Assisted Suicide in Canada
Moral, Legal, and Policy Considerations

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In recent years, legislatures around the world have wrestled with the issues of assisted suicide and voluntary active euthanasia. Proposals to legalize some such activities were defeated by the Australian state of Tasmania in 2013 and in separate acts by both the British and the Scottish Parliaments in 2015. Other proposals succeeded in various regions of the United States, such as California in 2015. Parallel with debates in regional and national legislatures have been judicial contests: the High Court of Ireland upheld its country’s ban on assisted suicide in a 2013 ruling, as did the United Kingdom Supreme Court in a 2014 ruling and the New Zealand High Court in 2015. The South African High Court ruled its nation’s ban on assisted suicide unconstitutional but was overruled in 2016 by the South African Supreme Court of Appeal. In contrast, the Constitutional Court of Colombia mandated the permission of voluntary active euthanasia in 2015, and Germany’s highest court did the same for assisted suicide in 2020.¹

The Supreme Court of Canada effectively decriminalized forms of both assisted suicide and voluntary active euthanasia in its February 2015 ruling in Carter v Canada. A key portion of that decision reads as follows:

Section 241 (b) and s. 14 of the Criminal Code unjustifiably infringe s. 7 of the Charter and are of no force or effect to the extent that they prohibit physician assisted death for a competent adult person who 1) clearly consents to the termination of life and 2) has a grievous and irremediable
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medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.\(^2\)

The ruling thus allows physicians both to prescribe appropriate narcotics (later self-administered by patients) and to perform the act themselves (e.g., by injecting a lethal narcotic).\(^3\) The court gave the federal government a twelve-month grace period before the invalidity of the existing law would take effect in order to allow the government to draft new legislation incorporating the ruling.

In April 2016, the federal government put forward Bill C-14 for first reading in Parliament. That bill expanded the range of legal indemnity, specifying that not only physicians but also nurse practitioners and pharmacists would be permitted to participate in these procedures. The bill also sought to clarify certain matters arguably left ambiguous by the court ruling, for instance the meaning of “grievous and irremediable,” which the federal government understood to mean that “natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.”\(^4\) As stated, this appeared to come close to restricting medical assistance in dying to the terminally ill and thereby constituted a substantial circumscription of the acceptable conditions laid out in Carter v Canada. Bill C-14 received royal assent on June 17, 2016.

Since then, aspects of the bill have been subjected to multiple legal challenges seeking to expand eligibility criteria in one form or another. So far, the most important challenges have focused on the criterion of “reasonably foreseeable death.” One such challenge in Quebec was successful – in September 2019, a Quebec Superior Court judge ruled that this aspect of Bill C-14 was unconstitutional and thus to be considered struck from the law. This ruling became an issue in the federal election campaign the following month, with Prime Minister Justin Trudeau vowing not to appeal the decision, thereby allowing expanded eligibility beyond the terminally ill. Opposition leader Andrew Scheer, in contrast, vowed that if his party formed the government it would appeal the ruling and seek to uphold Bill C-14 in its then current form. Trudeau’s party won the election (though with a minority government), so it was to be expected that this decision regarding expanded eligibility would stand. On February 24, 2020, the justice minister introduced a draft bill to that effect, Bill C-7, before Parliament. Shortly thereafter, the global COVID-19 pandemic hit Canada, and the
parliamentary agenda on this matter, as on so many others, stalled. Then Parliament was prorogued in August 2020, resulting in Bill C-7 dying on the order paper. The assumption is that a new iteration of the same bill will be reintroduced when the pandemic has subsided and Parliament can focus again on other matters.

If that bill is approved, then it would render Canada one of the most permissive countries in the world with respect to eligibility for assisted suicide and voluntary active euthanasia. Moreover, it remains to be seen whether further expansions would take place in the years ahead – perhaps the expansion of eligibility to include mature minors, legally incompetent adults suffering from dementia (via an advance directive written while still competent), or those suffering from no physical ailments at all (i.e., the legally competent mentally ill). As we shall see, prominent Canadian politicians, ethicists, journalists, and legal scholars have been advocating for precisely these additional expansions.

Assuming that it is neither negated by use of the notwithstanding clause nor overturned in future rulings by the Supreme Court itself, Carter v Canada and its legal aftermath will affect the lives, deaths, and attitudes of Canadians for generations to come and alter the common understanding and practice of medicine. A profession previously defined by the goals of enhancing and preserving human life will now be understood to include, as an equally legitimate feature, the deliberate termination of human life. Whether one approves or disapproves of this development, its profound import can hardly be denied. As Chan and Somerville (2016, p. 144) put it, Carter v Canada “is likely to go down as one of the most significant decisions ever issued by the Supreme Court of Canada.”

My aim in this book is to provide a concise and accessible introduction to some of the key moral, legal, and policy issues surrounding this decision. At the time of writing, no up-to-date single work of this sort has covered all three topic areas for a specifically Canadian audience. This is regrettable, especially since the issue remains a matter of active public debate in this country. My hope is that this book will not only enable interested lay readers to gain a clear idea of exactly what this new legal situation consists of and how it came about but also provide some assistance in reflecting on its normative implications. It also includes a number of original contributions of particular interest to scholars working in the area. For specialists who pick up the book simply wanting to key in on the original scholarship, those contributions are mainly in some of my evaluative remarks on the legal and moral reasoning in Carter v Canada, as seen in Chapters 1 and 4; in the
discussion of the notwithstanding clause in Chapter 5; in the disjunctive argument against public funding, developed in Chapter 6; and in my brief discussion of a heretofore unappreciated legal risk facing Canadian healthcare professionals who participate in assisted death, provided at the beginning of Chapter 8.

Although I intend to offer an accurate and fair presentation of the range of competing legal and moral arguments on offer, I have nonetheless written this introduction from a definite standpoint. I make no apology for that; in my opinion, an introductory work on a controversial topic usually functions best when the author drops the pretense of neutrality and is simply open about the framework within which she or he is operating. All else being equal, doing so tends to result in a more interesting work, providing readers with a thesis into which they can sink their teeth along the way. With that in mind, my stance is basically as follows: I will argue that the Supreme Court of Canada made errors, both legal and moral, in *Carter v Canada* and that assisted suicide and active euthanasia are morally impermissible acts that ought to be recriminalized. Perhaps many (most?) readers will disagree with that assessment. Ideally, I would like to change some minds on this count; however, I will also be content with the more modest aim of supplying readers with a clear idea of why some people remain opposed to these practices in the wake of their legalization and in the face of widespread public support for that legalization.

In the remainder of this introduction, I will say a bit about the heavily contested role of religion in the moral side of this debate, cover some key terminology, and conclude with a bird’s-eye preview of the book’s contents. *First, concerning religion,* it is incontrovertibly true that, in both recent scholarly literature and public debates concerning assisted suicide and euthanasia, religion has played an important role, whether *directly* (by way of prominent interlocutors explicitly invoking religious doctrines) or *indirectly* (by way of those doctrines – or their rejection – informing discussants’ background moral intuitions). In working through the moral issues, I will attempt to use arguments that presuppose no religious beliefs; moreover, in the hope of sidestepping contentious debates regarding the proper role of religion in public policy disputes, in the few instances when I do discuss theologically grounded arguments (specifically in Chapter 4), I formulate them in terms not of any specific type of theism but agnosticism. That is, I argue that anyone who merely allows the realistic possibility that there could be a God will have to consider seriously certain well-known arguments against the moral permissibility of these actions.
That said, in the interests of transparency, I will note that my own moral beliefs on this matter are a product of both my assessment of the relevant ethical arguments and my religious faith. Regarding the latter, I am a member of the Eastern Orthodox Church, which has always taught that suicide is gravely immoral. It is sometimes argued that one should not allow personal religious beliefs to play a role in debates on law or public policy, at least not in a modern pluralistic democracy such as Canada. Rather only arguments whose basic premises can be accepted by people of any religious faith (or none) ought to be employed. Typically underlying this claim is a broader set of commitments pertaining to the proper role of religion in public life. I am rather inclined toward the idea that a diverse range of religiously informed moral commitments ought to have a place at the table: morally relevant teachings from Buddhism, Islam, Judaism, Indigenous spiritualities, Sikhism, and so on should all receive a respectful hearing in the public domain. That diversity of views should be present whether or not these teachings are ultimately accepted by those members of the public who do not share their interlocutors’ beliefs. To suggest that a range of diverse voices should be ignored or otherwise excluded from the debate in the name of religious neutrality (itself a disputed notion – can de facto atheism be considered genuinely neutral?) is problematic for a number of reasons, not least of which is the risk of missing out on helpful insights arising from these traditions. So, even though I do not ground this book in any particular faith, I look forward to productive dialogue both with secular scholars and with colleagues from a broad range of faith traditions.8

**Second, regarding terminology,** before I dive into these issues, some terminological clarification is required. I have already been using the terms “assisted suicide” and “voluntary active euthanasia”: What exactly do they mean, and how do they relate to the use in Canada of the relatively new term “medical assistance in dying” (MAID)?

“Assisted suicide” is fairly straightforward. This term encompasses those cases in which one person intentionally kills himself or herself with the aid of another person, which can be indirect (e.g., providing advice on how to commit suicide) or direct (e.g., giving the individual a lethal prescription to take later). In both cases, the final act itself is carried out by the individual, not by the assisting party. “Physician-assisted suicide” means that the assistance is provided by a medical doctor.

“Euthanasia” in the original Greek means literally “good death.” As the term is employed in contemporary ethics, a distinction is often made between *passive* euthanasia and *active* euthanasia. In the former, medical
treatment is stopped, and the patient’s death proceeds as a result of natural causes (i.e., the underlying terminal medical condition). Consider, for example, a situation in which a patient in the final stages of terminal lung cancer is being kept alive by the use of an artificial respirator. If the respirator is unplugged and the patient is allowed to die of the underlying condition then that will count as a case of passive euthanasia (PE). If the attendant physician is guided by a directive of the patient (i.e., the patient has asked to be unplugged), then this instance can be considered voluntary passive euthanasia (VPE). If for some reason the patient cannot be consulted (e.g., he has fallen into a coma), and there is no guidance from an advance directive (e.g., a living will or other indication of the patient’s wishes in this situation), and the attendant physician takes it upon herself to unplug the patient, then that is an example of non-voluntary passive euthanasia (NVPE). If there is an advance directive available specifying that the patient wishes to be kept alive on artificial life support in such a situation, and the attendant physician acts against that wish and unplugs him, then that act can be considered involuntary passive euthanasia (IVPE).

Active euthanasia is rather different. Here, instead of a patient dying of natural causes as a result of the cessation of treatment, they die as a result of an active step taken by another person to cause death. Consider the following scenario in which a patient is in the final stages of terminal cancer. If they ask a physician to end their life (say by having the physician deliberately inject a lethal dose of barbiturates), and the physician accedes to the request, then this is an instance of active euthanasia (AE). Because that patient consented to the procedure, it is known more specifically as voluntary active euthanasia (VAE). If for some reason a patient cannot be consulted (e.g., they have fallen into a coma) and there is no advance directive (e.g., a living will or other statement of a patient’s wishes in this situation), and the attendant physician decides to give the patient a lethal injection, then that would count as an example of non-voluntary active euthanasia (NVAE). If there is an advance directive available specifying that the patient wishes to be kept alive on artificial life support in such a situation, and the attendant physician acts against the patient’s wishes and administers a lethal injection, then that could be considered involuntary active euthanasia (IVAE).

To sum up, we are left with the following notions:

- assisted suicide
- passive euthanasia (voluntary, non-voluntary, and involuntary)
- active euthanasia (voluntary, non-voluntary, and involuntary).
VPE has long been permitted legally in Canada – any legally competent adult has the right to refuse medical treatment, even life-preserving medical treatment. VPE is also comparatively morally uncontroversial, at least in cases of irremediable terminal conditions. Moral qualms, conversely, may be raised about declining treatment for a thoroughly remediable condition, such as a young and otherwise healthy person refusing to get rabies shots after being bitten by a rabid animal. However, those sorts of situations are not typically discussed in debates on the ethics of euthanasia.

The status of NVPE is more controversial both legally and morally. As interesting and important as these issues are, they are not the focus of Carter v Canada and its surrounding controversies, so I will not take them up here. In Canada, IVPE is not legally permitted (it is generally understood that advance directives are to be respected outside extreme or unique circumstances), and most people would agree that it is morally impermissible.

With respect to active euthanasia, both NVAE and IVAE have always been and remain illegal in Canada, even after Carter and Bill C-14. As we shall see, NVAE has a number of prominent advocates in the ethics literature, whereas IVAE does not. (In some cases, though, advocates of NVAE seem to drift toward IVAE.) Still, these practices are outside the scope of my discussion here. In this book, I examine the novel legal situation imposed by Carter and Bill C-14: specifically, the legalization of assisted suicide and voluntary active euthanasia.

Bill C-14 uses “medical assistance in dying” as a blanket term covering both assisted suicide and VAE. There is precedent for this terminology in the existing ethics literature (e.g., Young, 2007), and its use has become common in Canadian media coverage of the issue. However, it remains controversial among some opponents of the practice, who argue that it is misleadingly anodyne or ambiguous. I am less concerned about that first aspect of the terminology – I find the term “voluntary active euthanasia” to be equally anodyne, though it is commonly employed by both proponents and opponents of the practice. I do remain worried about the potential ambiguity of MAID insofar as someone might confuse it, for instance, with standard palliative care, which, in a sense, is also a form of “medical assistance in dying.”

By way of an imperfect terminological compromise, in the title of the book I have stuck to the term “assisted suicide,” both for the sake of clarity – even in Canada not everyone is yet familiar with the acronym MAID – and to make the book more accessible to a non-Canadian audience for whom that acronym is unknown. (Although this book is intended chiefly for my fellow Canadians, parts of it could be of use in other jurisdictions where legalization
is being debated [the chapter on ethics] or has passed [the chapter on public funding].) However, with some reluctance, I use MAID as a convenient shorthand for the comparatively cumbersome “assisted suicide and VAE.”

_Third, concerning the contents_, in Chapter 1, I provide an overview of the four crucial legal rulings that led to the circumstances permitting MAID in Canada. My goal is mostly to provide an accurate summary of the legal reasoning employed in these cases, though I include some evaluative remarks toward the end of the chapter. Chapter 2 consists of a review of developments since _Carter v Canada_, looking at reactions from the Harper government, the Trudeau government (in particular the passage of Bill C-14), as well as some responses from the provinces. Then I begin the discussion of the ethics of MAID. Insofar as some important arguments for and against the practice are grounded in divergent background ethical theories, a proper understanding of those arguments will be aided by an initial overview of some of these theories, which I take up in Chapter 3. This overview is intended for a general audience, and ethicists working their way through the book will already be familiar with this material. In Chapter 4, I move on to a discussion of some of the more prominent arguments for and against the moral permissibility of MAID. Chapter 5 briefly deals with the further normative question of what the policy response to _Carter v Canada_ ought to be, given the moral impermissibility of MAID. Specifically, I argue that a future federal government ought to repeal Bill C-14 and employ the notwithstanding clause to negate _Carter_. In Chapter 6, I argue further that, should this not occur and MAID remains legal, the provinces are nevertheless obligated to refrain from funding it. I develop a four-part disjunctive argument for this conclusion, according to which public funding turns out to be immoral irrespective of the actual moral status of MAID (i.e., whether the provision of MAID is impermissible, permissible, obligatory, or its moral status is inscrutable, it should not be publicly funded). Chapter 7 briefly takes up the contentious issue of rights of conscience for health-care providers, specifically the issue of whether physicians, nurse practitioners, and pharmacists who object to MAID should nevertheless be required to provide referrals for it. In Chapter 8, I offer a short treatment of three additional legal and policy issues: first, the overlooked question of whether Canadian health-care providers who participate in MAID are at risk of prosecution in other nations where MAID remains illegal; second, best practices for record-keeping and information sharing; and third, the legal prospects for future court rulings overturning _Carter v Canada_. Finally, in the conclusion, I provide a short recap and some final remarks.
An Overview of *Carter v Canada*

Before we begin exploring the moral, legal, and policy issues arising from the Supreme Court of Canada’s ruling in *Carter v Canada*, we should review the ruling itself. Insofar as much of the argumentation within that ruling is bound up with prior legal precedents, to understand it thoroughly we should first examine the key rulings that led up to it. Hence, in the next section, I review the Supreme Court of Canada’s ruling in the 1993 *Rodriguez v British Columbia* case; then the 2012 *Carter v Canada* ruling by the Supreme Court of British Columbia, which functionally overturned *Rodriguez*; then the 2013 *Carter v Canada* ruling by the BC Court of Appeal, which reversed the Supreme Court of British Columbia’s ruling and upheld *Rodriguez*; and then the Supreme Court of Canada’s ruling in *Carter v Canada*. I cannot provide an exhaustive overview of the legal reasoning employed in each case, but hopefully what follows will succeed in conveying the principal lines of argument. Since my chief purpose in this chapter is to provide an accurate and concise overview of these rulings, I will mostly delay until its final pages my own brief remarks concerning the cogency of the arguments employed in them.

To assist readers in legal scorekeeping as the chapter progresses, I provide the following summary table:
### Table 1  Key court rulings on MAID

<table>
<thead>
<tr>
<th>Year</th>
<th>Case</th>
<th>Result of ruling</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>Supreme Court of Canada: Rodriguez v British Columbia</td>
<td>Maintained the existing criminal prohibition on assisted death</td>
</tr>
<tr>
<td>2012</td>
<td>Supreme Court of British Columbia: Carter v Canada</td>
<td>Overturned the Supreme Court of Canada’s ruling in Rodriguez</td>
</tr>
<tr>
<td>2013</td>
<td>BC Court of Appeal: Carter v Canada</td>
<td>Overturned the Supreme Court of British Columbia’s ruling, upholding Rodriguez and the original criminal prohibition on assisted death</td>
</tr>
<tr>
<td>2015</td>
<td>Supreme Court of Canada: Carter v Canada</td>
<td>Overturned the BC Court of Appeal’s ruling and Rodriguez, decriminalizing assisted death by striking down section 241(b) and section 14 of the Criminal Code of Canada</td>
</tr>
</tbody>
</table>

### The Supreme Court of Canada’s Ruling in the 1993 Rodriguez Case

In the English legal tradition of which the Canadian criminal law is a part, suicide historically was viewed as a form of homicide, such that the act of attempted suicide was a criminal act subject to criminal penalties. In Canada, this changed in 1972 when attempted suicide was decriminalized. Here Canada was following the lead of the United Kingdom, which decriminalized attempted suicide in 1961. In both cases, decriminalization was prompted by benevolence and the thought that criminal prohibition failed as a deterrent. Yet in neither case could this be seen as a state sanction of suicide, especially considering that the act of assisting another to commit suicide was still classified as a form of homicide punishable by lengthy imprisonment. Moreover, the state retained the ability to commit the suicidal to protective state care in order to prevent self-harm. Although such forcible committal was carried out only under strict guidelines, the central legal ground for doing so remained the likelihood that such individuals were a danger to themselves (or others). Gorsuch (2006, pp. 46–47), for instance, writes that “the abandonment of criminal penalties for suicide betokened less any social or legal endorsement of the practice than a growing consensus that suicide is essentially a medical problem. This interpretation is confirmed by the advent of a legal privilege to detain those who attempt suicide.” That attempted suicide was not subject to criminal penalty in Canada after...
1972 did not imply that the state had no interest or obligation in preventing suicide, and the decriminalization of attempted suicide was not taken at the time to entail that we possess a right (whether negative or positive) to suicide.¹

Prior decriminalization of attempted suicide played a key role in some of the argumentation made in Rodriguez v British Columbia. The plaintiff in this famous case, Sue Rodriguez, was dying from amyotrophic lateral sclerosis (ALS), a degenerative disease of the central nervous system. She sought permission to have a physician assist her in terminating her life, arguing that the criminal prohibition on assisted suicide (contained in section 241(b) of the Criminal Code of Canada)² violated her rights under sections 7, 12, and 15 of the Canadian Charter of Rights and Freedoms.³ More precisely, with respect to section 7, her argument was that the criminal prohibition deprived her of both liberty and security of the person, interfering with her ability to control what happened to her body and infringing on her right to non-interference in personal decisions concerning the final stages of her life. With respect to section 12, the argument was that the state, by prohibiting physicians from assisting Rodriguez in committing suicide, was subjecting her to cruel treatment, forcing her to suffer through the final stages of a terrible disease when she could have ended that suffering. With respect to section 15, her argument was that, on entering into the final stages of her progressive neuronal disease, she would be unable physically to commit suicide. Since suicide itself was not a criminal act (attempted suicide having been decriminalized in 1972), the state could not properly prevent others from helping Rodriguez to engage in a non-criminal act – in fact, doing so violated her right to equal treatment under the law, for it meant that the state would be blocking her as a disabled person from carrying out an act available to the able-bodied. These arguments were first made to the lower courts in British Columbia, and after rejection by the BC Court of Appeal they were taken to the Supreme Court of Canada, which agreed to hear the case – hence its title, Rodriguez v British Columbia.⁴

In a narrow 5–4 majority, the Supreme Court of Canada rejected the appeal and upheld the criminal prohibition. Writing on behalf of the majority, Justice John Sopinka granted that the law engaged the plaintiff’s section 7 rights:

The effect of the prohibition in s. 241 (b) is to prevent the appellant from having assistance to commit suicide when she is no longer able to do so on her own. She fears that she will be required to live until the deterioration
from her disease is such that she will die as a result of choking, suffocation or pneumonia caused by aspiration of food or secretions. She will be totally dependent on machines to perform her bodily functions and completely dependent on others. Throughout this time, she will remain mentally competent and able to appreciate all that is happening to her. Although palliative care may be available to ease the pain and other physical discomfort which she will experience, the appellant fears the sedating effects of such drugs and argues, in any event, that they will not prevent the psychological and emotional distress which will result from being in a situation of utter dependence and loss of dignity. 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. In my view, these considerations lead to the conclusion that the prohibition in s. 241(b) deprives the appellant of autonomy over her person and causes her physical pain and psychological stress in a manner which impinges on the security of her person. The appellant's security interest (considered in the context of the life and liberty interest) is therefore engaged, and it is necessary to determine whether there has been any deprivation thereof that is not in accordance with the principles of fundamental justice. 5

The majority of the court here conceded a crucial claim: namely, that the criminal prohibition on assisted suicide did in fact impinge on Rodriguez's section 7 right to security of the person. However, that did not automatically invalidate the relevant section of the Criminal Code of Canada, insofar as section 7 of the Charter itself allows that deprivations of the right to life, liberty, or security of the person can be permitted legally when done in accordance with the principles of fundamental justice. 6 So the question taken up in the remainder of the majority's ruling was whether the relevant deprivation involved was in fact in accordance with the principles of fundamental justice.

As part of his answer, Justice Sopinka first went on to observe that one purpose of the criminal prohibition on assisted suicide was

the protection of the vulnerable who might be induced in moments of weakness to commit suicide. This purpose is grounded in the state interest in protecting life and reflects the policy of the state that human life should
The reasonable nature of this prohibition was supported by reference to the prevailing international legal context of the time. Sopinka pointed out that, as of the court’s ruling in 1993, assisted suicide had not been explicitly legalized in any Western democracy (pp. 601–602), one reason being the widely recognized risk of abuse and correlative potential for the failure of suggested legal safeguards (e.g., guidelines to ensure genuine consent/non-coercion). Moreover, public referendums in both Washington State in 1991 and California in 1992 opted against the legalization of assisted suicide.

Justice Sopinka then took note of the common objection that the distinction between voluntary passive euthanasia and assisted suicide amounted to a “legal fiction”: “The criticism is based on the fact that the withdrawal of life supportive measures is done with the knowledge that death will ensue, just as in assisting suicide, and that death does in fact ensue as a result of the action taken” (p. 606). Moreover, the line between the two might seem to be even more blurred in cases in which the administration of pain medication or other methods of palliative care, intended to ease suffering, might have the side effect of hastening death. Sopinka replied that such arguments erred by ignoring the vital role of intent: “In my view, distinctions based upon intent are important, and in fact form the basis of our criminal law. While factually the distinction may, at times, be difficult to draw, legally it is clear” (p. 607). A physician who administers pain medication to a terminally ill patient, medication that has the foreseen but not-intended side effect of hastening death, is engaged, from both a moral perspective and a legal perspective, in an act very different from that of a physician who administers a drug with the active intent of terminating the life of that patient. The law rightly enshrines a recognition of this distinction by criminalizing the latter but not the former.

Justice Sopinka further noted that there exists a broad societal consensus that intentionally taking the life of another human being is inherently wrong and that the legal system ought to recognize that fact. This principle finds expression in other areas of the criminal law, notably in that Canada now prohibits capital punishment:

This prohibition is supported, in part, on the basis that allowing the state to kill will cheapen the value of human life and thus the state will serve in a
sense as a role model for individuals in society. The prohibition against assisted suicide serves a similar purpose ... To permit a physician to lawfully participate in taking life would send a signal that there are circumstances in which the state approves of suicide.\textsuperscript{8}

Sopinka stated that various major medical associations, including the Canadian Medical Association, British Medical Association, and World Medical Association, were all (c. 1993) in favour of the continued criminalization of assisted suicide. Taking all of this into account, he drew the conclusion that “it can not be said that the blanket prohibition on assisted suicide is arbitrary or unfair, or that it is not reflective of fundamental values at play in our society. I am thus unable to find that any principle of fundamental justice is violated by s. 241 (b)” (p. 608). So the plaintiff’s argument that section 241(b) was unconstitutional was ultimately rejected, not because Rodriguez erred in thinking that the prohibition engaged her section 7 Charter right to security of her person but because she erred in thinking that the associated deprivation was not in accordance with the principles of fundamental justice.

Justice Sopinka then proceeded to consider the plaintiff’s second argument: namely, that the law infringed her section 12 rights against cruel and unusual treatment or punishment. Sopinka swiftly disregarded any idea that the state was engaged in any form of punishment here; the question of whether the law resulted in cruel and unusual treatment was regarded as less clear, but ultimately he argued that the mere prohibition of a certain action could not, in this context, properly count as the active imposition of a form of “treatment” by the state:

In the present case, the appellant is simply subject to the edicts of the Criminal Code, as are all other individuals in society. The fact that, because of the personal situation in which she finds herself, a particular prohibition impacts upon her in a manner which causes her suffering does not subject her to “treatment” at the hands of the state. The starving person who is prohibited by threat of criminal sanction from “stealing a mouthful of bread” is likewise not subjected to “treatment” within the meaning of s. 12 by reason of the theft provision of the Code, nor is the heroin addict who is prohibited from possessing heroin by the provisions of the Narcotic Control Act, R.S.C., 1985, c. N-1. There must be some more active state process in operation, involving an exercise of state control over the individual, in order for the state action in question, whether it be positive action, inaction or prohibition, to constitute “treatment” under s. 12.\textsuperscript{9}
Thus, the plaintiff’s second argument was likewise rejected.

Justice Sopinka declined to consider whether the plaintiff’s equality rights under section 15 of the Charter were infringed, on the ground that even if they were such an infringement would ipso facto be in accordance with the principles of fundamental justice (given his earlier assessment of the section 7 challenge) and by extension would be allowable under section 1 of the Charter.10

Finally, Justice Sopinka made the point that the prohibition on assisted suicide was proportionate to its aim of protecting life, in particular protecting those vulnerable members of society most at risk of being coerced into considering suicide. To the objection that other legal means short of outright prohibition might suffice (e.g., allowing assisted suicide under certain narrow conditions and with assorted regulatory safeguards in place), Sopinka replied that “a prohibition without exception on the giving of assistance to commit suicide is the best approach. Attempts to fine tune this approach by creating exceptions have been unsatisfactory and have tended to support the theory of the ‘slippery slope’” (p. 613). Moreover, the suggestion that access to assisted suicide could successfully be restricted to the terminally ill is problematic on a more foundational level, insofar as part of the intention behind the law was precisely “to discourage the terminally ill from choosing death over life” (p. 614). As such, the verdict of the majority of the court was to uphold the criminal prohibition on assisted suicide.

Before proceeding to the next two cases leading up to the Supreme Court of Canada’s 2015 ruling in Carter v Canada, I will review briefly certain arguments put forward by the dissenting justices in Rodriguez v British Columbia. Justice Beverley McLachlin wrote that she agreed with the majority that section 241(b) infringed the plaintiff’s section 7 Charter right, but she disagreed that this infringement accorded with the principles of fundamental justice: “In my view, the denial to Sue Rodriguez of a choice available to others cannot be justified. The potential for abuse is amply guarded against by existing provisions in the Criminal Code, as supplemented by the condition of judicial authorization, and ultimately, it is hoped, revised legislation” (p. 617). To deny Rodriguez the opportunity to obtain assistance in committing suicide on account of a desire to safeguard others from abuse was unreasonable: “Thus, Sue Rodriguez is asked to bear the burden of the chance that other people in other situations may act criminally to kill others or improperly sway them to suicide. She is asked to serve as a scapegoat” (p. 621). To Justice Sopinka’s claim that the prohibition reflected a societal consensus on the sanctity of life and the inherent
immorality of intentionally killing another person, McLachlin replied that
the law does not in fact consider all cases of intentional killing to be immoral
or properly subject to criminal penalty, with killing in self-defence being an
obvious example:

The law has long recognized that if there is a valid justification for bringing
about someone’s death, the person who does so will not be held criminally
responsible. In the case of Sue Rodriguez, there is arguably such a justifica-
tion – the justification of giving her the capacity to end her life which
able-bodied people have as a matter of course, and the justification of her
clear consent and desire to end her life at a time when, in her view, it makes
no sense to continue living it.11

In his own dissent, Justice Peter Cory made a point that would be taken up
and developed in detail in later rulings: namely, that section 241(b) could be
thought to violate not just the security of the person but also the right to life,
on a suitably broad understanding of “life”:

The life of an individual must include dying. Dying is the final act in the
drama of life. If as I believe, dying is an integral part of living, then as a part
of life it is entitled to the constitutional protection provided by s. 7. It fol-
lowrs that the right to die with dignity should be as well protected as is any
other aspect of the right to life. State prohibitions that would force a dread-
ful, painful death on a rational but incapacitated terminally ill patient are an
affront to human dignity.12

Chief Justice Antonio Lamer’s dissent focused on the infringement of
Rodriguez’s equality rights, developing the point that a total prohibition was
an unreasonably broad method of trying to fulfill the legitimate goal of pro-
tecting the vulnerable. Moreover, the speculative risk of a “slippery slope”
toward abuse, to which Sopinka referred, had to be weighed against the cer-
tainty of the harm prompted by the criminal prohibition on assisted
suicide:

The truth is that we simply do not and cannot know the range of implica-
tions that allowing some form of assisted suicide will have for persons with
physical disabilities. What we do know and cannot ignore is the anguish of
those in the position of Ms. Rodriguez. Respecting the consent of those in
her position may necessarily imply running the risk that the consent will
have been obtained improperly. The proper role of the legal system in these circumstances is to provide safeguards to ensure that the consent in question is as independent and informed as is reasonably possible.\(^{13}\)

The dissenting justices notwithstanding, the vindication of section 241(b) provided by the Supreme Court of Canada in *Rodriguez v British Columbia* would prove to be long lasting and resilient in the face of periodic challenges (especially in the form of parliamentarians attempting to use private members’ bills or motions to reopen the debate and liberalize the Criminal Code provisions on euthanasia).\(^{14}\) However, a more significant challenge arose in the 2012 ruling by the Supreme Court of British Columbia in *Carter v Canada*.

### The Supreme Court of British Columbia’s Ruling in the 2012 *Carter v Canada* Case

Providing an adequate summary of this ruling is challenging because of its imposing size – at 398 pages, it is by far the longest of the four rulings under consideration here. Still, its central conclusions, and some of its principal arguments, can be summarized concisely.\(^{15}\)

There were five plaintiffs in this case. Gloria Taylor suffered from ALS and argued that section 241(b) of the *Criminal Code of Canada* infringed not only her section 7 Charter rights to liberty and security of the person (as had been claimed by Rodriguez) but also her right to life, insofar as section 241(b) would force her to commit suicide prematurely: that is, it would force her to take her own life while she was still physically able to do so instead of waiting longer, delaying doing so until utter physical incapacity had taken hold, at which time a physician could terminate her life for her. Decriminalizing assisted dying (specifically, physician-assisted suicide and physician-facilitated active euthanasia, jointly referenced by the phrase “physician-assisted dying”) would allow Taylor to delay suicide and thus prolong her life. In effect, the criminal prohibition on assisted suicide violated her right to life by driving her to kill herself earlier than she otherwise would in a more permissive legal context. Taylor also argued that section 241(b) of the Criminal Code infringed unjustifiably her equality rights under section 15 of the Charter (i.e., infringed them in a way not in accordance with principles of fundamental justice, contra the reasoning of the majority court in *Rodriguez v British Columbia*).

Two other plaintiffs, Lee Carter and Hollis Johnson, likewise argued that section 241(b) infringed their section 7 Charter rights, though on very
different grounds: it violated their right to liberty by raising the prospect of imprisonment for their participation in helping a loved one (Kay Carter, mother of Lee Carter and mother-in-law of Hollis Johnson) to obtain assisted suicide in Switzerland, where it was legal. In other words, they feared being subject to extraterritorial prosecution – criminally charged for engaging in an action overseas involving a Canadian citizen that, though legal in the nation where the act was committed, is nevertheless regarded as homicide in Canada. The court viewed this as a legitimate fear, insofar as homicide tends to be treated as an exception to the general rule against engaging in extraterritorial prosecution. For instance, if, prior to the legalization of marijuana in Canada, a Canadian citizen bought and consumed marijuana while in the Netherlands (where its purchase and consumption were legal), that citizen had no fear of prosecution on returning to Canada. An action overseas that was legal in that nation but not legal in Canada would not result in prosecution on the citizen’s return to Canada. In other words, in such a case, the Canadian citizen had no reason to fear being subject to extraterritorial prosecution. However, homicide historically has been treated as an exception to that general rule. For example, if a Canadian citizen travelled to a nation where “honour” killings were legal and participated in such a killing of a Canadian citizen, and then returned to Canada, the killer could be criminally charged. With that possibility in mind, Carter and Johnson had a legitimate fear of prosecution in Canada for what they had done to a Canadian citizen while in Switzerland (even though it had been legal there), and thus they maintained that they had legitimate standing to participate with Taylor in this legal action.16

There were two further plaintiffs in the case, physician William Shoichet and the BC Civil Liberties Association. Together the plaintiffs sought the decriminalization of physician-assisted dying for consenting patients who are grievously and irremediably ill, which is defined in Carter v Canada as:

1. A person is “grievously and irremediably ill” when he or she has a serious medical condition that has been diagnosed as such by a medical practitioner and which (a) is without remedy, as determined by reference to treatment options acceptable to the person; and (b) causes the person enduring physical, psychological or psychosocial suffering that: (i) is intolerable to that person; and (ii) cannot be alleviated by any medical treatment acceptable to that person. 2. A “medical condition” means an illness, disease or disability, and includes a disability arising from traumatic injury.17
Thus, the scope of legal permission sought by the plaintiffs was substantially broader than that envisioned by the plaintiff in *Rodriguez v British Columbia*, encompassing a far wider range of potential cases, including non-terminal illnesses, non-physical (i.e., psychological) illnesses, and curable illnesses (provided that the cure is unacceptable to the patient for any reason). It would also allow those who are physically capable of committing suicide to receive assistance in doing so or to receive active euthanasia. Moreover, the plaintiffs sought to invalidate not only section 241(b) of the Criminal Code but also other sections relevant to physician-assisted dying (understood as encompassing both assisted suicide and active euthanasia), notably including section 241(a) and section 14.18

Before getting into the legal arguments put forward by the plaintiffs and the attorney general of Canada and their evaluation by the Supreme Court of British Columbia, I will discuss briefly some of the specifically ethical arguments raised. The author of the verdict in *Carter v Canada*, Justice Lynn Smith, noted that “ethical principles have shaped both the law and medical practice. Ethical principles, similarly, enter into constitutional analysis (for example, Justice Sopinka referred to the positions of medical associations regarding the ethics of assisted suicide and euthanasia in his Reasons in Rodriguez (at 608))” (p. 54). Consequently, the court viewed moral argumentation as legally relevant (though not by itself legally determinative), and the court heard submissions on the matter both from the direct parties to the case and from external intervenors. Briefly, the plaintiffs argued that there is a societal consensus that individuals have the moral right to autonomy over their own bodies. However, they argued, there is no such consensus on the absolute sanctity of life. The Canadian government, for its part, questioned the legal relevance of the ethical debate, but it added that Canadian society (irrespective of religious and cultural differences) regards human life as of fundamental value and that this high degree of respect for human life is reflected in the criminal law. The BC government similarly argued that there is a broad consensus in Canada on the sanctity of life, reflected in Canadians’ rejection of capital punishment.

Each side also made use of testimony from expert witnesses on the relevant ethical issues. Among the submissions presented by the plaintiffs was that of bioethicist Margaret Battin. Justice Smith quoted a portion of that submission:

Physician assistance in bringing about death is to be provided only when the patient voluntarily seeks it (autonomy) and only where it serves to avoid pain or suffering or the prospect of them (mercy). Because these principles
do not operate independently, it cannot be claimed that permitting physician-assisted dying would require assisting lovesick teenagers who are not suffering from a serious medical condition to die; likewise it cannot be claimed that permitting physician-assisted dying on the basis of the principle of mercy would require involuntary euthanasia for someone who is in pain but nevertheless desires to stay alive. Both principles must be in play; but when they are in play, they jointly provide a powerful basis for permitting and respecting physician aid in dying.

Those who oppose physician aid in dying must show that the principles of liberty and freedom from suffering that are basic to an open, liberal and democratic society should be overridden. This is the point of slippery-slope assertions about the potential for corrupting physicians and widespread abuse in the Netherlands and perhaps Oregon. Yet there is no empirical evidence that supports these claims, and substantial evidence to the contrary.19

Smith returned to the issue of empirical evidence of abuse later in the ruling.

Next she quoted another expert witness for the plaintiffs, physician and bioethicist Ross Upshur:

Based on my review of the empirical, psychological, and philosophical literature and my experience as a clinician, I believe that, under certain conditions, providing assistance with suicide or euthanasia can be an ethically appropriate course of conduct for a physician. The conditions that I support, on the same professional foundation, are that the request be free and informed and made by an individual when competent. I do not believe that assisted suicide and euthanasia should only be available to those who are diagnosed as terminally ill, but rather should be available to those for whom life has become not worth living to them.20

Given the broader scope of decriminalization sought by the plaintiffs in *Carter v Canada* (much broader than that sought in *Rodriguez v British Columbia*), Upshur’s comment regarding assisted dying for the non-terminally ill is especially relevant.

Another witness for the plaintiffs was neurologist Sharon Cohen, also quoted in the decision in *Carter v Canada*:

I have witnessed a number of patients with grievous and irremediable neurological diseases who have already experienced prolonged suffering, die slow and terrible deaths. I have witnessed patients with grievous and irremediable
neurological conditions at the end of life gasping for breath as they slowly drowned in their own secretions or choked on their own saliva. These patients appeared extremely uncomfortable, agitated and restless. Some patients explicitly told me that they were experiencing discomfort and pain. I have seen patients turn blue because they cannot get enough air. Some appeared terrified. For some of these patients, this slow and painful march to death lasted days. Some patients experienced multiple episodes of choking and a feeling of suffocation over a period of weeks. These deaths were extremely traumatic for both the patient and their family. Sometimes patients are provided sedation to the point of semi-consciousness so they are made more comfortable as they struggle for breath. Nonetheless, they may linger in a state of dying for hours to days with families standing by in distressed states that may take years to recover from. In my opinion, physician-assisted dying should have been an available treatment option in these situations. With all my training as a physician, I cannot accept that it is right to allow patients to die in this immeasurably cruel and useless fashion if to do so is against the patients’ wishes.\(^{21}\)

Two points here might have warranted further comment by the court. The first point is Cohen’s admission that such grievous suffering is in fact capable of being relieved through palliative sedation (which I will discuss in Chapter 4). The second point is the role that Cohen assigns to the psychological state of the dying individual’s family. Although her compassion for family members in this trying situation is admirable, and clearly born from the concrete experiences of a caring clinician, perhaps the court should have noted the potential complications (moral and legal) associated with taking someone else’s suffering as a justification for euthanasia. This is especially the case insofar as there might be other ways of alleviating this psychological distress, methods that do not entail terminating the life of the patient.

Among expert witnesses put forward by the government side was ethicist and legal scholar John Keown, who reaffirmed the vital importance of the inviolability of human life in both medicine and criminal law and argued that the risk of abuse and a slippery slope was real and supported by empirical evidence (contra the testimony offered by Battin).\(^{22}\) Another witness for the government was ethicist and gerontologist Thomas Koch, who questioned the plaintiffs’ use of the notion of personal autonomy. Justice Smith quoted a portion of his submission:

This claim isn’t about individual choice and autonomy. We cannot stop but we need not applaud suicide in the face of adversity. Ms. Taylor may kill
herself. She seeks not the right to do that but instead the obligation of us to agree her life is so insufficient that we will assist or direct her termination. This claim is about whether we honour each other irrespective of individual characteristics or set up a sliding scale by which some conditions devalue life until the point where its termination is appropriate. It is about whether we place our priorities in the arenas of rehabilitation, palliation, and social service or agree with the simplistic assumption that state-supported, physician-assisted or directed termination is or should be a reflexive response to restrictive medical conditions.23

Relatedly, defence witness Harvey Chochinov, Canada Research Chair in palliative care at the University of Manitoba, argued that medical advances can mitigate substantially the stated concerns about patient suffering and the alleged need to resort to assisted death to allay it. In his affidavit to Carter v Canada, he stated that

in the vast majority of instances, palliative care is able to mitigate suffering. As such, even in the absence of death hastening options, good outcomes in palliative care are regularly achieved. Palliative care has made great gains over the last few decades and can now attend to most sources of symptom distress. In some instances, managing physical distress may involve having to sacrifice conscious awareness … However, palliative care should no more be seen as the perfect foil to suffering, than medicine should be pitched as the perfect foil to death.24

Another palliative care physician, Romayne Gallagher, raised the worry that decriminalizing physician-assisted death would radically change the nature of the medical profession and undermine trust between doctor and patient:

The goals of medicine are prolonging life, relieving suffering and improving or maintaining function and have been so since the Hippocratic Oath was written thousands of years ago. Even then there was the strong pronouncement about not doing harm and not administering a deadly drug nor counselling a patient to take a deadly drug. The Canadian Medical Association Code of Ethics notes the core activities of a physician as health promotion, advocacy, disease prevention, diagnosis, treatment, rehabilitation, palliation, education and research. In no way is administering a drug with the intent to end the life of the patient consistent with the goals or core activities
of medicine. While drugs administered to treat patients can result in death, that is considered an adverse outcome and not the intention of the treatment. Giving a drug with the intention of causing the death of the patient does not relieve suffering but moves the patient to a state where we presume they are beyond suffering. In my opinion changing the law to allow physicians to administer a deadly drug would be to radically change the concept of what a physician is that has been held for over two thousand years. I believe it would also seriously undermine the trust that patients have in a physician to do what is in their best interest.25

The court also heard submissions from various organizations as intervenors, some of which raised ethical arguments as part of their submissions. For instance, the Christian Legal Fellowship argued that the intentional killing of an innocent person is always wrong and that recognition of this moral fact is foundational for all Western civilization. In contrast, the Canadian Unitarian Council emphasized the moral import of personal autonomy in medical decision making and argued further that society recognizes the moral legitimacy of some decisions to terminate life intentionally.

Justice Smith then turned to the issue of whether it is feasible to decriminalize assisted death while also providing safeguards to prevent abuses. This is relevant, of course, not only to the context of the ethical debate surrounding the plaintiffs’ case but also to the legal reconsideration of the Rodriguez ruling, given the role that concerns about safeguards played in the majority decision penned by Justice Sopinka. The claim of access to relevant new empirical data on this issue, data unavailable to the Supreme Court of Canada in 1993, Smith saw as supporting her contention that the Supreme Court of British Columbia possessed the capacity to invalidate the higher court’s ruling. A substantial portion of her ruling (p. 111–249) consists of a review and an assessment of expert testimony pertaining to the data. Smith discussed safeguards implemented in jurisdictions that had decriminalized one or another form of assisted death since 1993, including the American states of Oregon, Washington, and Montana, as well as the nations of Belgium, Holland, Luxembourg, and Switzerland. The criteria for legally obtaining assisted suicide and/or euthanasia varied greatly from one jurisdiction to another. For instance, in Oregon, assisted suicide is restricted to the terminally ill, whereas in Holland both assisted suicide and euthanasia are available to those who lack any physical ailment but suffer from a psychiatric disorder, and in Switzerland no medical condition at all is required to obtain assisted suicide – only consent by a legally competent
individual. Accordingly, the safeguards put in place also varied. Still, Smith found that within each jurisdiction the state’s rules were generally followed; crucially, she found that concerns about coercion and abuse of vulnerable individuals were unfounded, writing that “although none of the systems has achieved perfection, empirical researchers and practitioners who have experience in these systems are of the view that they work well in protecting patients from abuse while allowing competent patients to choose the timing of their deaths” (p. 197). Smith also determined that fears about a potential decline in the quality of palliative care services post-legalization, and fears about negative impacts on patient-physician relationships, were similarly unfounded. She concluded from this review that “the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced” (p. 249). Thus, Smith deemed an important ground for the Rodriguez decision against decriminalization to be mistaken in light of new empirical data.

That portion of the ruling led into the next major section, in which Justice Smith assessed to what extent the prior ruling in Rodriguez v British Columbia was determinative of the new Carter v Canada. She noted that both Canada and British Columbia submit that Rodriguez is binding on this Court because the facts pertaining to Gloria Taylor are virtually identical to those in Rodriguez, and the Charter provisions upon which the plaintiffs rely in this case are the same as those raised in Rodriguez. They say that it is not open to this Court to do anything other than dismiss the plaintiffs’ claim.26

Moreover, the government noted that just ten years previously, in 2002, the Supreme Court of Canada declined to reconsider Rodriguez when it denied the plaintiff in Wakeford v Canada leave to appeal. (In that case, the plaintiff argued before an Ontario court that section 241(b) of the Criminal Code violated his equality rights under section 15 of the Charter.) However, in Canada, rulings of the federal Supreme Court are not, of course, absolutely final (unlike the high courts of some other nations) and may be revisited both by that court and by lower courts should new facts emerge, should dominant societal values shift dramatically, or should it be shown that the new case (perhaps despite initial appearances) is substantially dissimilar to the precedent. The plaintiffs before Smith in Carter were arguing that there were multiple such legal grounds for the Supreme Court of British Columbia
to reconsider Rodriguez, and Smith came to agree with some of their points.

First, she deemed that the relevant facts in the Rodriguez and Carter cases were not equivalent. Social and legal contexts pertaining to assisted death had shifted between 1993 and 2012; more importantly, a great deal of empirical data on the feasibility of decriminalization had become available. As Justice Smith wrote,

the evidence as to legislative and social facts in this case, however, is different from that in Rodriguez. By evidence as to “legislative and social facts,” I refer to all of the evidence tendered in this case on matters other than the adjudicative facts – regarding topics such as the legislation and experience in jurisdictions with legalized physician-assisted death or assisted death, palliative care practice including palliative sedation, end-of-life decision making, Canadian public opinion regarding euthanasia or physician-assisted death, Parliamentary and other reports since Rodriguez, and medical ethics ... The most notable difference between the records in this case and in Rodriguez is that the record in this case includes: evidence pertaining to the experience with legal physician-assisted death in Oregon, Washington, Belgium, Luxembourg and the Netherlands and with assisted death in Switzerland; opinion evidence of medical ethicists and practitioners informed by the experience in jurisdictions with legalized assisted death; specific evidence pertaining to current palliative care and palliative or terminal sedation practices; and evidence regarding prosecution policies in British Columbia and the United Kingdom formulated since Rodriguez. The evidence regarding the experience in jurisdictions permitting physician-assisted death was available neither at the time Rodriguez was decided, nor when Wakeford was considered.27

Second, since 1993, there had been developments in the Supreme Court’s understanding of section 7 of the Charter, with its attendant reference to the principles of fundamental justice. The court had since clarified that those principles demand that criminal legislation not violate the notions of “overbreadth” and “gross disproportionality.” Basically, the notions are that the law cannot restrict liberty in a more sweeping and extreme fashion than is necessary to accomplish its purposes. The Supreme Court did not explicitly recognize these notions as implications of the principles of fundamental justice at the time of Rodriguez, and the plaintiffs in Carter were effectively claiming that the blanket prohibition on assisted death was in fact overbroad
and grossly disproportionate. Justice Smith maintained that this change post-1993 supplied adequate legal justification for reconsidering the constitutionality of that prohibition.

Third, the majority in *Rodriguez* had declined to consider whether section 15 of the Charter was infringed, on the ground that, even if it were, any associated deprivation would be counted as in accordance with the principles of fundamental justice (given the court’s verdict on the section 7 challenge) and justified by reference to section 1 of the Charter. However, in *Carter*, the issue of section 15 infringement could legitimately be raised anew, given the aforementioned post-1993 developments.

And fourth, the majority in *Rodriguez* had not explicitly stated whether the right to life under section 7 of the Charter was engaged by the prohibition on assisted death. However, the plaintiffs in *Carter* were now arguing that this right was infringed because the prohibition served to drive people at risk of total physical incapacitation to commit suicide earlier than they would otherwise. Justice Smith also saw that as raising a new point of law not determined by the precedent, which further justified the reconsideration of *Rodriguez*.

Having concluded that the Supreme Court of British Columbia had the legal authority to consider revisiting this prior decision by the Supreme Court of Canada, Justice Smith then turned to the detailed consideration of the plaintiffs’ relevant arguments. She began with the argument arising from section 15 of the Charter, observing that the dissenting justices in *Rodriguez* had likewise expressed concern that the prohibition on assisted suicide disadvantaged the physically disabled in a way not in accordance with the principles of fundamental justice. Although the Criminal Code prohibition on assisted suicide applied to everyone, and did not explicitly or intentionally single out the physically disabled,

> even distinctions created unintentionally and implicitly, through the disparate impact of the law on a particular group of persons, may infringe s. 15 and should be interrogated in the same way as are intentional or explicit distinctions. This is because the commitment to substantive equality entails consideration of the actual impact of the law on the persons it affects (p. 289)

The plaintiffs’ claim was that the impact was truly grievous, insofar as “people with physical disabilities who are unable to end their lives themselves are forced into the dilemma of either continuing to suffer or exposing other persons to criminal sanctions. Some resolve this dilemma by taking
An Overview of Carter v Canada

their lives before their illnesses progress to a point where they are no longer able to do so” (p. 294).

Later in the ruling, Smith quoted Elayne Shapray, a witness for the plaintiff suffering from secondary progressive multiple sclerosis:

I understand that suicide is no longer a crime in Canada. The irony of the current situation as I experience it is that an able-bodied person can commit suicide in a lawful manner but somebody such as myself, who is unable by reason of their disability to do so, cannot. The means available to me to terminate my life unassisted at this time, if I was so inclined, are extremely limited and would likely involve violent, painful or personally terrifying outcomes. I consider the option of taking my own life by conventional “suicide” means, assuming that I was otherwise physically and emotionally able to do so, not only to be dangerous and inhumane, but also likely to be extremely traumatic to my family and my friends. I live in dread of the day when I will have been robbed of all meaningful quality of life by the progression of my disease. I fear that I will not have the option that others have of ending one’s own life. I wish to have the choice of a dignified, physician-assisted termination of my life at the time of my choosing rather than being terrified daily about how I may end up simply because at a future date there would be no one able to legally help me. The current state of the law deprives me of the freedom to choose how and when I would end my life. The current law may cause me to initiate a premature termination of my life simply because if I wait until I am ready to do so, I may be unable to do so, in any humane fashion, without asking my loved ones to put themselves at legal risk.28

In response, lawyers for Canada and for British Columbia replied that even those suffering from total physical incapacity could commit suicide without external assistance, insofar as they could refuse food and hydration to the point of expiration. As such, section 241(b) served at worst to bar the disabled not from suicide per se but from certain methods of suicide. The plaintiffs in turn countered that this method of suicide would be slow and excruciating, such that, even if available to the utterly physically disabled, that it would be the only method available to them only served to highlight the ways in which the law affected them in a drastically unequal fashion vis-à-vis the able-bodied.

Lawyers for Canada then argued that the mere fact that attempted suicide was no longer subject to criminal sanction did not imply a right to
Assisted Suicide in Canada

Assisted Suicide in Canada

suicide, a right supposedly infringed by section 241(b) and disproportionately so for the physically incapacitated. Yet, Justice Smith pointed out, whether or not there is any right to suicide, plausibly there is a right to physical integrity and autonomous decision making with respect to important aspects of an individual’s life, including aspects pertaining to medical intervention. Autonomy, of course, was not the only relevant value under consideration, and here Smith noted an argument by one of the intervenors: “The intervenor Euthanasia Prevention Coalition submits that the principles of community interdependence and the sanctity of life justify the Criminal Code provisions. Legalizing assisted suicide, it says, would erode these principles by dehumanizing certain members of the community. The EPC says the Court must weigh these values against the values of autonomy and self-determination emphasized by the plaintiffs” (p. 328). Nevertheless, Smith maintained that autonomy is among the values that are fundamentally important and central to personhood and have long been affirmed in the common law and in the Canadian Constitution. It must not be overlooked that what is at stake for someone in Gloria Taylor’s situation is not merely autonomy, nor is it simply autonomy with respect to physical integrity. It is the autonomy to relieve herself of suffering.

Taking all of that into account, Justice Smith concluded that plaintiff Taylor’s equality rights under section 15 of the Charter were in fact infringed by section 241(b) of the Criminal Code. The next question was whether that infringement was legally justifiable, especially in light of some significant post-1993 Supreme Court of Canada case law. Keeping in mind the new empirical data on the practical feasibility of safeguards to protect the vulnerable and wider society in jurisdictions that have decriminalized assisted death, Smith found that section 241(b) was both overbroad and disproportionate; a complete prohibition was not necessary to meet the law’s goal of protecting the vulnerable from coercion to commit suicide. As Smith noted, the question, then, is whether there is an alternative means for the legislature to achieve its objective in a real and substantial way that less seriously infringes the Charter rights of Gloria Taylor and others in her situation. Clearly, it is theoretically possible for the legislature to do so. Parliament could prohibit assisted death but allow for exceptions. The exceptions could permit physician-assisted death under stringent conditions designed to
ensure that it would only be available to grievously ill, competent, non-ambivalent, voluntary adults who were fully informed as to their diagnosis and prognosis and who were suffering symptoms that could not be treated through means reasonably acceptable to those persons.31

Moreover, a careful weighing of the alleged potentially deleterious effects of decriminalization (e.g., undermining respect for life, eroding trust between physicians and their patients, weakening the palliative care system, etc.) with the salutary effects claimed by the plaintiffs (e.g., preserving personal autonomy, preventing needless suffering, etc.) failed to show that the alleged societal benefit of outlawing assisted death outweighed the infringement of equality rights under section 15.

Justice Smith turned next to the issue of whether section 241(b) infringed the right to life, a question not taken up explicitly by the majority in Rodriguez v British Columbia:

The plaintiffs submit that the right to life is also engaged because the provisions may cause her to end her own life earlier than she would otherwise want to, out of fear that the progression of her illness will prevent her from doing so later ... The defendant Canada argues, on the other hand, that the s. 7 right to life does not encompass quality of life issues, which it says may implicate security of the person, but not the right to life itself. Canada argues that the right to life does not include the right to choose death. It submits that such an interpretation would directly contradict the plain and obvious meaning of a right to life and would mark a significant departure from existing Supreme Court of Canada jurisprudence.32

Contra the submission from Canada, Smith concluded that plaintiff Taylor’s right to life was engaged, in the sense that Taylor had a right not to die, which was being infringed by the prohibition on assisted death, insofar as it could force her (and those in comparable situations of progressive physical incapacity) into an act of suicide earlier than she would otherwise have desired.

The next question was whether that infringement was consistent with the principles of fundamental justice and counted as a reasonable limit on the relevant right (thereby constituting a permissible infringement under section 1 of the Charter). After reviewing relevant post-1993 case law pertaining to overbreadth and gross disproportionality, and with reference again to the new empirical data on the workability of safeguards in the
context of decriminalization, Justice Smith inferred that the state’s interest in protecting the vulnerable could not justify the section 7 infringement entailed by the blanket prohibition on assisted death. That prohibition was in fact both overbroad and grossly disproportionate and thus inconsistent with the principles of fundamental justice.

The plaintiffs had asked the court not only to invalidate section 241(b) and thus Rodriguez but also to adopt certain specific recommendations regarding the conditions under which assisted death would be permitted. With respect to the latter, Justice Smith wrote that “it is the proper task of Parliament, not the courts, to determine how to rectify legislation that has been found to be unconstitutional. However, in a case such as this, where the unconstitutionality arises from the legislation’s application in certain specific circumstances, it is incumbent on the Court to specify what those circumstances are” (p. 384). Departing from the plaintiffs’ specific recommendations in several ways (e.g., intentionally dropping any reference to “psychosocial” illnesses), Smith put forward the following as constitutionally mandated:

A declaration that the impugned provisions unjustifiably infringe s. 7 of the Charter, and are of no force and effect to the extent that they prohibit physician-assisted suicide or consensual physician-assisted death by a medical practitioner in the context of a physician-patient relationship, where the assistance is provided to a fully-informed, non-ambivalent competent adult person who: (a) is free from coercion and undue influence, is not clinically depressed and who personally (not through a substituted decision-maker) requests physician-assisted death; and (b) has been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury), is in a state of advanced weakening capacities with no chance of improvement, has an illness that is without remedy as determined by reference to treatment options acceptable to the person, and has an illness causing enduring physical or psychological suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person.33

Smith gave the government a one-year period of grace within which to enact new legislation before the invalidation of sections 241(b) and 14 would take effect (likewise related sections 21, 22, and 222), in the meantime granting plaintiff Taylor an immediate constitutional exemption allowing her to receive assisted death.
The governments of Canada and of British Columbia then appealed the decision to the BC Court of Appeal.

The 2013 BC Court of Appeal Ruling on *Carter v Canada*

In a two-thirds majority verdict (dissent by Chief Justice Lance Finch), the BC Court of Appeal reversed Justice Smith's ruling in *Carter v Canada*. Writing as part of his dissent, Finch concisely summarized the grounds for appeal claimed by the government of Canada:

The AGC [attorney general of Canada] argues that Smith J. erred by finding that she was not fully bound by the decision in *Rodriguez* with respect to her analysis under ss. 7, 15, and 1. In *Rodriguez*, a majority of the Supreme Court of Canada found, on similar facts, that s. 241(b) of the *Criminal Code* did not infringe s. 7 or s. 12 of the *Charter*. Though assuming an infringement under s. 15, the Court found that it was saved under s. 1. The AGC further argues that the respondents’ rights under ss. 7 and 15 of the *Charter* were not infringed; and that, in any event, any infringement was justified under s. 1. The AGC says that in finding that the law infringed the respondents’ rights under ss. 7 and 15 of the *Charter*, Smith J. asked the wrong question, or applied the wrong test. In examining whether the impugned provisions were overly broad or minimally impaired the respondents’ rights, Smith J. should have asked whether there was a reasonable apprehension of harm that Parliament could only address with an absolute prohibition on assisted death. On the issue of minimal impairment under s. 1, the AGC’s fundamental position on this appeal, as it was before Smith J., is that the only issue before the Court is whether Parliament’s absolute prohibition against physician-assisted death was within the range of reasonable legislative alternatives.34

The Canadian government thus argued that the precedent in *Rodriguez v British Columbia* should have been allowed to stand and that Smith had erred in the manner in which she applied the more recently enumerated principles pertaining to overbreadth and gross disproportionality. Parliament is not obligated to demonstrate minimal impairments when its criminal prohibition on an activity clashes with Charter rights; rather, it need only show that the prohibition is a reasonable legislative response to a genuine risk of serious societal harm.
The BC Court of Appeal also heard from various intervenors supporting the government’s position, including the following, summarized from the submission by the Evangelical Fellowship of Canada, which contended that the sanctity of human life is a Charter value and merits special protection. One cannot consent to die. They argue that compassion is misdirected when it posits killing as an antidote to what is difficult about dying. There can be no assisted suicide without another moral agent engaged in the killing. It would also require the State to be complicit in the act. No one has the right to be killed.35

The opposing side replied that Justice Smith had been correct in her assessment that the Charter infringements entailed by section 241(b) and the related Criminal Code prohibitions on euthanasia and counselling suicide could not be saved under section 1 of the Charter; Smith had correctly applied the more recently recognized principles of fundamental justice (pertaining to overbreadth and gross disproportionality) in light of the empirical data available post-1993, which provided ample legal standing for a lower court to overturn Rodriguez.

In assessing Justice Smith’s ruling, the BC Court of Appeal first held that Smith was in fact bound by the earlier precedent set in Rodriguez as it pertained to section 15 equality rights. In part, this was because her analysis of post-1993 case law (notably, the 2009 Supreme Court of Canada ruling in Alberta v Hutterian Brethren of Wilson Colony Charter) was flawed. This was maintained both by Chief Justice Finch in his dissenting opinion and by the majority opinion authored by Justice Mary Newbury (paras 107, 270).

The remaining question concerned whether the Supreme Court of British Columbia had ruled appropriately regarding infringement of the section 7 right to life (a point not taken up explicitly in Rodriguez). The government of Canada argued that the prohibition on assisted suicide could not be seen as infringing the right to life, insofar as there are many possible responses available to the prohibition and no direct causal link between the prohibition and someone taking her own life earlier than desired. “To establish a causal connection, the AGC suggests there must be a direct link between the state conduct and the actual consequences of the prohibition. The AGC argues that premature suicides are not caused by the law and its prohibitive effect, but simply the fear of living
with a degenerative medical condition” (para 115). The plaintiffs replied that they had established a direct causal link by showing that there are cases in which patients at risk of complete physical incapacitation intend to kill themselves earlier than they otherwise would, precisely because they know that assisted suicide is illegal and that they cannot rely on help in the future. In his dissenting opinion, Chief Justice Finch accepted the plaintiffs’ argument that the section 7 right to life was indeed being infringed:

In my opinion, there is a sufficient causal connection between the impugned provisions and premature deaths. The standard advocated by the AGC, which would require showing a direct causal link between the legislation and its effects[,] is not the correct standard to apply. In Canada (Attorney General) v PHS Community Services Society, 2011 SCC 44, the Court accepted that depriving drug users of access to medical supervision amounted to depriving the users of the right to life.36

Whether or not this infringement was justified under section 1 of the Charter, Finch wrote that the absolute prohibition on assisted suicide was indeed broader than necessary to achieve the goals of the legislation (to protect the vulnerable and manifest the state’s regard for the inherent value of life) because steps short of absolute prohibition could plausibly accomplish these goals just as well, especially in light of the empirical data assembled by Justice Smith. Likewise, it was grossly disproportionate. As such, Finch would allow the decision in Carter v Canada to stand.

In contrast, in Justice Newbury’s decision for the majority, it was deemed that Justice Smith was mistaken about the implications of post-1993 case law relevant to the relationship between sections 7 and 1 of the Charter: “With all due respect to the trial judge, we believe that she was bound by stare decisis to conclude that the plaintiffs’ case had already been determined by the Supreme Court of Canada” (para 316). Newbury went on to grant that, if a piece of legislation could be shown to infringe a section 7 right, that would be a strong reason for deeming it unjustifiable under section 1, and indeed the Supreme Court of Canada had never found a section 7 infringement to be saved by section 1.37 However, the plaintiffs had not successfully shown this; moreover, issues of breadth and proportionality were in fact taken into account in Rodriguez, if somewhat obliquely, when Justice Sopinka determined that an absolute prohibition on assisted suicide
was necessary, not only to protect the vulnerable from coercion, but also to discourage the terminally ill from choosing death:

The trial judge was of the opinion in the case at bar that it was open to her to reconsider this “final step” because, she said, the Court had addressed it “only very summarily.” (Para. 936; but see also para. 998.) With respect, her opinion of the sufficiency of the Supreme Court of Canada’s analysis did not permit her to disregard its conclusion. As we hope we have demonstrated, it is inherent in the law relating to the Charter that it is not written in stone and that ways of assessing laws inevitably evolve. Again, the focus for purposes of stare decisis should be on what was decided, not how it was decided or how the result was described.38

The fact that Sopinka was making this point in the context of a discussion of section 15 rather than section 7 is not pertinent to the basic point at issue: namely, that the court had been properly cognizant of the issues of breadth and proportionality, even if the conclusion reached differed from that of Smith. Moreover, the new empirical data that Smith discussed (changes in ethical views and the new information on safeguards in nations such as Holland) did not suffice to warrant reconsideration of Rodriguez.

The plaintiffs then appealed this decision to the Supreme Court of Canada.

The 2015 Supreme Court of Canada Ruling in Carter v Canada

In a unanimous verdict, the Supreme Court of Canada granted the appeal, declaring that section 241(b) and section 14 of the Criminal Code of Canada violated the section 7 Charter right to life in a way inconsistent with the principles of fundamental justice and were irredeemable by reference to section 1. The blanket prohibition was overbroad, for the purpose of the law was to protect the vulnerable from coercion to commit suicide but in fact it had a much wider impact, including on those who are at no risk of coercion but rationally wish to end their lives. In its ruling in Carter v Canada, the Supreme Court rejected the government’s claim that preservation of life generally was a further goal of the legislation as understood in Rodriguez v British Columbia:

First, it is incorrect to say that the majority in Rodriguez adopted “the preservation of life” as the object of the prohibition on assisted dying. Justice
Sopinka refers to the preservation of life when discussing the objectives of s. 241(b) (pp. 590, 614). However, he later clarifies this comment, stating that “[s]ection 241(b) has as its purpose the protection of the vulnerable who might be induced in moments of weakness to commit suicide” (p. 595). Sopinka J. then goes on to note that this purpose is “grounded in the state interest in protecting life and reflects the policy of the state that human life should not be depreciated by allowing life to be taken” (ibid.). His remarks about the “preservation of life” in Rodriguez are best understood as a reference to an animating social value rather than as a description of the specific object of the prohibition.39

There is a problem with this particular portion of the Supreme Court’s ruling in 2015 in Carter v Canada: namely, it does not convincingly account for a further statement by Sopinka, adjacent to the passage just cited, in which, in reply to the potential objection that a blanket prohibition was overly broad, he wrote in 1993 in the decision in Rodriguez v British Columbia that

the foregoing is also the answer to the submission that the impugned legislation is overbroad. There is no halfway measure that could be relied upon with assurance to fully achieve the legislation’s purpose; first, because the purpose extends to the protection of the life of the terminally ill. Part of the purpose, as I have explained above, is to discourage the terminally ill from choosing death over life. Secondly, even if the latter consideration can be stripped from the legislative purpose, we have no assurance that the exception can be made to limit the taking of life to those who are terminally ill and genuinely desire death.40

This certainly appears to be a “description of the specific object of the prohibition.” At any rate, the court accepted the plaintiffs’ argument that prohibiting assisted death had the effect of forcing some people to commit suicide prematurely, thus violating their right to life. At the same time, it also violated the rights to liberty and security of the person by depriving them of autonomy over the process of dying. The section 7 infringements being sufficient to invalidate the prohibition and overturn Rodriguez, the court declined to assess the issue of a section 15 equality rights violation.

I will not say much more about the arguments of the Supreme Court in the 2015 decision in Carter v Canada since they mostly agree with those of Justice Smith in the Supreme Court of British Columbia’s ruling, already
summarized above. Still, before turning to the legal remedy laid down by the Supreme Court (which not only held that the blanket prohibition was incompatible with the Charter but also laid out criteria for the constitutionality of any future replacement legislation), I will note a few additional points. First, in making this decision, the court was explicit that it did not see itself as departing entirely from the ethical reference points employed by the majority in Rodriguez, notably that of the sanctity of life:

The sanctity of life is one of our most fundamental societal values. Section 7 is rooted in a profound respect for the value of human life. But s. 7 also encompasses life, liberty and security of the person during the passage to death ... And it is for this reason that the law has come to recognize that, in certain circumstances, an individual’s choice about the end of her life is entitled to respect.41

Second, in its submission, the government of Canada attempted to undermine the assessment of empirical data made by Justice Smith in her Supreme Court of British Columbia ruling, presenting further evidence on the matter from Professor Etienne Montero, a bioethicist. The court did not consider this new evidence probative against Smith’s position. But its statement on this point contains a passage that could be of considerable import for adjudicating an interpretive dispute that has since arisen concerning the court’s criteria for constitutionally valid assisted death legislation:

Canada says that Professor Montero’s evidence demonstrates that issues with compliance and with the expansion of the criteria granting access to assisted suicide inevitably arise, even in a system of ostensibly strict limits and safeguards. It argues that this “should give pause to those who feel very strict safeguards will provide adequate protection: paper safeguards are only as strong as the human hands that carry them out” (R.F., at para. 97). Professor Montero’s affidavit reviews a number of recent, controversial, and high-profile cases of assistance in dying in Belgium which would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions. Professor Montero suggests that these cases demonstrate that a slippery slope is at work in Belgium. In his view, “[o]nce euthanasia is allowed, it becomes very difficult to maintain a strict interpretation of the statutory conditions.” We are not convinced that Professor Montero’s evidence undermines the trial judge’s findings of fact.42
Third, the Supreme Court specified that nothing in its ruling could be taken as compelling physicians to participate in an assisted death procedure and that the Charter rights of both patients and physicians (to conscience and freedom of religion) need to be respected by future legislation and guidelines put forward by federal and provincial legislatures and likewise medical associations.

Having invalidated sections 241(b) and 14 of the Criminal Code, the court proceeded to lay down some foundational requirements that any future legislation pertaining to assisted death will have to meet:

The appropriate remedy is therefore a declaration that s. 241(b) and s. 14 of the Criminal Code are void insofar as they prohibit physician-assisted death for a competent adult person who 1) clearly consents to the termination of life; and 2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. “Irremediable,” it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought.  

Those last two sentences might lead one to think that the Supreme Court intended the scope of its remedy to apply only to those in precisely the same circumstances as Taylor (and Rodriguez): namely, suffering from a grievous and irremediable medical condition such as ALS, which leads to profound physical incapacity. And, indeed, to interpret the intended scope of the remedy as restricted in this fashion would make better sense of the court’s argument from the right to life (i.e., that people in such circumstances have a right to euthanasia because otherwise they are liable to kill themselves prematurely while still physically capable of doing so). However, subsequent public discussions of the court’s ruling have not reflected such an interpretation, nor has the government’s legislative response to Carter in Bill C-14 – and with good reason. Earlier passages of the ruling clearly indicate that, in the court’s view, the relevant “factual circumstances” are not the circumstances of an ALS patient specifically but of a much broader range. For instance,

an individual’s response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The law allows people in
this situation to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment, but denies them the right to request a physician’s assistance in dying. This interferes with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty. And, by leaving people like Ms. Taylor to endure intolerable suffering, it impinges on their security of the person.  

Or consider this passage: “For the foregoing reasons, we conclude that the prohibition on physician-assisted dying deprived Ms. Taylor and others suffering from grievous and irremediable medical conditions of the right to life, liberty and security of the person” (p. 371; emphasis added). The court could have written “and others suffering from ALS and comparable incapacitating terminal conditions” but clearly intended that its ruling encompass a larger range of ailments.

The Supreme Court suspended the declaration of invalidity for one year (from February 6, 2015), giving the federal government a period of grace within which to enact new legislation pertaining to assisted death.

**Concluding Evaluative Remarks**

With the summaries of the four key rulings now complete, I will conclude the chapter with some brief evaluative remarks. The Supreme Court of Canada, in seeking to redress a concern regarding the alleged overbreadth of sections 241(b) and 14 of the *Criminal Code of Canada*, made much the same mistake. The court ruled that those sections infringed section 7 Charter rights because they drove those at risk of utter physical incapacitation to premature suicide and likewise deprived them of a proper measure of autonomy over the process of dying. A number of terminal ailments gradually bring on a loss of fine motor control, notably ALS, the terrible disease suffered by both Sue Rodriguez and Gloria Taylor. Someone in the final stages of ALS would indeed be unable to engage in the minimal physical activity needed to commit suicide, such as the self-administration of a deadly narcotic. But the number of such ailments is relatively small, and the total percentage of Canadians who perish from them annually is far smaller still. As such, it is unclear why the court struck down sections 241(b) and 14 in the manner that it did instead of declaring those sections void for that limited class of individuals demonstrably at risk of physical incapacitation. In other words, if the criminal prohibitions on assisted suicide and
euthanasia violated the section 7 rights of the physically incapacitated and those facing imminent physical incapacitation, then the proper scope of the legal remedy would seem to be that of allowing assisted suicide and euthanasia for people in those situations. Instead, the court opted to strike down these laws for a far broader class: namely, any competent consenting adult with a grievous and irremediable medical condition that he or she finds intolerable. One might argue, of course, that the court’s vastly broader remedy is superior on moral grounds: perhaps there is an inherent right to die, and/or perhaps the values of autonomy and self-integrity justify the legalization of assisted suicide and euthanasia. Nevertheless, the reason provided by the court (securing the rights to life, liberty, and security of the person for those at risk of imminent physical incapacitation) is unsuited to the actual remedy that it laid down.

Furthermore, the Supreme Court seems to have adopted as a working principle something akin to the following: *If the government’s doing or prohibiting something is realistically liable to drive a small class of individuals to suicide, then that government action or prohibition infringes the section 7 right to life.* Adoption of this principle could have untoward results. For instance, a small percentage of people who face lengthy prison sentences kill themselves before going to prison, or kill themselves while in prison, because they cannot bear the thought of spending twenty years there. This is a demonstrable fact, well known to criminologists and legislators: Lengthy prison sentences drive some people to commit suicide. Does that mean lengthy prison sentences are unconstitutional? One might reply that the law does infringe the section 7 right to life but that the infringement is necessary for the broader public good and is consistent with the principles of fundamental justice (precisely because the offenders are guilty of serious crimes). Perhaps. But has not something gone awry with a legal doctrine that would lead one to think that lengthy imprisonment for serious crimes (for, say, murder or rape) could be seen as infringing in any way an offender’s right to life? Keown (2014, p. 17), in his initial published critique of the Supreme Court of British Columbia’s ruling by Justice Smith, raises a related worry regarding the larger implications of such a principle: “And if this plaintiff is able to invoke the right to life against the law prohibiting assisted suicide, could another plaintiff invoke it against a law prohibiting assisting female genital mutilation, on the ground that she would rather kill herself than not be able to obtain assistance to mutilate her genitals?” The example, though gruesome, is hardly fanciful. In some cultures, the demand that
women undergo cliterodectomy or even infibulation is pressing, and such mutilations are regarded as a moral or even religious imperative. Women in these oppressive social contexts routinely risk their lives to undergo them.

It became apparent later from some of the public debates and lower-court challenges emerging since *Carter v Canada* that the high court’s stated legal remedy is multiply ambiguous. The language of “grievous and irremediable medical condition (including an illness, disease or disability)” does not specify whether physical conditions alone are to be included or whether mental illnesses qualify as well. I would argue that an earlier portion of the ruling (see the highlighted passage in the citation from p. 384–385) indicates that the Supreme Court rejected the claim that legalization of assisted death would lead to its availability for the mentally ill and thus indicates that the court intended at least implicitly to limit availability to those suffering from physical conditions. Still, this ought to have been made clearer; certainly, an explicit ruling out of psychiatric conditions in the statement of remedy on page 390 would have prevented the subsequent confusion about precisely this question.45

Another reason that the ruling does not allow for assisted death for the legally competent mentally ill is that mental illnesses will not meet the criterion of irremediability, on a properly stringent understanding of that criterion. Since *Carter v Canada*, two presidents of the Canadian Psychiatric Association (CPA) have spoken out on this. Kirkey (2015a) reports the views of President Padraic Carr:

> After practising for generations to prevent suicide, psychiatrists across Canada could soon be asked to help some people kill themselves ... “I have been approached by many psychiatrists who have serious concerns about physician assisted death being applied to mental illnesses,” said Dr. Padraic Carr, president of the Canadian Psychiatric Association and a professor of psychiatry at the University of Alberta. “Legal definitions are extremely important here,” he said. **Remediable** could be defined as treatable, or curable. In psychiatry, he said, “complete cures are quite rare.” Most treatments are directed at relieving symptoms. “If remediable implies a cure, then almost all psychiatric illnesses could be considered irremediable,” he said. If, on the other hand, remediable is defined as treatable, most psychiatric illnesses wouldn’t meet the standard, “because there are almost always treatment options we can try,” Carr said. **Intolerable** and **enduring** suffering are also problematic.
An Overview of Carter v Canada

Carr’s successor as president of the CPA, K. Sonu Gaind (2016), argued in a similar fashion, writing the following in an opinion piece published in the Globe and Mail:

Assessing irremediability in mental illness is very difficult. In neurodegenerative diseases with continued decline, irremediability can confidently be predicted. Not so with mental illness; in most cases, we can’t say when there is no chance of improvement. Remediability goes beyond biomedical symptoms. Social isolation, underemployment, poverty or lack of housing all have an impact on the suffering from mental illness. It may be more a societal question, but the question is, at what point are these irremediable? These concerns aren’t academic: In the Netherlands, most of the people receiving a medically assisted death for psychiatric conditions cited depression and unresolved loneliness. The Canadian Psychiatric Association has cautioned that there is no established standard of care in Canada for defining when typical psychiatric conditions are irremediable. We are not alone in struggling with this. I have spoken with leaders of psychiatric associations from Australia, New Zealand, the United Kingdom and the United States, and none is any further ahead at defining this.

Given these difficulties and ambiguities, the most plausible legal interpretation of Carter v Canada on this issue is to maintain that it does not open the door to assisted death for the legally competent mentally ill. In the intervening few years, other Canadian legal and medical scholars have sought to buttress the case for this claim. Others disagree, however, and this issue might be the subject of future legal adjudication.

The Supreme Court also could have been clearer on the operative understanding of “consent.” Debate has emerged regarding the legality of advanced directives – for example, cases in which someone facing descent into dementia signs an order requesting assisted death after the dementia has taken hold, at which point the person will no longer be legally competent. Moreover, it is not obvious that consent is a sufficiently strict criterion in the present context. The ruling appears to count the following two scenarios equally as instances of consent. First, the dying patient requests MAID from his family physician, with no prompting from that physician, or from family members, all of whom attempt to dissuade the individual from following through on his request. Second, the dying patient reluctantly agrees to undergo MAID after his family physician brought it up as an option repeatedly over several months and after being strongly encouraged to consider
MAID by multiple close family members. Legally, both scenarios count as consent, provided that the patient meets criteria for legal competence. But might not this show that, when it comes to MAID, a criterion more robust than consent ought to be put in place?

This is debatable, of course, and one might reply that any attempt to tighten up the criteria here smacks of an objectionable paternalism and/or a lack of faith in the autonomy of the severely ill (i.e., a lack of faith in their ability to make rational decisions and evaluate arguments for and against receiving MAID). Moreover, given that MAID is now legal, what legal grounds could there be for objecting to a physician or family member suggesting (indeed repeatedly encouraging) a patient to receive it, provided that such attempts do not involve threats of force or other means that would meet existing legal criteria for coercion? Yet those inclined to oppose MAID in the first place might see the latter point as providing further indication that there is indeed a risk here of a slippery slope, insofar as legalized MAID will make it difficult to prevent the practice of persuading the dying to terminate their lives early, in cases in which they might not have requested it otherwise (i.e., absent the persuasion). Indeed, legalized MAID seemingly guarantees that such persuasion is legally unobjectionable. What could be problematic legally about suggesting to someone that she perform a legal activity or repeatedly attempting to persuade that individual (through rational argument) to perform that legal activity in the event that she seems to be reluctant initially?

Relatedly, the Supreme Court’s acceptance of Justice Smith’s interpretation of the new empirical data on safeguards is also questionable. Scholarly opinion regarding the efficacy of these safeguards remains divided. And, if one maintains that MAID for the mentally ill is morally and/or legally insupportable, then the fact that it is now legal and increasingly routine in Belgium, the Netherlands, and Switzerland should give one pause. Furthermore, the court assessed these safeguards in a medical context that undergoes frequent changes, some of which might prove to be crucial to issues of consent and coercion. For example, at the moment, the most common method of MAID the world over is the administration of lethal doses of certain medications, whether orally or intravenously. However, if that method is abandoned in favour of death by organ removal (with the organs then used for transplantation), then subtle pressure on patients might increase and with it the risk of coercion and abuse. These might be grounds for future court challenges of *Carter v Canada* as the relevant empirical facts change.
It is important to observe as well that, in striking down sections 241(b) and 14 of the Criminal Code as infringing on a fundamental right, the Supreme Court established at best a negative right to MAID. It manifestly did not establish it as a positive right, with the state thereby obliged to provide it to patients who meet the necessary criteria. Nothing in this ruling obliges provinces to fund assisted death, and nothing implies that the failure to do so would put a province in contravention of the *Canada Health Act*'s requirement to fund medically necessary services.

Finally, it is worth recalling the legislative change that opened the door to *Carter v Canada*: namely, the decriminalization of attempted suicide in 1972. This change, undertaken with the most laudable of humanitarian motives, ended up weakening the legal authority of the state to discourage suicide – weakening it to the point where the Supreme Court of Canada could declare that a prohibition on assisted suicide infringes the right to life. Regardless of whether this resulting shift was proper and necessary (as proponents of MAID will maintain, not without reason), it will surely go down in Canadian history as one of the more striking examples of the law of unintended consequences.