Towards the right to be killed?

Treatment refusal, assisted suicide and euthanasia in the United States and Canada

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This chapter describes some dominant trends of American and Canadian law in relation to treatment refusal, physician-assisted suicide and euthanasia. Although common law in both countries recognizes the right of patients to refuse treatment, problems have arisen, especially in the US, over treatment refusal on behalf of incompetent patients. One response has been to enact advance-directive legislation, promoting the use of living wills and proxy appointments. Courts have also specified criteria for withholding and withdrawing treatment from incompetent patients. The notion of a ‘right to die’, developed in court cases on treatment refusal, is now being invoked to support the legalization of assisted suicide. Courts are generally reluctant to recognize an extension of this right. Debates and court cases following the recent initiative to legalize assisted suicide in Oregon and the Sue Rodriguez case in Canada’s Supreme Court, which resulted in a special report of a Canadian Senate Committee, are of major importance for the development of law in this area.

The recent abundance of conflicting lawsuits, legislative initiatives and legal-ethical literature on end-of-life decisions indicate how fiercely Americans are divided on the issue of medical involvement in death. This chapter deals with two aspects: (1) treatment refusal; and (2) physician-assisted suicide and euthanasia. The distinction between these two issues is generally made by courts and in jurisprudence. Legal disputes surrounding end-of-life decisions focused originally on treatment refusal; trendy notions such as ‘the right to die’, now invoked to defend assisted suicide and euthanasia, were developed in that context. A sound discussion of assisted suicide and euthanasia requires some basic knowledge about the law on withholding or withdrawing treatment. Too often, it is argued that the law actually ‘forces’ terminally ill or vegetative patients to continue life or even ‘causes’ unbearable suffering. Polls in the US and Canada indicate that a majority in both countries support assisted suicide and euthanasia. But are they really informed about the current state of the law in relation to treatment refusal? This chapter provides some basic information on the law in the US and in Canada.
Treatment refusal, assisted suicide and euthanasia under American law

Withholding and withdrawing treatment

The right to refuse treatment under common law and constitutional law. American common law recognizes that every patient possesses the right of bodily self-determination. In the 1985 Conroy case, the New Jersey Supreme Court described the right of possession of and control over one's body as the most 'sacred right' guarded by common law. This right has been linked with the common-law doctrine of informed consent. Physicians who impose medical treatments without the consent of patients commit the tort of battery. Under common law, therefore, patients are clearly empowered to refuse medical treatment—even when such treatment might save their lives. The existence of a constitutional right to refuse treatment is less clear. In earlier cases, it was often argued that both federal and state constitutions protected the right to privacy and that this right included the right to refuse medical treatment. In 1990, in Cruzan vs Director, Missouri Department of Health, however, the US Supreme Court rejected this point of view. For the sake of argument alone, the Court stated that if there were a constitutional basis for the right to refuse treatment, it would have to be found under the fourteenth amendment's 'liberty interest'. Even though it thus questioned the constitutional character of this right, some still invoke the Cruzan case as the recognition of a constitutional 'right to hasten a person's inevitable death'. The discussion is not without importance. If it were a constitutional right, after all, the freedom of states to regulate end-of-life decisions would be seriously limited. If not, it is really left to the 'laboratory of the states'—who have jurisdiction over this matter—to do so.

Whether a constitutional right or only a common law right, the courts always recognized that the right to refuse treatment is not absolute. Countervailing state interests can justify its restriction. They include: preserving life, preventing suicide, maintaining the integrity of the medical profession and protecting innocent third parties. The state's interest in preserving life is the most common justification for intervention. It contains both a general notion of the sanctity of life and an interest in maintaining individual lives. When confronted with cases of treatment refusal, courts must carefully balance individual against state interests. The intrusiveness of any medical intervention and its prognosis are key factors in this balancing of interests. The right to refuse treatment becomes more forceful when the chances of recovery are diminishing and the degree of bodily invasion increases. On the basis of these criteria, courts have had few problems in recognizing that...
Towards the right to be killed?

competent patients who are terminally ill have the right to refuse medical treatment. There is more uncertainty as to, on the one hand, the right of competent but not terminally ill patients and, on the other hand, incompetent patients.

Many of the cases of competent but not terminally-ill patients have to do with the refusal of blood transfusions by Jehovah’s Witnesses. In one early case, a court made the interests of a 7-month-old child (in having a mother) prevail over those of its mother, a Jehovah’s Witness who refused to receive blood. Other state courts, however, respected refusals of blood transfusion, even when it involved parents with young children. More recently, in 1993, a quadriplegic prisoner’s right to refuse feeding and medical treatment was also recognized by the California Supreme Court, even though the patient was not terminally ill.

Incompetent patients’ right to forego treatment can be exercised, on their behalf, by proxy decision makers or on the basis of living wills. In the Cruzan case, however, the US Supreme Court ruled that states may impose strict standards of proof for determining what incompetent patients would have wanted. Nancy Cruzan was lingering in a permanent vegetative state as the result of a car accident. Her parents requested to terminate her life support. Because Missouri, where Cruzan was hospitalized, requires ‘clear and convincing evidence’ of patients’ preferences, this was rejected. The Supreme Court thus allowed states to employ a so called ‘subjective test’ for determining whether treatment of incompetent individuals may be foregone. According to this subjective test, decisions on behalf of incompetent patients must be based on previously expressed preferences. How clear the expression must be has been approached differently by various courts and legislators. A written document is obviously strong evidence, but other factors are also taken into consideration by the courts. These include previous statements, the maturity of patients at the time statements were made, religious views, a pattern of treatment decisions and so on.

Very often, patients have not expressed their preferences clearly. Some state courts refuse to consider quality-of-life factors in deciding for incompetent patients. Others invoke their best interest and seek a balance between those and the state’s interest in protecting life. In this approach, which has been labelled as the ‘objective test’, treatment may be withheld or withdrawn if the burdens of treatment clearly outweigh the benefits of further life. The medical diagnosis and prognosis, the degree of physical pain and suffering and the intrusiveness of the treatment are key factors in assessing the best interests of patients. These criteria might seem problematic when applied in the case of patients in a persistent vegetative state, who are not in severe pain and, if fed and hydrated, are not close to death. Nevertheless, many courts have
Euthanasia

decided that their life support and food may be withheld due to their poor quality of life and negative medical prognosis\textsuperscript{3}.

\textit{Legislative initiatives: advance-directive legislation} The last decades have seen an escalation of advance directive legislation. Legislative intervention became necessary because of reluctance by physicians to withhold or withdraw treatment. This was partly due to their fear of massive liability claims under American law, which induced them to seek court approval before respecting a family’s wish to halt treatment. The emphasis on personal autonomy by the courts and the tendency to recreate the ‘real’ will of incompetent patients has contributed to the decay of traditional proxy decision making. Federal and state legislators have been forced to turn the wheel by explicitly regulating advance directives.

Under the Constitution, the federal government has in principle no jurisdiction over advance-directive legislation. Nevertheless, it has tried to interfere in this matter on the basis of its spending power. The federal Patient Self-Determination Act of 1991\textsuperscript{14} aims at promoting the use of written instructions for future health-care preferences in order to facilitate treatment decisions for incompetent patients. It dictates that all health-care institutions receiving federal funding must inform patients about the advance-directive legislation of their state and the possibility of refusing treatment. Although it is doubtful that this Act will really stimulate patients to draft advance directives, providing the information might indeed be essential. Every state has its own advance directive legislation and large discrepancies exist from one to another\textsuperscript{12,15}. Two types of directive have been introduced: living wills and proxy appointments (also called ‘health care agent’ or ‘durable power of attorney’). The former regulate how written treatment preferences (living wills) are to be established and to what extent they are binding. The latter determine how surrogate decision makers are appointed, what their powers are and how they make treatment decisions. Although most states have statutes dealing with both living wills and the designation of a proxy, two states (Alabama and Alaska) explicitly authorize only the use of living wills and three (Massachusetts, Michigan and New York) have only proxy legislation\textsuperscript{16}. Discrepancies between statutes involve both the formal requirements of advance directives and their substance. Several statutes permit only removal of ‘life-sustaining procedures’ for the ‘terminally ill’, for example, and others still differentiate artificial hydration and nutrition from other medical treatments, contrary to current doctrine and case law\textsuperscript{3,12}. Most prohibit even withdrawal or withholding of treatment in case of pregnancy, although this might violate women’s constitutional rights\textsuperscript{12,15}. Advance directives help reduce conflicts among physicians, patients and families but cannot eradicate
Towards the right to be killed?

them, because most people do not have these directives\textsuperscript{16,17}. Fortunately, 24 states have now enacted legislation stipulating that, in the absence of advance directives, family members, in some states even friends, may act as surrogate decision makers\textsuperscript{12}.

**Active euthanasia and physician-assisted suicide: is there a constitutional right to assisted suicide?**

Active euthanasia, the direct killing of another person, remains prohibited under the criminal law of all states. Whether done at the victim’s request or not and whatever the motives, killing another person can lead to charges of murder, manslaughter or homicide\textsuperscript{18}. Initiatives to legalize euthanasia in Washington (1991) and California (1992) were rejected in popular votes by 54\% majorities\textsuperscript{18,19}.

Right-to-die organizations have chosen assisted suicide as the first station on the road to legalizing euthanasia. A legal battle is being fought on this issue, which is still a crime in most states. According to the Hemlock Society, 42 states prohibit assisted suicide, either under their statutory or common law, although the law is unclear in another 7 states\textsuperscript{20}. The only state that introduced legislation permitting the practice is Oregon. During the 1994 federal elections, a measure legalizing physician-assisted suicide was approved by a 51 to 49\% majority of the popular vote.\textsuperscript{21} Measure 16 allowed a physician to prescribe lethal doses of medication to a competent, adult patient whose life expectancy is lower than 6 months. Procedural safeguards were built in to avoid abuses and ensure choice: a confirmation of the diagnosis by a second physician was necessary; the patient had to produce 1 written and 2 oral requests; the written request had to be signed by 2 witnesses; waiting periods of 15 days from the first oral request and 48 hours from the written request had to be respected; and the patient had to be referred for counselling to a specialist if depressed or suffering from a psychological disorder. The Oregon measure inspired others. In more than 10 states, legislation to allow assisted suicide has been introduced\textsuperscript{22}. However, Oregon Measure 16 never entered into effect. On 3 August 1995, a federal District Judge struck it down as unconstitutional, after having issued a preliminary injunction some months earlier. Some terminally ill patients, with a history of depression, claimed that the measure violated the constitutional Equal Protection and Due Process clauses and the Americans with Disabilities Act and that it infringed on the Freedoms of Association and Exercise of Religion. Judge Hogan, who only dealt with the Equal Protection clause, ruled that the measure arbitrarily ‘withholds from terminally ill citizens the same protections from suicide the majority
enjoys’. He stressed that a treating physician was not qualified to evaluate potential mental impairments of suicide applicants. ‘With state-sanctioned and physician assisted death at issue’, the Judge warned, ‘some ‘good results’ cannot outweigh other lives lost due to unconstitutional errors and abuses’.

But, court procedures have also been introduced in other states to challenge the constitutionality of prohibitions on assisted suicide. It is argued that these prohibitions violate the constitutionally protected liberty interest in controlling one’s life. Michigan, where Dr Jack Kevorkian has already assisted at more than 20 suicides, has been at the forefront of this debate. In a 1992 attempt to stop Kevorkian, the Michigan legislature introduced a temporary ban on assisted suicide, later replaced by a permanent statute. Kevorkian and his supporters questioned the constitutionality of this ban. In December 1994, the Michigan Supreme Court ruled that there was no constitutional right to assisted suicide and that states had the authority to prohibit it.

Kevorkian’s appeal to the federal Supreme Court was rejected in April 1995. A federal court in New York and the 9th Circuit Court (a federal appeal court) also ruled that there is no constitutional right to assisted suicide.

Rejecting the existence of a ‘constitutional right to assisted suicide’ seems wise. Indeed, if one combines the ‘right to end one’s life’ with the notion of ‘equal protection’, it could become difficult to allow only physician-assisted suicide and limit it to cases of terminally ill but competent patients. If allowing patients to refuse life saving treatment while prohibiting the prescription of lethal doses to other patients amounts to unequal treatment, one is likely to say the same of the difference between prescribing lethal doses and killing paralysed patients who are unable to commit suicide. It would then also be perceived as unfair to remove the ‘right to die’ simply because patients are incompetent and have not been able to express their preferences clearly. Constitutional arguments for or against euthanasia and physician-assisted suicide might simply not be the most appropriate ones. If the Supreme Court had recognized a constitutional right to suicide it would have opened the floodgates and fostered unlimited euthanasia.

Treatment refusal, assisted suicide and euthanasia under Canadian law

In relation to decisions near the end of life, Canadian law is more uniform than American. Criminal law, which prohibits active euthanasia and assisted suicide, is a federal matter and therefore uniform throughout
Towards the right to be killed?

Canada. Moreover, few provinces have enacted advance-directive legislation. Therefore, general principles of common law determine what weight should be given to advance directives and substitute decisions in all common-law provinces. Common-law cases are often given authority even by Quebec civil law courts. (Quebec is the only Canadian province with a civil law system, based on the, now reformed, Civil Code.)

**Withholding and withdrawing of treatment**

There are relatively few cases of treatment refusal in Canada. This seems to be the result of a consensus on the idea that treatment should be terminated if there is no sound medical reason to continue. There has been a discussion as to whether some provisions of the Criminal Code could create criminal liability on the part of physicians who withdraw or withhold treatment. According to the Criminal Code, individuals are prohibited from endangering the lives of others by their acts or omissions and are obliged to provide 'the necessaries of life' to persons under their charge. The Criminal Code also decrees that physicians who undertake medical treatment that might endanger the lives of patients must use 'reasonable knowledge, skill and care in doing so'. In order to avoid misinterpretation of these provisions, the Law Reform Commission of Canada recommended that amendments to the Criminal Code be made. Amendments were introduced in Parliament but were never adopted. The Commission argued that the Criminal Code does not require physicians to provide medical treatments if these contradict the expressed wishes of patients, or if they are 'therapeutically useless' and not in their best interest. It is now generally accepted that the criminal law does not prohibit cessation of treatment. The 'reasonable physician' must respect standard medical practice and has no duty to prolong life at any price. On the contrary: aggressively delaying the inevitable, against the wishes or interest of the patient, is a violation of standard medical practice and could entail criminal liability for assault.

In fact, the common-law doctrine of informed consent and the right to self-determination clearly prohibit physicians from performing medical treatments without consent. In *Malette vs Schulman*, the Ontario Court of Appeal ruled that a physician was liable in battery when he submitted a Jehovah's Witness to a blood transfusion after having read her written request not to receive blood. According to the court, the state has a strong interest in protecting life, but this interest does not override the common-law right to refuse treatment.

The right to refuse treatment is also clearly accepted under the civil law of Quebec. The Civil Code provides explicitly that no person may be
submitted to medical care without her consent. The significance of this rule was clarified in Nancy B. vs Hôtel-Dieu de Québec\textsuperscript{32} in which the court held that Nancy B.’s request to be disconnected from a respirator had to be respected. She had Guillain-Barré syndrome, a neurological disorder that left her irreversibly paralysed and dependent on a respirator. Her intellectual faculties, though, were not affected. In his decision, the judge stressed that this was not a case of homicide or suicide but merely cessation of treatment, which would allow her to die a natural death.

Indeed, the law treats treatment refusal and suicide differently. Physicians may discontinue treatment, but they may not assist in suicide. Nevertheless, Canadian courts recognize that this prohibition does not imply that one should always treat suicidal patients against their will. In AG British Columbia vs Astaforoff\textsuperscript{331}, the British Columbia Supreme Court held that the provincial prison authorities were not obliged to force-feed an inmate who was consciously starving herself to death. The court confirmed that every person has a duty to use reasonable care in preventing suicide but held that force-feeding was unreasonable. It stressed that the decision was made in light of the circumstances of the case: force-feeding of an unwilling person was not without danger; the woman was frail and the treatment intrusive; the procedure would have been necessary for a long time and she likely would do the same thing again. The circumstances were different in another case, in which a refugee swallowed a steel wire and refused food as a protest against his deportation. The Quebec Superior Court authorized forced treatment and feeding to save his life\textsuperscript{34}.

If patients are incompetent, decisions must be made by those who, in accordance with provincial laws, may represent them\textsuperscript{35}. Some of the Canadian provinces explicitly recognize that competent individuals may appoint substitute decision makers to act on their behalf. In the absence of appointed proxies, provincial laws provide for a system of guardianship or tutorship. In most cases, close family members are appointed to represent incompetent patients. Proxies must act in the best interest of every patient. The Law Reform Commission pointed out that ‘[the incompetent patient’s] ‘best’ interests do not necessarily involve the initiation or continuation of treatment’ and that ‘the law should recognize that the incapacity of a person to express his wishes is not sufficient a reason to oblige a physician to administer useless treatment for the purpose of prolonging his life’\textsuperscript{29}. Physicians should be guided, in other words, by the dictates of sound medical practice.

When physicians or other health-care professionals are of the opinion that a proxy’s treatment refusal is not in the best interest of an incompetent patient, they may request authorization from the court to provide treatment. This has been done frequently in cases where parents
refused blood transfusions for their children. The Supreme Court recently made clear that although parents are best placed to nurture children and ensure their well-being, they do not have the right to refuse life saving blood transfusions. In *B. vs Children's Aid Society of Metropolitan Toronto*, the court rejected parents’ argument that the liberty and freedom of religion clauses of the Canadian Charter of Rights gave the right, as Jehovah’s Witnesses, to make the decision for their child. On the other hand, refusal of blood transfusion by mature minors has been accepted by courts in Canada.

**Assisted suicide and active euthanasia**

While there is a relative consensus on treatment refusal, euthanasia and assisted suicide have also been the subject of heated debate in Canada. Both are clearly prohibited under the Criminal Code. Attempted suicide has been decriminalized for some time now, but counselling, aiding or abetting a person to commit suicide can lead to imprisonment for up to 14 years. Killing another person is punishable as culpable homicide (murder or manslaughter). Feelings of compassion or even the victim’s consent do not change the nature of the act. Some argue that the common-law defence of necessity or even a new ‘defence of mercy’ may be invoked either to justify the mercy killing of suffering patients or to lessen the sentence. But, the intention of causing death is enough to categorize an act as murder. So, all cases of euthanasia, being the active killing for compassionate reasons, can be considered murder. S.235 of the Criminal Code prescribes ‘imprisonment for life’ as the minimum sentence for murder. The Law Reform Commission, which opposes the legalization of euthanasia or assisted suicide, recognized in its Working Paper that it could be reasonable to reduce the sentence for those acts motivated by mercy. There was recently some debate on this issue after a Saskatchewan father was sentenced to life imprisonment for killing his 12-year-old daughter, bedridden with cerebral palsy. She required continuous care and was, according to the family, in terrible pain. Even though the decision was very severe for this caring father, organizations for the handicapped were understandably troubled by suggestions that this case proved the necessity of legalizing euthanasia. On 18 July 1995, the Saskatchewan Court of Appeal confirmed the judgment of the lower court. It stated that the minimum sentence for murder, as provided for by the Criminal Code, is not a ‘cruel and unusual’ punishment, prohibited by the Canadian Charter of Rights and Freedoms. Furthermore, the prohibition of euthanasia did not infringe the Charter right to ‘life, liberty and security of the person’. The Court also dismissed the request for a
‘constitutional exemption’ based on these Charter provisions. In the same period, a more compassionate judgment was obtained in front of an Ontario Court, which imposed a non-custodial sentence in a case of mercy-killing. In this case, an 80-year-old woman was charged with manslaughter, after killing her husband who suffered from Alzheimer’s disease and consequential depression.

In Canada, the debate on assisted suicide has revolved around the case of Sue Rodriguez. She suffered from amyotrophic lateral sclerosis, a degenerative disease that inevitably leads to a total loss of physical control and results in dependence on a respirator and artificial feeding. As Rodriguez felt her strength diminishing, she launched a legal crusade to have her right to assisted suicide recognized by the courts. More than anything else, her battle was the expression of a desire to remain ‘in control’ over her life and body, a way of coping with the terrible disease that was slowly undermining her. The Canadian Supreme Court rejected her bid with a 5 to 4 majority. Though recognizing that the prohibition of assisted suicide deprived her of autonomy and impinged on the security of her person, the majority ruled that the restriction was justified on the basis of state interest in protecting the sanctity of life. They avoided the question of whether this prohibition discriminates against those who are unable to commit suicide without assistance. If the ruling had discriminatory effects, the Court argued, it could still have been justified under the Canadian Charter, because there was a pressing and substantial reason for it. As one observer remarked, both the majority and the minority failed to recognize that Rodriguez was not so much claiming a private right to kill herself, but ‘the right to publicly ratify, in court, a new form of cooperative action bent upon inducing a certain person’s death, at a certain time, and in a certain way’. The question of whether there is really a ‘right to suicide’ was neglected by the judges. Indeed, the judges did not pay attention to the fact that decriminalizing suicide does not make suicide a fundamental right. Humanitarian reasons are at the origin of its decriminalization, and not a concern to establish some new right.

Although Rodriguez did not obtain legal approval by the highest court, her legal struggle and subsequent physician-assisted death provoked a debate that might lead eventually to a revision of Canada’s assisted-suicide and euthanasia laws. Proposals were introduced in Parliament to grant immunity from prosecution to qualified physicians who assist competent patients in committing suicide. The federal Senate set up a ‘Special Committee on Euthanasia and Assisted Suicide’. In its final report, a majority of the Committee recommended, among others, that both euthanasia and assisted suicide remain prohibited in all circumstances, but that the legislator provide for a less severe penalty in cases on mercy-killing. A minority proposed to legalize assisted suicide and
Towards the right to be killed?

euthanasia in specific circumstances and sketched appropriate guidelines for such legalization. The Committee also reiterated that amendments to the Criminal Code should clarify the right to refuse treatment. It urged provincial and national governments to make palliative care a health care priority. Provinces and territories were advised to adopt advance directive legislation. The Committee thus suggested a sensible but cautious approach that characterizes Canadian law on these issues: federal and provincial governments should stimulate palliative care, should facilitate adequate relief of pain, and should assure that the public is informed about the right to refuse treatment; government should not, however, step onto the slippery slope of legalizing assisted suicide and euthanasia.

Conclusions

This overview indicates how the right to withhold or withdraw treatment is principally accepted under both American and Canadian law. Problems still arise when this right has to be exercised on behalf of incompetent patients. There is a tendency to recognize that, even in the case of incompetent patients, withholding or withdrawing treatment can be the most reasonable action. In the US, advance directives have been promoted to solve this problem. In both countries, the right to refuse treatment has lately been used for questioning the validity of laws prohibiting assisted suicide. Constitutional liberty and equality rights have been invoked to challenge criminal law provisions on assisted suicide. Most courts have rejected these arguments. One court ruled that, on the contrary, the Oregon legislation, allowing physicians to prescribe legal drugs to patients, deprives terminally ill patients of equal protection under the law. We are far from a legal recognition of a 'right to be killed' in Canada and the US, but further legal initiatives and intense political debate are to be expected.

Addendum March '96

Since the submission of this article, an important new decision on assisted suicide was rendered in the US, somehow at odds with the trend described earlier in this chapter. On March 6, 1996, in Compassion in Dying v. Washington (1996 WL 94848(9th Cir.(Wash.)), the 9th circuit court, rehearing the case en banc, overruled the decision of a three-judge panel of the same court mentioned earlier. The court ruled that there is a constitutional liberty interest in determining the time and manner of one's death, which can be limited by countervailing state interests. The Court
concluded that the Washington statute, making it a felony to assist in suicide, violates the Constitution's Due Process Clause insofar as it prohibits physicians from prescribing life-ending medication for terminally ill, competent patients. It suggested that there is no relevant distinction between assisted suicide and the right to reject treatment or to receive pain-relieving drugs that hasten death. This decision could have serious consequences for the law on assisted suicide in the 9 states that fall under the jurisdiction of the 9th circuit (e.g. California and Oregon).

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**References**

Towards the right to be killed?

20 Oregon’s assisted suicide law stokes the fires of controversy. State Health Notes 20 February 1995; 16(198): 1–3
23 Lee vs Oregon [Civ. No. 94-6467-HO] 1995 WL 471792; 471797 (D. Or.)
31 Malette vs Schulman. Ontario Rep (2d) 1990; 72: 417
34 Canada (PG) vs Hôpital Notre Dame (Niemic third party). Recueils de Jurisprudence du Québec 1984; 426
35 Glass KC. Elderly persons and decision-making in a medical context: challenging Canadian Law. Doctoral Thesis McGill University, Montréal 1992
36 B. vs Children’s Aid Society of Metropolitan Toronto, 27 January 1995, Supreme Court n.23298, unpublished
40 Report of the Special Senate Committee on euthanasia and assisted suicide: of life and death. Ottawa: Minister of Supply and Services, 1995