127.585]

APPENDIX 7-2 Washington's Death With Dignity Act⁴⁶

Initiative Measure No. 1000

AN ACT Relating to death with dignity; amending RCW 70.122.100; reenacting and amending RCW 42.56.360 and 42.56.360; adding a new chapter to Title 70 RCW; prescribing penalties; providing an effective date; and providing an expiration date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

THE WASHINGTON DEATH WITH DIGNITY ACT

General Provisions

NEW SECTION. Sec. 1. DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

- (1) "Adult" means an individual who is eighteen years of age or older.
- (2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
- (3) "Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
- (4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
- (5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
- (6) "Health care provider" means a person licensed, certified, or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.
- (7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
 - (a) His or her medical diagnosis;
 - (b) His or her prognosis;
 - (c) The potential risks associated with taking the medication to be prescribed;
 - (d) The probable result of taking the medication to be prescribed; and
 - (e) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.
- (8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.
- (9) "Patient" means a person who is under the care of a physician.

⁴⁶ Retrieved from <http://apps.leg.wa.gov/rcw/default.aspx?cite=70.245&full=true>

(10) “Physician” means a doctor of medicine or osteopathy licensed to practice medicine in the state of Washington.

(11) “Qualified patient” means a competent adult who is a resident of Washington state and has satisfied the requirements of this chapter in order to obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner.

(12) “Self-administer” means a qualified patient’s act of ingesting medication to end his or her life in a humane and dignified manner.

(13) “Terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months

Written Request for Medication to End Life in a Humane and Dignified Manner

NEW SECTION. Sec. 2. WHO MAY INITIATE A WRITTEN REQUEST FOR MEDICATION. (1) An adult who is competent, is a resident of Washington state, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication that the patient may self-administer to end his or her life in a humane and dignified manner in accordance with this chapter.

(2) A person does not qualify under this chapter solely because of age or disability.

NEW SECTION. Sec. 3. FORM OF THE WRITTEN REQUEST. (1) A valid request for medication under this chapter shall be in substantially the form described in section 22 of this act, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

(a) A relative of the patient by blood, marriage, or adoption;

(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(c) An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient’s attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long-term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the department of health by rule.

Safeguards

NEW SECTION. Sec. 4. ATTENDING PHYSICIAN RESPONSIBILITIES. (1) The attending physician shall:

(a) Make the initial determination of whether a patient has a terminal disease, is competent, and has made the request voluntarily;

- (b) Request that the patient demonstrate Washington state residency under section 13 of this act; (c) To ensure that the patient is making an informed decision, inform the patient of:
- (i) His or her medical diagnosis;
 - (ii) His or her prognosis;
 - (iii) The potential risks associated with taking the medication to be prescribed;
 - (iv) The probable result of taking the medication to be prescribed; and
 - (v) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control
- (d) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily;
- (e) Refer the patient for counseling if appropriate under section 6 of this act;
- (f) Recommend that the patient notify next of kin;
- (g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed under this chapter and of not taking the medication in a public place;
- (h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the fifteen-day waiting period under section 9 of this act;
- (i) Verify, immediately before writing the prescription for medication under this chapter, that the patient is making an informed decision;
- (j) Fulfill the medical record documentation requirements of section 12 of this act;
- (k) Ensure that all appropriate steps are carried out in accordance with this chapter before writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and
- (l)(i) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, if the attending physician is authorized under statute and rule to dispense and has a current drug enforcement administration certificate; or
- (ii) With the patient's written consent:
- (A) Contact a pharmacist and inform the pharmacist of the prescription; and
 - (B) Deliver the written prescription personally, by mail or facsimile to the pharmacist, who will dispense the medications directly to either the patient, the attending physician, or an expressly identified agent of the patient. Medications dispensed pursuant to this subsection shall not be dispensed by mail or other form of courier.
- (2) The attending physician may sign the patient's death certificate which shall list the underlying terminal disease as the cause of death.

NEW SECTION. Sec. 5. CONSULTING PHYSICIAN CONFIRMATION. Before a patient is qualified under this chapter, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is competent, is acting voluntarily, and has made an informed decision.

NEW SECTION. Sec. 6. COUNSELING REFERRAL. If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or

psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. Medication to end a patient's life in a humane and dignified manner shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

NEW SECTION. Sec. 7. INFORMED DECISION. A person shall not receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision. Immediately before writing a prescription for medication under this chapter, the attending physician shall verify that the qualified patient is making an informed decision.

NEW SECTION. Sec. 8. FAMILY NOTIFICATION. The attending physician shall recommend that the patient notify the next of kin of his or her request for medication under this chapter. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

NEW SECTION. Sec. 9. WRITTEN AND ORAL REQUESTS. To receive a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician at least fifteen days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the qualified patient an opportunity to rescind the request.

NEW SECTION. Sec. 10. RIGHT TO RESCIND REQUEST. A patient may rescind his or her request at anytime and in any manner without regard to his or her mental state. No prescription for medication under this chapter may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

NEW SECTION. Sec. 11. WAITING PERIODS. (1) At least fifteen days shall elapse between the patient's initial oral request and the writing of a prescription under this chapter.

(2) At least forty-eight hours shall elapse between the date the patient signs the written request and the writing of a prescription under this chapter.

NEW SECTION. Sec. 12. MEDICAL RECORD DOCUMENTATION REQUIREMENTS. The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending physician's diagnosis and prognosis, and determination that the patient is competent, is acting voluntarily, and has made an informed decision;

- (4) The consulting physician's diagnosis and prognosis, and verification that the patient is competent, is acting voluntarily, and has made an informed decision;
- (5) A report of the outcome and determinations made during counseling, if performed;
- (6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request under section 9 of this act; and
- (7) A note by the attending physician indicating that all requirements under this chapter have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

NEW SECTION. Sec. 13. RESIDENCY REQUIREMENT. Only requests made by Washington state residents under this chapter may be granted. Factors demonstrating Washington state residency include but are not limited to:

- (1) Possession of a Washington state driver's license;
- (2) Registration to vote in Washington state; or
- (3) Evidence that the person owns or leases property in Washington state.

NEW SECTION. Sec. 14. DISPOSAL OF UNUSED MEDICATIONS. Any medication dispensed under this chapter that was not self-administered shall be disposed of by lawful means.

NEW SECTION. Sec. 15. REPORTING REQUIREMENTS. (1)(a) The department of health shall annually review all records maintained under this chapter.

(b) The department of health shall require any health care provider upon writing a prescription or dispensing medication under this chapter to file a copy of the dispensing record and such other administratively required documentation with the department. All administratively required documentation shall be mailed or otherwise transmitted as allowed by department of health rule to the department no later than thirty calendar days after the writing of a prescription and dispensing of medication under this chapter, except that all documents required to be filed with the department by the prescribing physician after the death of the patient shall be mailed no later than thirty calendar days after the date of death of the patient. In the event that anyone required under this chapter to report information to the department of health provides an inadequate or incomplete report, the department shall contact the person to request a complete report.

(2) The department of health shall adopt rules to facilitate the collection of information regarding compliance with this chapter. Except as otherwise required by law, the information collected is not a public record and may not be made available for inspection by the public.

(3) The department of health shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section.

NEW SECTION. Sec. 16. EFFECT ON CONSTRUCTION OF WILLS, CONTRACTS, AND STATUTES. (1) Any provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, is not valid.

(2) Any obligation owing under any currently existing contract shall not be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner.

NEW SECTION. Sec. 17. INSURANCE OR ANNUITY POLICIES. The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication that the patient may self-administer to end his or her life in a humane and dignified manner. A qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner shall not have an effect upon a life, health, or accident insurance or annuity policy.

NEW SECTION. Sec. 18. CONSTRUCTION OF ACT. (1) Nothing in this chapter authorizes a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. State reports shall not refer to practice under this chapter as "suicide" or "assisted suicide." Consistent with sections 1 (7), (11), and (12), 2(1), 4(1)(k), 6, 7, 9, 12 (1) and (2), 16 (1) and (2), 17, 19(1) (a) and (d), and 20(2) of this act, state reports shall refer to practice under this chapter as obtaining and self-administering life-ending medication. (2) Nothing contained in this chapter shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist or psychologist, or other health care provider participating under this chapter.

Immunities and Liabilities

NEW SECTION. Sec. 19. IMMUNITIES- -BASIS FOR PROHIBITING HEALTH CARE PROVIDER FROM PARTICIPATION- -NOTIFICATION- -PERMISSIBLE SANCTIONS.

(1) Except as provided in section 20 of this act and subsection (2) of this section:

- (a) A person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this chapter. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner;
- (b) A professional organization or association, or health care provider, may not subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter;
- (c) A patient's request for or provision by an attending physician of medication in good faith compliance with this chapter does not constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator; and
- (d) Only willing health care providers shall participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(2)(a) A health care provider may prohibit another health care provider from participating under this act on the premises of the prohibiting provider if the prohibiting provider has given notice to all health care providers with privileges to practice on the premises and to the general public of the prohibiting provider's policy regarding participating under this act. This subsection does not prevent a health care provider from providing health care services to a patient that do not constitute participation under this act.

(b) A health care provider may subject another health care provider to the sanctions stated in this subsection if the sanctioning health care provider has notified the sanctioned provider before participation in this act that it prohibits participation in this act:

(i) Loss of privileges, loss of membership, or other sanctions provided under the medical staff bylaws, policies, and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in this act while on the health care facility premises of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(ii) Termination of a lease or other property contract or other nonmonetary remedies provided by a lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in this act while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(iii) Termination of a contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in this act while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subsection (2)(b)(iii) prevents:

(A) A health care provider from participating in this act while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(B) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions under (b) of this subsection shall follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For the purposes of this subsection:

(i) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider before the provider's participation in this act of the sanctioning health care provider's policy about participation in activities covered by this chapter.

(ii) "Participate in this act" means to perform the duties of an attending physician under section 4 of this act, the consulting physician function under section 5 of this act, or the counseling function under section 6 of this act. "Participate in this act" does not include:

(A) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(B) Providing information about the Washington death with dignity act to a patient upon the request of the patient;

(C) Providing a patient, upon the request of the patient, with a referral to another physician; or

(D) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider’s capacity as an employee or independent contractor of the sanctioning health care provider.

(3) Suspension or termination of staff membership or privileges under subsection (2) of this section is not reportable under RCW 18.130.070. Action taken under section 3, 4, 5, or 6 of this act may not be the sole basis for a report of unprofessional conduct under RCW 18.130.180.

(4) References to “good faith” in subsection (1)(a), (b), and (c) of this section do not allow a lower standard of care for health care providers in the state of Washington.

NEW SECTION. Sec. 20. LIABILITIES. (1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient’s death is guilty of a class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication to end the patient’s life, or to destroy a rescission of a request, is guilty of a class A felony.

(3) This chapter does not limit further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in this chapter do not preclude criminal penalties applicable under other law for conduct that is inconsistent with this chapter.

NEW SECTION. Sec. 21. CLAIMS BY GOVERNMENTAL ENTITY FOR COSTS INCURRED. Any governmental entity that incurs costs resulting from a person terminating his or her life under this chapter in a public place has a claim against the estate of the person to recover such costs and reasonable attorneys’ fees related to enforcing the claim.

Additional Provisions

NEW SECTION. Sec. 22. FORM OF THE REQUEST. A request for a medication as authorized by this chapter shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMAN AND DIGNIFIED MANNER

I,, am an adult of sound mind. I am suffering from, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician. I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care, and pain control. I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and to contact any pharmacist to fill the prescription.

INITIAL ONE:

. I have informed my family of my decision and taken their opinions into consideration.

. I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.
 I understand that I have the right to rescind this request at any time.
 I understand the full import of this request and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.
 I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.
 Signed:
 Dated:

DECLARATION OF WITNESSES

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing the above request:

Witness1 Witness 2
 Initials Initials

- 1. Is personally known to us or has provided proof of identity;
 2. Signed this request in our presence on the date of the person's signature;
 3. Appears to be of sound mind and not under duress, fraud, or undue influence;
 4. Is not a patient for whom either of us is the attending physician.

Printed Name of Witness 1:
 Signature of Witness 1/Date:
 Printed Name of Witness 2:
 Signature of Witness 2/Date:

NOTE: One witness shall not be a relative by blood, marriage, or adoption of the person signing this request, shall not be entitled to any portion of the person's estate upon death, and shall not own, operate, or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

Sec. 23. RCW 42.56.360 and 2007 c 261 s 4 and 2007 c 259 s 49 are each reenacted and amended to read as follows:

- (1) The following health care information is exempt from disclosure under this chapter:
 (a) Information obtained by the board of pharmacy as provided in RCW 69.45.090;
 (b) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;
 (c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510 or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056, for reporting of health care-associated infections under RCW 43.70.056, and notifications or reports of adverse events or incidents made under RCW 70.56.020 or 70.56.040, regardless of which agency is in possession of the information and documents;

- (d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;
 - (ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;
 - (iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;
 - (e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;
 - (f) Except for published statistical compilations and reports relating to the infant mortality review studies that do not identify individual cases and sources of information, any records or documents obtained, prepared, or maintained by the local health department for the purposes of an infant mortality review conducted by the department of health under RCW 70.05.170;
 - (g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1); ((and))
 - (h) Information obtained by the department of health under chapter 70.225 RCW; and
 - (i) Information collected by the department of health under chapter 70.- - RCW (sections 1 through 22, 26 through 28, and 30 of this act) except as provided in section 15 of this act.
- (2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients. Sec. 24. RCW 42.56.360 and 2007 c 273 s 25, 2007 c 261 s 4, and 2007 c 259 s 49 are each reenacted and amended to read as follows:
- (1) The following health care information is exempt from disclosure under this chapter:
 - (a) Information obtained by the board of pharmacy as provided in RCW 69.45.090;
 - (b) Information obtained by the board of pharmacy or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;
 - (c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056, for reporting of health care-associated infections under RCW 43.70.056, and notifications or reports of adverse events or incidents made under RCW 70.56.020 or 70.56.040, regardless of which agency is in possession of the information and documents;
 - (d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

(iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;

(e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;

(f) Except for published statistical compilations and reports relating to the infant mortality review studies that do not identify individual cases and sources of information, any records or documents obtained, prepared, or maintained by the local health department for the purposes of an infant mortality review conducted by the department of health under RCW 70.05.170;

(g) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1); ((and))

(h) Information obtained by the department of health under chapter 70.225 RCW; and

(i) Information collected by the department of health under chapter 70.- - RCW (sections 1 through 22, 26 through 28, and 30 of this act) except as provided in section 15 of this act.

(2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients. Sec. 25. RCW 70.122.100 and 1992 c 98 s 10 are each amended to read as follows:

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing ((or physician-assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying)), lethal injection, or active euthanasia.

NEW SECTION. Sec. 26. SHORT TITLE. This act may be known and cited as the Washington death with dignity act.

NEW SECTION. Sec. 27. SEVERABILITY. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. Sec. 28. EFFECTIVE DATE. This act takes effect one hundred twenty days after the election at which it is approved, except for section 24 of this act which takes effect July 1, 2009.

NEW SECTION. Sec. 29. Sections 1 through 22, 26 through 28, and 30 of this act constitute a new chapter in Title 70 RCW.

NEW SECTION. Sec. 30. CAPTIONS, PART HEADINGS, AND SUBPART HEADINGS NOT LAW. Captions, part headings, and subpart headings used in this act are not any part of the law.

NEW SECTION. **Sec. 31.** Section 23 of this act expires July 1, 2009

APPENDIX 7-3 Recommendations For Canada

Recommendations for Canada

Using Parliament as a way to legalize active euthanasia is problematic for various reasons. First, the issue may only receive two days of debate within the HOC, which is not enough time to have a full debate. The debate on active euthanasia should take longer than two days. The debate is mainly focuses on moral and ethical issues rather than medical and legal issues. Therefore when voting to legalize AE or maintain the status quo politicians are unable to divorce emotions and personal beliefs (religious, moral, etc.). However in order for active euthanasia to receive an adequate debate in Parliament politicians must avoid debating based on their personal beliefs and emotions. They must debate the factual evidence presented to them and must be divorced from emotion. The debate needs to focus on the legal and medical ramifications of maintaining the status quo and the legalization of AE.

The Parliament should consider revising the *Criminal Code* because it is the best available mechanism for legal reform for various reasons. First, because it is federal and comes from Parliament, it provides consistency across all of the provinces and territories. Second, it allows for the creation of a national body that could ensure an accurate and comprehensive picture of what is happening in the area of EOLC (Schuklenk et al 97). Third, it avoids leaving the burden of changing the law on the backs of individuals who wish to access EOLC. It relieves the courts from continually hearing cases on the issue thereby clogging up the courts. Lastly, by revising the *Criminal Code* it provides the greatest level of certainty that Canadians rights to EOLC treatment will be respected (Schuklenk et al 97).

Reform may be in amending prosecution services policy manuals if the federal government/Parliament refuses to revise the *Criminal Code*. The guidelines for the exercise of prosecutorial discretion could imply that in some circumstances in which cases of EOLC will not result in charges of assisted death or murder being laid on a physician. The Crown (prosecutors) has prosecutorial discretion regarding their ability to pursue or withdrawal criminal charges (Schuklenk et al 97). Prosecutorial discretion

can manifest through charging physicians with a lesser offence (for example, manslaughter instead of murder) or withdrawing the charges altogether. This has obvious significant implications because it can mean the difference between no criminal record, a conviction but no jail time, or a conviction and mandatory life sentence in jail for a physician who performs active euthanasia/PAD (Schuklenk et al 97). It is within the mandate of provincial and territorial Attorneys General and prosecution services to establish policies and processes that would not decriminalize active euthanasia/PAD but the provincial government can outline the administration of *Criminal Code* provisions are that are within their provincial or territorial jurisdiction (Schuklenk et al 97).

Provincial and territorial judges the discretion with respect to diverting individuals charged under the *Criminal Code* at the sentencing stage of the process. The independence of the Judge is strong, but limited by the rule of law, such as mandatory minimum sentences (Schuklenk et al 98). The courts can exercise judicial discretion in relation to determinations of how the law applies to the facts of a case, the interpretation of laws, and the authority to seek input and recommendations from third parties (Schuklenk et al 98). Judges have the authority to issue a different approach to sentences, which concurs with the sentencing principles in the *Criminal Code*, for example prison terms, community service and unconditional discharge). As an alternative to the traditional adversarial trial process, a judge can recommend that a defendant take part in an alternative process and then use information from that process to inform the sentencing decision, such as an unconditional or conditional discharge instead of jail time (Schuklenk et al 98).

Using prosecutorial discretion physicians as long as they can prove that the patient was terminally ill and the patient or POA made the request of PAD/active euthanasia may avoid being charged or harshly punished for their participation in this form of EOLC. Physicians may also avoid losing their medical licence, especially if they avoid receiving a criminal conviction (Schuklenk et al 100). In order for physicians to prove that they were acting in the interest of their patients written or other recorded requests are preferable because they can provide reliable evidence that a

patient made a request for active euthanasia/PAD by a patient or guardian. Verbal requests are sufficient, if the request is properly documented (Schuklenk et al 100). The Washington and Oregon models are excellent models of PAD and AE for governments to adopt. The Washington and Oregon models are excellent models documented requests and the delay between the initial request and carrying out the request allows the patient to reconsider this course of treatment.

If the judiciary and/or government legalized active euthanasia and physician-assisted death, physicians would not be obligated to provide assistance. Nevertheless, if they decide not to provide assistance they are obligated to refer the person requesting assistance to a physician who will perform active euthanasia and physician-assisted death.

Another recommendation would be for medical schools to more thoroughly provide education on active euthanasia if it were made legal. However, even if government or the judiciary do not legalize AE and PAD medical schools need to better equip physicians on end-of-life issues. Classes on active euthanasia/PAD should be mandatory for medical students and both sides of the discourse should be represented equally in order for physicians to come to their own conclusions regarding the ethics of AE and PAD. Medical students should be aware that it is legal for them to practice active euthanasia/PAD and it is legal for them to refuse to practice this type of treatment. This means classes must examine what sections of the Physicians Oath accept active euthanasia/PAD as a legitimate form of medical treatment. It is important to educate medical students on active euthanasia/PAD because the more students are educated in active euthanasia/PAD the more willing they are to perform it. Also the more educated they are in active euthanasia/PAD the less likely they are to receive misinformation on the subject and are more likely to gain a more in-depth knowledge on active euthanasia/PAD in order to construct a more rounded belief on the treatment.

Medical students are not the only ones that need to be educated on the subject. Practicing physicians should also be educated on the subject in order to construct their

own views and inform patients of this end-of-life treatment. Medical schools should offer courses in AE and PAD to interested physicians and other health care professionals. Patients need to be informed of PAD/AE as options, what they entail, and the patient's family, especially the patient's POA must be informed.

The last recommendation I would make is for the CMA and other medical associations or societies to make it easier for physicians to perform active euthanasia/PAD by taking a neutral stance on the treatment. If the CMA continues its strong stance against active euthanasia/PAD, it may make many physicians feel uncomfortable in practicing it. The CMA and other associations or societies should leave the decision to the individual physicians while creating association that allows physicians regardless of their beliefs on AE and PAD to feel welcomed and respected.

REFERENCE LIST

- [1] Alexander, Herbert. (2005). Comparative Analysis of Political Party and Campaign Financing in the United States and Canada. Steven Griner and Daniel Zovatto (Eds). *Funding of Political Parties and Election Campaigns in the Americas*. Organization of American States and the International Institute for Democracy and Electoral Assistance, San Jose, Costa Rica, 91-108.
Retrieved from
<http://dspace.cigilibrary.org/jspui/bitstream/123456789/25403/1/Funding%20of%20political%20parties%20and%20election%20campaigns%20in%20the%20Americas.pdf?1>
- [2] AMA. (2001). AMA Code of Medical Ethics. *American Medical Association*. Retrieved from <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page?>
- [3] AMA. (2012). About the AMA. *Alberta Medical Association*. Retrieved from <https://www.albertadoctors.org/about>
- [4] Anderson, Erin, and Anna Mecher Paperny. (16 Nov. 2011). Politicians of all stripes refuse to act on calls to legalize assisted suicide. *The Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/life/health-and-fitness/politicians-of-all-stripes-refuse-to-act-on-calls-to-legalize-assisted-suicide/article4200667/>
- [5] Angus Reid (26 July 2012). Canadians and Britons Would Allow Euthanasia Under Some Conditions. *Angus Reid Public Opinion*. Retrieved from <http://www.angus-reid.com/polls/45951/canadians-and-britons-would-allow-euthanasia-under-some-conditions/>
- [6] Antiel, Ryan, Farr Curlin, C. Christopher Hook, Jon Tilbert. (13 Mar. 2011). The Impact of Medical School Oaths and Other Professional Codes of Ethics. *Archives of Internal Medicine*. Vol. 171 (5), 469-471. Retrieved From doi:10.1001/archinternmed.2011.47.
- [7] “Assisted Suicide ruling to be appealed by Ottawa.” (13 July 2012). *CBC News*. Retrieved from <http://www.cbc.ca/news/canada/story/2012/07/13/pol-cp-federal-appeal-assisted-suicide.html>
- [8] Bailey, Ian. (Nov. 2011). Euthanasia issue won’t be reopened, Justice Minister Rob Nicholson says. *The Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/life/health-and-fitness/euthanasia-issue-wont-be-reopened-justice-minister-rob-nicholson-says/article4200466/>

- [9] Battin, Margaret Pabst. (2005). *Ending Life: Ethics and the Way We Die*. Oxford Press University Press USA. Print
- [9]“BC Woman joins right-to-die lawsuit.” (29 June 2011). *CBC British Columbia*. Retrieved from <http://www.cbc.ca/news/canada/british-columbia/story/2011/06/29/bc-assisted-suicide-taylor.html>
- [10] BCCLA. (20 March 1994). “Assisted Voluntary euthanasia and other end of life decisions”. [Executive Summary]. *British Columbia Civil Liberties Associations*. Part A. Retrieved from http://bccla.org/our_work/assisted-voluntary-euthanasia-and-other-end-of-life-decisions/
- [11] BCCLA. (2013). About. British Columbia Civil Liberties Association. Retrieved from <http://bccla.org/about/>
- [12] BCMA. (2013). Codes of Ethics. *British Columbia Medical Association*. Retrieved from <https://www.bcma.org/about-bcma/code-ethics>
- [13] BCMA. (2013). About the BCMA”. *British Columbia Medical Association*. Retrieved from <https://www.bcma.org/public-links/about-bcma>
- [14] Bell, Stephen. (Oct. 2011). Do We Really Need a New ‘Constructivist Institutionalism’ to Explain Institutional Change? *British Journal of Political Science*, Vol. 41(4), 883-906. Retrieved from DOI: <http://dx.doi.org/10.1017/S0007123411000147>
- [15] Biggs, Hazel. (2000). *Euthanasia, Death with Dignity and the Law*. Hart Publishing. Print
- [16] Bill C-384: An Act to Amend the Criminal Code (right to die with dignity). (2009). 1st Reading 40th Parl., 2nd sess. [Ottawa]; Library of Parliament, 2009. *Parliament of Canada*. Retrieved from <http://www.parl.gc.ca/HousePublications/Publication.aspx?Docid=3895681&file=4>
- [17] Blackburn, Simon.(2005). Oxford Dictionary of Philosophy. *Oxford University Press*. 2nd ed. Print.
- [18] Boudreau, J Donald. (Fall 2011). Physician-Assisted Suicide and Euthanasia: Can You Even Imagine Teaching Medical Students How to End their Patients’ Lives?. *The Permanente Journal*, Vol. 15 (4), 79-84. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3267569/pdf/i1552-5775-15-4-79.pdf>
- [19] Brock, Dan. (1997). Voluntary Active Euthanasia. Eldon Soifer (Ed). *Ethical Issues Perspectives for Canadians*. 2nd ed. Broadview Press Ltd, 1997: 392-409. Print.
- [20] Brooks, Stephen. (2009). Canadian Political Cultural. James Bickerton and Alain-G Gagnon (Ed). *Canadian Politics*. 5th ed. University of Toronto Press, 2009: 45-70.

- [21] Canadian Charter of Rights and Freedoms. (1982). *Constitutional Documents*. Canada. Department of Justice. *Department of Justice*. Print.
- [22] “Canadian Poll finds two-thirds support legalization of Euthanasia.” (24 Feb. 2010). *ARPA Canada*. Retrieved from <http://arpacanada.ca/index.php/issuesresearch/pro-life/849-canadian-poll-finds-two-thirds-support-legalization-of-euthanasia36>
- Callahan, Daniel. (1997). When Self-Determination Runs Amuck. Eldon Soifer (Ed). *Ethical Issues Perspectives for Canadians*. 2nd ed. Broadview Press Ltd, 409-415. Print
- [23] Carmen, Tara. (14 July 2012). Ottawa to appeal BC Supreme Court’s Assisted Suicide ruling. *Vancouver Sun*. Retrieved from <http://www.vancouversun.com/sports/Ottawa+appeal+Supreme+Court+assisted+suicide+ruling/6934409/story.html>
- [24] C&C. (n.d). Our Legislative Work. *Compassion & Choices*. Retrieved from <https://communitycompassionandchoices.org/sslpage.aspx?pid=227>.
- [25] C&C. (2012). Baxter et al v. Montana. *Compassion & Choices*. Retrieved from <https://community.compassionandchoices.org/sslpage.aspx?pid=416>
- [26] C&C. (2013) What We Do. *Compassion & Choices*. Retrieved from <http://www.compassionandchoices.org/what-we-do/>
- [27] CCD. (2009). Council of Canadians With Disabilities (CCD) Oppose Bill C-384. *Council of Canadians with Disabilities*. Retrieved from <http://www.ccdonline.ca/en/humanrights/endoflife/euthanasia/pressreleasebillc384>
- [28] CCD. (2010). Deadly Compassion. *Council of Canadians with Disabilities*. Retrieved from <http://www.ccdonline.ca/en/humanrights/endoflife/euthanasia/deadly-compassion-16june2010>
- [29] CCD. (2013). Human Rights. *Council of Canadians with Disabilities*. Retrieved from <http://www.ccdonline.ca/en/humanrights/>
- [30] Chantal Herbert. (20 Nov. 2011). Parliament out of step with public on euthanasia. *The Chronicle Herald*. Retrieved from <http://thechronicleherald.ca/thenovascotian/34815-parliament-out-step-public-euthanasia>
- [31] Charbonneau, Nadine. (Feb. 2006). Official position of Gilles Duceppe, leader of the Bloc Québécois on euthanasia and assisted suicide. [Newsletter #61]. Euthanasia Prevention Coalition. Retrieved from <http://www.euthanasiaprevention.on.ca/Newsletters/newsletter61.pdf>
- [32] CHPCA. (May 2012). Fact Sheet: Hospice Palliative Care in Canada. *Canadian Hospice Palliative Care Association*. Retrieved from http://www.chpca.net/media/7622/fact_sheet_hpc_in_canada_may_2012_final.pdf

- [33] Clemens, Katri Elina, Eva Klein, Brigit Jaspers, and Eberhard Klaschir. (2008). Attitudes toward active euthanasia among medical students at two German Universities. *Supportive Care in Cancer*, Vol. 16(5), 539-45. Retrieved from DOI: 10.1007/s00520-008-0427-z
- [34] CMA. (2004). CMA Code of Ethics. *Canadian Medical Association*. Retrieved from <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>
- [35] CMA. (2007). Euthanasia and Assisted Suicide. *Canadian Medical Association*. Retrieved from <http://policybase.cma.ca/dbtw-wpd/Policypdf/PD07-01.pdf>
- [36] Cohen, Jonathan S, Stephan D. Fihn, Edward J. Boyko, Albert R. Jonsen, and Robert W. Wood (14 July 1994). Attitude Toward Assisted Suicide and Euthanasia Among Physicians in Washington State. *The New England Journal of Medicine*, Vol. 331(2), 89-94. Retrieved from DOI: 10.1056/NEJM199407143310206
- [37] Constitution Act, 1867, 30 &31 Vict. C 3. *Constitutional Documents*. Canada. Department of Justice. 1867. *Department of Justice*. Print. S. 91 (27)
- [38] “Court upholds B.C. woman’s exemption from doctor- assisted suicide ban”. (10 Aug. 2012). *The Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/news/british-columbia/court-upholds-bc-womans-exemption-from-doctor-assisted-suicide-ban/article4474112/>
- [39] CPNS. (2012). 2011Annual Report. College of Physicians and Surgeons of Nova Scotia, Halifax Nova Scotia. Web. 8 Feb. 2013. Retrieved from <http://www.cpsns.ns.ca/Portals/0/Publications/Annual%20Report/2011-annual-report.pdf>
- [40]Cribb, Robert. (26 Oct. 2012). Physician-assisted suicide remains illegal in Canada. *Toronto Star*. Web. Retrieved from http://www.thestar.com/news/insight/2012/10/26/physicianassisted_suicide_remains_illegal_in_canada.html
- [41] Criminal Code R.S.C 1985 c.C-46. (1985). *Statutes of Canada*. Canada. Department of Justice. *Department of Justice*. Retrieved from <http://laws-lois.justice.gc.ca/PDF/C-46.pdf>
- [42] CURE. (2005). CURE. *Citizens United Resisting Euthanasia*. Retrieved from <http://www.hoover.k12.al.us/hcsnet/rfbms/makessense%207.4/donotopenfolder/implmnt/DONTOPEN/MSSstrats/EssUn/BeliefEU/Eutha.pdf>
- [43] Death with Dignity Act (Sep. 2012). Death with Dignity Act. *State of Oregon*. Retrieved from <http://library.state.or.us/repository/2012/201209260807593/index.pdf>

- [44] Declaration of Geneva. (1948). *General Assembly of the World Medical Association*. Geneva Switzerland. Sept. 1948. Retrieved from [http://www.wma.net/en/30publications/10policies/g1/index.html.pdf?print-media-type&footer-right=\[page\]/\[toPage\]](http://www.wma.net/en/30publications/10policies/g1/index.html.pdf?print-media-type&footer-right=[page]/[toPage])
- [45] DeLeo, Diego, J. Hawgood, and N, Ide. (19 Mar. 2012). Do we need education on right-to-die issues? Medical perspectives from Australia. *Asia-Pacific Psychiatry*, Vol. 4(1), pp. 10-19. Retrieved from DOI: 10.1111/j.1758-5872.2011.00174.x
- [46] Devlin, Kate. (Mar. 2009). One in three doctors support Euthanasia. *The Telegraph*. Retrieved from <http://www.telegraph.co.uk/health/healthnews/5044885/One-in-three-doctors-support-euthanasia.html>
- [47] Dhillon, Sunny. (15 June 2012). "BC Supreme Court Strikes down ban on physician assisted suicide." *The Globe and Mail*. Retrieved from <http://m.theglobeandmail.com/news/british-columbia/bc-supreme-court-strikes-down-ban-on-physician-assisted-suicide/article4267631/?service=mobile>
- [48] Dickinson, George E., and David Field. (2002). Teaching end-of-life issue: current status in the United Kingdom and United States Medical Schools. *American Journal of Hospice and Palliative Medicine*, Vol. 19 (3), 181-86. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/12026041>
- [49] Dickinson, George, David Clark, Michelle Winslow, and Rachael Marples. (Feb. 2005). US physicians' attitudes concerning euthanasia and physician-assisted death: A systematic literature review. *Mortality*, 10(1), 43-52. Retrieved from DOI:10.1080/13576270500030982
- [50] Diermeir, Daniel, and Keith Krehniel. (Apr. 2003). Institutionalism as a Methodology. *Journal of Theoretical Politics*, 15(2), 123-144. Retrieved from DOI: 10.1177/0951629803015002645
- [51] "Doctor in assisted suicide case has no regrets." (22 Aug. 2010). *The Telegraph*. Retrieved from <http://www.telegraph.co.uk/news/uknews/7959311/Doctor-in-assisted-suicide-case-has-no-regrets.html>
- [52] Downie, Jocelyn.(2004). *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada*. University of Toronto Press Incorporated. Print.
- [53] Downie, Jocelyn. (2000). Euthanasia. Jochen Taupitz (Ed). *Regulations of Civil Law to Safeguard the Autonomy of Patients at the End of their Life; An international Document*.. Springer Vertas Berlin Hedelberg, New York. 210-217. Print.

- [54] “Dr. Death in the Clear: Right-to-die GP won’t be charged for aiding cancer sufferer’s suicide.” (25 June 2010). *The Daily Mail Online*. Retrieved from <http://www.dailymail.co.uk/news/article-1289532/Dr-Death-Michael-Irwin-prosecuted-helping-Raymond-Cutkelvin-commit-suicide.html>
- [55] Drews, Keven. (13 Nov. 2011). Dying Woman Challenges Canada’s euthanasia laws. *CTVNews*. Retrieved from <http://bc.ctvnews.ca/dying-woman-challenges-canada-s-euthanasia-laws-1.725348>
- [56] DuBois, James and Jill Burkemper. (2002) Ethics Education in US Medical Schools: A study of Syllabi. *Academic Medicine*, Vol. 77(5), 432-57. Retrieved From <http://www.ncbi.nlm.nih.gov/pubmed/12010705>
- [57] Durkheim, Emile. (1982). “The Rules of Sociological Method”. *Free Press*. Print
- [58] Dworkin, Ronald. (1994). *Life’s Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom*. Vintage Books: Division of Random House Inc. New York. Print
- [59] Elections Canada. (2006). Spending Limits for Election Advertising – 2006 General Election. *Elections Canada*. Retrieved from <http://www.patientsrightscouncil.org/site/funding-watch/>
- [60] Emanuel, Ezekel J, et al. (2000). Attitudes and Practices of U.S. Oncologists regarding Euthanasia and Physician-Assisted Suicide. *Annals of Internal Medicine*, Vol. 133(7), 527-32. Retrieved from <http://annals.org/article.aspx?articleid=713899>
- [61] EPC Admin.(2012) Contact Justice Minister. *Euthanasia Prevention Coalition*. Retrieved from <http://www.epcc.ca/470/>
- [62] EPC. (2013). Purpose. *Euthanasia Prevention Coalition*. Retrieved from <http://www.epcc.ca/about-us/purpose>
- [63] ERGO. (2010). About ERGO. *Euthanasia Research & Guidance Organization*. Retrieved http://www.finalexit.org/what_is_ergo.html
- [64] “Farewell Foundation, Right-To-Die Group, Loses BC Case”. (17 Oct. 2011). *The Huffington Post*. Retrieved from http://www.huffingtonpost.ca/2011/08/17/farewell-foundation-right-to-die_n_929700.html
- [65] Feasby, Colin. (2007). Constitutional Questions About Canada’s New Political Finance Regime. *Osgoode Hall Law Journal*, Vol. 45(3), 517-570. http://www.ohlj.ca/english/documents/OHLJ_45_3_Feasby_FINAL.pdf

- [66] Follow the Money. (2008). I-1000: Assisted Suicide. *Follow the Money*. Table 1. Retrieved from <http://www.followthemoney.org/database/StateGlance/ballot.phtml?m=443>
- [67] Follow the Money. (2008). Contributors Results. *Follow the Money*. Retrieved from <http://www.followthemoney.org/database/search.phtml?searchbox=Euthanasia+Prevention>
- [68] Follow the Money. (2012). Question 2: Massachusetts Compassion & Choices Follow the Money. National Institute on Money in State Politics. Retrieved from www.followthemoney.org/database/StateGlance/committee.phtml?c=11918
- [69] Fosnot, C. (1996). *Constructivism: A Psychological Theory of Learning*. Ed. C Fosnot *Constructivism: Theory perspectives and practices*. Teachers College Press, New York. Print
- [70] Gabel, Kevin, Saul Miller, Jeffery So, Andrew Sues. (2005). Examining Medical Student Attitudes toward Physician-Assisted Suicide. *McGill Journal of Medicine*, Vol., 8(2), 122-26. Retrieved from http://www.medicine.mcgill.ca/MJM/issues/v08n02/orig_articles/82122.pdf
- [71] Gatner, Joseph A. (1980). In Pursuit of Public Opinion: Politics of Pressure Groups. *Canadian Parliamentary Review*, Vol., 3(1), 32-36. http://www.revparl.ca/3/3/03n3_80e_Gatner.pdf
- [72] Gorman, Daniel. (23 Mar. 1999). Active and Passive Euthanasia: the Case of Drs. Claude, De la Roche, and Nancy Morrison. *Canadian Medical Journal*, Vol. 160(6), 857. Retrieved from <http://www.cmaj.ca/content/160/6/857.full.pdf>
- [73] Gorsuch, Neil M. (2006). *The Future of Assisted Suicide and Euthanasia*. Princeton University Press. Print
- [74] Gouras, Matt. (31 Dec. 2009). Montana Third State to Allow Doctor-Assisted Suicide. *Flathead Beacon*. Retrieved from http://www.flatheadbeacon.com/articles/article/montana_third_state_to_allow_doctor-assisted_suicide/15086
- [75] Gurney, Matt. (22 Mar. 2012). Euthanasia a right long denied. *National Post*. Retrieved from <http://fullcomment.nationalpost.com/2012/03/22/matt-gurney-euthanasia-a-right-long-denied/>
- [76] Hebert, Chantal. (20 Nov. 2011). Parliament out of step with public on euthanasia. *The Chronicle Herald*. <http://thechronicleherald.ca/thenovascotian/34815-parliament-out-step-public-euthanasia>

- [77] Hein, George E. (15-22 October 1991). Constructivist Learning Theory: The Museum and the Needs of the People. Paper Contributed to the CECA (International Committee of Museum Educators), Conference, Jerusalem Israel. *Institute for Inquiry*. Retrieved from <http://www.exploratorium.edu/ifi/resources/constructivistlearning.html>
- [78] Helmke, Gretchen, and Steven Levitsky.(Sep. 2003). Informal Institutions and Comparative Politics: A Research Agenda. Working Paper #30. *Kellogg Institute*. Retrieved from <http://kellogg.nd.edu/publications/workingpapers/WPS/307.pdf>
- [79] Hendrix, Jerry A., Darrell C. Hayes. (2009). *Public Relations Cases*. Cengage Learning. 8th ed. Print
- [80] Hume, Mark. (16 Nov. 2011).“Famous medical ethics lecturer’s credentials challenged in euthanasia case”. *The Globe and Mail*. <http://www.theglobeandmail.com/life/health-and-fitness/famous-medical-ethics-lecturers-credentials-challenged-in-euthanasia-case/article4200668/>
- [81] Hume, Mark. (8 Dec. 2011). Government lawyer draws line between euthanasia and war. *The Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/life/health-and-fitness/government-lawyer-draws-line-between-euthanasia-and-war/article4247245/>
- [82] Hurst. Samia A., and Alex Mauron.(1 Feb. 2003). Assisted Suicide and Euthanasia in Switzerland allowing a role for non-physicians. *British Medical Journal*, Vol. 326, 271-73. Retrieved from DOI: <http://dx.doi.org/10.1136/bmj.326.7383.271>
- [83] Johnson, Kirk. (31 Aug 2009). Montana Court to Rule on Assisted Suicide Case. *New York Times*. Retrieved from http://www.nytimes.com/2009/09/01/us/01montana.html?_r=0
- [84] Karlsson, Murit, Anna Milberg, and Peter Strang. (2000). Dying with Dignity according to Swedish Medical Students. *Supportive Care in Cancer*, Vol. 14, 334-39. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/16231123>
- [85] “Kevorkian released from prison after 8 years”. (1 June 2007). *NBCNews*. <http://www.nbcnews.com/id/18974940/>
- [86] Keown, John. (2002). *Euthanasia, Ethics, and Public Policy: An Argument against legislation*. Cambridge University Press. Print
- [87] Koelble, Thomas A. (Jan. 1995). The New Institutionalism in Political Science and Sociology. *Comparative Politics*, Vol. 27 (2), 231-243. Retrieved from <http://www.jstor.org/discover/10.2307/422167?uid=3739432&uid=2129&uid=2&uid=70&uid=3737720&uid=4&sid=21101928613917>

- [88] Kon, Alexander A. (2011). Palliative Sedation: It's not a Panacea. *The American Journal of Bioethics*, Vol. 11(6), 41-2. Retrieved from DOI:10.1080/15265161.2011.577513
- [90] Kotalik, Jaro. (n.d.). Euthanasia and Assisted Suicide. *Royal College of Physicians and Surgeons*. Section 5.2. Retrieved from http://www.royalcollege.ca/portal/page/portal/rc/common/documents/bioethics/section5/case_5_2_e.html
- [89] Labranche, Leslie. (3 Nov. 2009). The Collège des médecins du Québec Reveals Its Reflections on End-of-Life Care. *Collège des médecins du Québec*. Retrieved from <http://www.cmq.org/en/etudiantsresidents/profil/commun/Nouvelles/2009/2009-11-03/communiqu.aspx>
- [90] Lewin, Adrienne Mand. (17 Jan. 2006). Supreme Court Upholds Oregon Assisted Suicide Law. *Good Morning America: ABC*. Retrieved from <http://abcnews.go.com/GMA/SupremeCourt/story?id=1514248>
- [91] Liberal Biennial Convention, (January 13-15). 120. Support of Euthanasia. 2012, Ottawa, Ontario. The Federal Liberal Agency of Canada; Liberal Party of Canada. Retrieved from <http://convention.liberal.ca/health-2/120-support-of-euthanasia/>
- [92] Lloyd-Williams M. and N. Dagra. (2004). Attitudes of preclinical Medical Students towards caring for Chronically Ill and Dying patients does palliative care teaching make a difference. *Postgrad Medical Journal*, Vol. 88 (1040), 31-34. Retrieved from DOI: 10.1136/pmj.2003.009571
- [93] Lowndes, Vivien. (1997). Change in public service management: New institutions and new managerial regimes. *Local Government Studies*, Vol. 23(2), 42-66. Retrieved from DOI:10.1080/03003939708433864
- [94] Lowy, Frederick, Douglas M. Sawyer and John R. Williams. (1993). *Canadian Physicians and Euthanasia*. Canadian Medical Association. Print
- [95] Lunge, Robin, Maria Royle, and Michael Slater. (2004). Oregon's Death with Dignity law and Euthanasia in the Netherlands: Factual Disputes. *Vermont Legislative Council*. Retrieved from http://www.leg.state.vt.us/reports/04death/death_with_dignity_report.htm
- [96] MacLachlan, Richard A., and Phillip C Herbert. (Feb. 2000) Statement concerning euthanasia and physician-assisted suicide. *Canadian Family Physician*. Vol.46. 254-56. Web. 4 June 2012.
- [97] Manning, Michael M.D. (1998). *Euthanasia and Physician-Assisted Suicide: Killing or Caring?*. Paulist Press. Print

- [98] March, James G., and Johan P. Olsen. (Sep. 1984). The New Institutionalism: Organizational Factors in Political Life. *The American Political Science Review*, Vol. 78(3), Sep., 1984: 734-749. Retrieved from DOI: <http://dx.doi.org/10.2307/1961840>
- [99] McCuen, Gary E. (1994). *Doctor Assisted Suicide and the Euthanasia Movement*. Gary E. McCuen Publications Inc USA. Print
- [100] McDougall, Jennifer Fecio, Martha Gorman. (2008). *Euthanasia*. 2nd ed. ABC – CLIO Santa Barbara Cal. Print
- [101] Medicine Act S.O. 1991. Ch 30. Ontario. *Consolidated Laws*. 15 Dec. 2009. Retrieved from https://www.e-laws.gov.on.ca/.../elaws_statutes_91m30_e.doc
- [102] Meier, Diane E., Sean Morrison, and Christie K Cassel. (1 Aug. 1997). Improving Palliative Care. *Annals of Internal Medicine*, Vol. 127(3), 225-30. Retrieved from <http://annals.org/article.aspx?articleid=710731>
- [103] Miles, Stephen H. (2004). *The Hippocratic Oath and the Ethics of Medicine*. Oxford Press, Inc., New York, NY. Print
- [104] Monpetit, Eric. Are Interest Groups Useful or Harmful??. *Canadian Politics*. Eds. James Bickerton and Alain-G Gagnon. 5th ed. University of Toronto. 265-81. Print.
- [105] Monroe, Kristen Remwick. (1991). The Theory of Rational Action: What Is It? How Useful Is It for Political Science?. Ed. William J. Crotly. *Political Science: The Theory and Practice of Political Science*. Northwestern University Press. 77-98. Print
- [106] “Nancy Morrison reprimanded by doctors governing body” (10 Nov. 2000). *CBC News Canada*. Retrieved from <http://www.cbc.ca/news/canada/story/1999/03/30/morrison990330.html>
- [107] National Governors Association. (2011). Oregon: Past Governors Bio. *National Governors Association*. Retrieved from http://www.nga.org/cms/home/governors/past-governors-bios/page_oregon.html
- [108] Nicol, Julia, Melissa Tiedemann, and Dominique Valiquet. (3 Dec. 2010). Euthanasia and Assisted Suicide in Canada. Ottawa, Canada *Library of Parliament*. Publication No 2010-68-E. Retrieved from <http://www.parl.gc.ca/Content/LOP/researchpublications/919-e.pdf>
- [109] Odgen, Russell D., and Michael G. Young. (1998). Euthanasia and Assisted Suicide: A Survey of Registered Social Workers in British Columbia. *British Journal of Social Work*, Vol.28 (2), 161-75. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/14626254>

- [110] Olukoya A.A. (1983). Attitudes of Medical Students to medical ethics in their curriculum. *Medical Education*, Vol. 17, 83-6. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/6843394>
- [111] OMA. (2013). About the OMA". *Ontario Medical Association*. Retrieved from <https://www.oma.org/About/Pages/default.aspx>
- [112] Open Parliament (2010). Bill C-384 (Historical). *Open Parliament*. 1-4. Retrieved from <http://openparliament.ca/bills/40-3/C-384/>
- [113] Open Secrets. (2011). Compassion & Choices. *Open Secrets: Center for Responsive Politics*. Retrieved from <http://www.opensecrets.org/lobby/clientsum.php?id=D000044766>
- [114] O'Reilly, Kevin B. (18 Jan. 2010). Physician-assisted suicide legal in Montana, court rules. *American Medical Association*. Retrieved from <http://www.amednews.com/article/20100118/profession/301189939/6/>
- [115] O'Reilly, Kevin B. (1 Apr. 2011). Medical oaths less of a moral compass for physicians. *American Medical News*. Retrieved from <http://www.amednews.com/article/20110401/profession/304019996/8/>
- [116] Ostgathe, Christoph, Raymond Voltz, Friedemann Nauck, and Eberhard Klaschik. (2007) Undergraduate training in palliative medicine in Germany: what effect does a curriculum without compulsory palliative care have on medical students' knowledge, skills and attitudes?. *Palliative Medicine*, Vol. 21, 155-56. Retrieved from DOI: 10.1177/0269216306075543
- [117] Palmer, Jason. (2011). Religion may become extinct in nine months study says. *BBC*. Retrieved from <http://www.bbc.co.uk/news/science-environment-12811197>
- [118] Pascale C. Gruber, Charles D. Gomersall, Gavin M. Joynt, Anna Lee, Pui Yin Grace Tang, Adelina Shuan Young, Nga Yui Florrie Yu, and Oi Ting Yu (2008). Changes in Medical Students: Attitude Towards End-of-Life Decisions Across Different Year of Medical Training. *Journal of General Internal Medicine*, Vol. 23 (10), 1608-14. Retrieved from DOI: 10.1007/s11606-008-0713-y
- [119] PBS. (2012). Chronology of Dr. Jack Kevorkian's Life and Assisted Suicide Campaign. *The Public Broadcasting System*. Retrieved from <http://www.pbs.org/wgbh/pages/frontline/kevorkian/chronology.html>
- [120] Perreux, Les. (7 Sep. 2010). Quebec euthanasia inquiry hears gruelling tales of suicide. *The Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/life/health-and-fitness/quebec-euthanasia-inquiry-hears-gruelling-tales-of-suicide/article4200465/>

- [121] Peters, B, Guy. (2005) Institutional Theory in Political Science: The New Institutionalism. *Continuum International Publishing Group*. Print
- [122] PRC. (2008).Funding for Washington State Assisted Suicide Initiative. *Patients Rights Council*. Retrieved from <http://www.patientsrightscouncil.org/site/funding-watch/>
- [123] PRC. (2013). About the Patients Rights Council. *Patients Rights Council*. Retrieved from <http://www.patientsrightscouncil.org/site/about-the-prc/>
- [124] Presthus, Robert. (May 1997). Interest Group Lobbying: Canada and the United States. *The Annals of the American Academy of Political and Social Science*, Vol. 413(1), 44-57. Retrieved from DOI: 10.1177/000271627441300105
- [125] Priest, Lisa. (06 Sep. 2012). How much does dying cost Canadians?. *The Globe and Mail*. Retrieved from <http://m.theglobeandmail.com/life/health-and-fitness/how-much-does-dying-cost-canadians/article554853/?service=mobile>
- [126] Pross, Paul A. (1992). *Group Politics and Public Policy*. 2nd ed. Oxford University Press, Canada, Toronto. Print.
- [127] “Quebec Specialists Support legalizing Euthanasia”. (13 Oct. 2009). *CBC News Montreal*. Retrieved from <http://www.cbc.ca/news/canada/montreal/story/2009/10/13/quebec-md-spec-euthanasia.html>
- [128] Richardson, Virginia. (1997). Constructivist Teaching and Teacher Education: Theory and Practice. Virginia Richardson Ed. *Constructivist Teacher Education: Building a World of New Understandings*. Psychology Press. 3-13. Print
- [129] Rietjens, Judith, Paul J. van der Maas, Bregje D. Onwuteaka-Philipsen, Johannes J. M. van Delden, and Agnes van der Heide. (2009). Two Decades of Research on Euthanasia from the Netherlands. What Have We Learnt and What Questions Remain?. *Bioethical Inquiry*, Vol. 6(3), 271-83. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2733179/>
- [130] Riker, William H. (1995). The Political Psychology of Rational Choice Theory. *Political Psychology*, Vol. 16(1), 23-44. Retrieved from <http://www.jstor.org/stable/3791448>
- [131] Rodriguez v. British Columbia (A.G.) 3 S.C.R. 519. (1993). Retrieved from <http://scc.lexum.org/decisia-scc-csc/scc-csc/scc-csc/en/item/1054/index.do>

- [132] Suarez-Almazor, Maria Catherine Newman, John Hanson, Eduardo Bruera. (15 Apr. 2002). Attitudes of Terminally Ill Cancer Patients About Euthanasia and Assisted Suicide: Predominance of Psychosocial Determinants and Beliefs Over Symptom Distress and subsequent Survival. *Journal of Clinical Oncology*, Vol. 20 (8), 2134-41. Retrieved from
DOI: 10.1200/JCO.2002.08.023
- [133] Schafer, Arthur. (23 Aug. 2012). The great Canadian euthanasia debate. *The Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/life/health-and-fitness/the-great-canadian-euthanasia-debate/article4200477/>
- [134] Schildmann, January, Eva Hermann, Nicole Burchardi, Ulrich Sohwantes, Jochen Vollmann. (2006). Physicians Assisted Suicide: Knowledge and Views of fifth-year Medical students in Germany. *Death Studies*, Vol. 30, 29-39. Retrieved from
DOI:10.1080/07481180500236693
- [135] Schmidt, Vivien. (2008). "Discursive Institutionalism: *The Explanatory Power of Ideas and Discourse*". *Annual Review of Political Science*, Vol. 11, 303-26. Retrieved from
DOI: 10.1146/annurev.polisci.11.060606.135342
- [136] Schuklenk, Udo. (6 Sep. 2012). The assisted suicide Dilemma. *The Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/commentary/editorials/the-assisted-suicide-dilemma/article594080/?page=all>
- [137] Schuklenk, Udo, Johannes SM Van Delden, Jocelyn Downie, Shelia McLean, Ross Upstiar, Daniel Weistock. (Nov. 2011). The Royal Society of Canada Expert Panel End-of-life Decision. *Royal Society of Canada*. Retrieved from http://rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf
- [138] Scott, John. (2000). Rational Choice Theory. Eds. Gary Browning, Abigail Halcli, and Frank Webster, *Understanding Contemporary Society: Theories of the Present*. Sage Publications Ltd, 126-138. Print.
- [139] Silving, Helen. (Dec. 1954). Euthanasia; A Study in Comparative Criminal Law. *University of Pennsylvania Law Review*, Vol. 103 (3), 350-89. Retrieved from <http://www.jstor.org/stable/3310143>
- [140] Simon, Herbert A. (1955). A Behavioral Modes of Rational Choice. *The Quarterly Journal of Economics*. Vol. 69(1), 99-118. Retrieved from <http://links.jstor.org/sici?sici=0033-5533%28195502%2969%3A1%3C99%3AABMORC%3E2.0.CO%3B2-A>
- [141] SMA. (2009). About SMA. *Saskatchewan Medical Association*. Retrieved from <https://www.sma.sk.ca/Default.aspx?cid=2&lang=1>

- [142] Smith, Miriam. (2008). Interest Groups and Social Movements. Eds. Michael Whittington and Glen Williams. Canadian Politics in the 21st Century. 7th ed. Nelson: Thomson of Canada, Toronto, Canada. Print
- [143] Sniderman, Andrew Stobo. (21 Aug. 2012). Harper v. Judges: The biggest issues facing the country are being tackled not by Parliament but in court. MacLeans.CA. Retrieved from <http://www2.macleans.ca/2012/08/21/harper-v-the-judges/>
- [144] Sommerville, A. (Apr. 1996). Euthanasia: the institutional response. British Medical Association, London UK, Vol. 52(2), 308-316. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/8759228>
- [145] Stanford Encyclopedia. (2011). Social Institutions. *Stanford Encyclopedia of Philosophy*. Retrieved from <http://plato.stanford.edu/entries/social-institutions/>.
- [146] Starks, Helen. (2010). Washington Death with Dignity Act Overview of the Law & Report of 1st Year (2009) Data. University of Washington Dept. of Bioethics & Humanities. [PowerPoint slides]. Retrieved from http://depts.washington.edu/bhdept/WDDA_Overview_03-12-10.pdf
- [147] Sterling, Terry Greene. (22 Apr. 2011). Lawrence Egbert: Suicide Doctor's Lucky Break. The Daily Beast. Retrieved from <http://www.thedailybeast.com/articles/2011/04/22/lawrence-egbert-suicide-doctor-acquitted.html>
- [148] Stronegger, Willibald J.,Christin Schmölder, Éva Rásky, Wolfgang Freidl. (2011). Changing attitudes towards euthanasia among medical students in Austria. *Journal of Medical Ethics*, Vol. 37(4), 227-29. Retrieved from DOI:10.1136/jme.2010.039792
- [149] Sullivan, Patrick. (16 Oct. 2009). CMA reiterates opposition to euthanasia, assisted suicide. Canadian Medical Association. Retrieved from http://www.cma.ca/index.php?ci_id=10043406&la_id=1
- [150] Sullivan, Patrick. (8 Feb. 2013). Physician views' end-of-life issues vary widely: CMA Survey Canadian Medical Association. Retrieved from http://www.cma.ca/index.php?ci_id=205556&la_id=1
- [151] Sullivan, Sean. (14 Nov. 2011). B.C. Court to hear Challenge to assisted-suicide law. Global B.C News. Retrieved from <http://www.globaltvbc.com/bc+court+to+hear+challenge+to+assisted-suicide+laws/6442521283/story.html>
- [152] Suicide Act 1961 Ch 60 9 and 10 Eliz 2. UK Public General Acts. Retrieved from <http://www.legislation.gov.uk/ukpga/Eliz2/9-10/60>

- [153] “The 2011 election campaign.” (10 May 2011). *The Interim*. Retrieved from <http://www.theinterim.com/issues/the-2011-election-campaign/>
- [154] The Oregon Death with Dignity Act Ch 127. (1994). *Oregon Revised Statute*. Retrieved from <http://public.health.oregon.gov/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/ors.aspx>
- [155] The OMA. (2011). About OMA. *Oregon Medical Association*. Retrieved from <http://www.theoma.org/about>
- [156] The OMA. (7 May 2011). Physician Assisted Suicide. *Oregon Medical Association*. Retrieved from http://www.theoma.org/sites/default/files/documents/pas_compliance.pdf
- [157] The Washington Death with Dignity Act. [2009 c 1 § 1 (Initiative Measure No. 1000, approved November 4, 2008)]. *Washington State Legislature*. Retrieved from <http://apps.leg.wa.gov/rcw/default.aspx?cite=70.245&full=true>
- [158] Tiedemann, Melissa, and Dominique Valiquet (17 July 2008). Euthanasia and Assisted Suicide: International Experiences PRB 07-03E. *Current Issue Review: Parliamentary Information and Research Service, Library of Parliament*. Retrieved from <http://www.parl.gc.ca/Content/LOP/researchpublications/919-e.pdf>
- [159] Tuns, Paul. (22 June 2010). Euthanasia bill soundly defeated. *The Interim*. <http://www.theinterim.com/issues/euthanasia-suicide/euthanasia-bill-soundly-defeated/>
- [160] Tyson, Peter. (27 Mar. 2001). The Hippocratic Oath Today. *PBS Nova*. Retrieved from <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>
- [161] Vaughan, Diane.(1998). Rational Choice, Situated Actions, and the Social Control of Organizations. *Law and Society Review*, Vol. 32 (1), 23-61. Retrieved from http://pdf.aminer.org/000/326/473/it_alternatives_to_social_control_in_organizations.pdf
- [162] Vodicka, Bruce. (8 Mar. 1976). Medical Discipline Part VIII Procedural Matter. *Journal of the American Medical Associations*, Vol.235 (10), 1051-53. Retrieved from DOI: 10.1001/jama.1976.03260360051032
- [163] VonGlaserfeld, E. (1995). A Constructivist Approach to Teaching. Eds. L. Steffie and J. Gale. *Constructivism In Education*. Laverence Eribaum Associations Inc., New Jersey, 3-16. Print.
- [164] “Vote no. 34”. (21 Apr. 2010). Sitting no. 30 40th Parl. 3rd sess. Ottawa. Chamber of Business.. *Parliament of Canada*. Retrieved from <http://www.parl.gc.ca/HouseChamberBusiness/ChamberVoteDetail.aspx?Language=E&Mode=1&Parl=40&Ses=3&Vote=34>

- [165] “Voter turnout inches up to 61.4%.” (3 May 2011). *CBC News*. Retrieved from <http://www.cbc.ca/news/politics/canadavotes2011/story/2011/05/03/cv-election-voter-turnout-1029.html#>
- [166] PRC. (n.d.). Washington. *Patients Rights Council*. Retrieved from <http://www.patientsrightscouncil.org/site/washington/>
- [167] Weber, Martin, Seven Schmiedel, Friedermann Nauck, and Bernard Alt-Epping. (2011). Knowledge and attitude of final year medical students in Germany towards palliative care in an interinstitutional questionnaire-based study. *BMC Palliative Care*, 10 (19), 2-7. Retrieved from DOI 10.1186/1472-684X-10-19.
- [168] Wilcox, Clyde. (2005). Campaign Finance Law Enforcement in Canada and the US. Steven Griner and Daniel Zovatto (Eds). *Funding of Political Parties and Election Campaigns in the Americas*. Organization of American States and the International Institute for Democracy and Electoral Assistance. San Jose, Costa Rica, 123-32. Print
- [169] WSMA (1984). WSMA Principles of Medical Ethics. *Washington State Medical Association*. Retrieved from <https://www.wsma.org/policies>
- [170] WSMA (June 2012). Washington State Medical Association: Policy Compendium. *Washington State Medical Association*. Retrieved from http://www.wsma.org/Media/AboutWSMA-pdfs/policy_compendium_2012.pdf
- [171] UWO. (2010-11). Year 4 – MEDS 2011 Transition Handbook 2010-2011. *University of Western Ontario: Schulich Medical Dentistry. University of Western Ontario*. Retrieved from <http://www.schulich.uwo.ca/medicine/undergraduate/year4/files/Year3and4/TransitionHandbook.pdf>