# CARTER V. CANADA DECISION SUMMARY

*Carter v. Canada (Attorney General),* 2012 BCSC 886 is a decision of Justice Lynn Smith of the British Columbia Supreme Court.

The plaintiffs in this case were Lee Carter, Hollis Johnson, Dr. William Shoichet, the British Columbia Civil Liberties Association (BCCLA) and Gloria Taylor. Lee Carter and Hollis Johnson took a family member to Switzerland to have their death facilitated by a physician. They are concerned about prosecution in Canada for this. Dr. William Shoichet is a physician who would be willing to perform physician-assisted death. Gloria Taylor who is 64, has amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease), and is concerned that at some point in the progression of her illness she may become too disabled to commit suicide on her own. The BCCLA is a civil rights advocacy group.

The defendants in the case are the Attorneys General of British Columbia and Canada. A number of other parties had intervener status.

Madame Justice Smith struck down s. 241(b) of the Criminal Code (the assisted suicide prohibition) for three reasons:

1. The section infringed on the plaintiffs rights to life, liberty and security of the person. (s. 7 Charter)

> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

2. The section infringed on the plaintiffs right to equal protection under the law. (s. 15 Charter)

> 15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

3. The limitations on the plaintiff's rights could not be justified (s.1 Charter)

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

Justice Smith struck down the Criminal Code section, under the provisions of s.24 of the Charter but delayed the implementation of her order by one year to give Parliament time to amend the Criminal Code. She gave the plaintiff Gloria Taylor a constitutional exclusion so that her physician assisted death might be facilitated.

In her final order, she clearly outlined what in her mind would be acceptable criteria for the exercise of physician-assisted death.

> by a medical practitioner in the context of a physician-patient relationship, where the assistance is provided to a fully-informed, non-ambivalent competent adult person who: (a) is free from coercion and undue influence, is not clinically depressed and who personally (not through a substituted decision-maker) requests physician-assisted death; and (b) has

> been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury), is in a state of advanced weakening capacities with no chance of improvement, has an illness that is without remedy as determined by reference to treatment options acceptable to the person, and has an illness causing enduring physical or psychological suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person. (para. 1393)

In order to reach her decision, Madame Justice Smith had a major hurdle to overcome. This was the decision of the Supreme Court of Canada in *R. vs. Rodriguez* in 1993. Sue Rodriguez was a woman who also suffered from ALS, and was in a similar position to the plaintiff Gloria Taylor in this case. Normally, previous decisions by the Supreme Court of Canada are binding on subsequent cases that have similar facts or points of law under discussion. The majority in the Rodriguez case upheld the Criminal Code section by a five to four vote. They held that while s. 241(b) affected Ms. Rodriguez rights to liberty and security of the person, this was a justifiable limitation given the inherent danger of the wrongful death of vulnerable sick and elderly people if the section were struck down. The majority did not rule on the applicability of s.15 with reference to possible discrimination, but indicated if there was an issue it would also have been justified as a reasonable limit under s.1.

In her decision, Justice Smith distinguished the precedent before her in several ways:

1. she noted that there had been no direct consideration of the limitation of the right to life in the Rodriguez decision. She accepted the plaintiff's argument that Gloria Taylor would be forced to commit suicide earlier if s. 241(b) were to remain in effect. In essence, if Ms. Taylor were free to access physician assisted death she could afford to live longer, knowing that she would continue to have that option after she ceased being physically capable of performing the act herself. Therefore, her right to life was being curtailed by the effect of s. 241(b). (para. 1322)
2. she utilized Supreme Court decisions subsequent to *Rodriguez* which had dealt with the requirements of natural law in consideration of cases related to s.7 to find that the solution of maintaining s. 241(b) as a protection of the vulnerable from coercion was too broad (paras. 1361-1371) She held that the state must find the least restrictive way of achieving its aims; and that a blanket prohibition on PAD was over reaching and disproportionate.
3. she held that the s.15 rights of people in the plaintiffs position were also affected. As there is no legislation prohibiting suicide, there should be equal access to suicide regardless of the person's level of physical ability.

The key to understanding the decision rests on two main points.

1. There is in this decision no difference between the ethics of current end of life practices (such as withholding life sustaining treatment or providing pain management) and physician-assisted death. This seems to be at odds with the majority opinion in *Rodriguez*. Justice Sopinka, speaking for the majority saw intention as being the critical differentiating factor:

> > However, the distinction drawn here is one based upon intention – in the case of palliative care the intention is to ease pain, which has the effect of hastening death, while in the case of assisted suicide, the intention is undeniably to cause death. . . The fact that in some cases, the third party will, under the guise of palliative care, commit euthanasia or assist in suicide and go unsanctioned due to the difficulty of proof cannot be said to render the existence of the prohibition fundamentally unjust." p. 607 Rodriguez, as quoted at para. 324.

Justice Smith, on the other hand, concludes as follows:

> In particular, I found that the preponderant ethical opinion is that there is no bright-line ethical distinction, in an individual case, between physician-assisted dying and end-of-life practices such as withholding or withdrawing life-sustaining treatment or administering palliative sedation where the highly probable consequence is to hasten death. (para. 1336)

2. The second key point is that Justice Smith holds that there is a way to protect the vulnerable from the loss of their s.7 right to life, liberty and security of the person in a PAD regime through legal restrictions.

> The question, then, is whether there is an alternative means for the legislature to achieve its objective in a real and substantial way that less seriously infringes the Charter rights of Gloria Taylor and others in her situation.
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> Clearly, it is theoretically possible for the legislature to do so. Parliament could prohibit assisted death but allow for exceptions. The exceptions could permit physician-assisted death under stringent conditions designed to ensure that it would only be available to grievously ill, competent, non-ambivalent, voluntary adults who were fully informed as to their diagnosis and prognosis and who were suffering symptoms that could not be treated through means reasonably acceptable to those persons. (paras. 1232, 1233)
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> I have reviewed the evidence regarding the inherent challenges in creating and enforcing safeguards that depend upon physicians' assessment of matters such as competence, voluntariness and non-ambivalence. As well, I have reviewed the evidentiary record, particularly regarding Oregon, the Netherlands and Belgium, where much research has been done and data accumulated. This Court has had the benefit of the opinions of respected scientists, medical practitioners and other persons who are familiar with the end-of-life decision-making both in Canada and in other jurisdictions. (para. 1238)
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> The evidence shows that the effectiveness of safeguards depends upon, among other factors, the nature of the safeguards, the cultural context in which they are situate, the skills and commitment of the physicians who are responsible for working within them, and the extent to which compliance with the safeguards is monitored and enforced. (para. 1239)
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> 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. 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. (para. 1240)
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> Further, the evidence from other jurisdictions shows that the risks inherent in legally permitted assisted death have not materialized in the manner that may have been predicted. For example, in both the Netherlands and Belgium, the legalization of physician-assisted death emerged in a context in which medical practitioners were

> already performing life-ending acts, even without the explicit request of their patients. After legalization, the number of LAWER deaths has significantly declined in both jurisdictions. This evidence serves to allay fears of a practical slippery slope. (para. 1241) LAWER = life ending assistance without explicit request.
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> A less drastic means of achieving the objective of preventing vulnerable persons from being induced to commit suicide at times of weakness would be to keep the general prohibition in place but allow for a stringently limited, carefully monitored system of exceptions. 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.
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> I conclude that the defendants have failed to show that the legislation impairs Ms. Taylor's Charter rights as little as possible. (paras. 1243, 1244)

The defendants Canada and British Columbia expressed concern that it would be impossible to create a protocol that would remove the risk of vulnerable people having their s.7 right to life, liberty and the security of the person eroded in the absence of s. 241(b).

> Canada and British Columbia both point to multiple possible sources of error. Prognostic predictions about the length of a person's remaining life can be wrong. Cognitive impairment, depression or other mental illness in a patient can be overlooked, especially when the physician has not had a long-term relationship with the patient. Coercion or influence from persons who do not see value in the patient's life or who might stand to gain from a patient's hastened death can escape detection. People who seem resolute about their wish to die may in fact be ambivalent. Insufficient pain management or symptom control can undermine a patient's will to live. The possibility of such errors gives rise to risks. (para. 1236)

Next steps:

> A judge of the BC Supreme Court made this decision. There are two other levels of appeal available to the defendants – Canada and British Columbia – the British Columbia Court of Appeal, and the Supreme Court of Canada. Those governments have until July 15th to decide whether they will appeal that decision. If they do nothing then Parliament will have one year to revise the legislation to bring it into line with the judge's decision.