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Résumé de l'article

Parmi les nombreux aspects remarquables de l'introduction, en juin 2016, d'une législation permettant l'aide médicale à mourir (AMM) au Canada, on peut citer le rôle central et même dominant que les femmes ont joué pour faire avancer cette législation, et leur influence permanente alors que la loi continue d'être examinée et révisée. Les cas médicaux indexés sur lesquels les tribunaux supérieurs ont délibéré concernent des patientes, et les décisions juridiques des différents tribunaux ont été présidées par des femmes juges. Depuis que la loi est entrée en vigueur au Canada, les femmes ont été parmi les plus virulentes et les plus enthousiastes partisans de l'élargissement des critères afin de garantir que l'AMM soit plus accessible à un plus grand nombre de Canadiens. Dans cet article, j'explique comment la voix des femmes dans ce débat n'est pas la « voix différente » du féminisme de la deuxième vague, d'abord exprimée par Carol Gilligan, puis adaptée et développée dans la littérature à l'éthique des soins et l'éthique relationnelle, mais plutôt la voix très familière de l'éthique de l'autonomie personnelle, des droits individuels et de la justice, que les critiques féministes ont longtemps décrit comme inadéquate pour articuler une morale sociale globale. Je plaide pour la nécessité de réaffirmer la voix différente de l'éthique relationnelle et de l'éthique des soins dans notre discussion actuelle sur l'AMM.

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Daryl Pullman^a

Résumé

Parmi les nombreux aspects remarquables de l'introduction, en juin 2016, d'une législation permettant l'aide médicale à mourir (AMM) au Canada, on peut citer le rôle central et même dominant que les femmes ont joué pour faire avancer cette législation, et leur influence permanente alors que la loi continue d'être examinée et révisée. Les cas médicaux indexés sur lesquels les tribunaux supérieurs ont délibéré concernent des patientes, et les décisions juridiques des différents tribunaux ont été présidées par des femmes juges. Depuis que la loi est entrée en vigueur au Canada, les femmes ont été parmi les plus virulentes et les plus enthousiastes partisans de l'élargissement des critères afin de garantir que l'AMM soit plus accessible à un plus grand nombre de Canadiens. Dans cet article, j'explique comment la voix des femmes dans ce débat n'est pas la "voix différente" du féminisme de la deuxième vague, d'abord exprimée par Carol Gilligan, puis adaptée et développée dans la littérature à l'éthique des soins et l'éthique relationnelle, mais plutôt la voix très familière de l'éthique de l'autonomie personnelle, des droits individuels et de la justice, que les critiques féministes ont longtemps décrié comme inadéquate pour articuler une morale sociale globale. Je plaide pour la nécessité de réaffirmer la voix différente de l'éthique relationnelle et de l'éthique des soins dans notre discussion actuelle sur l'AMM.

Mots-clés

AMM, autonomie, soins, éthique, éthique relationnelle, éthique féministe

Abstract

Among the many remarkable aspects of the June 2016 introduction of legislation to permit medical assistance in dying (MAiD) in Canada, is the central and even dominant role that women have played in moving this legislation forward, and their ongoing influence as the law continues to be reviewed and revised. The index medical cases on which the higher courts have deliberated concern women patients, and the legal decisions in the various courts have been presided over by women justices. Since the legislation has become law in Canada, women have been among the most vocal and enthusiastic proponents for expanding the criteria to ensure MAiD is more accessible to more Canadians. In this paper, I discuss how the voice of women in this debate is not the 'different voice' of second wave feminism first articulated by Carol Gilligan and then adapted and expanded in the ethics of care and relational ethics literature. Instead it is the very familiar voice of the ethics of personal autonomy, individual rights and justice which feminist critics have long decried as inadequate to the task of articulating a comprehensive social morality. I argue for the need to reassert the different voice of relational ethics and the ethics of care into our ongoing discussion of MAiD.

Keywords

MAiD, autonomy, care, ethics, relational ethics, feminist ethics

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INTRODUCTION

Palliation is more a philosophy of care than a medical act; it requires broad social engagement across a spectrum of disciplines to attend to the physical, emotional, and spiritual needs of patients, families and communities. As such it trades on social and relational values of caring and compassion that are broad and amorphous and hence difficult to quantify and control. Put otherwise, it takes a village...

Medical assistance in dying (MAiD)¹, on the other hand, is narrow and focused and trades on more manageable notions of individual rights, personal autonomy, and choice. It is focused, quantifiable and eminently manageable and hence more amenable to technological control. Put otherwise, it takes a doctor ...²

¹ "Medical assistance in dying" (MAiD) is a uniquely Canadian term which was introduced with the passing of legislation in 2016 permitting individuals to seek assistance in ending their lives under specified conditions. As such it replaced earlier terminology such as 'physician assisted death', 'active euthanasia', and so forth. For the purposes of this paper the term MAiD will be used to refer to various discussions of assisted dying that have occurred in Canadian social and legal parlance, even prior to the 2016 legislation in which this terminology was introduced. As such the term is used to discuss earlier legal cases that served to shape Canadian policy even though the term 'MAiD' was not yet in use at the time.

² In Canada, medical assistance in dying can be performed by either physicians or nurse practitioners. The contrasting statements presented here regarding the characterization of palliative care and medical assistance in dying respectively, are intended to highlight the broad social and political contexts and underlying attitudes and values that support these respective paradigms, and should not be taken to imply that nurse practitioners cannot or do not participate in medical assistance in dying. That being said, nursing, as a profession, has generally encouraged more of a collaborative culture in the provision of healthcare services consistent with the characterization of palliative care outlined here. Medicine, by contrast, is often characterized by professional independence. Indeed, the vast majority of cases of medically assisted deaths in Canada are performed by physicians.

Two seemingly unrelated events that occurred in 1982 are noteworthy as they pertain to Canadian social history in general and the development of legislation related to medical assistance in dying (MAiD) in particular. The first was the publication of Carol Gilligan's still highly influential *In a Different Voice* (1). Gilligan's book served as a kind of manifesto for second wave feminism as she decried the central role that the concept of autonomy and a concomitant narrow focus on individual rights and justice, had come to play in social and political discourse. In Gilligan's view this focus represented an essentially male perspective, and as such, it failed to acknowledge the 'different voice' that women bring to these discussions. Women's voice, she argued, places a greater emphasis on relationships and the concomitant virtues of caring and nurturing. Gilligan's work galvanized the thinking of a generation of feminist scholars and activists, spawning an influential movement in political and moral philosophy that still marches under a variety of banners including "feminist ethics" (2,3) "relational ethics" (4) and the "ethics of care" (5,6). Canadian feminist scholars have made important contributions to this literature (3,7).

Coincidentally and somewhat paradoxically, the other significant event of 1982 that informs the present discussion, was the patriation of the *Constitution Act, 1982* enacting the *Canadian Charter of Rights and Freedoms* (8) The term 'patriation' is itself instructive, as it has its roots in the notion of 'patriarchy,' thus contrasting starkly with the feminist ethic Gilligan espoused. Nevertheless, this event enacted the *Charter* thus granting certain fundamental rights to all Canadians. The patriation of the constitution was a watershed event in Canadian legal and social history in that it effectively shifted the locus of authority for establishing fundamental social policy in Canada away from the elected officials of parliament, while granting an increasingly influential role to the unelected justices appointed to the Supreme Court of Canada (SCC). Since the patriation of the Constitution, the SCC has assumed a central role in setting Canadian social policy as it interprets and applies the *Charter*. As such, appeals to individual rights and considerations of personal autonomy and justice now figure ever more prominently in Canadian social and political discourse.

The Charter challenges that serve as the focus of the current discussion are those relating to MAiD. To date, two major Charter challenges relating to MAiD have come before the courts, Rodriguez (9) and Carter (10). More recently the Quebec Superior Court case concerning Truchon and Gladu (11) presented another potential challenge (although it now appears the federal government will not oppose the decision in that case).

There are many remarkable aspects to this still evolving story regarding MAiD in Canada, not the least being the central and even dominant role that women have played in advancing this cause.³ Madame Justice Beverley McLachlin wrote a dissenting opinion on the Rodriguez decision in 1993, and she was serving as Chief Justice of the SCC when it rendered its 2015 unanimous decision in Carter, effectively reversing the original SCC ruling on Rodriguez. The initial British Columbia Supreme Court decision in favour of Carter (12) was presided over by Justice Lynn Smith, and another female justice, Christine Baudouin of the Quebec Superior Court, rendered the decision in Truchon which aims to expand the eligibility criteria for MAiD thus granting wider access. In particular, the Truchon decision challenges the criterion that requires that a person's death must be reasonably foreseeable. In addition to these powerful and capable women justices, numerous other women have figured prominently and continue to exert great influence in shaping social opinion, legal policy and clinical practice pertaining to MAiD. However, far from speaking the 'different voice' espoused by Carol Gilligan and championed in feminist ethics and the ethics of care, these women uniformly echo the familiar voice of personal autonomy, individual rights and justice.

In what follows, I review some of the key considerations that informed Gilligan's initial arguments regarding the supposed different voice women speak in moral discussion and debate, and the subsequent development of those ideas in feminist ethics and the ethics of care. I then contrast this 'different voice' with the all too familiar voice of personal autonomy and individual rights spoken by these powerful women in the ongoing discussion of MAiD in Canada. Indeed this familiar voice threatens to silence the 'different voice' of relational ethics and the ethics of care, irrespective of whether it is spoken by women or men. I argue that any social discourse that fails to account for this different voice is in danger of robbing us of some of the most important relational and caring aspects of the political and social discourse which has defined us historically, as Canadians.

A DIFFERENT VOICE AND THE ETHIC OF CARE

Carol Gilligan began writing *In a Different Voice* in the early 1970s while working as a researcher in developmental psychology at Harvard University. Gilligan was interested in the process of moral development, and the developmental psychology lab at Harvard provided opportunities for collaboration with some of the leading theorists in the field including such luminaries as Erik Erickson and Lawrence Kohlberg. Kohlberg's theory would be particularly influential as a counterpoint to the understanding of moral development Gilligan presents in her ground-breaking book.

Kohlberg, like other leading theorists of the day, drew on the earlier works of Freud, Mead, and Piaget to inform his understanding of human development. However, the so-called 'human subject' at the centre of their various social experiments had a decidedly male bias. The paradigm studies uniformly referenced the development of young boys as they progressed from childhood, through puberty and adolescence into adulthood. Kohlberg's own work was based on an empirical study of eighty-four boys whose development he had followed for more than twenty years (16). As such, male development served as

³ While the focus of this paper is on the role of influential women in the Canadian MAiD discussion and debate, this should not be taken to imply that men have been silent on this topic. Philosopher Wayne Sumner, for example, has been a major contributor to the academic literature over the years (12,13), and philosopher Udo Schuklenk has been one of the most vocal and prolific proponents for expanding the criteria for access to MAiD (14).

a proxy for human development in general. From this perspective the moral development of girls and women was viewed as either a curiosity or an aberration.

Kohlberg posited a theory of six stages that ostensibly describe the development of moral judgment from childhood through adulthood (16, Figure 1).

Figure 1: Kohlberg’s Stages of Moral Development

Premoral Level	
Stage 1: Punishment-Avoidance and Obedience	Make moral decisions strictly on the basis of self-interests. Disobey rules if can do so without getting caught.
Stage 2: Exchange of favors	Recognize that others have needs, but make satisfaction of own need a higher priority.
Conventional Level	
Stage 3: Good boy/Good girl	Make decisions on the basis of what will please others. Concerned about maintaining interpersonal relations.
Stage 4: Law and order	Look to society as a whole for guidelines about behavior. Think of rules as inflexible, unchangeable.
Principled Level	
Stage 5: Social contract	Recognize that rules are social agreements that can be changed when necessary.
Stage 6: Universal ethical principle	Adhere to a small number of abstract principles that transcend specific, concrete rules. Answer to an inner conscience.

The six stages were in turn divided into three subgroups representing the ‘Pre-moral Level’ (Stages 1 & 2), the ‘Conventional Level’ (Stages 3 & 4) and the ‘Principled Level’ (Stages 5 & 6) respectively. Gilligan, who worked with Kohlberg in the early 1970s, was troubled by the implications of this six stage model for its characterization of female moral development: “Prominent among those who...appear to be deficient in moral development when measured by Kohlberg’s scale,” notes Gilligan, “are women, whose judgments seem to exemplify the third stage of his six stage sequence. At this stage morality is conceived in interpersonal terms and goodness is equated with helping and pleasing others...” (1, p.18). In Kohlberg’s view, women’s general sensitivity to the needs of others and their willingness to respond to those needs in a caring manner, marked them as deficient in moral development. Male subjects, by comparison, tend to progress further on Kohlberg’s moral development scale, the pinnacle of which describes the autonomous, independent self.

In a Different Voice serves both as a critique of the male bias in developmental psychology exemplified by Kohlberg, as well as an opportunity to offer an alternate understanding of female moral development. Gilligan does not argue that Kohlberg is wrong in characterizing the moral development of male subjects according to his six stages; his mistake is in characterizing his male biased research as descriptive of human moral development in general, and female development in particular. Gilligan argues that females speak a ‘different voice’ when dealing with social relationships and hence progress through different stages in their moral development. “The different voice,” states Gilligan, “...is a relational voice: a voice that insists on staying in connection and most centrally staying in connection with women, so that *psychological separations which have long been justified in the name of autonomy, selfhood, and freedom no longer appear as the sine qua non of human development but as a human problem.*” (1, p.xiii, emphasis added)

Gilligan’s thesis about the nature of the relationship between the largely male oriented ‘justice perspective’ and the female oriented ‘care perspective’ has been subjected to extensive study, interpretation and critique over the years (5,17,18). Are the justice and care perspectives separate but equal, or are they complementary? Is the voice of autonomy and justice in some sense inferior to the voice of care? Each of these distinct positions can be found in various aspects of Gilligan’s writings (18). For present purposes it is sufficient to note that *In a Different Voice* motivated a generation of feminist scholars to develop relational ethics and the ethics of care, perspectives that trade on differing notions of the self, the importance of relationships in moral development, and indeed, an alternate view of morality in general.

While Kohlbergian male oriented moral development aims to produce an autonomous, independent self whose relationships are governed by formal, objective principles, Gilligan’s female oriented ‘different voice’ informs an interdependent, connected self who prioritizes the responsibilities inherent in preserving caring relationships (Figure 2). Gilligan sums it up this way:

[J]ust as the conventions that shape women’s moral judgment differ from those that apply to men, so also women’s definition of the moral domain diverges from that derived from studies of men. Women’s construction of the moral problem as a problem of care and responsibility in relationships rather than one of rights and rules ties the development of their moral thinking to changes in their understanding of responsibility and relationships, just as the conception of morality as justice ties development to the logic of equality and reciprocity. Thus the logic underlying an ethic of care is a psychological logic of relationships, which contrasts with the formal logic of fairness that informs the justice approach. (1, p.73)

Figure 2: Contrasting Kohlberg and Gilligan on the Nature of Self, Relationships, and Morality (19)

Kohlberg	Gilligan
<ul style="list-style-type: none"> • Formal and Abstract • Rights and Rules • Founded on Principles • Self-Separate/Objective = Justice • Relationships: experienced in terms of reciprocity, mediated through rules, grounded in roles 	<ul style="list-style-type: none"> • Concrete and Circumstantial • Responsibilities and Relationships • Expressed in Activities • Self-Connected = Care • Relationships: responding to others, mediated through activity of care, grounded in interdependence

The decades following the publication of *In a Different Voice* saw that voice echoed in influential works by a variety of feminist authors who have jointly contributed to the development and popularization of care/relational ethics. “Relations, not individuals, are ontologically basic,” writes Nel Noddings, (4, p.xxi) and as such ‘caring’ describes a certain kind of relational encounter. Later she states: “Caring is a relationship that contains another, the cared for...the one caring and the cared-for are reciprocally dependent...” (4, p.58). Joan Tronto in turn emphasizes the need to redraw what she describes as ‘moral boundaries’ to ensure that the care ethic which Gilligan describes is not relegated to the margins of our daily lives by identifying it with the private morality of personal relationships, while justice and autonomy continue to reign supreme in the public sphere. “As we transform current moral boundaries to focus on an integral concept of care,” states Tronto, “we will also need to alter other central aspects of moral and political theory. We will need to rethink our conceptions of human nature to shift from the dilemma of autonomy or dependency to a more sophisticated sense of human interdependence.” (5, p.101) Finally, Virginia Held observes:

Many persons will become ill and dependent for some periods of their later lives, including in frail old age, and some who are permanently disabled will need care the whole of their lives. *Moralities built on the image of the independent, autonomous, rational individual largely overlook the reality of human dependence and the morality for which it calls.* The ethics of care attends to this central concern of human life and delineates the moral values involved. It refuses to relegate care to a realm ‘outside morality’. (6, p.10 emphasis added)

Similar statements and related notions can be found in a range of feminist authors over the past decades. If one takes the time to compare the different voices outlined so far with the statements placed in the prologue to this essay, it would seem that generally the voice of care articulated by Gilligan and other feminist authors maps neatly to the underlying social philosophy exemplified in palliative care. Conversely, the voice of autonomy and individualism that takes pride of place in Kohlbergian moral development is heard most clearly in discourses focusing on MAiD. We will return to these themes when we consider the role that the different voice an ethic of care can and should play in our contemporary discussions about MAiD. Before doing so, however, it behooves us to review the contributions of influential women in the Canadian MAiD debate to date. As noted earlier, far from speaking the different voice championed by Gilligan and other feminist writers, these women speak the all too familiar voice of autonomy and justice which ever threatens to marginalize or even silence that different voice.

RIGHTS VERSUS RESPONSIBILITIES: THE FAMILIAR VOICE OF WOMEN IN THE CANADIAN MAID DEBATE

Canada’s original *Criminal Code* (20), established by an act of Parliament in 1892, included a prohibition against attempting suicide. Looking back from our 21st century perspective, it seems odd that an individual could be charged under the *Criminal Code* with unsuccessfully attempting to take his or her life. What was the rationale for including such a prohibition in the *Criminal Code* in the first place? Answering this question requires some appreciation of the historical social and political context in which that first *Criminal Code* was enacted. Understanding that early Canadian ethos will also help us better appreciate the Canadian social and political milieu in which our current discussion about MAiD is unfolding.

The *Criminal Code* was initially instituted when Canada was a developing nation, struggling to establish its economic and political identity and independence vis-à-vis the behemoth with which it shares its southern border. Although the United States established what came to be known as its *Bill of Rights* in 1791 (21), only 15 years after its *Declaration of Independence* (22), the patriation of the Canadian *Charter of Rights and Freedoms* occurred some 115 years after Confederation. As such, the notion of ‘individual rights’ did not figure prominently in Canadian social and political discourse in those early formative years when the *Criminal Code* was first established by Parliament. Instead the emphasis was on social responsibility and the duties that citizens owed to one another individually and collectively in establishing the country. “This was...an age” states legal historian, R.C. Macleod, “in which people believed strongly that positive social goals could be achieved by negative means, that is, by prohibiting certain kinds of behaviour.” (23, p.71) Suicide, as such, was considered a selfish act and a breach of social duty; taking one’s life would effectively rob society of one’s contribution to the greater social good. Hence in 1892 attempting suicide was deemed a criminal act (24).

It was not until 1972 that Parliament removed attempting suicide from the *Criminal Code*, reflecting the shifts that had occurred in the social and political landscape in the intervening years. Open immigration policies after the Second World War had resulted in a more diverse population spread over Canada’s expansive geographical territory. National interests, as such, were often secondary to regional concerns as provinces and territories began to assert both their relative independence from federal control and the concomitant rights of their citizens. This social and political shift was seen most dramatically, perhaps, in the

so-called 'Quiet Revolution' that took place in Quebec in the 1960's (25), but similar appeals to the importance of regional autonomy, the interests of particular groups and the demands of justice and individual rights were echoed in other parts of the country. It was in this context that Parliament amended the *Criminal Code* in 1972 removing attempting suicide as a criminal offense. However, a prohibition from counseling or assisting someone in ending their life remained in section 241b of the *Code* (26). A decade later, in 1982, the *Charter of Rights and Freedoms* came into effect, establishing the priority of individual rights over any perceived duties to promote some greater social good. It also granted authority to the Supreme Court of Canada (SCC) to be the final arbiter on major social issues. The stage was set for the *Charter* challenge regarding medically assisted suicide launched by Sue Rodriguez in 1993 (9).

Ms. Rodriguez argued that section 241b of the *Criminal Code* discriminated against her as a disabled person, thus violating her rights under the *Charter*. She suffered from amyotrophic lateral sclerosis (ALS), an incurable, degenerative neurological disorder. Although she was still physically capable of taking her own life at the point when she initiated her *Charter* challenge, she did not want to end her life at that time. However, given the nature of her degenerative condition, she foresaw a time when she might want to commit suicide, but feared that by then she would be physically incapable of doing so without assistance. Thus she argued that Sec 241b violated her rights as a disabled person in that it prohibited her from committing suicide at a time of her choosing, a right that since 1972 any able bodied person in Canada ostensibly held.

While the Supreme Court justices generally agreed with Ms. Rodriguez, the majority held that such discrimination could be justified as a 'reasonable limitation' under Sec. 1 of the *Charter*. Essentially the majority argued that there was insufficient evidence available to assuage concerns that the potential negative effects of permitting assisted suicide justified removing the prohibition from the *Criminal Code*. So, while Sec 241b violated Ms. Rodriguez's equality rights as a disabled person, five of the nine Supreme Court justices in 1993 decided that such a violation could be justified.

Justice Beverley McLachlin was one of the dissenting justices in the Rodriguez case. She wrote passionately in defense of Ms. Rodriguez's right to an assisted death. Far from expressing the 'different voice' of Gilligan and second wave feminism, however, Justice McLachlin invoked the familiar voice of personal autonomy and the individual's right to choose: "Security of the person," she said, "has an element of personal autonomy, protecting the dignity and privacy of individuals with respect to decisions concerning their own body. It is part of the persona and dignity of the human being that he or she have the autonomy to decide what is best for his or her body." (9, p.415-16) Justice McLachlin's arguments notwithstanding, in 1993 the majority of the SCC ruled against Ms. Rodriguez.

It would be twenty-two years before the issue of assisted dying came before the SCC again, this time in the case of *Carter v. Canada* (10). By then, Madam Justice McLachlin was Chief Justice of the SCC, and this time all nine justices supported reversing the 1993 decision, declaring Sec 241b and related sections of the *Criminal Code* unconstitutional as they pertain to physician assisted death, paving the way for the legalization of MAiD in Canada.

In the intervening years between *Rodriguez* and *Carter*, many had advocated passionately and tirelessly for the decriminalization of euthanasia and assisted suicide. Legal scholar Jocelyn Downie has been amongst the most vocal and prolific advocates in this regard. Again, however, she champions the familiar voice of autonomy rights and fundamental justice in forwarding her cause. "I believe the case for a permissive regime with respect to voluntary assisted death hangs largely on the principle of respect for autonomy," she writes in *Dying Justice*, her 2004 book setting forth a case for decriminalizing euthanasia and assisted suicide in Canada (27, p.9). Although Downie has written elsewhere in favour of a broader notion of 'relational autonomy' in interpreting and applying health law, and even cites Gilligan in support of this perspective (28), that broader notion and the voice with which it is ostensibly spoken is seldom heard in her substantive discussions of MAiD.

Of the various women who were instrumental in changing the law in Canada to permit MAiD, none has exerted more direct influence than Madam Justice Lynn Smith of the Supreme Court of British Columbia (BCSC). Justice Smith was the sole presiding judge who reviewed the evidence and arguments martialled on either side of the assisted suicide debate when Carter et al first brought their case before the BCSC in 2012 (12). It was Justice Smith alone who rendered the decision that declared Sec. 241b and related sections of the *Criminal Code* to be unconstitutional as they pertain to MAiD. Her decision was subsequently overturned by the British Columbia Court of Appeal on the grounds that the issue had already been decided by the SCC in *Rodriguez*, and that a lower court could not overrule the highest court in the land (26). However, the Court of Appeal decision was appealed to the SCC, then presided over by Chief Justice McLachlin. There the BCSC decision rendered by Justice Smith was ultimately upheld. Again, the notion of individual autonomy is singled out especially, and figures prominently in the SCC's decision (10, sec 67).

Although Justice McLachlin and the SCC overruled the BC Court of Appeal, it was not the job of the SCC to review the evidence that had been ruled upon previously by Justice Smith. Rather, the role of the SCC was only to review whether Justice Smith had made an error in law when rendering her decision. As such, the SCC decision in *Carter* is relatively brief (only 85 pages in length) compared to the lengthy decision written by Justice Smith (323 pages). In fact, the SCC found no legal errors in Justice Smith's original ruling and hence upheld her decision. However, the original *Carter* decision and the underlying rationale are effectively the work of Justice Smith alone, and again the voice in which she speaks is quite familiar.

The case is now referred to as 'the Carter decision,' but the main focus of the legal arguments throughout is a woman named Gloria Taylor. According to Ms. Taylor's own account of her life and how she became involved in the legal proceedings, she

was a late addition to the case (30). As Ms. Taylor describes it, she learned of the pending legal challenge of Sec 241b through the media. She then approached the British Columbia Civil Liberties Association and the other plaintiffs with a request to be added to the case: “It seems to me that you’re missing one thing,” she told the other plaintiffs as they prepared to take their case to the BCSC, “and that’s the person who’s dying. And I’m it.” (30) This explains why Taylor’s name appears last in the list of plaintiffs in this landmark case, even though the vast majority of Justice Smith’s legal commentary focuses on the details of her situation. Indeed the ‘Carter’ after whom the decision will forever be referenced and remembered is not Kay Carter, the woman who travelled to Switzerland in 2010 to receive MAiD, but rather her daughter, Lee Carter, who, with her husband, had accompanied Kay Carter on that last journey. It was Lee Carter and her husband who then initiated the case in British Columbia in 2012 with assistance from the British Columbia Civil Liberties Association. They did so out of frustration that they had to take Kay out of the country to receive MAiD, and then faced potential criminal prosecution when they returned. Gloria Taylor was therefore a late addition to the Carter case, although she quickly became the focal point of the legal arguments presented by Justice Smith. In effect, Gloria Taylor became the ‘camel’s nose’ under the tent because her case is now associated with the assisted death of Kay Carter. However, Kay Carter did not have a terminal illness when she received MAiD in Switzerland, and, as will be noted presently, the details of her case do not figure at all in key legal arguments presented before the various courts (10,12,29). Nevertheless, the nature of her illness and subsequent death have been instrumental in the subsequent expansion of the eligibility criteria for MAiD.

Again, a careful reading of Justice Smith’s BCSC decision in ‘Carter’ reveals that virtually all the legal reasoning in the case pertains to Gloria Taylor, with only passing and ancillary references to Lee Carter and the potential legal peril she and her husband faced by assisting her mother to receive an assisted death (12, sec 17). Any references to Kay Carter refer only to her medical condition and the process undertaken for her to receive an assisted death in Switzerland (12, secs 57-71). Specifically, Justice Smith makes no direct comment about Kay Carter’s non-terminal medical condition as it pertains to the right to MAiD in Canada, confining her comments to the *theoretical* possibility that the Section 7 liberty rights of her daughter Lee Carter and her husband Hollis Johnson *might* be violated if they faced criminal prosecution for assisting Kay Carter in her suicide by taking her to Switzerland (12, sec 17). Indeed, when the SCC reviewed Justice Smith’s ruling when addressing the *Carter* decision, it stated explicitly that it would not be considering the legal issues pertaining to Lee Carter and her husband in taking Kay Carter to Switzerland, but were focusing instead on the case of Gloria Taylor (10, sec 69). I belabour this point because it is commonly perceived that the ‘Carter’ decision is about Kay Carter when in point of fact it is named after her daughter for whom the legal references in both Justice Smith’s decision and in that of the SCC are tangential at best. Nevertheless, some physicians have taken liberties in interpreting the law to justify extending MAiD to non-terminal cases such as Kay Carter, on the erroneous assumption that the BCSC decision, and by extension, the SCC decision that upheld the earlier decision, effectively sanctions extending MAiD to such non-terminal cases. We will return to this point presently when discussing Dr. Ellen Wiebe’s role in expanding the clinical application of MAiD.

The case of *Carter v. Canada* (12) is remarkable in many respects including, as noted previously, the list of plaintiffs involved. Notable in that list is the British Columbia Civil Liberties Association (BCCLA), a group for which Justice Smith herself had once served as a board member. While one of Justice Smith’s tasks as the presiding judge was to determine whether the testimony she had to consider was given impartially (12, sec 116), her own capacity to assess the arguments set before her in an impartial manner is apparently taken for granted. Be that as it may, in her decision Justice Smith systematically lays out the arguments of the interveners on either side of the issue, and then proceeds to render her opinion as to whether or not she finds the various arguments compelling. Again, the voices which appear to resonate most clearly with Justice Smith, and the voice with which she herself speaks in discussing the various arguments when offering her own considered opinion on the relative strength and relevance of those arguments, is the familiar voice we’ve by now come to expect.

In sections 314 and 315 respectively Justice Smith summarizes key elements of the opposing arguments as she has come to understand them. In particular, she acknowledges that the notion of ‘autonomy’ central to the pro-MAiD position is considered by some to be too restrictive. “While individual autonomy is an important value,” she writes in summarizing this perspective, “it does not take precedence over all other values, including concern for society as a whole. Individual autonomy should be understood as ‘relational’, taking into account that individuals are part of society and their decisions affect others and are influenced by others. Suicide affects many people, and particularly the deceased’s family or others close to him.” (12, sec 314f) This argument, as Justice Smith summarizes it – including the term ‘relational’ which she singles out in scare quotes – echoes aspects of the ‘different voice’ perspective of Gilligan and other feminist writers, including Jocelyn Downie, which were reviewed earlier. Indeed, it is an argument that harkens back, in some respects, to the reasoning underlying the original *Criminal Code* at a time when broader social and communal responsibilities generally took precedence over a narrower focus on individual rights. It resonates as well with the language of those who advocate for greater access to palliative care, as presented to Justice Smith (12, sec 270). But she finds such reasoning unconvincing and the different voice with which it is spoken, mute, or of little significance, when compared to the more familiar voice that expresses narrow autonomy-based arguments. She states her own conclusion forcefully: “No-one should be deprived of liberty, or forced to suffer, without adequate cause. Failing to respect an autonomous choice to die risks paternalism.” (12, sec 215d) She continues: “Physicians are required to respect patient autonomy, to act in their patients’ best interests and not to abandon them.” (12, sec 215e)

Curiously, despite testimony that many Canadians lack access to adequate palliation, such that permitting MAiD in these circumstances would be premature (12, secs 247 & 270), Justice Smith suggests that failing to respond positively to a request for MAiD would be tantamount to abandoning the patient. Advocates for greater access to palliative care might take the

opposite view, arguing that offering MAiD as opposed to adequate palliation, especially when resources for palliation are often woefully inadequate, is the ultimate act of abandonment.

While one might think that the advent of Bill C-14 (31), the federal legislation that permits MAiD in Canada, would be considered a triumph for Downie and other advocates, Downie has been relentless in advocating for expanding the eligibility criteria laid out in Bill C-14. If the different voice of which Downie speaks approvingly and for which she advocates elsewhere (28) is audible in her later arguments, it is but a whisper (32). At the time of this writing, the most recent legal challenge to Bill C-14 – now characterized by Downie and others as narrow, restrictive and even cruel legislation – has been rendered by Quebec Superior Court Justice Christine Baudouin in the case of Truchon and Gladu (11). She has ruled that the Bill C-14 provision that requires that death must be reasonably foreseeable, is also unconstitutional. In light of this decision, Downie has argued the federal government should not delay expanding the criteria for access to MAiD by appealing Justice Baudouin's decision but should rather move immediately to amend Bill C-14 to allow wider accessibility to MAiD. (32) Indeed, Downie and others have recommended that eligibility for MAiD be extended to those for whom a mental illness is the sole underlying condition (33). It appears now that Downie and her colleagues have been successful in the first instance as the federal government will not appeal Baudouin's decision and will instead be amending Bill C-14. However, for now at least, MAiD will not be extended to those for whom mental illness is the only underlying condition (34).

The last familiar voice that bears mentioning in this review is that of Dr. Ellen Wiebe. Dr. Wiebe is a physician from British Columbia who has been the most prolific purveyor of MAiD since Bill C-14 came into effect in June of 2016. In an article she wrote for the *Economist* magazine in August 2018, little more than two years after MAiD was legalized, Dr. Wiebe reports having already provided around 150 medically assisted deaths (35). Her liberal interpretation of the *Carter* decision and her willingness to provide MAiD where other physicians hesitate, is effectively pushing the boundaries of clinical practice in Canada.

As noted earlier, Dr. Wiebe takes an expansive view of the *Carter* decision attributing Justice Smith's comments pertaining to Gloria Taylor's medical situation as applying to Kay Carter as well. As noted previously, however, Justice Smith makes no comment whatsoever about the law as it pertains to Kay Carter or others who might leave the country to pursue an assisted death elsewhere. Indeed, Justice Smith makes only a passing reference to the law as it pertains to Lee Carter and her husband who accompanied Kay Carter on her final journey to Switzerland. Although Kay Carter suffered from spinal stenosis, a debilitating condition that caused her much pain and suffering, her condition was not terminal. Nevertheless, Dr. Wiebe concludes that a terminal condition is not required by the criterion specified in Bill C-14 which states "natural death must be reasonably foreseeable" (26). Based on her review of actuarial charts, Dr. Wiebe concluded Kay Carter would likely have lived at least another five to seven years. She thus interprets the 'reasonably foreseeable' criterion of Bill C-14 accordingly (36), even though neither the BCSC nor the SCC decisions address the details of Kay Carter's case,

Dr. Wiebe's focus is squarely on the individual, with little sympathy for those who offer broader relational considerations like those championed by Gilligan and other feminist writers who foreground responsibilities for the care of others. In one well documented case, Dr. Wiebe clandestinely entered a faith-based nursing home that did not support MAiD on grounds of conscience, to euthanize one of the residents. Although that facility was willing to transfer residents elsewhere who insisted on receiving MAiD, Dr. Wiebe concluded unilaterally that such accommodation was unwarranted on the grounds that only individuals and not institutions can have a conscience. Although a complaint was lodged against Dr. Wiebe with the British Columbia College of Physicians and Surgeons, the College decided not to discipline her on the grounds that her actions did not violate professional standards. Nevertheless, the nursing home continues to take issue with Dr. Wiebe's narrow view of conscience rights but expansive view of individual autonomy. "We have a lot of Holocaust survivors," notes David Keselman, CEO of the nursing home that serves mainly Jewish residents, "To have a doctor sneak in and kill someone without telling anyone, they're going to feel like they're at risk." (37)

In another case, of which I have first-hand knowledge, when two local physicians involved in the continuing care of a particular non-terminal patient concurred that the patient did not meet the criteria for MAiD and would likely benefit from continuing rehabilitation interventions, the patient sought a third opinion. Dr. Wiebe was referred by an outside organization and provided her assessment via Skype. Another physician, also referred by the outside organization, concurred with Dr. Wiebe. Although the local physicians who were familiar with the case continued to express reservations, the familiar voice of autonomy precluded their concerns. While it is of course common for patients to seek second or even third opinions about a given medical condition, we should be cautious about this line of reasoning when it involves remote consultations for MAiD. After all, MAiD is the only medical intervention with the express purpose of terminating the patient's life; it is also the only act under Canadian law that permits a civilian (physician or nurse practitioner) to intentionally end the life of another human being. Hence, the law outlines strict criteria to ensure that this unique act is not abused. As such, greater familiarity with the patient, the patient's history, social support network, and so forth, should factor more heavily in a broader care assessment. But the voice of personal autonomy and individual rights often precludes such broader considerations, and all the more so when assessments are offered remotely.

Dr. Wiebe is pushing the boundaries of MAiD through her liberal interpretation of the law. To this point her professional body has decided not to censure her actions. Other physicians appear to be following suit, apparently convinced that a narrow understanding of autonomy rights supports more expansive access to MAiD. In a recent case, physicians in British Columbia ended the life of Alan Nichols, a non-terminal patient who suffered from chronic mental illness, despite the protests of his family

who had helped him cope with the darkest moments of his disease throughout most of his life (38). That man's family was particularly dismayed that physicians who barely knew him could make a determination that he possessed the capacity to make the momentous decision to end his life, when those who knew him best and who had willingly participated in his care over the years, were not consulted and were even rebuffed when they attempted to intervene. This kind of case is a paradigm example of how the familiar voice that champions a narrow view of autonomy effectively silences the different voice that emphasizes the importance of relationships and sacrificial care. This last is especially important at a time when, as noted previously, some continue to advocate for the expansion of MAiD to include those for whom a mental disorder is the sole underlying criterion (33). Others have raised concerns that we in Canada may be experiencing the beginning of the mission creep evidenced in some other jurisdictions, resulting in an increasingly permissive regime (39,40). Although it appears the federal government is currently not ready to go quite that far as it amends the law to expand the criteria for access to MAiD (34), based on a history of aggressive advocacy we should anticipate continuing calls to respect the autonomous choices of the chronically mentally ill, and on-going pressure to further amend the law.

Carol Gilligan and other feminist writers have alerted us to the importance of listening for a different voice in the ongoing social, political and moral discourse by which we define ourselves both individually and corporately. That different voice, we are told, is most often articulated by women who decry the narrow focus on personal autonomy and individual rights, emphasizing instead the value of relationships and the responsibilities of care. But as argued here, that different voice has been largely silenced in the Canadian MAiD debate, and it is often powerful and articulate women who have silenced it.

HARKENING FOR THAT DIFFERENT VOICE IN OUR ON-GOING DISCUSSION OF MAiD

The patriation of the *Canadian Charter of Rights and Freedoms* was a significant event in Canadian history. It established the legal foundation for individual rights and has set the context for ongoing legal and political discourse on a broad range of social and moral issues. In this respect, our continuing discussion and debate about MAiD and the conditions under which it should be available is a microcosm of the social and political discourse that has been unfolding in Canada for the past four decades. As such, the *Charter* and the manner in which it is interpreted and applied by the courts is serving to define and redefine us as a people. However, the dominant voice that has emerged in this ongoing discourse is increasingly the familiar voice that champions a narrow view of personal autonomy and individual rights. We must question whether this voice speaks to the needs of the most vulnerable members in our midst, namely those contemplating the end of their existence.

It was against this narrow view of an autonomous, independent self – a legal fiction, in many respects, that is seldom if ever realized in the real world – that Carol Gilligan and other feminist writers have offered an alternative ethic of care, an ethic that trades on a richer and more nuanced sense of human flourishing. The wisdom at the core of this ethic concerns the nature of the self. Indeed, Jocelyn Downie and Jennifer Llewellyn sum up this wisdom eloquently as they compare and contrast the self that is assumed by liberal individualism with the self as presented in an ethic of care. “The conception of the self that dominates contemporary Canadian health law and policy is a liberal individualistic one,” they write; “[i]t is isolated, independent, socially unencumbered, rational, and self-created. In contrast, a relational conception of self is socially connected, interdependent, socially encumbered, relationally constructed, socially constituted, and embodied.” (28, p.196) But it is one thing to recognize a relational conception of the self; it is quite another to operationalize it in the context of a legal and social discourse that is continually mediated through the *Charter of [Individual] Rights and Freedoms*. As the foregoing discussion has amply illustrated, the liberal individualistic self and the familiar voice with which it speaks continually overwhelms the different voice of care, even for some feminists who ostensibly recognize and value that latter perspective.

Joan Tronto has written extensively about the challenge of transforming political culture to embrace an ethic of care. She writes not only from the perspective of a feminist scholar, but importantly for our current discussion, from the perspective of an American feminist scholar raised in a culture that gives pride of place to that all too familiar voice which second wave feminism decries. Recall that America established its *Bill of Rights* more than 200 years ago; as such, the familiar voice of individualism and the companion ethic of personal autonomy is woven into the very fabric of American culture. Bellah et al. sum it up this way: “Individualism lies at the very core of American culture...We believe in the dignity, indeed the sacredness of the individual. Anything that would violate our right to think for ourselves, judge for ourselves, make our own decisions, live our lives as we see fit, is not only morally wrong, it is sacrilegious. Our highest and noblest aspirations, not only for ourselves, but for those we care about, for our society and for the world, are closely linked to our individualism.” (41, p.142) Tronto, like Gilligan before her, pushes back against this dominant individualistic culture even as she recognizes the challenge in doing so. “As we transform current moral boundaries to focus on an integral concept of care,” states Tronto, “we will also need to alter other central aspects of moral and political theory. We will need to rethink our conceptions of human nature to shift from the dilemma of autonomy or dependency to a more sophisticated sense of human interdependence.” (5, p.101)

Reframing the notion of dependency is central to Tronto's project. In outlining her ethic of care she describes the various phases of caring relationships, each of which emphasizes our human interdependence. The phases she describes culminate in 'care receiving' (5). Tronto argues that in order for an ethic of care to be broadly operationalized across society it is not enough simply to offer care, but the care offered must be received. Yet, in an increasingly individualistic society, care receiving often represents the most challenging phase for an ethic of care. When a culture champions personal autonomy and independence, the thought of being dependent upon another is often characterized as 'being a burden.' As such, the idea of relying upon others to provide care can create existential anguish for those who are increasingly dependent on the care of others.

This point is noted by one of the interveners in the original *Carter* case who was interviewed by Justice Smith. That intervener observes that loss of control and the fear of dependency are more often the reasons patients ask for MAiD, as opposed to relief of physical pain and suffering (12, sec. 272). Years of data gathered from the Oregon experience with physician assisted suicide supports this observation. Consistently over the years, physical pain and suffering are not mentioned as the primary reasons individuals seek physician assisted death. Rather, the most frequently reported end-of-life concerns are loss of autonomy and dignity, where the greatest indignity is construed as depending on others as a recipient of their care (42). As such, the different voice of care is continually shouted down by the familiar voice of individual autonomy. Anita Ho has stressed this point eloquently with regard to the broader notion of disability in general (43).

I have argued elsewhere that the notion of personal dignity is very much shaped by dominant cultural values (44). As Tronto maintains, there need be no indignity in receiving care, even though the dominant voice of individualism informs us otherwise (5). Consequently, the ethic of care which Gilligan and other feminist writers have championed over the past four decades continues to be undervalued and marginalized. Indeed, while it has been almost 30 years since Tronto published her critique of American individualism and offered her alternative ethic of care, there is scant evidence to suggest that American culture has moved toward embracing broader communal values, and much to suggest the contrary.

We are a long way from the cultural ethos reflected in the original *Criminal Code* of 1892, when responsibility to the state and to one another as citizens took priority over the interests of individual selves. While we do not want the interests of the state routinely to supersede those of individual citizens, we nevertheless need to make room in our social and political discourse for that different voice of care that recognizes our interdependence and values our mutual responsibilities one to another. That voice of care insists there is no shame in either asking for or receiving care. Failing to harken to that voice may leave Canadian bioethicists asking the same question Daniel Callahan asked of American bioethics some 25 years ago, namely “can the moral commons survive autonomy?” (45)

Although the focus of this discussion has been on the role of women in shaping MAiD policy in Canada, the broader message and deeper concern is about the ongoing cultural shift that has been occurring in Canada over the past century, accelerated in recent decades with the patriation of the *Charter*. That shift involves a steady move away from broadly communitarian values that focus on our mutual interdependencies and responsibilities toward one another, and toward notions of individual liberty and personal autonomy. As noted previously, the ongoing debate regarding MAiD and the conditions under which it should be available serves as a kind of microcosm of this broader social and cultural discourse. The fact that courageous and articulate women, many of whom would no doubt align themselves ideologically with the different voice espoused by Carol Gilligan, nevertheless find themselves speaking in that all too familiar voice in the context of the MAiD debate, is an indication of just how deeply entrenched this cultural shift has become.

Susan Wolf has observed: “It is easy to declare with great fanfare that we will brook no diminution in our commitment to supporting and caring for those at the edge, even if euthanasia [MAiD] is allowed. But...physicians are fallible, hospitals are bureaucracies, and stress is real. There is ample cause to fear that providing an exit marked ‘euthanasia’ [MAiD] would make all – families, clinicians, and researchers – less prone to linger in the room of the dying.” (46) Indeed, as the familiar voice of individual rights and personal autonomy continues to dominate social discourse in Canada with regard to MAiD, and as the criteria for access to this service continue to expand, there is ample cause for concern about our willingness to linger in the room of the dying, and to both raise and listen for that different voice of care.

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