

Supreme Court of Canada: Carter v Canada (AG)

Carter v Canada (AG) is a Supreme Court of Canada decision made in February 2015.

The prohibition on assisted suicide was challenged as contrary to the Canadian Charter of Rights and Freedoms¹ by several parties, including the family of Kay Carter, a woman suffering from degenerative spinal stenosis, and Gloria Taylor, a woman suffering from amyotrophic lateral sclerosis (ALS). In a unanimous decision, the Court struck down the provision in the Criminal Code of Canada, giving Canadian adults who are mentally competent and suffering intolerably the right to a doctor's help in dying.

The court suspended its ruling for 12 months, with the decision taking effect in 2016, to give the government time to amend the law.

The Court's Summary of the Ruling

It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.

The question on this appeal is whether the criminal prohibition that puts a person to this choice violates her Charter rights to life, liberty and security of the person (s. 7) and to equal treatment by and under the law (s. 15). This is a question that asks us to balance competing values of great importance. On the one hand stands the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable.

The trial judge found that the prohibition violates the s. 7 rights of competent adults who are suffering intolerably as a result of a grievous and irremediable medical condition. She concluded that this infringement is not justified under s. 1. of the Charter. We agree. The trial judge's findings were based on an exhaustive review of the extensive record before her. The evidence supports her conclusion that the violation of the right to life, liberty and security of the person guaranteed by s. 7 of the Charter is severe. It also supports her finding that a properly administered regulatory regime is capable of protecting the vulnerable from abuse or error.

¹ As referred to in the excerpts from the judgement, the relevant sections of the Charter are:

s. 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.

s. 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.

s. 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.

We conclude that the prohibition on physician-assisted dying is void insofar as it deprives a competent adult of such assistance where (1) the person affected clearly consents to the termination of life; and (2) the person has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. We therefore allow the appeal.

EXCERPTS FROM THE JUDGEMENT

Background: Judicial History

Twenty-one years ago, this Court upheld this blanket prohibition on assisted suicide by a slim majority: *Rodriguez v. British Columbia (Attorney General)*, [1993] Four justices disagreed.

Despite the Court's decision in *Rodriguez*, the debate over physician-assisted dying continued. Between 1991 and 2010, the House of Commons and its committees debated no less than six private member's bills seeking to decriminalize assisted suicide. None was passed. While opponents to legalization emphasized the inadequacy of safeguards and the potential to devalue human life, a vocal minority spoke in favour of reform, highlighting the importance of dignity and autonomy and the limits of palliative care in addressing suffering.

The legislative landscape on the issue of physician-assisted death has changed in the two decades since *Rodriguez*. In 1993 Sopinka J. noted that no other Western democracy expressly permitted assistance in dying. By 2010, however, eight jurisdictions permitted some form of assisted dying: the Netherlands, Belgium, Luxembourg, Switzerland, Oregon, Washington, Montana, and Colombia.

The debate in the public arena reflects the ongoing debate in the legislative sphere. Some medical practitioners see legal change as a natural extension of the principle of patient autonomy, while others fear derogation from the principles of medical ethics. Some people with disabilities oppose the legalization of assisted dying, arguing that it implicitly devalues their lives and renders them vulnerable to unwanted assistance in dying, as medical professionals assume that a disabled patient "leans towards death at a sharper angle than the acutely ill — but otherwise non-disabled — patient". Other people with disabilities take the opposite view, arguing that a regime which permits control over the manner of one's death respects, rather than threatens, their autonomy and dignity, and that the legalization of physician-assisted suicide will protect them by establishing stronger safeguards and oversight for end-of-life medical care.

The Claimants

The impetus for this case arose in 2009, when Gloria Taylor was diagnosed with a fatal neurodegenerative disease, amyotrophic lateral sclerosis (or ALS), which causes progressive muscle weakness. ALS patients first lose the ability to use their hands and feet, then the ability to walk, chew, swallow, speak and, eventually, breathe. Like Sue Rodriguez before her, Gloria Taylor did "not want to die slowly, piece by piece" or "wracked with pain," and brought a claim before the British Columbia Supreme Court challenging the constitutionality of the Criminal Code provisions that prohibit assistance in dying, specifically ss. 14, 21, 22, 222, and 241.

By 2010, Ms. Taylor's condition had deteriorated to the point that she required a wheelchair to go more than a short distance and was suffering pain from muscle deterioration. She required home support for assistance with the daily tasks of living, something that she described as an assault on her privacy, dignity, and self-esteem..... She did not want to "live in a bedridden state, stripped of dignity

and independence”, she said; nor did she want an “ugly death”. This is how she explained her desire to seek a physician-assisted death:

“I do not want my life to end violently. I do not want my mode of death to be traumatic for my family members. I want the legal right to die peacefully, at the time of my own choosing, in the embrace of my family and friends.... I live in apprehension that my death will be slow, difficult, unpleasant, painful, undignified and inconsistent with the values and principles I have tried to live by.....What I fear is a death that negates, as opposed to concludes, my life. I do not want to die slowly, piece by piece. I do not want to waste away unconscious in a hospital bed. I do not want to die wracked with pain.

This left her with what she described as the “cruel choice” between killing herself while she was still physically capable of doing so, or giving up the ability to exercise any control over the manner and timing of her death.

Other witnesses also described the “horrible” choice faced by a person suffering from a grievous and irremediable illness. The stories in the affidavits vary in their details: some witnesses described the progression of degenerative illnesses like motor neuron diseases or Huntington’s disease, while others described the agony of treatment and the fear of a gruesome death from advanced-stage cancer. Yet running through the evidence of all the witnesses is a constant theme — that they suffer from the knowledge that they lack the ability to bring a peaceful end to their lives at a time and in a manner of their own choosing.

A number of the witnesses made clear that they — or their loved ones — had considered or in fact committed suicide earlier than they would have chosen to die if physician-assisted death had been available to them.

In the British Columbia Supreme Court

The trial judge began by reviewing the current state of the law and practice in Canada regarding end-of-life care. She found that current unregulated end-of-life practices in Canada — such as the administration of palliative sedation and the withholding or withdrawal of lifesaving or life-sustaining medical treatment — can have the effect of hastening death and that there is a strong societal consensus that these practices are ethically acceptable. After considering the evidence of physicians and ethicists, she found that the “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”. Finally, she found that there are qualified Canadian physicians who would find it ethical to assist a patient in dying if that act were not prohibited by law.

Based on these findings, the trial judge concluded that, while there is no clear societal consensus on physician-assisted dying, there is a strong consensus that it would only be ethical with respect to voluntary adults who are competent, informed, grievously and irremediably ill, and where the assistance is “clearly consistent with the patient’s wishes and best interests, and [provided] in order to relieve suffering”.

The trial judge then turned to the evidence from the regimes that permit physician-assisted dying. She reviewed the safeguards in place in each jurisdiction and considered the effectiveness of each regulatory regime. In each system, she found general compliance with regulations, although she noted some room for improvement. The evidence from Oregon and the Netherlands showed that a system can be designed to protect the socially vulnerable. Expert evidence established that the “predicted abuse and disproportionate impact on vulnerable populations has not materialized” in Belgium, the Netherlands, and Oregon. She concluded that:

although none of the systems has achieved perfection, 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.

While stressing the need for caution in drawing conclusions for Canada based on foreign experience, the trial judge found that “weak inference[s]” could be drawn about the effectiveness of safeguards and the potential degree of compliance with any permissive regime.

The trial judge then considered the risks of a permissive regime and the feasibility of implementing safeguards to address those risks. After reviewing the evidence tendered by physicians and experts in patient assessment, she concluded that physicians were capable of reliably assessing patient competence, including in the context of life-and-death decisions. She found that it was possible to detect coercion, undue influence, and ambivalence as part of this assessment process. She also found that the informed consent standard could be applied in the context of physician-assisted death, so long as care was taken to “ensure a patient is properly informed of her diagnosis and prognosis” and the treatment options described included all reasonable palliative care interventions (para. 831). Ultimately, she concluded that the risks of physician-assisted death “can be identified and very substantially minimized through a carefully-designed system” that imposes strict limits that are scrupulously monitored and enforced.

The trial judge concluded that the deprivation of the claimants’ s. 7 rights was not in accordance with the principles of fundamental justice, particularly the principles against overbreadth and gross disproportionality. The prohibition was broader than necessary, as the evidence showed that a system with properly designed and administered safeguards offered a less restrictive means of reaching the government’s objective. Moreover, the “very severe” effects of the absolute prohibition in relation to its salutary effects rendered it grossly disproportionate. As with the s. 15 infringement, the trial judge found the s. 7 infringement was not justified under s. 1.

In the result, the trial judge declared the prohibition unconstitutional, granted a one-year suspension of invalidity, and provided Ms. Taylor with a constitutional exemption for use during the one-year period of the suspension. Ms. Taylor passed away prior to the appeal of this matter, without accessing the exemption.

British Columbia Court of Appeal

The trial judge found that the prohibition on physician-assisted dying had the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable.... We see no basis for interfering with the trial judge’s conclusion on this point. The evidence of premature death was not challenged before this Court. It is therefore established that the prohibition deprives some individuals of life.

We do not agree that the existential formulation of the right to life *requires* an absolute prohibition on assistance in dying, or that individuals cannot “waive” their right to life. This would create a “duty to live”, rather than a “right to life”, and would call into question the legality of any consent to the withdrawal or refusal of lifesaving or life-sustaining treatment. The sanctity of life is one of our most fundamental societal values. Section 7 is rooted in a profound respect for the value of human life. But s. 7 also encompasses life, liberty and security of the person during the passage to death. It is for this reason that the sanctity of life “is no longer seen to require that all human life be preserved at all costs” (*Rodriguez*, at p. 595, per Sopinka J.). And it is for this reason that the law has come to

recognize that, in certain circumstances, an individual's choice about the end of her life is entitled to respect. It is to this fundamental choice that we now turn.

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

The law has long protected patient autonomy in medical decision-making. In *A.C. v. Manitoba (Director of Child and Family Services)*, a majority of this Court...endorsed the "tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity". This right to "decide one's own fate" entitles adults to direct the course of their own medical care (para. 40): it is this principle that underlies the concept of "informed consent" and is protected by s. 7's guarantee of liberty and security of the person. As noted in *Fleming v. Reid* (1991), the right of medical self-determination is not vitiated by the fact that serious risks or consequences, including death, may flow from the patient's decision. It is this same principle that is at work in the cases dealing with the right to refuse consent to medical treatment, or to demand that treatment be withdrawn or discontinued.

We therefore conclude that ss. 241 (b) and 14 of the Criminal Code, insofar as they prohibit physician-assisted dying for competent adults who seek such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering, infringe the rights to liberty and security of the person.

For the foregoing reasons, we conclude that the prohibition on physician-assisted dying deprived Ms. Taylor and others suffering from grievous and irremediable medical conditions of the right to life, liberty and security of the person. The remaining question under s. 7 is whether this deprivation was in accordance with the principles of fundamental justice.

Section 7 does not promise that the state will never interfere with a person's life, liberty or security of the person — laws do this all the time — but rather that the state will not do so in a way that violates the principles of fundamental justice.

Life, Liberty and the Security of the Person

While the Court has recognized a number of principles of fundamental justice, three have emerged as central in the recent s. 7 jurisprudence: laws that impinge on life, liberty or security of the person must not be arbitrary, overbroad, or have consequences that are grossly disproportionate to their object.

Arbitrariness

The object of the prohibition on physician-assisted dying is to protect the vulnerable from ending their life in times of weakness. A total ban on assisted suicide clearly helps achieve this object. Therefore, individuals' rights are not limited arbitrarily.

Overbreadth

The overbreadth inquiry asks whether a law that takes away rights in a way that generally supports the object of the law, goes too far by denying the rights of some individuals in a way that bears no relation to the object.

We conclude that the prohibition on assisted dying is overbroad. The object of the law, as discussed, is to protect vulnerable persons from being induced to commit suicide at a moment of weakness. Canada conceded at trial that the law catches people outside this class: “It is recognised that not every person who wishes to commit suicide is vulnerable, and that there may be people with disabilities who have a considered, rational and persistent wish to end their own lives” (trial reasons, at para. 1136). The trial judge accepted that Ms. Taylor was such a person — competent, fully informed, and free from coercion or duress. It follows that the limitation on their rights is in at least some cases not connected to the objective of protecting *vulnerable* persons. The blanket prohibition sweeps conduct into its ambit that is unrelated to the law’s objective.

Gross Disproportionality

The trial judge concluded that the prohibition’s negative impact on life, liberty and security of the person was “very severe” and therefore grossly disproportionate to its objective. We agree that the impact of the prohibition is severe: it imposes unnecessary suffering on affected individuals, deprives them of the ability to determine what to do with their bodies and how those bodies will be treated, and may cause those affected to take their own lives sooner than they would were they able to obtain a physician’s assistance in dying. Against this it is argued that the object of the prohibition — to protect vulnerable persons from being induced to commit suicide at a time of weakness — is also of high importance. We find it unnecessary to decide whether the prohibition also violates the principle against gross disproportionality, in light of our conclusion that it is overbroad.

Minimal Impairment

The question in this case comes down to whether the absolute prohibition on physician-assisted dying, with its heavy impact on the claimants’ s. 7 rights to life, liberty and security of the person, is the least drastic means of achieving the legislative objective.

This question lies at the heart of this case and was the focus of much of the evidence at trial. In assessing minimal impairment, the trial judge heard evidence from scientists, medical practitioners, and others who were familiar with end-of-life decision-making in Canada and abroad. She also heard extensive evidence from each of the jurisdictions where physician-assisted dying is legal or regulated. In the trial judge’s view, an absolute prohibition would have been necessary if the evidence showed that physicians were unable to reliably assess competence, voluntariness, and non-ambivalence in patients; that physicians fail to understand or apply the informed consent requirement for medical treatment; or if the evidence from permissive jurisdictions showed abuse of patients, carelessness, callousness, or a slippery slope, leading to the casual termination of life.

The trial judge, however, expressly rejected these possibilities. After reviewing the evidence, she concluded that a permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error. While there are risks, to be sure, a carefully designed and managed system is capable of adequately addressing them:

My review of the evidence in this section, and in the preceding section on the experience in permissive jurisdictions, 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.

The trial judge found that it was feasible for properly qualified and experienced physicians to reliably assess patient competence and voluntariness, and that coercion, undue influence, and ambivalence

could all be reliably assessed as part of that process. In reaching this conclusion, she particularly relied on the evidence on the application of the informed consent standard in other medical decision-making in Canada, including end-of-life decision-making. She concluded that it would be possible for physicians to apply the informed consent standard to patients who seek assistance in dying, adding the caution that physicians should ensure that patients are properly informed of their diagnosis and prognosis and the range of available options for medical care, including palliative care interventions aimed at reducing pain and avoiding the loss of personal dignity.

As to the risk to vulnerable populations (such as the elderly and disabled), the trial judge found that there was no evidence from permissive jurisdictions that people with disabilities are at heightened risk of accessing physician-assisted dying. She thus rejected the contention that unconscious bias by physicians would undermine the assessment process. The trial judge found there was no evidence of inordinate impact on socially vulnerable populations in the permissive jurisdictions, and that in some cases palliative care actually improved post-legalization. She also found that while the evidence suggested that the law had both negative and positive impacts on physicians, it did support the conclusion that physicians were better able to provide overall end-of-life treatment once assisted death was legalized. Finally, she found no compelling evidence that a permissive regime in Canada would result in a “practical slippery slope”.

Further evidence

Professor Montero’s affidavit reviews a number of recent, controversial, and high-profile cases of assistance in dying in Belgium which would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions. Professor Montero suggests that these cases demonstrate that a slippery slope is at work in Belgium. In his view, “[o]nce euthanasia is allowed, it becomes very difficult to maintain a strict interpretation of the statutory conditions.”

We are not convinced that Professor Montero’s evidence undermines the trial judge’s findings of fact. First, the trial judge (rightly, in our view) noted that the permissive regime in Belgium is the product of a very different medico-legal culture. Practices of assisted death were “already prevalent and embedded in the medical culture” prior to legalization. The regime simply regulates a common pre-existing practice. In the absence of a comparable history in Canada, the trial judge concluded that it was problematic to draw inferences about the level of physician compliance with legislated safeguards based on the Belgian evidence. This distinction is relevant both in assessing the degree of physician compliance and in considering evidence with regards to the potential for a slippery slope.

Second, the cases described by Professor Montero were the result of an oversight body exercising discretion in the interpretation of the safeguards and restrictions in the Belgian legislative regime — a discretion the Belgian Parliament has not moved to restrict. These cases offer little insight into how a Canadian regime might operate.

Safeguards and Slippery Slopes

Concerns about decisional capacity and vulnerability arise in all end-of-life medical decision-making. Logically speaking, there is no reason to think that the injured, ill, and disabled who have the option to refuse or to request withdrawal of lifesaving or life-sustaining treatment, or who seek palliative sedation, are less vulnerable or less susceptible to biased decision-making than those who might seek more active assistance in dying. The risks ... are already part and parcel of our medical system.

The evidence, she concluded, did not support the contention that a blanket prohibition was necessary in order to substantially meet the government’s objectives. We agree. A theoretical or

speculative fear cannot justify an absolute prohibition. As Deschamps J. stated in *Chaoulli*, at para. 68, the claimant “d[oes] not have the burden of disproving every fear or every threat”, nor can the government meet its burden simply by asserting an adverse impact on the public. Justification under s. 1 is a process of demonstration, not intuition or automatic deference to the government’s assertion of risk.

Finally, it is argued that without an absolute prohibition on assisted dying, Canada will descend the slippery slope to euthanasia and condoned murder. Anecdotal examples of controversial cases abroad were cited in support of this argument, only to be countered by anecdotal examples of systems that work well. The resolution of the issue before us falls to be resolved not by competing anecdotes, but by the evidence. The trial judge, after an exhaustive review of the evidence, rejected the argument that adoption of a regulatory regime would initiate a descent down a slippery slope into homicide. We should not lightly assume that the regulatory regime will function defectively, nor should we assume that other criminal sanctions against the taking of lives will prove impotent against abuse.

Declaration of Invalidity

It is for Parliament and the provincial legislatures to respond, should they so choose, by enacting legislation consistent with the constitutional parameters set out in these reasons.

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

We would suspend the declaration of invalidity for 12 months.

In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians’ colleges, Parliament, and the provincial legislatures.