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Legalizing therapeutic homicide and assisted suicide

A tour of *Carter v. Canada*

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Abstract

The trajectory of the trial was determined by the unchallenged fundamental premise that suicide can be a rational and moral act, and that the sole purpose of the law against assisted suicide is to prevent suicides by vulnerable people in moments of weakness, who might be tempted to commit suicide that is not rational and moral. The only issue was whether or not safeguards could be designed to permit legitimate access to assisted suicide, while preventing the vulnerable from accessing it in moments of weakness.

It was not thought reasonable to demand that a system of safeguards be 100% effective. A different standard was required. The standard chosen was the current regime of end-of-life practices, since the outcome of a mistake in this regime ('death before one's time') is the same as the outcome of a mistake in regulating assisted suicide.

Patient safety in end-of-life care is currently ensured by the principle of informed consent, assessment of patient competence, and the use of legal substitute decision-makers for incompetent patients. Since these measures are considered sufficient for the purposes of withholding, withdrawing or refusing treatment, it was decided that they should be sufficient for the regulation of assisted suicide for competent adults.

The burden of proof was on the defendant governments to prove that this could not be done. The text of the ruling indicates that they provided evidence of risk, but failed to prove that safeguards cannot be effective.

Madam Justice Smith does not rely on any part of the ethical discussion in Part VII of the ruling in reaching her conclusion about the constitutional validity of the law against assisted suicide. The discussion of ethics in Part VII is a judicial soliloquy that is likely to capture the attention of readers, but it is likely to distract them from the pith and core of the judgement and contribute to rather than minimize confusion and controversy.

In legal argument, keeping prudent silence about morality, philosophy or religion does not produce a morally neutral judicial forum. It simply allows dominant moral or philosophical beliefs to set the parameters for argument and adjudication. However, in the case of conscientious objection to participation in assisted suicide or therapeutic homicide, an appeal to freedom of conscience or religion must make direct reference to the beliefs of the objector about the moral nature of the act to which he objects.

Table of Contents

I. The decision

I.1 A British Columbia Supreme Court Justice has struck down Canada's absolute ban on assisted suicide as well as the rule that one cannot legally consent to be murdered.[1] The lengthy judgment of Madame Justice Lynn Smith in *Carter v. Canada* was delivered in June, 2012, following a trial in the fall of 2011. It pertains only to cases of physician-assisted suicide or homicide.[2] She has suspended the ruling for a year to give the government time to decide how to respond, but, in the meantime, has ruled that a physician may help one of the plaintiffs, Gloria Taylor, to commit suicide or provide her with therapeutic homicide, depending upon her medical condition at the time she wishes to die.[3] The government of Canada has filed notice of appeal.

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[1] *Carter v. Canada (Attorney General)* 2012 BCSC 886. Supreme Court of British Columbia, 15 June, 2012. Vancouver, British Columbia. (http://www.courts.gov.bc.ca/jdb-txt/SC/12/08/2012BCSC0886.htm) Accessed 15 June, 2012. Hereinafter "*Carter v. Canada*." The judgement refers to the "impugned provisions" of the Criminal Code, including the law against counselling or assisting suicide (Criminal Code, Section 241) and the law that consent is not a defence to a charge of murder (Criminal Code, Section 14). *Carter v. Canada*, para. 101.

[2] In the summary of the ruling, the judge states that Taylor "will be permitted to seek, and her physician will be permitted to proceed with, physician assisted death." (*Carter v. Canada*, para. 19). However, the judge later specifies she is striking down the "impugned provisions" to the extent that they prohibit physician-assisted suicide *or consensual physician-assisted death." (Carter v. Canada*, para. 1393(b), emphasis added.) "Consensual physician-assisted death" is distinguished from physician-assisted suicide in the plaintiffs' Amended Notice of Claim (para. 7, 8) and defined as the act of a medical practitioner that causes the death of a patient. This is acknowledged by the judge in the ruling (*Carter v. Canada*, para. 23). The judge herself does not define the term, but "consensual physician-assisted death" is encompassed by her definition of euthanasia (*Carter v. Canada*, para. 38). Consistent with this, the constitutional exemption granted to plaintiff Gloria Taylor states that "the mechanism for the physician-assisted death shall be one that involves her own unassisted act and not that of any other person," unless she is "physically incapable." (*Carter v. Canada*, para. 1414(f)) This would authorize a lethal injection by a physician, which, but for the ruling, would be homicide, not assisted suicide.

[3] "Therapeutic homicide" refers to this kind of act, otherwise called euthanasia. The term was not used in the judgement, but in the title of an editorial in the *Canadian Medical Association Journal* responding to the ruling (Flegel K. and Fletcher J. "Choosing when and how to die: Are we ready to perform therapeutic homicide?" Early release, 25 July, 2012. CMAJ 2012. DOI:10.1503/cmaj.120961. [http://www.cmaj.ca/content/early/2012/06/25/cmaj.120961.1] Accessed 2012-06-26). While novel, it is actually a legally precise formulation, since, in Canadian law, 'homicide' refers simply to the killing of a human being, without an implication of illegality.

II. Legal background

II.1 The decision is particularly noteworthy because of the 1993 Supreme Court of Canada decision in *Rodriguez v. British Columbia (Attorney General)*.[4] Sue Rodriguez, who had amyotrophic lateral sclerosis ("ALS" or "Lou Gehrig's Disease"), sought to overturn the law so that a physician could assist her in suicide. In a 5-4 decision, the Supreme Court rejected her claim and upheld the constitutional validity of the law against assisted suicide. The circumstances in the *Carter* case are very similar, so the ruling raises important questions about the doctrine of precedent, the legal rule of *stare decisis*: the practice of lower courts being bound by higher courts' rulings.

II.2 The Hon. Antonio Lamer, Chief Justice of the Supreme Court of Canada in 1993, was one of the dissenting minority who supported Rodriguez's application. He was willing to order a physician to assist her in suicide, but did not do so because she had not sought such an order.[5] A young lawyer named Jocelyn Downie was a clerk for the Chief Justice at the time.[6]

II.3 Jocelyn Downie is now a professor in the Faculties of Law and Medicine at Dalhousie University in Halifax, Nova Scotia. She is a Fellow of the Royal Society of Canada and the Canadian Academy of Health Sciences, and Canada Research Chair in Health Law and Policy.[7]

II.4 In a 2007 symposium at Carleton University in Ottawa,[8] Professor Downie asserted that

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[4] *Rodriguez v. British Columbia (Attorney General)*, 3 S.C.R. 519 (1993), 107 D.L.R. (4th) 342, 85 C.C.C. (3d) 15 (http://scc.lexum.org/en/1993/1993scr3-519/1993scr3-519.html) Accessed 2012-06-27

[5] Protection of Conscience Project, *Chief Justice favours assisted suicide, willing to order assistance* (http://www.consciencelaws.org/issues-background/assist/assist01.html)

[6] Jocelyn Downie, curriculum vitae (http://www.med.mun.ca/dignitysymposium/pdfs/bios/Downie.cv.pdf) Accessed 2012-07-01

[7] Dalhousie University, Schulich School of Law, Jocelyn Downie. (http://law.dal.ca/Faculty/Full_Time_Faculty/Bio-J_Downie.php) Accesssed 2012-07-16

[8] The two day conference at Carelton University was called "Ethical, Legal, and Social Perspectives on Physician Assisted Suicide." Professor Downie presented "Rodriguez Revisited: Canadian Assisted Suicide Law and Policy in 2007." Dalhousie University, ListServ Home Page, FABLIST Archives, Message from Rebecca Kukla, 6 February, 2007. "Symposium on physician assisted suicide." (https://listserv.dal.ca/index.cgi?A2=ind0702&L=FABLIST&F=P&P=154) Accessed 2012-06-27

the Supreme Court of Canada might be willing to reverse its 1993 ruling in *Rodriguez*.[9] She outlined the strategy for a legal challenge under Canada's *Charter of Rights and Freedoms* (the *Charter*) and said that she was looking for an ideal test case to use to strike down the law.[10] She published a paper and essay in 2008 that appear to have drawn from her Carleton presentation. The 2007 presentation and subsequent publication set out the strategy for the plaintiffs' successful argument in *Carter*.[11] Professor Downie assisted the plaintiffs in the *Carter* case in instructing their expert witnesses.[12]

III. The litigation

III.1 *Charter of Rights* claims: life, liberty, security of the person and equality

III.1.1 The case began in April, 2011, with a claim filed by the BC Civil Liberties Association (BCCLA), family physician Dr. William Shoichet of Victoria, B.C. and Lee Carter and her husband, Hollis Johnson. Lee Carter's 90 year old mother had committed suicide at the Dignitas facility in Zurich, Switzerland, in 2010, because assisted suicide was illegal in Canada.[13]

III.1.2 The plaintiffs claimed that the law violates the *Charter* guarantee of equality (Section 15) because able-bodied persons can commit suicide without assistance, but disabled persons may not be able to do so, and are thus "deprived of the ability to choose and carry out their death in any lawful way."[14] They also argued that the law against assisted

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[9] *Rodriguez v. British Columbia (Attorney General)*, 3 S.C.R. 519 (1993), 107 D.L.R. (4th) 342, 85 C.C.C. (3d) 15 (http://scc.lexum.org/en/1993/1993scr3-519/1993scr3-519.html) Accessed 2012-06-27

[10] It does not appear that Prof. Downie's presentation was published. A detailed account of it was written by Alex Schadenberg of the Euthanasia Prevention Coalition, who was present when it was delivered. Schadenberg, Alex, *Dalhousie law professor seeks to re-visit Rodriguez court decision.* Euthanasia Prevention Coalition.

[11] Downie, Jocelyn and Bern, Simone, "Rodriguez Redux." *Health Law Journal* 2008 16:27-64. (http://www.dyingwithdignity.ca/database/files/Rodriguez_Redux.pdf) Accessed 2012-06-27.

[12] *Carter v. Canada*, para. 124

[13] In the Supreme Court of British Columbia, *Notice of Civil Claim between Lee Carter, Hollis Johnson, Dr. William Shoichet and the British Columbia Civil Liberties Association (Plaintiffs) and the Attorney General of Canada (Defendant)* dated 26 April, 2011 (http://www.consciencelaws.org/archive/documents/carter/2011-04-26-noticeofclaim01.pdf) Accessed 2011-05-01. Hereinafter "*Original Notice of Claim*."

[14] *Original Notice of Claim*, Part 3, para. 23

suicide violates *Charter* guarantees of "life, liberty and the security of the person" (Section 7) with respect to the "grievously and irremediably ill," who seek physician-assisted suicide[15] and persons wishing to assist them to obtain that service,[16] including physicians.[17]

III.2 Constitutional claim: jurisdiction over health care

III.2.1 The third legal argument advanced by the plaintiffs was that "treatment and management of the physical and emotional suffering of a grievously and irremediably ill patient" are matters that fall within the "exclusive jurisdiction" of the provinicial government, which is constitutionally mandated to manage health care.[18] Since (according to the plaintiff physician) physician-assisted suicide and voluntary euthanasia are "important component[s] of the provision of health care to grievously and irremediably ill patients,"[19] the lawsuit asked that sections of the Criminal Code (a federal statute) that prevent the provision of this "health care" should be struck down as an unconstitutional interference in provincial jurisdiction, "to the extent that [they] prohibit physician-assisted dying."[20]

III.3 Remedy sought

III.3.1 In short, the plaintiffs sought the court-ordered legalization of physician-assisted suicide and euthanasia by physicians, or by persons acting under their direction[21] for anyone "grievously and irremediably ill" (not "terminally ill"). Similarly, the BCCLA press release referred, not to terminal illness, but to "serious illness that cannot be remedied" and "seriously and incurably ill individuals." Though it seems that the Association was thinking primarily of "mentally competent adults,"[22] no age restriction was indicated.[23]

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[15] *Original Notice of Claim*, Part 3, para. 5-11

[16] *Original Notice of Claim*, Part 3, para. 12-14

[17] *Original Notice of Claim*, Part 3, para. 15-17

[18] *Original Notice of Claim*, Part 3, para. 2

[19] *Original Notice of Claim*, Part 2, para. 35

[20] *Original Notice of Claim*, Part 2, para. 1-3.

[21] *Original Notice of Claim*, Part 1, para. 6, 7

[22] BC Civil Liberties Association, "BCCLA launches lawsuit to challenge criminal laws against medically-assisted dying." *BC Civil Liberties press release* (undated)(http://www.bccla.org/pressreleases/11Medically_assisted_dying.html) Accessed 2011-05-01. (Hereinafter *BCCLA release 2011-05-01*)

[23] *Original Notice of Claim*, Part 1, para. 6-9

III.4 New plaintiff joins case

III.4.1 63 year old Gloria Taylor formally joined the action in August, 2011. She had been diagnosed in January, 2010 with amyotrophic lateral sclerosis ("ALS" or "Lou Gehrig's Disease") and advised that she would likely die within a year. The addition of Taylor to the case did not change the plaintiffs' arguments, but it strengthened the claim because she was a living person whose interests were directly affected by the existing law.[24] Her diagnosis also gave the plaintiffs the opportunity to argue for an expedited trial.

IV. The trial

IV.1 Summary trial process

IV.1.1 Over the objections of the governments of Canada and British Columbia, a summary trial rather than a conventional trial was held in November and December, 2011. A summary trial is a proceeding in which the evidence consists largely of affidavit evidence, legislative facts and expert opinion evidence. The judge agreed to a modified expedited summary trial because of Taylor's deteriorating condition and the inability of counsel for the plaintiffs to represent them *pro bono* in a lengthy conventional trial.[25]

IV.1.2 Interventions in support of the plaintiffs were filed by the Farewell Foundation for the Right to Die, the Canadian Unitarian Council and the Ad Hoc Coalition of People with Disabilities Who are Supportive of Physician-Assisted Dying. The Christian Legal Fellowship (CLF) and Euthanasia Prevention Coalition (EPC) intervened in support of the absolute ban on assisted suicide.

IV.1.3 The plaintiffs did not pursue the claim that the prohibition of assisted suicide and euthanasia was a federal trespass on provincial jurisdiction.[26] However, this conclusion may be implicit in the ruling,[27] and, if so, may yet have significant consequences.

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[24] In the Supreme Court of British Columbia, between Lee Carter, Hollis Johnson, Dr. William Shoichet, the British Columbia Civil Liberties Association and Gloria Taylor (Plaintiffs) and the Attorney General of Canada (Defendant), Notice of Application and Amended Notice of Civil Claim dated 15 August, 2011 (http://www.consciencelaws.org/archive/documents/carter/2011-04-26-noticeofclaim02.pdf) Accessed 2011-05-01. Hereinafter "*Amended Notice of Claim*."

[25] *Carter v. Canada,* para. 137-142

[26] *Carter v. Canada*, para. 29

[27] "British Columbia . . . argued that if physician-assisted death is proper medical treatment, as the plaintiffs suggest, there may be considerable debate whether Parliament even has the constitutional jurisdiction to enact safeguards . . ." *Carter v. Canada*, para. 1397

IV.2 Overview of the analytical method

IV.2.1 Madam Justice Smith followed the analytical method established by precedent in adjudicating the claims of violations of equality guarantees (*Charter* Section 15) and life, liberty and security of the person (*Charter* Section 7).

IV.2.2 With respect to equality (Section 15)[28] the following questions are considered:

A. Is the law discriminatory? That is:

1) Does it create a distinction based on physical disability?

2) Does the distinction create a disadvantage?[29]

B. If the law is discriminatory, can it, nonetheless, be demonstrably justified as a reasonable limit prescribed by law in a free and democratic society under Section 1 of the *Charter*?[30] That is:

3) Is the purpose pressing and substantial?

4) Are the means proportionate to the end? Specifically:

a) Is the limit rationally connected with the purpose?

b) Does the limit minimally impair the Charter right?

c) Is the law proportionate in its effect?[31]

IV.2.3 The analysis of alleged violations of life, liberty and security of the person (Section 7)[32] is different, but some aspects of the analysis overlap with the Section 15 analysis:

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[28] *Canadian Charter of Rights and Freedoms*, Section 15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[29] *Carter v. Canada*, para. 1026

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

[31] *Carter v. Canada*, para. 1169

[32] *Canadian Charter of Rights and Freedoms*, Section 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

A. Does the law deprive the plaintiff of life, liberty or security of the person?

B. Is the deprivation in accordance with principles of fundamental justice? Specifically:

a) Is the deprivation arbitrary?[33]

b) Is the law overbroad?[34]

c) Is the effect of the law grossly disproportionate to the problem it addresses?[35]

C. Again, if the law contravenes principles of fundamental justice, can it, nonetheless, be demonstrably justified under Section 1 of the *Charter*?[36]

IV.2.4 There is some dispute about the necessity of this step (C) if a Section 7 violation is demonstrated,[37] but this is a moot point because the judge stated that her conclusion in this case would be identical to her conclusion in the Section 15 analysis (above).[38]

IV.3 Burden of proof

IV.3.1 With respect to equality *claims* under Section 15, the burden of proof lies on the plaintiffs to show that the law is discriminatory. Under Section 7 they must prove that the law deprives them of life, liberty or security of the person and violates principles of fundamental justice.[39] Madam Justice Smith noted that, with respect to the latter, the plaintiffs must show either that the law is not the least restrictive that could have been chosen to achieve its purpose,[40] or that it is so extreme that it is "disproportionate to any legitimate government interest."[41]

IV.3.2 Once the plaintiffs have proved that the law is discriminatory and/or that it improperly

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[33] *Carter v. Canada*, para. 1331-1332

[34] *Carter v. Canada*, para. 1339

[35] *Carter v. Canada*, para. 1373-1375

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

[37] *Carter v. Canada*, para. 1379-1382

[38] *Carter v. Canada*, para. 1383

[39] *Carter v. Canada*, para. 1288

[40] *Carter v. Canada*, para. 1339, 1348, 1361

[41] *Carter v. Canada*, para. 1376

deprives them of life, liberty or security of the person, the burden of proof shifts to the government to justify the law under Section 1 of the *Charter*. The government must prove that the infringement of rights or freedoms is justified.[42]

IV.4 Standard of proof

IV.4.1 Neither plaintiffs nor defendants are required to provide "proof beyond reasonable doubt," the standard used in criminal prosecution. All that is required is proof on the balance of probabilities:[43] that a party produce evidence to show that something is more probably the case than not.[44] Empirical evidence is not required:

> While some matters can be proved with empirical or mathematical precision, others, involving philosophical, political an social considerations cannot. . . It is enough that the justification be convincing, in the sense that it is sufficient to satisfy the reasonable person looking at all the evidence and relevant considerations, that the state is justified in infringing the right at stake to the degree that it has. *Sauve v. Canada (Chief Electoral Officer)* 2002 SCC 68 at para. 18.[45]

IV.4.2 However, while empirical evidence is not required, empirical evidence, when it exists with respect to a point in issue, will be more persuasive than other forms of evidence, including expert opinion.

IV.5 The evidentiary record

IV.5.1 The evidence received by the judge included 116 affidavits, some hundreds of pages long with secondary sources attached as exhibits, as well as other documents, all of which filled 36 binders. 18 witnesses were cross-examined.[46] The judge commented that the parties thoroughly reviewed the materials in their submissions.[47] She noted that Canada had been especially and unexpectedly thorough in identifying risks associated with legalization of assisted suicide.[48] While the timelines for the trial were tight, the

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[42] *Carter v. Canada*, para. 952, 954, 1172, 1217

[43] *Carter v. Canada*, para. 1172, 1288, 1348.

[44] *F.H. v. McDougall*, 2008 SCC 53, 2008 (http://scc.lexum.org/en/2008/2008scc53/2008scc53.html) Accessed 2012-07-02

[45] Quoted in *Carter v. Canada*, para. 1178

[46] *Carter v. Canada*, para. 114

[47] *Carter v. Canada*, para. 115

[48] *Carter v. Canada*, para. 157

defendant governments did not identify any evidence that they were unable to provide because of the summary trial process.[49] Madam Justice Smith reviewed the entire evidentiary record, but does not refer to every affidavit or the evidence of every witness in her ruling.[50]

V. Judge's review of the evidence

V.1 Introduction

V.1.1 It is beyond the scope of this paper to examine the evidence presented at the trial in detail, something that cannot be done without access to all of the documents and transcripts of the proceeding. However, it is possible to summarize the judge's findings on issues that were central to her reasoning and determined the outcome of the case. The latter primarily concern the question of whether or not it is possible to establish safeguards that will prevent harms that might flow from legalizing assisted suicide and euthanasia.

V.2 Safeguards: effectiveness, palliative care, and physician-patient relationships

V.2.1 In Part VIII (paragraphs 359 to 747) Madam Justice Smith reviewed the evidence concerning the practice of assisted suicide and euthanasia and the effectiveness of safeguards in Oregon, Washington, Belgium, the Netherlands, Luxembourg and Switzerland.

V.2.2 With respect to compliance with safeguards, the judge found that the process in Oregon, "is working fairly well but could be improved,"[51] and compliance in the Netherlands " is continually improving" but not yet ideal.[52] Things are clearly less satisfactory in Belgium, where she acknowledged "low rates of reporting. . . and high rates of LAWER." [life ending acts without explicit request] However, she noted evidence that the incidence of LAWER had declined since legalization of euthanasia and assisted suicide.[53]

V.2.3 Concerning the effectiveness of safeguards, the judge concluded that there is no empirical evidence that legalizing assisted suicide and euthanasia "has imposed a particular risk to socially vulnerable populations" in the Netherlands and Oregon.[54] She added that the evidence "does not support the conclusion that pressure or coercion is at all wide-spread

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[49] *Carter v. Canada*, para. 144

[50] *Carter v. Canada*, para. 115

[51] *Carter v. Canada*, para. 653

[52] *Carter v. Canada*, para. 656

[53] *Carter v. Canada*, para. 657

[54] *Carter v. Canada*, para. 667

or readily escapes detection" in those jurisdictions.[55] She could not reach firm conclusions about Belgium.[56]

V.2.4 Summing up the evidence on the effectiveness of safeguards, Madam Justice Smith noted that, with respect to the Netherlands, Belgium and Oregon, "the predicted abuse and disproportionate impact on vulnerable populations has not materialized,"[57] and, though the systems were not perfect, "empirical researchers and practitioners who have experience in those 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."[58]

V.2.5 After reviewing the evidence of the impact of legal assisted suicide and euthanasia on palliative care[59] she decided that it showed that palliative care had not been undermined by legalization, but had in some respects improved.[60] However, she was reluctant to apply the findings directly to Canada[61] and concluded only that, while legalizaton could affect palliative care, the effect would not necessarily be negative.[62]

V.2.6 Similarly, she found that the evidence indicated that if assisted suicide and euthanasia were legalized, physician-patient relationships "would not necessarily change for the worse," and that "the net effect could prove to be neutral or for the good."[63]

V.2.7 Madam Justice Smith succinctly summarized her findings:

> Research findings show differing levels of compliance with the safeguards and protocols in permissive jurisdictions. No evidence of inordinate impact on vulnerable populations appears in the research. Finally, the research does not clearly show either a negative or a positive impact in permissive jurisdictions on the availability of palliative care or on the physician-patient

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[55] *Carter v. Canada*, para. 671

[56] *Carter v. Canada*, para. 672

[57] *Carter v. Canada,* para. 684

[58] *Carter v. Canada*, para. 685

[59] *Carter v. Canada*, para. 709-730

[60] *Carter v. Canada*, para. 731

[61] *Carter v. Canada*, para. 732-735

[62] *Carter v. Canada*, para. 736

[63] *Carter v. Canada*, para. 746

relationship.[64]

V.3 Feasibility of safeguards: risks to patients

V.3.1 In Part IX 9 (paragraphs 748 to 853) she considers the evidence about the feasibility of safeguards and addresses the following topics:

a) patient competence

i) general considerations (para. 762-769)

ii) cognitive impairment (para. 770-784)

iii) depression (para. 785-798)

b) voluntariness (para. 799-815)

c) informed consent (para. 816-831)

d) patient ambivalence (para. 832-843)

e) the elderly (para. 844-847)

f) the disabled (para. 848-853)

V.3.2 While acknowledging the difficulties associated with ensuring that patients are competent to decide to seek assisted suicide or euthanasia, the judge decided "that it is feasible for properly-qualified and experienced physicians reliably to assess patient competence . . . so long as they apply the very high level of scrutiny appropriate to the decision and proceed with great care."[65]

V.3.3 In considering the issue of voluntariness and concerns that patients might be pressured into committing suicide, she accepted the evidence of defendant witnesses Gallagher, Chochinov, Heisel and Frazee concerning the subtley of influences that can be brought to bear on patients, but also accepted the evidence of plaintiff witnesses Ganzini and Donnelly "that coercion and undue influence can be detected as part of a capacity assessment."[66]

V.3.4 In the view of the judge, the evidence demonstrates that the issue of informed consent presents no more difficulty in the case of assisted suicide and euthanasia than in seeking or refusing medical treatment.[67] The conclusion is consistent with evidence from one of the plaintiff witnesses that "the risks and benefits of a lethal prescription are

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[64] *Carter v. Canada*, para. 9

[65] *Carter v. Canada*, para. 798

[66] *Carter v. Canada*, para. 815

[67] *Carter v. Canada*, para. 831

straightforward and not cognitively complex."

> This risk is that the prescription might not work; the benefit is that the patient's life will end at a time of her choosing.[68]

V.3.5 With respect to patient ambivalence about dying, the judge concluded "that it is feasible to screen out. . . patients who are ambivalent, by assessing capacity and requiring some time to pass between the decision and its implementation."[69]

V.3.6 Finally, while she recognized the elderly are vulnerable to abuse and that the disabled "face prejudice and stereotyping," the judge ruled "there is no evidence that the elderly access physician-assisted dying in disproportionate numbers in permissive jurisdictions"[70] and that the risks to the disabled can be "avoided through practices of careful and well-informed capacity assessments by qualified physicians who are alert to those risks."[71]

V.3.7 Madam Justice Smith concluded her review of the effectiveness and feasibility of safeguards as follows:

> My review of the evidence. . . leads me to conclude 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.[72]

VI. The legal analysis

VI.1 Finding of "discrimination"

VI.1.1 The judge's reasoning in *Carter* begins with the fact that neither suicide nor attempted suicide are illegal,[73] and relies upon her belief that suicide (and, hence, assisted suicide)

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[68] *Carter v. Canada*, para. 775

[69] *Carter v. Canada*, para. 843

[70] *Carter v. Canada*, para. 853, 847

[71] *Carter v. Canada*, para. 853

[72] *Carter v. Canada*, para. 883

[73] *Carter v. Canada*, para. 102-107. The parties and most commentators often fail to distinguish between suicide and *attempted* suicide. As the judge explicitly states (para. 103-105), it was the offence of *attempted* suicide - not suicide - that was abolished in 1972. Suicide was an offence at common law in England at Confederation and was thus part of criminal law at that time, but was arguably abolished as an offence in Canada with the enactment of the first *Criminal Code* in 1892. It was certainly abolished when Parliament formally abolished all

is not only legal, but can be a rational and moral act: not that it *always* is, but that it *can* be.[74] This inescapably moral position is obscured by a claim of neutrality.[75]

VI.1.2 That suicide can be deliberately chosen by someone who is of sound mind has long been recognized by the law, but the common law that came to Canada from England held that such an act was immoral and contrary to reason.[76] Subsequent changes to the law were intended to make it more effective in preventing suicide, not to create a right to suicide (see below.) Indeed, the majority of the Supreme Court of Canada in *Rodriguez* suggested unconditional disapprobation when they observed that one reason for prohibiting physician assisted suicide is that to allow it "would send a signal that there are circumstances in which the state approves of suicide."[77] Consistent with this, many people continue to believe that suicide, while not blameworthy if it results from severe mental or emotional disorder, is immoral or unethical if deliberately chosen, and should always be prevented. The most significant difference between their beliefs and those of

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common law offences in 1955 (*Criminal Code*, Section 9).

[74] *Carter v. Canada*, para. 339. The judge uses the term "ethical," not "moral," and more frequently employs the former, but she treats them as synonyms when addressing the question, "Does the law attempt to uphold a conception of morality inconsistent with the consensus in Canadian society?" (para. 340-358) Moreover, witnesses on both sides do not typically distinguish between ethical and moral issues. See, for example, Dr. Shoichet (plaintiffs) at para. 75, Prof. Sumner (plaintiffs) at para. 237, Dr. Bereza (defendants) at para. 248, Dr. Preston (plaintiffs) at para. 262. The judge defines ethics as "a discipline consisting of rational inquiry into questions of right and wrong" and frames the question accordingly: " whether it is right, or wrong, to assist persons who request assistance in ending their lives and, if it is right to do so, in what circumstances." *Carter v. Canada*, para. 164. Most would see in this passage no way to distinguish between ethics and moral philosophy.

[75] *Carter v. Canada*, para. 180-181

[76] "The party must be of years of discretion, and in his senses, else it is no crime. But this excuse ought not to be strained to that length, to which our coroner's juries are apt to carry it, viz. that the very act of suicide is an evidence of insanity; as if every man, who acts contrary to reason, had no reason at all: for the same argument would prove every other criminal non compos, as well as the self-murderer. The law very rationally judges that every melancholy or hypochondriac fit does not deprive a man of the capacity of discerning right from wrong; which is necessary, as was observed in a former chapter, to form a legal excuse." Blackstone, William, *Commentaries on the Laws of England* (12th ed), Vol. IV. London: A. Strahan and W. Woodfall, 1795, p. 188-189.

[77] *Rodriguez v. British Columbia (Attorney General)*, 3 S.C.R. 519 (1993), 107 D.L.R. (4th) 342, 85 C.C.C. (3d) 15 (http://scc.lexum.org/en/1993/1993scr3-519/1993scr3-519.html) Accessed 2012-07-08.

Madam Justice Smith is that her beliefs can directly shape the law, and theirs cannot.

VI.1.3 Thus, it is important to recognize that the trajectory of the ruling in the *Carter* case was determined by the judge's beliefs about suicide: that, *Rodriguez* notwithstanding, there *are* circumstances in which it can be approved. Further: the ruling proceeds as if people who continue to hold that deliberate suicide is immoral don't exist, or that their beliefs are of no account in legal reasoning. Neither of these points invalidates the ruling; both are actually irrelevant to the issues before the Court in *Carter*. Both, however, are of interest within the broader context of the significance of *Carter* for freedom of conscience, because the ruling has implications for people other than the plaintiffs, especially those who disagree with the ruling but may be expected to implement it.

VI.1.4 Returning to the judge's reasoning, she observed that the able-bodied can (rationally and morally) commit suicide[78] without assistance in order to relieve themselves of the burden of pain or suffering, and are not hampered by the law in so doing. In contrast, she said, disabled people may not be able to commit suicide without assistance, and are thus forced to carry a burden of pain or suffering,[79] a burden she graphically illustrated by reference to the evidence.[80] She decided that the law, though neutral on its face, disproportionately affects disabled people,[81] and thus creates a distinction based on physical disability.[82] Madam Justice Smith concluded that the distinction is discriminatory because it disadvantages a particular subset of persons (the disabled)[83] by perpetuating and exacerbating their disadvantages.[84]

VI.2 The question of justification

VI.2.1 Having decided that the law against assisted suicide violates the *Charter* guarantee of equality (Section 15) and is thus discriminatory, the judge asked if it could, nonetheless, be "demonstrably justified" as a "reasonable limit" to the rights and freedoms of disabled

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[78] The qualifications "rationally and morally"are implicit in the reasoning but not stated.

[79] *Carter v. Canada*, para. 1039-1050, 1064

[80] *Carter v. Canada*, para. 258, 1277-1278

[81] *Carter v. Canada*, para. 1032-1036

[82] *Carter v. Canada*, para. 1156

[83] *Carter v. Canada*, para. 1159

[84] *Carter v. Canada*, para. 1161

people.[85]

> . . . it is the absolute nature of the prohibition against assisted suicide that requires justification, not the prohibition overall. In other words, the real question is whether or not the defendants have demonstrated justification for criminalizing the rendering of assistance in suicide to persons such as Gloria Taylor.[86]

VI.2.2 The analysis here required the judge to determine whether or not the purpose of the law is "pressing and substantial," if the prohibition imposed by the law is "rationally connected with the purpose", if it minimally impairs the *Charter* right or freedom, and if it is proportionate in its effect.[87]

VI.3 Purpose of the law

VI.3.1 There was some discussion about ethical principles that inform the law. Canada was somewhat incoherent on this point. It claimed that an ethical position is irrelevant to the legal issues, but then said that the preservation of human life "is a fundamental value," as if that statement had no ethical content. In any case, it argued that the criminal law embodied the state's interest in preserving human life by not condoning the taking of human life.[88] British Columbia suggested the principle of "the sanctity of life" as fundamental,[89] while the Christian Legal Fellowship put forward the "inviolability principle" - "that the intentional taking of innocent human life is always wrong."[90] Similarly, the Euthanasia Prevention Coalition stated that "human life is intrinsically valuable and inviolable."[91]

VI.3.2 All of these principles could be applied to make the case that suicide is always wrong or at least always undesirable, and that the purpose of the law and goal of public policy is to prevent *all* suicides. This approach would have been entirely consistent with the origin of

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[85] *Carter v. Canada*, para. 1163 to 1168

[86] *Carter v. Canada*, para. 1171

[87] *Carter v. Canada*, para. 1169

[88] *Carter v. Canada*, para. 168, 1147, 1187

[89] *Carter v. Canada*, para. 169

[90] *Carter v. Canada*, para. 171

[91] *Carter v. Canada*, para. 172

the law.[92] It would also have been consistent with the rationale for abolishing the offence of attempted suicide; the law was changed try to prevent suicide because it was thought it was more likely to be prevented by the intervention of medical experts rather than magistrates.[93]

VI.3.3 However, the judge observed that many of the defendant witnesses "[did] not base their opinions upon the need to uphold the sanctity of human life, or on that alone."[94] None of the parties explicitly argued that the purpose of the law is to prevent all suicides, and none addressed the morality of suicide, probably because the subject is not one that can be argued effectively in an environment of moral pluralism. Note, however, that the failure to address the morality of suicide did not produce a forum cleansed of moral beliefs. It simply allowed the moral belief that suicide can be rational and moral set the parameters for argument and adjudication.

VI.3.4 While Canada agreed that protecting vulnerable people is one of the purposes of the law, it claimed that the law also had other valid objectives: preventing damage to physician-patient relationships, preventing adverse impacts on palliative care, and preventing the spread of negative messages about the value of human life.[95] The judge did not ignore these considerations,[96] but subtly reminded Canada that it had insisted that she was bound

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[92] ". . . the law of England widely and religiously considers, that no man hath a power to destroy life, but by commission from God, the author of it:and, as the suicide is guilty fo a double offence; one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes, making is a peculiar species of felony, a felong committed on one's self. And this admits of accessories before the fact, as well as other felonies; for if one persuades another to kill himself, and he does so, the adviser is guilty of murder." Blackstone, William, *Commentaries on the Laws of England* (12th ed), Vol. IV. London: A. Strahan and W. Woodfall, 1795, p. 188.

[93] *Carter v. Canada*, para. 105, 1146

[94] *Carter v. Canada*, para. 352

[95] *Carter v. Canada*, para. 1187

[96] *Carter v. Canada*, para. 1191

to follow the *Rodriguez* judgement,[97] and then purported to follow *Rodriguez*[98] by rejecting the additional purposes suggested by Canada.[99]

VI.3.5 Consistent with her belief that suicide can be a rational and moral act, the judge concluded that the sole purpose of the law against assisted suicide is to prevent suicides by vulnerable people who, in a moment of weakness, might succumb to suggestions or pressures by others.[100] In other words, it is not the purpose of the law to prevent suicide by the likes of Gloria Taylor, or by absolutely everyone. The law is meant to protect only

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[97] *Canada v. Carter*, para. 1187: "In submissions that I take to be alternative to its main submission that *Rodriguez* is binding. . . "

[98] In *Rodriguez*, the majority opinion was given by Mr. Justice Sopinka. He adopted the expressions used by judges in the B.C. Court of Appeal when he said that the prohibition of assisted suicide "has as its purpose the protection of the vulnerable who might be induced in moments of weakness to commit suicide," and characterized the issue "as being whether the blanket prohibition on assisted suicide is arbitrary or unfair in that it is unrelated to the state's interest in protecting the vulnerable. . . Creating an exception for the terminally ill might therefore frustrate the purpose of the legislation of protecting the vulnerable because adequate guidelines to control abuse are difficult or impossible to develop. . . .The prohibition against assisted suicide . . .may discourage those who consider that life is unbearable at a particular moment, or who perceive themselves to be a burden upon others, from committing suicide. " Thus far, *Carter* is consistent with *Rodriguez*. *Rodriguez v. British Columbia (Attorney General)*, 3 S.C.R. 519 (1993), 107 D.L.R. (4th) 342, 85 C.C.C. (3d) 15 (http://scc.lexum.org/en/1993/1993scr3-519/1993scr3-519.html) Accessed 2012-07-08.

[99] *Canada v. Carter*, para. 1188-1190. One of the additional purposes - "preventing the spread of negative messages about the value of human life"- was consistent with the majority opinion in *Rodriguez*, which stated that the purpose of protecting the vulnerable "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." Similarly, the majority stated that this "is part of our fundamental conception of the sanctity of human life." Nonetheless, it is possible to interpret the majority opinion to mean that a principle of respect for the sanctity of human life underlies the law in general, and that the law against assisted suicide applies the principle in specific circumstances for a particular purpose (the protection of the vulnerable in moments of weakness.) *Rodriguez v. British Columbia (Attorney General)*, 3 S.C.R. 519 (1993), 107 D.L.R. (4th) 342, 85 C.C.C. (3d) 15 (http://scc.lexum.org/en/1993/1993scr3-519/1993scr3-519.html) Accessed 2012-07-08.

[100] *Carter v. Canada*, para. 16, 926, 1116, 1126, 1166, 1184-1185, 1187-1188, 1190, 1199, 1348, 1362

those who might be pressured to commit suicide or who might do so for irrational reasons. The judge agreed that this was a "pressing and substantial" purpose,[101] and that the means (absolute prohibition) was rationally connected to this end.[102]

VI.3.6 The judge's narrow construction of the purpose of the law reflected common ground among the parties to the case[103] and the unchallenged presumption that suicide can be a rational and moral act. It was at the next stage of the analysis that the differences among the parties became apparent.

VI.4 Minimal impairment: the meaning of "effective"

VI.4.1 Once the judge decided that the law was discriminatory, the burden of proof shifted to the defendant governments.[104] It was up to them to demonstrate that nothing short of absolute prohibition could achieve the objective of protecting vulnerable people, and that there is no alternative that "less seriously infringes the *Charter* rights of Gloria Taylor and others in her situation."[105]

VI.4.2 This is precisely what the defendants did claim. Canada, supported by British Columbia, the CLF and EPC, argued that "nothing short of a blanket prohibition against assisted dying is sufficient to protect vulnerable individuals."[106]

VI.4.3 The defendants could prove this by proving that safeguards are ineffective in jurisdictions where assisted suicide and euthanasia are legal, or that such safeguards are not feasible in Canada, or, at the very least, that the evidence is inconclusive with respect to the effectiveness or feasibility of safeguards. However, on this critical issue, it appears from the text of the ruling that the evidence of the defendants' witnesses could not match that of the plaintiff witnesses. (See Appendix "A")

VI.4.4 There was another problem. How does one measure effectiveness?

VI.4.5 The defendants' assertion that only blanket prohibition could be effective rested on the

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[101] *Carter v. Canada*, para. 1202-1206

[102] *Carter v. Canada*, para. 1207-1210

[103] *Carter v. Canada*, para. 237, 339, 1124, 1136, 1185, 1190, 1362.

[104] *Carter v. Canada*, para. 1172

[105] *Carter v. Canada*, para. 1232

[106] *Carter v. Canada*, para. 359

premise that even one 'wrongful' death is too many:[107] that safeguards can only be considered effective if they absolutely eliminate any possibility of error. By way of analogy, Canada asserted that capital punishment was abolished in Canada because of concern about the possibility of error.[108] This is at least doubtful as a matter of history[109] and was not supported by the submissions of British Columbia[110] or the Supreme Court of Canada in the *Rodriguez* decision.[111]

VI.4.6 Madam Justice Smith rejected the analogy.[112] More important, she rejected the standard of absolute inerrancy altogether, accepting the plaintiffs' argument that this "zero tolerance standard [is] so extreme that no claimant could ever succeed in a challenge

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[107] *Carter v. Canada*, para. 1192-1196, 1230, 1236, 1349, 1351. The term "wrongful death" was rejected by the judge, but for the sake of convenience, she uses it in the ruling nonetheless. Carter v. Canada, para. 755 to 758

[108] *Carter v. Canada*, para. 1193.

[109] The possibility of error does not seem to have been a significant factor when abolition actually occurred. The government had a *de facto* policy of commuting all death sentences to life imprisonment. However, in the summer of 1976 it was faced with the prospect of having to review the death sentences of four men who had unquestionably murdered policemen in circumstances that provided no publicly acceptable rationale for commutation. Two (Vincent Cockriell and John Harvey Miller) had gone looking for a policeman to kill, and two (James Hutchison and Richard Ambrose) had murdered two policemen in New Brunswick (See Malette, Chris, Cop killers don't deserve mercy (commenet). *The Intelligencer*, 12 June, 2009. (http://www.intelligencer.ca/ArticleDisplay.aspx?e=1609369) Accessed 2012-07-02. The trial judge in the latter case said that there were no extenuating circumstances to justify a recommendation for the royal prerogative of mercy. "Moncton hangings delayed." *Montreal Gazette*, 10 June, 1975 (http://news.google.com/newspapers?nid=1946&dat=19750610&id=65AjAAAAIBAJ&sjid=jKEFAAAAIBAJ&pg=1179,2665552) Accessed 2012-07-03. Seven other men were also awaiting execution at the time. Gadoury, Lorraine and Lechasseur, Antonio, *Persons Sentenced to Death in Canada, 1867-1976: An Inventory of Case Files in the Fonds of the Department of Justice*. Government Records Division, Government of Canada. (http://data2.archives.ca/pdf/pdf001/p000001052.pdf) Accessed 2012-07-02

[110] *Carter v. Canada*, para. 169, 284

[111] *Carter v. Canada*, para. 1190

[112] *Carter v. Canada,* para. 1200, 1356

under the *Charter*."[113] Instead, recalling the narrowly construed purpose of the law, she accepted the plaintiffs' argument that the objective of the law cannot possibly be to prevent *all* 'wrongful' deaths, because 'wrongful' deaths can now occur as a result of accepted but unregulated end-of-life practices like refusing or withdrawing treatment.[114] Considering the problem strictly from the perspective of risk management, she explained:

> In my view, the evidence supports the conclusion that the risks of harm in a regime that permits physician-assisted death can be greatly minimized. Canadian physicians are already experienced in the assessment of patients' competence, voluntariness and non-ambivalence in the context of end-of-life decision-making. It is already part of sound medical practice to apply different levels of scrutiny to patients' decisions about different medical issues, depending upon the gravity of the consequences.[115]

VI.4.7 Combined with the narrow construction of the purpose of the law, this development was fatal to the defendants' case. Their witnesses produced evidence of risk, and the judge was willing to accept that evidence,[116] but the problem was judicially defined as one of managing or reducing risk, not eliminating it altogether.

> The scrutiny regarding physician-assisted death decisions would have to be at the very highest level, but would fit within the existing spectrum. That spectrum already encompasses decisions where the likely consequence of the decision will be the death of the patient.[117]

VI.4.8 Thus, Madam Justice Smith ruled that the defendant governments had failed to prove that the protection of vulnerable persons could not be achieved by means less drastic than absolute prohibition.

> Permission for physician-assisted death for grievously ill and irremediably suffering people who are competent, fully informed, non-ambivalent, and free from coercion or duress, with stringent

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[113] *Carter v. Canada*, para. 1353

[114] *Carter v. Canada*, para. 435, 1198-1199, 1230-1231, 1237

[115] *Carter v. Canada*, para. 1240

[116] For example, *Carter v. Canada*, para. 653, 815

[117] *Carter v. Canada*, para. 1240

> and well-enforced safeguards, could achieve that objective in a real and substantial way.[118]

VI.5 Proportionality

VI.5.1 Granted a finding of more than minimal impairment, the next stage in the analysis requires the Court to consider the possibility that the benefits of the law are, nonetheless, worth the limitations imposed.[119] At this stage the judge considered Canada's claims (rejected with respect to the purpose of the law) that absolute prohibition of assisted suicide provides benefits that outweigh any burdens it might impose: "promoting the value of every life, preserving life, protecting the vulnerable, preventing abuses, maintaining the physician-patient relationship . . . promoting palliative care," and preventing 'wrongful' deaths.[120]

VI.5.2 Returning to her review of the evidence, Madam Justice Smith held that absolute prohibition of assisted suicide "has the advantage of simplicity and clarity,"[121] but that the evidence fails to show that it clearly benefits patients, physicians, or palliative care.[122] She speculated that there may be some benefit to regulating a practice that occurs from time to time despite the prohibition.[123] But she was quite clear that, in her view, absolute prohibition of assisted suicide imposes a disproportionate burden on the disabled.[124] The alleged benefits of prohibition, she said, "are experienced by unknown persons who may be protected" from a variety of ills, while the burdens "are experienced by persons who are in the position of Sue Rodriguez or Gloria Taylor, and are considerable."[125]

VI.5.3 Ultimately, she agreed that absolute prohibition probably has salutary effects in comparison to no prohibition,[126] and admitted that "suicide and attempts at suicide are

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[118] *Carter v. Canada*, para. 1243

[119] *Carter v. Canada*, para. 1246

[120] *Carter v. Canada*, para. 1247-1249; 1252

[121] *Carter v. Canada*, para. 1268

[122] *Carter v. Canada*, para. 1269-1274

[123] *Carter v. Canada*, para. 1282

[124] *Carter v. Canada*, para. 1264, 1277-1279, 1281

[125] *Carter v. Canada*, para. 1275-1276.

[126] *Carter v. Canada*, para. 1267

serious public health problems."[127] Nonetheless, she ruled that "the salutary effects of the legislation can be preserved by leaving an almost-absolute prohibition in effect, and permitting only stringently-limited exceptions."[128]

VI.6 Life, liberty and security of the person

VI.6.1 The Section 7 claims of violations of liberty and security of the person in *Carter* differed from those in *Rodriguez* because the plaintiffs included not only Gloria Taylor, who was seeking assisted suicide or therapeutic homicide for herself, but Hollis Johnson and Lee Carter, who had arguably assisted in the suicide of Lee Carter's mother, and were thus at least theoretically liable to prosecution and imprisonment.[129]

VI.6.2 There was no dispute that the law against assisted suicide engaged the liberty interests of Johnson and Carter.[130] After considering objections made by Canada,[131] Madam Justice Smith ruled that the law deprived Gloria Taylor of liberty and security of the person by interfering with her personal autonomy and control over her bodily integrity.[132]

VI.6.3 Turning to the guarantee of the right to life, Canada argued "that the right to life does not include the right to choose death,"[133] insisting that court rulings have "consistently recognized that the right to life protects individuals from death or the risk of death" and do not confer "a right to die."[134]

VI.6.4 Madam Justice Smith agreed "that the right to life is engaged only when there is a threat of death,"[135] but added (apparently as a kind of extension of that principle) that the prohibition of assisted suicide "has the effect of shortening the lives of persons who fear that they will become unable to commit suicide later, and therefore take their lives at an

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[127] *Carter v. Canada*, para. 1265

[128] *Carter v. Canada*, para. 1283

[129] *Carter v. Canada*, para. 940

[130] *Carter v. Canada*, para. 1294,1304

[131] *Carter v. Canada*, para. 1296-1297

[132] *Carter v. Canada*, para. 1303, 1304

[133] *Carter v. Canada*, para. 1314

[134] *Carter v. Canada,* para. 1315

[135] *Carter v. Canada*, para. 1320

earlier date than would otherwise be necessary."[136]

VI.6.5 Before considering whether or not the deprivations of life, liberty and security of the person could be justified, the judge commented briefly on the nature of the deprivations.

VI.6.6 Concerning people like Gloria Taylor, the judge asserted that:

- they will have shorter lives if they choose to kill themselves sooner rather than take the chance that they will be unable to have assistance later;[137]
- they are denied the opportunity to choose something that may be very important to them, and "their ability to discuss and receive support in this choice from their physicians is impaired."[138] Particularly in light of evidence before the court of physician opposition to assisted suicide, it is remarkable that the judge made the assumption that their physicians would always be supportive.
- the physically disabled are denied the autonomy of the able-bodied, and thus "deprived of a measure of self-worth."[139]
- palliative care may be unavailable or unacceptable, so that they may continue to experience pain and suffering.[140]
- they suffer stress because they are unable to have the comfort of knowing that assisted suicide or euthanasia will be available if they so choose.[141]

VI.6.7 The possibility that a law is arbitrary is the first point to consider in determining whether or not such deprivations are in accordance with the principles of fundamental justice. Since the Supreme Court had decided in Rodriguez that the law is not arbitrary, the judge accepted that ruling.[142]

VI.6.8 The concept of "overbreadth" re-states in a slightly different form the principle of minimal impairment, with the burden of proof on the plaintiffs, not the defendants. The

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[136] *Carter v. Canada*, para. 1322

[137] *Carter v. Canada*, para. 1325

[138] *Carter v. Canada*, para. 1326

[139] *Carter v. Canada*, para. 1327

[140] *Carter v. Canada*, para. 1328

[141] *Carter v. Canada*, para. 1329

[142] *Carter v. Canada*, para. 1337

plaintiffs must prove "that the blanket prohibition is broader than is necessary to achieve the state's goal of preventing vulnerable persons from being induced, in moments of weakness, to commit suicide."[143] The judge's analysis on this point was essentially the same as her reasoning on "minimal impairment," discussed above. She reiterated her findings that the evidence

- does not demonstrate that physicians are insufficiently skilled at assessing patients;[144]
- does not demonstrate that, where assisted suicide and therapeutic homicde are legal, that patients are abused, that physicians become careless or callous, or that a "slippery slope" exists;[145]

  does not demonstrate that assisted suicide and euthanasia are inconsistent with medical ethics;[146]
- supports the conclusion that a "very small number" of cases of assisted suicide and euthanasia occur despite prohibition, and the belief that legalizing and strictly regulating the procedures "would probably greatly reduce or even eliminate such deaths."[147]

VI.6.9 Finally, Madam Justice Smith ruled that the adverse effects of the absolute prohibition of assisted suicide "is grossly disproportionate to its effect on preventing the inducement of vulnerable people to commit suicide, promoting palliative care, protecting physician-patient relationships, protecting vulnerable people, and upholding the state interest in the preservation of human life."[148]

VII. The remedy

VII.1 Declaration of invalidity

VII.1.1 In consequence of her findings and reasoning, Madam Justice Smith declared that the "impugned provisions" of the law unjustifiably infringed Sections 7 and 15 of the

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[143] *Carter v. Canada*, para. 1348

[144] *Carter v. Canada,* para. 1365, 1367

[145] *Carter v. Canada*, para. 1366-1367

[146] *Carter v. Canada*, para. 1369

[147] *Carter v. Canada*, para. 1370

[148] *Carter v. Canada*, para. 1378

Charter of Rights and are of no force and effect to the extent that they prevent physicians from providing assisted suicide and euthanasia to a certain class of patients. Her description of the circumstances and the class of patients effectively sets out her terms for the legalization of the procedures.[149]

a) Only medical practitioners may provide assisted suicide or euthanasia;

b) Assisted suicide and euthanasia may be provided only within the context of a physician-patient relationship;

c) The patient must make the request personally, not through someone else;

d) The patient must be

i) an adult,

ii) fully informed, non-ambivalent, and competent,

iii) free from coercion and undue influence, not clinically depressed;

e) The patient must be diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury)

i) that is without remedy acceptable to the patient,

ii) that causes enduring physical or psychological suffer that is intolerable to the patient and that cannot be alleviated by any medical treatment acceptable to the patient;

f) The patient must be in a state of advanced weakening capacities with no chance of improvement.

VII.2 "Constitutional exemption"

VII.2.1 The judge suspended the application of her declaration for a year to give the government time to decide how to respond.[150] In the meantime, she granted a "constitutional exemption" to Gloria Taylor and her physician so that she can seek assisted suicide or euthanasia while the ruling has been suspended.

VII.2.2 The conditions and procedure set by the court provide some insight into the process of legal assisted suicide and therapeutic homicide envisaged by the judge.

[149] *Carter v Canada*, para. 1393

[150] *Carter v. Canada,* para. 1399

VII.2.3 The conditions:[151]

a) The request must be made in writing by Ms. Taylor.

b) Her attending physician must attest (the context throughout suggests that the attestation must be written) that she is "terminally ill and near death, and there is no hope of recovering." The references to terminal illness and nearness to death depart from the terms of the declaration of invalidity.

c) The attending physician must attest that Ms. Taylor has been informed of her diagnosis and prognosis and of feasible treatment options and palliative care options.

d) Ms. Taylor must be referred to a palliative care specialist for consultation.

e) Ms. Taylor must be advised that she has a continuing right to change her mind.

f) Both attending physician and a consulting psychiatrist must attest that Ms. Taylor is competent, non-ambivalent and acting voluntarily. Should either decline to do so, that must be made known to physicians and psychiatrists subsequently involved and to the court.

g) The attending physician must attest to the kind and amount of medication to be used for assisted suicide or euthanasia.

h) Unless Ms. Taylor is physically incapable, "the mechanism for the physician-assisted death shall be one that involves her own unassisted act and not that of any other person."

VII.2.4 The procedure:[152]

a) Ms. Taylor must apply to the British Columbia Supreme Court and prove that the conditions set out above have been met. The Court, if satisfied, will issue an order authorizing a physician to "legally provide Ms. Taylor with a physician-assisted death at the time of her choosing" as long as, at that time, she is "suffering from enduring and serious physical or psychological distress that is intolerable to her and that cannot be alleviated by any medical or other treatment acceptable to her." She must also be competent and "voluntarily seeking a physician-assisted death."

VII.2.5 The final element of the order is of particular interest. Madam Justice Smith ruled that the court should also authorize the physician who assists the suicide or provides

[151] *Carter v. Canada*, para. 1414

[152] *Carter v. Canada*, para. 1415

euthanasia to "complete her death certificate indicating death from her underlying illness as the cause of death."[153]

VII.2.6 That Madam Justice Smith should authorize a physician to falsify a death certificate seems markedly inconsistent with her repeated insistence upon the importance of "stringent limits that are scrupulously monitored and enforced."[154] The rationale for this appears to have been articulated by one of the plaintiffs witnesses:

> Dr. Nancy Crumpacker, a retired oncologist . . . says that it is the common, if not invariable, practice of physicians who fill out the death certificates of persons who hasten their deaths under the *ODDA*[155] to record the underlying illness as the cause of the death. This is done to protect patient confidentiality and to avoid any confusion with settlements from insurance companies. Completing the death certificate in this manner is not inconsistent with the legislation, as s. 3.14 of the *ODDA* provides that actions taken in accordance with it do not constitute suicide or homicide for any purposes. Section 3.13 additionally provides that "[n]either shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy.[156]

VII.2.7 Whether justification is sought in patient confidentiality, statute or a judicial order, the falsification of the cause of death (and, presumably, the falsification of the classification of death) is contrary to death reporting and classification practices in British Columbia[157]

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[153] *Carter v. Canada*, para. 1415(b)

[154] *Carter v. Canada*, para. 883; also para. 16, 342, 1233, 1243, 1267, 1283.

[155] *Oregon Death With Dignity Act*

[156] *Carter v. Canada*, para. 414

[157] In British Columbia, it is acknowledged that suicides may result from stress and depression arising from terminal or debilitating illness or a mental disorder. The cause of death is plainly stated, and the death is classified as a suicide, but if the underlying illness or disorder is known it is reported as a contributing factor. This better serves the end of transparency. "Suicides sometime occur as a result of stress and depression because the decedent may have been suffering from a terminal or debilitating illness or mental disorder."
Vital Statistics British Columbia, *Physicians' and Coroners' Handbook on Medical Certification of Death and Stillbirth*, 2004 Revision, p. 13.

and internationally[158] and will produce confusion, not transparency.

VII.2.8 It is remarkable that, having concluded that assisted suicide and therapeutic homicide are morally and ethically justifiable in the circumstances set out in the judgement, Madam Justice Smith should feel it necessary to authorize physicians to conceal the procedures when certifying such deaths.

VIII. Summary

VIII.1 The trajectory of the trial was determined by the unchallenged fundamental premise that suicide can be a rational and moral act, and that the sole purpose of the law against assisted suicide is to prevent suicides by vulnerable people in moments of weakness, who might be tempted to commit suicide that is not rational and moral.

VIII.2 Since, on this understanding, the vulnerable are not to be protected against something that is always wrong, but something that they might, in some circumstances, legitimately pursue, it was natural to search for a means to permit those legitimately seeking assisted suicide to obtain the service.

VIII.3 The only issue was whether or not safeguards could be designed to permit legitimate access to assisted suicide, while preventing the vulnerable from accessing it in moments of weakness.

VIII.4 Since perfection is not to be expected in any human endeavour, it was not thought reasonable to demand that a system of safeguards be 100% effective. A different standard was required.

VIII.5 The standard chosen was the current regime of end-of-life practices, since the outcome of a mistake in this regime ('death before one's time') is the same as the outcome of a mistake in regulating assisted suicide.

VIII.6 The argument advanced was, in effect, that one cannot reasonably demand a higher standard of safety in the delivery of assisted suicide than in the delivery of palliative care

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(http://unstats.un.org/unsd/vitalstatkb/Attachment32.aspx) Accessed 2012-07-04

[158] The underlying cause of death is defined by the World Health Organization as "(a) the disease or injury which initiated the train of morbid events leading directly to the death, or (b) the circumstances of the accident or violence which produced the fatal injury." The reason for the definition "is to ensure that all the relevant information is recorded and the certifier does not select some conditions for entry and reject others." World Health Organization, *International Statistical Classification of Diseases and Health Related Problems* (Tenth Revision) Vol. 2, Second Edition, 2004, p. 23.
(http://www.who.int/classifications/icd/ICD-10_2nd_ed_volume2.pdf) Accessed 2012-07-04

because the results of a mistake in either case are the same.

VIII.7 Patient safety in end-of-life care is currently ensured by respect for and enforcement of the principle of informed consent, by assessment of patient competence, and by the use of legal substitute decision-makers for incompetent patients. Since these measures are considered sufficient for the purposes of end-of-life decisions in withholding, withdrawing or refusing treatment, it was decided that they should be sufficient for the regulation of assisted suicide for competent adults.

VIII.8 The burden of proof was on the defendant governments to prove that this could not be done. The text of the ruling indicates that they provided evidence of risk, but failed to prove that safeguards cannot be effective.

IX. Postscript

IX.1 About ten days after the *Carter* decision was released, the CBC Radio's *Cross Country Checkup* dedicated a full programme to the subject. The interviewer spoke by telephone with invited guests, including Professor Jocelyn Downie, one of the architects of the plaintiffs' case, and Dr. Eugene Bereza, a defendant witness. She also spoke to listeners from across the country who called in to voice their opinions.[159]

IX.2 Most of those who opposed the decision argued, as the defendant governments did at trial, that the risks associated with legalizing assisted suicide and euthanasia were too great: that to do so would endanger vulnerable people. When the interviewer asked these people if they would take away from Gloria Taylor what the court had given her - the right to physician-assisted suicide at the time of her choosing - all avoided the question. Not one was willing to state that Gloria Taylor should not be provided assisted suicide, though none said that it was a good thing or that they supported her choice.

IX.3 They had argued against legalizing assisted suicide solely because vulnerable people might be exploited if it were: that no regulatory process could adequately protect them. But Gloria Taylor could not be plausibly described as a vulnerable and exploited person, so they could not explain why, in her case, assisted suicide should not be permitted, And if they could think of no reason to deny it to her, upon what basis would they deny it to others?

IX.4 Had they argued from the outset against suicide and homicide on moral, philosophical or religious grounds (though not excluding others), they might have been able to answer differently. But, like the government defendants, they did not do so, either because their objections were purely practical or logistical, or because they believed - probably correctly - that moral, philosophical or religious would be abruptly dismissed, either with

[159] CBC Radio, *Cross Country Checkup*, 24 June, 2012. (http://podcast.cbc.ca/mp3/podcasts/checkup_20120624_66105.mp3/) Accessed 2012-06-28

contempt, or with condescension.

IX.5 When facing a court in a case like *Carter* - the Supreme Court or the court of public opinion - perhaps it is prudent and even necessary to avoid arguments based on moral, philosophical or religious principles that are likely to excite adverse responses and even intolerant passions in those who will pass judgement. On the other hand, as noted above, keeping silent about morality, philosophy or religion does not produce a morally neutral judicial forum or public square. It simply allows dominant moral or philosophical beliefs to set the parameters for argument and adjudication.

IX.6 However, in the case of conscientious objection to participation in assisted suicide or therapeutic homicide, silence about one's moral, religious or philosophical beliefs is impossible. An appeal to freedom of conscience or religion must make direct reference to the beliefs of the objector about the moral nature of the act to which he objects.

APPENDIX "A"

The Witnesses

A1 Overview

A1.1 The defendant governments called 18 witnesses. Four witnesses came from outside Canada. Of these, three were from the United States and one from the United Kingdom. Only two witnesses came from a jurisdiction (Oregon) where assisted suicide and/or euthanasia are legal.[160]

A1.2 In contrast, the plaintiffs called more than twice the number of expert witnesses as the two defendant governments (39 to 18). 24 of their witnesses came from outside the country, and 11 of these were from jurisdictions where assisted suicide and/or euthanasia are legal (Oregon, Washington, Belgium, Switzerland, Netherlands).[161] Their evidence included testimony from two physicians who actually provide assisted suicide or therapeutic homicide, something quite outside the experience of defendant witnesses.[162]

A1.3 12 Canadian physicians[163] and six physicians from other countries[164] gave evidence that they believed that assisted suicide and euthanasia can be ethically provided. The judge quoted the testimony of four of these witnesses as representative of their views.[165]

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[160] Dr. Charles Bentz and Dr. N. Gregory Hamilton (Oregon); Prof. John Keown (U.S.A.); Baroness Illora Finlay of Llandaff (United Kingdom). *Carter v. Canada*, para. 160.

[161] Dr. Jean Bernheim and Prof. Luc Deliens (Belgium); Dr. Georg Bosshard (Switzerland); Dr. Linda Ganzini, Ms. Ann Jackson and Dr. Peter Rasmussen (Oregon); Dr. Gerrit Kimsma, Prof. Johan Legemaate and Dr. Johannes J.M. van Delden (Netherlands); Prof. Helene Starks and Dr. Thomas Preston (Washington). *Carter v. Canada*, para. 160.

[162] *Carter v. Canada*, para.743-745

[163] *Carter v. Canada*, para. 254: Dr. William Shoichet, Dr. Bell, Dr. Marcel Boisvert, Dr. Boyes, Dr. Eric Cassell, Dr. Cohen, Dr. Klein, Dr. Librach, Dr. Meckling, Dr. Smith, Dr. Upshur, Dr. Welch. Canada challenged the weight to be given to the opinions of Dr. Boyes and Dr. Boisvert (para. 255).

[164] *Carter v. Canada*, para. 261: Dr. Ashby (Australia), Dr. Nancy Crumpacker (Oregon, U.S.A.), Dr. Kimsma (Netherlands), Dr. jThomas Preston (Washington, U.S.A.), Dr. Peter Rasmussen (Oregon, U.S.A.) and Dr. Syme (Australia)

[165] *Carter v. Canada*, para. 256. Cites Klein, para. 257, Cohen, para. 258, Librach para. 259-260; quotes Preston, para. 262.

A1.4 Only six physicians, all from Canada, spoke against the notion that the procedures could be ethical,[166] and, of these, three appear to have been ambivalent,[167] and one did not speak directly to the issue.[168] Dr. Gallagher spoke strongly against it;[169] Dr. Pereira was not cited or quoted, but presumably did so as well.

A1.5 The numbers alone suggest that the plaintiffs were at an advantage, but numbers alone do not tell the whole story. The judge was required to assess the credibility of the witnesses and the weight to give their evidence. To some extent this is an unavoidably subjective process, so it is important to take note of factors that might reasonably be considered in weighing the evidence, and to pay particular attention when the judge explains why she accepts or rejects the evidence of witnesses.

A2 Defendants' witnesses

A2.1 Three of the defendant witnesses were somewhat ambivalent about the ethics of participation in or morality of assisted suicide or euthanasia.

A2.2 Professor of psychiatry Dr. Harvey Chochinov[170] stated, "*At this point in time*, I would not be prepared to participate in a scheme permitting physician-assisted suicide or intentional death by medical practitioner," (emphasis added), which suggests that he might be willing to do so in future.[171] The judge took note. [172]

A2.3 Dr. Eugene Bereza, Director of the Biomedical Ethics Unit, McGill University Faculty of Medicine,[173] was not sure if it is possible in all cases to clearly distinguish between

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[166] *Carter v. Canada*, para. 263: Dr. Chochinov, Dr. Downing, Dr. Hendin, Dr. Romayne Gallagher, Dr. McGregor, Dr. Jose Pereira, Dr. Sheldon

[167] *Carter v. Canada*, para. 265 (McGregor); para. 267 (Downing); para. 268-270

[168] *Carter v. Canada*, para. 272 (Hendin)

[169] *Carter v. Canada*, para. 271

[170] University of Manitoba, *Dr. Harvey Max Chochinov* (http://umanitoba.ca/honours/index.php?s=gg&pg=ppl&det=199) Accessed 2012-07-16

[171] *Carter v. Canada*, para. 270

[172] *Carter v. Canada*, para. 353

[173] McGill University, Biomedical Ethics: *Eugene Bereza* (http://www.mcgill.ca/biomedicalethicsunit/faculty/bereza) Accessed 2012-07-16

withholding or withdrawing life-sustaining treatment and assisted suicide or euthanasia.[174] He allowed that "there may be morally persuasive arguments for physician-assisted death in some cases," though he was against a change in the law because of the risk "of unjustifiable death to vulnerable individuals."[175] His admission at trial is consistent with comments he made after the *Carter* decision was announced, to the effect that, in rare cases, assisted suicide or euthanasia might be considered, and that it may be possible to have both good, accessible palliative care and assisted suicide and euthanasia.[176] That statement is not inconsistent with the outcome of the trial. Although it cannot be said that Dr. Bereza favours legalization of the procedures, neither were the plaintiffs unjustified in citing his evidence in support of their proposition that "assisted dying and palliative care are not mutually exclusive."[177]

A2.4 Dr. Douglas McGregor, a palliative care specialist, agreed that if the procedures were legalized, with appropriate safeguards, physicians could comply with the law without violating tenets of medical ethics, though he added, "I'm not sure that's the right thing to

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[174] *Carter v. Canada*, para. 251

[175] *Carter v. Canada*, para. 253

[176] In response to the interviewer's question, "Why can't we have both?" (i.e. accessible palliative care and assisted suicide/euthanasia for the 3-6% who can't be palliated) he said, ". . . What I think I'm saying to you is 'exactly,' right? Um, in my experience - and it's just my experience - I would honestly say that in the thousands and thousands of cases I've been party to. . . there probably has been, have been a very few where I would argue that it was ethically permissible to consider something like physician assisted suicide or euthanasia. But I'm talking about, possibly I could count on one hand. Because all the others . . . the 98% of the others would have been very well and better handled through good palliative care. For those other rare ones, what can we do? Well, maybe then we should consider some kind of exception, but that's not what we're doing now. We're jumping to that other one before we've taken care of that huge percentage. So my concern - I mean, at the end of the day, I think we might possibly need both, but we're already thinking about changing the second one way before we've addressed the issue of, you know, 65-70% of Canadians can't access the very thing that, if they had, wouldn't make us have to consider this option." CBC Radio, *Cross Country Checkup*, 24 June, 2012. (http://podcast.cbc.ca/mp3/podcasts/checkup_20120624_66105.mp3/) Accessed 2012-06-28

[177] Carter v. Canada, *Written Submissions of the Plaintiffs*, 1 December, 2011, para. 225 (http://www.consciencelaws.org/archive/documents/carter/2011-12-01-submission-plaintiffs.pdf) Accessed 2012-06-16

be doing in our society."[178] The judge took note.[179]

A2.5 With respect to the effectiveness of safeguards and the consequences of legalization in other countries, the text of the ruling indicates that the defendants' evidence was provided primarily[180] by six witnesses: Baroness Ilora Finlay,[181] Dr. Charles Bentz,[182] Professor John Keown,[183] Professor Brian Mishara,[184] Dr. Herbert Hendin[185] and Dr. Jose Pereira.[186]

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[178] *Carter v. Canada*, para. 265

[179] *Carter v. Canada*, para. 354

[180] Note that the comments about safeguards in the submission of the Christian Legal Fellowship referred only to Professor Keown (para. 23, note 17; para. 70, note 48; para. 72, note 49; para. 73, note 50; para. 75, note 51; para. 78, note 56) and Dr. Hendin (para. 28, note 18) *Carter v. Canada*, *Christian Legal Fellowship's Written Submissions*, (http://www.consciencelaws.org/archive/documents/carter/2011-12-01-submission-plaintiffs.pdf) Accessed 2012-07-27

[181] United Kingdom House of Lords, *Baroness Finlay of Llandaff*. (http://www.parliament.uk/biographies/lords/26933) Accessed 2012-06-30.
General Medical Council (U.K.) Developing medical guidance on End of Life Care: Consultative Conference, 3 June, 2009: *Professor Baroness Finlay of Llandaff* (http://www.gmc-uk.org/static/documents/content/biog_baroness_finlay.pdf) Accessed 2012-06-30.

[182] Physicians for Compassionate Care Board Members: *Charles J. Bentz, M.D.* (http://www.pccef.org/whoweare/boardmembers.htm) Accessed 2012-06-30.

[183] Georgetown University. *John Keown* (http://explore.georgetown.edu/people/ijk2/) Accessed 2012-06-30.

[184] Centre for Research and Intervention on Suicide and Euthanasia: *Brian L. Mishara* (http://www.crise.ca/eng/mb_details.asp?section=membres&usager=misharab) Accessed 2012-06-30

[185] Suicide Prevention Initiatives, *Dr. Herbert Hendin* (http://www.suicidepreventioninitiatives.org/2011/12/normal-0-false-false-false.html) Accessed 2012-06-30.

[186] University of Ottawa Department of Medicine, *José Pereira MBChB DA CCFP MSc(MEd)* (http://thinkottawamedicine.ca/divisions/division-of-palliative-care/leadership-members-in-pallia

- Baroness Finaly, a pioneer and specialist in palliative care, offered opinions, not research results,[187] though the judge considered her opinions to be within her field of expertise as a palliative care physician.[188]
- Dr. Bentz is an internal medicine specialist who has published papers about tobacco smoking cessation. His evidence about safeguards was based upon his experience with only one patient.[189]
- The evidence of Dr. Keown, a professor of law who holds the Rose Kennedy Chair of Christian Ethics at Georgetown University in Washington, D.C., consisted of his opinions, apparently unsupported by empirical research.[190]
- Professor Mishara stated that the high rate of assisted suicide in Switzerland results from the absence of legal controls,[191] a point that did not speak to the effectiveness of controls where they exist.
- Dr. Pereira acknowledged that he had not done original research, that he relied entirely on secondary sources, that his interest in the subject was of recent origin, that he had not made a lengthy study of the effectiveness of safeguards, and that his single paper on the subject appeared in a relatively low-ranking medical journal.[192]

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tive-care/jose-pereira-mbchb-da-ccfp-mscmed/) Accessed 2012-06-30

[187] *Carter v. Canada*, para. 382-386. Baroness Finlay appears to have been responsible for only two articles about assisted suicide and euthanasia in professional journals, both of them responses rather than research papers. Finlay IG, Wheatley VJ, Izdebski C. *The House of Lords Select Committee on the Assisted Dying for the Terminally III Bill: implications for specialist palliative care*. Palliat Med. 2005 Sep;19(6):444-53; Finlay IG, George R. *Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups--another perspective on Oregon's data.* J Med Ethics. 2011 Mar;37(3):171-4. Epub 2010 Nov 11. (http://www.ncbi.nlm.nih.gov/pubmed/21071568)

[188] *Carter v. Canada*, para. 387

[189] *Carter v. Canada*, para. 411

[190] *Carter v. Canada*, para. 244-245, 374-375, 452, 501

[191] *Carter v. Canada*, para. 603

[192] *Carter v. Canada*, para. 377. Pereira, J. "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls." Curr Oncol 2011:18:c38-45.

- The judge acknowledged that Dr. Hendin is a leader in suicide prevention, but noted that he had not done empirical research into euthanasia and assisted suicide. His evidence was challenged,[193] and his testimony that "voluntariness is compromised, alternatives not presented and the criterion of unrelievable suffering is bypassed" was "significantly weakened" on cross-examination.[194] The judge was left in doubt about his impartiality.[195]

A2.6 The evidence provided by Dr. Pereira on the subject of safeguards proved unexpectedly problematic. He testified all day on 22 November, 2012. He was cross-examined at length the following day about the paper published in *Current Oncology*,[196] which had been submitted in evidence and formed the basis for his expert report.[197] The Farewell Foundation, an intervenor supporting the plaintiffs, described the cross-examination:

> Again and again, counsel for the plaintiffs handed up the references that Dr. Pereira had cited, saying that his references did not seem to support the propositions he was making in his paper. Repeatedly, Dr. Pereira conceded that he had not provided an appropriate source for various propositions and facts. Sometimes he even interrupted counsel, admitting "That was an error," because he could see the improper citation before counsel could finish the question.[198]

A2.7 Although the Farewell Foundation writer asserted that the paper was "strongly discredited," the judge made no comment on Dr. Pereira's performance under cross-examination. It is possible that intervenor bias coloured the writer's assessment (hence the absence of comment by the judge), but subsequent developments support the view

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[193] *Carter v. Canada*, para. 373

[194] *Carter v. Canada*, para. 504

[195] *Carter v. Canada*, para. 664

[196] Pereira, J. "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls." Curr Oncol 2011:18:c38-45. (http://www.current-oncology.com/index.php/oncology/article/view/883/) Accessed 2012-07-16

[197] Downie J. Chambaere K. "Pereira's attack on legalizing euthanasia or assisted suicide: smoke and mirrors." Curr Oncol 2012:19:3:133-138 at 133. (http://www.current-oncology.com/index.php/oncology/article/view/1063) Accessed 2012-07-16.

[198] Farewell Foundation for the Right to Die, *Carter Trial, Day 8: Wednesday, November 23, 2011*. (http://farewellfoundation.ca/wordpress/?p=323) Accessed 2012-06-28

that the impugned paper was poorly written, and that Dr. Pereira's credibility as an expert about safeguards has been severely damaged.[199]

A2.8 However, the judge's adverse comments about Dr. Hendin were consistent with the following account, also provided by the Farewell Foundation:

> When counsel for the plaintiffs asked Dr. Hendin to confirm references that were cited in his affidavit for Canada, Hendin declared that he could not actually affirm that the references supported his propositions. He told the Court that he never actually read some of the articles, it was a mistake, and he did not have the chance to check his own references.[200]

A3 Plaintiffs' witnesses

A3.1 The plaintiffs provided evidence from nineteen witnesses about jurisdictions where assisted suicide and euthanasia are legal. Six of these appear to have contributed primarily factual information and some explanatory commentary on the text and operation of laws and regulations. Their evidence seems to have been largely neutral with respect to the issues before the court, and the judge relied on a number of them when describing legal regimes and practices.[201]

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[199] "Pereira makes a number of factual statements without providing any sources. Pereira also makes a number of factual statements with sources, where the sources do not, in fact, provide support for the statements me made. Peirera also makes a number of false statements about the law and practice in jurisdictions that have legalized assisted suicide and euthanasia." Downie J. Chambaere K. "Pereira's attack on legalizing euthanasia or assisted suicide: smoke and mirrors." Curr Oncol 2012:19:3:133-138. (http://www.current-oncology.com/index.php/oncology/article/view/1063) Accessed 2012-07-16.

Dr. Pereira responded to the criticism, acknowledging "some errors in the references and subtleties that are regrettable," insisting that most of the paper is correct. (Pereira J. "Casting stones and casting aspersions: let's not lose sight of the main issues in the euthanasia debate." Curr Oncol 2012:19:3:139-142. (http://www.current-oncology.com/index.php/oncology/article/view/1088) Accessed 2012-07-16.

[200] Farewell Foundation for the Right to Die, *Carter Trial, Day 9-10: November 24-25, 2011*. (http://farewellfoundation.ca/wordpress/?paged=2) Accessed 2012-07-16

[201] Professor Penney Lewis (professor of law, researcher)(commentator); Professor Mary Shariff (researcher); Professor Sabine Machalowski (law); Professor Johan Legematte (professor of health law); Mark Connelly (lawyer, civil liberties advocate); Dr. Georg Bosshard (family

A3.2 Of the plaintiff witnesses who addressed the effectiveness of safeguards and the consequences of legalization,

- three members of a euthanasia/assisted suicide advocacy group spoke of their experience in counselling patients,[202]
- two physicians discussed their direct involvement in assisted suicide or euthanasia,[203]
- a retired director and CEO of the Oregon Hospice Association explained how her observations and experience had moved her from opposing assisted suicide to supporting it,[204]
- two specialist/researchers offered opinions that safeguards can be effective in preventing the abuses and reducing the risks feared by the defendants.[205]

A3.3 The most extensive evidence on the subject of safeguards was provided by six plaintiff witnesses with notable credentials: Professor Luc Deliens,[206] Professor Helene Starks,[207]

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physician, ethicist, researcher).

[202] George Eighmey, Jason Renaud and Robb Miller of Compassionate & Choices. *Carter v. Canada*, para. 407-408

[203] Dr. Gerritt Kimsma and Dr. Nancy Crumpacker. *Carter v. Canada*, para. 744-745

[204] Ann Jackson (retired director and CEO of Oregon Hospice Association). *Carter v. Canada*, para. 409

[205] Dr. Michael Ashby (palliative care specialist), Dr. Jean Berheim (oncology, researcher)

[206] Ghent University & Vrije Universteit Brussel End of Life Care Research Group: *Luc Deliens* (http://www.endoflifecare.be/lucdeliens) Accessed 2012-06-30

[207] University of Washington, Department of Health Services: *Helene E. Starks*. (http://depts.washington.edu/hserv/faculty/Starks_Helene) Accessed 2012-06-30

Dr. Gerritt Kimsma,[208] Dr. Linda Ganzini,[209] Professor Margaret Pabst Battin[210] and Dr. Johannes J.M. van Delden.[211]

- Professor Deliens was the co-author of numerous empirical studies on end-of-life decisions,[212] several of which were cited in the ruling.[213]

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[208] "A Dutch family practitioner, and an Extern Associate Professor of medical ethics and philosophy at the Radbout University Medical Center in Nijmegen, the Netherlands. He has been a program developer and instructor for the program in the Netherlands that provides support and consultation to physicians in connection with patient requests for euthanasia ("SCEN"). *Carter v. Canada*, para. 160

[209] Oregon University, Health and Science: *Linda Ganzini* (http://www.ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/psychiatry/faculty/linda-ganzini.cfm) Accessed 2012-06-30

[210] University of Utah Dept. of Philosophy, *Margaret Battin*. (http://www.hum.utah.edu/philosophy/?module=facultyDetails&personId=60&orgId=300/) Accessed 2012-06-30

[211] Johannes J.M. van Delden, MD, PhD, curriculum vitae (http://www.med.mun.ca/dignitysymposium/pdfs/bios/van%20Delden.cv.pdf) Accessed 2012-06-30

[212] *Carter v. Canada*, para. 521

[213] Bilsen J. et al, *Changes in medical end-of-life practices during the legalization process of euthanasia in Belgium*. Soc Sci Med 2007 Aug; 65(4) 803-8 (http://www.ncbi.nlm.nih.gov/pubmed/17490798)

Chambaere K. et al., *Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey*. Can Med Assoc J 2010 June 15; 182(9) 895-901 (http://www.ncbi.nlm.nih.gov/pubmed/20479044)

Chambaere K. et al., *Trends in Medical End-of-Life Decision Making in Flanders, Belgium 1998-2001-2007.* Med Decis Making 2011 May-June 31(3) 500-10 (http://www.ncbi.nlm.nih.gov/pubmed/21191121)

Deliens, L. *End of Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey*. Lancet 2000 Nov. 25 356 (9244) 1806-11 (http://www.ncbi.nlm.nih.gov/pubmed/11117913)

- Professor Starks spent five years as a research manager and co-investigator in a study exploring assisted suicide and euthanasia from the perspective of the patients and families involved in the procedures.[214]
- Dr. Kimsma developed and instructs in a Netherlands program that supports and consults with physicians dealing with euthanasia requests and, with Professor Battin, co-authored one of the studies cited in the ruling.[215]
- Professor Battin's research focus is assisted suicide and euthanasia; the judge referred to three of her papers.[216]

Smets et al. *Legal euthanasia in Belgium: characteristics of all reported euthanasia cases*. Med Care. 2010 Feb;48(2):187-92. (http://www.ncbi.nlm.nih.gov/pubmed/19890220)

Smets T. et al, *Euthanasia in patients dying at home in Belgium: interview study on adherence to legal safeguards*. Brit J Gen Pract 2010 April: 60 (573) (http://www.ncbi.nlm.nih.gov/pubmed/20353662)

Smets et al., *Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases*. Brit Med J 2010 Oct 5:341: c5174 (http://www.ncbi.nlm.nih.gov/pubmed/20923842)

Van Wesemael Y. et al, *Process and outcomes of euthanasia requests under the Belgian Act on euthanasia: a nationwide survey*. J Pain Symptom Manage. 2011 Nov;42(5):721-33. (http://www.ncbi.nlm.nih.gov/pubmed/21570807)

[214] *Carter v. Canada*, para. 439. One study she co-authored was cited in the ruling: A.J. Bharucha et al., *The Pursuit of Physician-Assisted Suicide: Role of Psychiatric Factors*. J Palliat Med 2003 Dec; 6(6) 873-83. (http://www.ncbi.nlm.nih.gov/pubmed/14733679)

[215] *Carter v. Canada*, para. 160, 489. The study is Norwood F. et al, *Vulnerability and the 'slippery slope' at the end-of-life: a qualitative study of euthanasia, general practice and home death in The Netherlands*. Fam Prac 2009 26(6): 472-80 (http://www.ncbi.nlm.nih.gov/pubmed/19828573)

[216] Battin MP et al, *Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on 'vulnerable' groups*. J Med Ethics 2007 Oct; 33(1); 591-7 (http://www.ncbi.nlm.nih.gov/pubmed/17906058)

Battin, MP *Physician-Assisted Dying and the Slippery Slope: the Challenge of Empirical Evidence* (2008) 45 Willamette L Rev 91

- Dr. Ganzini, an Oregon pyschiatrist, had fifteen years' experience studying physician-assisted suicide in the state, co-authoring numerous studies on the subject.[217]
    - One should also note that defendant witnesses, including Dr. Keown and Dr. Pereira, sought support for their positions in research done by Dr. Ganzini.[218]
- Dr. van Delden is said to have participated in "all of the major empirical studies into end-of-life care that have taken place in the Netherlands since 1990."[219]

A4 Assessing the evidence of the witnesses

A4.1 Madam Justice Smith described Dr. Ganzini and Professor Battin as "impressive, respected researchers, who have both made a long-term study of the ethics, and risks, of assisted suicide and euthanasia" and had carefully analyzed the evidence. She said that Dr. Starks' evidence was "carefully and fairly presented" and accepted it, commenting favourably on her objectivity.[220]

A4.2 In contrast, the judge acknowledged the expertise of Dr. Pereira, Baroness Finlay and Dr. Hendin, but commented that none had done empirical research to support their opinions.[221] She accepted the anecdotes provided by Dr. Hendin and Dr. Bentz, but the value of anecdotal evidence is limited: in this case, to demonstrating that "safeguards cannot be assumed to be 100% effective."[222]

A4.3 It should be noted that Madam Justice Smith did not uncritically accept all of the

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Battin MP et al, *Legal physician-assisted dying in Oregon and the Netherlands: The question of 'vulnerable' groups. A reply to I.G. Finlay and R. George*. 2011;37:3 171-174 (http://jme.bmj.com/content/37/3/171/reply)

[217] *Carter v. Canada*, para. 160

[218] *Carter v. Canada*, para. 447, 451. The paper is Ganzini L. et al, *Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey*. Brit Med J 2008 Oct 7; 337 a1682 (http://www.ncbi.nlm.nih.gov/pubmed/18842645)

[219] *Carter v. Canada*, para. 160

[220] *Carter v. Canada*, para. 651-652

[221] *Carter v. Canada*, para 664

[222] *Carter v. Canada*, para. 653

plaintiffs' evidence. For example, she found Professor Luc Deliens evasive with respect to one point on cross-examination, and that it seemed he did not want to admit that a study he had co-authored reported that patients 80 years of age and older were especially vulnerable to "life-ending acts without explicit request."[223] In other respects she appears to have found his evidence satisfactory.

A4.4 The judge also reviewed the evidence of fourteen defendant witnesses[224] and eleven plaintiff witnesses[225] to consider the feasibility of establishing effective safeguards in Canada.

A4.5 With respect to risks associated with patient competence, she gave greater weight to the evidence of plaintiff witnesses, Dr. Donnelly, Dr. Smith and Dr. Ganzini, two of whom (Dr. Connelly and Dr. Smith) were psychiatrists with particular expertise in assessing competence. In comparison, she noted that defendant witnesses the expertise of Dr. Hendin, Professor Heisel and Professor Mishara lay in suicide prevention, that of Dr. Gallagher and Dr. Finlay in palliative care, and appears to have disregarded Dr. Sheldon's views as outside the "mainstream."[226] On the issue of risks arising from subtle pressures or coercion, she reached her conclusion by drawing on the evidence of both defendant and plaintiff witnesses.[227]

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[223] *Carter v. Canada*, para. 576-577

[224] Dr. Eugene Bereza: para. 807, 821; Dr. Harvey Chochinov: para. 801, 815, 827-828, 830; Dr. G. Michael Downing: para. 839; Euthanasia Prevention Coalition: para. 853; Baroness Finlay: para. 774, 797, 808, 841 ; Professor Catherine Frazee: para. 811, 815, 848-851, 853; Dr. Romayne Gallagher: para. 765, 771-772, 797, 801, 808, 815, 821, 822-823, 840; Professor Marnin Heisel: para. 768-769, 792, 796, 812, 815, 827, 845; Dr. Herbert Hendin: para. 794, 796; David Martin: para. 848; Professor Brian Mishara: para. 766-767, 791, 796, 799-800, 809, 832-834, 838 ; Dr. Jose Pereira: para. 821; Dr. Gary Rodin:para. 827-828; Dr. Leslie J. Sheldon: para. 776, 796 ; Rhonda Wiebe: para. 848.

[225] Professor Margaret Battin: para. 833, 835, 842-843, 847, 852; Professor Jean Bernheim: para. 807, 821, 846; Professor Luc Deliens: para. 846-847, 852; Dr. Martha Donnelly: para. 762-764, 781-784, 790, 803-804, 815; Mr. Eighmey: para. 836; Dr. Linda Ganzini: para. 775, 777, 788-789, 793-794, 802-803, 805, 809, 815, 824, 828-829, 835, 847; Dr. Scott K. Meckling: para. 773, 825; Dr. Peter Rasmussen: para. 810; Mr. Renaud: para. 836; Dr. Derryck Smith: para. 778-780, 786-787, 794; Professor Helene Starks: para. 828, 835; Dr. Johannes J. M. van Delden: para. 847; Professor James Werth: para. 813-814, 833.

[226] *Carter v. Canada*, para. 795-797

[227] *Carter v. Canada*, para. 815

APPENDIX "B"

Carter Part VII: A Judicial Soliloquy on Ethics

B1 A note of caution

B1.1 Part VII of the judgement illustrates the difference between the role of a scholar and the role of a judge: between an investigative and deliberative process that can be followed by parliamentary subcommittees or royal commissions and the process followed in a trial conducted on adversarial principles. As the Christian Legal Fellowship observed, a trial judge "does not have the benefit of the wide-ranging consultations that are available to government."[228]

B1.2 A judge is not a scholar who has the freedom and the obligation to go beyond evidence that is ready to hand in order to identify all issues raised by a problem and locate all evidence that may be relevant to resolving it. A judge is largely confined to the issues as defined by the pleadings and to the evidence presented by the parties. One of the strengths of judicial office is this demanding specificity that can bring a bright light to bear on dark doings, or bring into focus something not readily seen without the assistance of a judge's lens, be it microscopic or telescopic.

B1.3 However, this restricted focus and dependence on the evidence "as presented" becomes a handicap when a wide angle lens is needed and the evidence "as presented" is selected, shaped and limited by the interests and practical judgement of the parties in conflict. Part VII of the judgement, in which the judge tries to make sense of the evidence "as presented," seems to reflect this limitation.

B2 The question addressed in Part VII

B2.1 In Part VII, Madam Justice Smith concentrates on the question of whether or not it would ever be ethical - not legal - for a physician to provide assisted suicide or euthanasia at the request of a competent, informed patient.[229]

B2.2 The reason for this exercise is unclear.

B2.3 Madam Justice Smith asserts that the question before her is constitutional, not legal or ethical, adding that the realms of ethics, law and constitutionality "tend to converge even

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[228] *Carter v. Canada*, *Christian Legal Fellowship's Written Submissions*, para. 85 (http://www.consciencelaws.org/archive/documents/carter/2011-12-01-submission-plaintiffs.pdf) Accessed 2012-07-27

[229] *Carter v. Canada*, para. 161-162, 183, 316

though they do not wholly coincide." [230] However, she does not explain why a legal challenge to the constitutionality of the law against assisted suicide is not a legal question. And if the question before her is *not* ethical, one may reasonably ask why she embarks upon a lengthy discussion of ethics. Her explanation that the law and medical practice are shaped by ethical principles[231] is not germane in the circumstances of the case before her, in which ethical principles and/or their application were either in dispute or in conflict.

B2.4 Moreover, Madam Justice Smith does not confine herself to the ethical question she proposes to answer. Instead, in Part VII she seems to wander through the evidence, perhaps attempting to synthesize disparate and incomplete evidentiary materials and arguments provided by the parties in conflict.

B3 Plaintiffs' claim shapes and limits the analysis

B3.1 It seems that the judge's opinion that "the ethics of *physician*-assisted death are relevant to, although certainly not determinative of, the assessment of the constitutional issues in this case,"[232] originates in the plaintiffs' claim, which was specifically for *physician* assisted suicide and euthanasia.

B3.2 However, the law forbids *anyone* - not just physicians - from assisting in suicide or therapeutic homicide. If there is an ethical question central to constitutional issues, it is the ethics of assisted suicide and therapeutic homicide by *anyone* - not just physicians. Of course, to begin here would have complicated the case enormously, since it would have been difficult to avoid questions about how suicide and homicide are consistent with the high value the law and society assign to human life, be it described in terms like "the sanctity of life" or "the inviolability principle" or "fundamental value."

B3.3 The plaintiffs chose to begin with *physician*-assisted suicide and euthanasia,[233] thus avoiding these logically prior ethical questions, and Madam Justice Smith does the same when she expressly accepts this framework for her analysis.[234] Thus, Part VII includes

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[230] *Carter v. Canada*, para. 173

[231] *Carter v. Canada*, para. 165

[232] *Carter v. Canada*, para. 173. Emphasis added.

[233] *Carter v. Canada*, para. 175. See Original Notice of Claim, Part 2, para. 1-3. This refers to the liberty interests of others who wish to help someone obtain "*physician-assisted* dying services," not suicide *per se.* (*Original Notice of Claim*, Part 3, para. 12-14)

[234] *Carter v. Canada*, para. 175

one strand of discussion that addresses a central question identified by the judge: "whether or not it is ethical for physicians to provide such assistance."[235]

B4 Ethics: which one?

B4.1 Madam Justice Smith does not acknowledge the first and most obvious difficulty that has to be faced in answering that question: identifying the ethical or moral standard to be applied. Since physicians provide assisted suicide and therapeutic homicide in Belgium and the Netherlands, it would seem that either they are acting unethically, or that Canadian physicians are acting unethically by refusing to do so. Alternatively, a moral or ethical relativist would likely assert that medical ethics are cultural or social constructs with no transcendent significance, so that we should expect that different countries may have different ethics.

B4.2 Here, the law itself is of no assistance. The judge recognizes that what is ethical or moral may not be legal, and what is legal may not be moral or ethical,[236] a proposition with which St Augustine, St. Thomas Aquinas and Martin Luther King Jr. (among others) would agree.[237] But these men accepted that proposition because they recognized a transcendent or objective standard to which human law ought to conform, while *Carter* was presented, argued and decided as if such a standard does not exist or is irrelevant.

B4.3 Instead, in Part VII, the judge tries to establish a common standard by searching for ethical consensus. This is not surprising, since seeking common ground is a legitimate and important conflict resolution strategy, and a civil trial can be understood as a formal conflict resolution process. Thus, the judge frequently refers to what she identifies as common ground, points of agreement, and what is "accepted."[238]

B4.4 However, the search for common ground in *Carter* is subject to the limitations noted in B1.2 and B1.3. Thus, the judge confines herself to the sources recommended to her by the parties, and her review of these sources is largely circumscribed by their submissions

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[235] *Carter v. Canada*, para. 164

[236] *Carter v. Canada*, para. 173

[237] St. Augustine, *On the Free Choice of the Will (De Libero Arbitrio Voluntatis)*, Book I,V. Indianapolis-New York: Bobbs-Merrill, 1964, p. 11; St. Thomas Aquinas, Summa Theologica, II.I.96.4 (http://www.newadvent.org/summa/2096.htm) Accessed 2012-07-10; King, Martin Luther, *Letter from Birmingham Jail*, 16 April, 1963. http://www.africa.upenn.edu/Articles_Gen/Letter_Birmingham.html (Accessed 2012-07-10)

[238] *Carter v. Canada*, para. 163, 200, 234, 236, 300, 303-306, 308-309, 311, 322, 349. Such reference also occur outside Part VII: para.5, 8, 492, 1198, 1336, 1369.

and arguments.

B5 Medical ethics

B5.1 Ethics and the willingness of physicians

B5.1.1 In her search for consensus in medical ethics, the sources relied upon by the judge include the opinions of physicians, medical associations and ethicists, and current end-of-life practices.

B5.1.2 Thus, the judge asks if Canadian physicians "would be willing to assist patients" with suicide and euthanasia if the law were changed.[239] She concludes that "there are experienced and reputable Canadian physicians" who are "unchallenged with respect to their standing in the medical community or their understanding of and respect for medical ethics" who are willing to provide assisted suicide and euthanasia.[240]

B5.1.3 But exactly the same thing could have been said of the German physicians and leaders of the German medical profession who supported the Nazi euthanasia programme and medical atrocities of the Nazi regime.[241] The willingness of reputable physicians to provide assisted suicide and therapeutic homicide hardly demonstrates that the services are ethical.

B5.1.4 After all, some physicians are willing to have sex with consenting patients, but Canadian professional and regulatory authorities are generally clear that it is always unethical for a physician to do so, even though it is not against the law.[242] This is also the case in the

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[239] *Carter v. Canada*, para. 318

[240] *Carter v. Canada*, para. 319, 344. They are identified in para. 254.

[241] "Germany's medical association has adopted a declaration apologizing for sadistic experiments and other actions of doctors under the Nazis. . . The medical association says "these crimes were not the actions of individual doctors but involved leading members of the medical community" and should be taken as a warning for the future." German medical association apologizes for Nazi-era crimes committed by doctors. *Associated Press*, 25 May, 2012. (http://www.foxnews.com/world/2012/05/25/german-doctors-apologize-for-nazi-era-crimes) Accessed 201-07-23. See alslo Lifton, Robert Jay, The Nazi Doctors: Medical Killing and the Psychology of Genocide. United States: Basic Books, 1986, p.33-35.

[242] For example, "The nature of a fiduciary relationship makes a consensual sexual relationship between physician and patient impossible." College of Physicians and Surgeons of British Columbia, Professional Standards and Guidelines: *Sexual Boundaries in the Physician-Patient Relationship* (October, 2009) (https://www.cpsbc.ca/files/u6/Sexual-Boundaries-in-the-Patient-Physician-Relationship.pdf)

Netherlands. The Royal Dutch Medical Association forbids physicians to have sex with patients who consent,[243] though it allows physicians to kill patients who consent.[244] In the United Kingdom, on the other hand, physicians must neither have sex with patients nor kill them or help them to kill themselves, their consent notwithstanding.[245]

B5.1.5 Certainly, these comparisons would have raised interesting ethical questions about different understandings of physician-patient relationships and consent,[246] had any of the parties chosen to bring them forward. However, the willingness of physicians to have sex with patients or to kill them (or help them commit suicide) does not enter into the ethical justification of any of these policies. One cannot see how it can enter into an ethical justification of physician-assisted suicide and therapeutic homicide.

B5.2 Ethics and the positions of medical associations

B5.2.1 It appears that neither defendants nor plaintiffs provided an adequate survey of the policies of medical associations or physician regulators on assisted suicide and euthanasia, but offered a sampling of policies from different organizations. The selection,

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Accessed 2012-07-10

[243] Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG), *Seksueel contact tussen arts en patiënt: Het mag niet, het mag nooit*. [Royal Dutch Medical Association, *Sexual contact between doctor and patient: It should not be, it should never be.*](2000) (http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/Seksueel-contact-tussen-arts-en-patient-het-mag-niet-het-mag-nooit-2000.htm) Accessed 2012-07-10

[244] Royal Dutch Medical Association, *The Role of the Physician in the Voluntary Termination of Life* (30 August, 2011) (http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/Position-paper-The-role-of-the-physician-in-the-voluntary-termination-of-life-2011.htm) Accessed 2012-07-12

[245] General Medical Council, *Maintaining Boundaries: Guidance for Doctors*. (November, 2006) (http://www.gmc-uk.org/guidance/ethical_guidance/maintaining_boundaries.asp) Accessed 2012-07-19; Hunt, Liz, "Sex with patients remains taboo. BMA conference: Doctors take steps to repair their tarnished image." *The Independent*, 28 June, 1996 (http://www.independent.co.uk/news/sex-with-patients-remains-taboo-1339111.html) Accessed 20-12-07-19

[246] Barilan, Y Michael, *Of Doctor-Patient Sex and Assisted Suicide* IMAJ 5:460-463. June, 2003. (http://www.ima.org.il/imaj/ar03ju-23.pdf) Accessed 2012-07-10

such as it is, illustrates only that there are differing views, while the judge acknowledges that the "official" position of an association on assisted suicide and euthanasia does not necessarily represent the views of all of the members of a profession.[247]

B5.3 Ethics and the opinions of ethicists

B5.3.1 Predictably, the ethicists called by the plaintiffs differed from those called by the defendants about the ethics of physician-assisted suicide and euthanasia.[248]

B5.3.2 For the plaintiffs, Dr. Marcia Angell, Professor Margaret Battin and Dr. Upshur justified physician-assisted suicide and euthanasia primarily by appeals to patient autonomy.[249] Defendant witness Professor Koch responded that one can hardly claim to be acting autonomously while demanding that society support and assist with suicide.[250]

B5.3.3 For the defendant governments, Prof. John Keown asserted that "any intentional taking of life is unethical and should not be permitted," a statement that would presumably include suicide, though this point was not pursued. He insisted that the inviolability of human life was at the heart of both law and medical practice. He opposed physician-assisted suicide and euthanasia because of his belief in the sanctity of life, and because he believed that the practices cannot be controlled if legalized.[251]

B5.4 Ethics and current end-of-life practices

B5.4.1 Ethicists and other witnesses also discussed current end-of-life practices. Dr. Gerrit Kimsma of the Netherlands argued that assisted suicide and euthanasia are consistent with the goals of medicine and already occurring in fact, though "under a veil of confusion, ambiguity and lack of truth/disclosure."[252]

B5.4.2 However, the judge found that the law has deterred all but a very few Canadian

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[247] *Carter v. Canada*, para. 274-277

[248] *Carter v. Canada*, para. 233. Plaintiff witnesses: Prof. Wayne Sumner; Dr. Marcia Angell; Prof. Margaret Battin; Dr. Upshur; Dr. Gerritt Kimsma. Defendant witnesses: Prof. John Keown; Prof. Thomas Koch; Dr. Bereza.

[249] *Carter v. Canada*, para. 238-242

[250] *Carter v. Canada*, para. 246-247

[251] *Carter v. Canada*. para. 244

[252] *Carter v. Canada*, para. 243

physicians from providing assisted suicide and euthanasia.[253] The evidence, she says, suggests that Canadian physicians provide assisted suicide or euthanasia in only "a very small number of instances."[254]

B5.4.3 The withdrawal of life support or treatment is of particular interest to Madam Justice Smith because 90% of patients die "following the withdrawal of some form of life support, most commonly the withdrawal of medical ventilation, dialysis or inotrope medications."[255]

B5.4.4 With respect to end-of-life practices generally, Madam Justice Smith identifies the pivotal principle of informed consent, which (she says) rests on the foundational concept of individual autonomy. Medical procedures cannot be undertaken or sustained without the continuing informed consent of a competent patient, who is entitled to refuse treatment even if death will result. In the case of non-competent patients whose wishes are not known, "medical decisions will be made in the patient's best interests." Patients can make their wishes known by means of advance directives, and such directives must be respected if the patient is incapacitated. Alternatively, decisions about withdrawal or refusal of treatment can be made by legally recognized third parties.[256] Madam Justice Smith held that the law concerning the right of physicians to withdraw or refuse treatment despite the objections of third-party decision-makers is uncertain.[257]

B5.4.5 However, much that is necessary to understand the ethical issues and controversies associated with end-of-life practices is absent from Part VII, particularly with reference to palliative sedation. (See Appendix "C") Thus, while the judge's explanation of the *law* of informed consent is satisfactory, as is her explanation of the *law* concerning withdrawal and refusal of treatment,[258] her discussion of the *ethics* of end-of-life decision-making is seriously deficient.

B5.4.6 The deficiency is especially problematic because Madam Justice Smith also attempts to answer another question: whether or not current end of life practices are ethically

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[253] *Carter v. Canada*, para. 203-204, 680.

[254] *Carter v. Canada*, para. 1370.

[255] *Carter v. Canada*, para. 185

[256] *Carter v. Canada*, para. 207-223.

[257] *Carter v. Canada*, para. 227-230.

[258] *Carter v. Canada*, para. 231.

distinguishable from physician-assisted suicide and euthanasia,[259] one of the plaintiffs' central claims.[260] (See B8.3)

B6 Ethics of society

B6.1 A second strand of discussion in Part VII, occasionally spliced into the discussion of medical ethics, is whether or not an ethical or moral consensus exists outside the medical profession on the subject of assisted suicide and therapeutic homicide. This, too, originates in the plaintiffs' claim, since they asserted that the current law is invalid if its purpose is "to uphold a particular religious conception of morality" that is unsupported by social consensus in Canada.[261]

B6.2 Ethics and public opinion

B6.2.1 The reliability of public opinion polls as an indicator of ethical consensus was disputed.[262] British Columbia urged that consensus should be recognized in a plurality of sources: "in the refusal of successive governments and Parliaments to legalize assisted dying," in the fact that "the overwhelming majority of Western democracies" forbid assisted suicide and euthanasia, in a comprehensive report from the Canadian Senate, and in laws and judicial rulings that are unspecified in the judgement.[263]

B6.2.2 The judge ultimately cites an opinion poll showing a majority of Canadians "are supportive of physician-assisted death in some circumstances."[264] This is an inaccurate description of the poll, which referred to "euthanasia," not "physician-assisted death." Moreover, the poll posed the question without reference to circumstances and without defining "euthanasia."[265]

B6.2.3 A poll of this type is of no value in assessing the ethical content or ethical significance of the opinions of respondents. While the judge notes that public opinion polls (in general)

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[259] Carter v. Canada, para. 318, 320

[260] *Carter v. Canada*, para. 163, 176; 186, 234-237, 321-322

[261] *Carter v. Canada*, para. 177

[262] *Carter v. Canada*, para. 278-284, 286-287

[263] *Carter v. Canada*, para. 285

[264] *Carter v. Canada*, para. 347

[265] *Carter v. Canada*, para. 280

"provide some indication as to societal values overall,"[266] she fails to explain how this particular poll could reasonably contribute to the ethical evaluation she attempts in Part VII.

B6.3 Ethics and public committees

B6.3.1 The judge notes that the 1995 Special Senate Committee Report was the result of a 14 month enquiry that heard evidence from witnesses across the country and received hundreds of letters and briefs, but adds that the report was not unanimous on the subject of assisted suicide and euthanasia.[267]

B6.3.2 She appears to give equal weight to subsequent reports produced by committees of the Royal Society of Canada (RSC) and the Quebec National Assembly (QNA), both of which unanimously recommended legalization of assisted suicide and euthanasia.[268]

B6.3.3 Quite apart from challenges that might be made concerning the comprehensiveness of the reports, the reference to the RSC and QNA reports in the ruling might be questioned for three reasons.

- First: five of the six authors of the RSC report favoured at least voluntary euthanasia before joining the RSC panel,[269] and the report was alleged to present a biased (largely legal) argument.[270]
- Second: three authors of the RSC report were plaintiff witnesses at trial, and one helped to instruct plaintiff witnesses.[271]
- Third: the recommendations of the QNA committee report are reported to have contradicted the majority of submissions received by the committee.[272]

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[266] *Carter v. Canada*, para. 347

[267] *Carter v. Canada*, para. 288-292

[268] *Carter v. Canada*, para. 295-296, 298

[269] Prof. Sheila McLean, Prof. Jocelyn Downie, Prof. Ross Upshur, Prof. Johannes J.M. van Delden, Prof. Udo Schuklenk

[270] *Carter v. Canada*, para. 123. The witnesses were Prof. Ross Upshur, Prof. Johannes J.M. van Delden and Prof. Udo Schuklenk. Prof. Jocelyn Downie instructed plaintiff witnesses.

[271] *Carter v. Canada*, para. 124

[272] Couture, Linda, *Results of public hearings held by The Select Committee on dying with dignity in Quebec: Briefs submitted.* (15 November, 2011)

B6.3.4 However, Madam Justice Smith does not treat the reports as evidence of a consensus that assisted suicide and euthanasia are ethical. Instead, she relies upon them only to demonstrate a *lack* of social consensus. She contrasts the majority and minority Senate Committee positions,[273] and the recommendations of the RSC and QNA reports with the adverse response of Parliament in 2010.[274]

B6.4 Ethics and prosecution policies

B6.4.1 In considering Crown Counsel policy governing prosecution of assisted suicide in British Columbia,[275] Madam Justice Smith notes that the policy appears to recognize that the public interest may not always require prosecution of assisted suicide or euthanasia, even if there is a strong likelihood of conviction. She finds this conceivably supportive of legalization of the procedures.[276]

B6.4.2 However, she completely ignores the prosecution policy of the United Kingdom, which was also part of the evidentiary record[277] and directly relevant to the subjects she considers in Part VII. According to the English policy, if there is sufficient evidence to support a charge, there is a *greater* public interest in prosecuting physicians, healthcare workers and others who assist in the suicide of someone in their care than in prosecuting those who are *not* in positions of authority.[278] Madam Justice Smith's silence concerning this document is inexplicable.

B7 Summary of the ethical debate

B7.1 Madam Justice Smith correctly notes agreement that palliative care is not always

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(http://www.vivredignite.com/en/docs/positon_csmd_nov15_11.pdf) Accessed 2012-07-22

[273] *Carter v. Canada*, para. 290-292, 346

[274] *Carter v. Canada*, para. 346

[275] *Carter v. Canada*, para. 300-307.

[276] *Carter v. Canada*, para. 355.

[277] *Carter v. Canada*, para. 299.

[278] Director of Public Prosecutions, *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*. February, 2010, para. 43.14 (http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html) Accessed 2012-07-13

effective, and, more commonly, often not accessible.[279]

B7.2 She also states that there is no disagreement about the facts related in Part VII concerning "existing clinical end-of-life practices and the understood legal and ethical justification for them."[280] Given her incomplete treatment of the subject, it would be imprudent to accept this assertion at face value. (See Appendix "C")

B7.3 The judge asserts that there is "little dispute" that principles of autonomy, compassion and non-abandonment "play a central role in the formation of medical ethics" and that the principle "do no harm" is of continuing importance for physicians."[281] This is correct, but insufficient.

B7.4 In the first place, this comment implies that "medical ethics" is a monolithic entity, and suggests that the judge was unaware that there are distinct traditions of medical ethics that are not always in agreement on all points.

B7.5 Moreover, autonomy, compassion, non-abandonment and non-maleficence are not the only principles that shape medical ethics, and there are ongoing disputes about the application of these principles. For example: the principle of non-abandonment is generally accepted, but that it could be applied (as suggested by Professor Battin) to compel an objecting physician to facilitate assisted suicide[282] would be sharply contested. The judge's failure to appreciate this is illustrated by her casual dismissal of references in the evidence and in submissions to conscientious objection by physicians.[283]

B7.6 Finally, Madam Justice Smith acknowledges (without explaining) controversies associated with palliative sedation and the withdrawal of food and fluids from patients unable to give informed consent, but deems them irrelevant to the claims made by the plaintiffs.[284]

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[279] *Carter v. Canada*, para. 309; 190-193

[280] *Carter v. Canada*, para. 309

[281] *Carter v. Canada*, para. 310

[282] *Carter v. Canada*, para. 239

[283] *Carter v. Canada*, para. 311. Her comment also demonstrates she shaping and limiting power of the pleadings, which exclude consideration of others whose interests might be affected by the judgement.

[284] *Carter v. Canada*, para. 312-313

B8 Conclusions about the ethical debate.

B8.1 The judge provides succinct and useful summaries of the arguments for and against legalizing assisted suicide and euthanasia before drawing conclusions about the ethical debate.[285] She then arranges her conclusions under three headings.

B8.2 Would Canadian physicians provide the services?

B8.2.1 Ultimately, the exploration of the willingness of physicians to provide assisted suicide or euthanasia reveals only what ought to have been obvious from the pleadings: that some are willing, others not. The judge's conclusion that some "experienced and reputable physicians" would be willing to do so resolves nothing with respect to the ethics of the practices.

B8.3 Does current medical practice with respect to end-of-life care make distinctions that are ethically defensible?

B8.3.1 Much of this section of the ruling concerns peripheral legal issues[286] and a re-statement of the ethical arguments of the plaintiffs and defendants.[287]

B8.3.2 The subject of intention as an ethically significant element in decision-making is introduced,[288] but the judge does not pursue it because, in her view, the focus of the Supreme Court of Canada's discussion of intention in *Rodriguez* was law, not ethics.[289] It does not seem to have occurred to her that intention might nonetheless be relevant to her consideration of the ethics of end-of-life care. Nor does she explain why she thinks that intention can provide the basis of a valid distinction in law[290] but not in ethics.

B8.3.3 In any case, Madam Justice Smith offers the following summary of her study:

> The evidence shows that within the medical and bioethical community the question still remains open whether an ethical distinction is maintainable between withholding or withdrawing life-sustaining treatment and palliative sedation on the one hand,

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[285] *Carter v. Canada*, para. 314-315

[286] *Carter v. Canada*, para. 326-333

[287] *Carter v. Canada*, para. 321-323

[288] *Carter v. Canada*, para. 324-325

[289] *Carter v. Canada*, para. 330

[290] *Carter v. Canada*, para. 929

and physician-assisted death on the other.[291]

B8.3.4 Consistent with this, in summarizing the ruling, she states that "currently accepted practices bear similarities to physician-assisted death, but opinions differ as to whether they are ethically on a different footing."[292] This plainly concedes that she cannot answer the question she poses (B8.3) by reference to the evidence from "the medical and bioethical community."

B8.3.5 However, the judge also contradicts herself. Immediately after declaring the question still open, she claims that "[t]he preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death," adding that she finds this view "persuasive."[293] Further, she notes that a number of defendant and plaintiff witnesses were doubtful about the distinction,[294] and that she finds it difficult to make a distinction in individual cases.[295] It is unclear how doubts and difficulties (possibly exacerbated by avoiding reference to intention) contribute anything of substance to self-contradiction and personal opinion.

B8.3.6 Ultimately, Madam Justice Smith's conclusion about the ethical relationship between current end-of-life practices and physician-assisted suicide and euthanasia is inconclusive at best, and, at worst, incoherent. It is certainly confusing. It has misled even a knowledgeable (if controversial) ethicist, Princeton's Peter Singer, who, quoting the judge's self-contradictory afterthoughts, applauds the ruling as a model textbook about assisted suicide and euthanasia.[296]

B8.4 Does the law attempt to uphold a conception of morality inconsistent with the consensus in Canadian society?

B8.4.1 Madam Justice Smith asserts that there appears to be a "strong consensus that currently

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[291] *Carter v. Canada*, para. 334

[292] *Carter v. Canada*, para. 5

[293] *Carter v. Canada*, para. 335

[294] *Carter v. Canada,* para. 336-337

[295] *Carter v. Canada*, para. 338

[296] Singer, Peter, "Dying in Court." *Project Syndicate*, 23 July, 2012 (http://www.project-syndicate.org/commentary/dying-in-court) Accessed 2012-07-23

legal end-of-life practices are ethical."[297] While this conclusion may be open to question in some respects (See Appendix "C"), and the judge comments on it in her summary of the ruling,[298] it does not enter into the reasoning offered to support the judge's decision to strike down the law.[299]

B8.4.2 The judge's belief that consensus about end-of-life practices is ultimately based on the "value of individual autonomy" is a hazardous oversimplification. Personal autonomy is arguably the most highly prized legal principle in Canada, and in dominant theories of bioethics it is frequently the value that trumps all others. However, other ethical traditions give priority to other principles, like the sanctity of life or human dignity.[300] Practitioners from these traditions may share in a consensus about a particular end-of-life practice, but their agreement may not be based on the concept of autonomy.

B8.4.3 In attempting to identify the key difference of opinion that frustrates ethical consensus, Madam Justice Smith concludes that there is really no difference of opinion about the value of human life. [N]o one questions that the preservations of human life has a very high value in our society," she writes. "Rather, the difference of opinion is about whether the preservation of human life is an absolute value, subject to no exceptions."[301]

B8.4.4 With respect, this statement is a formulation that could be construed as a caricature of the position of the principal opponents of assisted suicide and therapeutic homicide. They do not hold that human life must be preserved at all costs. Madam Justice Smith acknowledged that the Christian Legal Fellowship had explicitly repudiated this view in its submission.[302] It apepars that the judge's interest here is not on "cost" but on "exceptions." That is, she may simply mean, "Granted that the preservation of human life has very high value, when can we make an exception and kill someone?"

B8.4.5 Rephrasing the question in this way accounts for the judge's reference in the next paragraph to the "deprivation account of the badness of death" offered by Professor Sumner. "[W]hat makes death such a bad thing in the normal case," he says, "is what it

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[297] *Carter v. Canada*, para. 340, 357

[298] *Carter v. Canada*, para. 5

[299] *Carter v. Canada*, para. 8-10, 15-18

[300] Sachedina, Abdulaziz, *Islamic Biomedical Ethics: Principles and Application*. Oxford: University Press, 2009, p. 166

[301] *Carter v. Canada*, para. 350

[302] *Carter v. Canada*, para. 171

takes away from us - the continuation of a life worth living."[303] It follows that if a life is not worth living, assisted suicide or euthanasia could be a good for that person.

B8.4.6 In any case, Madam Justice Smith does not address the difference of opinion she purports to identify or Professor Sumner's provocative ethical reflections. In fact, neither seems to be related directly to the judge's eventual conclusions in Part VII, though perhaps they reveal something of her personal outlook.

B8.4.7 Instead, the judge emphasizes differences of opinion among medical associations, individual physicians and politicians,[304] among panels, committees, parliaments and senates,[305] and among professional ethicists and medical practitioners.[306] Consistent with these differences, she concludes that there is no "clear societal consensus" about assisted suicide or euthanasia in the case of competent adults who are "grievously ill and suffering symptoms that cannot be alleviated."[307]

B8.4.8 In addition, however, Madam Justice Smith purports to discover a "strong consensus" supporting the view that if physician assisted suicide were ever ethical, it would only be in strictly limited circumstances.[308] This is like claiming a strong consensus that, *if* violence against women were ever to be ethical, it would only be in strictly limited circumstances.

B8.4.9 The judge's claim is a rhetorical conjuring trick. A significant number of people and a number of religious groups hold that assisted suicide can never be ethical; they absolutely reject the judge's "if." That being the case, the so-called "strong consensus" depends upon making these people and groups disappear, adopting the pretense that they do not exist, or dismissing their views as irrelevant.

B8.4.10 In the end, Madam Justice Smith simply does not answer the question she poses; she does not say whether or not the law attempts to uphold a conception of morality inconsistent with social consensus. Since she holds that no consensus exists with respect to assisted suicide and euthanasia, it would be difficult to argue a concept of morality upheld by the law could be inconsistent with it.

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[303] *Carter v. Canada*, para. 351

[304] *Carter v. Canada*, para. 343

[305] *Carter v. Canada*, para. 345-346

[306] *Carter v. Canada*, para. 348

[307] *Carter v. Canada*, para. 358. See also para. 6, 7

[308] *Carter v. Canada*, para. 342, 358

B9 *Carter* Part VII: in brief

B9.1 Unanswered questions

B9.1.1 In Part VII of the judgement, Madam Justice Smith is unable to answer three important questions she poses:

- whether or not it would ever be ethical for a physician to provide assisted suicide or euthanasia at the request of a competent, informed patient;
- whether or not current end of life practices are *ethically* distinguishable from physician-assisted suicide and euthanasia;
- whether or not the law attempts to uphold a conception of morality inconsistent with social consensus.

B9.2 Meaningless findings

B9.2.1 The judge's finding that "experienced and reputable Canadian physicians" are willing to provide assisted suicide and euthanasia discloses nothing about the ethics of the procedures.

B9.2.2 The purported "strong consensus" about assisted suicide "if" it were ethical is a fabrication constructed by excluding those who are absolutely opposed to it.

B9.3 Inconclusiveness

B9.3.1 Madam Justice Smith is unable to identify an ethical consensus concerning assisted suicide and euthanasia among professional associations, physicians, ethicists, public committees and the public as a whole.

B9.3.2 The judge is unable to determine whether or not current end-of-life practices can be ethically distinguished from assisted suicide and euthanasia.

B9.4 Neglected evidence

B9.4.1 Madam Justice Smith reviews British Columbia's prosecution policy, but inexplicably fails to consider the prosecution policy of the United Kingdom, which speaks to issues dealt with in Part VII.

B9.5 Deficient review of end-of-life decision-making

B9.5.1 Much that is necessary to understand the ethical issues and controversies associated with end-of-life practices is lacking in Part VII, particularly with reference to palliative sedation. (See Appendix "C")

B9.5.2 Despite prompting by the Christian Legal Foundation,[309] the judge does not explain why intention cannot be a valid element in ethical decision-making at the end of life.

B10 Carter Part VII: A judicial soliloquy on ethics

B10.1 Madam Justice Smith does not rely on any part of the ethical discussion in Part VII in reaching her conclusion about the constitutional validity of the law against assisted suicide. Given the problems identified in B9, this is not surprising.

B10.2 The discussion of ethics in Part VII is a soliloquy that is likely to capture the attention of readers, but it is likely to distract them from the pith and core of the judgement and contribute to rather than minimize confusion and controversy.

[309] *Carter v. Canada*, *Christian Legal Fellowship's Written Submissions*, para. 41, 44-45 (http://www.consciencelaws.org/archive/documents/carter/2011-12-01-submission-plaintiffs.pdf) Accessed 2012-07-27

APPENDIX "C"
Carter Part VII: Postscript

C1 Introduction

C1.1 Much that is necessary to understand the ethical issues and controversies associated with end-of-life practices is absent from Part VII. While the judge's explanation of the *law* of informed consent is satisfactory, as is her explanation of the *law* concerning withdrawal and refusal of treatment,[309] her discussion of the *ethics* of end-of-life decision-making is seriously deficient.

C1.2 Thus, when she states that there is no disagreement about the facts related in Part VII about "existing clinical end-of-life practices and the understood legal and ethical justification for them,"[310] it would be imprudent to accept this assertion at face value, particularly in view of the studied vagueness that attends her discussion of palliative sedation. One reason for this may be that the evidence appears to have been focused on palliative care - the care of those who are dying - while the most spectacular controversies about euthanasia have concerned patients who were *not* dying.(C2.4.5)

C1.3 Moreover, the treatment of *ethical* justification (as opposed to *legal* justification) is slender indeed. Part VII contains virtually no information about factors that are considered in decision-making about withholding or withdrawing interventions.

C1.4 Ultimately, the discussion of the ethics and end-of-life practices in Part VII produces unanswered questions, meaningless findings and inconclusive results (See Appendix "B", B9), and it does not contribute to the reasoning that led the judge to strike down the prohibition on assisted suicide and euthanasia.

C1.5 However, Part VII is likely to contribute to confusion and make it more difficult for conscientious objectors among health care workers to be heard with respect. Accordingly, this Appendix reviews Part VII with a view to providing information that has been obscured by the ruling or left out of it altogether, so that readers will be better placed to understand the basis for objections when they arise.

C2 Palliative sedation

C2.1 Madam Justice Smith offers the following explanation of palliative sedation:

> In the context of palliative care, it is fairly widely accepted that

[309] *Carter v. Canada*, para. 231.

[310] *Carter v. Canada*, para. 309

> when a patient is close to the end of life, and is experiencing symptoms that are severe and refractory (that is, resistant to treatment), it is ethical practice for her physician to sedate her and maintain her in a state of deep, continuous unconsciousness to the time of death, with or without providing artificial hydration or nutrition ("terminal sedation" or "palliative sedation")[311]

C2.2 Palliative sedation is unregulated, has not been judicially considered in Canada, and standards are under development. The judge notes that palliative sedation cannot be assumed to "hasten death" when provided to patients "in the final stages of dying," and is usually provided when a patient is within a week of death, "although it is not always possible to be accurate in such assessments."[312]

C2.3 According to the judge, the practice of palliative sedation "remains somewhat controversial,"[313] and she elsewhere admits that "some aspects of palliative sedation" are "possibly" problematic for Canadian ethicists and practitioners. However, she does not elaborate further, and claims that there is apparently a strong or relatively strong consensus that "currently legal end-of-life practices are ethical."[314] These include the use of palliative sedation "and acting on patients' or substitute decision-makers' directions regarding withholding or withdrawal of life-sustaining treatment."[315]

C2.4 The meaning of "somewhat controversial"

C2.4.1 The controversy is not about palliative sedation *per se*: rendering a patient unconscious in order to provide relief from otherwise intractable pain. The controversy is about the withdrawal or withholding of food and fluids: the withdrawal or withholding of assisted nutrition and hydration during the process of palliative sedation.[316]

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[311] *Carter v. Canada*, para. 200.

[312] *Carter v. Canada*, para. 201, 202, 226

[313] *Carter v. Canada*, para. 201, 202, 226, 312.

[314] *Carter v. Canada*, para. 340

[315] *Carter v. Canada*, para. 357

[316] The judge also mentions controversy about the use of palliative sedation for "relief of existential suffering," (*Carter v. Canada*, para. 312), which refers to a sense of loss of dignity or other non-physical symptoms (*Carter v. Canada* para. 190, 312). There is controversy among palliative care practitioners about this, but the judge gives no account of it in the ruling. Moreover, the context of the remark is again indicative of the context of the withdrawal of

C2.4.2 The two acts (sedation on the one hand, withholding/withdrawing nutrition and hydration on the other) are clearly distinguishable in terms of their structure and their potential consequences. There is no evidence that properly administered sedation can cause the death of a patient, but it is clear that depriving a patient of food and fluids can. The controversy arises when it is believed that a patient is committing suicide or being deliberately killed by dehydration and starvation, and that palliative sedation is being used to ameliorate and mask the effects of the killing process.[317]

C2.4.3 However, a killing process must be distinguished from a dying process. A patient who is approaching death will naturally and gradually lose the ability to assimilate food and fluids, so that assisted nutrition and hydration will at some point serve no purpose and may even be contra-indicated. There is no dispute that discontinuation is justified in such circumstances. However, In some cases, there may be some practical difficulty in determining whether or not the patient has reached this stage in the dying process, and judgements may vary.[318]

C2.4.4 On the other hand, a patient who is capable of assimilating food and fluids and is not dying will not die merely because he is unconsciousness, whether as a result of an injury or illness or because of sedation. But withholding or withdrawing assisted nutrition and hydration will lead to his death, and this is controversial because, as noted above, it can be considered euthanasia in some circumstances. That is the position of the Euthanasia

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assisted nutrition and hydration. This lack of clarity is unhelpful.

[317] The Royal Society of Canada, *Report of the Expert Panel: End of Life Decision Making*, p. 34. (http://www.rsc.ca/documents/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf) Accessed 2012-07-27

[318] For an exchange of views on this and an introduction to some of the complexities of providing assisted nutrition and hydration, see Craig G, *On withholding nutrition and hydration in the terminally ill: has palliative medicine gone to far?* JMed Ethics, 1994 20: 139-143 (http://jme.bmj.com/content/20/3/139.full.pdf) Accessed 2012-07-27); Dunlop RJ, Ellershaw JE, Baines MJ, Sykes N, Saunders CM, *On withholding nutrition and hydration in the terminally ill: has palliative medicine gone to far? A reply*. JMed Ethics 1995; 21:141-143 (http://jme.bmj.com/content/21/3/141.full.pdf) Accessed 2012-07-27; Ashby M, Stoffell B, *Artificial hydration and alimentation at the end of life: a reply to Craig*. J Med Ethics 1995; 21:135-140 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1376687/pdf/jmedeth00296-0007.pdf) Accessed 2012-07-27

Prevention Coalition, one of the intervenors in the case in support of the existing law,[319] but the Coalition does not appear to have referred to it during the trial.[320]

C2.4.5 This issue is not just "somewhat" controversial; it is highly so. There have been several high-profile court rulings over the last three decades that have led to the withdrawal of nutrition and hydration from patients who were not dying, all of whom then died.[321] A number of the cases generated heated public debate; one precipitated a constitutional crisis in Italy.[322]

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[319] "To withdraw fluids and food from a person who is not otherwise dying, even if that person has a significant cognitive disability, is euthanasia because death is directly and intentionally caused by the withdrawal of basic care, that being fluids and food. Whether fluids and food are provided by a fork, a spoon or a tube, they represent a basic necessary of life that should be provided unless the person cannot assimilate or is actually nearing death." Schadenberg, Alex, "UK Judge decides not to dehydrate woman to death." *Euthanasia Prevention Coalition*, 29 September, 2011. (http://alexschadenberg.blogspot.ca/2011/09/uk-judge-decides-not-to-dehydrate-woman.html) Accessed 2012-07-26

[320] Johnston WD, Dore M, Schadenberg A, "The Carter Case and Assisted Suicide." (Summary of key arguments). *Euthanasia Prevention Coalition Newsletter 123*, November, 2011. (http://www.euthanasiaprevention.on.ca/Newsletters/Newsletter.123.Nov.2011.pdf) Accessed 2012-07-27

[321] Patricia Brophy (1986) [*Patricia E. Brophy v. New England Sinai Hospital*, 398 Mass. 417; 497 N.E.2d 626; 1986 Mass. LEXIS 1499 (http://academic.udayton.edu/LawrenceUlrich/brophy.htm) Accessed 2012-07-26]; Nancy Cruzan (1990) [*Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990) (http://supreme.justia.com/cases/federal/us/497/261/case.html) Accessed 2012-07-25)]; Tony Bland (1993) [*Airedale NHS Trust (Respondents) v.Bland (acting by his Guardian ad Litem)* (Appellant) (4 February 1993) (http://www.bailii.org/uk/cases/UKHL/1992/5.html) Accessed 2012-07-26]; Terri Schiavo (1998-2005) [Findlaw Special Coverage, *Terri Schiavo Case: Legal Issues Involving Health Care Directives, Death and Dying.* (http://news.findlaw.com/legalnews/lit/schiavo/) Accessed 2012-07-26]; Eulana Englaro (2009) [*Procedimento Escritto Nel Reg. della Vol. Giur. al n.:88/2008, La Corte d'Appello di Milano, Prima Sezione Civile* (25 June, 2008) (http://www.corriere.it/Media/Foto/2008/07/09/eluana_low.pdf) Accessed 2012-07-26

[322] Donadio, Rachel, "Death ends coma case that set of furor in Italy." *New York Times*, 9 February, 2009 (http://www.nytimes.com/2009/02/10/world/europe/10italy.html?_r=1) Accessed 2012-07-25. Three Canadian cases cited in *Carter* concerned withdrawal of

C2.4.6 Madam Justice Smith must have been aware of this because she refers to the case of Tony Bland[323] and to the cross-examination of Professor John Keown concerning it.[324] Professor Keown's point was that Bland was not dying and would not have died but for the withdrawal of assisted nutrition and hydration; the intervention was withdrawn with the intention to cause his death. The Christian Legal Fellowship drew this to judge's attention in its written submission.[325]

C2.4.7 Moreover, the judge quotes the evidence of Dr. Michael Klein, who stated that he had been required to stop both ventilator and tube feeding and hydration for patients who specifically intended to die by such means,[326] and evidence from Dr. Rodney Syme that appears to describe the death of someone being killed by dehydration and starvation while under palliative sedation.[327]

C2.4.8 One suspects that the judge had all of this in mind when summarizing the plaintiffs' claim that there is no ethical distinction between physician-assisted suicide or euthanasia and

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interventions, but none raised the specific issue of assisted nutrition and hydration. In *Golubchuk* and *Rasouli* the patients were on ventilators as well as having assisted nutrition and hydration, while in *Sawatzky* the issue was a "Do Not Resuscitate" order that had been improperly issued. *Golubchuk v. Salvation Army Grace General Hospital* 2008 MBQB 49 (http://www.euthanewsia.ca/archive/anno/golubchukinjunction.pdf) Accessed 2012-07-26; *Rasouli v. Sunnybrook Health Sciences Centre* 2011 ONCA 482 (Leave to appeal to SCC granted [2011] SCCA No. 329) (http://www.ontariocourts.ca/decisions/2011/2011ONCA0482.htm) Accessed 2012-07-26;
Sawatzky v. Riverview Health Centre Inc. (1998) 167 DLR (4th) 359 (Man QB)
Benson, Iain T., Miller Brad, "Court Gives Course in Medical Ethics to Public Trustee." *Lexview 23.0*, 8 December, 1998. (http://www.cardus.ca/lexview/article/2306/) Accessed 2012-07-26

[323] *Carter v Canada*, para. 224

[324] *Carter v. Canada*, para. 245

[325] Christian Legal Fellowship, *Carter v. Canada*, *Christian Legal Fellowship's Written Submissions*, para. 46, citing cross examination of Prof; Keown at p. 29-30 and 80. (http://www.christianlegalfellowship.org/legal_issues/interventions/Carter/Carter%20Case%20-%20CLF%20Written%20Arguments%20Dec.%2010,%202011.pdf) Accessed 2012-07-27

[326] *Carter v. Canada,* para. 257

[327] *Carter v. Canada*, para. 1071

"end-of-life practices which are lawful."[328]

C2.4.9 What, then, to make of Madam Justice Smith's statement that there is an "apparently strong consensus that currently legal end-of-life practices are ethical"?[329] Is it to be applied to the withdrawal of assisted nutrition and hydration from a patient who is not dying, with the intention of causing his death? This is unquestionably legal when the requirements of informed consent have been met, but, as the evidence of Professor Keown indicates, there is no consensus - let alone a *strong* consensus - that this 'legal end-of-life practice' is ethically acceptable.

C2.4.10 However, the defendants were unwilling to describe this practice as unethical. To do so would have been awkward, since it would have brought into question both the legal and bioethical *status quo* in Canada. They do seem to have argued that it can be ethically distinguished from physician-assisted suicide and euthanasia.[330]

C3 Patient autonomy: the distinction between legal and ethical evaluation

C3.1 In Canada, a competent person can legally refuse any kind of intervention or assistance, or require that it be discontinued, even if that will result in death. When the wishes of a competent person are known, they will be respected if he becomes incapacitated and unable to communicate.

C3.2 Incompetent persons are those who, by reason of age or disability, are unable to provide or withdraw informed consent to intervention or assistance. Such decisions must be made by a proxy or substitute decision-maker, typically a family member or relative defined by common law or statute.

C3.3 Health care workers commit an assault and are liable to civil action and perhaps criminal charges if they provide intervention or assistance against the wishes of a competent patient, or, in the case of an incompetent person, against the direction of a substitute decision maker.

C3.4 The preceding explanation of the law in Canada is found in Part VII in the *Carter*

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[328] *Carter v. Canada*, para. 321

[329] *Carter v. Canada*, para. 340

[330] *Carter v. Canada*, para. 323. Note how the reference to "legally approved end-of-life practices in Canada" includes this practice without identifying it. Thus, absent a direct reference to the position of the defendants, one cannot be certain about the meaning of generic references to 'legal practices.'

ruling,[331] but there is no discussion of the associated ethical or moral issues, even though, in Part VII, the judge claims to be addressing ethical rather than legal questions.

C3.5 What is missing from the judge's account is an acknowledgement that a decision to refuse intervention or assistance or to require that it be discontinued has a moral or ethical dimension, and that different religious, moral and ethical traditions may disapprove of the decision, even though the law does not. This can cause conflicts within families, between families and health care workers, and among health care workers who have different moral, ethical or religious views.

C3.6 Consider, for example, a decision by a competent patient to commit suicide by refusing food and fluids. It was acknowledged at trial that this cannot be prevented, but nothing in the representations of the parties or in the comments of the judge suggests that the decision might be morally or ethically controversial. In fact, the defendants argue that the law against assisted suicide is not discriminatory precisely because everyone *can* commit suicide in this manner.[332]

C3.7 No one disputes that this is the law, and that health care workers are bound by the law. But it is misleading to imply that the fact that health care workers comply with the law is evidence of an ethical consensus in favour of suicide, so that health care workers might reasonably be expected to help someone commit suicide.

C4 Proportionality of interventions

C4.1 The distinction between ordinary and extraordinary (or proportionate and disproportionate) interventions relates to the principle that one is not ethically obliged to preserve one's health or life by recourse to extraordinary interventions or those that are disproportionately burdensome. Similarly, health care workers are not ethically obliged to provide extraordinary or disproportionate interventions. This principle is acceptable to many who believe that human life is sacred (or of inestimable value) but, nonetheless, need not be preserved at all costs.[333]

C4.2 One of the most common applications of this principle is in advance directives or orders that specify "Do Not Resuscitate" (DNR) or "No Cardiopulmonary Resuscitation" (No CPR). These are often prepared for elderly people in frail health or those with terminal illnesses because CPR can cause harm (such as broken ribs), while research indicates that

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[331] *Carter v. Canada*, para. 231

[332] *Carter v. Canada*, para. 1065-1076

[333] Sachedina, Abdulaziz, *Islamic Biomedical Ethics: Principles and Application*. Oxford: University Press, 2009, p. 170.

there is very little likelihood that CPR will have a positive outcome for such patients. In contrast, CPR is encouraged when there is a prospect of recovery (such as a witnessed collapse) because the benefits outweigh adverse effects.[334] The example illustrates another important point: that interventions are not categorized as "proportionate" or "disproportionate" without reference to circumstances.

C4.3 Evaluation of the proportionality of interventions and assistance is a ubiquitous feature of the provision of health care, so much so that in non-critical situations it may hardly be noticed. However, in critical care and palliative care the importance of and difficulties associated with this kind of evaluation are likely to be more pronounced: so, too, in the case of patients who are in a state of persistently minimal consciousness. Much depends on circumstances of each case, and some degree of subjectivity cannot be avoided.[335]

C4.4 In particular, since the patient bears most of the burdens - and usually the most significant burdens - one would expect the patient's views about interventions and assistance to carry the greatest weight. In fact, in law, a competent patient (or substitute decision-maker) can refuse *any* kind of intervention or assistance, even those others would consider ordinary or proportionate. The legal basis for this is the principle of personal autonomy.

C4.5 The law notwithstanding, a broad spectrum of significant religious traditions and medical ethics derived from them hold that one is morally obliged to seek and accept ordinary or proportionate interventions and assistance that will preserve one's health and life, and that health care workers are obligated to provide and maintain such services.[336] From this perspective, the decision of a patient who is not in the final stages of dying to refuse an intervention (or of a health care worker to provide it) may be seen to be blameworthy, as in the example above of suicide by starvation.

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[334] Hilberman M, Kutner J, Parsons D, Murphy DH, *Marginally effective medical care: ethical analysis of issues in cardiopulmonary resuscitation (CPR).* J Med Ethics, 1997; 23: 361-367 (http://jme.bmj.com/content/23/6/361.full.pdf) Accessed 2012-07-29. Note that the decision to complete an advance directive or order is properly determined by the medical history, needs and condition of an individual, not by membership in a sub-group of patients.

[335] Somerville, Margaret, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide*. Montreal & Kingston: McGill-Queens University Press, 2001, p., 73

[336] Eisenberg, Daniel, *The Sanctity of the Human Body*. (http://www.consciencelaws.org/\issues-ethical/ethical015.html) *Catechism of the Catholic Church*, 2288; Sachedina, Abdulaziz, *Islamic Biomedical Ethics: Principles and Application*. Oxford: University Press, 2009, p. 168, 183-184

C4.6 Again, health care workers are expected to comply with the law. However, a health care worker who believes that a patient is wrong to refuse an intervention may conform to the patient's wishes, not primarily because of the law, but because that response is somehow respectful of the human person who is the patient. It may, in short, be an ethical response, and one that can be described as ethically correct.[337] But such a response is not indicative of an "ethical consensus" about the patient's choice. This becomes clear when someone who has moral or ethical objections to a patient's decision is asked to do something to make it effective.

C5 Withdrawal and refusal of assisted nutrition and hydration

C5.1 Assisted nutrition and hydration: the methods

C5.1.1 Nutrition and hydration are different needs and in a clinical situation should be considered separately, but for present purposes they will be discussed together because the ethical considerations relevant to withdrawing, withholding or refusing them are the same.

C5.1.2 Assisted nutrition and hydration (also known as "artificial nutrition and hydration" or "clinically assisted nutrition and hydration") include techniques for the delivery of nourishment and fluids to sustain life when a patient is unable to eat or drink, or when there is a significant risk of aspiration. They involve medical interventions like nasogastric tubes, percutaneous endoscopic gastrostomy (PEG) or radiologically inserted gastrostomy tubes inserted through the abdominal wall.[338]

C5.1.3 If a patient is incapacitated, assisted nutrition and hydration may be instituted while his condition is stabilized and assessed, and maintained until the patient has recovered sufficiently to resume eating and drinking. This is uncontroversial. However, if recovery does not occur and the patient does not die from the underlying illness or injury, he will be dependent upon assisted nutrition and hydration to sustain his life. At this point, a conflict may occur between those who want to terminate assisted nutrition and hydration, and those who want to continue it.

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[337] See, for example, *Carter v. Canada*, *Christian Legal Fellowship's Written Submissions*, para. 45 (http://www.christianlegalfellowship.org/legal_issues/interventions/Carter/Carter%20Case%20-%20CLF%20Written%20Arguments%20Dec.%2010,%202011.pdf) Accessed 2012-07-27

[338] General Medical Council, End of life care: *Clinically assisted nutrition and hydration*. (http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_clinically_assisted_nutrition_and_hydration.asp) Accessed 2012-07-27

C5.2 Assisted nutrition and hydration: optional "treatment" or obligatory "care"?

C5.2.1 In Canada (and in many other jurisdictions), assisted nutrition and hydration are legally considered to be forms of medical treatment, and, from the perspective of the patient, the law considers all forms of treatment to be optional. Reflecting the primacy of the principle of personal autonomy, a competent patient can legally refuse any kind of medical treatment, even life-saving or life-sustaining treatments like assisted nutrition and hydration.[339] It was acknowledged at trial that a patient cannot be prevented from committing suicide in this manner.[340] In the case of incompetent patients, substitute decision-makers can legally refuse all forms of treatment on their behalf, including assisted nutrition and hydration.[341]

C5.2.2 The law reflects the opinions of widely influential ethicists, but cannot be said to represent an ethical consensus, unless one discounts the views of those who disagree. Notwithstanding the law and the opinions of influential schools of bioethics, some ethical traditions consider assisted nutrition and hydration to be forms of care, not medical treatment.[342]

C5.2.3 The distinction is important, because those who make it typically insist that, unlike treatment, care is not optional; it is a duty one owes to others by virtue of our common humanity. While acknowledging that assisted nutrition and hydration may be withheld or withdrawn when it cannot be assimilated or is otherwise medically contra-indicated, they assert that it must be provided in other circumstances if it is ordinarily accessible and affordable.[343]

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[339] *Carter v. Canada*, para. 207-220; CLF para. 42-44

[340] *Carter v. Canada*, para. 1065-1076

[341] *Carter v. Canada*, para. 221-224. The patient's instructions must not be contrary to the law, or public policy or public order and good morals. However, they are legally bound to adhere to the patient's express instructions, absent which they must make decisions in the patient's "best interests."

[342] Rosin J, Sonnenblick M, Autonomy and paternalism in geriatric medicine. The Jewish ethical approach to issues of feeding terminally ill patients, and to cardiopulmonary resuscitation. J Med Ethics 1998; 24:44-48 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1377431/pdf/jmedeth00312-0048.pdf) Accessed 2012-07-27

[343] Congregation for the Doctrine of the Faith, *Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration* (1

C5.3 Assisted nutrition and hydration as "extraordinary" or "disproportionate"

C5.3.1 Two further approaches can be identified. Some deem assisted nutrition and hydration to be part of an overall treatment regime that may include other medical interventions, like the artificial evacuation of bladder and bowels.[344] Alternatively (or, in addition) they may consider assisted nutrition and hydration to be an artificial substitute for a failed organ system, analogous to a ventilator used by someone unable to breathe independently.[345] On either view, refusal or withdrawal of the intervention could be justified by reference to the principle of proportionality.

C6. Intention

C6.1 The subject of intention as an ethically significant element in decision-making is introduced,[346] but the judge does not pursue it because, in her view, the focus of the Supreme Court of Canada's discussion of intention in *Rodriguez* was law, not ethics.[347] It does not seem to have occurred to her that intention might nonetheless be relevant to her consideration of the ethics of end-of-life care. Nor does she explain why she thinks that intention can provide the basis of a valid distinction in law[348] but not in ethics.

C6.2 The consequences of the judge's failure to attend to intention have consequences. For example, in summarizing the plaintiffs' claim that physician-assisted suicide and euthanasia cannot be distinguished from accepted end-of-life practices, she said:

> . . .the argument is that withdrawing a ventilator tube or maintaining a patient under sedation without hydration or nutrition are acts that will result in death, just as much as the act of

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August, 2007) (http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html) Accessed 2012-07-27

[344] This was the view of Lord Keith in *Airedale NHS Trust (Respondents) v.Bland (acting by his Guardian ad Litem)* (Appellant) (4 February 1993) (http://www.bailii.org/uk/cases/UKHL/1992/5.html) Accessed 2012-07-26

[345] Somerville, Margaret, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide*. Montreal & Kingston: McGill-Queens University Press, 2001, p. 362, note 161

[346] *Carter v. Canada*, para. 324-325

[347] *Carter v. Canada*, para. 330

[348] *Carter v. Canada*, para. 929

> providing a lethal prescription or administering lethal medications. To perform those acts, knowing of their inevitable consequences, is to hasten death.[349]

C6.3 However, withdrawing a ventilator may not, in fact, result in death; Karen Ann Quinlan lived nine years after her ventilator was withdrawn.[350] The judge cannot properly analyze the argument as she presents it because she inappropriately conflates two different procedures that can have two different outcomes.

C6.4 Note that her reference is to "knowing" the consequences, not intending them. The plaintiffs claim and that knowledge and intention are ethically equivalent in this situation; the defendants deny it; the judge fails to articulate a rational and coherent position on the ethical significance of intention.

C7. Summary

C7.1 Part VII of the *Carter* ruling fails to articulate and distinguish ethical issues associated with palliative sedation.

C7.2 Madam Justice Smith also fails to consider the distinction between legal and ethical evaluation of patient autonomy, and ignores the principle of proportionality and its application to refusing or withdrawing interventions. She also ignores other factors, principles or concepts that have a bearing on the ethical evaluation of refusing or withdrawing assisted nutrition and hydration, such as the nature of the intervention, the distinction between treatment and care and the related concept of moral obligation.

C7.3 Finally, the judge fails to provide a satisfactory explanation of her view of intention as it relates to the ethics of end-of-life decision making.

C7.4 Having neglected these distinctions, principles and concepts, Madam Justice Smith cannot credibly claim to have identified a consensus to the effect that physician-assisted suicide and euthanasia are not ethically distinguishable from currently legal end-of-life practices. To her credit, she does not make such a claim.[351]

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[349] *Carter v. Canada*, para. 321. She later states that she found this argument "persuasive." *Carter v. Canada*, para. 335

[350] Karen Ann Quinlan Memorial Foundation, *History of Karen Ann Quinlan and the Memorial Foundation.* (http://www.karenannquinlanhospice.org/history/) Accessed 2012-07-30

[351] *Carter v. Canada*, para. 5