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Legalizing therapeutic homicide and assisted suicide: A tour of *Carter v. Canada*

Reviewing *Carter v. Canada* (Attorney General) 2012 BCSC 886

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Abstract

In 2012 a British Columbia Supreme Court Justice struck down Canada's absolute ban on assisted suicide as well as the rule that one cannot legally consent to be murdered. The decision pertained only to cases of physician-assisted suicide or homicide. She suspended the ruling for a year to give the government time to decide how to respond, but, in the interim, ruled that a physician could help one of the plaintiffs to commit suicide or provide her with therapeutic homicide. The decision was ultimately appealed to the Supreme Court of Canada and decided in the fall of 2014.

The trajectory of the trial was determined by the fundamental premise that suicide can be a rational and moral act, and that the sole purpose of the law against assisted suicide was to prevent suicides by vulnerable people in moments of weakness, who might be tempted to commit suicide that was not rational and moral. The premise that suicide could be acceptable was not challenged by the defendant governments or interveners supporting them, probably because they believed that the subject was not one that could be argued effectively in a judicial environment permeated by secularism and moral pluralism. However, the failure to address the morality of suicide did not produce a morally neutral judicial forum. It simply allowed the moral belief that suicide could be acceptable to set the parameters for argument and adjudication.

The only issue was whether or not safeguards could be designed to permit legitimate access to assisted suicide, while preventing the vulnerable from accessing it in moments of weakness. It was not thought reasonable to demand that a system of safeguards be 100% effective. A different model was required. The model chosen was the regime of accepted end-of-life practices, since the outcome of a mistake ('death before one's time') would be the same as the outcome of a mistake in regulating assisted suicide.

Patient safety in end-of-life care was ensured by the principle of informed consent, assessment of patient competence, and the use of legal substitute decision-makers for incompetent patients. Since these measures were considered sufficient for the purposes of withholding, withdrawing or refusing treatment, it was decided that they should be sufficient for the regulation of assisted suicide for competent adults. The burden of proof was on the defendant governments to prove that this could not be done. The text of the ruling indicates that they

provided evidence of risk, but failed to prove that safeguards could not be effective.

Joseph Arvay, counsel for the plaintiffs, subsequently told the Supreme Court of Canada that the trial court judge had concluded that it was ethical for physicians to provide euthanasia and assisted suicide. Moreover, he claimed that she had found that there was "no ethical distinction" between withdrawing/withholding life saving treatment on the one hand, and euthanasia/assisted suicide on the other.

Neither of these claims is supported by the text of the decision. The review was unsatisfactory because much that was necessary to understand the ethical issues and controversies associated with end-of-life practices was lacking. Further, nothing in Part VII was essential to the judge's decision about the constitutionality of the law. Part VII is *obiter dicta*; it could have been left out without affecting the outcome of the case. Other courts are not bound to adhere to or defer to it, and, in view of the shortcomings in the analysis, it is without persuasive weight.

Nonetheless, Justice Smith's review of ethical issues in Part VII of the ruling is of interest because it was there that the judge erected the ethical falsework that influenced evaluation of the evidence and legal reasoning.

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I. The decision, appeal and implementation

I.1 In June, 2012, Justice Lynn Smith of the British Columbia Supreme Court struck down Canada's absolute ban on assisted suicide as well as the rule that one cannot legally consent to be murdered.[1] The lengthy judgment, which followed a trial in the fall of 2011, pertained only to cases of physician-assisted suicide or homicide.[2] She suspended the ruling for a year to give the government time to decide how to respond, but, in the interim, ruled that a physician could help one of the plaintiffs, Gloria Taylor, to commit suicide or provide her with therapeutic homicide, depending upon her medical condition at the time she wished to die.[3] Taylor died of natural causes four months later.[4]

I.2 In June, 2014, as the trial court decision was making its way to the Supreme Court of Canada, Quebec effectively legalized euthanasia by physicians, relying on its constitutional jurisdiction over the provision of health care. Quebec could not, in fact, override the criminal prohibition of euthanasia and assisted suicide, since criminal law in Canada is exclusively within the jurisdiction of the federal government. However, provincial governments are constitutionally responsible for enforcing criminal law and prosecuting criminal offences. The Quebec government promised that it would not prosecute physicians who provided euthanasia in accordance with the provincial law, thus circumventing the criminal prohibition.[5]

I.3 Justice Smith's decision was ultimately upheld in a unanimous ruling by the Supreme Court of Canada in the fall of 2014. The ruling exempted physicians from prosecution for assisted suicide, murder and related offences in circumstances defined by the Court. The Supreme Court suspended its judgement for one year to give the federal and provincial governments time to amend legislation and plan for implementation of the new euthanasia/assisted suicide (EAS) regime.[6] The

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[1] *Carter v. Canada (Attorney General)* 2012 BCSC 886 [*Carter BCSC*] at para 101, online: <http://www.courts.gov.bc.ca/jdb-txt/SC/12/08/2012BCSC0886cor1.htm>.

[2] *Ibid* at para 19,38, 1393(b), 1414(f).

[3] "Therapeutic homicide" refers to euthanasia. The term was not used in the judgement, but in the title of an editorial in the *Canadian Medical Association Journal* responding to the ruling. See Ken Flegel & John Fletcher,"Choosing when and how to die: Are we ready to perform therapeutic homicide?" (2012) 184:11 CMAJ 1227, online:<http://www.cmaj.ca/content/early/2012/06/25/cmaj.120961.1>. While novel, it is actually a legally precise formulation if one accepts the premise that homicide can be therapeutic, since, in Canadian law, 'homicide' refers simply to the killing of a human being, without an implication of illegality. See *Criminal Code*, RSC 1985, c C-46, online: <https://laws-lois.justice.gc.ca/eng/acts/c-46/>[*Criminal Code*], s 222(1).

[4] "Assisted-suicide crusader Gloria Taylor dies in B.C." CBC News (5 October, 2012), online:<https://www.cbc.ca/news/canada/british-columbia/assisted-suicide-crusader-gloria-taylor-dies-in-b-c-1.1164650>.

[5] Sean Murphy, "Redefining the Practice of Medicine: Euthanasia in Quebec - An Act Respecting End-of-Life Care (June, 2014)" (28 October, 2015), *Protection of Conscience Project* (website), online:<https://www.consciencelaws.org/law/commentary/legal068-001.aspx>.

[6] *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*].

regulation of health care professions and institutions and delivery of EAS are within the constitutional jurisdiction of Canadian provinces, subject to criminal law , which is within federal jurisdiction.[7] 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. 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,[8] but delayed panel consultations until late October by calling a federal election.

I.4 In the absence of action by the federal government, others took the initiative. The Canadian Medical Association approved a procedural framework for EAS that included a protection of conscience provision acceptable to groups representing objecting physicians.[9] A nine member Expert Advisory Group formed under the auspices of the Ontario government produced a report adverse to the exercise of freedom of conscience by objecting individuals and institutions.[10] By the time the Experts made their report, the Conservatives had lost the federal election to the Liberals. The new Liberal government under Prime Minister Justin Trudeau could not amend the *Criminal Code* before the deadline set by the Supreme Court, so it obtained a six month extension of the suspension of the Court's judgement.[11] Outside Quebec (where the provincial euthanasia law had come into force) EAS could be obtained during the extension by making an application to a superior court. The first iteration of the Criminal Code amendments implementing the *Carter* decision became law in June, 2016.[12]

II. Legal background

II.1 The decision was particularly noteworthy because of the 1993 Supreme Court of Canada

[7] Sean Murphy, "Jurisdictional, organizational and regulatory framework for health care delivery in Canada" (15 September, 2020), *Protection of Conscience Project* (website), online:<https://www.consciencelaws.org/law/commentary/legal109.aspx>.

[8] 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>.

0. Sean Murphy, "Canadian Medical Association and euthanasia and assisted suicide in Canada: Critical review of CMA approach to changes in policy and law - Part 2 - CMA on freedom of conscience after Carter"(26 September, 2018) *Protection of Conscience Project* (website), online:<https://www.consciencelaws.org/background/procedures/assist029-02.aspx>.

[10] Sean Murphy, "A 'uniquely Canadian approach' to freedom of conscience: Provincial-Territorial Experts recommend coercion to ensure delivery of euthanasia and assisted suicide" (15 June, 2018), *Protection of Conscience Project* (website), online:<https://www.consciencelaws.org/law/commentary/legal073-012.aspx>.

[11] *Carter v. Canada (Attorney General)* 2016 SCC 4, online:<http://scc-csc.lexum.com/scc-csc/scc-csc/en/15696/1/document.do>..

[12] *An Act to amend the Criminal Code (medical assistance in dying)*, SC 2021 c C-2, online:<https://laws-lois.justice.gc.ca/eng/AnnualStatutes/2021_2/page-1.html>.

decision in *Rodriguez v. British Columbia (Attorney General)*.[13] Sue Rodriguez, who had amyotrophic lateral sclerosis ("ALS" or "Lou Gehrig's Disease"), sought to overturn the law so that a physician could assist her in suicide. In a 5-4 decision, the Supreme Court rejected her claim and upheld the constitutional validity of the law against assisted suicide. The circumstances in the *Carter* case were very similar, so the ruling raised important questions about the doctrine of precedent — the legal rule of *stare decisis* that requires lower courts to follow higher courts' rulings.

II.2 Then Supreme Court Chief Justice Antonio Lamer was one of the dissenting minority who supported Rodriguez's application. He was apparently willing to authorize a physician to assist her in suicide, but did not do so because she had not sought such an order.[14] A young lawyer named Jocelyn Downie was a clerk for the Chief Justice at the time.[15] By the time of the *Carter* trial court ruling she was a professor in the Faculties of Law and Medicine at Dalhousie University in Halifax, Nova Scotia, a Fellow of the Royal Society of Canada and the Canadian Academy of Health Sciences, and Canada Research Chair in Health Law and Policy.[16] Four years earlier she had co-authored a paper setting out a strategy for reversing *Rodriguez*[17] that informed the plaintiffs' successful argument in *Carter*. Professor Downie assisted the plaintiffs in the Carter case in instructing their expert witnesses.[18]

III. The litigation

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

III.1.1 The case began in April, 2011, with a claim filed by the BC Civil Liberties Association (BCCLA), family physician Dr. William Shoichet of Victoria, B.C. and Lee Carter and her husband, Hollis Johnson. Lee Carter's 90 year old mother had recently committed suicide at the Dignitas facility in Zurich, Switzerland, because assisted suicide was illegal in Canada.[19]

III.1.2 The plaintiffs claimed that the law violated the guarantee of equality in s. 15 of the

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[13] *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*]

[14] *Ibid* at 578.

[15] "Jocelyn Downie *Curriculm Vitae*" (undated) Impact Ethics (website), online:<https://cdn.dal.ca/content/dam/dalhousie/pdf/sites/noveltechethics/nte_downie.cv.pdf>.

[16] "Jocelyn Downie" (undated) *Dalhousie University, Schulich School of Law* (website), online:<http://law.dal.ca/Faculty/Full_Time_Faculty/Bio-J_Downie.php>.

[17] 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>.

[18] *Carter BSCC supra* note 1 at para 124.

[19] *Carter v. Canada (Attorney General)* 2012 BCSC 886 (Notice of Civil Claim) [*Notice of Claim*] at Part 1, para 17-24, online:<../archive/documents/carter/2011-04-26-noticeofclaim01.pdf>.

Canadian Charter of Rights and Freedoms (*Charter*)[20] because able-bodied persons could commit suicide without assistance, but disabled persons might not be able to do so, and were thus "deprived of the ability to choose and carry out their death in any lawful way."[21] They also argued that the law against assisted suicide violated *Charter* guarantees of "life, liberty and the security of the person" (s. 7) with respect to the "grievously and irremediably ill" seeking physician-assisted suicide[22] and persons wishing to assist them to obtain that service,[23] including physicians.[24]

III.2 Constitutional claim: jurisdiction over health care

III.2.1 The third legal argument advanced by the plaintiffs was that "treatment and management of the physical and emotional suffering of a grievously and irremediably ill patient" were matters that fell within the "exclusive jurisdiction" of provinicial governments, which were constitutionally mandated to manage health care.[25] Since (according to plaintiff physician Dr. Soichet) physician-assisted suicide and voluntary euthanasia were "important component[s] of the provision of health care to grievously and irremediably ill patients,"[26] the lawsuit asked that sections of the *Criminal Code* (a federal statute) that prevented the provision of this "health care" should be struck down as an unconstitutional interference in provincial jurisdiction, "to the extent that [they] prohibit physician-assisted dying" — defined by the plaintiffs to include physician-administered euthanasia and physician-assisted suicide.[27] The "impugned provisions" included those rendering persons "criminally liable for aiding or counselling . . . or otherwise render someone a party to a criminal offence for arranging, supporting or otherwise participating in physician-assisted dying."[28]

III.3 Remedy sought

III.3.1 In short, the plaintiffs sought the court-ordered legalization of physician-assisted suicide and physician-administered euthanasia, or by persons acting under their direction for anyone "grievously and irremediably ill" (not "terminally ill").[29] Similarly, the BCCLA press release referred, not to terminal illness, but to "serious illness that cannot be remedied" and "seriously and incurably ill individuals." Though it seems that the Association was thinking primarily of "mentally

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[20] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), c 11, online:<https://laws-lois.justice.gc.ca/eng/Const/page-12.html> [*Charter*].

[21] *Notice of Claim*, *supra* note 19 at Part 3, para 23.

[22] *Ibid* at Part 3, para 5-11.

[23] *Ibid* at Part 3, para 12-14.

0. *Ibid* at Part 3, para 15-17.

[25] *Ibid* at Part 3, para 2.

[26] *Ibid* at Part 2, para 35.

[27] *Ibid* at Part 2, para 1-3.

[28] *Ibid* at Part 1, para 9 (identifying *Criminal Code* ss. 14, 21, 22, 222 and 241).

[29] *Ibid* at Part 1, para 6-7; Part 3, para 1-3.

competent adults,"[30] no age restriction was indicated.[31]

III.4 New plaintiff joins case

III.4.1 63 year old Gloria Taylor formally joined the action in August, 2011. She had been diagnosed in January, 2010 with amyotrophic lateral sclerosis ("ALS" or "Lou Gehrig's Disease") and advised that she would likely die within a year. The addition of Taylor to the case did not change the plaintiffs' arguments, but it strengthened the claim because she was a living person whose interests were directly affected by the existing law.[32] Her diagnosis also gave the plaintiffs the opportunity to argue for an expedited trial.

IV. The trial

IV.1 Summary trial process

IV.1.1 Over the objections of the governments of Canada and British Columbia, a summary trial rather than a conventional trial was held in November and December, 2011. A summary trial is a proceeding in which the evidence consists largely of affidavit evidence, legislative facts and expert opinion evidence. The judge agreed to a modified expedited summary trial because of Taylor's deteriorating condition and the inability of counsel for the plaintiffs to represent them *pro bono* in a lengthy conventional trial.[33]

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

IV.1.3 The plaintiffs did not pursue the claim that the prohibition of assisted suicide and euthanasia was a federal trespass on provincial jurisdiction.[34]

IV.2 Overview of the analytical method

IV.2.1 Justice Smith followed the analytical method established by precedent in adjudicating the claims of violations of constitutional guarantees of equality and life, liberty and security of the person.

IV.2.2 With respect to equality (*Charter* s. 15) the following questions were considered:

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[30] BC Civil Liberties Association, News Release, "BCCLA launches lawsuit to challenge criminal laws against medically-assisted dying" (26 April, 2011) [BCCLA News Release] online:<https://bccla.org/news/2011/04/611/>.

[31] *Notice of Claim*, *supra* note 19 at Part 1, para. 6-9.

[32] *Carter v. Canada (Attorney General)* 2012 BCSC 886 (Notice of Application and Amended Notice of Civil Claim), online:<../archive/documents/carter/2011-08-15-noticeofclaim02.pdf>.

[33] *Carter BCSC*, *supra* note 1 at para. 137-142.

[34] *Ibid* at para 29.

A. Is the law discriminatory? That is:

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

2) Does the distinction create a disadvantage?[35]

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

3) Is the purpose pressing and substantial?

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

a) Is the limit rationally connected with the purpose?

b) Does the limit minimally impair the *Charter* right?

c) Is the law proportionate in its effect?[36]

IV.2.3 Some aspects of the analysis of alleged violations of life, liberty and security of the person (*Charter* s. 7) overlapped with the s. 15 analysis:

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

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

a) Is the deprivation arbitrary?[37]

b) Is the law overbroad?[38]

c) Is the effect of the law grossly disproportionate to the problem it addresses?[39]

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

IV.2.4 There was some dispute about the necessity of this step (C) if a s. 7 violation were demonstrated, but this was a moot point because the judge stated that her conclusion would be identical to her conclusion in the s. 15 analysis (above).[40]

IV.3 Burden of proof

IV.3.1 With respect to equality claims under *Charter* s. 15, the burden of proof lay on the

[35] *Ibid* at para 1026.

[36] *Ibid* at para 1169.

[37] *Ibid* at para 1331-1332.

[38] *Ibid* at para 1339.

[39] *Ibid* at para 1373-1375.

[40] *Ibid* at para 1379-1383.

plaintiffs to show that the law was discriminatory. Under *Charter* s. 7 they had to prove that the law deprived them of life, liberty or security of the person and violated principles of fundamental justice.[41] Justice Smith noted that, with respect to the latter, the plaintiffs had to show either that the law was not the least restrictive that could have been chosen to achieve its purpose,[42] or that it was so extreme that it is "disproportionate to any legitimate government interest."[43]

IV.3.2 Once the plaintiffs had proved that the law was discriminatory and/or that it improperly deprived them of life, liberty or security of the person, the burden of proof shifted to the government. It had to prove that the infringement of rights or freedoms was demonstrably justifiable "in a free and democratic society" (*Charter* s. 1).[44]

IV.3.3 Subsequently, in *Canada (Attorney General) vs Bedford*, the Supreme Court of Canada clarified that, once the plaintiffs had proved that a law violates principles of fundamental justice, the burden of proof shifts to the government to prove under *Charter* s.1 that the law is not minimally restrictive or disproportionate.[45] This was advantageous to the plaintiffs when the trial court decision reached the Supreme Court of Canada in 2014.

IV.4 Standard of proof

IV.4.1 Neither plaintiffs nor defendants were required to provide "proof beyond reasonable doubt," the standard used in criminal prosecution. All that was required was proof on the balance of probabilities:[46] that a party produce evidence to show that something is more probably the case than not.[47] Empirical evidence is not required:

> While some matters can be proved with empirical or mathematical precision, others, involving philosophical, political an social considerations cannot. . . It is enough that the justification be convincing, in the sense that it is sufficient to satisfy the reasonable person looking at all the evidence and relevant considerations, that the state is justified in infringing the right at stake to the degree that it has.[48]

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

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[41] *Ibid* at para 1288.

[42] *Ibid* at para 1339, 1348, 1361.

[43] *Ibid* at para 1376.

[44] *Ibid* at para 952, 954, 1172, 1217.

[45] *Canada (Attorney General) vs Bedford*, 2013 SCC 72, 3 SCR 1101, online:<https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/13389/index.do> at para 125–127.

0. *Ibid* at para 1172, 1288, 1348.

[47] *F.H. v. McDougall*, 2008 SCC 53.

[48] *Sauve v. Canada (Chief Electoral Officer)* 2002 SCC 68 at para 18, quoted in *Carter BCSC*, *supra* note 1 at para 1178.

expert opinion.

IV.5 The evidentiary record

IV.5.1 The evidence received by the judge included 116 affidavits, some hundreds of pages long with secondary sources attached as exhibits, as well as other documents, all of which filled 36 binders. 18 witnesses were cross-examined.[49] The judge commented that the parties thoroughly reviewed the materials in their submissions.[50] She noted that Canada had been especially and unexpectedly thorough in identifying risks associated with legalization of assisted suicide.[51] While the timelines for the trial were tight, the defendant governments did not identify any evidence that they were unable to provide because of the summary trial process.[52] Justice Smith reviewed the entire evidentiary record, but did not refer to every affidavit or the evidence of every witness in her ruling.[53]

V. Judge's review of the evidence

V.1 Introduction

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

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

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

V.2.2 With respect to compliance with safeguards, the judge found that the process in Oregon was "working fairly well but could be improved,"[54] and compliance in the Netherlands was "continually improving" but not yet ideal.[55] Things were clearly less satisfactory in Belgium, where she acknowledged "low rates of reporting. . . and high rates of LAWER (Life ending Acts Without

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[49] *Carter BCSC*, *supra* note 1 at para 114.

[50] *Ibid* at para 115.

[51] *Ibid* at para 157.

[52] *Ibid* at para 144-145.

[53] *Ibid* at para 115.

[54] *Ibid* at para 653.

[55] *Ibid* at para 656.

Explicit Request)." However, she noted evidence that the incidence of LAWER had declined since legalization of euthanasia and assisted suicide.[56]

V.2.3 Concerning the effectiveness of safeguards, the judge concluded that there was no empirical evidence that legalizing assisted suicide and euthanasia had led to "a particular risk to socially vulnerable populations" in the Netherlands and Oregon.[57] She added that the evidence "does not support the conclusion that pressure or coercion is at all wide-spread or readily escapes detection" in those jurisdictions.[58] She found it difficult to reach a "firm conclusion" about Belgium, but noted evidence that elderly patients and patients with diseases of the nervous system were not proportionately at greater risk of LAWER.[59]

V.2.4 Summing up the evidence on the effectiveness of safeguards, Justice Smith noted that, with respect to the Netherlands, Belgium and Oregon, "the predicted abuse and disproportionate impact on vulnerable populations has not materialized,"[60] and, though the systems were not perfect, "empirical researchers and practitioners who have experience in those systems are of the view that they work well in protecting patients from abuse while allowing competent patients to choose the timing of their deaths."[61]

V.2.5 After reviewing the evidence of the impact of legal assisted suicide and euthanasia on palliative care[62] she decided that it showed that palliative care had not been undermined by legalization, but had in some respects improved.[63] However, she was reluctant to apply the findings directly to Canada [64] and concluded only that, while legalization could affect palliative care, the effect would not necessarily be negative.[65]

V.2.6 Similarly, she found that the evidence indicated that if assisted suicide and euthanasia were legalized, physician-patient relationships "would not necessarily change for the worse," and that "the net effect could prove to be neutral or for the good."[66]

V.2.7 Justice Smith succinctly summarized her findings:

> Research findings show differing levels of compliance with the safeguards and

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[56] *Ibid* at para 657.

[57] *Ibid* at para 667.

[58] *Ibid* at para 671.

[59] *Ibid* at para 672.

[60] *Ibid* at para 684.

[61] *Ibid* at para 685.

[62] *Ibid* at para 709-730.

[63] *Ibid* at para 731.

[64] *Ibid* at para 732-735.

[65] *Ibid* at para 736.

[66] *Ibid* at para 746.

> protocols in permissive jurisdictions. No evidence of inordinate impact on vulnerable populations appears in the research. Finally, the research does not clearly show either a negative or a positive impact in permissive jurisdictions on the availability of palliative care or on the physician-patient relationship.[67]

V.3 Feasibility of safeguards: risks to patients

V.3.1 In Part IX (paragraphs 748 to 853) the judge considered the evidence about the feasibility of safeguards and addressed the following topics:

a) patient competence

i) general considerations (para. 762-769)

ii) cognitive impairment (para. 770-784)

iii) depression (para. 785-798)

b) voluntariness (para. 799-815)

c) informed consent (para. 816-831)

d) patient ambivalence (para. 832-843)

e) the elderly (para. 844-847)

f) the disabled (para. 848-853)

V.3.2 While acknowledging the difficulties associated with ensuring that patients were competent to decide to seek assisted suicide or euthanasia, the judge decided "that it is feasible for properly-qualified and experienced physicians reliably to assess patient competence . . . so long as they apply the very high level of scrutiny appropriate to the decision and proceed with great care."[68]

V.3.3 In considering the issue of voluntariness and concerns that patients might be pressured into committing suicide, she accepted the evidence of defendant witnesses Gallagher, Chochinov, Heisel and Frazee concerning the subtley of influences that can be brought to bear on patients, but also accepted the evidence of plaintiff witnesses Ganzini and Donnelly "that coercion and undue influence can be detected as part of a capacity assessment."[69]

V.3.4 In the view of the judge, the evidence demonstrated that the issue of informed consent presented no more difficulty in the case of assisted suicide and euthanasia than in seeking or refusing medical treatment.[70] The conclusion was consistent with evidence from one of the plaintiff witnesses that "the risks and benefits of a lethal prescription are straightforward and not cognitively complex . . . The risk is that the prescription might not work; the benefit is that the patient's life will end at a

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[67] *Ibid* at para 9.

[68] *Ibid* at para 798.

[69] *Ibid* at para 815.

[70] *Ibid* at para 831.

time of her choosing."[71]

V.3.5 With respect to patient ambivalence about dying, the judge concluded "that it is feasible to screen out. . . patients who are ambivalent, by assessing capacity and requiring some time to pass between the decision and its implementation."[72]

V.3.6 Finally, while she recognized the elderly are vulnerable to abuse and that the disabled "face prejudice and stereotyping," the judge ruled "there is no evidence that the elderly access physician-assisted dying in disproportionate numbers in permissive jurisdictions"[73] and that the risks to the disabled could be "avoided through practices of careful and well-informed capacity assessments by qualified physicians who are alert to those risks."[74]

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

> My review of the evidence. . . leads me to conclude that the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced.[75]

VI. The legal analysis

VI.1 Suicide at common law

VI.1.1 That suicide can be deliberately chosen by someone who is of sound mind has long been recognized by the law, but the common law that came to Canada from England held that such an act was immoral and contrary to reason.[76] Subsequent changes to the law in Canada were intended to make it more effective in preventing suicide, not to create a right to suicide (VI.5.2). Indeed, the majority of the Supreme Court of Canada in *Rodriguez* suggested unconditional disapprobation when they observed that one reason for prohibiting physician assisted suicide is that to allow it "would send a signal that there are circumstances in which the state approves of suicide."[77] Consistent with

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[71] *Ibid* at para 775.

[72] *Ibid* at para 843.

[73] *Ibid* at para 853, 847.

[74] *Ibid* at para 853.

[75] *Ibid* at para 883.

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

[77] *Rodriguez*, *supra* note 13 at 608.

this, many people continue to believe that suicide, while not blameworthy if it results from severe mental or emotional disorder, is immoral or unethical if deliberately chosen, and should always be prevented.

VI.2 Ethical underpinnings

VI.2.1 The trial judge's reasoning in *Carter* began with the fact that neither suicide nor attempted suicide were illegal.[78] Before considering whether or not the law against physician-assisted suicide and euthanasia should be struck down, she reviewed the "ethical debate" about assisted suicide in Part VII of the ruling.[79]

VI.2.2 Contrary to claims later made by lead appellant counsel Joseph Arvay at the Supreme Court of Canada,[80] the judge did not rely upon this review in reaching her conclusions about the constitutionality of the law, and it was problematic for a number of reasons (see Appendix "B" and "C"). It is here submitted that Part VII of the ruling has neither authority nor persuasive force with respect to the issues in *Carter*.

VI.2.3 This rested on the belief that suicide could be ethical. The logically prior discussion of the ethics of suicide was avoided because the plaintiffs had brought a case for *assisted* suicide and euthanasia[81] (thus assuming the acceptability of suicide) and Justice Smith expressly adopted this approach in her analysis.

> [T]he focus is not on whether it is ethical for persons to make a request for assistance in death. The ethics of suicide *per se* are not at issue.[82]

VI.2.4 The ethics of suicide were not at issue only because the judge accepted the assumption implicit in the plaintiffs' claim: that suicide can be ethically or morally acceptable — not that it

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[78] *Carter BCSC*, *supra* note 1 at para 102-107. As the judge explicitly stated (para 103-105), it was the offence of *attempted* suicide — not suicide — that was abolished in 1972. Suicide was an offence at common law in England at Confederation and was thus part of criminal law at that time, but was arguably abolished as an offence in Canada with the enactment of the first *Criminal Code* in 1892, which codified only the offence of attempted suicide (See *Criminal Code*, 55-56 Victoria, c 29, online: <https://www.canadiana.ca/view/oocihm.9_02094/2>, s 238. It was certainly abolished when Parliament explicitly abolished all common law offences in 1955 (*Criminal Code*, *supra* note 3 at s 9).

[79] *Ibid* at para 161-884.

[80] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 (Oral argument, Appellant), 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 webcast*] at 00:38:35 to 00:40:31

[81] *Carter BCSC*, *supra* note 1 at para 175; *Notice of Civil Claim*, *supra* note 19 at Part 2, para. 1–3 and Part 3, para 12–14.

[82] *Ibid* at para 175, 180–181.

always is, but that it *can* be.[83]

VI.2.5 None of the defendants or interveners supporting the law contested the premise that suicide can be rational and moral, even to the limited extent of arguing that the ethics/morality of suicide cannot be established without reference to an ethical/moral framework provided by philosophy or religion.[84]

VI.2.6 Unexpressed disagreement was perhaps implicit in at least some of the more generic statements, such as those offering support for "the sanctity of life" (British Columbia)[85] the "inviolability principle" (Christian Legal Fellowship)[86] and the assertion that "human life is intrinsically valuable and inviolable" (Euthanasia Prevention Coalition).[87] The nearest approach to a challenge appears to have come in a later part of the case from Canada, which asserted that "suicide is not a fundamental institution" and emphasized that "suicide is not condoned, let alone recognized as a legal right."[88] However, Canada also argued that disabled people were not disadvantaged by the prohibition of assisted suicide because they could still commit suicide "by refusing treatment, hydration or nutrition," which implied that suicide could be considered advantageous.[89]

VI.2.7 The judge believed that suicide could be ethical if it resulted from a "sound, rational and well reasoned" decision by someone not suffering from clincial depression, mental illness, substance abuse, trauma or similar psychosocial factors.[90] The latter she appears to have classed as

[83] *Ibid* at para 339. The judge used the term "ethical," not "moral," and more frequently employed the former, but she treats them as synonyms when addressing the question, "Does the law attempt to uphold a conception of morality inconsistent with the consensus in Canadian society?" (*Ibid* at para 340-358). Moreover, witnesses on both sides did not typically distinguish between ethical and moral issues. See, for example, Dr. Shoichet (plaintiffs) at para 75, Prof. Sumner (plaintiffs) at para 237, Dr. Bereza (defendants) at para 248, Dr. Preston (plaintiffs) at para 262.

[84] "One justification for the different legal treatment of suicide and assisted suicide is that suicide is essentially a private act and should be judged according to one's own morality." Margaret Somerville, *Death Talk: The Case Against Euthanasia and Physician-Assisted Suicide* (2001: Queen's University Press, Montreal & Kingston) [*Somerville 2001*] at 103.

[85] *Carter BCSC*, *supra* note 1 at para 169.

[86] *Ibid* at para 171.

[87] *Ibid* at para 172.

[88] *Ibid* at para 1146–1147.

[89] *Ibid* at para 1049.

[90] *Ibid* at para 813-814.

"traditionally-defined suicide,"[91] — "suicide arising out of mental illness or transitory sadness."[92] She agreed that it would be rational to choose suicide in order to avoid serious future evils.[93]

VI.2.8 The belief that suicide can be ethical implies that *assisted* suicide can be ethical. Thus, the judge said that where suicide is ethical, the distinction between suicide and assisted suicide "vanishes" when "the patient's decision for suicide is entirely rational and autonomous, it is in the patient's best interest, and the patient has made an informed request for assistance."

> The physician provides the means for the patient to do something which is itself ethically permissible. It is unclear, therefore, how it could be ethically impermissible for the physician to play this role.[94]

VI.2.9 In addition, ethical conduct is associated with the good, either because it is protective of certain goods or because it involves the pursuit of them. Thus, a belief that suicide is ethical naturally invites the conclusion that it is beneficial: "in the patient's best interest." The plaintiffs asserted that suicide can be in the best interest of a patient if it prevents or avoids needless suffering.[95] Indeed, the basis of their case was that the prohibition of assisted suicide denied them a good to which they were entitled, and to which others had access.

VI.2.10 The belief that suicide could be ethical and beneficial effectively shifted the rhetorical burden of proof to those opposed to assisted suicide. It put them in the position of having to argue against allowing people access to something that could be ethical and beneficial. This may explain, in part, why Professor Margaret Somerville, upon reading the judgement, was left with "a strong impression that [the judge] is far from neutral about physician-assisted suicide and euthanasia" and that she favoured the interventions in some cases.[96]

VI.2.11 If, in circumstances in which suicide and assisted suicide were ethical (and, thus, beneficial), and the person seeking suicide were unable to perform the lethal act even with assistance, euthanasia in response to a request from that person would seem to be ethical and beneficial.[97] Thus, beginning with the premise that suicide can be ethical and beneficial, one can

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[91] *Ibid* at para. 812, 827. The judge later applied this distinction (para 833) in referring to evidence from the plaintiffs' witness: "[W]hile it is possible for a person who is grievously and irremediably ill to be 'suicidal' in the traditional sense, this is not necessarily the case for those seeking physician-assisted death and it cannot be assumed to be so. Instead, the decisions often reflect long-held, deep-seated values and are rational, consultative, informed and considered." Note that the "traditional" view applied by the judge was narrower than the older common law approach, which encompassed both culpable and non-culpable suicide.

[92] *Ibid* at para 1262.

[93] *Ibid* at para 842.

[94] *Ibid* at para. 339, citing plaintiff witness Professor Wayne Sumner; *Ibid* at para 237.

[95] *Ibid* at para 234 (Sumner).

[96] Margaret Somerville, "Legalizing Euthanasia: Evolution or Revolution in Societal Values?" in Margaret Somerville, *Bird on an Ethics Wire: Battles about Values in the Culture Wars* (Montreal & Kingston: McGill-Queen's University Press, 2015) [*Somerville 2015*] at 120.

[97] *Carter BCSC*, *supra* note 1 at para 234-236 (plaintiff witness Sumner), 242 (plaintiff witness Upshur).

conclude that assisted suicide and euthanasia can be ethical and beneficial. This ethical equivalence was arguably implicit in the plaintiff's definition of "assisted dying," which included both assisted suicide and voluntary euthanasia[98] and which was adopted by Justice Smith.[99]

VI.2.12 This chain of reasoning can be broken between suicide and assisted suicide. Even if suicide *per se* can be ethical, it can be argued that assisting suicide is a different kind of act because "it is action not by a person on herself but by one person upon another."[100]

VI.2.13 On the basis of this distinction, it can be argued that, whatever the ethical status of suicide, assisted suicide is unethical if it entails harm for others or society not entailed by suicide *per se*. It can also be argued that assisted suicide is unethical if it entails the *risk* of harm for others or society. In either case, however, harm must be defined, and proof of harm or risk is required to make good the ethical argument. It is also necessary to establish what level of risk or harm is ethically unacceptable.

VI.2.14 That was the tack taken by the defendant governments and interveners and the focus of much of the evidence and argument. However, the effect of the premise that suicide can be moral and rational (and thus beneficial, not harmful) escaped the notice of the parties as they argued points of law and legal principle, and none appear to have recognized that it was in play in the legal arguments and evaluation of the evidence. This reflects part of the significance of the ethical underpinnings of the *Carter* trial court ruling described here. Like the falsework used to support a masonry arch while the stones are being laid, it was essential in constructing the judgement and implied in the shape of the finished product.

VI.2.15 The ethical underpinning was important for another reason. Faced with moral/ethical problems, people naturally choose what they believe to be good, or the best among competing goods, and reject what they believe to be evil.[101] Particularly when serious moral or ethical issues are in play (as they are when the subject is killing people or helping them to commit suicide), a judge will either assume or construct a moral or ethical justification that supports a decision. This is unlikely to be articulated in argument or in the ruling, but it may well determine the outcome by influencing the evaluation of evidence and legal reasoning. In *Carter* the traces of this are found in Part VII, where the judge erected the ethical falsework used in the construction of the judgement.

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[98] *Ibi*d at para 23.

[99] *Ibid* at para 39.

[100] *Ibid*, at para 237 (plaintiff witness Sumner). Margaret Somerville made particular note of this point in her critique of the ruling: see Somerville 2015, supra note 95 at 129-130.

[101] They may be culpably or non-culpably mistaken in identifying the good, or culpably or non-culpably fail to pursue it, but this does not affect the natural orientation of moral reasoning toward something thought to be good in some sense.

Fleming v Ireland & Ors

VI.2.17 That this happened in the *Carter* trial court is supported by a review of *Fleming v Ireland & Ors*, a 2013 decision in which the High Court of Ireland considered but declined to follow the *Carter* trial court decision.[102]

VI.2.18 Arguing in the *Carter* appeal at the Supreme Court of Canada, Joseph Arvay claimed that the Irish High Court had reached a different conclusion because "there was either no evidence or very little evidence, and indeed, whatever evidence there was was a fraction of the evidence that was before the [*Carter*] trial judge."[103] However, the Irish High Court stated that "detailed evidence available to us" demonstrated "an ample evidential basis" to support absolute prohibition of assisted suicide, and that, in reviewing the *Carter* trial court decision, it had "reviewed the same evidence and . . . drawn exactly the opposite conclusions."[104]

VI.2.19 *Fleming* can be distinguished from *Carter* in a number of respects, including the differences between Canadian and Irish jurisprudence on proportionality,[105] claims and counterclaims as presented,[106] the quality of evidence provided by defendant witnesses[107] and the acuity of government counsel, at least as reflected in the judgement.[108] Such differences may well have contributed to the different outcome.

VI.2.20 Nonetheless, the Irish court made a number of striking statements that reflect underlying ethical views about suicide quite different from what is found in *Carter*. Notably, the High Court in *Fleming* stated:

> It is nevertheless idle to suggest that even the intentional taking of another's life – even if this is consensual — or actively assisting them so to do does not have objective moral dimensions.[109]

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[102] *Fleming v. Ireland & Ors* [2013] IEHC 2, (Ireland), online: <(http://www.bailii.org/ie/cases/IEHC/2013/H2.html> [*Fleming*].

[103] *Carter SCC webcast*, *supra* note 80 at 00:08:23 to 00:09:04.

[104] *Fleming*, *supra* note 103 at Summary of judgement, para 5, 7.

[105] *Ibid* at para. 87, 90.

[106] The Irish government asserted that the Irish Constitution did not "expressly or implicitly" provide a right to die, while the Human Rights Commission claimed that people have a right to take their own lives in "defined and extreme" circumstances (*Ibid*, at para 6, 9). These sharply contrasting statements may have enabled the Irish judges to see and approach key issues differently.

[107] The evidence of defendant witnesses Dr. Tony O'Brien (*Ibid* at para 34–41) and Professor Robert George (*Ibid* at para 42–47) appears to have been clearer and stronger on palliative care, the use of opioids, sedation, palliative sedation and the likely efficacy of safeguards than that offered by defendant witnesses in *Carter*, although this could also reflect differences in the receptivity to and reporting of the evidence by the judges.

[108] Cross examination of Professor Margaret Pabst Battin, who was also a plaintiff witness in the *Carter* trial, may have been more effective (*Ibid* at para 30-33).

[109] *Ibid* at para 69.

VI.2.21 In the same paragraph, far from assuming that suicide could be an ethical act or a benefit, the Court referred to "obvious and self-evident considerations" against legalization of assisted suicide, including "deterring suicide and anything that smacks of the 'normalisation' of suicide."[110]

VI.2.22 The Irish court also strongly and repeatedly emphasized that "there is an enormous and defining difference" between discontinuing medical treatment to allow a patient to die a natural death and physician assisted suicide.[111]

VI.2.23 Considering evidence of the practice of euthanasia and assisted suicide in Belgium, the Netherlands and Switzerland, as well as Justice Smith's discussion of the evidence, the Court rejected her conclusions.

> [W]e would simply observe in this general regard that she herself acknowledged that compliance with essential safeguards in the Netherlands — more than thirty years after liberalisation — was "not yet at an ideal level." In fact, it might well be said that this is altogether too sanguine a view and that the fact such a *strikingly high level* of legally assisted deaths without explicit request occurs . . . *without any obvious official or even popular concern speaks for itself as to the risks involved in any such liberalisation*.[112] (Emphasis added)

VI.2.24 Consistent with this, the Court had earlier observed that "that relaxing the ban on assisted suicide would bring about a paradigm shift with unforeseeable (and perhaps uncontrollable) *changes in attitude and behaviour to assisted suicide* struck the Court as compelling and *deeply worrying*."[113] (Emphasis added)

VI.2.25 What is of particular interest in these passages is the stress placed on the need to maintain an attitude unfavourable to assisted suicide, and on the High Court's obvious disapproval of popular and official attitudes about potentially non-voluntary euthanasia where euthanasia is allowed. That the Court found it "deeply worrying" to contemplate a shift of popular opinion in favour of assisted suicide strongly indicates an ethical outlook decidedly unsuited to constructing a legal argument favourable to euthanasia.

VI.2.26 There is also reason to believe that the apparent difference in ethical beliefs affected the evaluation of evidence and the conclusions drawn from it. The passage above demonstrates that the Irish court and Justice Smith, relying on exactly the same evidence, came to radically different conclusions about the risks presented by legalization of assisted suicide and euthanasia. Similarly, while the Irish court found the absence of concern in Belgium and the Netherlands "deeply worrying," Joseph Arvay, counsel for the plaintiffs in *Carter*, told the Supreme Court of Canada that the absence of concern demonstrated that there was "no slippery slope in Belgium."[114]

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[110] *Ibid*.

[111] *Ibid* at para 53, 55, 93.

[112] *Ibid* at para 104.

[113] *Ibid* at para 67.

[114] *Carter SCC webcast*, *supra* note 80 at 00:24:08 to 00:24:29.

VI.3 Finding of "discrimination"

VI.3.1 With respect to the issue of discrimination, the judge observed that the able-bodied can (ethically) commit suicide[115] without assistance in order to relieve themselves of the burden of pain or suffering, and are not hampered by the law in so doing. In contrast, she said, disabled people may not be able to commit suicide without assistance, and are thus forced to carry a burden of pain or suffering,[116] a burden she graphically illustrated by reference to the evidence.[117] She decided that the law, though neutral on its face, disproportionately affected disabled people,[118] thus creating a distinction based on physical disability.[119] Justice Smith concluded that the distinction was discriminatory because it disadvantaged a particular subset of persons (the disabled)[120] by perpetuating and exacerbating their disadvantages.[121]

VI.4 The question of justification

VI.4.1 Having decided that the law against assisted suicide was discriminatory because it violated the *Charter* guarantee of equality (s. 15), the judge asked if it could, nonetheless, be "demonstrably justified" as a "reasonable limit" to the rights and freedoms of disabled people.[122]

> . . . it is the absolute nature of the prohibition against assisted suicide that requires justification, not the prohibition overall. In other words, the real question is whether or not the defendants have demonstrated justification for criminalizing the rendering of assistance in suicide to persons such as Gloria Taylor.[123]

VI.4.2 The analysis here required the judge to determine whether or not the purpose of the law was "pressing and substantial," if the prohibition imposed by the law was "rationally connected with the purpose," if it minimally impaired the *Charter* right or freedom, and if it was proportionate in its effect.[124]

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[115] The qualification "ethically" is implicit in the reasoning but not stated.

[116] *Carter BCSC*, *supra* note 1 at para 1039–1050, 1064.

[117] *Ibid* at para. 258, 1277– 278.

[118] *Ibid* at para 1032–1036.

[119] *Ibid* at para 1156.

[120] *Ibid* at para 1159.

[121] *Ibid* at para 1161.

[122] *Ibid* at para 1163–1168.

[123] *Ibid* at para 1171.

[124] *Ibid* at para 1169.

VI.5 Purpose of the law

VI.5.1 There was some discussion about ethical principles that inform the law. Canada was somewhat incoherent on this point. It claimed that an ethical position is irrelevant to the legal issues, but then said that the preservation of human life "is a fundamental value," as if that statement had no ethical content. In any case, it argued that the criminal law embodied the state's interest in preserving human life by not condoning the taking of human life.[125] British Columbia suggested the principle of "the sanctity of life" as fundamental,[126] while the Christian Legal Fellowship put forward the "inviolability principle" – "that the intentional taking of innocent human life is always wrong."[127] Similarly, the Euthanasia Prevention Coalition stated that "human life is intrinsically valuable and inviolable."[128]

VI.5.2 All of these principles could have been applied to make the case that suicide was always wrong or at least always undesirable, and that the purpose of the law and goal of public policy was to prevent *all* suicides. This approach would have been entirely consistent with the origin of the law.[129] It would also have been consistent with the rationale for abolishing the offence of attempted suicide; the law was changed because it was thought that the intervention of medical experts rather than magistrates would be more effective in preventing suicide.[130] Finally, it would have been consistent with some key statements in *Rodriguez* (see the italicized passages in VI.5.5).

VI.5.3 However, the judge observed that many of the defendant witnesses "[did] not base their opinions upon the need to uphold the sanctity of human life, or on that alone."[131] None of the parties explicitly argued that the purpose of the law was to prevent all suicides, and none addressed the morality of suicide, probably because the subject was not one that could be argued effectively in a judicial environment permeated by secularism and moral pluralism. Note, however, that the failure to address the morality of suicide did not produce a judicial forum cleansed of moral beliefs. It simply allowed the moral belief that suicide could be acceptable to set the parameters for argument and adjudication.

VI.5.4 While Canada agreed that protecting vulnerable people was one of the purposes of the

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[125] *Ibid* at para 168, 1147, 1187.

[126] *Ibid* at para 169.

[127] *Ibid* at para 171.

[128] *Ibid* at para 172.

[129] "[T]he law of England widely and religiously considers, that no man hath a power to destroy life, but by commission from God, the author of it:and, as the suicide is guilty fo a double offence; one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes, making is a peculiar species of felony, a felong committed on one's self. And this admits of accessories before the fact, as well as other felonies; for if one persuades another to kill himself, and he does so, the adviser is guilty of murder." *Blackstone*, *supra* note 75 at 188.

[130] *Carter BCSC*, *supra* note 1 at para 105, 1146.

[131] *Ibid* at para 352.

law, it claimed that the law also had other valid objectives: preventing damage to physician-patient relationships, preventing adverse impacts on palliative care, and – citing *Rodriguez* — preventing the spread of negative messages about the value of human life.[132]

VI.5.5 "Preventing the spread of negative messages about the value of human life" was consistent with the majority opinion in *Rodriguez*, which accepted the policy of the state "that human life should not be depreciated by allowing life to be taken." However, this and similar statements (in italics below) were interconnected in *Rodriguez* with emphasis on "the protection of the vulnerable" (underlined below):

> The issue here, then, can be characterized as being whether the blanket prohibition on assisted suicide is arbitrary or unfair in that it is unrelated to the state's interest in protecting the vulnerable, and that it lacks a foundation in the legal tradition and societal beliefs which are said to be represented by the prohibition.
>
> Section 24l(b) has as its purpose the protection of the vulnerable who might be induced in moments of weakness to commit suicide. This purpose is grounded in the state interest in protecting life and reflects *the policy of the state that human life should not be depreciated by allowing life to be taken. . . . This is not only a policy of the state, however, but is part of our fundamental conception of the sanctity of human life.*[133]

And later:

> Creating an exception for the terminally ill might therefore frustrate the purpose of the legislation of protecting the vulnerable because adequate guidelines to control abuse are difficult or impossible to develop.[134]

And again, comparing the abolition of capital punishment to the blanket prohibition against assisted suicide:

> This prohibition [of capital punishment] is supported, in part, on the basis that *allowing the state to kill will cheapen the value of human life and thus the state will serve in a sense as a role model for individuals in society*. The prohibition against assisted suicide serves a similar purpose. In upholding the respect for life, it may discourage those who consider that life is unbearable at a particular moment, or who perceive themselves to be a burden upon others, from committing suicide. *To permit a physician to lawfully participate in taking life would send a signal that there are circumstances in which the state approves of suicide.* [135]

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[132] *Ibid* at para 1185, 1187

[133] *Rodriguez*, *supra* note 13 at 595. Note that "purpose" in relation to the law against assisted suicide is singular.

[134] *Ibid* at 601. Again, note that "purpose" is singular.

[135] *Ibid* at 608.

VI.5.6 The judge did not ignore Canada's argument,[136] but subtly reminded Canada that it had insisted that she was bound to follow the *Rodriguez* judgement,[137] and then purported to follow *Rodriguez* by rejecting the additional purposes suggested by Canada.

VI.5.7 Citing the Supreme Court of Canada, Justice Smith stated that the purpose of legislation "should be stated as precisely and as specifically as it can be."[138] She quoted the "terse language" of *Rodriguez* that, she said, "captured the very essence of the purpose" of the law: "Section 24l(b) has as its purpose the protection of the vulnerable who might be induced in moments of weakness to commit suicide."[139]

VI.5.8 Consistent with her belief that suicide could be a rational and ethical act, the judge concluded that the sole purpose of the law against assisted suicide was to prevent suicides by vulnerable people who, in a moment of weakness, might succumb to suggestions or pressures by others.[140] In other words, it was not the purpose of the law to prevent suicide by the likes of Gloria Taylor, or by absolutely everyone. The law was meant to protect only those who might be pressured to commit suicide and might do so for irrational reasons. The judge agreed that this was a "pressing and substantial" purpose,[141] and that the means (absolute prohibition) was rationally connected to this end.[142]

VI.5.9 The judge's narrow construction of the purpose of the law reflected common ground among the parties to the case,[143] and the presumption — unchallenged by any of them — that suicide can be an acceptable act. It was at the next stage of the analysis that the differences among the parties became apparent.

VI.6 Minimal impairment: the meaning of "effective"

VI.6.1 Once the judge had decided that the law was discriminatory, the burden of proof shifted to the defendant governments.[144] It was up to them to demonstrate that nothing short of absolute prohibition could achieve the objective of protecting vulnerable people, and that there was no alternative that would "less seriously [infringe] the *Charter* rights of Gloria Taylor and others in her

[136] *Carter BCSC*, *supra* note 1 at para 1191.

[137] *Ibid* at para 1187 ("In submissions that I take to be alternative to its main submission that *Rodriguez* is binding. . . ").

[138] *Ibid* at para 1189.

[139] *Ibid* at para 1184, 926.

[140] *Ibid* at para 16, 926, 1116, 1126, 1166, 1184-1185, 1187-1188, 1190, 1199, 1348, 1362.

[141] *Ibid* at para 1202-1206

[142] *Ibid* at para 1207-1210.

[143] *Ibid* at para 237, 339, 1124, 1136, 1185, 1190, 1362.

[144] *Ibid* at para 1172.

situation."[145]

VI.6.2 This was precisely what the defendants did claim. Canada, supported by British Columbia, the CLF and EPC, attempted to prove that "nothing short of a blanket prohibition against assisted dying is sufficient to protect vulnerable individuals."[146]

VI.6.3 The defendants could have accomplished this by demonstrating that safeguards were ineffective in jurisdictions where assisted suicide and euthanasia were legal, or that such safeguards were not feasible in Canada, or, at the very least, that the evidence was inconclusive with respect to the effectiveness or feasibility of safeguards. However, on this critical issue, it appears from the text of the ruling that the evidence of the defendants' witnesses could not match that of the plaintiff witnesses (See Appendix "A").

VI.6.4 There was another problem. How was "effectiveness" to be measured?

VI.6.5 The assertion that only a blanket prohibition could be effective rested on the premise that even one 'wrongful' death[147] was too many: that safeguards could be considered effective only if they absolutely eliminated any possibility of error.[148] By way of analogy, Canada asserted that capital punishment was abolished in Canada because of concern about the possibility of error.[149] This was at least doubtful as a matter of history.[150] The claim was not supported by the submissions of British Columbia[151] or the Supreme Court of Canada in the *Rodriguez* decision.[152]

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[145] *Ibid* at para 1232.

[146] *Ibid* at para 359

[147] The judge rejected the term "wrongful death," but, for the sake of convenience, she nonetheless used it in the ruling (*Ibid* at para 755 - 758).

[148] *Ibid* at para 1192-1196, 1230, 1236, 1349, 1351.

[149] *Ibid* at para 1193.

[150] The possibility of error does not seem to have been a significant factor when abolition occurred. The government had a *de facto* policy of commuting all death sentences to life imprisonment. However, in the summer of 1976 it was faced with the prospect of having to review the death sentences of four men who had unquestionably murdered policemen in circumstances that provided no publicly acceptable rationale for commutation. Two had "set out with a rifle . . . hunted until they found a policeman" and shot him. (*R v Miller*, 63 DLR (3d) 193 at 250, online: <https://canlii.ca/t/gcf2r>), and two had murdered two policemen in New Brunswick. The trial judge in the latter case said that there were no extenuating circumstances to justify a recommendation for the royal prerogative of mercy ("Moncton hangings delayed" Montreal Gazette (10 June, 1975), online: <http://news.google.com/newspapers?nid=1946&dat=19750610&id=65AjAAAAIBAJ&sjid=jKEFAAAAIBAJ&pg=1179,2665552>; Esther Crandall, "Death penalty bill stirs Canadian controversy" *The Bangor Daily News* (9 June, 1975), online:<https://www.newspapers.com/image/663589187/?>). Seven other men were also awaiting execution when capital punishment was abolished (Persons sentenced to death in Canada, 1867-1976 : an inventory of case files in the fonds of the Department of Justice / Lorraine Gadoury and Antonio Lechasseur, Ottawa, National Archives of Canada, online: <https://publications.gc.ca/collections/collection_2017/bac-lac/SB4-46-1994-eng.pdf>).

[151] *Carter BCSC supra* note 1 at para 169, 284.

[152] *Ibid* at para 1190.

VI.6.6 Justice Smith rejected the analogy.[153] More important, she rejected the standard of absolute inerrancy altogether, accepting the plaintiffs' argument that this "zero tolerance standard [is] so extreme that no claimant could ever succeed in a challenge under the *Charter*."[154] Instead, recalling the narrowly construed purpose of the law, she accepted the plaintiffs' argument that the objective of the law could not possibly be to prevent *all* 'wrongful' deaths, because 'wrongful' deaths could occur as a result of accepted but unregulated end-of-life practices like refusing or withdrawing treatment.[155] Considering the problem strictly from the perspective of risk management, she explained:

> In my view, the evidence supports the conclusion that the risks of harm in a regime that permits physician-assisted death can be greatly minimized. Canadian physicians are already experienced in the assessment of patients' competence, voluntariness and non-ambivalence in the context of end-of-life decision-making. It is already part of sound medical practice to apply different levels of scrutiny to patients' decisions about different medical issues, depending upon the gravity of the consequences.[156]

VI.6.7 Combined with the narrow construction of the purpose of the law, the rejection of the "zero tolerance" standard was fatal to the defendants' case. Their witnesses produced evidence of risk, and the judge was willing to accept that evidence,[157] but the problem was judicially defined as one of managing or reducing risk, not eliminating it altogether.

> The scrutiny regarding physician-assisted death decisions would have to be at the very highest level, but would fit within the existing spectrum. That spectrum already encompasses decisions where the likely consequence of the decision will be the death of the patient.[158]

VI.6.8 Thus, Justice Smith ruled that the defendant governments had failed to prove that the protection of vulnerable persons could not be achieved by means less drastic than absolute prohibition.

> Permission for physician-assisted death for grievously ill and irremediably suffering people who are competent, fully informed, non-ambivalent, and free from coercion or duress, with stringent and well-enforced safeguards, could achieve that objective in a real and substantial way.[159]

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[153] *Ibid* at para 1200, 1356.

[154] *Ibid* at para 1353.

[155] *Ibid* at para 435, 1198-1199, 1230–1231, 1237.

[156] *Ibid* at para para. 1240.

[157] *Ibid* at para 653, 815.

[158] *Ibid* at para 1240.

[159] *Ibid* at para 1243.

VI.7 Proportionality

VI.7.1 Granted a finding of more than minimal impairment, the next stage in the analysis required the Court to consider the possibility that the limitations imposed by law were, nonetheless, justified by the benefits it provided.[160] At this stage the judge considered Canada's claims (rejected with respect to the purpose of the law) that absolute prohibition of assisted suicide provided benefits that outweighed any burdens it might impose: "promoting the value of every life, preserving life, protecting the vulnerable, preventing abuses, maintaining the physician-patient relationship . . . promoting palliative care," and preventing 'wrongful' deaths.[161]

VI.7.2 Returning to her review of the evidence, Justice Smith held that absolute prohibition of assisted suicide had "the advantage of simplicity and clarity,"[162] but that the evidence failed to show that it clearly benefitted patients, physicians, or palliative care.[163] She speculated that there might be some benefit to regulating a practice that occurs from time to time despite the prohibition.[164] But she was quite clear that, in her view, absolute prohibition of assisted suicide imposed a disproportionate burden on the disabled.[165] The alleged benefits of prohibition, she said, were experienced "by unknown persons who may be protected" from a variety of ills, while the burdens were experienced "by persons who are in the position of Sue Rodriguez or Gloria Taylor, and are considerable."[166]

VI.7.3 Ultimately, she agreed that absolute prohibition probably had salutary effects in comparison to no prohibition,[167] and admitted that suicide and attempted suicide were "serious public health problems."[168] Nonetheless, she ruled that "the salutary effects of the legislation can be preserved by leaving an almost-absolute prohibition in effect, and permitting only stringently-limited exceptions."[169]

VI.8 Life, liberty and security of the person

VI.8.1 The s. 7 claims of violations of liberty and security of the person in *Carter* differed from those in *Rodriguez* because the plaintiffs included not only Gloria Taylor, who was seeking assisted suicide or therapeutic homicide for herself, but Hollis Johnson and Lee Carter, who had arguably assisted in the suicide of Lee Carter's mother, and were thus at least theoretically liable to

[160] *Ibid* at para 1246.

[161] *Ibid* at para 1247–1249; 1252.

[162] *Ibid* at para 1268 .

[163] *Ibid* at para 1269 274.

[164] *Ibid* at para 1282.

[165] *Ibid* at para 1264, 1277–279, 1281.

[166] *Ibid* a tpara 1275–1276.

[167] *Ibid* at para 1267.

[168] *Ibid* at para 1265.

[169] *Ibid* at para 1283.

prosecution and imprisonment.[170]

VI.8.2 There was no dispute that the law against assisted suicide engaged the liberty interests of Johnson and Carter.[171] After considering objections made by Canada,[172] Justice Smith ruled that the law deprived Gloria Taylor of liberty and security of the person by interfering with her personal autonomy and control over her bodily integrity.[173]

VI.8.3 Turning to the guarantee of the right to life, Canada argued "that the right to life does not include the right to choose death,"[174] insisting that court rulings had "consistently recognized that the right to life protects individuals from death or the risk of death" and do not confer "a right to die."[175]

VI.8.4 Justice Smith agreed "that the right to life is engaged only when there is a threat of death,"[176] but added (apparently as a kind of extension of that principle) that the prohibition of assisted suicide "has the effect of shortening the lives of persons who fear that they will become unable to commit suicide later, and therefore take their lives at an earlier date than would otherwise be necessary,"[177] an argument obviously reflecting the fundamental premise that committing suicide can be an acceptable (so conceivably "necessary") act.

VI.8.5 Before considering whether or not the deprivations of life, liberty and security of the person could be justified, the judge commented briefly on the nature of the deprivations.

VI.8.6 Concerning people like Gloria Taylor, the judge made a number of assertions.

- They would have shorter lives if they chose to kill themselves sooner rather than take the chance that they would be unable to have assistance later;[178]
- They were denied the opportunity to choose something that may be very important to them, and "their ability to discuss and receive support in this choice from their physicians is impaired."[179] (Particularly in light of evidence before the court of physician opposition to assisted suicide, it is remarkable that the judge assumed — or perhaps *expected* — that their physicians would always be supportive.)
- The physically disabled were denied the autonomy of the able-bodied, and thus

[170] *Ibid* at para 940.

[171] *Ibid* at para 1294,1304.

[172] *Ibid* at para 1296–1297.

[173] *Ibid* at para 1303, 1304.

[174] *Ibid* at para 1314.

[175] *Ibid* at para 1315.

[176] *Ibid* at para 1320.

[177] *Ibid* at para 1322.

[178] *Ibid* at para 1325.

[179] *Ibid* at para 1326.

"deprived of a measure of self-worth."[180]

- Palliative care may be unavailable or unacceptable, so that they may continue to experience pain and suffering.[181]
- They suffered stress because they were unable to have the comfort of knowing that assisted suicide or euthanasia would be available if they so chose.[182]

VI.8.7 The judge concluded that the absolute prohibition of assisted suicide violated Gloria Taylor's right to life "because it may shorten her life."

> Ms. Taylor's reduced lifespan would occur if she concludes that she needs to take her own life while she is still physically able to do so, at an earlier date than she would find necessary if she could be assisted.[183]

VI.8.8 The possibility that the law was arbitrary was the first point to consider in determining whether or not such deprivations were in accordance with the principles of fundamental justice. The Supreme Court had decided in *Rodriguez* that the law was not arbitrary, and the judge accepted that ruling.[184]

VI.8.9 The concept of "overbreadth" re-stated in a slightly different form the principle of minimal impairment. As the law then stood (see IV.3.3), the burden of proof was on the plaintiffs, not the defendants. The plaintiffs had to prove that a blanket prohibition was "broader than is necessary to achieve the state's goal of preventing vulnerable persons from being induced, in moments of weakness, to commit suicide."[185] The judge's analysis on this point was essentially the same as her reasoning on "minimal impairment," discussed above. She reiterated her findings that the evidence

- did not demonstrate that physicians were insufficiently skilled at assessing patients;[186]
- did not demonstrate that, where assisted suicide and therapeutic homicide were legal, that patients were abused, that physicians had become careless or callous, or that a "slippery slope" existed;[187]
- did not demonstrate that assisted suicide and euthanasia were inconsistent with

[180] *Ibid* at para 1327.

[181] *Ibid* at para 1328.

[182] *Ibid* at para 1329.

[183] *Ibid* at para 17.

[184] *Ibid* at para 1337.

[185] *Ibid* at para 1348.

[186] *Ibid* at para 1365, 1367.

[187] *Ibid* at para 1366–1367.

medical ethics;[188]

- supported the conclusion that a "very small number" of cases of assisted suicide and euthanasia occur despite prohibition, and the belief that legalizing and strictly regulating the procedures "would probably greatly reduce or even eliminate such deaths."[189]

VI.8.10 Finally, Justice Smith ruled that the adverse effects of the absolute prohibition of assisted suicide were "grossly disproportionate to its effect on preventing the inducement of vulnerable people to commit suicide, promoting palliative care, protecting physician-patient relationships, protecting vulnerable people, and upholding the state interest in the preservation of human life."[190]

VII. The declaration of invalidity

VII.1 In consequence of her legal analysis, Justice Smith declared that the "impugned provisions" of the law unjustifiably infringed *Charter* ss. 7 and 15 and were of no force and effect to the extent that they prevented physicians from providing assisted suicide and euthanasia to a certain class of patients.[191]

VII.2 Joseph Arvay, counsel for the plaintiffs, subsequently told the Supreme Court of Canada that the trial court judge had concluded, on the basis of "a massive amount of evidence," that it was ethical for physicians to provide euthanasia and assisted suicide.[192] Moreover, he claimed that, having considered the evidence "of ethicists and philosophers and physicians and practitioners," she had found that there was "no ethical distinction" between withdrawing/withholding life saving treatment on the one hand, and euthanasia/assisted suicide on the other.[193]

VII.3 Neither of these claims is supported by the text of the decision. The discussion of the ethics of physician assisted suicide and euthanasia, comprising Part VII of the judgement (paragraphs 161 to 358) did not enter into the analysis that led to declaration of invalidity (See Appendices "B" and "C") .

VII.4 Justice Smith introduced her ruling with a summary of the findings of fact[194] and legal reasoning.[195] Far from offering the conclusions claimed by Mr. Arvay, she stated that opinion was

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[188] *Ibid* at para 1369.

[189] *Ibid* at para 1370.

[190] *Ibid* at para 1378.

[191] *Ibid*, at para 1393.

[192] *Carter SCC webcast*, *supra* note 1 at 100:20/491:20 – 100:44/491:20.

[193] *Ibid* at 101:27/491:20 - 102:01/491:20. However, the terms "active" and "passive" euthanasia were not used by the trial court judge. She did not characterize the withdrawal or withholding of treatment as "passive euthanasia."

[194] *Carter BCSC supra* note 1 at para 4 to 10.

[195] *Ibid* at para 12 to 18.

divided about the comparative ethical nature of contemporaneous end-of-life practices and euthanasia and assisted suicide, and that medical practitioners, professional bodies, government committees and the public were divided in their opinions.

VII.5 In short, the judge's statements in Part VII were judicial *dicta* that provide neither authority nor even persuasive weight for Mr. Arvay's extravagant claims. The whole of Part VII could be removed from the judgement without affecting the legal analysis and conclusions in Parts XI, XII and XIII (Appendix "B").

VIII. The remedy

VIII.1 Justice Smith described the circumstances and the class of patients under which and for whom physicians could provide euthanasia or assisted suicide without facing criminal prosecution.

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

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

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

d) The patient had to be

i) an adult,

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

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

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

i) that was without remedy acceptable to the patient,

ii) that caused enduring physical or psychological suffering that was intolerable to the patient and that could not be alleviated by any medical treatment acceptable to the patient;

f) The patient had to be in a state of advanced weakening capacities with no chance of improvement.[196]

VIII.2 "Constitutional exemption"

VIII.2.1 The judge suspended the application of her declaration for a year to give the government time to decide how to respond.[197] However, she granted a "constitutional exemption" to Gloria Taylor and her physician so that she could seek assisted suicide or euthanasia while the ruling was suspended.

[196] *Ibid* at para 1393.

[197] *Ibid* at para 1399.

VIII.2.2 The conditions and procedure set out by Justice Smith were, in some respects, more restrictive than the terms specified in the declaration of invalidity. This may have reflected an abundance of caution, since the probability of an appeal to the Supreme Court of Canada made the ultimate outcome uncertain.

VIII.2.3 The conditions:[198]

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

b) Her attending physician had to attest (the context throughout implied a written attestation) that she was "terminally ill and near death, and there is no hope of recovering."

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

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

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

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

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

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

VIII.2.4 The procedure:[199]

a) Ms. Taylor had to apply to the British Columbia Supreme Court and prove that the conditions set out above had been met.

b) The Court, if satisfied, would issue an order authorizing a physician to "legally provide Ms. Taylor with a physician-assisted death at the time of her choosing" as long as, at that time, she was "suffering from enduring and serious physical or psychological distress that is intolerable to her and that cannot be alleviated by any medical or other treatment acceptable to her."

c) She also had to be competent and "voluntarily seeking a physician-assisted death."

VIII.2.5 The final element of the order is of particular interest. Justice Smith ruled that the court should also authorize the physician who assisted the suicide or provided euthanasia to "complete her

[198] *Ibid* at para 1414.

[199] *Ibid* at para 1415.

death certificate indicating death from her underlying illness as the cause of death."[200]

VIII.2.6 That Justice Smith authorized a physician to falsify a death certificate seems markedly inconsistent with her repeated insistence upon the importance of "stringent limits that are scrupulously monitored and enforced."[201] The rationale for falsification appears to have been provided by one of the plaintiffs' witnesses:

> Dr. Nancy Crumpacker, a retired oncologist . . . says that it is the common, if not invariable, practice of physicians who fill out the death certificates of persons who hasten their deaths under the *ODDA*[202] to record the underlying illness as the cause of the death. This is done to protect patient confidentiality and to avoid any confusion with settlements from insurance companies. Completing the death certificate in this manner is not inconsistent with the legislation, as s. 3.14 of the *ODDA* provides that actions taken in accordance with it do not constitute suicide or homicide for any purposes. Section 3.13 additionally provides that "[n]either shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy.[203]

VIII.2.7 Whether justification is sought in patient confidentiality, statute or a judicial order, the falsification of the cause of death (and, presumably, the falsification of the classification of death) was contrary to death reporting and classification practices in British Columbia[204] and internationally[205] and more likely to produce confusion than promote transparency.

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[200] *Ibid* at para 1415(b)

[201] *Ibid* at para. 883; 16, 342, 1233, 1243, 1267, 1283.

[202] *Oregon Death With Dignity Act*

[203] *Carter BCSC*, *supra* note 1 at para 414.

[204] In British Columbia it was acknowledged that suicides may result from stress and depression arising from terminal or debilitating illness or a mental disorder. The cause of death was plainly stated, and the death was classified as a suicide, but if the underlying illness or disorder was known it is reported as a contributing factor. This better served the end of transparency.
Vital Statistics British Columbia, *Physicians' and Coroners' Handbook on Medical Certification of Death and Stillbirth* (Victoria, British Columbia: Ministry of Health Services,2004) online: <https://unstats.un.org/wiki/download/attachments/106498886/pchandbook2004.pdf >at 13.

[205] The underlying cause of death was defined by the World Health Organization as "(a) the disease or injury which initiated the train of morbid events leading directly to the death, or (b) the circumstances of the accident or violence which produced the fatal injury." The reason for the definition "is to ensure that all the relevant information is recorded and the certifier does not select some conditions for entry and reject others." World Health Organization, International Statistical Classification of Diseases and Health Related Problems , 2nd ed, 10th revision, vol 2 (Geneva: World Health Organization, 2004) online: <https://apps.who.int/iris/bitstream/handle/10665/42980/9241546530_eng.pdf#page=29> at 4.1.1–4.1.2. Instructions for ICD coding stated, "suicide (X60–X84) should not be accepted as 'due to' any other cause." World Health Organization, *International Statistical Classification of Diseases and Health Related Problems: Instruction Manual*, 2010 ed, 10th revision, vol 2 (Geneva: World Health Organization, 2004) online: <https://icd.who.int/browse10/Content/statichtml/ICD10Volume2_en_2010.pdf#page=88> at 82.

VIII.2.8 It is remarkable that, having concluded that assisted suicide and therapeutic homicide were justifiable in the circumstances set out in the judgement, Justice Smith felt it necessary to authorize physicians to falsify death certificates.

IX. Summary

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

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

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

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

IX.5 The standard chosen was the contemporaneous regime of end-of-life practices, since the outcome of a mistake in this regime ('death before one's time') was the same as the outcome of a mistake in regulating assisted suicide and euthanasia. The argument advanced was, in effect, that one cannot reasonably demand a higher standard of safety in the delivery of assisted suicide and euthanasia than in the delivery of palliative care because the results of a mistake in either case are the same: the death of the patient.

IX.6 Patient safety in end-of-life care was ensured by respect for and enforcement of the principle of informed consent, by assessment of patient competence, and by the use of legal substitute decision-makers for incompetent patients. Since these measures were considered sufficient for the purposes of end-of-life decisions in withholding, withdrawing or refusing treatment, it was decided that (proxy decision-making excepted) they should be sufficient for the regulation of assisted suicide and euthanasia for competent adults.

IX.7 The burden of proof was on the defendant governments to prove that this could not be done. The text of the ruling indicates that they provided evidence of risk, but failed to convince the judge that safeguards could not be effective.

X. Postscript

X.1 About ten days after the *Carter* decision was released, CBC Radio's *Cross Country Checkup* dedicated a full programme to the subject. The interviewer spoke by telephone with invited guests, including Professor Jocelyn Downie, one of the architects of the plaintiffs' case, and Dr. Eugene Bereza, a defendant witness. She also spoke to listeners from across the country who called in to voice their opinions.[206]

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

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

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

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

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

[206] CBC Radio, *Cross Country Checkup*, 24 June, 2012.

APPENDIX "A"
The Witnesses

A1. Overview

A1.1 The defendant governments called 18 expert witnesses. Four came from outside Canada; of these, three were from the United States and one from the United Kingdom.[207] Only two came from a jurisdiction (Oregon) where assisted suicide and/or euthanasia were legal.

A1.2 In contrast, the plaintiffs called more than twice the number of expert witnesses as the two defendant governments (40 to 18). 24 of their witnesses came from outside the country; 11 of these were from jurisdictions where assisted suicide and/or euthanasia were legal (Oregon, Washington, Belgium, Switzerland, Netherlands).[208] Their evidence included testimony from two physicians who actually provided assisted suicide or therapeutic homicide, something quite outside the experience of defendant witnesses.[209]

A1.3 Of the plaintiff witnesses, 12 Canadian physicians[210] and six physicians from other countries[211] gave evidence that they believed that assisted suicide and euthanasia could be ethically provided. Canada challenged the weight to be given to the opinions of two of the Canadian physicians,[212] who were not among the four witnesses whom the judge cited as representative of the views of the group.[213]

A1.4 Only six physicians, all from Canada, spoke against the notion that the procedures could be ethical.[214] Of these, Dr. Romayne Gallagher spoke strongly against it,[215] one was not cited or

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[207] *Carter BCSC*, *supra* note 1 at para 160 (Dr. Charles Bentz and Dr. N. Gregory Hamilton [Oregon, USA]; Prof. John Keown [USA.]; Baroness Illora Finlay of Llandaff [United Kingdom]).

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

[209] *Ibid* at para 743-745 (Dr. Gerrit Kimsma, Dr. Nancy Crumpacker).

[210] *Ibid* at para 254 (Dr. William Shoichet, Dr. David Bell, Dr. Marcel Boisvert, Dr. David Boyes, Dr. Eric Cassell, Dr. Sharon Cohen, Dr. Michael Klein, Dr. S. Lawrence Librach, Dr. Scott K. Meckling, Dr. Derryck Smith, Dr. Ross Upshur, Dr. Philip Welch).

[211] *Ibid* at para 261 (Dr. Michael Ashby [Australia], Dr. Nancy Crumpacker [Oregon, USA], Dr. Kimsma [Netherlands], Dr. Thomas Preston [Washington state, USA], Dr. Peter Rasmussen [Oregon, USA] and Dr. Rodney Syme [Australia]).

[212] *Ibid* at para 255 (Dr. David Boyes and Dr. Marcel Boisvert).

[213] *Ibid* at para 256, 257 (Dr. Michael Klein), 258 (Dr. Sharon Cohen), 259–260 (Dr. S. Lawrence Librach), 262 (Dr. Thomas Preston).

[214] *Ibid* at para 263 (Dr. Harvey Chochinov, Dr. G. Michael Downing, Dr. Herbert Hendin, Dr. Romayne Gallagher, Dr. Douglas McGregor, Dr. José Pereira, Dr. Leslie J. Sheldon).

[215] *Ibid* at para 271 (Dr. Romayne Gallagher).

quoted, but presumably did so as well,[216] one did not speak directly to the issue,[217] and three appear to have been ambivalent.[218]

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

A2. Defendants' witnesses

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

A2.2 Professor of psychiatry Dr. Harvey Chochinov stated, "*At this point in time*, I would not be prepared to participate in a scheme permitting physician-assisted suicide or intentional death by medical practitioner," (emphasis added),[219] which suggested that he might be willing to do so in future. The judge took note. [220]

A2.3 Dr. Eugene Bereza, Director of the Biomedical Ethics Unit, McGill University Faculty of Medicine, was not sure if it was possible in all cases to clearly distinguish between withholding or withdrawing life-sustaining treatment and assisted suicide or euthanasia.[221] He allowed that "there may be morally persuasive arguments for physician-assisted death in some cases," though he was against a change in the law because of the risk "of unjustifiable death to vulnerable individuals."[222] His admission at trial was consistent with comments he made after the *Carter* decision was announced, to the effect that, in rare cases, assisted suicide or euthanasia might be considered, and that it may be possible to have both good, accessible palliative care and assisted suicide and euthanasia.[223] That statement was not inconsistent with the outcome of the trial. Although it cannot

[216] Dr. José Pereira.

[217] *Ibid* at para 272 (Dr. Herbert Hendin).

[218] *Ibid*, para. 265 (Dr. Douglas McGregor), 267 (Dr. G. Michael Downing); 268-270 (Dr. Harvey Chochinov).

[219] *Ibid* at para 270.

[220] *Ibid* at para 353.

[221] *Ibid* at para 251.

[222] *Ibid* at para 253.

[223] In response to the interviewer's question, "Why can't we have both?" (i.e. accessible palliative care and assisted suicide/euthanasia for the 3-6% who can't be palliated) he said, ". . . What I think I'm saying to you is 'exactly,' right? Um, in my experience - and it's just my experience - I would honestly say that in the thousands and thousands of cases I've been party to. . . there probably has been, have been a very few where I would argue that it was ethically permissible to consider something like physician assisted suicide or euthanasia. But I'm talking about, possibly I could count on one hand. Because all the others . . . the 98% of the others would have been very well and

be said that Dr. Bereza testified in favour of legalizing the procedures, neither were the plaintiffs unjustified in citing his evidence in support of their proposition that "assisted dying and palliative care are not mutually exclusive."[224]

A2.4 Dr. Douglas McGregor, a palliative care specialist, agreed that if the procedures were legalized, with appropriate safeguards, physicians could comply with the law without violating tenets of medical ethics, though he added, "I'm not sure that's the right thing to be doing in our society."[225] The judge took note.[226]

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

- Baroness Finaly, a pioneer and specialist in palliative care, offered opinions, not research results, though the judge considered her opinions to be within her field of expertise as a palliative care physician.[227]
- Dr. Bentz was an internal medicine specialist who had published nine papers about tobacco smoking cessation. His evidence about safeguards was based upon his experience with only one patient.[228]
- The evidence of Dr. Keown, a professor of law who held the Rose Kennedy Chair of Christian Ethics at Georgetown University in Washington, D.C., consisted of his opinions, apparently unsupported by empirical research.[229]
- Professor Mishara stated that the high rate of assisted suicide in Switzerland resulted from the absence of legal controls,[230] a point that did not speak to the effectiveness of controls where they existed.

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better handled through good palliative care. For those other rare ones, what can we do? Well, maybe then we should consider some kind of exception, but that's not what we're doing now. We're jumping to that other one before we've taken care of that huge percentage. So my concern - I mean, at the end of the day, I think we might possibly need both, but we're already thinking about changing the second one way before we've addressed the issue of, you know, 65-70% of Canadians can't access the very thing that, if they had, wouldn't make us have to consider this option." CBC Radio, *Cross Country Checkup*, 24 June, 2012.

[224] *Carter v. Canada (Attorney General)* 2012 BCSC 886 (Written Submissions of the Plaintiffs: Plaintiffs' Application – Rule9-7) online: <http://www.consciencelaws.org/archive/documents/carter/2011-12-01-submission-plaintiffs.pdf> at para 225.

[225] *Carter BCSC*, *supra* note 1 at para 265.

[226] *Ibid* at para 354.

[227] *Ibid* at para 387.

[228] *Ibid* at para 411.

[229] *Ibid* at para 244-245, 374-375, 452, 501.

[230] *Ibid* at para 603.

- Dr. Pereira acknowledged that he had not done original research, that he relied entirely on secondary sources, that his interest in the subject was of recent origin, that he had not made a lengthy study of the effectiveness of safeguards, and that his single paper on the subject had appeared in a relatively low-ranking medical journal.[231]
- The judge acknowledged that Dr. Hendin was a leader in suicide prevention, but noted that he had not done empirical research into euthanasia and assisted suicide. His evidence was challenged,[232] and his testimony that "voluntariness is compromised, alternatives not presented and the criterion of unrelievable suffering is bypassed" was "significantly weakened" on cross-examination.[233] The judge was left in doubt about his impartiality.[234]

A2.6 The evidence provided by Dr. Pereira on the subject of safeguards proved unexpectedly problematic. He testified all day on 22 November, 2012. He was cross-examined at length the following day about the paper published in *Current Oncology*,[235] which had been submitted in evidence and formed the basis for his expert report.[236] The Farewell Foundation, an intervener supporting the plaintiffs, described the cross-examination:

> Again and again, counsel for the plaintiffs handed up the references that Dr. Pereira had cited, saying that his references did not seem to support the propositions he was making in his paper. Repeatedly, Dr. Pereira conceded that he had not provided an appropriate source for various propositions and facts. Sometimes he even interrupted counsel, admitting "That was an error," because he could see the improper citation before counsel could finish the question.[237]

A2.7 Although the Farewell Foundation writer asserted that the paper was "strongly discredited," the judge made no comment on Dr. Pereira's performance under cross-examination. It is possible that intervener bias coloured the writer's assessment (perhaps accounting for the absence of comment by the judge), but subsequent developments support the view that the impugned paper was poorly written, and that Dr. Pereira's credibility as an expert about safeguards was severely

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[231] *Ibid* at para 377.

[232] *Ibid* at para 373.

[233] *Ibid* at para 504.

[234] *Ibid* at para 664.

[235] José Pereira, "Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls"(2011) 18:2 Current Oncology 38, online: <https://www.mdpi.com/1718-7729/18/2/883>.

[236] J Downie, K Chambaere K & JL Bernheim, "Pereira's attack on legalizing euthanasia or assisted suicide: smoke and mirrors" (2012) 19:3 Current Oncology 133 [*Downie et al* 2012], online: <https://www.mdpi.com/1718-7729/19/3/1063> at 133.

[237] "Carter Trial, Day 8: Wednesday, November 23, 2011" (24 November, 2011), *Farewell Foundation for the Right to Die* (blog), online: <https://web.archive.org/web/20120119192557/http://farewellfoundation.ca/wordpress/?p=323>.

damaged.[238]

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

> When counsel for the plaintiffs asked Dr. Hendin to confirm references that were cited in his affidavit for Canada, Hendin declared that he could not actually affirm that the references supported his propositions. He told the Court that he never actually read some of the articles, it was a mistake, and he did not have the chance to check his own references . . .
>
> . . . It was expected that Dr. Hendin's testimony would last a minimum of 4 hours, but it terminated after only 2.5 hours. His very long and rambling answers appeared to bewilder the court when a yes or no response was all that was requested. A number of times counsel apologized for interrupting Dr. Hendin in order to redirect him to the question. Justice Smith intervened a couple of times to ask Dr. Hendin to please answer the question directly.[239]

A3. Plaintiffs' witnesses

A3.1 The plaintiffs provided evidence from nineteen witnesses about jurisdictions where assisted suicide and euthanasia were legal. Six of these appear to have contributed primarily factual information and some explanatory commentary on the text and operation of laws and regulations. Their evidence seems to have been largely neutral with respect to the issues before the court, and the judge relied on a number of them when describing legal regimes and practices.[240]

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

- three members of a euthanasia/assisted suicide advocacy group spoke of their experience in counselling about 2,900 terminally ill patients and their physicians,[241]

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[238] *Downie et al 2012*, *supra* note 236 ("Pereira makes a number of factual statements without providing any sources. Pereira also makes a number of factual statements with sources, where the sources do not, in fact, provide support for the statements me made. Peirera also makes a number of false statements about the law and practice in jurisdictions that have legalized assisted suicide and euthanasia.") Dr. Pereira acknowledged "some errors in the references and subtleties that are regrettable" but insisted that most of the paper was correct: (José Pereira, "Casting stones and casting aspersions: let's not lose sight of the main issues in the euthanasia debate" (2012) 19:3 Current Oncology 139. online: <https://www.mdpi.com/1718-7729/19/3/1088> at 139.

[239] "Carter Trial, Day 9-10: November 24-25, 2011" (30 November, 2011), *Farewell Foundation for the Right to Die* (blog), online: <https://web.archive.org/web/20120112033709/http://farewellfoundation.ca/wordpress/>.

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

[241] *Carter BCSC*, *supra* note 1 at para 407–408 (George Eighmey, Jason Renaud and Robb Miller of Compassionate & Choices).

- two physicians discussed their direct involvement in assisted suicide or euthanasia,[242]
- a retired director and CEO of the Oregon Hospice Association explained how her observations and experience had moved her from opposing assisted suicide to supporting it,[243]
- two specialist/researchers offered opinions to the effect that legalization of euthanasia in Netherlands and Belgium had not resulted in the harms feared by the defendants, including a "slippery slope" harmful to vulnerable people.[244]

A3.3 The most extensive evidence on the subject of safeguards was provided by six plaintiff witnesses with notable credentials: Professor Luc Deliens, Professor Helene Starks, Dr. Gerritt Kimsma, Dr. Linda Ganzini, Professor Margaret Pabst Battin and Dr. Johannes J.M. van Delden.

- Professor Deliens was the co-author of numerous empirical studies on end-of-life decisions,[245] several of which were cited in the ruling.[246]
- Professor Starks spent five years as a research manager and co-investigator in a study exploring assisted suicide and euthanasia from the perspective of the patients and families involved in the procedures. One study she co-authored was cited in the

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[242] *Ibid* at para 744–745 (Dr. Gerritt Kimsma, Dr. Nancy Crumpacker).

[243] *Ibid* at para 409 (Ann Jackson).

[244] *Ibid* at para 582–587 (Dr. Michael Ashby, Dr. Jean Berheim).

[245] *Ibid* at para 521.

[246] Johan Bilsen et al, "Changes in medical end-of-life practices during the legalization process of euthanasia in Belgium" (2007) 65:4 Soc Sci Med 803, online: <https://www.sciencedirect.com/science/article/abs/pii/S0277953607002018?via%3Dihub>

- Kenneth Chambaere et al, "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey" (2010) 182:9 Can Med Assoc J 895, online:<https://www.cmaj.ca/content/182/9/895.long>
- Kenneth Chambaere et al, "Trends in Medical End-of-Life Decision Making in Flanders, Belgium 1998-2001-2007" (2011) 31:3 Med Decis Making 500, online: <https://journals.sagepub.com/doi/10.1177/0272989X10392379>
- Luc Deliens, "End of Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey" (2000) 356:9244 Lancet 1806, online: <https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(00)03233-5/fulltext>
- Tinne Smets et al, "Legal euthanasia in Belgium: characteristics of all reported euthanasia cases" (2010) 48:2 Med Care 187, online: <https://journals.lww.com/lww-medicalcare/Abstract/2010/02000/Legal_Euthanasia_in_Belgium__Characteristics_of.15.aspx>
- Tinne Smets et al, "Euthanasia in patients dying at home in Belgium: interview study on adherence to legal safeguards" (2010) 60:573 Brit J Gen Pract, online: <https://bjgp.org/content/60/573/e163.long>
- Tinne Smets et al, "Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases" (2010) 341:c5174 Brit Med J, online: <https://www.bmj.com/content/341/bmj.c5174.long>
- Yanna Van Wesemael et al, "Process and outcomes of euthanasia requests under the Belgian Act on euthanasia: a nationwide survey" (2011) 42:5 J Pain Symptom Manage 721, online: <https://www.jpsmjournal.com/article/S0885-3924(11)00154-0/fulltext>

ruling.[247]

- Dr. Kimsma developed and was an instructor in a Netherlands program that supported and consulted with physicians dealing with euthanasia requests and, with Professor Battin, co-authored one of the studies cited in the ruling.[248]
- Professor Battin's research focus was assisted suicide and euthanasia; the judge referred to three of her articles.[249]
- Dr. Ganzini, an Oregon pyschiatrist, had fifteen years' experience studying physician-assisted suicide in the state, co-authoring numerous studies on the subject.[250] Defendant witnesses, including Dr. Keown and Dr. Pereira, sought support for their positions in research done by Dr. Ganzini.[251]
- Dr. van Delden was said to have participated in "all of the major empirical studies into end-of-life care that have taken place in the Netherlands since 1990."[252]

[247] *Carter BCSC*, *supra* note 1 at para 439 (Ashok J Bharucha et al, "The Pursuit of Physician-Assisted Suicide: Role of Psychiatric Factors" (2003) 6:6 J Palliat Med 873, online: <https://www.liebertpub.com/doi/10.1089/109662103322654758?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed>.

[248] *Ibid* at para 160, 489 (Frances Norwood, "Vulnerability and the 'slippery slope' at the end-of-life: a qualitative study of euthanasia, general practice and home death in The Netherlands" (2009) 26:6 Fam Prac 472, online: <https://academic.oup.com/fampra/article/26/6/472/547039?login=false>.

[249] Margaret P Battin et al, "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on 'vulnerable' groups" (2007) 33:1 J Med Ethics 591, online: <https://jme.bmj.com/content/33/10/591.long>

Margaret P Battin, "Physician-Assisted Dying and the Slippery Slope: the Challenge of Empirical Evidence" (2008) 45 Willamette L Rev 91, online: <https://willamette.edu/law/resources/journals/review/pdf/volume-45/wlr45-1-battin-11-8-08.pdf>

Margaret P Battin et al, "Legal physician-assisted dying in Oregon and the Netherlands: The question of 'vulnerable' groups. A reply to I.G. Finlay and R. George" (2011) 37:3 J Med Ethics 171, online: <https://jme.bmj.com/content/37/3/171.responses#legal-physician-assisted-dying-in-oregon-and-the-netherlands-the-question-of-vulnerable-groups-a-reply-to-ig-finlay-and-r-george>

[250] *Carter BCSC*, *supra* note 1 at para 160.

[251] *Ibid* at para 447, 451 (Linda Ganzini, Elizabeth R Goy & Stephen K Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey" (2008) 337:a1682 Brit Med J online: <https://www.bmj.com/content/337/bmj.a1682>).

[252] *Ibid* at para 160.

A4. Assessing the evidence of the witnesses

A4.1 Justice Smith described Dr. Ganzini and Professor Battin as "impressive, respected researchers, who have both made a long-term study of the ethics, and risks, of assisted suicide and euthanasia" and had carefully analyzed the evidence. She said that Dr. Starks' evidence was "carefully and fairly presented" and accepted it, commenting favourably on her objectivity.[253]

A4.2 In contrast, the judge acknowledged the expertise of Dr. Pereira, Baroness Finlay and Dr. Hendin, but commented that none had done empirical research to support their opinions.[254] She accepted the anecdotes provided by Dr. Hendin and Dr. Bentz, but the value of anecdotal evidence is limited: in this case, to demonstrating that "safeguards cannot be assumed to be 100% effective."[255]

A4.3 Justice Smith did not uncritically accept all of the plaintiffs' evidence. For example, she found Professor Luc Deliens evasive with respect to one point on cross-examination; it seemed he did not want to admit that a study he had co-authored reported that patients 80 years of age and older were especially vulnerable to "life-ending acts without explicit request."[256] In other respects she appears to have found his evidence satisfactory.

A4.4 The judge also reviewed the evidence of the Euthanasia Prevention Coaltion and fourteen defendant witnesses[257] and thirteen plaintiff witnesses[258] to consider the feasibility of establishing effective safeguards in Canada.

A4.5 With respect to risks associated with patient competence, she gave greater weight to the evidence of plaintiff witnesses Dr. Donnelly, Dr. Smith and Dr. Ganzini, two of whom (Dr. Connelly and Dr. Smith) were psychiatrists with particular expertise in assessing competence. In comparison, she noted that the expertise of defendant witnesses Dr. Hendin, Professor Heisel and Professor Mishara lay in suicide prevention, that of Dr. Gallagher and Dr. Finlay in palliative care, and appears

[253] *Ibid* at para 651–652.

[254] *Ibid* at para 664.

[255] *Ibid* at para 653.

[256] *Ibid* at para 576-577.

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

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

to have disregarded Dr. Sheldon's views as outside the "mainstream."[259] On the issue of risks arising from subtle pressures or coercion, she reached her conclusion by drawing on the evidence of both defendant and plaintiff witnesses.[260]

[259] *Carter BCSC, supra* note 1 at para 795-797.

[260] *Ibid* at para 815.

APPENDIX "B"
Carter Part VII: Judicial Dicta on Ethics

B1. A note of caution

B1.1 Part VII of the judgement illustrates the difference between the role of a scholar and the role of a judge: between an investigative and deliberative process that can be followed by parliamentary subcommittees or royal commissions and the process followed in a trial conducted on adversarial principles. As the Christian Legal Fellowship observed, a trial judge "does not have the benefit of the wide-ranging consultations that are available to government."[261]

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

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

B2. The question addressed in Part VII

B2.1 In Part VII (paragraphs 161 to 358) Justice Smith 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.[262] Unfortunately, she did not confine herself to this question, but seems to have wandered through the evidence, perhaps attempting to synthesize disparate and incomplete evidentiary materials and arguments provided by the parties in conflict. Her explanation of the purpose of this exercise was muddled.

B2.2 The judge asserted that the question before her was constitutional, not legal.[263] This implied that a challenge to the constitutionality of the law against assisted suicide was not a legal question, which seems at least a very peculiar view.

B2.3 In the same breath, the judge said that the question before her was not ethical.[264] If the

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[261] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331 (Written Submissions of the Intervener, Christian Legal Fellowship) [*CLF Submission*] online: <https://www.consciencelaws.org/archive/documents/carter/2011-12-10-submission-clf.pdf> at para 40–53.

[262] *Carter BCSC*, *supra* note 1 at para 161-162, 183, 316.

[263] *Ibid* at para 173.

[264] *Ibid*.

question was *not* ethical, one might reasonably ask why she embarked upon a lengthy discussion of ethics.

B2.4 Observing that the realms of ethics, law and constitutionality "tend to converge even though they do not wholly coincide,"[265] the judge explained that the law and medical practice are shaped by ethical principles.[266] She later noted that legal and constitutional principles are derived from and shaped by societal values."[267] The explanation was not germane in the circumstances of the case before her, in which ethical principles and societal values were either in dispute or in conflict: hence her references to "the ethical *debate*."

B2.5 In any case, the judge stated that she intended to "review the evidence that the parties provided regarding the ethical debate and end-of-life medical practices . . . in order to create a record for higher courts and because this body of evidence and law has some relevance to other issues that are necessary for me to address."[268]

B2.6 To this she added, with apparently less assurance, three further reasons that indicated, in her words, that "the ethical debate *may* bear on the issues in this case." (Emphasis added)[269]

B2.7 The first was that, since the plaintiffs were seeking physician-assisted suicide and euthanasia, it was important to determine whether or not at least some physicians believed it would be ethical to provide the services.[270] While this was a reasonable question, the ensuing review of "the ethical debate" was not required to answer it, since it was obvious from the plaintiffs' notice of claim that some physicians held that opinion.

B2.8 The second reason offered was that the plaintiffs claimed that there was no ethical distinction between permissible forms of end of life care and assisted suicide/euthanasia, and no ethical distinction between suicide and assisted suicide.[271] The judge having previously declared that the question before her was *not* ethical (B2.3) and that the ethics of suicide were *not* at issue (VI.2.3), these claims (and her review of the ethical debate) would seem irrelevant.

B2.9 Finally, the judge referred to plaintiffs' claim that the law was invalid if its purpose was "to uphold a particular religious conception of morality."[272] However, the ruling on this point identified an entirely different purpose, and, in arriving at that conclusion, made no reference to this

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[265] *Ibid*.

[266] *Ibid* at para 165.

[267] *Ibid* at para 317.

[268] *Ibid* at para 163.

[269] *Ibid* at para 174.

[270] *Ibid* at para 175.

[271] *Ibid* at para 176.

[272] *Ibid* at para 177.

claim.[273] The review of the ethical debate for this purpose seems superfluous.

B2.10 Nonetheless, "to create a record for the higher courts," because the ethical debate had "some relevance" to the points she had to address, and because of the possibility that it could bear on the issues, Justice Smith deemed it "worthwhile to review the parameters of the ethical debate."[274]

B2.11 It is instructive to compare her explanation of the purpose of Part VII to her explanation of the purpose of Part VIII, where she considered evidence from other jurisdictions on the efficacy of safeguards:

> In this section, I will summarize, and make findings of fact with regard to the extensive evidence that has been tendered with respect to permissive jurisdictions and their safeguards."[275]

After outlining how she would approach the subject, she added, "I will then return to the practical slippery slope questions and set out my conclusions on those questions, based on the evidence."[276]

B2.12 She promised "findings of fact" and "conclusions" in relation to Part VIII, but not Part VII.

B3. Plaintiffs' claim shapes and limits the analysis

B3.1 It seems that the judge's opinion that "the ethics of physician-assisted death are relevant to, although certainly not determinative of, the assessment of the constitutional issues in this case"[277] originated in the plaintiffs' claim, which was specifically for *physician*-assisted suicide and euthanasia.

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

B3.3 The plaintiffs chose to begin with *physician*-assisted suicide and euthanasia,[278] thus avoiding these logically prior ethical questions, and Justice Smith did the same when she expressly

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[273] *Ibid* at para 1184–1190.

[274] *Ibid* at para 163, 174, 178.

[275] *Ibid* at para 364.

[276] *Ibid* at para 370.

[277] *Ibid* at para 173.

[278] *Ibid* at para 175. See *Notice of Claim*, *supra* note 19 at Part 2, para. 1–3, Part 3, para 12–14. This referred to the liberty interests of others who wish to help someone obtain "*physician-assisted* dying services," not suicide *per se.*

accepted this framework for her analysis.[279] Thus, Part VII included one strand of discussion that addressed a central question identified by the judge: "whether or not it is ethical for physicians to provide such assistance."[280]

B4. Ethics: which one?

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

B4.2 Here, the law itself was of no assistance. The judge recognized that what is ethical or moral may not be legal, and what is legal may not be moral or ethical,[281] a proposition with which St Augustine, St. Thomas Aquinas and Martin Luther King Jr. (among others) would agree.[282] But these men accepted that proposition because they recognized a transcendent or objective standard to which human law ought to conform, while *Carter* was presented, argued and decided as if such a standard did not exist or was irrelevant.

B4.3 Instead, in Part VII, the judge tried to establish a common standard by searching for ethical consensus. This is not surprising, since seeking common ground is a legitimate and important conflict resolution strategy, and a civil trial can be understood as a formal conflict resolution process. Thus, the judge frequently referred to what she identified as common ground, points of agreement, and what was "accepted."[283]

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

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[279] *Ibid* at para 175, 180-181.

[280] *Ibid* at para 164.

[281] *Ibid* at para 173.

[282] St. Augustine, *On the Free Choice of the Will*, translated by Thomas Williams (Indianapolis/Cambridge: Hacket Publishing Co., 1993) at 11; *The Summa Theologiae of St. Thomas Aquinas*, 2nd ed, translated by Fathers of the English Dominican Province (1920) online: <http://www.newadvent.org/summa/2096.htm> at II.I.96.4; Letter from Martin Luther King Jr. to Bishop C.C.J. Carpenter, Bishop Joseph A. Durick, Rabbi Milton L. Grafman, Bishop Nolan B. Harmon, The Rev. George H. Murray, The Rev. Edward V. Ramage, The Rev. Earl Stallings (16 April, 1963), a.k.a. Letter from Birmingham Jail, online: <http://okra.stanford.edu/transcription/document_images/undecided/630416-019.pdf> at 7–8.

[283] *Carter BCSC, supra* note 1 at para 163, 200, 234, 236, 300, 303-306, 308-309, 311, 322, 349 (Such references also occur outside Part VII: e.g., para 5, 8, 492, 1198, 1336, 1369).

B5. Medical ethics

B5.1 Ethics and practitioners

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

B5.1.2 The plaintiffs produced 13 Canadian medical practitioners who considered euthanasia or assisted suicide to be ethically acceptable in some circumstances[284] and six physicians from other countries who were of the same opinion.[285] The defendants provided evidence from six Canadian physicians who offered opposing views,[286] three of whom proved to be somewhat ambivalent.[287]

B5.1.3 From all of this, the judge concluded that "experienced and reputable Canadian physicians" who were "unchallenged with respect to their standing in the medical community or their understanding of and respect for medical ethics" were willing to provide assisted suicide and euthanasia.[288]

B5.1.4 But the willingness of reputable physicians to provide or participate in procedures was hardly proof that the procedures were ethical. For example, in 1996 Alberta Eugenics Board physicians were found to have engaged in "unlawful, offensive and outrageous" medical procedures, and the court excoriated a respected Canadian geneticist for encouraging them to use Down Syndrome children as "medical guinea pigs."[289]

B5.1.5 Some physicians are willing to have sex with consenting patients, but Canadian professional and regulatory authorities are generally clear that it is always unethical for a physician to do so, even though it is not against the law.[290] This is also the case in the Netherlands, where physicians are forbidden to have sex with consenting patients,[291] though they can kill consenting patients.[292]

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[284] *Ibid* at para 254, 259.

[285] *Ibid* at para 261.

[286] *Ibid* at para 263.

[287] *Ibid* at para 265–267, 270.

[288] *Ibid* at para 319, 344 (They are identified in para 254).

[289] *Muir v. Alberta*, 1996 CanLII 7287, online: <http://canlii.ca/t/1p6lq>.

[290] College of Physicians and Surgeons of British Columbia, *Practice Standard: Sexual Misconduct*, Vancouver, BC: CPSBC, 2022, online: <https://www.cpsbc.ca/files/pdf/PSG-Sexual-Misconduct.pdf>.

[291] Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG), *Affectieve relatie met de patiënt,* Utrecht: KNMG, 2023, online: <https://www.knmg.nl/advies-richtlijnen/dossiers/affectieve-relatie-met-de-patient>.

[292] Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG), "The Role of the Physician in the Voluntary Termination of Life" (30 August, 2011), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/archive/documents/2011-08-30%20KNMG-position-paper.pdf>, cited in

B5.1.6 Certainly, these comparisons would have raised interesting ethical questions about different understandings of physician-patient relationships, power imbalances and consent, had any of the parties chosen to bring them forward.[293] However, the willingness of physicians to treat Down Syndrome children as guinea pigs or to have sex with patients is irrelevant to an ethical evaluation of such conduct. One cannot see how it could enter into an ethical justification of physician-assisted suicide and therapeutic homicide.

B5.2 Ethics and the positions of medical associations

B5.2.1 It appears that neither defendants nor plaintiffs provided an adequate survey of the policies of medical associations or physician regulators on assisted suicide and euthanasia, but offered a sampling of policies from different organizations. The selection, such as it was, illustrated only that there were differing views, while the judge acknowledged that the "official" position of an association on assisted suicide and euthanasia did not necessarily represent the views of all of the members of a profession.[294]

B5.3 Ethics and the opinions of ethicists

B5.3.1 Predictably, the ethicists called by the plaintiffs differed from those called by the defendants about the ethics of physician-assisted suicide and euthanasia.[295]

B5.3.2 For the plaintiffs, Professor Wayne Sumner asserted that, like contemporaneous forms of end-of-life and palliative care, euthanasia and assisted suicide could be ethically justified by the informed and voluntary choice of a competent patient.[296] Dr. Marcia Angell appealed to the principle of patient autonomy in support of the procedures,[297] which also appears to have been the basis for Dr. Ross Upshur's assertion that euthanasia and assisted suicide could be provided on the basis of a free and informed request by a competent person for whom life is "not worth living."[298]

B5.3.3 Plaintiff witness Professor Margaret Battin agreed that the principle of autonomy was fundamental, but insisted that assisted suicide and euthanasia could not be justified solely by the informed choice of a patient because the services were being provided by physicians. She argued that justification required the additional principle of "mercy."

Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst (KNMG), "Euthanasia in the Netherlands" (16 August, 2017), *KNMB* (website) online: <https://www.knmg.nl/actualiteit-opinie/nieuws/nieuwsbericht/euthanasia-in-the-netherlands>.

[293] Y Michael Barilan, "Of Doctor-Patient Sex and Assisted Suicide" (2003 5:June Israeli Med Ass J 460, online: < https://www.ima.org.il/MedicineIMAJ/viewarticle.aspx?year=2003&month=06&page=460>.

[294] *Carter BCSC*, *supra* note 1 at para 274-277.

[295] *Ibid* at para 233 (Plaintiff witnesses: Prof. Wayne Sumner; Dr. Marcia Angell; Prof. Margaret Battin; Dr. Upshur; Dr. Gerritt Kimsma. Defendant witnesses: Prof. John Keown; Prof. Thomas Koch; Dr. Eugene Bereza).

[296] *Ibid* at para 234.

[297] *Ibid* at para 238.

[298] *Ibid* at para 242.

> The nature of the patient's suffering and why it is intolerable to the patient must also be understood by the physician, who then is obliged to try to respond as a matter of mercy and in fulfilment of his or her commitment not to abandon the dying patient. Thus autonomy and mercy go hand in hand: for the physician to offer assistance in dying, it must be the patient's choice and it must also be done to help the patient avoid suffering that is either intolerable or about to be so.[299]

B5.3.4 This strongly implied that physicians were ethically obliged to provide assisted suicide and euthanasia in response to pain or suffering, and that failure to kill the patient or assist with suicide amounted to patient abandonment. The claim was and is absolutely rejected by those opposed to the procedures, but the judge made no comment about it.

B5.3.5 For the defendant governments, witness Professor Koch argued that justifications based on autonomy were overly simplistic and misplaced, pointing out that euthanasia/assisted suicide advocates were seeking not just autonomy, but the communal and medical support for the procedures. Against such claims he appealed to the Hippocratic Oath and rejected what he described as a consumer model of medical practice based soley on consumer choice.[300]

B5.3.6 Defendant witness Professor John Keown asserted that "any intentional taking of life is unethical and should not be permitted," which would presumably include suicide, though this was not stated in the ruling. He insisted that the inviolability of human life was at the heart of both law and medical practice. He opposed physician-assisted suicide and euthanasia because of his belief in the sanctity of life, and because he believed that the practices could not be controlled if legalized.[301]

B5.3.7 The evidence of defendant witness Dr. Eugene Bereza was decidedly ambivalent. He allowed that "there may be morally persuasive arguments for physician-assisted death in some cases," though he was against a change in the law because of the risk "of unjustifiable death to vulnerable individuals."[302]

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

B5.4.1 Ethicists and other witnesses also discussed contemporaneous end-of-life practices. For the plaintiffs, Professor Sumner denied that there was any "ethical bright line" by which to distinguish euthanasia/assisted suicide from legal and accepted end-of-life practices.[303] Defendant witness Dr. Eugene Bereza was not sure if it was possible in all cases to clearly distinguish between withholding or withdrawing life-sustaining treatment and assisted suicide or euthanasia.[304]

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[299] *Ibid* at para 240.

[300] *Ibid* at para 246–247.

[301] *Ibid* at para 244.

[302] *Ibid* at para 253.

[303] *Ibid* at para 235–236.

[304] *Ibid* at para 251.

B5.4.2 Plaintiff witness Dr. Gerrit Kimsma of the Netherlands argued that assisted suicide and euthanasia were consistent with the goals of medicine and already occurring in fact, though "under a veil of confusion, ambiguity and lack of truth/disclosure."[305]

B5.4.3 On this point, however, the judge ultimately found that the law had deterred all but a very few Canadian physicians from providing assisted suicide and euthanasia.[306] The evidence, she said, suggested that Canadian physicians had provided assisted suicide or euthanasia in only "a very small number of instances."[307]

B5.4.4 The withdrawal of life support or treatment was of particular interest to Justice Smith because 90% of patients died "following the withdrawal of some form of life support, most commonly the withdrawal of medical ventilation, dialysis or inotrope medications."[308]

B5.4.5 With respect to end-of-life practices generally, Justice Smith identified the pivotal principle of informed consent, which (she said) rested on the foundational concept of individual autonomy. Medical procedures could not be undertaken or sustained without the continuing informed consent of a competent patient, who was entitled to refuse treatment even if death would result. In the case of non-competent patients whose wishes were not known, "medical decisions will be made in the patient's best interests." Patients could make their wishes known by means of advance directives, and such directives had to be respected if the patient were incapacitated. Alternatively, decisions about withdrawal or refusal of treatment could be made by legally recognized third parties.[309] Justice Smith held that the law concerning the right of physicians to withdraw or refuse treatment despite the objections of third-party decision-makers was uncertain.[310]

B5.4.6 However, much that was necessary to understand the ethical issues and controversies associated with end-of-life practices was absent from Part VII, particularly with reference to palliative sedation (See Appendix "C"). Thus, while the judge's explanation of the *law* of informed consent was satisfactory, as was her explanation of the *law* concerning withdrawal and refusal of treatment,[311] her discussion of the *ethics* of end-of-life decision-making was seriously deficient.

B5.4.7 The deficiency was especially problematic because Justice Smith also attempted to answer another question: whether or not contemporaneous end of life practices were ethically distinguishable from physician-assisted suicide and euthanasia (B8.6).[312] One of the plaintiffs'

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[305] *Ibid* at para 243.

[306] *Ibid* at para 203-204, 680.

[307] *Ibid* at para 1370.

[308] *Ibid* at para 185.

[309] *Ibid* at para 207-223.

[310] *Ibid* at para 227-230.

[311] *Ibid* at para 231.

[312] *Ibid* at para 318, 320.

central claims was that they were not.[313]

B6. Ethics of society

B6.1 A second strand of discussion in Part VII, occasionally spliced into the discussion of medical ethics, was whether or not an ethical or moral consensus existed outside the medical profession on the subject of assisted suicide and euthanasia. This, too, originated in the plaintiffs' claim, since they asserted that the law against assisted suicide and euthanasia was invalid if its purpose was "to uphold a particular religious conception of morality" that was unsupported by social consensus in Canada.[314]

B6.2 Ethics and public opinion

B6.2.1 The reliability of public opinion polls as an indicator of ethical consensus was disputed.[315] British Columbia urged that consensus should be recognized in a plurality of sources: "in the refusal of successive governments and Parliaments to legalize assisted dying," in the fact that "the overwhelming majority of Western democracies" forbid assisted suicide and euthanasia, in a comprehensive report from the Canadian Senate, and in laws and judicial rulings that were not identified in the judgement.[316]

B6.2.2 The judge ultimately cited an opinion poll showing a majority of Canadians were "supportive of physician-assisted death in some circumstances."[317] This was an inaccurate description of the poll, which referred to "euthanasia," not "physician-assisted death." Moreover, the poll posed the question without reference to circumstances and without defining "euthanasia."[318]

B6.2.3 A poll of this type was of no value in assessing the ethical content or importance of the opinions of respondents. While the judge noted that public opinion polls (in general) "provide some indication as to societal values overall,"[319] she failed to explain how this particular poll could have reasonably contributed to the ethical evaluation she attempted in Part VII.

B6.3 Ethics and public committees

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

[313] *Ibid* at para 163, 176; 186, 234–237, 321–322.

[314] *Ibid* at para 177.

[315] *Ibid* at para 278-284, 286-287.

[316] *Ibid* at para 285.

[317] *Ibid* at para 347.

[318] *Ibid* at para 280.

[319] *Ibid* at para 347.

euthanasia.[320]

B6.3.2 She appears to have given equal weight to subsequent reports produced by committees of the Royal Society of Canada (RSC) and the Quebec National Assembly (QNA), both of which unanimously recommended legalization of assisted suicide and euthanasia.[321]

B6.3.3 Quite apart from concerns that might be raised concerning the comprehensiveness of the reports, the judge's reliance on the RSC and QNA reports in the ruling was questionable for three reasons.

- First: five of the six authors of the RSC report favoured at least voluntary euthanasia before joining the RSC panel,[322] and the report was alleged to present a biased (largely legal) argument.[323]
- Second: three authors of the RSC report were plaintiff witnesses at trial, and one helped to instruct plaintiff witnesses.[324]
- Third: the recommendations of the QNA committee report were reported to have contradicted the majority of submissions received by the committee.[325]

B6.3.4 However, Justice Smith did not treat the reports as evidence of a consensus that assisted suicide and euthanasia *were* ethical. Instead, she relied upon them only to demonstrate a *lack* of social consensus. She contrasted the majority and minority Senate Committee positions,[326] and the recommendations of the RSC and QNA reports with the adverse response of Parliament in 2010.[327]

B6.4 Ethics and prosecution policies

B6.4.1 In considering Crown Counsel policy governing prosecution of assisted suicide in British Columbia,[328] Justice Smith noted that the policy appeared to recognize that the public interest may not always require prosecution of assisted suicide or euthanasia, even if there were a strong

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[320] *Ibid* at para 288–292.

[321] *Ibid* at para 295-296, 298.

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

[323] *Carter BCSC, supra* note 1 at para 123.

[324] *Ibid* at para 124 (The witnesses were Prof. Ross Upshur, Prof. Johannes J.M. van Delden and Prof. Sheila McLean. Prof. Jocelyn Downie instructed plaintiff witnesses.)

[325] Linda Couture, "Results of public hearings held by The Select Committee on dying with dignity in Quebec: Briefs submitted (15 November, 2011), *Vivre Dans La Dignité* (blog), online: <https://web.archive.org/web/20111125055321/http://www.vivredignite.com:80/en/docs/positon_csmd_nov15_11.pd>.

[326] *Carter BCSC, supra* note 1 at para 290–292, 346.

[327] *Ibid* at para 346

[328] *Ibid* at para 300–307.

likelihood of conviction. She found this conceivably supportive of legalization of the procedures.[329] This was a peculiar conclusion. Crown Counsel may decide not to prosecute offenders for a variety of crimes for public interest reasons, despite the likelihood of conviction; for example: the Crown may decline to prosecute a dying offender for robbing a bank. However, such an exercise of discretion would not be cited as a reason to abolish the crime of robbery.

B6.4.2 More significant, the judge ignored the prosecution policy of the United Kingdom, which was also part of the evidentiary record[330] and directly relevant to the subjects she considered in Part VII. According to the English policy, if there were sufficient evidence to support a charge, there was *more* reason to prosecute physicians, healthcare workers and others who assisted in the suicide of someone in their care than in prosecuting those who were *not* in positions of authority.[331] Since Justice Smith emphasized that she had reviewed the *entire* evidentiary record (see IV.5), her silence concerning this document seems indicative of a personal preference for an outcome favourable to legalization of physician-assisted suicide.

B7. Summary of the ethical debate

B7.1 Justice Smith provided succinct summaries of arguments for and against legalizing assisted suicide and euthanasia.[332]

B7.2 She correctly noted agreement that palliative care is not always effective, and, more commonly, often not accessible.[333]

B7.3 She also claimed that there was no disagreement about the facts related in Part VII concerning "existing clinical end-of-life practices and the understood legal and ethical justification for them."[334] Given her incomplete treatment of the subject, this assertion was at least a gross oversimplification, if not simply inaccurate. (See Appendix "C")

B7.4 The judge asserted that there was "little dispute" that principles of autonomy, compassion and non-abandonment "play a central role in the formation of medical ethics" and that the principle "do no harm" was of continuing importance for physicians."[335] This was correct, but insufficient.

B7.5 In the first place, this comment implied that "medical ethics" was a monolithic entity; it suggests that the judge was unaware that there were different traditions of medical ethics that were

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[329] *Ibid* at para 355.

[330] *Ibid* at para 299.

[331] Director of Public Prosecutions, "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide" (February 2010, updated October 2014), *Crown Prosecution Service* (website) at para 43.14, online: <https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide>.

[332] *Ibid* at para 314-315

[333] *Ibid* at para 309; 190-193

[334] *Ibid* at para 309

[335] *Ibid* at para 310

not always in agreement on all points.

B7.6 Moreover, autonomy, compassion, non-abandonment and non-maleficence were not the only principles that had shaped medical ethics, and there were ongoing disputes about the application of these principles. For example: the principle of non-abandonment was generally accepted, but that it could be applied to compel an objecting physician to facilitate assisted suicide (as implied by Professor Battin: B5.3.3) would have been sharply contested. The judge's failure to appreciate this was illustrated by her casual dismissal of references to conscientious objection by physicians in the evidence and in submissions.[336]

B7.7 Finally, Justice Smith acknowledged (without explaining) controversies associated with palliative sedation and the withdrawal of food and fluids from patients unable to give informed consent, but deemed them irrelevant to the claims made by the plaintiffs.[337]

B8. "Conclusions about the ethical debate"

B8.1 Recall that Justice Smith promised "findings of fact" and "conclusions" in relation to Part VIII, but not Part VII (B2.12). This is reflected in her opening paragraph under the heading, "Conclusions about the Ethical Debate." Justice Smith there stated that she would "*attempt* to draw some conclusions about the ethics of physician-assisted death"(Emphasis added.). [338]

B8.2 Consistent with this, a difference in language pervades Part VII and Part VIII that suggests statements about ethics in Part VII should not be considered on par with findings in Part VIII.

> **Part VII (Ethics):**
>
> [335] The preponderance of the evidence from ethicists is . . .
>
> [335] I find the arguments . . . persuasive.
>
> [338] . . . a bright-line ethical distinction is elusive.
>
> [339] I also find persuasive the arguments . . . I agree that . . . It is unclear, therefore. . .
>
> [343] The evidence shows that thoughtful and well-motivated people can and have come to different conclusions . . .
>
> [344] Their evidence shows that the view. . .is not universally held . . .
>
> [347] . . . provide some indication as to . . .

[336] *Ibid* at para 311 (Her comment also demonstrated the shaping and limiting power of the pleadings, which excluded consideration of practitioners and other health care workers whose interests were affected by the judgement).

[337] *Ibid* at para 312–313.

[338] *Ibid* at para 316.

[348] As I see it, the divergence is with respect to. . .

[350] . . . I think that the real difference . . . Rather, the difference . . .

[357] . . . there appears to be relatively strong societal consensus about . . .

[358] . . . weighing all of the evidence, I do not find that there is a clear societal consensus either way . . . However, there is a strong consensus that if . . .

Part VIII (Efficacy of safeguards):

[647] What conclusions can be reached . . .? . . . The data do not permit firm conclusions about . . .

[648] Having said that, I am able to reach some conclusions . . .

[652] I accept that . . . I also found . . . and I accept it.

[656] The evidence supports the conclusion that . . .

[665] . . . I find that . . .

[667] I find that the empirical evidence . . . does not support . . .The evidence does support. . .

[668] No conclusion can be drawn from that study with respect to. . .

[671] It is impossible to know from statistical evidence . . . However, the evidence . . . does not support the conclusion that . . .

[672] . . . it is difficult to reach any firm conclusion.

[678] . . . I do view that as a significant difference . . .

[680] The evidence suggests ...There is no evidence suggesting

[682] Overall, the evidence permits the following conclusions . . .

[736] In summary, having reviewed the evidence and the submissions on this point, I conclude that . . . I find that the evidence establishes that . . .

[737] I will review. . . and. . . before setting out my conclusions.

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

798] Weighing the evidence as a whole, I conclude that . . .

[814] I accept Professor Werth's evidence that . . .

815] Although I accept the evidence of . . . I accept the evidence of . . .

[831] The evidence as to informed consent permits me to conclude that . . .

[837] I agree with the evidence of the plaintiffs' experts that . . .

[843] The evidence . . . leads me to the conclusion that . . .

[847] I accept that . . . and that . . .

[852] . . . there is no evidence that . . .

[853] I accept that . . .and that . . . I am not persuaded that . . .

[854] This review of the evidence permits no conclusion other than . . .

[883] My review of the evidence . . . leads me to conclude that . . .

B8.3 Turning to particulars, recall that, when introducing Part VII, Justice Smith identified the purported focus of Part VII by stating the question she proposed to address: "Would it ever be ethical for a physician to provide assisted suicide or euthanasia at the request of a competent, informed patient?"(B2.1)

B8.4 In her "conclusions" the judge ignored the focal question. Instead, she substituted four different questions under three headings (one including two questions).

B8.5 Would Canadian physicians be willing . . .?

B8.5.1 The exploration of the willingness of physicians to provide assisted suicide or euthanasia revealed only what ought to have been obvious from the pleadings: that some were willing, others were not. The judge's conclusion that some "experienced and reputable physicians" would be willing to do so resolved nothing with respect to the ethics of the practices.

B8.6 Does current medical practice with respect to end-of-life care make distinctions that are ethically defensible and is the distinction between suicide and assisted suicide ethically defensible?

B8.6.1 Much of this section of the ruling concerned peripheral legal issues[339] and a re-statement of the ethical arguments of the plaintiffs and defendants.[340]

B8.6.2 The subject of intention in ethical decision-making was introduced,[341] but the judge did not pursue it because, in her view, the focus of the Supreme Court of Canada's discussion of intention in *Rodriguez* was law, not ethics.[342]

B8.6.3 This was, arguably, a misapplication of *Rodriguez*, in which the majority held that "distinctions based upon intent are important, and in fact *form the basis of* our criminal law." (Emphasis added.)[343] The distinctions in question were philosophical or ethical distinctions and thus relevant to Justice Smith's question about ethical distinctions in end-of-life care.

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[339] *Ibid* at para 326–333.

[340] *Ibid* at para 321–323.

[341] *Ibid* at para 324–325.

[342] *Ibid* at para 330.

[343] *Rodriguez*, *supra* note 13 at 607.

B8.6.4 In any case, in Part VII, Justice Smith offered the following summary of her study:

> The evidence shows that within the medical and bioethical community the question still remains open whether an ethical distinction is maintainable between withholding or withdrawing life-sustaining treatment and palliative sedation on the one hand, and physician-assisted death on the other.[344]

This was consistent with the summary with which she introduced the ruling, in which she stated that "currently accepted practices bear similarities to physician-assisted death, but opinions differ as to whether they are ethically on a different footing."[345]

B8.6.5 Immediately after declaring the question still open, however, she claimed that "[t]he preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death," adding that she found the *arguments* for this view "persuasive."[346] She noted that a number of defendant and plaintiff witnesses were doubtful about the distinction,[347] and that she found it difficult to make an ethical distinction in individual cases, "whether based on a distinction between foreseeing and intending, on a distinction between acts and omissions, or on other grounds."[348]

B8.6.6 However, on the judge's own account, the evidence from "the medical and bioethical community" consisted of a sampling of conflicting ethical opinions provided by parties to a contentious suit, and the expression of doubts and difficulties by some of the witnesses. The evidence actually demonstrated that there was no consensus: that ethicists were divided, even though "a number of respected ethicists and practitioners" favoured the position she found "persuasive."[349] In short, the evidence, such as it was, actually could not answer the question the judge posed. (B8.5).

B8.6.7 The judge's reference to a "preponderance of evidence" involved the misapplication of an evidentiary rule developed for other purposes. The "preponderance of evidence" or "balance of probabilities" rule expresses the judicial standard of proof in civil cases, but it pertains to findings of contested facts, not to the evaluation of contested ethical beliefs. A judge cannot properly make a finding of fact to the effect that ethical position A is correct and ethical position B is not: that, for example, capital punishment is ethical, and those who think otherwise are mistaken.

B8.6.8 Further, the binary system of reasoning and rules about standards and burdens of proof

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[344] *Carter BCSC, supra* note 1 at para 334.

[345] *Ibid* at para 5.

[346] *Ibid* at para 335 (Emphasis added. She elsewhere referred to this as "the preponderant ethical opinion": para 1336).

[347] *Ibid* at para 336–337.

[348] *Ibid* at para 338.

[349] *Ibid* at para 1369.

used by our courts is sufficient for the purposes of a common law civil proceeding,[350] but fall short of what is normative in other disciplines. For example, "more likely than not" or 51% probability is sufficient to prove facts required for judicial decision-making in civil litigation,[351] but not for building bridges or forming some medical opinions.[352]

B8.6.9 Nonetheless, Justice Smith said that she had been persuaded that the intention of the actor is of no ethical consequence, and that there is no ethical difference between lethally injecting a willing patient and withdrawing treatment to allow a patient to die of natural causes. Similarly, she was persuaded that there was no ethical distinction between suicide and assisted suicide in the circumstances contemplated by the plaintiffs' application.[353]

B8.6.10 While this doubtless expressed her personal opinions, for the reasons noted above she could not have made such findings of fact based on the evidence. This likely explains why she stated that she was persuaded by *arguments*, not by *evidence*.[354]

B8.7 Does the law attempt to uphold a conception of morality inconsistent with the consensus in Canadian society?

B8.7.1 Justice Smith asserted that there appeared to be a "strong consensus that currently legal end-of-life practices are ethical."[355] While this conclusion was questionable in some respects (see Appendix "C"), and the judge commented on it in her summary of the ruling,[356] it did not enter into the reasoning offered to support her decision to strike down the law.[357]

B8.7.2 The judge believed that consensus about end-of-life practices was ultimately based on the "value of individual autonomy," but this was a hazardous oversimplification. Personal autonomy is arguably the most highly prized legal principle in Canada, and in dominant theories of bioethics it is frequently the value that trumps all others. However, other ethical traditions give priority to other

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[350] "If a legal rule requires a fact to be proved (a "fact in issue"), a judge or jury must decide whether or not it happened. There is no room for a finding that it might have happened. The law operates a binary system in which the only values are 0 and 1. The fact either happened or it did not. If the tribunal is left in doubt, the doubt is resolved by a rule that one party or the other carries the burden of proof. If the party who bears the burden of proof fails to discharge it, a value of 0 is returned and the fact is treated as not having happened. If he does discharge it, a value of 1 is returned and the fact is treated as having happened." Re B (Children) [2008] UKHL 35, online: <http://www.publications.parliament.uk/pa/ld200708/ldjudgmt/jd080611/child-1.htm> at para 2.

[351] "In any civil case the plaintiff must prove their case on a balance of probabilities if they are to succeed. This means that the plaintiff must prove that his facts tip the scale in his favor even if it is only a 51% probability that he is correct." *McIver v. Power*, [1998] CanLII 4858 (PE SCT) online:<https://canlii.ca/t/1cvr3> at para 5.

[352] *Snell vs. Farrell* [1990] 2 SCR 311, online: <http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/634/index.do> at 330.

[353] *Ibid* at para 339.

[354] *Ibid* at para 335, 339.

[355] *Ibid* at para 340, 357

[356] *Ibid* at para 5.

[357] *Ibid* at para 8-10, 15-18

principles, like the sanctity of life or human dignity.[358] Practitioners from these traditions may share in a consensus about a particular end-of-life practice, but their agreement may not be based on the concept of autonomy.

B8.7.3 In attempting to identify the key difference of opinion that frustrated ethical consensus, Justice Smith concluded that there was no difference of opinion about the value of human life. "[N]o one questions that the preservation of human life has a very high value in our society," she wrote. "Rather, the difference of opinion is about whether the preservation of human life is an absolute value, subject to no exceptions."[359]

B8.7.4 With respect, this statement misrepresented, or, at least, caricatured the position of the principal opponents of assisted suicide and therapeutic homicide. They did not hold that human life must be preserved in all cases, without exception. In fact, Justice Smith acknowledged that the Christian Legal Fellowship had explicitly repudiated this view in its submission.[360]

B8.7.5 It appears that the judge's interest here was in emphasizing the possibility of "exceptions" rather than "value." That is, she may simply have meant, "Granted that the preservation of human life has very high value, when can we make an exception and kill someone?"

B8.7.6 Rephrasing the question in this way accounts for the judge's reference in the next paragraph to the "deprivation account of the badness of death" offered by Professor Sumner. "[W]hat makes death such a bad thing in the normal case," he said, "is what it takes away from us - the continuation of a life worth living."[361] It follows that if a life is not worth living, assisted suicide or euthanasia could be a good for that person.

B8.7.7 In any case, Justice Smith did not address the difference of opinion about the value of life that she inaccurately articulated nor Professor Sumner's provocative ethical reflections about "a life worth living." Neither seems to have been related directly to the judge's eventual "conclusions" in Part VII.

B8.7.8 Instead, the judge emphasized differences of opinion among medical associations, individual physicians and politicians,[362] among panels, committees, parliaments and senates,[363] and among professional ethicists and medical practitioners.[364] Consistent with these differences, she concluded that there was no "clear societal consensus" about assisted suicide or euthanasia in the case of competent adults who were "grievously ill and suffering symptoms that cannot be

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[358] Abudaziz Sachedina, *Islamic Biomedical Ethics: Principles and Application* (Oxford: University Press, 2009) [*Sachedina 2009*) at 166.

[359] *Ibid* at para 350.

[360] *Ibid* at para 171.

[361] *Ibid* at para 351.

[362] *Ibid* at para 343.

[363] *Ibid* at para 345–346.

[364] *Ibid* at para 348.

alleviated."[365]

B8.7.9 In addition, however, Justice Smith 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.[366] By means of this rhetorical hypothesis she avoided the question that Part VII was supposed to answer.

B9. *Carter* Part VII: in brief

B9.1 Justice Smith's review of ethical issues in Part VII of the ruling was unsatisfactory because much that was necessary to understand the ethical issues and controversies associated with end-of-life practices was lacking (See Appendix "C").

B9.2 Of the four questions ultimately posed and discussed in Part VII (B2.1, B8.4, B8.5, B8.6), Justice Smith actually answered only one. However, her answer — that some "experienced and reputable Canadian physicians" were willing to provide euthanasia or assisted suicide — disclosed nothing that was not already known and nothing about the ethics of assisted suicide or euthanasia.

B9.3 The judge was unable to identify any actual ethical consensus concerning physician assisted suicide and euthanasia among professional associations, physicians, ethicists, public committees and the public as a whole.

B9.4 The evidence considered by Justice Smith indicated that the question as to whether or not contemporaneous end of life practices could be distinguished from euthanasia/assisted suicide was unresolved. The judge was personally persuaded by argument — not by evidence — that there was no ethical distinction between them. Similarly, she was personally persuaded by argument — not evidence — that there was no ethical distinction between suicide and assisted suicide in defined circumstances. She did not propose these personal views as conclusions or findings of fact.

B9.6 This was notably evident in the opening paragraphs of the ruling that summarized the findings of fact and legal reasoning underlying the decision about the constitutional validity of the law against assisted suicide.[367] Justice Smith 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, findings later attributed to her by lead appellant counsel Joseph Arvay at the Supreme Court of Canada.[368] On the contrary: in summarizing Part VII, she noted the lack of agreement about the ethics of assisted suicide/euthanasia and about their ethical relationship to contemporaneous end-of-life practices.[369] Those findings did not contribute to her decision about the constitutionality of the law.

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[365] *Ibid* at para 358 (See also para 6, 7).

[366] *Ibid* at para 342, 358.

[367] *Ibid* at para 4–18.

[368] *Carter SCC webcast*, *supra* note 80 at 00:38:35 to 00:40:31.

[369] *Carter BCSC*, *supra* note 1 at para 4–7.

B10. *Carter* Part VII: judicial dicta on ethics

B10.1 The discussion of the ethical debate in Part VII was not on the same footing in relation to the ruling as the review of evidence concerning safeguards and conclusions in Part VIII. That is evident from the judge's different explanations of the purpose of each part (B2.11-B2.12) and the different language she used in each. The language in Part VIII is that of adjudication: in Part VII, of discussion and comparison (B8.1-B8.2).

B10.2 Although briefly summarized in the opening paragraphs of the ruling,[370] nothing in Part VII actually contributed to the judge's decision about the constitutionality of the law. Part VII is *obiter dicta*; it could have been left out without affecting the outcome of the case.[371] Other courts are not bound to adhere to or defer to it.[372] This is not true of Part VIII, also summarized in the opening paragraphs of the ruling.[373]

B10.3 In *R v Henry* the Supreme Court of Canada noted that all statements that can be classed as *obiter dicta* do not have the same weight. Analysis that is clearly offered for guidance may be considered authoritative.[374] Consistent with Justice Smith's explanation of her purpose,[375] Part VII lies outside this, in a category described in *Henry* as "commentary, examples or exposition that are intended to be helpful and may be found to be persuasive."[376] However, the review of ethics in Part VII is unsatisfactory and has neither binding authority nor persuasive weight.

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[370] *Ibid*.

[371] Irwin Law, *Canadian Online Legal Dictionary*, (Toronto, Ont: 2023) *sub verbo* "obiter dicta", online: <https://irwinlaw.com/cold/obiter-dicta/>.

[372] The Honorable Justice Malcolm Rowe & Leanna Katz, "A Practical Guide to Stare Decisis" (2020) 41:May Windsor Rev Legal Soc Issues 1, online: <http://wrlsi.ca/wp-content/uploads/2020/06/VOL-41-pages-5-31.pdf> at 7.

[373] *Carter BCSC, supra* note 1 at para 8–10.

[374] *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.

[375] *Carter BCSC, supra* note 1 at para 163–164,178.

[376] *Henry*, *supra* note 375 at para 57.

APPENDIX "C"
Carter Part VII: Filling in the Blanks

C1. Introduction

C1.1 Much that is necessary to understand the ethical issues and controversies associated with end-of-life practices was absent from Part VII. While the judge's explanation of the *law* of informed consent was satisfactory, as was her explanation of the *law* concerning withdrawal and refusal of treatment,[377] her discussion of the *ethics* of end-of-life decision-making was seriously deficient.

C1.2 Thus, her assertion that there was no disagreement about facts related to "existing clinical end-of-life practices and the understood legal and ethical justification for them"[378] cannot be accepted at face value, particularly in view of the studied vagueness that attended her discussion of palliative sedation. One reason for this may have been that the evidence appears to have been focused on palliative care — the care of those who are dying — while the most spectacular controversies about euthanasia have concerned patients who are *not* dying (C2.3.4).

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

C1.4 As a result, Part VII is likely to contribute to confusion and make it more difficult for conscientious objectors among health care workers to be heard with respect. Accordingly, this Appendix reviews Part VII with a view to providing information that was obscured by the ruling or left out of it altogether, so that readers will be better placed to understand the basis for objections when they arise.

C1.5 Note that the trial court decision is now over ten years old. References here are to contemporaneous sources. To preserve their relevance to the decision they have not been updated.

C2. Patient autonomy: the distinction between legal and ethical evaluation

C2.1 In Canada, a competent person can legally refuse any kind of intervention or assistance, or require that it be discontinued, even if that will result in death. When the wishes of a competent person are known, they will be respected if he becomes incapacitated and unable to communicate.

C2.2 Incompetent persons are those who, by reason of age or disability, are unable to provide or withdraw informed consent to intervention or assistance. Such decisions must be made by a proxy or substitute decision-maker, typically a family member or relative defined by common law or statute.

C2.3 Health care workers commit an assault and are liable to civil action and perhaps criminal charges if they provide interventions or assistance against the wishes of a competent patient, or, in

[377] *Carter* BCSC, *supra* note 1 at para 231.

[378] *Ibid* at para 309.

the case of an incompetent person, against the direction of a substitute decision maker.

C2.4 The preceding explanation of the law in Canada was offered in Part VII in the *Carter* ruling,[379] but there was no discussion of the associated ethical or moral issues, even though, in Part VII, the judge claimed to be addressing ethical rather than legal questions.

C2.5 What was missing from the judge's account was an acknowledgement that a decision to refuse intervention or assistance or to require that it be discontinued has a moral or ethical dimension, and that different religious, moral and ethical traditions may disapprove of the decision, even though the law does not. This can cause conflicts within families, between families and health care workers, and among health care workers who have different moral, ethical or religious views.

C2.6 Consider, for example, a decision by a competent patient to commit suicide by refusing food and fluids. It was acknowledged at trial that this could not be prevented, but nothing in the representations of the parties or in the comments of the judge suggested that the decision might be morally or ethically controversial. In fact, the defendants argued that the law against assisted suicide was not discriminatory precisely because everyone *could* commit suicide in this manner (C3.7.7).

C2.7 No one disputes that this is the law, and that health care workers are bound by the law. But it would be misleading to imply that compliance with the law is evidence of an ethical consensus in favour of suicide, so that health care workers might reasonably be expected to help someone commit suicide.

C3. Withdrawal and refusal of assisted nutrition and hydration

C3.1 Nutrition and hydration are different needs and in a clinical situation should be considered separately, but for present purposes they will be discussed together because the ethical considerations relevant to withdrawing, withholding or refusing them are the same.

C3.2 Assisted nutrition and hydration: the methods

C3.2.1 Assisted nutrition and hydration (also known as "artificial nutrition and hydration" or "clinically assisted nutrition and hydration") include techniques for the delivery of nourishment and fluids to sustain life when a patient is unable to eat or drink, or when there is a significant risk of aspiration. They involve medical interventions like nasogastric tubes, percutaneous endoscopic gastrostomy (PEG) or radiologically inserted gastrostomy tubes inserted through the abdominal wall.

C3.3 The dying patient

C3.3.1 A patient who is approaching death will naturally and gradually lose the ability to assimilate food and fluids, so that assisted nutrition and hydration will at some point serve no purpose and may even be contra-indicated. There was no dispute that discontinuation is justified in such circumstances, even if there may be some practical difficulty in determining whether or not the

[379] *Ibid* at para 231.

patient has reached this stage in the dying process.[380]

C3.4 Patients who are not dying

C3.4.1 If a patient is incapacitated, assisted nutrition and hydration may be instituted while his condition is stabilized and assessed, and maintained until the patient has recovered sufficiently to resume eating and drinking. This is uncontroversial. However, if recovery does not occur and the patient does not die from the underlying illness or injury, he will be dependent upon assisted nutrition and hydration to sustain his life. At this point, a conflict may occur between those who want to terminate assisted nutrition and hydration, and those who want to continue it.

C3.4.2 A patient who is capable of assimilating food and fluids and is not dying will not die merely because he is unconsciousness, whether as a result of an injury or illness or because of sedation. But withholding or withdrawing assisted nutrition and hydration will cause his death, and this is controversial.[381]

C3.4.3 Moreover, it is not just "somewhat" controversial; it is highly so. There had been several high-profile court rulings over the three decades prior to *Carter* that led to the withdrawal of nutrition and hydration from patients who were not dying, all of whom then died: Patricia Brophy,[382]

[380] For an exchange of views on this and an introduction to some of the complexities of providing assisted nutrition and hydration, see Gillian M Craig, "On withholding nutrition and hydration in the terminally ill: has palliative medicine gone to far?" (1994) 20:3 J Med Ethics139, online: < http://jme.bmj.com/content/20/3/139.full.pdf>; RJ Dunlop et al, "On withholding nutrition and hydration in the terminally ill: has palliative medicine gone too far? A reply" (1995) 21:3 J Med Ethics 141, online: <http://jme.bmj.com/content/21/3/141.full.pdf >; Michael Ashby M & Brian Stoffell B, "Artificial hydration and alimentation at the end of life: a reply to Craig" (1995) 21:3 J Med Ethics 135, online: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1376687/pdf/jmedeth00296-0007.pdf>.

[381] "To withdraw fluids and food from a person who is not otherwise dying, even if that person has a significant cognitive disability, is euthanasia because death is directly and intentionally caused by the withdrawal of basic care, that being fluids and food. Whether fluids and food are provided by a fork, a spoon or a tube, they represent a basic necessary of life that should be provided unless the person cannot assimilate or is actually nearing death." Alex Schadenberg, "UK Judge decides not to dehydrate woman to death" (29 September, 2011), *Euthanasia Prevention Coalition* (blog), online: <http://alexschadenberg.blogspot.ca/2011/09/uk-judge-decides-not-to-dehydrate-woman.html> (Commenting on *W v M & Ors* [2011] EWHC 2443 (Fam), online:<http://www.bailii.org/ew/cases/EWHC/Fam/2011/2443.html>).

[382] *Brophy v. New England Sinai Hosp, Inc*, 497 N.E (2d) 626, 398 Mass 417 (Sup Jud Ct Mass 1986), online: <https://case-law.vlex.com/vid/brophy-v-new-england-894036508>.

Nancy Cruzan,[383] Tony Bland,[384] Terri Schiavo[385] and Eulana Englaro. [386] A number generated heated public debate; the Englaro case precipitated a constitutional crisis in Italy.[387] Three Canadian cases cited in *Carter* concerned withdrawal of interventions, but none had raised the specific issue of assisted nutrition and hydration.[388]

C3.5 Assisted nutrition and hydration: optional "treatment" or obligatory "care"?

C3.5.1 In Canada (and in many other jurisdictions), assisted nutrition and hydration are legally considered to be forms of medical treatment, and, from the perspective of the patient, the law considers all forms of treatment to be optional. Reflecting the primacy of the principle of personal autonomy, a competent patient can legally refuse any kind of medical treatment, even life-saving or life-sustaining treatments like assisted nutrition and hydration.[389] It was acknowledged at trial that a patient cannot be prevented from committing suicide in this manner.[390] In the case of incompetent patients, substitute decision-makers can legally refuse all forms of treatment on their behalf, including assisted nutrition and hydration.[391]

C3.5.2 The law reflects the opinions of widely influential ethicists, but cannot be said to represent an ethical consensus, unless one discounts the views of those who disagree. Notwithstanding the law and the opinions of influential schools of bioethics, some ethical traditions consider assisted nutrition and hydration to be forms of care, not medical treatment.[392]

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[383] *Cruzan v Director, MDH*, 497 US 261 (1990), online: <http://supreme.justia.com/cases/federal/us/497/261/case.html>.

[384] *Airedale NHS Trust v Bland* [1993] UKHL 17 [*Airedale*], online: <http://www.bailii.org/uk/cases/UKHL/1993/17.html>.

[385] Fred Charatan, "US Supreme Court refuses to intervene in 'right to die' case" (2005) 330(7494) Brit Med J 746, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC555906/>.

[386] Corte Constituzionale, Rome, 8 October, 2008 (2008) Order 334 of 2008 (Italy), online: <https://www.cortecostituzionale.it/documenti/download/doc/recent_judgments/O2008334_Bile_DeSiervo_en.pdf>.

[387] Rachel Donadio, "Death ends coma case that set of furor in Italy", *The New York Times* (9 February), online: <http://www.nytimes.com/2009/02/10/world/europe/10italy.html?_r=1>.

[388] *Golubchuk v. Salvation Army Grace General Hospital et al*, 2008 MBQB 49 (CanLII) online:<https://canlii.ca/t/1vs2m>; *Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONCA 482 (CanLII), online: <https://canlii.ca/t/fm31l>; *Sawatzky v. Riverview Health Centre Inc*, 1998 CanLII 19469, online: <<https://canlii.ca/t/gbsfj> (In *Golubchuk* and *Rasouli* the patients were on ventilators as well as having assisted nutrition and hydration, while in *Sawatzky* the issue was a "Do Not Resuscitate" order that had been improperly issued).

[389] *Carter BCSC*, *supra* note 1 at para 207-220; *CLF Submission*, *supra* note 261 at para 42–44.

[390] *Ibid* at para 1065–1076.

[391] *Ibid* at para 221–224.

[392] Arnold J Rosin & Moshe Sonnenblick, "Autonomy and paternalism in geriatric medicine. The Jewish ethical approach to issues of feeding terminally ill patients, and to cardiopulmonary resuscitation"(1998) 24:1 J Med Ethics 44, online: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1377431/pdf/jmedeth00312-0048.pdf>.

C3.5.3 The distinction is important, because those who make it typically insist that, unlike treatment, care is not optional; it is a duty one owes to others by virtue of our common humanity. While acknowledging that assisted nutrition and hydration may be withheld or withdrawn when it cannot be assimilated or is otherwise medically contra-indicated, they assert that it must be provided in other circumstances if it is ordinarily accessible and affordable.[393]

C3.6 Assisted nutrition and hydration as "extraordinary" or "disproportionate"

C3.6.1 Two other approaches can be identified. Some deem assisted nutrition and hydration to be part of an overall treatment regime that may include other medical interventions, like the artificial evacuation of bladder and bowels.[394] Alternatively (or, in addition) they may consider assisted nutrition and hydration to be an artificial substitute for a failed organ system, analogous to a ventilator used by someone unable to breathe independently.[395] On either view, refusal or withdrawal of the intervention could be justified by reference to the principle of proportionality (C5).

C3.7 *Carter* and withdrawal/refusal of nutrition and hydration

C3.7.1 Justice Smith was aware of the controversies concerning the withdrawal of assisted nutrition and hydration because she referred to the case of Tony Bland[396] and to the cross-examination of Professor John Keown concerning it.[397] Professor Keown's point was that Bland was not dying and would not have died but for the withdrawal of assisted nutrition and hydration; the intervention was withdrawn, not because it was futile, but with the intention of causing his death. The Christian Legal Fellowship drew this to judge's attention in its written submission.[398]

C3.7.2 Moreover, the judge quoted the evidence of Dr. Michael Klein, who stated that he had been required to stop both ventilator and tube feeding and hydration for competent patients who specifically intended to die by such means,[399] and evidence from Dr. Rodney Syme that appears to describe the death of someone being killed by dehydration and starvation while under palliative sedation.[400]

C3.7.3 It appears that, in considering all of this, the judge overlooked the issue of intention and

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[393] William Cardinal Levada, "Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration" (1 August, 2007), *Congregation for the Doctrine of the Faith* (website), online: <http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html>.

[394] This was the view of Lord Keith in *Airedale*, *supra* note 286 at 858 F to H.

[395] *Somerville 2001*, *supra* note 84 at 362, note 161.

[396] *Carter BCSC*, *supra* note 1 at para 224.

[397] *Ibid* at para 245.

[398] *CLF Submission*, *supra* note 261 at para 46.

[399] *Carter BCSC*, *supra* note 1 at para 257.

[400] *Ibid* at para 1071.

acknowledged only an ethical controversy associated with the withdrawal/withholding of treatment from a patient who had not provided informed consent or an advance directive. She considered this irrelevant because the plaintiffs' claims concerned only competent adults who were acting freely on the basis of informed consent.[401]

C3.7.4 The plaintiffs asserted that, assuming the requirements of informed consent had been met, deliberately causing the death of patients by dehydration and starvation was legally and ethically acceptable in Canada, so deliberately causing their deaths by other means should be equally so. Justice Smith summed up their position:

> In brief, the argument is that withdrawing a ventilator tube or maintaining a patient under sedation without hydration or nutrition are acts that will result in death, just as much as the act of providing a lethal prescription or administering lethal medications. To perform those acts, knowing of their inevitable consequences, is to hasten death. Similarly, refraining from life-saving treatment may result in the death of the patient, and is a passive form of hastening death. If those practices are ethical, then so is physician-assisted dying. "[402] (Emphasis added.)

C3.7.5 Recall, on the one hand, the distinction between withholding nutrition and hydration from a patient when they are of no benefit or contra-indicated, and, on the other, deliberately causing the death of a patient by starvation and dehydration (C3.3, C3.4). This difference was ignored and obscured by the judge's generic reference to "maintaining a patient under sedation without hydration or nutrition."

C3.7.6 Withdrawing a ventilator tube, sedation, and refraining from life-saving treatment are different kinds of acts that may or may not be ethically justified, depending upon the circumstances and the ethical norms applied. Moreover, physicians are legally prohibited from providing or continuing treatment against the wishes of a competent patient (C2). Again, the judge failed to acknowledge the differences between the acts, the ethical and legal significance of differing circumstances, and the existence of conflict between ethical norms drawn from different sources.

C3.7.7 The defendant governments insisted that "legally approved end-of-life practices in Canada" could be ethically distinguished from physician-assisted suicide and euthanasia, but they did not assert that any "legally approved" practices were unethical.[403] In fact, both Canada and British Columbia argued that committing suicide by dehydration and starvation was a legal option available to everyone.[404] Neither suggested that this would be considered ethically unacceptable by anyone.

C3.7.8 More to the point, they did not assert that it was unethical for an incompetent patient who was not dying to be deliberately starved and dehydrated to death on the orders of a substitute

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[401] *Ibid* at para 312–313.

[402] *Ibid* at para 321.

[403] *Ibid* at para 323.

[404] *Ibid* at para 1049, 1067, 1068.

decision-maker, a "legally approved" practice in Canada that remained ethically controversial.[405] Here the plaintiffs had the advantage, because the defendant governments would have been hard placed to distinguish the practice from euthanasia; that is how it was characterized by their own witness, Professor Keown (C3.7.1). However, they could not identify it with euthanasia without acceding to the plaintiffs' argument, provoking a heated response from those in the medico-ethical establishment who supported the practice and generating widespread controversy.

C4. Palliative sedation

C4.1 Justice Smith offered the following explanation of palliative sedation:

> In the context of palliative care, it is fairly widely accepted that when a patient is close to the end of life, and is experiencing symptoms that are severe and refractory (that is, resistant to treatment), it is ethical practice for her physician to sedate her and maintain her in a state of deep, continuous unconsciousness to the time of death, with or without providing artificial hydration or nutrition ("terminal sedation" or "palliative sedation")[406]

C4.2 Palliative sedation was unregulated, had not been judicially considered in Canada, and standards were under development. The judge noted that palliative sedation could not be assumed to "hasten death" when provided to patients "in the final stages of dying," and was usually provided when a patient was within a week of death, "although it is not always possible to be accurate in such assessments."[407]

C4.3 According to the judge, the practice of palliative sedation "remains somewhat controversial,"[408] and she elsewhere admitted that "some aspects of palliative sedation" were "possibly" problematic for Canadian ethicists and practitioners. For example, she mentioned controversy about the use of palliative sedation for "relief of existential suffering," which referred to "a profound sense of loss of dignity."[409] However, she did not elaborate further.

C4.4 The controversies were not about palliative sedation *per se*: rendering a patient unconscious in order to provide relief from otherwise intractable symptoms. The controversies were about using palliative sedation as an anaesthetic while withdrawing or withholding food and fluids (assisted nutrition and hydration) in order to cause death, or suppressing consciousness in order to eliminate awareness of gravely trying personal circumstances, circumstances not unique to some seriously ill patients.

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[405] *Ng v. Ng*, 2013 BCSC 97, online: <https://www.thaddeuspope.com/images/2013_BCSC_97_Ng_v.pdf> (While the case was decided after the trial court ruling in *Carter*, the relevant statutory framework predated the *Carter* decision.)

[406] *Ibid* at para 200.

[407] *Ibid* at para 201, 202, 226

[408] *Ibid* at para 201, 202, 226, 312.

[409] *Ibid* at para 190, 312.

C4.5 The two acts (sedation on the one hand, withholding/withdrawing nutrition and hydration on the other) are clearly distinguishable in terms of their structure and their potential consequences. A competent patient can commit suicide and an incompetent patient can be killed by deliberate dehydration and starvation, and palliative sedation can be used to ameliorate and mask the effects of the process.[410] This is unquestionably legal when the requirements of informed consent have been met, but, as the evidence of Professor Keown indicated, there was no consensus — let alone a *strong* consensus — that deliberately causing the death of a patient by dehydration and starvation was ethically acceptable. In these circumstances, the controversy was not about the ethics of palliative sedation, but the ethics of euthanasia and suicide (C3).

C5. Proportionality of interventions

C5.1 The distinction between ordinary and extraordinary (or proportionate and disproportionate) interventions relates to the widely accepted principle that one is not ethically obliged to preserve one's health or life by recourse to extraordinary interventions or those that are disproportionately burdensome. Similarly, health care workers are not ethically obliged to provide extraordinary or disproportionate interventions. This principle is acceptable to many who believe that human life is sacred (or of inestimable value) but who also believe that life need not be preserved at all costs.[411]

C5.2 One of the most common applications of this principle is in advance directives or orders that specify "Do Not Resuscitate" (DNR) or "No Cardiopulmonary Resuscitation" (No CPR). These are often prepared for elderly people in frail health or those with terminal illnesses because CPR can cause harm (such as broken ribs), while research indicates that there is very little likelihood that CPR will have a positive outcome for such patients. In contrast, CPR is encouraged when there is a prospect of recovery (such as a witnessed collapse) because the benefits outweigh adverse effects.[412] The example illustrates another important point: that interventions are not categorized as "proportionate" or "disproportionate" without reference to circumstances.

C5.3 Evaluation of the proportionality of interventions and assistance is a ubiquitous feature of the provision of health care, so much so that in non-critical situations it may hardly be noticed. However, in critical care and palliative care the importance of and difficulties associated with this kind of evaluation are likely to be more pronounced: so, too, in the case of patients who are in a state of persistently minimal consciousness. Much depends on circumstances of each case, and some degree of subjectivity cannot be avoided.[413]

C5.4 In particular, since the patient bears most of the burdens — and usually the most

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[410] 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> at 34.

[411] *Sachedina 2009*, *supra* note 159 at 170.

[412] Mark Hilberman et al, "Marginally effective medical care: ethical analysis of issues in cardiopulmonary resuscitation (CPR)" (1997) 23:6 J Med Ethics 361, online: <http://jme.bmj.com/content/23/6/361.full.pdf>.

[413] *Somerville 2001*, *supra* note 84 at 73.

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

C5.5 The law notwithstanding, a broad spectrum of prominent religious traditions and medical ethics derived from them hold that one is morally obliged to seek and accept ordinary or proportionate interventions and assistance that will preserve one's health and life, and that health care workers are obliged to provide and maintain such services.[414] From this perspective, the decision of a patient who is not in the final stages of dying to refuse an intervention (or of a health care worker to provide it) may be seen to be blameworthy, as in the example above of suicide by starvation.

C5.6 Again, health care workers are expected to comply with the law. However, a health care worker who believes that a patient is wrong to refuse an intervention may conform to the patient's wishes, not primarily because of the law, but because that response is somehow respectful of the human person who is the patient. It may, in short, be an ethical response, and one that can be described as ethically correct.[415] But such a response is not indicative of an "ethical consensus" about the patient's choice. This becomes clear when someone who has moral or ethical objections to a patient's decision is asked to do something to make it effective.

C6. Intention

C6.1 The subject of intention as an ethically significant element in decision-making was introduced,[416] but the judge did not pursue it because, in her view, the focus of the Supreme Court of Canada's discussion of intention in *Rodriguez* was law, not ethics.[417]

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

> . . .the argument is that withdrawing a ventilator tube or maintaining a patient under sedation without hydration or nutrition are acts that will result in death, just as much as the act of providing a lethal prescription or administering lethal medications. To perform those acts, knowing of their inevitable consequences, is to hasten death.[418]

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[414] Daniel Eisenberg, "The Sanctity of the Human Body" (undated), *Protection of Conscience Project* (website), online: <https://www.consciencelaws.org/religion/religion015.aspx>; *Catechism of the Catholic Church* (Vatican City: Libreria Editrice Vaticana, 1993), online:<https://www.vatican.va/archive/ENG0015/__P80.HTM> at para 2288–2291 ; *Sachedina 2009*, *supra* note 159 at 168, 183–184.

[415] *CLF Submission*, *supra* note 261 at para 45.

[416] *Ibid* at para 324-325.

[417] *Ibid* at para 330.

[418] *Ibid* at para 321 (At para 335 she said she found this argument "persuasive.").

C6.3 However, withdrawing a ventilator may not, in fact, result in death; Karen Ann Quinlan lived nine years after her ventilator was withdrawn.[419] The judge did not properly analyze the argument she presented because she conflated three different procedures (withdrawing a ventilator, palliative sedation, withdrawing hydration/nutrition) that may be motivated by different intentions and can have three different outcomes .

C6.4 Note that her reference was to *knowing* the consequences, not *intending* them. The plaintiffs claimed and that knowledge and intention were ethically equivalent in this situation; the defendants denied it; the judge failed to articulate a rational and coherent position on the distinction and the ethical significance of intention because she ignored it.

C7. Summary

C7.1 In Part VII of the *Carter* ruling Justice Smith failed to articulate and address important ethical issues associated with the withdrawal/refusal of treatment or care and euthanasia/assisted suicide. She also failed to distinguish between palliative sedation used as a last resort to relieve intractable symptoms during the dying process, on the one hand, and used as anaesthesia for euthanasia or assisted suicide by dehydration and starvation on the other.

C7.2 The judge also failed to consider the distinction between legal and ethical evaluation of patient autonomy and ignored the principle of proportionality and its application to refusing or withdrawing interventions. Further, she ignored other factors, principles and concepts that relevant to an ethical evaluation of refusing or withdrawing assisted nutrition and hydration, such as the nature of the intervention and the distinction between treatment and care. Finally, she failed to provide a satisfactory explanation of her view of intention in relation to the ethics of end-of-life decision making.

C7.3 In sum, assertions made by the appellants at the Supreme Court of Canada that Justice Smith had established that physician-assisted suicide and euthanasia were ethical or that physician-assisted suicide and euthanasia were ethically equivalent to legal end-of-life practices[420] were without foundation. Her review of the ethical debate in Part VII was inadequate for that purpose and she did not claim to have made such findings.

[419] "The Story of Karen Ann Quinlan Made Headlines!" (Undated) *Karen Ann Quinlan Hospice* (website), online: < https://karenannquinlanhospice.org/about/history/>.

[420] *Carter SCC webcast*, *supra* note 80 at 00:38:35 to 00:40:31.