Supreme Court of Canada orders legalization of physician assisted suicide and euthanasia

Carter v. Canada (Attorney General) 2015 SCC 5

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Executive Summary

Outline

This paper offers a retrospective analysis of the Supreme Court of Canada decision legalizing physician-assisted suicide and physician-administered euthanasia (EAS). The analysis is informed by later controversy about providing EAS for mental disorders and by the development of practice environments increasingly hostile to objecting practitioners. It explores the meaning of irremediablilty in the trial court and Supreme Court decisions, the contested status of EAS in relation to medical practice and health care, and claims that Canadian courts have determined that there is no ethical difference beween EAS and accepted contemporaneous end-of-life practices like withdrawing inefficacious or disproportionately burdensome treatment.

The decision

In February, 2015, the Supreme Court of Canada reversed its 1993 decision in *Rodriguez v. British Columbia (Attorney General)* and invalidated the criminal law to the extent that it prohibited physician-assisted suicide and physician-administered euthanasia (EAS, known in Canada as Medical Assistance in Dying or MAID) in circumstances defined by the Court. The unanimous *en banc* decision affirmed a ruling three years earlier by the Supreme Court of British Columbia. The leadership of the Canadian Medical Association (CMA) had approved EAS (subject to legal constraints) as a possible response to "the suffering of patients with incurable diseases" two months before the *Carter* ruling. The criteria for EAS set by the Court in *Carter* were more restrictive than the revised CMA policy.

The ruling exempted physicians from prosecution for murder, assisted suicide and related offences in relation to a competent, adult patient who was acting voluntarily and met other criteria set by the Court. The patient had to have "a grievous and irremediable medical condition (including an illness, disease or disability)," which meant that EAS could be provided not only for "illness, disease or disability" but for other medical conditions. While the Court remarked that "minor medical conditions" would not qualify, the ruling captured a remarkably broad range of conditions. The Court indicated that the parameters it would propose would not apply to "persons with psychiatric

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disorders." However, the parameters the Court actually laid out did not explicitly exclude EAS for mental illness.

The Court limited the provision of EAS to a competent adult "who clearly consents" to the procedure. This has been understood to mean that consent is required from the patient (not a substitute decision-maker) at the time EAS is provided: that it cannot be given by an advance directive. A subsequent *Criminal Code* amendment allowed practitioners to provide euthanasia for patients who have fixed a date for the procedure and have given written consent to proceed if they become incapacitated before that time.

The final criterion specified in *Carter* was that the grievous and irremediable medical condition had to cause "enduring suffering that is intolerable to the individual in the circumstances of his or her condition." This has been understood to include either or both physical or psychological suffering as it is subjectively assessed by the individual experiencing it.

The Court limited its ruling to the facts of the *Carter* case, but offered no opinion "on other situations" where physicians might be asked to kill patients or help them commit suicide. The probability of expansion was obvious even at the time of the ruling. EAS for disabilities became available in 2021 and in the spring of 2024 will become available as treatment for mental disorders. It would be a serious mistake to assume that the goalposts set in *Carter* will not continue to be moved. This must be kept in mind in developing legal and policy responses to the ruling, particularly those touching upon freedom of conscience for physicians and other health care workers.

Carter and the criminal law

Though there was much argument about the importance of protecting vulnerable *patients*, the *Carter* decision actually enabled EAS (in circumstances defined by the Court) by protecting *physicians* vulnerable to criminal prosecution. Canadian physicians willing to provide euthanasia and assisted suicide wanted statutory assurance that they would not be prosecuted if they did so in good-faith compliance with the law. A *Criminal Code* amendment provided that assurance. Six years after the ruling, Canadian EAS death rates were the highest in the world. These results could not have been achieved without active collaboration by health care workers and administrators. Amending the *Criminal Code* to guarantee practitioner protection was arguably essential for that purpose.

The need to revisit *Carter*

The government was forced to delay EAS for mental disorders until 2024 because a controversy exploded about the application of the criterion of irremediability to mental illness. Eruption of the controversy was only the most dramatic and public manifestation of a deeper conflict that had been seething since EAS became legal.

Pressure on objecting practitioners has been enormous. They risk discipline and expulsion from their profession for refusing to collaborate in killing their patients. Palliative care specialists have left the discipline or retired early. These pressures often reflect claims that the *Carter* decision made EAS a constitutional right or a form of medical treatment practitioners are obliged to provide or arrange for.

This paper revisits the decision to see what the Supreme Court decided (or did not decide) about irremediability, the ethics of EAS, its relationship to accepted contemporaneous end-of-life practices

and the practice of medicine, and practitioner freedom of conscience.

Irremediability

The Supreme Court accepted the criterion of irremediability (not incurability) and separately affirmed patient freedom to refuse unwanted interventions. This protected the integrity of medical practice by ensuring practitioners' freedom to form an evidence-based opinion that could not be overridden by a patient's refusal. It also protected patients' freedom to refuse treatment and seek EAS elsewhere. The distinction between the two holds for irremediability or incurability. Unfortunately, the distinction was erased in amending the *Criminal Code.* Nonetheless, it is reasonable, plausible and preferable to insist that determinations of irremediability, incurability or irreversibility must be established by evidence-based medical criteria and cannot be reversed or nullified by patient refusal of treatment. This informs medical practice in other areas and is consistent with principles of fiduciarity.

Medical practice and killing

The appellants argued that the federal government could not prohibit physician-administered euthanasia and physician-assisted suicide because they were "core" forms of medical treatment, and thus under provincial constitutional jurisdiction. Underlying this claim was the sharply contested premise that homicide and assisted suicide were forms of medical treatment. The Court sidestepped the underlying issue and responded within the context of constitutional law and legal regulation of health care. It rejected the claim, apparently because it could not see how EAS could be described only as medical treatment (exclusive provincial jurisdiction) but not also as homicide and assisted suicide (concurrent federal jurisdiction). The Court did not decide or even address the philosophical dispute about whether killing patients or helping them to commit suicide were forms of medical treatment or properly part of medical practice or the profession of medicine. This left room not only for the exercise of concurrent federal jurisdiction, but for the accommodation of different philosophies of medicine within state regulatory regimes.

EAS vs. accepted end-of-life practices

The appellants insisted that the trial court judge (and later the Supreme Court) had determined that there were no "ethical, moral or practical differences" between, on the one hand, deliberately killing patients to relieve suffering, and, on the other, withdrawing treatment. Exchanges between Justice Michael Moldaver and lead appellant counsel Joseph Arvay made clear that at least one of the authors of the *Carter* decision did not share Mr. Arvay's view.

The trial judge did not conclude that physician-assisted suicide and euthanasia were ethical, nor did she conclude that there was no ethical difference between withdrawing/withholding inefficacious treatment and lethally injecting a patient. On the contrary: she noted lack of agreement about the ethics of assisted suicide/euthanasia and their ethical relationship to contemporaneous end-of-life practices.

The Supreme Court stated that the issue at the heart of the case was whether vulnerable persons could be adequately protected by anything less than a blanket prohibition of EAS, and it addressed this at length in reviewing the trial court decision. It remarked (erroneously) that the decision in

Rodriguez had relied on evidence of acceptance of a moral/ethical distinction between "passive and active euthanasia" that could be undermined by evidence in the trial court record, but it did not elaborate, and the observation seems to have contributed nothing of substance to the *Carter* decision.

Contrary to the appellants' claims, neither the trial court judge nor the Supreme Court of Canada determined that there was "no rational or ethical or moral distinction" between EAS and accepted contemporaneous end-of-life practices. Neither did they disturb the *Rodriguez* finding that the distinction, though contested, was rationally defensible.

Why treat euthanasia/assisted suicide differently?

The Supreme Court affirmed that both federal and provincial governments can make laws about EAS, depending on their focus and the circumstances. The focus of federal (criminal) legislation is on controlling or managing non-culpable homicide and assisted suicide. The focus of provincial legislation is on regulating the activities of health professionals and delivery of health care.

Parliament might think it prudent to set higher standards to control or manage killing people than a province might set to control or manage the provision of palliative care. Only if homicide and assisted suicide in accordance with the *Carter* criteria are *nothing other* than healthcare or therapeutic medical treatment might a redefinition by Parliament of terms relevant to the procedures be redundant or possibly unconstitutional. However, the Supreme Court rejected that position in *Carter*.

Carter and freedom of conscience and religion

Upholding practitioner freedom of conscience is particularly important because only a very small minority of authorized practitioners are willing to provide EAS: about 1.8% in 2022. Remarkably, the appellants argued that there was "no fundamental social conception" that EAS was immoral, an extraordinary and inexplicable claim unsupported by the trial court ruling.

The appellants asserted that physicians' unwillingness to harm their patients made them ideal euthanasia practitioners, apparently oblivious of their need to exercise freedom of conscience in order to persist in refusal. And, while they promised that objecting practitioners would *not* be forced to *provide* EAS, they offered arguments and evidence suggesting or insisting that practitioners *should* be forced to *collaborate* in it. After winning the appeal, lead appellant counsel Joseph Arvay characterized protection of practitioner freedom of conscience as mere "bells and whistles."

During and after the appeal the Canadian Medical Association supported physician freedom of conscience in relation to physician participation in EAS. However, after the appeal hearing and before the ruling the association unconditionally approved euthanasia and assisted suicide as legitimate forms of medical treatment for persons suffering from incurable diseases. This was to have serious adverse implications for practitioners opposed to EAS for reasons of conscience, particularly in relation to the contentious issue of referral.

The problem of referral was addressed in a joint intervention by the Catholic Civil Rights League, Faith and Freedom Alliance and the Protection of Conscience Project which had been opposed by the appelllants. The intervention challenged the appellants' failure to promise that objecting practitioners would not be forced to collaborate in EAS, and it insisted that no practitioners should

be in professional or legal jeopardy for refusing to kill or collaborate in killing their patients.

What the Supreme Court decided

The Supreme Court limited itself to declaring that the absolute prohibition of EAS was constitutionally invalid, noting that the declaration of invalidity did not compel physicians to *provide* EAS. The relevant passage indicates that invalidating the criminal prohibition did not create an obligation on the part of physicians (individually or collectively) to provide the service.

The Court added that a physician's decision *to participate* in assisted dying was a matter of conscience and sometimes religious belief. In that regard, it affirmed the comments of Justice Beetz in *R v Morgentaler,* addressing the participation of hospitals in abortion. Justice Beetz' comments are authority for the proposition that the state is not only precluded from forcing individuals or institutions to provide morally contested procedures, but also precluded from forcing them to participate indirectly by referral or other forms of causal facilitation.

What the Supreme Court did not decide

The *Carter* decision did not impose a legal duty on the state or upon anyone else to provide or participate in euthanasia or assisted suicide. The Court did not decide that killing patients or helping them to commit suicide was medical treatment, nor that EAS and accepted contemporaneous end-of-life interventions were legally, morally, or ethically equivalent, nor did it address the contentious issue of referral.

The *Charter* right of patients clearly established by *Carter* is a legal right not to be impeded or obstructed by the state in seeking euthanasia and assisted suicide from willing practitioners in accordance with the Court's guidelines, except to the extent that impediments or obstructions can be demonstrably justified in a free and democratic society. The *Charter* right of willing practitioners clearly established by *Carter* is their legal right not to be to impeded or obstructed by the state in providing euthanasia and assisted suicide in accordance with the Court's guidelines, except to the extent that impediments or obstructions can be demonstrably justified in a free and democratic society. Any additional rights claims are derived by reading into the ruling what the judges either did not address, or purposefully and often expressly left out.

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I. The *Carter* decision

I.1 In February, 2015, the Supreme Court of Canada reversed its 1993 decision in *Rodriguez v. British Columbia (Attorney General)*[1] and invalidated the criminal law to the extent that it prohibited physician-assisted suicide and physician-administered euthanasia (EAS, known in Canada as Medical Assistance in Dying or MAID) in circumstances defined by the Court.[2] The unanimous *en banc* decision affirmed a ruling three years earlier by the Supreme Court of British Columbia.[3] The Court suspended the decision for one year to give the federal and provincial governments time to plan implementation of the ruling.[4] In January, 2016 it extended the suspension for four months to allow more time for amendment of the *Criminal Code*.[5]

Assisted suicide *and* euthanasia

I.2 It appears that, at first, most or all major Canadian media outlets understood the ruling to mean that the Court had legalized physician-assisted suicide;[6] so did the Canadian Medical Association (CMA), which had intervened in the case at the Supreme Court.[7] However, the appellants had made clear from the very beginning that they were seeking legalization of both euthanasia and assisted suicide,[8] and the Supreme Court authorized both, including them under the

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[1] *Rodriguez v. British Columbia (Attorney General)*, 3 SCR 519 (1993), online:<https://decisions.scc-csc.ca/scc-csc/scc-csc/en/1054/1/document.do> [*Rodriguez*].

[2] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331, online:<https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do> [*Carter SCC 2015*].

[3] *Carter v. Canada (Attorney General)* 2012 BCSC 886, online: <https://bccla.org/wp-content/uploads/2012/06/Carter-v-Canada-AG-2012-BCSC-886.pdf> [*Carter BCSC 2012*].

[4] *Carter SCC 2015, supra* note 2 at para 147.

[5] *Carter v. Canada (Attorney General)*, 2016 SCC 4, [2016] 1 SCR 13, online: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/15696/index.do> [*Carter SCC 2016*].

[6] For example: Tonda MacCharles, "Supreme Court strikes down assisted suicide ban", *The Toronto Star* (6 February, 2015), online: <http://www.thestar.com/news/canada/2015/02/06/supreme-court-rules-strikes-down-assisted-suicide-ban.html>; Sean Fine, "Canadians have right to doctor-assisted suicide, rules", *The Globe and Mail* (6 February, 2015), online: <https://www.theglobeandmail.com/news/national/supreme-court-rules-on-doctor-assisted-suicide/article22828437/> ; Ian MacLeod I. "Supreme Court of Canada strikes down ban on doctor-assisted suicide", *National Post* (6 February, 2015).

[7] Sharon Kirkey, "How far should a doctor go? MDs say they 'need clarity' on Supreme Court's assisted suicide ruling", *National Post*, (23 February, 2015), online: <http://news.nationalpost.com/news/canada/how-far-should-a-doctor-go-mds-say-they-need-clarity-on-supreme-courts-assisted-suicide-ruling>.

[8] *Carter v. Canada (Attorney General)* 2012 BCSC 886 (Plaintiffs' Notice of Civil Claim [*Plaintiffs' Claim*] at Part 1, para 6–8), online: <https://www.consciencelaws.org/archive/documents/carter/2011-04-26-noticeofclaim01.pdf>.

term proposed by the appellants: "physician assisted dying."[9]

I.3 The source of the confusion was probably inconsistent terminology. By "physician-assisted dying" the Supreme Court meant *both* physician-assisted suicide *and* physician-administered euthanasia, but, for the CMA, "physician-assisted death,"meant *only* physician-assisted *suicide*. The CMA used "medical aid in dying" to refer to *both* physician-assisted suicide and physician-administered euthanasia;[10] this was implied in its written submission to the Supreme Court.[11] On the other hand, the CMA's counsel had referred in his oral submission only to "physician-assisted death/dying," *not* "medical aid in dying," perhaps reflecting the usage of the term among lawyers involved in the appeal rather than the terminology used by his client.[12]

I.4 In any case, the Court authorized physicians not only to help certain patients commit suicide, but to kill them, procedures later grouped under the term "Medical Assistance in Dying" (MAID) in the amended *Criminal Code*.[13] The Court did not restrict physician-administered euthanasia to patients unable to kill themselves; patients were allowed to request euthanasia as a preferred option. This, too, had been sought by the appellants.[14]

"A grievous and irremediable medical condition"

I.5 One of the criteria set by the Supreme Court for physician exemption from prosecution for murder or assisted suicide was that the patient must have "a grievous and irremediable medical condition (including an illness, disease or disability)."[15] The word "including" meant that EAS could be provided not only for "illness, disease or disability" but for other medical conditions.

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[9] *Carter SCC 2015*, *supra* note 2 at para 40, 147.

[10] The Canadian Medical Association, *Policy: Euthanasia and Assisted Suicide (Update 2014)*, Ottawa: CMA, 2014) online: <https://www.consciencelaws.org/archive/documents/cma-cmaj/2014-06-CMA-euthanasia-policy-correct.pdf> [*CMA EAS 2014*] at 1–2.

[11] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 (Factum of the Intervener, The Canadian Medical Association, at para 5) [*CMA Factum*], online: <https://www.scc-csc.ca/WebDocuments-DocumentsWeb/35591/FM230_Intervener_Canadian-Medical-Association.pdf>.

[12] Sean Murphy, "Re: Joint intervention in *Carter v. Canada* . Selections from oral submissions, Supreme Court of Canada, 15 October, 2014" at Harry Underwood (Counsel for the Canadian Medical Association) (25 March, 2021), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/law/commentary/legal073-009.aspx#Harry_Underwood>.

[13] *Criminal Code*, RSC 1985, c C-46, online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/> [*Criminal Code*] at s 241.2(2).

[14] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 (Oral argument, Appellant), Supreme Court of Canada (SCC), "Webcast of the Hearing on 2014-10-15" (22 January, 2018), online: <https://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&id=2014%2f2014-10-15--35591&date=2014-10-15&fp=n&audio=n> [*Carter SCC 2015 webcast*] at 00:33:21 to 00:34:18.

[15] *Carter SCC 2015*, *supra* note 2 at para 4, 127, 147.

I.6 Mental illness is a medical condition, and some kinds of mental illness are thought not to affect decisional capacity or competence. In passing, the Court indicated that the parameters to be proposed in its reasons would not apply to "persons with psychiatric disorders."[16] However, the parameters actually laid out did not explicitly exclude EAS for mental illness.

I.7 The Court also indicated that "minor medical conditions" would not qualify,[17] but the broad range of conditions captured by the ruling was noteworthy. It could include frailty[18,19] and drug addiction,[20] for example, and neurocognitive or neurodevelopmental disorders (e.g., dementias, autism, and spectrum disorders.[21] An early complaint by CMA Vice President Dr. Jeff Blackmer that the ruling "would essentially leave anyone with any medical condition the ability to request assisted dying" was an exaggeration,[22] but an observation by a Provincial-Territorial Expert Advisory Group was not: "No list of specific conditions could capture the range of illnesses, disease and disabilities that might meet the parameters established by the Supreme Court."[23]

I.8 Just after the ruling, CMA President Dr. Chris Simpson said that he had not anticipated that the judges would permit euthanasia and assisted suicide for any "grievous and irremediable medical condition" rather than terminal illness.[24] Within days, the CMA's Dr. Jeff Blackmer acknowledged that physicians willing to provide euthanasia in cases of terminal illness might be less

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[16] *Ibid* at para 111.

[17] *Ibid*.

[18] Marlene Cimons, "Frailty Is a Medical Condition, Not an Inevitable Result of Aging (Op-Ed)", *Livescience* (29 November, 2013), online: <http://www.livescience.com/41602-frailty-is-medical-condition.html>.

[19] Marco Proietti and Matteo Cesari, "Frailty: What Is It?" (2020) Adv Exp Med Biol 1216:1-7, online: <https://link.springer.com/chapter/10.1007/978-3-030-33330-0_1>.

[20] Canadian Society of Addiction Medicine, News Release, "Addiction Medicine Leaders Call On Canadian Government to Decriminalize Drug Use" (25 February, 2021), online: <http://csam-smca.org/wp-content/uploads/2021/03/21-02-22-CSAM-SMCA-Press-Release-Decriminalization-1-3.pdf>.

[21] Health Canada, "Model Practice Standard for Medical Assistance in Dying (MAID)" (27 March, 2023), Health Canada (website) [*MAID Model Standard*], online: <https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/model-practice-standard/model-practice-standard.pdf> at 23 (Mental disorder).

[22] House of Commons, *Standing Committee on Justice and Human Rights*, 32nd Parliament, 1st Sess, No. 13 (4 May, 2016), online: <https://publications.gc.ca/collections/collection_2016/parl/xc66-1/XC66-1-2-421-013-eng.pdf> [*SCJHR 2016*] at 9.

[23] "Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, Final Report" (30 November, 2015), *Government of Nova Scotia* (website), online: <https://novascotia.ca/dhw/publications/Provincial-Territorial-Expert-Advisory-Group-on-Physician-Assisted-Dying.pdf> [*Provincial-Territorial Expert Report*] at 35.

[24] "Doctor-assisted suicide a therapeutic service, says Canadian Medical Association", *CBC News* (6 February, 2015), online: <http://www.cbc.ca/news/health/doctor-assisted-suicide-a-therapeutic-service-says-canadian-medical-association-1.2947779>.

willing to do so for suffering caused by other medical conditions.[25] He expressed concern that "irremediable" (rather than "terminal") "opens too many doors and generates too many questions," since it could be applied to medical conditions like blindness, chronic depression and spinal cord injuries.[26]

I.9 Dr. Blackmer also complained that the term "grievous" was not "a technical medical term" and was entirely subjective.[27] Expanding upon this a few months later, he referred to "some angst and discomfort" among physicians about the breadth of the *Carter* criteria.

> "I've now given dozens or hundreds of presentations on this and every time I speak about it and I ask doctors, 'Look, have any of you ever told a patient that you're really sorry but their condition is grievous?' Of course, no one ever has," Blackmer said. "No doctor in Canadian history, I don't think, has ever told a patient that they're suffering from a 'grievous' condition. So none of us know what that means."[28]

A year after the ruling he continued to insist that the phrase "grievous and irremediable medical condition" had "no meaning to physicians whatsoever"[29] and was still describing the *Carter* criteria as "very vague."[30]

I.10 However, the question put to the courts by the plaintiffs from the very beginning in 2011 was never about terminal illness, but about "grievous and irremediable illness."[31] The term was defined in the trial court ruling, where it was used extensively,[32] and it appeared again in the first

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[25] Alex Ballingall A, "Assisted death: How to weigh doctors' rights with right to die? Canada's medical circles abuzz with debate over how to balance newly recognized right to assisted death with doctors' right not to provide it", *The Star* (7 February, 2015), online: <http://www.thestar.com/news/gta/2015/02/07/assisted-death-how-to-weigh-doctors-rights-with-right-to-die.html>.

[26] Nicolas Santi, "From Courtroom to Bedside - A Discussion with Dr. Jeff Blackmer on the Implications of Carter v. Canada and Physician-Assisted Death", (2015) University Ottawa J Med, online:<https://uottawa.scholarsportal.info/ojs/index.php/uojm-jmuo/article/view/1276/1270> at 1–2.

[27] *Ibid*.

[28] Sharon Kirkey, "Doctors' group proposes assisted death protocols in absence of rules from government", *National Post* (29 June, 2015), online: <https://nationalpost.com/news/canada/doctors-group-proposes-assisted-death-protocols-in-absence-of-rules-from-government>.

[29] *SCJHR 2016*, *supra* note 22 at 9.

[30] Shannon Proudfoot, "A CMA doctor on the burdens and ethics of assisted death" (8 June, 2016) *MacLean's Magazine*, online: <https://macleans.ca/society/health/a-cma-doctor-on-assisted-death-and-navigating-the-ethical-grey-area/> [*CMA Doctor*].

[31] *Plaintiffs' Claim*, *supra* note 8 at Part 1, para 6–7.

[32] *Carter BCSC 2012*, *supra* note 3 at para 24.

sentence of the appellants' factum filed in the Supreme Court of Canada.[33] Moreover, the CMA factum — "reviewed and approved by several senior CMA elected officials"[34] — stated that it seemed wrong to deny assisted suicide and euthanasia to "*grievously* ill" (not terminally ill) patients just because palliative care is unavailable (emphasis added).[35] Neither the CMA's written nor oral submissions at the Supreme Court of Canada remotely implied that physicians did not understand what "grievous" meant nor that the term "grievous and irremediable medical condition" was "very vague."

I.11 In point of fact, the CMA leadership had revised the association's policy two months before the *Carter* ruling. The revised policy — which the Supreme Court consulted[36] — did *not* suggest that euthanasia or assisted suicide should be limited to patients with terminal illnesses or those with uncontrollable pain, and it did not exclude EAS for minors, the incompetent or the mentally ill. It referred directly only to "patients" and "the suffering of persons with incurable diseases."[37] In short, neither in its intervention nor in its revised policy did the CMA offer the Supreme Court of Canada any criteria beyond this as relevant for the purpose of providing EAS. The legal criteria set by the Court in *Carter* were actually more restrictive than anything the CMA had included in its new policy.

Patient age, competence and consent

I.12 The ruling required that physician assisted suicide and euthanasia be limited to a competent adult "who clearly consents" to the procedure.[38] The use of the present tense was understood to indicate that consent was required at the time EAS was provided: that it could not be given in an advance directive or provided by a substitute medical decision maker if the patient was otherwise unable to express valid consent. This interpretation was reflected in the first *Criminal Code* amendment implementing the decision.[39] A subsequent amendment allowed practitioners to provide euthanasia for patients who had fixed a date for the procedure and had given written consent

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[33] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 (Factum of the Appellant at para 1), online <https://scc-csc.ca/WebDocuments-DocumentsWeb/35591/FM010_Appellants_Lee-Carter-et-al.pdf> [*Appellant Factum*].

[34] Margaret Somerville, "There's no "mushy middle" on euthanasia" (2 October, 2014), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/ethics/ethics006.aspx>.

[35] *CMA Factum*, *supra* note 11 at para 20.

[36] *Carter SCC 2015*, *supra* note 2 at 131.

[37] The Canadian Medical Association, *Policy: Euthanasia and Assisted Death (Update 2014)*, Ottawa: CMA, 2014) online: <https://www.consciencelaws.org/archive/documents/cma-cmaj/2014-12-cma%20euthanasia%20policy.pdf> [*CMA EAD 2014*] at 1, 3.

[38] *Carter SCC 2015*, *supra* note 2 at para 4, 127, 147.

[39] *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2016 c C-3, online: <https://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/page-1.html> [*Crim Code 2016*] at s 3.

to proceed if they become incapacitated before that time.[40]

"Enduring suffering that is intolerable"

I.13 The final criterion specified in *Carter* was that a medical condition must not only be grievous and irremediable, but had to cause "enduring suffering that is intolerable to the individualin the circumstances of his or her condition."[41] Since the Court acknowledged the distinction between physical and psychological suffering[42] and pain and suffering,[43] the reference to intolerable suffering could be and has been understood to mean both. Although the ruling did clearly not say so, it has generally been understood that suffering must be subjectively assessed by the individual experiencing it.

II. *Carter* and the criminal law

II.1 *Carter* did not entirely invalidate murder and assisted suicide laws. They were rendered inoperative only to the extent that they prevented homicide and assisted suicide by physicians adhering to the Court's guidelines. The term of art for this kind of ruling is "reading down" legislation.

Implementing *Carter*

II.2 The federal and provincial governments had a year to plan implementation of the decision, and it was expected that the federal government would amend the *Criminal Code* to conform to the Supreme Court ruling and that provinces would follow by amending their legislation if need be. However, the federal government under Conservative Prime Minister Steven Harper seems to have done nothing for five months. It appointed a three member panel in July, 2015,[44] but delayed panel consultations until late October by calling a federal election — which the Conservatives lost. The new Liberal government could not amend the *Criminal Code* before the deadline set by the Supreme Court, so it sought an extension of the suspension of the Court's judgement.[45]

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[40] Limited to cases in which natural death is reasonably foreseeable. *Criminal Code*, *supra* note 13 at s 241.2(3.2)–(3.5).

[41] *Carter SCC 2015*, *supra* note 2 at para 4, 127, 147.

[42] *Ibid* at para 40, 64.

[43] *Ibid* at para 68.

[44] Department of Justice, News release: "Government of Canada Establishes External Panel on options for a legislative response to *Carter v. Canada*" (17 July, 2015), online: <https://www.canada.ca/en/news/archive/2015/07/government-canada-establishes-external-panel-options-legislative-response-carter-v-canada-.html>.

[45] *Carter SCC 2016*, *supra* note 5.

Appellants: *Criminal Code* amendment not necessary

II.3 Physicians could have begun to provide EAS once the extension had run out even if the government had not amended the *Criminal Code*, as long as they conformed to the guidelines set out by the Supreme Court. This was one of the points made by the appellants in *Carter*, who opposed the extension.[46] Pursuing his claim that there was no rational or ethical difference between lethal injection and withdrawing ineffective treatment, Joseph Arvay argued that, since there were no laws governing the latter, and "[t]he public isn't harmed," there was no need for a *Criminal Code* amendment to control lethal injection.[47]

> **[01:08:29] Joseph Arvay**: This court read down the legislation and that's why [Professor Burningham] . . . said there was no need for suspension because you had already read down legislation to make sure that this would only be applied to people who were adult, they were are competent, they were voluntary, they were grievously, irremediably ill, they were suffering intolerably. The public was protected.[48]

> **[01:27:26] Joseph Arvay**: And . . . we're not talking . . . a large number of people. There's not going to be a rush to the doctors' offices to die on February 6. Most people don't want to die. Most physicians will be — all physicians will be very reluctant to accede to the request unless a compelling case is made. There's no — Any fear that . . . refusing the extension is going to put the public in jeopardy or harm is totally fanciful. Totally fanciful.[49]

The need to protect vulnerable physicians

II.4 Had the appellants been successful in blocking the extension or had they convinced the federal government that a *Criminal Code* amendment was unnecessary, they would have significantly impeded or largely prevented the practice of EAS outside Quebec. The reason for this was that, though there was much argument about the importance of protecting vulnerable *patients*, the *Carter* decision actually enabled EAS (in circumstances defined by the Court) by protecting *physicians* vulnerable to criminal prosecution. Indeed, Mr. Arvay recognized this when he noted that the *Criminal Code* could be amended to "protect not just the doctor but the health care team."[50] However, he does not appear to have recognized that, even after *Carter*, physicians willing to provide or facilitate EAS would not have done so unless they were confident that they would *not* be

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[46] *Carter v Canada (Attorney General)*, 2016 SCC 4, [2016] 1 SCR 13, (Oral argument, Appellant), Supreme Court of Canada (SCC), "Webcast of the Hearing on 2016-01-11" (22 January, 2018), online: <https://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&id=2016/2016-01-11--35591&date=2016-01-11&fp=n&audio=n> [*Carter SCC 2016 webcast*] at 01:05:38 to 01:06:22.

[47] *Ibid* at 01:07:20 to 01:08:20.

[48] *Ibid* at 01:09:10 to 01:10:00.

[49] *Ibid* at 01:27:26 to 01:28:00.

[50] *Ibid* at 01:04:00 to 01:04:44.

charged for first or second degree murder,[51] assisted suicide[52] or administering a noxious substance.[53]

II.5 After the ruling, physicians remained vulnerable to criminal investigation and prosecution for murder and related offences if they provided EAS in circumstances that allegedly failed to meet the *Carter* criteria. Further, in such cases they (and others) were liable to charges of conspiracy,[54] aiding,[55] abetting,[56] or counselling, procuring, soliciting or inciting EAS[57] — even if a patient were not ultimately killed.[58] In short, had the extension not been granted and if the *Criminal Code* had not been amended, anyone who deliberately participated in or facilitated euthanasia or assisted suicide by effective referral or similar means could have been charged for murder or related offences *unless clearly protected by Carter*.

II.6 The immediate reaction of CMA officials to the *Carter* ruling demonstrated that physicians were anything but certain that they would be protected (see I.8– 9). CMA Vice President Jeff Blackmer explained:

> So if you're a Canadian doctor and you go ahead in this interim period and help someone to die, and you think they met those criteria, and then you get taken to court and a judge finds that in fact the patient did not meet those very vague criteria, you will face federal sanctions. So we're not talking about a slap on the wrist—we're talking about jail time.
>
> For the average physician who's trying to navigate this ethical minefield, it's just one bridge too far to say that not only am I going to participate in something that I've always been taught is anathema to the medical profession, but I'm going to do it without any federal law in place to protect me.[59]

Historical parallel: *R. v. Bourne*

II.7 The appropriate historical reference point for understanding the practical effect of *Carter* without an amendment to the *Criminal Code* is the period between the 1938 case of *R. v. Bourne* and Canada's 1969 abortion law reform. *Bourne* was an English case that established a defence for physicians who provided abortions deemed necessary to preserve the life of the mother. This

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[51] *Criminal Code*, *supra* note 13 at s 229(a)i, 231(1), (2), (7), online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/page-34.html#h-119808>

[52] *Ibid* at s 241(1), online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/page-35.html#h-119931>.

[53] *Ibid* at s 245, online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/page-36.html#h-120071>.

[54] *Ibid* at s 465, online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/page-65.html#h-123847>.

[55] *Ibid* at s 21(1)b, online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/page-3.html#h-115570>.

[56] *Ibid* at s 21(1)c, online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/page-3.html#h-115570>.

[57] *Ibid* at s 22, online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/page-3.html#h-115570>.

[58] *Ibid* at s 464, online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/page-65.html#h-123847>.

[59] *CMA Doctor*, *supra* note 30.

criterion was broadly construed; it was sufficient to establish a threat to the mother's health that could result in death. For example, in the *Bourne* case it was argued that the girl, a rape victim, was likely to commit suicide if an abortion were not provided.[60]

II.8 Nonetheless, physicians were still liable to prosecution if the abortion were shown not to have been required for that purpose. In 1967, CMA representatives told a parliamentary committee that "uncertainty about transgression of the law" was one of the reasons the Association supported reform of the abortion law.[61] Physicians wanted more than a defence based on interpretation of a judge's charge to a jury thirty years earlier. They wanted positive assurance that they would not be prosecuted. The 1969 reform of the abortion law gave that assurance to physicians who provided abortions approved by therapeutic abortion committees. The effect of the assurance was dramatic. 262 abortions had been provided in Canadian hospitals under the *Bourne* criteria from 1954 to 1964;[62] in 1970 it was over 11,000[63] (a 42,000% annual increase in the first year).

II.9 Like their predecessors who were willing to provide abortion in 1968, Canadian physicians willing to provide euthanasia and assisted suicide wanted statutory assurance that they would not be prosecuted if they did so in good-faith compliance with the law. Indeed, in its intervention at the Supreme Court the CMA insisted that "any regime of medical aid in dying must legally protect those physicians who choose to participate from criminal, civil or disciplinary proceedings or sanctions."[64]

Practical necessity and effect of *Criminal Code* amendment

II.10 The *Criminal Code* amendment implementing *Carter* ensured that practitioners could not be charged for murder or assisted suicide unless it could be proved beyond reasonable doubt that they had deliberately provided EAS to someone they actually believed did not meet the exemption criteria:[65] to borrow Joseph Arvay's words, a "totally fanciful" scenario. The maximum penalty for knowingly failing to comply with any of the other requirements was five years imprisonment.[66] The amendment came into force in June, 2016; by the end of the year EAS had been provided to 1,018

[60] *R. v Bourne* (1939) 1KB 687, 3 All ER 615 (1938) <online: <https://www.law.utoronto.ca/sites/default/files/documents/reprohealth/united_kingdom_1938_bourne.pdf>.

[61] Gerald Waring, "Report from Ottawa" (1967) 97:20 CMAJ 1233, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1923621/?page=1>.

[62] *Ibid*.

[63] "Therapeutic abortion: Government figures show big increase in '71" (1972) 106:10 CMAJ 1131, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1940739/?page=5>; {[(11,000-26.2)/26.2]*100}.

[64] *CMA Factum*, *supra* note 11 at para 26.

[65] *Criminal Code*, *supra* note 13 at s 227, s 241.3.

[66] *Ibid* at s 241.3.

people. Six years later the number had climbed to 13,241 (4.1% of all deaths in Canada);[67] virtually all died by euthanasia.[68] This was a level that Netherlands and Belgium had not reached 13 years after legalization.[69] These results could not have been achieved without active collaboration by health care workers and administrators. Amending the *Criminal Code* was arguably essential to secure their collaboration, even if, strictly speaking, practitioners could have legally provided EAS without a *Criminal Code* amendment.

III. Moving the goalposts

Carter Plus

III.1 The Court limited its ruling to the facts of the *Carter* case, but offered no opinion "on other situations" where physicians might be asked to kill patients or help them commit suicide.[70] The ruling did not preclude legislation or further litigation to allow EAS in circumstances beyond those contemplated in *Carter*. This was consistent with the goal the appellants described during the appeal hearing:

> [A]ll we're asking the court is to recognize the floor of what the constitutional rights are of our clients, not the ceiling, not what Parliament might do in its wisdom. That's not a slippery slope, and indeed, if a subsequent case comes around and says that, as a matter of constitutional law, the law should be extended not just to adults or not just to those who are competent, but those who perhaps left advanced directives and . . . were afflicted with dementia, well then that's the *Charter* working, that's not the slippery slope. We call that the living tree in this country.[71]

Again, in a subsequent hearing the appellants argued that *Carter* specified only the constitutional minimum: that Parliament could not narrow the ruling, but was free to expand upon it and develop a

[67] Health Canada, "Fourth annual report on Medical Assistance in Dying in Canada 2022" (October, 2023), *Government of Canada* (website), online: <https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/annual-report-2022/annual-report-2022.pdf#page=20> [*MAID 2022*] at Chart 3.1, s 3.2.

[68] *Ibid* at s 3.1.

[69] Sean Murphy, "Euthanasia reported in Netherlands: statistics compiled from the Regional Euthanasia Review Committees' Annual Reports" (August, 2017), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/background/procedures/assist019.aspx>; Sean Murphy, "Euthanasia reported in Belgium: statistics compiled from the Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie Bi-annual Reports" (August, 2017), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/background/procedures/assist018.aspx>.

[70] *Carter SCC 2015*, *supra* note 2 at para 127.

[71] *Carter SCC 2015 webcast, supra* note 14 at 00:25:47 to 00:26:22.

more permissive EAS regime,[72] popularly referred to as "*Carter* Plus."

III.2 The probability of expansion was obvious even at the time of the ruling. For example: Quebec's euthanasia law was supposed to apply only to competent adults, but, even before the law was passed, members of the Quebec establishment urged legislators to consider expanding the law to authorize euthanasia of incompetent patients by advance directives and permit euthanasia for disability, mental illness and children.[73] A Provincial Territorial Expert Advisory Group stated that

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[72] *Carter SCC 2015 webcast*, *supra* note 14 at 00:24:29–00:25:12; *Carter SCC 2016 webcast*, supra note 46 at 01:05:10 to 01:05:38.

[73] **Federation of General Practitioners of Quebec**. See Quebec, Assemblée Nationale, Journal des débats de la Commission permanente de la santé et des services sociaux, 40th Législature , 1st Sess, Vol. 43 No. 34 (17 septembre, 2013), online: <https://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_81797&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz> at 18 (Dr. Louis Godin). The Project has provided what appears to be the only English translation available: see "Consultations & hearings on Quebec Bill 52, Federation of General Practitioners of Quebec: Dr. Louis Godin, Dr. Marc-André Asselin. Tuesday 17 September 2013 - Vol. 43 no. 34", *Protection of Conscience Project* (website) online: <https://www.consciencelaws.org/background/procedures/assist009-002.aspx#024> at T#024.
Quebec Ombudsman. See Quebec, Assemblée Nationale, Journal des débats de la Commission permanente de la santé et des services sociaux, 40th Législature , 1st Sess, Vol. 43 No. 37 (24 septembre, 2013)online: <https://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_82247&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz> at 8 (Raymonde Saint-Germain). Protection of Conscience Project English translation: "Consultations & hearings on Quebec Bill 52, Quebec Ombudsman: Raymonde Saint-Germain, Marc André Dowd, Michel Clavet. Tuesday 27 September 2013 - Vol. 43 no. 37", *Protection of Conscience Project* (website) online: <https://www.consciencelaws.org/background/procedures/assist009-012.aspx#080> at T#080.
College of Social Workers & Marriage & Family Therapists of Quebec — see Quebec, Assemblée Nationale, Journal des débats de la Commission permanente de la santé et des services sociaux, 40th Législature , 1st Sess, Vol. 43 No. 35 (18 septembre, 2013), online: <https://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_81799&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz> at 2, 7 (Claude Leblond). Protection of Conscience Project English translation: "Consultations & hearings on Quebec Bill 52, College of Social Workers & Marriage & Family Therapists of Quebec: Claude Leblond, Marielle Pauzé. Wednesday, 18 September 2013 - Vol. 43 no. 35", *Protection of Conscience Project* (website) online: <https://www.consciencelaws.org/background/procedures/assist009-007.aspx#016, https://www.consciencelaws.org/background/procedures/assist009-007.aspx#092> at T#016, T#092.
Ghislain Leblond and Dr. Yvon Bureau — see Quebec, Assemblée Nationale, Journal des débats de la Commission permanente de la santé et des services sociaux, 40th Législature , 1st Sess, Vol. 43 No. 38 (25 septembre, 2013) online: <https://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_81953&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz> at 22 (Ghislain Leblond), 31 (Ghislain Leblond, Dr. Yvon Bureau). Protection of Conscience Project English translation: "Consultations & hearings on Quebec Bill 52, Ghislain Leblond, Dr. Yvon Bureau. Wednesday, 25 September 2013 - Vol. 43 no. 38", *Protection of Conscience Project* (website) online: <https://www.consciencelaws.org/background/procedures/assist009-019.aspx#130> at T#15, T#16, T#126, T#130.
Observatory for Aging and Society — see Quebec, Assemblée Nationale, Journal des débats de la Commission permanente de la santé et des services sociaux, 40th Législature , 1st Sess, Vol. 43 No. 40 (1 octobre, 2013), online: <https://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_83099&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz> at 29

the ruling made EAS available for mental illness and recommended extending EAS to children.[74]

Euthanasia for disability and mental illness

III.3 The first amendment to the *Criminal Code* implementing the *Carter* decision specified that a patient's natural death had to be "reasonably foreseeable," which effectively excluded EAS for disabilities and mental illness alone.[75] The requirement was struck down by the Quebec Superior Court in 2019;[76] the federal government chose to conform to the ruling rather than appeal. It amended the *Criminal Code* in 2021, dropping the requirement that natural death be reasonably foreseeable. This legalized EAS at any time for any medical condition deemed "grievous and irremediable," including disabilities. A temporary exception prohibiting EAS for mental disorders alone was to end in March, 2023.[77,78] However, a serious controversy erupted during parliamentary committee hearings exploring the subject, forcing the government to delay implementing the law until 2024.[79]

(Hélène Daneault), 30 (Gloria Jeliu). Protection of Conscience Project English translation: "Consultations & hearings on Quebec Bill 52, Observatory for Aging and Society: André Ledoux, Gloria Jeliu, Denise Destrempes, Claude Tessier. Tuesday, 1 October 2013 - Vol. 43 no. 40", *Protection of Conscience Project* (website) online: [*Consultations*, online: < at <http://www.consciencelaws.org/background/procedures/assist009-025.aspx#129; http://www.consciencelaws.org/background/procedures/assist009-025.aspx#130)> at T#128, T#129, T#130.
Commission on Human Rights and Youth Rights — see Quebec, Assemblée Nationale, Journal des débats de la Commission permanente de la santé et des services sociaux, 40th Législature , 1st Sess, Vol. 43 No. 43 (4 octobre, 2013) online:
<https://www.assnat.qc.ca/Media/Process.aspx?MediaId=ANQ.Vigie.Bll.DocumentGenerique_83225&process=Original&token=ZyMoxNwUn8ikQ+TRKYwPCjWrKwg+vIv9rjij7p3xLGTZDmLVSmJLoqe/vG7/YWzz> at 12, 19 (Jacques Fremont). Protection of Conscience Project English translation: "Consultations & hearings on Quebec Bill 52,Commission on Human Rights and Youth Rights: Jacques Fremont, Renée Dupuis, Daniel Carpentier, Marie Carpentier. Friday, 4 October 2013 - Vol. 43 no. 40", *Protection of Conscience Project* (website) online:
<https://www.consciencelaws.org/background/procedures/assist009-031.aspx#010;
https://www.consciencelaws.org/background/procedures/assist009-031.aspx#011;
https://www.consciencelaws.org/background/procedures/assist009-031.aspx#013;
https://www.consciencelaws.org/background/procedures/assist009-031.aspx#014;
https://www.consciencelaws.org/background/procedures/assist009-031.aspx#114> at T#010, T#011, T#013, T#014, T#114.

[74] *Provincial-Territorial Expert Report*, *supra* note 23 at 15, 34 (Recommendation 17).

[75] *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2016 c C-3, online: <https://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/page-1.html> [*Crim Code 2016*].

[76] *Truchon c. Procureur général du Canada*, 2019 QCCS 3792 (CanLII), online: <https://www.canlii.org/en/qc/qccs/doc/2019/2019qccs3792/2019qccs3792.html>.

[77] Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, 2nd Sess, 43rd Parl, 2020-2021, cf 1(2), 6 (assented to 17 March, 2021), RSC 1985, c C-46, online: <https://parl.ca/DocumentViewer/en/43-2/bill/C-7/royal-assent>.

[78] Joan Bryden, "Canadian Senate passes Bill C-7, expanding assisted dying to include mental illness", *Global News* (17 March, 2021), online: <https://globalnews.ca/news/7703262/canada-senate-passes-bill-c-7/>.

[79] "Canada's medical assistance in dying (MAID) law"(19 June, 2023), *Government of Canada* (website), online: <https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html>.

IV. The need to revisit *Carter*

IV.1 The controversy that forced the government to delay EAS for mental illness exploded because the new law put a match to a volatile issue that had been identified six years earlier: the application of the criterion of irremediability to mental illness. In this paper the way forward begins by going back to the *Carter* decision and rereading it in light of the current dispute.

IV.2 However, eruption of the controversy about mental illness and irremediability was only the most dramatic and public manifestation of a deeper conflict that had been seething since EAS became legal. Only two years after the *Criminal Code* amendment implementing *Carter* came into force, seven Canadian physicians writing in the *World Medical Journal* reported that "public discourse in Canada has since centred largely on whether or under what circumstances physicians and institutions should be allowed to refuse to provide or collaborate in homicide and suicide." Accused of human rights violations and "even called bigots," they wrote, "[f]or refusing to collaborate in killing our patients many of us now risk discipline and expulsion from the medical profession."[80]

IV.3 Almost 60 Canadian physicians from across the country endorsed the article. Signatories included a Canadian Medical Hall of Fame member known as the father of palliative care in North America,[81] a member of the Canadian Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying,[82] and a regional director of palliative care who resigned when a health authority demanded that objecting hospices permit euthanasia and assisted suicide on their premises.[83]

IV.4 Four years later, one of the authors of the WMJ paper provided an update during an interview for a story that appeared in Canada's *National Post*:

> She's withstood relentless attacks on her professional integrity by other physicians. She's weary, despairing even as she wades into dangerous waters, citing hospital colleagues who complain they're pressured, even bullied into going along with policies that trouble them. Doctors across the country call her to report that some MAiD providers refuse to assume transfer of care as the "most responsible physician," thereby implicating them in a practice they are philosophically opposed to. Some institutions, perhaps lacking sufficient MAiD providers, even expect the MRP-conscientious objectors to conduct the initial MAiD assessment. All worry about professional ramifications. Some

[80] Rene Leiva *et al*, "Euthanasia in Canada: A Cautionary Tale" (2018) 64:3 World Med J 17, online: <https://www.wma.net/wp-content/uploads/2018/10/WMJ_3_2018-1.pdf#page=19> at 17.

[81] "2018 Inductee Balfour Mount, MD" (2023) *Canadian Medical Hall of Fame* (website), online: <https://www.cdnmedhall.ca/laureates/balfourmount>.

[82] *Provincial-Territorial Expert Report*, *supra* note 23 at 13 (Dr. Nuala Kenny).

[83] Pamela Fayerman, "Delta hospice rebels against Fraser Health's mandate to provide medical assistance in dying", *Vancouver Sun* (6 February, 2018), online: <https://vancouversun.com/news/local-news/delta-hospice-rebels-against-fraser-healths-mandate-to-provide-medical-assistance-in-dying> (Dr. Neil Hilliard).

> who've voiced doubts about MAiD in certain clinical scenarios have been called obstructionist, of trying to block access to a legal service. There's no protection for whistleblowers. She knows of many doctors who've left the specialty or retired early. Her colleagues know of more. Some have left medicine for good. But they're not talking. Few were willing to speak to me.[84]

IV.5 While these developments might be seen to support a recent assertion that Canadian medicine "has been captured by a uniquely Canadian MAID ideology,"[85] they often reflect claims ostensibly rooted in the *Carter* decision: that EAS is an "end-of-life right,"[86] a "constitutional right,"[87] a form of "clinical care"[88] and an option among "medical treatments and therapies."[89] Thus, after addressing the issue of irremediability, this paper considers what the Supreme Court decided (or did not decide) about the ethics of euthanasia and assisted suicide, the relationship of EAS to accepted contemporaneous end of life practices and the practice of medicine, and practitioner freedom of conscience.

V. Irremediability: a brief history

V.1 In oral argument during the appeal at the Supreme Court of Canada the appellants had suggested that "irremediable" could be understood as "incurable,"[90] but the meaning of the term was not further explored. In approving EAS in defined circumstances for a "grievous and irremediable

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[84] Ferrukh Farqui, "'Nothing about this felt OK': The troubling debate over a 'good' death for all", *National Post* (1 April, 2022), online: <https://nationalpost.com/news/canada/the-troubling-debate-over-a-good-death-for-anyone-who-chooses>.

[85] Scott Kim, "In Canada, MAID has become a matter of ideology" (25 February, 2023), *The Globe and Mail*, online: <https://www.theglobeandmail.com/opinion/article-in-canada-maid-has-become-a-matter-of-ideology/>.

[86] "Tell your Member of Parliament to respect our end-of-life rights: Unwanted suffering is wrong" (March, 2021), Dying with Dignity Canada (website), online: <https://www.dyingwithdignity.ca/advocacy/allow-advance-requests-now/>.

[87] *Debates of the Senate*, 43rd Parl, 2nd Sess, No 152 Iss 2610 (10 February, 2021), online: <https://sencanada.ca/content/sen/chamber/432/debates/pdf/026db_2021-02-10-e.pdf#page=13> at 897 (Hon. Marc Gold).

[88] Dr. T. Daws et al, "Bringing up Medical Assistance in Dying as a Clinical Care Option", (February, 2022) *Canadian Association of MAID Assessors and Providers* (website), online: <https://camapcanada.ca/wp-content/uploads/2022/02/Bringing-up-MAiD.pdf>.

[89] Shawn Whatley, "More than we imagined? Unresolved tensions and the current state of physician-assisted suicide and euthanasia in Canada" (20 April, 2023), MacDonald Laurier Institute (website), online: <https://macdonaldlaurier.ca/wp-content/uploads/2023/04/20230414_Euthanasia_Whatley_COMMENTARY_FWeb.pdf#page=6> at 6 (Incorporating MaiD into Medicine).

[90] "We are limiting our case to people whose condition is irremediable, or incurable if you want to use that language, because it, assisted dying should only be allowed in the most serious cases. And not just because somebody wants to. It's because their condition is not going to get any better." *Carter SCC 2015 webcast*, *supra* note 14 at 00:52:33–00:53:18.

medical condition," the Supreme Court affirmed that patients were entitled to refuse any treatments they found unacceptable.[91]

Determined by patient refusal of treatment?

V.2 In 2015 a Provincial-Territorial Expert Advisory Group purported to apply the *Carter* decision by recommending that "irremediable" should mean "a condition that cannot be alleviated by any means acceptable to the patient."

> The determination of whether a condition is irremediable should be a two-step process. First, the physician must determine whether any treatments exist for the condition. Second, the patient must determine whether any of the available treatments are acceptable to him or her.[92]

V.3 At a hearing at the Supreme Court in early 2016, Joseph Arvay, lead counsel for the appellants, was dismissive of concerns about the meaning of "grievous and irremediable." "'Grievous,'" he said, "is in the *Criminal Code*. Everybody knows what grievous is, it's serious. This court addressed "'irremediable.'"[93]

V.4 In fact, the Court had not addressed the meaning of either term in its ruling. Challenged by Justice Michael J. Moldaver, Mr. Arvay insisted that Parliament did not have to define either "grievous" or "irremediable."[94] He went on to quote the Provincial-Territorial Expert Advisory Group: "'Grievous and irremediable medical condition should be defined as a very severe serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient.' [T]hat's just really what *Carter* said," he claimed[95] — not so, as will be seen presently — but a useful partisan gloss.

V.5 The first skirmish about mental illness and irremediabilty appears to have occurred soon after this exchange. Dr. Sonu Gaind, President of the Canadian Psychiatric Association, told a parliamentary committee that it would be difficult to definitively classify any mental illness as "irremediable," since some kind of remedial therapy was normally available even in the most severe cases. Some committee members became concerned that the criterion of irremediability could never be met in real life by someone who was mentally ill.[96]

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[91] *Carter SCC 2015*, *supra* note 2 at para 127.

[92] *Provincial-Territorial Expert Report*, *supra* note 23 at 35.

[93] *Carter SCC 2016 webcast*, *supra* note 46 at 01:16:50.

[94] *Ibid* at 01:16:44 to 01:20:31.

[95] *Ibid* at 01:19:33 to 01:19:52.

[96] Parliament, Special Joint Committee on Physician-Assisted Dying, *Minutes of Proceedings*, 42nd Parl, 1st Session, No 006 (27 January, 2016) online: <https://publications.gc.ca/collections/collection_2016/sen/yc3-421-1/YC3-421-1-6-eng.pdf#page=17> at 15 (Dr. K. Sonu Gaind), 17 (Mr. Murray Rankin & Dr. K. Sonu Gaind at 2000), 18 (Mr. Robert Oliphant & Dr. K. Sonu Gaind), 19 (Hon. James S. Cowan and Dr. K. Sonu Gaind in right column).

V.6 The next day Professor Jocelyn Downie appeared before the committee. She had been an architect of the appellants' successful legal strategy,[97] had assisted in instructing their expert witnesses in the trial court,[98] and had been a member of the Provincial-Territorial Expert Advisory Group. Responding to questions, Professor Downie told them that the Supreme Court had defined "irremediable" to mean the condition "cannot be remediated or alleviated by any means *acceptable to the patient*."

V.7 "Therefore," she said, "while you may say that a certain condition is treatable, *it can be irremediable if the treatment is unacceptable to the patient*" (emphasis added).[99]

V.8 Commenting on the committee discussion shortly afterward, the Project Administrator observed, "This could well mean that physicians may be unable to provide a written medical opinion to the effect that a condition is irremediable."

> The most that they may be able to provide with respect to the criterion of irremediability is a diagnosis of the medical condition and the various treatments available to cure or ameliorate it. A patient who preferred euthanasia or assisted suicide would be free to reject the treatments, which would have the effect of making the condition *legally* irremediable, even if not *medically* so.[100]

V.9 The Administrator did not address the issue of whether or not a physician could be compelled to accept and act upon a legal determination that was contrary to his considered medical opinion. Further conflict was postponed because the first *Criminal Code* amendment implementing *Carter* effectively excluded EAS for mental illness. The issue resurfaced during parliamentary committee hearings six years later, after the *Criminal Code* was amended to allow EAS for mental disorders alone.

A scientific/medical issue?

V.10 Dr. Derryk Smith, a psychiatrist, was among witnesses who told parliamentarians that some mental illness can be considered irremediable and EAS services should be available as a treatment option when it is. In arguing for this position, Dr. Smith applied Professor Downie's definition of irremediablity: "The patient must agree. If they don't agree and there are no other

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[97] Jocelyn Downie & Simone Bern "Rodriguez Redux" 16 Health LJ (2008) 27, online:<https://digitalcommons.schulichlaw.dal.ca/cgi/viewcontent.cgi?article=1911&context=scholarly_works>.

[98] *Carter BSCC 2012, supra* note 3 at para 124.

[99] Parliament, Special Joint Committee on Physician-Assisted Dying, *Minutes of Proceedings*, 42nd Parl, 1st Session, No 007 (28 January, 2016) online: <https://parl.ca/Content/Committee/421/PDAM/Evidence/EV8077830/PDAMEV07-E.PDF#page=16> at 14 (Prof. Jocelyn Downie).

[100] Sean Murphy, "Shocking News: Assisted Dying Means Euthanasia and Assisted Suicide. Ethical, medical and legal perspectives in tension at committee hearing" (8 February, 2016), *Protection of Conscience Project* (website), online: < https://www.consciencelaws.org/background/procedures/assist013.aspx>.

treatments available, then the person has an irremediable condition."[101]

V.11 Among those disagreeing with Dr. Smith was Dr. Sonu Gaind, who had testified as President of the Canadian Psychiatric Association six years earlier. Dr. Gaind, who did not object to EAS in principle, insisted that what counted as an irremediable condition had to be determined scientifically — not by patient refusal of treatment — and that science had not established that mental illness was irremediable. He described the criterion of irremediability as "the primary safeguard" in the law.[102]

A negotiated conclusion?

V.12 In contrast, Dr. Mona Gupta, a psychiatrist who was a member of the Expert Panel on MAID and Mental Illness convened by the government, asserted that a finding of irremediability should be negotiated by practitioners and patients,[103] a position later advanced by a Task Group she chaired in the Health Canada *Model Practice Standard* for EAS.[104,105] The CMA had previously taken essentially the same position.[106]

VI. Irremediability: *Carter* revisited

VI.1 We here revisit the *Carter* decision, informed by the different proposals subsequently offered for the determination of irremediabilty: (a) the patient-determined model, (b) the

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[101] Parliament, Special Joint Committee on Physician-Assisted Dying, *Minutes of Proceedings*, 42nd Parl, 1st Session, No 008 (25 May, 2022) online: <https://parl.ca/Content/Committee/441/AMAD/Evidence/EV11814179/AMADEV08-E.PDF#page=5> at 3 (Dr. Derryk Smith).

[102] Parliament, Special Joint Committee on Physician-Assisted Dying, *Minutes of Proceedings*, 42nd Parl, 1st Session, No 003 (25 April, 2022) online: <https://parl.ca/Content/Committee/441/AMAD/Evidence/EV11721028/AMADEV03-E.PDF#page=26> at 24, 29 (Dr. K. Sonu Gaind).

[103] Parliament, Special Joint Committee on Physician-Assisted Dying, *Minutes of Proceedings*, 42nd Parl, 1st Session, No 009 (26 May, 2022), online: <https://parl.ca/Content/Committee/441/AMAD/Evidence/EV11816254/AMADEV09-E.PDF#page=25> at 23 (Dr. Mona Gupta).

[104] Health Canada, "Model Practice Standard for Medical Assistance in Dying (MAID)" (27 March, 2023), Health Canada (website) [*MAID Model Standard*], online: <https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/model-practice-standard/model-practice-standard.pdf> at 9.5.2, 9.6.4.

[105] Health Canada, "Advice to the Profession: Medical Assistance in Dying (MAID)" (27 March, 2023), Health Canada (website) [*MAID Advice*], online: <https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying/advice-profession/advice-profession.pdf> at 4, question 3(b).

[106] Parliament, Special Joint Committee on Physician-Assisted Dying, *Minutes of Proceedings*, 42nd Parl, 1st Session, No. 006 (27 January, 2016), online: <https://parl.ca/Content/Committee/421/PDAM/Evidence/EV8075735/PDAMEV06-E.PDF#page=8> at 6 (Dr. Cindy Forbes).

scientific/medical model, and (c) the negotiated agreement model.

In the trial court

VI.2 The phrase "grievous and irremediable" was coined by the plaintiffs in *Carter*. They defined grievous and irremediable medical conditions as being "without remedy, *as determined by* reference to treatment options acceptable to the person" (emphasis added), causing intolerable suffering that "cannot be alleviated by any medical treatment acceptable to that person."[107] The trial court judge adopted these elements in her ruling,[108] thus making the irremediability of a medical condition something ultimately determined by the patient.

In the Supreme Court of Canada

VI.3 Notwithstanding claims by Joseph Arvay, the Provincial-Territorial experts and Jocelyn Downie, on this point the Supreme Court of Canada took a different approach. It ruled that the laws against murder and assisted suicide do not apply to physicians providing EAS to a competent adult who

> [127] . . . (1) clearly consents to the termination of life; and (2) has a grievous and *irremediable* medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. (emphasis added).[109]

VI.4 The terms "irremediable" and "incurable" are often used interchangeably, as exemplified by Joseph Arvay's careless equation of the terms (see note 90), but sometimes a distinction is possible. When the effects of a medical condition can be alleviated or relieved, it may be considered remediable to that extent, even if it cannot be fully cured. The Supreme Court uncritically and unreflectively accepted the criterion of irremediability (*not* incurability)[110] in the first sentence of paragraph 127 and affirmed patient freedom in the second (underlined). "Irremediable" appears in both sentences, but there are two different issues in paragraph 127, not one.

In the Ontario High Court of Justice

VI.5 The distinction was exemplified in a practice direction from the Ontario High Court of Justice applying the *Carter* decision. It described the evidence required from a physician supporting an application for EAS:

> 10. The application record should include an affidavit from the applicant's attending physician addressing whether,

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[107] *Carter BCSC 2012*, *supra* note 3 at para 24, 1385.

[108] *Ibid* at para 1393(a).

[109] *Carter SCC 2015, supra* note 2 at para 127.

[110] The Court did not state that it considered irremediability and incurability to be synonymous.

> a) the applicant has *a grievous irremediable* medical condition (illness, disease, or disability) that causes suffering; (emphasis added)
>
> b) as a result of his or her medical condition, the applicant is suffering enduring intolerable pain or distress *that cannot be alleviated by any treatment acceptable to the applicant*; . . . (emphasis added)[111]

A necessary distinction

VI.6 The Supreme Court of Canada in *Carter* and the practice direction from the Ontario High Court of Justice maintained the distinction between irremediability and patient freedom that had been elided in the trial court ruling, a distinction that holds whether or not one equates irremediability with incurability or irreversibility. The distinction is significant for both practitioner and patient. On the one hand, it prevents a practitioner's clinical judgement that a condition is *not* irremediable from being reversed by a patient's refusal to accept potentially beneficial treatments. On the other, the physician's determination does not force a patient to accept unwanted interventions, and EAS might be accessed through a different practitioner.

VI.7 The distinction is also necessary to safeguard the concept of fiduciarity. The duty to act in the patient's best interests imposes an obligation upon practitioners to assess what is in a patient's best interests independently and in good faith, using their own judgement, without becoming a "puppet" directed by others,[112] including the patient or state regulators. This obligation by no means excludes discussion and negotiation, but it may preclude a negotiated agreement.

Conflation of irremediability and patient freedom

VI.8 Unfortunately, the criterion of irremediability and recognition of patient freedom were conflated in implementing the *Carter* decision, to the point of erasing the distinction in the *Criminal Code.* The *Code* amendment defined "grievous and irremediable medical condition" as "a serious and incurable illness, disease or disability" that causes "an advanced state of irreversible decline in capability" resulting in intolerable "enduring physical or psychological suffering. . . that cannot be relieved under conditions that they consider acceptable."[113]

VI.9 This appears to have displaced the Supreme Court's criterion of irremediability, substituting incurability *as determined by the will of the patient*. The substitution of the criterion of incurability for irremediability was arguably within the purview of Parliament, since it can be seen to

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[111] Heather J. Smith CJ, "Application for Judicial Authorization of Physician Assisted Death", Practice Advisory on *Carter v. Canada (Attorney General)*, 2016 SCC 4 (29 January, 2016), Ontario Superior Court of Justice (website), online: <https://www.ontariocourts.ca/scj/practice/application-judicial-authorization-carter/> at para 10.

[112] Canadian Aero Service Ltd. v. O'Malley, [1974] SCR 592, 1973 CanLII 23 (SCC)at 606; McInerney v MacDonald, [1992] 2 SCR 138, 1992 CanLII 57 (SCC) at 139, 149, 152; United Kingdom, Law Commission, Report No. 350 Fiduciary Duties of Investment Intermediaries (Williams Lea Group for HM Stationery Office,2014), Law Commission [UKLCR350] at para 3.53, note 107, citing *Selby v Bowie* (1863) 8 LT 372, *Re Brockbank* [1948] Ch 206.

[113] *Criminal Code*, *supra* note 13 at s 241.2(2).

have expanded rather than restricted the reach of the *Carter* ruling. That is, an exemption from prosecution based on irremediability would not apply to incurable conditions that could be alleviated, but an exemption based on incurability would.

VI.10 However, both the irremediability-determined-by-patient position and the irremediability-is-negotiable position deny the primacy of medical science in determining the irremediability, incurability or irreversibility of medical conditions, as well as subverting the concept of fiduciarity. This cannot have been intended by the Supreme Court of Canada.

VI.11 It is reasonable, plausible and preferable to insist that determinations of irremediability, incurability or irreversibility must be established by evidence-based medical criteria: that they are independent of and cannot be established by patient refusal to accept treatment. This approach informs medical practice in other areas and is consistent with principles of fiduciarity. On the other hand, the law is clear that the patient does not have to accept any treatment, and need not have what a practitioner considers a "good reason" to refuse.

Patient refusal is neither negotiable nor determinative

VI.12 This balance was upset by the trial court judge, the Provincial-Territorial Experts and the first *Criminal Code* amendment implementing *Carter*, but not by the Supreme Court of Canada. On the one hand, the Court insisted that patient refusal to accept potentially efficacious treatments is not negotiable.[114] On the other, it ensured the integrity of medical practice by preserving practitioners' freedom to form an evidence-based opinion that a patient's medical condition is not irremediable, an opinion that cannot be overridden by a patient's refusal.

VII. Medical practice and killing

"Core" medical treatment and interjurisdictional immunity

VII.1 While the meaning of irremediability engaged the *integrity* of medical practice, the *nature* of medical practice was engaged by the plaintiffs' argument that physician-administered euthanasia and physician-assisted suicide were healthcare or therapeutic medical treatment. They argued that the criminal prohibition was *ultra vires* the federal government because healthcare delivery and regulation was within provincial constitutional jurisdiction.[115] However, the claim (one of "interjurisdictional immunity") was not pursued or addressed in the trial court.[116]

VII.2 The plaintiffs resurrected the issue in their appeal to the Supreme Court of Canada, arguing that physician-administered euthanasia and physician-assisted suicide were "core" forms of medical treatment: that is, "medically-indicated medical treatments for which there is no alternative treatment capable of meeting the patient's medical need."[117]

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[114] *Carter SCC 2015*, *supra* note 2 at para 67.

[115] *Plaintiffs' Claim*, *supra* note 8 at Part 1, para 35; Part 2, para 1; Part 3, para 2–3.

[116] *Carter BCSC 2012*, *supra* note 10 at para 29.

[117] *Appellant Factum*, *supra* note 33 at 43.

The contested premise

VII.3 Underlying this claim was the premise that homicide and assisted suicide in the circumstances they described were forms of medical treatment. This premise was and is sharply contested; the Canadian Medical Association explicitly drew the Court's attention to the issue during the appeal:

> In general, those CMA members who oppose medical aid in dying do so because of the derogation from established medical ethical principles and clinical practices that would result. Those who support medical aid in dying do so because of the equally established principles of considering patient well-being and patient autonomy. . .
>
> It is acknowledged that just moral and ethical arguments form the basis of arguments that both support and deny assisted death. The CMA accepts that, in the face of such diverse opinion, based on individuals' consciences, it would not be appropriate for it to seek to impose or advocate for a single standard for the medical profession.[118]

Focus of adjudication

VII.4 The dispute about EAS described by the CMA reflected different interpretations of medical ethics and even different philosophies of medicine. Purposefully or not, the Court's response sidestepped the controversy, thus avoiding entanglement in the affairs of ethics and philosophy. It addressed the appellants' claim within the context of constitutional law and legal regulation of health care.[119]

VII.5 For regulatory purposes it is necessary to define medical practice in purely functional terms. [120] From that functional regulatory perspective, the Court recognized overlapping federal and provincial jurisdiction in relation to health[121] and found the appellants' terminology too "vague" to exclude federal jurisdiction in relation to EAS.[122] It appears the Court could not see how EAS could be described *only* as medical treatment (exclusive provincial jurisdiction) but *not also* as homicide and assisted suicide (concurrent federal jurisdiction). This was sufficient to dismiss the appellants' claim. It was not necessary to go deeper into the issue, and, indeed, it is not clear from the terse wording of the relevant paragraphs that it was even on the Court's radar.

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[118] *CMA Factum*, *supra* note 11 at para 11, 16.

[119] *Carter SCC 2015*, *supra* note 2 at para 49–53.

[120] For example, Ontario defines medical practice as "the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction" listing specific acts that physicians are authorized to perform. EAS is not one of them, but the enumerated acts include those necessary to provide the service. *Medicine Act, 1991*, SO 1991, c30, s 3–4, online: <https://www.ontario.ca/laws/statute/91m30>.

[121] *Carter SCC 2015*, *supra* note 2 at para 51, 53.

[122] *Ibid* at para 53.

VII.6 In any case, in responding to the interjurisdictional immunity claim the Court did not decide or even address the philosophical dispute about whether killing patients or helping them to commit suicide were forms of medical treatment or properly part of medical practice or the profession of medicine. This left room not only for the exercise of concurrent federal jurisdiction, but for the accommodation of different philosophies of medicine within state regulatory regimes.

Enabling regulation, protecting fundamental freedoms

VII.7 The significance of what the Court did not decide on this point can be better understood by considering British Columbia's *Medical Practitioner Regulation* issued under the province's *Health Professions Act*. The *Regulation* defines "medical assistance in dying" to mean "the administration of a substance . . . to a person . . . that is intended to cause the death of the person" and "the prescription or provision of a substance . . . [that] the person. . . may [self-administer] . . . for the purpose of causing his or her own death."[123]

VII.8 The Regulation goes on to define "medicine" (i.e., the practice of medicine) as "the health profession" providing the services of

> (a) assessment and management of the physical or mental condition of an individual or group of individuals at any stage of the biological life cycle, including the prenatal and postmortem periods,
>
> (b) prevention and treatment of physical and mental diseases, disorders and conditions,
>
> (c) promotion of good health, and
>
> (d) medical assistance in dying;[124]

VII.9 This definition does not require those who reject the notion that EAS promotes good health or can be properly considered medical treatment to affirm the contrary as a condition of entry to medical school or medical practice. Those who believe that all of the enumerated services are part of ethical medical practice are free to provide them. By explicitly setting "medical assistance in dying" apart from "promotion of good health" and treatment of diseases, disorders, etc., the formulation enables regulation of both groups without purporting to resolve a serious dispute between different philosophies of medicine. British Columbia has taken the same approach in the regulation of nursing.[125]

VII.10 These regulations demonstrate that it is possible to develop a purely functional definition of medical practice that enables implementation of the *Carter* decision without suppressing the fulsome exercise of freedom of conscience based on serious philosophical disagreements within a regulated profession.

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[123] *Medical Practitioners Regulation*, BC Reg 168/2020, s 1, online: <https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/416_2008>.

[124] *Ibid.*

[125] *Nurses (Registered) and Nurse Practitioners Regulation*, BC Reg 100/2023, s 1; online: <https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/284_2008>.

VIII. EAS vs. accepted end-of-life practices

Crossing the Rubicon

VIII.1 While the appellants ignored the disputed status of EAS as medical treatment within the context of their interjurisdictional immunity claim, they insisted that the trial court judge (and later the Supreme Court) had determined that there were no "ethical, moral or practical differences"[126] between deliberate killing to relieve suffering and withdrawing treatment.[127]

VIII.2 In his opening remarks to that effect at the appeal hearing, Joseph Arvay lauded the trial court judge and groomed the Supreme Court justices:

> The proceedings below are a paradigmatic example of just how institutionally competent courts are and can be in dealing with admittedly complex issues. The courtroom heard some of the very evidence that these many and various committees from around the world have heard from these, from the people who were before the trial court, but in the trial court, unlike in those parliamentary committees, witnesses gave their evidence under oath. Many were cross-examined and the trial judge . . . approached her task with objectivity, impartiality concerned solely with the evidence, concerned solely with the constitutionality of the law, not the policy, not the wisdom, not the politics.[128]
>
> . . . With respect to the evidence of the ethical debate, the trial judge said that one of the reasons why it was important because, she says, if the law permitted it, would it ever be ethical, in an individual case for a physician to assist a competent and informed patient who requests hastened death? And she heard a massive amount of evidence on that, and she came to the conclusion that . . . it would be ethical for a physician to do that. . . .[129]
>
> And then the trial judge's finding that there's no ethical distinction between what this court called passive and active euthanasia in *Rodriguez*. In *Rodriguez*, the courts referencing some UK decision said that so that's the line, that's the Rubicon we're not going to cross. Well, we asked the trial judge to cross that Rubicon. And she did, based on evidence of ethicists and philosophers and physicians and practitioners and she said there is no ethical distinction between active and passive [euthanasia].[130]

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[126] *Carter SCC 2015 webcast*, *supra* note 14 at 00:12:35 to 00:12:58.

[127] *Appellant Factum*, *supra* note 32 at para 10–17, 35.

[128] *Carter SCC 2015 webcast*, *supra* note 14 at 00:07:40 to 00:08:23.

[129] *Ibid* at 00:38:49 to 00:39:13.

[130] *Ibid* at 00:39:53 to 00:40:31, referring to *Rodriguez*, *supra* note 1 at 599. The final spoken phrase quoted here was "no ethical distinction between active and passive distinction," but the context clearly indicates that the final word intended was "euthanasia", not "distinction".

The crossing opposed

VIII.3 Having won the appeal, when Mr. Arvay returned to the Supreme Court to argue against extending the suspension of the ruling he claimed, "[T]his court essentially said, there's no rational or ethical or moral distinction between what a doctor does when when requested to withdraw, withhold lifesaving treatment and what we were asking in terms of allowing physician assisted dying."[131] However, when he asserted that the Ontario's state medical regulator was "just applying the same principles that apply to all of other end of life measures," Justice Moldaver interrupted:

> **[01:13:06] Justice Michael J. Moldaver**: Is that really so? Here we are saying that the doctor can actually take an active part in injecting someone, for example, and killing them. Now I see a difference — maybe you don't — maybe we're dancing on the head of a pin — I see a difference between that and saying, OK, we're going to stop the life support and let the patient die the the natural death. You, you don't seem to see a distinction between that, but, and based on what you're saying it seems to me that the whole concept of unlawful homicide is really not at play here.
>
> **[01:13:41] Joseph Arvay:** Well, I think after *Carter* there is no distinction, and, but the point is, Justice Moldaver, after *Carter* it's now clear that a physician is enti . . . allowed to intentionally take a, assist in the taking of a life, so long as the conditions are met.[132]

MAID = killing people

VIII.4 Mr. Arvay's answer was telling, inasmuch as he had to twice rephrase it in mid-sentence to avoid saying that physicians were "entitled" to provide EAS and to avoid admitting that *Carter* authorized physicians to intentionally take a life (not just "assist" in doing so). However, on the subject of "purposefully and deliberately [taking] someone's life" Justice Moldaver did not mince words:

> **[01:15:37] Justice Michael J. Moldaver:** [M]aybe when Parliament authorizes someone to kill somebody, they might want judicial approval first. They might want other conditions beyond what we talked about, just the circumstances. They might want to put in measures that, that ensure so far as possible that we are not killing people who really ought not to be killed.
>
> **[01:16:03] Joseph Arvay**: Right.[133]

VIII.5 This appears to have been the only time that Mr. Arvay expressly conceded that the focus of *Carter* litigation was the circumstances under which it should be lawful to kill people or help them commit suicide. Justice Moldaver's questions indicated that he was acutely aware of this,

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[131] *Carter SCC 2016 webcast*, *supra* note 46 at 01:07:20 to 01:08:20.

[132] *Ibid* at 01:13:06 and 01:13:41.

[133] *Ibid* at 01:15:37 and 01:16:03.

leading him to emphasize the importance of Parliament's role in developing safeguards deemed essential by both the trial court and the Supreme Court of Canada.[134] Indeed, he expressed some exasperation at what he perceived to be Mr. Arvay's lack of concern about safeguards.[135]

VIII.6 Mr. Arvay correctly observed that, after *Carter*, physicians could lethally inject patients without being charged as long as the exemption conditions were met. However, he failed to add that if the conditions were *not* met they could be charged with first degree murder or assisted suicide, which seems to be what Justice Moldaver meant by his reference to "unlawful homicide."[136] In contrast, accepted contemporaneous end-of-life medical practices in Canada had never been considered homicide or assisted suicide, and *Carter* did not change that.

VIII.7 For present purposes, what is of interest is that Justice Moldaver's question made clear that at least one of the Supreme Court judges who joined in the *Carter* decision did not share Mr. Arvay's view that the Court had erased any distinction between, on the one hand, lethally injecting patients to kill them, and, on the other, withdrawing life support to allow them to die naturally. What, in fact, did the trial court and Supreme Court have to say on this issue?

Carter trial court decision[137]

VIII.8 Mr. Arvay emphasized Part VII (i.e., paragraphs 161 to 358) of the trial court decision, in which the judge proposed to address 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.

VIII.9 However, the trial judge's review of ethical issues in Part VII was unsatisfactory because much that was necessary to understand the ethical issues and controversies associated with end-of-life practices was lacking, especially in relation to palliative sedation and the withdrawal of nutrition and hydration. She purported to have discovered a "strong consensus" supporting the view that *if* physician assisted suicide were ever to be ethical, it would only be in strictly limited circumstances. This was not a substantive conclusion, but a merely rhetorical hypothesis that enabled her to avoid answering the question she had set for herself at the outset: whether or not it *would* be ethical for a physician to provide EAS for a competent, informed patient.

VIII.10 Of the four questions she ultimately posed and discussed she actually answered only one, and her answer disclosed nothing that was not already known and nothing about the ethics of assisted suicide or euthanasia. She was unable to identify any actual ethical consensus concerning physician

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[134] *Carter BCSC 2012*, *supra* note 3 at para 10, 315(i), 1243; *Carter SCC 2015*, *supra* note 2 at para 29, 117.

[135] *Carter SCC 2016 webcast*, *supra* note 46 at 01:16:04 to 01:16:22.

[136] To be clear, at this point they were considering the effect of the *Carter* decision prior to subsequent amendments of the *Criminal Code*.

[137] The précis in paragraphs VIII.9–13 is derived from a lengthy and detailed review of the trial court ruling; see Sean Murphy, "Legalizing therapeutic homicide and assisted suicide: A tour of *Carter v. Canada*. Reviewing *Carter v. Canada (Attorney General)* 2012 BCSC 886" (26 July, 2023), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/law/commentary/legal073-001.aspx>

assisted suicide and euthanasia among professional associations, physicians, ethicists, public committees and the public as a whole.

VIII.11 Contrary to the appellants' claim, the trial judge found that the *evidence* indicated that the question as to whether or not contemporaneous end of life practices could be ethically distinguished from euthanasia/assisted suicide was unresolved. Her personal opinion that there was no ethical distinction between them reflected her view of the arguments, not evidence, and she did not propose her personal view as a conclusion or finding of fact. She was clear that *some* physicians might share that view and was naturally sympathetic, but did not assert that it was correct or normative.[138]

VIII.12 In her summary of the findings of fact and legal reasoning grounding her decision, the trial judge did *not* conclude that physician-assisted suicide and euthanasia were ethical, nor did she conclude that there was no ethical difference between withdrawing/withholding inefficacious treatment and lethally injecting a patient. On the contrary: she noted *lack of agreement* about the ethics of assisted suicide/euthanasia and their ethical relationship to contemporaneous end-of-life practices.

VIII.13 Part VII was briefly summarized in the opening paragraphs of the trial court ruling, but nothing in it actually contributed to the judge's decision about the constitutionality of the law. Part VII was *obiter dicta*; it could have been left out without affecting the outcome of the case. Consistent with the judge's explanation of her purpose, the review in Part VII did not contain analysis intended as authoritative guidance, but fell within the category of "commentary, examples or exposition" meant to be helpful.[139] Helpful or not, it contradicts the appellants' claim that the trial judge had determined that EAS and contemporaneous accepted end-of-life practices were ethically indistinguishable.

Carter Supreme Court of Canada decision

VIII.14 Part I of the appellants' factum included an opening statement and their construction of the trial judge's comments about ethics,[140] safeguards in other jurisdictions[141] and decisional vulnerability of persons who may seek EAS.[142] Their summary of the trial judge's comments about ethics was drawn from Part VII of her ruling, which, as noted above, actually contradicted their claim that she had determined that EAS and contemporaneous end-of-life practices were ethically equivalent.

VIII.15 Part II of the factum opened with a succinct statement of the eight issues raised by the appellants. The ethical findings they erroneously attributed to the trial judge were applied in arguments advanced in relation to two issues:

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[138] *Carter BCSC 2012*, *supra* note 3 at para 1271.

[139] *R v Henry* 2005 SCC 76, [2005] 3 SCR 609 online: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2258/index.do> at para 57.

[140] *Appellant Factum*, *supra* note 33 at para 9–19.

[141] *Ibid* at para 20.

[142] *Ibid* at para 21–23.

a. How, if at all, does the doctrine of *stare decisis* apply to the constitutional legal questions raised in this case?

c. Do the impugned laws infringe s. 7 of the *Charter*?

(a) *Stare Decisis*

VIII.16 The legal principle of *stare decisis* binds lower courts in Canada to conform to the legal determinations of higher courts in the same province and the Supreme Court of Canada unless the case before them can be distinguished from the higher court decision ("vertical *stare decisis*"). Courts are expected to follow previous legal determinations by the same level of court in the same province, but may overrule them in certain circumstances ("horizontal *stare decisis*").[143]

VIII.17 In the 1993 *Rodriguez* decision the Supreme Court of Canada ruled that the law absolutely forbidding euthanasia and assisted suicide was not unconstitutional. The appellants argued that the *Carter* case could be distinguished from *Rodriguez* because "the facts and/or circumstances relevant to the constitutional analysis have changed so as to 'fundamentally shift the parameters of the debate'"[144] and that there were compelling reasons to overrule *Rodriguez*.

VIII.18 One of the facts alleged to have changed was that the Supreme Court in *Rodriguez* had found that "there was a moral (or ethical) distinction between what it characterized as passive and active euthanasia," but the trial court judge in *Carter* had established that there was no distinction "on the basis of a thorough and encompassing record that markedly differs from that in *Rodriguez*."[145] We have seen that the trial court decision does not support the claim; neither does *Rodriguez*.

VIII.19 Recall Mr. Arvay's assertion that in *Rodriguez* the Supreme Court identified the distinction as "the Rubicon" it would not cross. That was not the case. In considering end-of-life medical care, the Court canvassed Canadian, American, and British authorities and the Law Reform Commission of Canada. A passage quoted from *Airedale NHS Trust v Bland* identified the active/passive distinction as "the Rubicon."[146] The Court observed only that neither the House of Lords nor the Commission were prepared to condone "active assistance" of third parties to end someone's life, apparently because they considered it "intrinsically morally and legally wrong" and because abuses might follow from "anything less than a complete prohibition."[147] It did not apply *Airedale* or a "Rubicon" approach in deciding *Rodriguez*.

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[143] Myles Brown, "On Deviations From Declarations: The SCC Gets Decisive on *Stare Decisis*" (13 June, 2022) *Miller Titerle +Co.* (blog), online: <https://millertiterle.com/on-deviations-from-declarations-the-scc-gets-decisive-on-stare-decisis/>.

[144] *Appellant Factum*, *supra* note 32 at para 33, citing *Canada (Attorney General) v. Bedford*, 2013 SCC 72 [2013] 2 SCR 1101 at para 42, 44, 46, online: <https://decisions.scc-csc.ca/scc-csc/scc-csc/en/item/13389/index.do>.

[145] *Ibid* at para 34, citing *Rodriguez*, *supra* note 1 at 605–608 and *Carter BCSC 2012, supra* note 3 at para 942–945.

[146] *Rodriguez*, *supra* note 1 at 599, quoting *Airedale NHS Trust v Bland*, [1993] 2 WLR 316 at 368–69.

[147] *Ibid* at 601 (e) to (h).

VIII.20 In *Rodriguez* the Supreme Court identified a distinction maintained by Canada and other western democracies between "passive and active forms of intervention in the dying process,"[148] but did not stop there. The Court did not rely on widespread acceptance of the distinction, but went on to ask if the rationales supporting it were "constitutionally supportable."[149] That is: did the rationales (hence the distinction) violate principles of fundamental justice, which, according to the Court, included "principles which are 'fundamental' in the sense that they would have general acceptance among reasonable people"?[150] The Court briefly outlined the arguments for and against the distinction[151] and concluded that it was "unable to discern anything approaching unanimity with respect to the issue before us."

> Regardless of one's personal views as to whether the distinctions drawn between withdrawal of treatment and palliative care, on the one hand, and assisted suicide on the other are practically compelling, the fact remains that these distinctions are maintained and can be persuasively defended.[152]

VIII.21 Moreover, in view of the common law, it explicitly stated the distinction was irrelevant to practitioner decision-making when patients refuse interventions in order to die.[153] In sum, *Rodriguez* noted a *lack* of unanimity about an ethical distinction between purportedly passive and active end-of-life interventions, but found the distinction rationally defensible. That was sufficient to establish that it did not violate principles of fundamental justice. The Court did not determine the distinction to be ethically correct, nor give weight to it, except to the extent that it might reflect a fundamental consensus "that human life must be respected and we must be careful not to undermine the institutions that protect it."[154]

VIII.22 The subject of intention in ethical decision-making was introduced in the *Carter* trial court, but the judge did not pursue it.[155] She canvassed the ethical debate about the distinction between EAS and acceptable contemporaneous end of life practices. However, her conclusion that the debate was unresolved (see VIII.11–12) indicated only that the lack of unanimity noted in *Rodriguez* continued unabated, and did not disturb the *Rodriguez* finding that the distinction was rationally defensible.

VIII.23 Responding to the appellants on *stare decisis*, the Supreme Court held that the trial court judge had correctly taken into account changes in the legal framework[156] and changes in evidence

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[148] *Ibid* at 605 (i) to (j).

[149] *Ibid* at 605–606.

[150] *Ibid* at 607 (h) to (i).

[151] *Ibid* at 606 (a) to (g).

[152] *Ibid* at 607–608.

[153] *Ibid* at 606 (h) to (j).

[154] *Ibid* at 608 (a).

[155] *Carter BCSC 2012*, *supra* note 3 at para 324--330.

[156] *Carter SCC 2015*, *supra* note 2 at para 45–46.

about "controlling the risk of abuse."[157] With respect to the latter, it noted that, in upholding the law, the majority of the Court in *Rodriguez* had relied on evidence about the lack of protective halfway measures and "substantial consensus in Western countries" about the consequent necessity of a blanket prohibition to protect the vulnerable.[158] The Court identified these issues as lying "at the heart" of the case[159] and addressed them at length in reviewing the trial court decision.[160]

VIII.24 The Court also asserted that the majority opinion in *Rodriguez* had relied upon evidence of "the widespread acceptance of a moral or ethical distinction between passive and active euthanasia," but stated that there was (unidentified) evidence in the trial court record that, "if accepted," could undermine that "conclusion."[161] This was a misreading of *Rodriguez*. The majority in *Rodriguez* had noted the distinction, lack of unanimity with respect to it, and did not rely upon its "wide acceptance" in upholding the constitutionality of the law (see VIII.20–21).

VIII.25 Unlike the issue of safeguarding the vulnerable, however, this point was clearly not "at the heart" of the case and was not discussed. It seems, in fact, to have contributed nothing of substance to the *Carter* decision. The outcome would have been the same had there been no reference to it.

(c) *Charter* s. 7

VIII.26 The appellants argued that there was no legal difference between accepted contemporaneous end-of-life practices and EAS, but the criminal law allowed the former while punishing the latter with life imprisonment. This, they said, violated what they identified as the principle of "parity," a new principle of fundamental justice."[162] Having decided the s. 7 issue on other grounds, the Court explicitly declined to consider the argument.[163]

Conclusion

VIII.27 Contrary to the appellants' claims, neither the trial court judge nor the Supreme Court of Canada determined that there was "no rational or ethical or moral distinction" between lethally injecting patients in accordance with *Carter* and accepted contemporaneous end-of-life practices, and neither the trial court nor the Supreme Court relied on such a finding to invalidate the absolute prohibition of EAS.

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[157] *Ibid* at para 45.

[158] *Ibid* at para 47.

[159] *Ibid* at para 104.

[160] *Ibid* at para 103–120.

[161] *Ibid* at 47.

[162] *Appellant Factum*, *supra* note 33 at para 85–86.

[163] *Carter SCC 2015*, *supra* note 2 at 91–92.

IX. Why treat euthanasia/assisted suicide differently?

IX.1 EAS is provided by physicians and nurse practitioners in health care environments and funded by state health care budgets, so one might ask why any distinction might be made between EAS and medical treatment and why the distinction might be considered important. An incidental exchange about competence opened a portal to an unexplored dimension of the *Carter* ruling relevant to this question. It occurred between Justice Michael Moldaver and lead appellant counsel Joseph Arvay when the Supreme Court of Canada heard an application for an extension of the suspension of the decision.

IX.2 Justice Moldaver asked Mr. Arvay how, in amending the *Criminal Code* to reflect the *Carter* decision, Parliament might want to define "competent."[164] Mr. Arvay began to argue that defining competence for the provision of healthcare fell within the constitutional jurisdiction of the provinces, not the federal government,[165] but was cut short by Justice Moldaver:

> Well, for *Criminal Code* purposes, for allowing someone to purposefully and deliberately take someone's life with impunity. That's what I'm talking about. I'm talking criminal law now.[166]

IX.3 Mr. Arvay responded with care and precision:

> Well, I would think that if Parliament tries to define competency in a way that in any way departed from the facts and the evidence supporting the facts in *Carter* then Parliament would be reading *Carter* in an unduly restrictive way and that legislation itself might be challengeable. I don't think that there is any any question in the medi — there is no question in the medical profession about how to assess competency. Why would Parliament now come up with a different test for competency in the context of physician assisted dying than is applied any other way?[167]

IX.4 He went on to describe the suggestion that Parliament might redefine competence as a "highly, highly speculative" possibility that none of the parties opposing him was suggesting.[168] Justice Moldaver did not press the point further. Nonetheless, he had — perhaps unwittingly, perhaps only intuitively — touched upon a fundamental distinction.

IX.5 Return to what Joseph Arvay posed as a merely rhetorical question: "Why would Parliament now come up with a different test for competency in the context of physician assisted dying than is applied any other way?" and take the question seriously rather than rhetorically.

IX.6 The Supreme Court stated that both federal and provincial governments can pass laws

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[164] *Carter SCC 2016 webcast*, *supra* note 46 at 01:25:18 to 01:25:29.

[165] *Ibid* at 01:25:29 to 01:25:38.

[166] *Ibid* at 01:25:38 to 01:25:50.

[167] *Ibid* at 01:25:50 to 01:26:32.

[168] *Ibid* at 01:26:32 to 01:27:26.

governing physician-administered euthanasia and physician-assisted suicide, "depending on the circumstances and focus of the legislation."[169] The focus of federal (criminal) legislation is on controlling or managing non-culpable homicide and assisted suicide. The focus of provincial legislation is on regulating the activities of health professionals and delivery of health care.

IX.7 Within the criminal law context specified by Justice Moldaver, Parliament might think it prudent to set higher standards to control or manage killing people than a province might set to control or manage the provision of palliative care. Within that context Parliament might propose a more stringent definition of competence for consenting to be "purposefully and deliberately" killed than is required for consenting to an appendectomy. Mr. Arvay's question is rhetorical only if one accepts his view that homicide and assisted suicide in accordance with the *Carter* criteria are, in fact, nothing other than healthcare or therapeutic medical treatment.[170] Only then might a redefinition of competence by Parliament be redundant or possibly unconstitutional. But the Supreme Court rejected that position in *Carter* (see VII.5).

X. *Carter* and freedom of conscience and religion

Freedom of conscience: fundamental freedom or "bells and whistles"?

X.1 What did the Supreme Court have to say about practitioners who do *not* want to kill patients or help them to commit suicide?[171] The question is important because only a very small minority of authorized practitioners are willing to do so; 1.8% of all physicians and non-Quebec nurse practitioners provided EAS in 2022.[172] Yet, remarkably, the appellants argued, "There is no fundamental social conception of [physician-administered euthanasia and physician-assisted suicide] as immoral."[173]

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[169] *Carter SCC 2015*, *supra* note 2 at para 53.

[170] *Carter SCC 2015 webcast*, *supra* note 14 at 00:34:55 to 00:35:14.

[171] The *Criminal Code* amendment implementing *Carter* extended protection from prosecution for providing EAS to include nurse practitioners, so, except in Quebec, both physicians and nurse practitioners can provide the service. Canadian Institute for Health Information. *Nurse Practitioner Scopes of Practice in Canada, 2020 — Data Table*. Ottawa, ON: CIHI; 2020. online: <https://www.cihi.ca/sites/default/files/document/nurse-practitioner-scopes-of-practice-canada-2020-data-table-en.xlsx>.

[172] The proportion of nurse practitioners providing EAS was over 12 times that of physicians (24.9% to 1.8%) . *MAID 2022*, *supra* note 153 at 5.3; Canadian Institute for Health Information. *Supply, Distribution and Migration of Physicians in Canada, 2022 — Data Tables*. Ottawa, ON: CIHI; 2023, online:<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiC6-PLhbWCAxXQODQIHSfmDMYQFnoECAsQAQ&url=https%3A%2F%2Fwww.cihi.ca%2Fsites%2Fdefault%2Ffiles%2Fdocument%2Fsupply-distribution-migration-physicians-in-canada-2022-data-tables-en.xlsx&usg=AOvVaw1GG7xQ8LSk5kw_TYmDLM9Q&opi=89978449 >. Canadian Institute for Health Information. *Nursing in Canada, 2022 — Data Tables*. Ottawa, ON: CIHI; 2023, online:<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjk18DuhbWCAxUwGDQIHSb2DZIQFnoECA4QAQ&url=https%3A%2F%2Fsecure.cihi.ca%2Ffree_products%2Fnursing-in-canada-2013-2022-data-tables-en.xlsx&usg=AOvVaw3Yc1_QFtLAVQlb-c5e6LWs&opi=89978449 >.

[173] *Appellant Factum*, *supra* note 32 at para 86.

X.2 Particularly in light of acknowledged "vociferous" opposition to the practices by what Joseph Arvay called "some church groups,"[174] this was an extraordinary and inexplicable claim. Nothing in the trial court ruling could be construed to support it. The claim was perhaps predicated on the premise that arguments advanced by "church groups" might be "views"[175] but not "social conceptions," or, at least, not valid social conceptions deserving judicial notice or consideration. If so, the premise was erroneous. "[N]othing in the *Charter*, political or democratic theory, or a proper understanding of pluralism," wrote Justice Gonthier in *Chamberlain v Surrey School District No. 36* "demands that atheistically based moral positions trump religiously based moral positions on matters of public policy."

> The problem with this approach is that everyone has 'belief' or 'faith' in something, be it atheistic, agnostic or religious. To construe the 'secular' as the realm of the 'unbelief' is therefore erroneous. Given this, why, then, should the religiously informed conscience be placed at a public disadvantage or disqualification? To do so would be to distort liberal principles in an illiberal fashion and would provide only a feeble notion of pluralism. The key is that people will disagree about important issues, and such disagreement, where it does not imperil community living, must be capable of being accommodated at the core of a modern pluralism.[176]

The "no fundamental social conception" claim appears to betray a dismissive attitude fundamentally at odds with that reflected in *Chamberlain*.

X.3 Mr. Arvay asserted that "no one is suggesting that a physician who has a religious objection to assisting a patient with his or her death must do so,"[177] but this fell short of a promise that objecting practitioners would not be forced to collaborate in EAS in other ways. In fact, an obligation to at least facilitate the procedures was implicit in the appellants' claim that they were at the "core" of health care and medical treatment.[178] One of their most prominent witnesses had implied that a physician's refusal to provide the services would amount to unethical abandonment of patients.[179] The Royal Society report introduced by Mr. Arvay as evidence at trial explicitly recommended that objecting practitioners be forced to collaborate in killing by referring patients to willing colleagues.[180]

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[174] *Carter SCC 2015 webcast*, *supra* note 14 at 00:13:05 to 00:13:34.

[175] *Ibid*.

[176] *Chamberlain v. Surrey School District No. 36* [2002] 4 S.C.R. 710 (SCC), oline: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2030/index.do?r=AAAAAQALIm1hbmRhdG9yeSIAAAAAAAAB> at para 137, (Gonthier J dissenting, but the full court concurring on this point).

[177] *Carter SCC 2015 webcast*, *supra* note 14 at 00:13:05 to 00:13:34.

[178] *Ibid* at 00:06:53 to 00:07:06; *Appellant Factum*, *supra* note 33 at para 43.

[179] *Carter BCSC 2012*, *supra* note 3 at para 239–240.

[180] Udo Schuklenk (Chair) et al, "Report of the Expert Panel: End of Life Decision Making" (November, 2011), *Royal Society of Canada* (website), online: <https://rsc-src.ca/sites/default/files/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf> [*Royal Society Report*]

X.4 In light of this, the appellants' explanation for opposing the Protection of Conscience Project's joint intervention seems disingenuous:

> [Their] main submission appears to be that no physician and/or medical institution should be compelled to assist in a patient's death because this would violate that physician's freedom of religion and conscience. *As the appellants have never argued that any physician should be compelled to perform PAD,* these proposed interveners seek to raise issues not properly before the Court (emphasis added).[181]

X.5 It is significant that *(after* winning the appeal) Mr. Arvay cited that report in characterizing protection of practitioner freedom of conscience as mere "bells and whistles":

> The Provincial Territorial Working Group, said we don't really even need any laws about conscientious objectors. We have the laws and the laws would be redundant. But we'll put in laws, if that makes everybody feel better.[182]

X.6 Bluntly, that is not what the experts said. Their report baldly claimed (citing no law) that objecting practitioners were obliged to refer patients for EAS.[183] They recommended that objectors should be forced to actively connect patients to willing colleagues or an EAS delivery service.[184] But their report, while clearly hostile to practitioner freedom of conscience, was not flippant. Mr. Arvay's unguarded moment of flippancy revealed a regrettably cavalier attitude to the fundamental freedoms of objecting practitioners, perhaps reflecting the view that they lacked a correct "fundamental social conception" of the issue.

X.7 Ironically — some would say perversely — the appellants lauded physicians' unwillingness to harm their patients as an outstanding virtue that made them ideal euthanasia practitioners. "[I]t is an irrefutable truth," Joseph Arvay told the Supreme Court of Canada, "that all doctors believe it is their professional and ethical duty to do no harm."

> Which means, in almost every case, that they will want to help their patients live, not die. It is for the very reason that we advocate only physician assisted dying and not any kind of assisted dying because we know physicians will be reluctant gatekeepers, and only agree to it as a last resort.[185]

X.8 Mr. Arvay seems not to have noticed that the determination to do no harm that he so highly praised depended upon the exercise of freedom of conscience that would be subverted if

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at 61--62, 69.

[181] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 (Appellants' Response to Motions to Intervene at para 5), online: <https://www.consciencelaws.org/archive/documents/carter/2014-06-20-response-to-interventions.pdf>.

[182] *Carter SCC 2016 webcast*, *supra* note 39 at 01:32:27 to 01:32:54.

[183] *Provincial-Territorial Expert Report*, *supra* note 22 at 3.

[184] *Ibid* at 44–45 (Recommendation 33).

[185] *Carter SCC 2015 webcast*, *supra* note 14 at 00:20:03 to 00:20:40.

opinions and recommendations from experts he commended were accepted. Further, practitioners' ability to refuse EAS *except* as a "last resort" would be nullified by his definition of irremediability, which enabled patients to trump a "last resort" approach by refusing treatment (see VI.2).

Canadian Medical Association

X.9 During the appeal the CMA had taken a position of neutrality on the acceptability of EAS as a form of medical treatment (see VII.3), but it supported physician freedom of conscience in relation to physician participation in killing patients:

> In addition, if the law were to change, no physician should be compelled to participate in or provide medical aid in dying to a patient, either at all, because the physician conscientiously objects to medical aid in dying, or in individual cases, in which the physician makes a clinical assessment that the patient's decision is contrary to the patient's best interests.[186]

X.10 After the appeal hearing the CMA unconditionally approved euthanasia and assisted suicide as legitimate forms of medical treatment for persons suffering from incurable diseases — should the law change. The Court consulted the new CMA policy in deciding *Carter*.[187]

X.11 The new CMA policy placed no limits on criteria for euthanasia and assisted suicide and no limits on what non-objecting physicians might agree to do. It reaffirmed support for physicians who did not wish to "participate" in the service, but added, "However, there should be no undue delay in the provision of end of life care, including medical aid in dying."[188] This implied that freedom of conscience for objecting physicians could be limited in order to ensure timely patient access to the services. After the *Carter* ruling it became clear that the CMA policy change had serious adverse implications for practitioners opposed to EAS for reasons of conscience, particularly in relation to the contentious issue of referral.[189]

The issue of referral

X.12 As the *Carter* case was making its way through the courts, Quebec had passed a law purporting to legalize euthanasia, notwithstanding the criminal prohibition.[190] Jean-Yves Bernard appeared at the *Carter* hearing at the Supreme Court representing the Attorney General of Quebec. Near the end of his oral submission he stated that the Quebec College of Physicians believed that a "continuum of care" ending ultimately with euthanasia ("end-of-life care") could be reconciled with

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[186] *CMA Factum*, *supra* note 11 at para 27.

[187] *Carter SCC 2015*, *supra* note 2 at 131.

[188] *CMA EAD 2014*, *supra* note 37 at 1–3.

[189] Sean Murphy, "Canadian Medical Association and euthanasia and assisted suicide in Canada: Critical review of CMA approach to changes in policy and law" (September, 2018), Protection of Conscience Project (website), online: <https://www.consciencelaws.org/background/procedures/assist029-01.aspx>.

[190] *Act respecting end-of-life care*, CQLR c S-32.0001, online: <https://www.canlii.org/en/qc/laws/stat/rsq-c-s-32.0001/latest/rsq-c-s-32.0001.html>.

its *Code of Ethics,* and a physician should participate.[191] Justice Louis Lebel recognized that the state regulator's position was likely to cause a dilemma for some physicians. "[I]f you define this act as treatment," he asked, "then the conscientious objection of doctors or others involved in the health care system, is that taken into account?"[192]

X.13 Citing sections of the Quebec law, M. Bernard replied that objecting physicians could not "be forced" to provide the service and individual physicians were "never compelled to act against their conscience." He explained that "they have to refer to other medical authorities who will take the necessary steps to ensure that someone else who is willing to take on the task."[193]

X.14 Counsel for the Canadian Medical Association made no comment on M. Bernard's response or on the issue of referral. That fell to Robert W. Staley, representing the Catholic Civil Rights League (CCRL), Faith and Freedom Alliance (FFA), and Protection of Conscience Project (PCP) in a joint intervention.[194]

X.15 Mr. Staley explained that the joint interveners had diverse views on the merits of the appeal[195] but were united in urging the Court to explicitly support freedom of conscience for healthcare providers unwilling to directly or indirectly participate in EAS.[196] The factum explained that compulsion to personally provide EAS was not the only issue:

> Even if a healthcare provider objects to directly participating in physician-assisted death, they may be called upon to refer the patient to a non-objecting heaIthcare provider, which may equally infringe the objecting provider's freedom of conscience by compelling him or her to become a party to what they believe is morally wrong.[197]

Referring to M. Bernard's explanation, he warned the Court that the Quebec law represented "precisely the sort of thinking that. . .ought to be protected against."[198]

X.16 Noting Mr. Arvay's promise that no one would be compelled to perform or assist with EAS (see X.3), he apprised the Court of the concerns of those unwilling to incur moral culpability by

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[191] *Carter SCC 2015 webcast*, *supra* note 14 at 01:47:50–01:48:38.

[192] *Ibid* at 01:48:38–01:48:56

[193] *Ibid* at 01:48:56 to 01:49:36.

[194] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 (Factum of the interveners Catholic Civil Rights League, Faith and Freedom Alliance, Protection of Conscience Project), online: <https://www.scc-csc.ca/WebDocuments-DocumentsWeb/35591/FM180_Intervener_Faith%20and%20Freedom%20Alliance%20and%20Protection%20of%20Conscience%20Project.pdf> [*Protection of Conscience Factum*].

[195] *Carter SCC 2015 webcast*, *supra* note 14 at 06:28:20 to 06:28:43. Unlike the Catholic Civil Rights League and Faith and Freedom Alliance, the Protection of Conscience Project does not take a position on the acceptability of morally contested procedures like euthanasia and assisted suicide.

[196] *Ibid* at 06:28:56 to 06:29:44.

[197] *Protection of Conscience Factum*, *supra* note 194 at para 20.

[198] *Carter SCC 2015 webcast*, *supra* note 14 at 06:29:44 to 06:30:10.

assist *indirectly* with the procedures.[199] He drew the Court's attention to the report of the Royal Society panel entered by Mr. Arvay as evidence in the trial court, which recommended that "where a physician decides that he or she is not going to help kill a patient, he or she has a duty to refer the patient to somebody who will kill them."[200] No health care professional, argued Mr. Staley, should be in professional or legal jeopardy "because he or she refuses to kill patients or take steps to indirectly assist patients who wish to kill themselves."[201]

X.17 After critiquing M. Bernard's explanation of the Quebec euthanasia law[202] he returned to the central theme of his submission. Recalling that killing patients or helping them to commit suicide had been considered criminal acts,[203] he pointed out that people who would refuse to engage in such acts were being told, "you have to cooperate to the extent that you refer them to somebody who will actually kill them."[204] Hence, if the Court decided to allow the appeal, he said, it should direct that consequent changes to legislation must consider "the constitutional rights of those who object, as a matter of conscience, to killing, directly or indirectly, other people."[205]

X.18 The joint intervention on the need to protect freedom of conscience was the last submission heard by the Court.

What the Supreme Court decided

X.19 The Supreme court limited itself to declaring that the absolute prohibition of EAS was constitutionally invalid for the reasons summarized in the case headnote.[206] Further:

> In our view, *nothing* in the declaration of invalidity which we propose to issue would compel physicians to *provide* assistance in dying. *The declaration simply renders the criminal prohibition invalid*. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures.[207] (emphasis added)

X.20 Note that the Court here referred to "physicians" (plural), not "a physician" (singular). This passage indicates that invalidating the criminal prohibition did not, in the Court's view, create an obligation on the part of physicians (individually or collectively) to provide assisted suicide or euthanasia.

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[199] *Ibid* at 06:32:45 to 06:33:03.

[200] *Ibid* at 06:33:11 to 06:33:29.

[201] *Ibid* at 06:33:59 to 06:34:16.

[202] *Ibid* at 06:34:23 to 06:36:05. M. Bernard made a brief reply clarifying the sections of the Quebec law to which he had referred. *Ibid* at 06:37:24 to 06:37:44.

[203] His use of the past tense may have reflected passage of the Quebec euthanasia law.

[204] *Ibid* at 06:36:05 to 06:36:23.

[205] *Ibid* at 06:36:45 to 06:37:04.

[206] *Carter SCC 2015*, *supra* note 2 at 333–337.

[207] *Ibid* at para 132.

X.21 While the Court initially referred to being compelled to provide — being forced to personally kill or provide the lethal prescription — the Court included a broader term — participation — as it continued:

> . . . we note - as did Beetz J. in addressing the topic of physician participation in abortion in *R. v. Morgentaler* -- that a physician's decision *to participate* in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the *Charter* rights of patients and physicians will need to be reconciled.[208] (Emphasis added)

X.22 Unfortunately, prominent euthanasia proponents understand reconciliation to mean forcing practitioners unwilling to kill patients to help find a colleague who will.[209] However, forcing unwilling physicians to become parties to homicide and suicide would be inconsistent with the comments of Justice Beetz in *Morgentaler*, cited with approval by the full bench of the Court in *Carter*:

> Nothing in the *Criminal Code* obliges the board of an eligible hospital to appoint therapeutic abortion committees. Indeed, a board is entitled to refuse . . . in a hospital that would otherwise qualify to perform abortions, and boards often do so in Canada. Given that the decision to appoint a committee is, in part, one of conscience, and, in some cases, one which affects religious beliefs, a *law cannot force a board to appoint a committee any more than it could force a physician to perform an abortion*.[210] (Emphasis added)

X.23 Note that Justice Beetz, while distinguishing between appointing a committee and performing an abortion, nonetheless considered both acts to involve judgements of conscience and religious belief, and the legal suppression of one to be the equivalent of the legal suppression of the other. Further, therapeutic abortion committees did not provide abortions. In fact, members of therapeutic abortion committees were prohibited from doing so.[211] The committees facilitated abortions by authorizing them. The refusal of boards to approve the formation of such committees was a refusal to become part of (participate in) a chain of causation culminating in abortion, even if not every case brought to a committee resulted in abortion.

X.24 Thus, Justice Beetz' comments, affirmed by *Carter*, are authority for the proposition that

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[208] *Ibid.*

[209] *Provincial-Territorial Expert Report*, *supra* note 22 at 3, 44–45 (Recommendation 33).

[210] *R v Morgentaler* (1988) 1 SCR 30, online: <http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/288/index.do > at 95-96.

[211] *Criminal Code*, *supra* note 13 at 287(4)a, online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/20181218/P1TT3xt3.html#h-120918>, as repealed by 2019, c. 25, s. 111.

the state is not only precluded from forcing individuals or institutions to provide morally contested procedures, but also precluded from forcing them to participate indirectly by referral or other forms of causal facilitation.

X.25 At the very least, this passage indicates that the suppression or restriction of freedom of conscience or religion by compelling *indirect* participation in a morally contested procedure is legally equivalent to compelling *direct* participation. The same constitutional standard applies, whether the state means to force unwilling physicians to kill patients themselves, or to force them to arrange for patients to be killed by someone else. Put another way, compelling indirect participation in a morally contested act is not a constitutionally valid 'solution' for the 'problem' of an inability to compel direct participation.

What the Supreme Court did not decide

X.26 The *Carter* decision did not impose a legal duty on the state or upon anyone else to provide or participate in euthanasia or assisted suicide. Consistent with this, Joseph Arvay argued that *Carter* was not "a positive rights case," so there was "no duty on Parliament to enact legislation" and governments were not required to do so.[212]

X.27 Like the trial court, the Supreme court did not decide that killing patients or helping them to commit suicide was medical treatment, that EAS and accepted contemporaneous end-of-life interventions were legally/morally/ethically equivalent, nor did it address the contentious issue of referral. The Court's statement that "the *Charter* rights of patients and physicians will need to be reconciled" is not, as some seem to think, a warrant for the suppression of freedom of conscience and religion among health care workers.

X.28 The *Charter* right of patients clearly established by *Carter* is a legal right not to be impeded or obstructed by the state in seeking euthanasia and assisted suicide in accordance with the Court's guidelines from willing practitioners, except to the extent that impediments or obstructions can be demonstrably justified in a free and democratic society. The *Charter* right of practitioners clearly established by *Carter* is their legal right not to be to impeded or obstructed by the state in providing euthanasia and assisted suicide in accordance with the Court's guidelines, except to the extent that impediments or obstructions can be demonstrably justified in a free and democratic society. Any additional rights claims are derived by reading into the ruling what the judges either did not address, or purposefully and often expressly left out.

[212] *Carter SCC 2016 webcast*, *supra* note 39 at 01:11:21 to 01:12:15.