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ARTICLES

A RIGHT TO VOLUNTARY EUTHANASIA? CONFUSION IN CANADA IN *CARTER*

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In Carter v. Canada (Attorney General)*, Justice Lynn Smith held that the Canadian Criminal Code's prohibitions on murder and assisting suicide infringe Sections 7 and 15 of the Canadian Charter of Rights and Freedoms to the extent that those prohibitions outlaw voluntary, active euthanasia and physician-assisted suicide. This Article suggests the judgment is defective in at least four key respects: misunderstanding the principle of the inviolability of human life; concluding that laws against assisting suicide discriminate against those physically incapable of committing suicide; evading the logical "slippery slope" argument; and (as the Irish High Court has since concluded in* Fleming v. Ireland*) misinterpreting the evidence from jurisdictions with relaxed laws. Although the judgment of Justice Smith has been reversed by the British Columbia Court of Appeal, the reversal turned on questions of constitutional law, not on these four criticisms. These criticisms remain important, not least as the case is to be heard by the Supreme Court of Canada.*

INTRODUCTION

At the heart of the ongoing public policy debate about whether voluntary euthanasia or physician-assisted suicide should be decriminalized is the question whether they could be effectively controlled. Could a relaxed law achieve the degree of control and protection that is warranted by the importance of the rights and interests to be protected, and that has regularly been accepted by proponents of decriminalization to be desirable, and asserted by them to be attainable, in virtue of safeguards stipulated in their various proposals?

In *Carter v. Canada*,[1] a first instance decision in the Supreme Court of British Columbia, Justice Lynn Smith found a right to voluntary euthanasia and physician-assisted suicide in Sections seven and fifteen of the Canadian Charter of Rights and Freedoms. Her holding hangs to a large extent on her controversial factual finding that the evidence

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1. Carter v. Canada (Att'y General), [2012] B.C.S.C. 886 (Can. B.C.). The judgment runs to over 1400 paragraphs.

from jurisdictions which have relaxed their laws shows that the risks of decriminalization "can be very largely avoided through carefully-designed, well-monitored safeguards."[2]

Section 241 of the Canadian Criminal Code prohibits counseling, aiding, or abetting suicide, whether suicide ensues or not, with imprisonment for up to fourteen years.[3] Section 222(1) of the Code provides that a person commits homicide when, directly or indirectly, by any means, he causes the death of a human being,[4] and Section 222(4) provides that culpable homicide is murder, manslaughter or infanticide.[5] Section 14 states that no person is entitled to consent to have death inflicted upon him and that such consent does not affect the criminal responsibility of any person by whom death may be inflicted.[6]

Section 7 of the Canadian Charter of Rights and Freedoms provides:

> 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.[7]

Section 15(1) states:

> 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.[8]

Justice Smith held that the Criminal Code unjustifiably infringes Section 15 to the extent that it prohibits a medical practitioner from assisting suicide where the assistance is provided in the context of a "physician-patient relationship" to a "fully-informed, non-ambivalent competent adult patient" who is "free from coercion and undue influence"; is not "clinically depressed" and personally requests such assistance; is "materially physically disabled or is soon to become so"; has been diagnosed with a "serious illness, disease or disability"; is in "a state of advanced weakening capacities with no chance of improvement"; who has an illness that is "without remedy" as determined by treatment options "acceptable to the person," and the illness is causing "enduring physical or psychological suffering" that is "intolerable" to that person and which cannot be alleviated by medical treatment "acceptable to that person."[9]

The judge also declared that the Criminal Code unjustifiably infringes Section 7 in two additional respects. It infringes that section

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2. *Id.* at para. 10.
3. Criminal Code, R.S.C. 1985, c. C-46, § 241 (Can.).
4. Criminal Code, R.S.C. 1985, c. C-34, § 222(1) (Can.).
5. Criminal Code, R.S.C. 1985, c. C-34, § 222(4) (Can.).
6. Criminal Code, R.S.C. 1985, c. C-34, § 14 (Can.).
7. Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, *being* Schedule B to the Canada Act, 1982, c. 11, § 7 (U.K.).
8. *Id.* at § 15(1).
9. Carter v. Canada (Att'y General), [2012] B.C.S.C. 886, at para. 1393a (Can. B.C.).

even if the patient is not "materially physically disabled or is soon to become so" and to the extent that it prohibits "consensual physician-assisted death."[10] The plaintiffs defined "consensual physician-assisted death" as involving "the administration of medication or other treatment that intentionally brings about a patient's death by the act of a medical practitioner. . . ."[11] This clearly goes beyond assisting a patient to commit suicide and includes the active, intentional ending of a patient's life, in other words, voluntary, active euthanasia. The plaintiffs' definition was adopted by the judge.[12] In short, the judge held that the Code's prohibitions on both physician-assisted suicide and on voluntary euthanasia infringe the Charter. She suspended the effect of her declarations for one year to allow Parliament time to enact legislation which would accommodate her ruling.[13]

Déjà vu? Indeed. Twenty years ago the Supreme Court of Canada rejected a right to physician-assisted suicide in *Rodriguez v. British Columbia*, albeit by a bare majority.[14] However, Justice Smith thought that a new principle of disproportionality had since emerged, that fresh empirical evidence from jurisdictions with relaxed laws was available, that the situation of some of the plaintiffs differed from that of the plaintiff in *Rodriguez*, and that she was therefore free to reconsider the issue.[15] Canada's appeal was allowed by the British Columbia Court of Appeal, which held that no new principle of disproportionality had emerged since *Rodriguez*, and that the decision of the Supreme Court in that case was binding.[16]

Prescinding from issues of constitutional law, this Article offers four key criticisms of the judgment of Justice Smith, criticisms which were not made by the Court of Appeal. These criticisms remain valid and relevant, particularly as the case is to be heard by the Supreme Court of Canada.

The Article maintains that the judgment of Justice Smith, a judgment which is out of line with decisions of the Supreme Court of Canada,[17] the Supreme Court of the United States,[18] the House of Lords,[19] the European Court of Human Rights,[20] the Supreme Court

10. *Id.* at para. 1393b.

11. *Id.* at para. 23. For their definition of "grievously and irremediably ill" see *id.* at para. 24.

12. The judge narrowed the definition to "competent, fully-informed, non-ambivalent adult persons" who were free from undue influence and clinical depression and who personally requested physician-assisted death; to require "grievously and irremediably ill" persons to be in "an advanced state of weakening capacities, with no chance of improvement", and to exclude "psychosocial suffering" and the provision of assistance by non-physicians. *See id.* at para. 1387-91.

13. *Id.* at para. 1399.

14. Rodriguez v. British Columbia (Att'y General), [1993] 3 S.C.R. 519 (Can.)

15. *Carter*, [2012] B.C.S.C. at para. 1001–03.

16. Carter v. Canada (Att'y General), [2013] B.C.C.A. 435 (B.C., Can.).

17. *Rodriguez*, [1993] 3 S.C.R at 581.

18. *See* Washington v. Glucksberg, 521 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793 (1997).

19. R. (Pretty) v. Dir. of Pub. Prosecutions, [2001] U.K.H.L. 61, [2002] 1 A.C. 800 (Eng.).

of Ireland[21]—and with the conclusions of the vast majority of expert committees and legislatures which have considered, across seventy-five years,[22] whether voluntary euthanasia could safely be decriminalized—is seriously defective.

The Article considers four of the judgment's central flaws:

1. Its failure accurately to appreciate and affirm the fundamental legal principle of the inviolability of human life, a principle which has historically provided a bright line between, on the one hand, *intentionally* ending the lives of patients (euthanasia) and, on the other, treatment aimed at palliation, and the withdrawal of treatments because they are futile or excessively burdensome, where the shortening of life is *foreseen*;

2. Its holding that the prohibition on assisting suicide discriminates against those physically unable to commit suicide;

3. Its evasion of the important argument that, once the inviolability principle is abandoned by the endorsement of voluntary euthanasia, such endorsement logically entails the endorsement of non-voluntary euthanasia (that is, the intentional termination of incompetent patients like infants or those with advanced dementia); and

4. Its erroneous finding that the experience of jurisdictions with relaxed laws shows that the risks of decriminalization "can be very largely avoided through carefully-designed, well-monitored safeguards."[23]

I. The Inviolability of Human Life

The principle of the inviolability of life is a fundamental principle of the common law.[24] The principle has historically been referred to as the "sanctity of life," but as this Article is concerned with a philosophical, rather than a theological principle, the phrase "inviolability of life" will be used to avoid any distracting theological connotations. As Lord Goff noted in *Airedale N.H.S. Trust v. Bland*, the principle has long been recognized in most, if not all, civilized societies throughout the modern world as is evident from Article 2 of the European Convention on Human Rights and Article 6 of the International Covenant on Civil and Political Rights.[25]

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20. Pretty v. United Kingdom, 35 Eur. Ct. H.R. Rep. 1 (2002).

21. Fleming v. Ireland, [2013] I.E.S.C. 19 (Ir.). Delivering the judgment of the Irish Supreme Court in *Fleming*, Chief Justice Denham noted that *Carter* "is not consistent with many judgments from supreme and constitutional courts of other nations." *Id.* at para. 74.

22. The Voluntary Euthanasia Legalisation Society was founded in the UK in 1935 and the Euthanasia Society of America in 1938. Ian Dowbiggin, A Concise History of Euthanasia 80–82 (2007). In the UK, from 1936 to 2009, Parliament has rejected a succession of proposals to relax the law. *Id.* at 145; John Keown, The Law and Ethics of Medicine: Essays on the Inviolability of Human Life 304 (2012).

23. Carter v. Canada (Att'y General), [2012] B.C.S.C. 886, para. 10 (Can. B.C.).

24. *See* Keown, *supra* note 22, at chapter 1.

25. Airedale N.H.S. Trust v. Bland, [1993] A.C. 789, 863-64 (H.L.) (Eng.).

The principle is grounded in an understanding of each human being as having an intrinsic and ineliminable dignity. The essence of the principle is the prohibition on the intentional taking of human life, intention used in its ordinary sense of aim or purpose.[26] The House of Lords Select Committee on Medical Ethics (one of the several expert committees which have carefully examined, and rejected, the case for voluntary euthanasia) described the prohibition on intentional killing as "the cornerstone of law and of social relationships" which "protects each one of us impartially, embodying the belief that all are equal."[27] The principle is clearly central to the question whether the law should be relaxed to permit voluntary, active euthanasia (currently the crime of murder) and physician-assisted suicide (currently the crime of assisting suicide).

The judgment of Justice Smith fails, however, to exhibit an accurate understanding of the principle; to recognize its foundational importance in the law; to provide anything approaching a reasoned case for rejecting it; and to appreciate that its rejection cannot logically be confined to the circumstances her judgment adumbrates.

The starting point of the judgment should have been a clear acknowledgment that historically the law has been profoundly shaped by recognition of the intrinsic worth of the life of each human being and the principle that it is always wrong to intentionally kill innocent human beings (that is, those not involved in unjust aggression). The judgment should also have made clear that, while this principle rules out euthanasia and assisting suicide, it permits the palliation of symptoms, and the withdrawal of futile or excessively burdensome treatments, even if the hastening of death is foreseen as a side-effect.[28]

The key distinction between intending, and merely foreseeing, the hastening of death was clearly endorsed by the Supreme Court of Canada in *Rodriguez*.[29] Delivering the judgment of the majority, Justice Sopinka rejected the argument that assisting suicide was similar to the withdrawal of life-preserving treatment at the patient's request.[30] He also rejected the argument that the distinction between assisting suicide and accepted medical treatment was even more attenuated in the case of palliative treatment which was known to hasten death. He observed:

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26. The inviolability of life is distinct from, though not unrelated to, the prohibition on intentional interference with a person's bodily integrity, a prohibition some describe as protecting bodily 'inviolability'.

27. House of Lords, Report of the Select Committee on Medical Ethics, H.L. Paper No. 21-I, para. 237 (1994).

28. Here and throughout, "side-effect" denotes an effect that is not intended, whether as end or as means. Moreover, an effect's being intended rather than a side-effect (or vice versa) has nothing to do with whether it can be foreseen as certain: walking in shoes is foreseen as certain to wear down their soles but—save where someone has some purpose of wearing them down, such as to win an unusual bet—is not intended to do so, and so is a mere side-effect. For the same reason, what in some or many cases is a side-effect may be not a side-effect; that is, when the acting person intends the effect, he or she chooses it as a means or perhaps as an end (that is, for its own sake).

29. Rodriguez v. British Columbia (Att'y General), [1993] 3 S.C.R. 519 (Can.).

30. *Id.* at 606.

> [T]he 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.[31]

He added:

> In my view, distinctions based on intent are important, and in fact form the basis of our criminal law. While factually the distinction may, at times, be difficult to draw, legally it is clear.[32]

Echoing Justice Sopinka, the Supreme Court of the United States has affirmed the distinction between trying to hasten death and merely foreseeing the hastening of death. In *Vacco v. Quill*,[33] Chief Justice Rehnquist, delivering the judgment of the Court, noted that the distinction between assisting suicide and withdrawing life-sustaining treatment is a distinction widely recognized and endorsed in the medical profession and in law and is important, logical, and rational.[34] The distinction, he added, comports with fundamental legal principles of causation and intent. When a patient dies after refusing treatment, he dies from an underlying fatal disease, but if a patient ingests lethal medication, he is killed by that medication.[35] Moreover, a physician who withdraws life-sustaining treatment "purposefully intends, or may so intend, only to respect his patient's wishes" and to cease doing futile things to the patient.[36] The same is true when a doctor administers palliative drugs: even if the drugs hasten death "the physician's purpose and intent is, or maybe, only to ease his patient's pain," unlike the physician whose purpose is to assist suicide.[37] The law, he continued, had long used the actor's intent to distinguish between two acts with the same result. The law distinguishes actions taken "because of" a given end from actions taken "in spite of" their unintended but foreseen consequences.[38]

Similarly, the Law Lords have distinguished between an intention to kill, on the one hand, and foresight of death, even as a virtual certainty, on the other. They have held that, while foresight may be *evidence* from which intention may be inferred, it is not *equivalent* to intention.[39] In *Hancock and Shankland*, Lord Scarman noted that in

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31. *Id.* at 607.

32. *Id. See also id.* at 586 (referring to suicide as involving a "choice of death over life.").

33. 521 U.S. 793 (1997).

34. *Id.* at 800–01.

35. *Id.* at 801.

36. *Id.*

37. *Id.* at 802.

38. *Id.* at 802–03.

39. *See* R. v. Moloney [1985] A.C. 905 (H.L.) (Eng.); R. v. Hancock & Shankland [1986] A.C. 455 (H.L.) (Eng.); R. v. Woollin [1999] 1 A.C. 82 (H.L.) (Eng.). Although some sentences in *Woollin* could have been clearer, the case does uphold the distinction between intention and foresight. As the Court of Appeal has subsequently confirmed, it is clear from *Woollin* read as a whole that it affirms the distinction between intention and foresight, and that it is a misdirection for a judge to tell a jury that foresight of the virtual certainty of death amounts to an intention to kill. R. v. Matthews & Alleyne, [2003]

Moloney the House of Lords had made it "absolutely clear that foresight of consequences is no more than evidence of the existence of intent."[40] His Lordship stated that foresight must be considered, and its weight assessed, together with all the evidence in the case, adding:

> Foresight does not necessarily imply the existence of intention, though it may be a fact from which when considered with all the other evidence a jury may think it right to infer the necessary intent.[41]

In *Bland*, Lord Goff observed that it was lawful for a doctor to administer drugs to ease pain even if the doctor foresaw that they would have the effect of hastening death. His Lordship referred to:

> the established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer pain-killing drugs despite the fact that he knows that an incidental effect of that application will be to abbreviate the patient's life.[42]

Lord Goff was echoed by Lord Steyn in *Pretty*:

> Under the double effect principle medical treatment may be administered to a terminally ill person to alleviate pain although it may hasten death: *Airedale NHS Trust v Bland* [1993] AC 789, 867D, per Lord Goff of Chieveley. This principle entails a distinction between foreseeing an outcome and intending it . . . .[43]

The distinction between intending and foreseeing death is also endorsed by the Dutch, the pioneers of legalized euthanasia. In the Netherlands, "euthanasia" requires an intention to kill, not merely foresight of death.[44]

In light of the endorsement of the distinction between intention and foresight by the highest authorities in Canada, the United States, and England, it is surprising that Justice Smith should have conflated

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EWCA (Crim) 192, [2003] 2 Criminal Appeal Reports 30, at [43]-[44]. *Cf.* Re A [2001] Fam 147, discussed in KEOWN, *supra* note 22, at 11.

40. *Hancock*, [1986] A.C. at 471.

41. *Id.* at 472.

42. Airedale N.H.S. Trust v. Bland, [1993] A.C. 789, 867 (H.L.) (Eng.).

43. R. (Pretty) v. Dir. of Pub. Prosecutions, [2001] U.K.H.L. 61, para. 55 [2002] 1 A.C. 800 (Eng.). The ethical principle or idea of "double effect" holds that an effect that is intended is subject to moral and legal rules that do or may well differ from the rules applicable to a side-effect, so that an effect of a kind that is morally and/or legally culpable when caused as an intended effect is *or may be* morally acceptable when caused as a foreseen side-effect. (It is not sufficient that a bad effect is merely foreseen: there must also be a sufficiently serious reason to justify conduct which foreseeably brings about a bad consequence.) The principle or idea was also defended by the House of Lords Select Committee on Medical Ethics, which examined the case for legalizing voluntary euthanasia. House of Lords, Report of the Select Committee on Medical Ethics, H.L. Paper No. 21-I, para. 242–44 (1994). Defending the principle or idea in debate in the House of Lords, Lord Williams of Mostyn Q.C., Parliamentary Under-Secretary of State at the Home Office (and later Attorney General), rejected the argument that double effect was sophistry and that the law was difficult or obscure. The law was, he said, "perfectly plain." 583 PARL. DEB., H.L., (5th ser.) (1997) 743–44 (UK). For a brief introduction to double effect, see ALFONSO GÓMEZ-LOBO, MORALITY AND THE HUMAN GOODS 54–56, 79–80 (2012).

44. P.J. VAN DER MAAS ET AL., EUTHANASIA AND OTHER MEDICAL DECISIONS CONCERNING THE END OF LIFE 11 (1992).

intention and foresight.[45] No less surprisingly, counsel for the Attorney General of Canada did little to help the judge from falling into this error. Remarkably, counsel submitted[46] that the criminal law does not appear to recognize the distinction between intention and foresight. If, however, the criminal law draws no distinction between administering drugs to palliate pain, *foreseeing* they will as a side-effect shorten life, and administering a lethal drug *in order to* kill the patient, how can the former be lawful and the latter unlawful?

Justice Smith sought to explain away the affirmation in *Rodriguez* of the distinction between intended and foreseen consequences on the ground[47] that *Rodriguez* was not a criminal case. However, although *Rodriguez* was concerned with Charter issues, it considered them in relation to the crime of assisting suicide. Justice Smith added[48] that Justice Sopinka, delivering the majority judgment in *Rodriguez*, had acknowledged the difficulty of drawing a bright-line factual distinction, and that *Rodriguez* was clearly focused on a legal, rather than a factual or ethical, distinction.[49] However, the *evidential* problems which may exist in determining a defendant's intention have scant bearing on the reality and importance of the *conceptual and psychologically*—that is, humanly—*factual* and *real* distinction, a distinction which explains why administering morphine with intent to ease pain, merely foreseeing the shortening of life, is lawful and endorsed by professional medical ethics, whereas administering morphine with intent to shorten life is murder and rejected by professional medical ethics.[50]

Moreover, this key legal distinction tracks the ethical distinction between *trying to* bring about a bad consequence and *merely foreseeing* that one's conduct will do so. Between, for example, administering chemotherapy merely *foreseeing* it will cause the patient to suffer nausea and hair loss, and administering chemotherapy *with intent* to cause the patient to suffer nausea and hair loss.[51]

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45. Carter v. Canada (Att'y General), [2012] B.C.S.C. 886, para. 328 (Can. B.C.).
46. *Id.* at para. 327.
47. *Id.* at para. 328.
48. *Id.* at para. 329.
49. *Id.* at para. 330.
50. The evidence of palliative care experts is that palliative drugs, properly titrated, do not in fact shorten life. *See, e.g.,* S.A. Fohr, *The Double Effect of Pain Medication: Separating Myth from Reality*, 1 J. PALLIATIVE MED. 315 (1998).
51. *See supra* note 43. Further, the importance of intention is evident in Justice Smith's own definitions of "assisted suicide," "euthanasia," "palliative care," and "palliative sedation" set out early in the judgment. *See Carter*, [2012] B.C.S.C. at para. 37–38; para. 41–42. For example, Justice Smith uses "euthanasia" to mean "the intentional termination of the life of a patient by a physician, or someone acting under the direction of a physician, at the patient's request, for compassionate reasons." *Id.* at para. 38. She also states that, since *Rodriguez*, "[I]t has been clear that potentially life-shortening symptom relief is permissible where the physician's intention is to ease pain." and cites the passage from Justice Sopinka's judgment in that case where he notes that distinctions based on intention are important and form the basis of the criminal law. *Id.* at para. 225; *see supra* note 32. She also states that "the law in Canada" lets physicians legally administer medications even though they know that the doses of medication in question may hasten death, "so long as the intention is to provide palliative care by easing the patient's pain." *Id.* at para. 231(c).

Oddly, Justice Smith omitted to disclose the authority she relied upon to reject the clear distinction made by the Supreme Court in *Rodriguez* between intending and merely foreseeing death. It appears to have been a later decision of the Supreme Court: *R. v. Chartrand*.[52] The defendant in that case was charged with abducting a person under the age of fourteen contrary to section 281 of the Criminal Code. The section provides that anyone not being a parent, guardian, or person having the lawful care or charge of a child who unlawfully takes the child "with intent to deprive" such a person of the possession of the child is guilty of an offense. The defendant took a child from a schoolyard, although the child's companions protested, without telling the companions where he was taking the child. He took the child three kilometers from the schoolyard in a car and took photographs of the child. The child's father did not know of the child's whereabouts for up to ninety minutes. The trial judge directed an acquittal.[53] An appeal to the Court of Appeal of Ontario was dismissed on the ground that there was no evidence on which a jury, properly instructed, could find that there was an intent to deprive the parents of possession of their child.[54] A further appeal to the Supreme Court of Canada was allowed and a new trial ordered.

Before examining the Supreme Court's judgment, we should notice that the offense of abduction contrary to Section 281[55] has much the same logic as ordinary cases of theft contrary to Section 322(1) of the Code: taking a thing "with intent to deprive, temporarily or absolutely, the owner of it . . . ."[56] As reflection on the ordinary case of theft easily shows, the thief's intent to get the thing, temporarily or not, *just is* the intent to deprive the owner of it, and the fact that some thieves do not *think* of the owner's loss but only of their own gain does not mean that the owner's loss is a mere consequence and side-effect; rather, even in such a case, it is one and the same intent looked at from different angles. The thief's gain is the owner's loss; intention of one is intention of the other; the thief cannot get his gain save by means of depriving the owner. Similarly, the abductor cannot achieve his unlawful control over the child save by means of depriving the parents of such control and possession.

The judgments of the Ontario courts were misguided, confused by a merely sophistical labeling of an intended consequence as a merely foreseen consequence. This sort of case is far removed indeed from administering analgesics with one or other of two different intentions:

52. R. v. Chartrand, [1994] 2 S.C.R. 864 (Can.). This was the authority cited to the author by counsel for the Attorney General of Canada, Ms. Donnaree Nygard, in an email dated 12 February 2014, in response to an email of 10 February asking what authority counsel had in mind when submitting that Canadian criminal law equated the foreseen hastening of death with the purposeful hastening of death. I am grateful to Ms. Nygard for confirming my suspicion that this was the relevant authority. Emails on file with the author.

53. *Chartrand*, [1994] 2 S.C.R. at 870-73.

54. *Id.* at 873-74.

55. Criminal Code, R.S.C. 1985, c. C-46, § 281 (Can.).

56. Criminal Code, R.S.C. 1985, c. C-46, § 322(1) (Can.).

to shorten life, or to ease pain. The doctor's calculation of how much analgesic to administer follows a different route, depending on his or her purpose, even in the rare case when the result of the calculation coincides. No such difference exists in the thief's or the abductor's "calculations," in which his gain and the owner's or parents' loss are in lockstep, even if he averts his attention from the loss. The Supreme Court of Canada thus reached the indubitably right result, but did so in a rather clumsy way, failing to identify clearly the sophistry and inappropriateness of the Ontario courts' distinction between intention and consequences, a distinction which would make nonsense of plain theft in those cases where the wrongdoer is resolutely diverting his own attention from the loss that his gain (the focus of his attention) entails and imposes on the owner, not as a side-effect of the gain but as part of what the thief intends and needs as a means. To repeat: this is quite different from the situation where the doctor who intends only pain relief needs to administer analgesics in a quantity that has the side-effect of hastening death. The hastening of death in such a case is not needed for pain relief, and in and of itself does not promote that relief. But the owner's loss is needed for the thief's gain, and does promote it—owner and thief *cannot* simultaneously enjoy the rights to exclusive possession.

Delivering the judgment of the Supreme Court, Justice L'Heureux-Dubé stated that the issue was whether the intent required by Section 281 should, as the Crown submitted, be broad in order to promote the section's purpose of protecting children, or instead restrictive, as the respondent submitted.[57] The judge stated that general principles of *mens rea* applied to "with intent to" and it was "sufficient that the taker knows or foresees that his or her actions would be certain or substantially certain" to result in the parents or guardians being deprived of the ability to exercise control over the child. She cited a passage from the judgment of Justice Martin in *R. v. Buzzanga*, a case on the "wilful" promotion of hatred.[58] The passage reads (with emphases supplied by Justice L'Heureux-Dubé):

> I agree . . . that, *as a general rule, a person who foresees that a consequence is certain or substantially certain to result from an act which he does in order to achieve some other purpose, intends that consequence.* The actor's foresight of the certainty or moral certainty of the consequence resulting from his conduct compels a conclusion that if he, none the less, acted so as to produce it, then he decided to bring it about (albeit regretfully), in order to achieve his ultimate purpose. *His intention encompasses the means as well as to his ultimate objective.*[59]

57. *Chartrand*, [1994] 2 S.C.R. at 869. It was clear that "possession" was not limited to circumstances in which the parent or guardian was actually in physical control of the child at the time of the taking. *Id.* at 888.

58. R. v. Buzzanga & Durocher [1979] 49 C.C.C. (2d) 369, 384-85. (Ont. Can.).

59. *Chartrand*, [1994] 2 S.C.R. at 890.

Justice L'Heureux-Dubé continued[60] that this definition of intent was subsequently approved by the Canadian Supreme Court in *Keegstra*,[61] and that in *Olan*[62] the same court "examined the possibility" that "intent" under Section 338 (now Section 380[63]) of the Criminal Code may encompass a contemplated outcome distinct from the purpose of the conduct and adopted the *dictum* of the English Court of Appeal in *Allsop*:

> Generally, the primary objective of fraudsmen is to advantage themselves. The detriment that results to their victims is secondary to that purpose and incidental. It is 'intended' only in the sense that it is a contemplated outcome of the fraud that is perpetrated.

This *dictum* is rather artless for, as the discussion above of theft and abduction shows, the fraudster's gain is the victim's loss, and the intent to gain involves the intent to impose loss, even if the fraudster/thief/abductor contrives not to attend to the full content of his intention. In any event, Justice L'Heureux-Dubé went on (having noted[64] that "innocent motive or purpose," while relevant, is not dispositive of the question of intent) to quote (again supplying the emphases) Don Stuart's *Canadian Criminal Law*:[65]

> The Code provides no general definition of intent and our courts have not found it necessary to fill the gap. *'Intent' seems to have been construed in a loose colloquial sense of actual desire, end, purpose, aim, objective or design and knowledge to mean actual knowledge, for example, of the contents of the package possessed.* It seems futile for criminal law to enter the unfathomable depths of the philosophical debate as to the meaning of 'intent'. *Our courts are, as we shall soon explore, increasingly prepared to extend mens rea to wider concepts of states of mind.* This being so, the debate as to the meaning of intent will often be totally irrelevant.[66]

The difficulties of defining and proving intent had, added Justice L'Heureux-Dubé, been examined by the Canadian Government in its white paper on amendment of the Criminal Code. The white paper, like Professor Glanville Williams, proposed that intention should include not only purpose but, more broadly, awareness that a consequence will occur,[67] though she also noted authorities, such as *Steane*,[68]

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60. *Id.*

61. R. v. Keegstra, [1990] 3 S.C.R. 697, 774-75 (Can.).

62. R. v. Olan, [1978] 2 S.C.R. 1175 (Can.).

63. Section 380(1) provides: "Every one who, by deceit, falsehood or other fraudulent means, whether or not it is a false pretence within the meaning of this Act, defrauds the public or any person, whether ascertained or not, of any property, money or valuable security or any service" is guilty of an indictable offence. Criminal Code, R.S.C. 1985, c. C-46, § 380(1) (Can.).

64. *Chartrand*, [1994] 2 S.C.R. at 891.

65. Don Stuart, Canadian Criminal Law 128–30 (2d ed., 1987).

66. *Chartrand*, [1994] 2 S.C.R. at 891–92. It is, of course, one thing for courts to extend the *mens rea* of a crime by including recklessness; quite another to do so by artificially and problematically stretching the ordinary meaning of 'intention.'

67. *Id.* at 893.

going the other way.[69] She concluded that the element of intent in Section 281 must be interpreted in the broader way so as to give the section a meaning consistent with its legislative intent and the social context.[70] It would be "rare indeed" that that deprivation of possession of a child from the parents or guardians was not the intent of the impugned act, but if the purpose of the section were to be achieved, foresight of the certainty or near certainty of the end result must be sufficient.[71]

If *Chartrand* was thought by Justice Smith to be an authority for rejecting the distinction between intending and foreseeing death affirmed in *Rodriguez*, her Ladyship was surely mistaken. Justice Sopinka carefully considered and answered *the precise question* whether a doctor who merely foresaw the hastening of death therefore intended it, and his consideration of the argument to the contrary was, moreover, careful and thorough. *Chartrand* was, by contrast, concerned with the statutory meaning of "intent" in relation to an entirely different offence—the meaning to be attributed to the use of the term in a context where it could (in the court's view) be equated or elided with far wider concepts such as "wilfully" or even "with a guilty mind," and where (on a better analysis) the distinction between intention and consequences is uniquely artificial, indeed sophistical.

Moreover, the reasoning in *Chartrand* is unsatisfactory in several further respects. First, it relies heavily and uncritically on the passage lifted from the judgment of Justice Martin in *Buzzanga*. We should begin by noting that, like *Chartrand* itself, *Buzzanga* was not concerned with the law of homicide. *Buzzanga* was not even concerned with a crime whose *mens rea* was formulated in terms of "intent." It concerned the crime of "wilfully" promoting hatred against an identifiable group contrary to Section 281.2(2) of the Criminal Code.[72] It does not follow that "wilfully" in a statute means the same as "intentionally." Moreover, in common idiom "intentionally" is often used more broadly than "with intent" so as to mean "not unintentionally," that is, not by mistake or accident.[73] Such linguistic looseness, which is obviously even greater in relation to "wilfully" or "with *mens rea*," does not undermine the distinct reality of intention as, precisely, seeking to achieve, either as an end or as a means. Further, the crime of murder in Canadian law clearly requires proof of intention.[74]

As for the passage from the judgment of Justice Martin quoted by Justice L'Heureux-Dubé,[75] it begins with two qualifications, one of

68. R. v. Steane [1947] K.B. 997.

69. *Chartrand*, [1994] 2 S.C.R. at 894.

70. *Id.*

71. *Id.* at 894-95.

72. R. v. Buzzanga & Durocher, [1979] 49 C.C.C. (2d) 369.

73. *See* JOHN FINNIS, INTENTION AND IDENTITY: COLLECTED ESSAYS VOLUME II 184 (2011).

74. Section 229(a)(1) of the Code provides that it is murder to cause the death of another human being and to "mean to" cause death, a clear requirement of purpose. Criminal Code, R.S.C. 1985, c. C-46, § 229(a)(1) (Can.).

75. *Buzzanga*, [1979] 49 C.C.C. (2d) at 384–85.

which is excised by an ellipsis inserted by Justice L'Heureux-Dubé. The excised—and not insignificant—qualification reads:

> (assuming without deciding that there may be cases in which intended consequences are confined to those which it is the actor's conscious purpose to bring about).[76]

The second qualification limits the equation of foresight with intention to "a general rule." Therefore, Justice Martin was not purporting to equiparate foresight of certainty with intention in all cases. Moreover, the passage is hardly a model of clarity. It confuses ends, means and foreseen consequences. It speaks of acting "in order to achieve some other purpose;" acting "so as to produce it," and concludes (in a sentence emphasized by Justice L'Heureux-Dubé) that an agent's intention "encompasses the means as well as to his ultimate objective."[77] The passage is correct that one intends not only one's end but also the means one chooses to bring about that end. But this is hardly sound authority for—indeed, it tells against—the proposition that one also intends those foreseen consequences which one's end or means may or will produce as side-effects—"side-effects" precisely because neither ends nor means to ends, and thus not intended. The passage thus discloses serious confusion and is weak authority for conflating intention with foresight, either in general or in relation to murder.

Further, Justice Martin, in the pages of his judgment leading up to the quoted passage, recognized that the meaning of intention had been the subject of academic and judicial disagreement, and that there was authority that it was limited to "purpose."[78] Before embracing a definition extending to foresight of certainty, he cited authorities including Glanville Williams, and the decision of the House of Lords in *Hyam*[79] that foresight of death as highly probable was equivalent to an intention to kill.[80] Justice Martin then enunciated the passage that was quoted by Justice L'Heureux-Dubé.[81]

The judgment of Justice L'Heureux-Dubé fails to recognize not only the confusion in that passage but also the outdated nature of the discussion of intention which precedes it. The English law of murder has come a long way since *Hyam*, and has (as we noted above[82]) rejected the conflation of foresight and intention. Glanville Williams' notion of "oblique" intent has, then, been judicially rejected. Lord Goff also extrajudicially rejected it in his signal paper on the mental element in the law of murder.[83] Nor has it escaped heavyweight academic criticism.[84]

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76. *Id.* at 384.
77. R. v. Chartrand, [1994] 2 S.C.R. 864, 890 (Can).
78. *Buzzanga*, [1979] 49 C.C.C. (2d) at 383.
79. Hyam v. Director of Public Prosecutions [1975] A.C. 55.
80. *Buzzanga*, [1979] 49 C.C.C. (2d) at 383–84.
81. *Chartrand*, [1994] 2 S.C.R. at 890.
82. *See supra* text accompanying notes 39-41.
83. Lord Goff, *The Mental Element in the Crime of Murder*, 104 L. Q. Rev. 30 (1988).
84. *See* Finnis, *supra* note 73, at Part Three, especially chapter 10, "Intention and Side-Effects".

Justice L'Heureux-Dubé also noted[85] that the definition of intent in *Buzzanga* was approved in *R. v. Keegstra*. But, if *Chartrand* was mistaken in approving that definition, so too was *Keegstra*. Moreover, *Keegstra* was, like *Buzzanga*, a case concerning the crime of "wilfully" promoting hatred against an identifiable group, and the Supreme Court in *Keegstra* explicitly noted that in *Buzzanga*, Justice Martin had observed that "wilfully" has no fixed meaning in the criminal law.[86] *Keegstra* was, moreover, decided before *Rodriguez*.

Justice L'Heureux-Dubé observed further[87] that the Supreme Court in *R. v. Olan* "examined the possibility that intent under s.338 (now s.380) of the *Code* may encompass a contemplated outcome distinct from the purpose of the conduct," and that it approved the *dictum* of the English Court of Appeal in *R. v. Allsop*.[88] However, *Olan*, like *Keegstra*, preceded *Rodriguez*. Moreover, it is one thing for a court, as in *Olan*, to "examine the possibility" that in the law of fraud intention may include foresight (though we should note that the word "intent" appears neither in Section 338(1) nor Section 380(1) as it now is).[89] It is quite another for a court to decide, as in *Rodriguez*, that in the law of murder it does not. Further, it is far from clear that *Allsop* undermines the distinction drawn between intention and foresight drawn in *Rodriguez*.

Allsop concerned the *mens rea* for the crime of conspiracy to defraud. Allsop, a "sub-broker" for a hire-purchase company, was convicted of that crime for dishonestly making false statements on applications for the hire-purchase of cars so as to induce the company to accept applications they might otherwise have rejected. He appealed on the ground that the trial judge had failed to direct that it was necessary for the Crown to prove an intention to cause economic loss to the company. Dismissing the appeal, the Court of Appeal held:

> Where a person intends by deceit to induce a course of conduct in another which puts that other's economic interests in jeopardy he is guilty of fraud even though he does not intend or desire that

85. *Chartrand*, [1994] 2 S.C.R. at 890.

86. R. v. Keegstra, [1990] 3 S.C.R. 697 (Can.). Chief Justice Dickson, delivering the judgment of the court, wrote that the interpretation of "wilfully" as requiring that the promotion of racial hatred be intended or foreseen as substantially certain significantly restricted the reach of the offence. *Id.* at 774. He added that the Law Reform Commission of Canada favored a narrow reach on the ground that "removing an intent or purpose requirement" could well result in successful prosecutions of cases similar to *Buzzanga*, where members of a minority group publish hate propaganda against their own group in order to create controversy or to agitate for reform: the Commission did not think that the crime should be used to prosecute such individuals. Chief Justice Dickson continued that he endorsed the Commission's view. *Id.* However, artificially stretching 'intention' to include 'foresight of substantial certainty' *extends* the reach of the crime and is liable to catch those whose purpose is solely to create controversy or agitate for reform but not to promote hatred either as an end or a means.

87. *Chartrand*, [1994] 2 S.C.R. at 890.

88. R. v. Allsop, (1976) 64 Cr. App. R. 29 (Eng.). *See supra* text accompanying notes 62–64.

89. *See supra* note 63.

> actual loss should ultimately be suffered by that other in this context.[90]

Allsop is a case on the scope of the *mens rea* of the crime of conspiracy to defraud, and holds that the *mens rea* is satisfied by an intention to induce another to put his or her economic interests in jeopardy, even if there is no further intention to cause economic loss to the victim. The crime is not, then, limited to the typical case—discussed above in tandem with typical theft and abduction—which involves an intention to cause economic loss to the victim as a means of enriching the fraudsman.[91] But it does not follow that the *dictum* from *Allsop* quoted in *Chartrand* is sound authority for equating foresight with intention. First, the *dictum* states that the loss to victims of fraud "is 'intended' only in the sense that it is a contemplated outcome of the fraud." This, not least because of the quotation marks surrounding "intention," can equally be read as supporting a *distinction* between foresight ("contemplation") and intention. Second, the *dictum* fails to realize that, generally, fraudsmen very much intend the detriment to their victims, precisely *as a means* of enriching themselves, even if they only advert consciously to the more seductive and vivid aspect of their intent: their own gain. Third, while the Court of Appeal in *Allsop* did go on to adopt the view expressed by Lord Diplock in *Hyam* that no distinction was to be drawn between the state of mind of one who does an act because he "desires" to produce an evil consequence and one who does an act "knowing full well that it is likely to produce that consequence,"[92] *Hyam* is old and bad law.

Chartrand provides, then, anything but a clear and coherent analysis of intention, ends, means and foresight, and is frail authority indeed for conflating intention and foresight.[93] It does not even mention *Rodriguez*, let alone purport to overrule it.[94] Moreover, *Chartrand* was decided only the year after *Rodriguez* and the same nine judges sat in

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90. *Allsop*, (1976) 64 Cr. App. R. at 32.

91. Even if *Allsop* was not such a case. The judgment states that it was common ground that the company did in fact suffer loss because it paid too much for part-exchanged cars, which were worth less than their pretended value, and because deposits which had been represented as having been paid had not in fact been paid. *Id.* at 32.

92. *Id.*

93. It is also puzzling that the judgment concludes in relation to section 281 that, "[I]f the purpose of the section is to be achieved, foresight of the certainty or near certainty of the end result must be sufficient." R. v. Chartrand, [1994] 2 S.C.R. 864, 895. It is not easy to imagine a case in which someone foresees that they are depriving a parent or guardian of a child without intending to do so. The quotation also raises questions about the meaning of "near certainty," and why "near certainty" should suffice for liability but not "high probability." Finally, is it remotely just that the law should regard a surgeon who, as a last resort, performs an extremely risky operation to try to save the life of a dying child, and who foresees that death from the operation is a "near certainty," as having not only an unlawful state of mind, but the same *mens rea*, the same murderous intent, as a man who deliberately strangles the child to death?

94. *Chartrand*, [1994] 2 S.C.R. at 866–67.

both.[95] Are we to believe that the Supreme Court overruled itself without adverting to the fact?

There is, in sum, nothing in *Carter* to support the judge's departure from the clear ruling of the Supreme Court in *Rodriguez*, a case exactly on point, that foreseeing the hastening of death is not equivalent to intending the hastening of death.

Not only did Justice Smith misunderstand the inviolability of life by conflating foresight with intention, she also appeared to conflate the inviolability of life with vitalism—that is, with a doctrine calling for the preservation of human life at all costs. She claimed[96] that the difference of ethical opinion about euthanasia "is about whether the preservation of human life is an absolute value, subject to no exceptions." But the principle of the inviolability of life does not require the preservation of human life "subject to no exceptions"; it is a principle exceptionlessly *excluding* certain kinds of choice (those intended as life shortening), not a principle that of itself requires the choice of life-preserving measures.[97] The judgment also referred to[98] the absence of a societal consensus "that life must always be preserved at all costs." This, again, suggests that the judge confused the inviolability of life with "vitalism," despite the judgment's acknowledgment[99] that this distinction had been drawn to the court's attention. Society's rejection of measures intended to shorten life, its upholding of the inviolability principle and its maintenance of the law against assisting suicide are completely compatible with acceptance that measures needed to preserve life can lawfully and ethically be omitted because they are disproportionately burdensome in any of a number of ways.

Rather than recounting the opinions of witnesses critical of the inviolability of life, the judgment should have demonstrated a sound understanding of that principle together with a recognition of its foundational importance to the criminal law in Canada and beyond. The principle remains of foundational legal importance, regardless of the extent to which it met with the approval of particular ethicists who gave evidence in the case.[100]

Finally, the judgment of Justice Smith concluded, strangely, that the prohibition on euthanasia breached the right to life of one of the plaintiffs because she might kill herself before she became too disabled to do so without assistance.[101] How the right to life—the right not to

95. Chief Justice Lamer and Justices La Forest, L'Heureux-Dubé, Sopinka, Gonthier, Cory, McLachlin, Iacobucci, and Major.

96. Carter v. Canada (Att'y General), [2012] B.C.S.C. 886, para. 350 (Can. B.C.).

97. Nor is self-defence an "exception" to the principle. *Id.* at para. 315a. The principle has long been understood to prohibit the intentional killing of the innocent, not those engaged in unjust aggression; hence the legal justification of reasonable force, even if lethal, in self-defense.

98. *Id.* at para. 355.

99. *Id.* at para. 171.

100. *Id.* at para. 335, 352.

101. *Id.* at para. 17.

be intentionally killed—can be thought to be breached by legislation prohibiting intentional killing or assistance in self-killing is puzzling.[102]

II. Discrimination Against the Disabled?

The second major criticism of *Carter*, which overlaps with the first, is that the judgment failed to recognize clearly (if at all) that not only are euthanasia and assisting suicide inconsistent with the inviolability principle, but that so, too, is suicide itself, which explains why the law has consistently discouraged suicide. This failure in the judgment paved the way for its mistaken holding[103] that the law against assisting suicide discriminates against those physically unable to commit suicide.

As the judgment recognized,[104] the common law considered suicide to be a form of homicide. The judgment noted[105] that in 1972 attempted suicide was decriminalized in Canada, and it quoted[106] the then Minister of Justice who explained that this was done "on the philosophy that this is not a matter which requires a legal remedy, that it has its roots and its solutions in sciences outside of the law and that certainly deterrent [sic] under the legal system is unnecessary." But the judgment nowhere appears clearly to recognize that decriminalization did not amount to an endorsement of suicide, let alone create a right to suicide.[107] Indeed, it quoted the following opinion tendered by an expert ethicist called by the plaintiffs, Professor Wayne Sumner: "The role of the physician [in physician-assisted suicide] is limited to providing the means for the patient to do something which is itself ethically permissible . . . . The ethical burden of justifying assistance with suicide is discharged by justifying suicide itself."[108] However, neither the law nor professional medical ethics has regarded suicide as ethical, which is one reason why it remains illegal and, in the view of the medical profession as a whole, unethical to assist suicide regardless of how autonomous and informed the decision to commit suicide may be.[109] The judge's apparent agreement with Sumner that there is no ethical distinction between suicide and assisting suicide[110] is accurate, but not because both are ethical: it is accurate because both are unethical. Significantly, the World Medical Association has been consistently opposed

102. And if this plaintiff is able to invoke the right to life against the law prohibiting assisting suicide, could another plaintiff invoke it against a law prohibiting assisting female genital mutilation, on the ground that she would rather kill herself than not be able to obtain assistance to mutilate her genitalia?

103. *Id.* at para. 15.

104. *Id.* at para. 102.

105. *Id.* at para. 105.

106. *Id.*

107. Though it does appear to appreciate that the majority in *Rodriguez* did not interpret decriminalization as an endorsement of suicide. *Id.* at para. 926.

108. *Id.* at para. 237.

109. Again failing accurately to articulate the inviolability of life, the judgment summarized the ethical case against euthanasia as involving the contention "[w]hether or not suicide may be ethical." *Id.* at 314(d). The inviolability of life holds suicide to be seriously unethical.

110. *Id.* at para. 339.

to assisting suicide and to euthanasia. Its "Statement on Physician-Assisted Suicide" reads:

> Physician[s]-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient.[111]

In *Rodriguez*, Justice Sopinka observed:

> [T]he decriminalization of attempted suicide cannot be said to represent a consensus by Parliament or by Canadians in general that the autonomy interest of those wishing to kill themselves is paramount to the state interest in protecting the life of its citizens. Rather, the matter of suicide was seen to have its roots and its solutions in sciences outside the law, and for that reason not to mandate a legal remedy.[112]

It was a similar story in England, where suicide was decriminalized by the Suicide Act 1961. Responding to concerns (concerns which subsequent misunderstanding has shown to be well-founded) that decriminalization might be interpreted as a condonation of suicide, the responsible government minister made it clear that it should not be thought that because the government was changing the method of treatment for the suicidal it was seeking to depreciate the gravity of attempted suicide, and stressed that it should not be thought that "self murder" was regarded at all lightly by the government.[113] The maintenance of the prohibition on assisting or encouraging suicide, punishable by up to fourteen years' imprisonment, provides further evidence that decriminalization was not intended to condone suicide, let alone create a right to suicide. After suicide was decriminalized, it ceased to be criminal, but remained unlawful. (The fact that conduct is not, or is no longer, criminal does not mean it is not contrary to law.) Hence the serious crime of assisting or encouraging suicide. And, in English law at any rate, it remains criminal to incite another to assist one to commit suicide. Justice Smith stated that, "it is clear that requesting assistance in death does not in and of itself contravene any law."[114] Even if that is

111. *WMA Resolution on Euthanasia*, WORLD MED. ASS'N (Oct. 2002, reaffirmed with minor revision in 2013) http://www.wma.net/en/30publications/10policies/e13b/. Moreover, the *Carter* judgment's summary of the ethical debate states that intentionally ending the life of a patient is either ethically inconceivable for physicians "or conceivable only in stringently defined exceptional circumstances." *Carter*, [2012] B.C.S.C. at para. 310. Does this accurately reflect the continuing condemnation of euthanasia in *any* circumstances by professional bodies such as the WMA?

112. Rodriguez v. British Columbia (Att'y General), [1993] S.C.R. 519 at 597–98 (Can.).

113. 644 PARL. DEB., H.C., (4th ser.) (1960–61) 1425–26 (U.K.); 645 PARL. DEB., H.C., (4th ser.) (1960-61) 822–23 (U.K.).

114. *Carter*, [2012] B.C.S.C. at para. 180.

an accurate statement of Canadian criminal law (and the judgment cites no authority to support it), the continuing prohibition of assisting suicide in Canadian law, as in English law, provides clear evidence of the law's disapproval of suicide.

In *R. (Pretty) v. Director of Public Prosecutions*,[115] the House of Lords rejected the appellant's argument that the law against assisting suicide discriminated against those who, like the appellant, were physically unable to commit suicide. Lord Bingham pointed out that such an argument rested on a misconception, for the law conferred no right to suicide. Suicide was decriminalized because the prohibition was not thought to act as a deterrent; because it cast an unwarranted stigma on innocent members of the suicide's family, and because it led to the distasteful result of prosecuting attempted suicides. That the Suicide Act conferred no right to commit suicide was illustrated by the serious punishment it provided for assisting suicide. The criminal law could not, he added, be regarded as discriminatory because it applied to everyone. The broad policy of the criminal law was to apply its offence-creating provisions to everyone. Provisions criminalizing the misuse of drugs did not exempt the addict. Moreover, "mercy killing" was, in law, killing. His Lordship concluded: "If the criminal law sought to proscribe the conduct of those who assisted the suicide of the vulnerable, but exonerated those who assisted the suicide of the non-vulnerable, it could not be administered fairly and in a way which would command respect."[116]

Carter appears to equate decriminalization with condonation. But this is, as Lord Bingham (and Justice Sopinka before him) indicated, a false equation. Imagine that a legislature, wishing to eradicate recreational heroin use, lifts the criminal prohibition on the recreational possession and use of heroin—on the ground that heroin addicts can be better helped by medical treatment than by criminal prosecution—but maintains the prohibition on supplying heroin. Would this discriminate against a person too disabled to procure a supply? Would such a person be entitled to a judicially-approved fix? Or imagine a legislature

115. R. (Pretty) v. Dir. of Pub. Prosecutions, [2001] U.K.H.L. 61, [2002] 1 A.C. 800 (Eng.).

116. *Id.* at para. 35–36. Similarly, in Fleming v. Ireland, [2013] I.E.S.C. 19 (a case discussed in Part V, *infra*) the Supreme Court of Ireland rejected the appellant's argument that the law's prohibition on assisting suicide discriminated against those who were physically unable to commit suicide without assistance. Chief Justice Denham, delivering the judgment of the court, stated that the prohibition applied "equally to everybody," adding:

> It is difficult to succeed in an equality challenge to a law which applies to everyone without distinction, and which is based on the fundamental equal value of each human life. It is often the case that neutral laws will affect individuals in different ways: in the absence of impact on a fundamental right that does not normally give rise to any unconstitutionality.

Id. at para. 133. Moreover, when the appellant lost the ability to commit suicide, this was not through operation of any law before which she was required to be held equal, but through the fact of her condition. *Id.* at para. 134. The Supreme Court held that the appellant had no right which could be interfered with by any disability, and that, as there was no right to commit suicide, issues such as discrimination did not arise. *Id.* at para. 138.

which, wishing to eradicate female genital mutilation, but regarding the women who undergo it as victims of a barbaric practice, decriminalizes self-mutilation, while maintaining the prohibition on assisting mutilation. Would this discriminate against a woman too disabled to mutilate her own genitalia? Would such a woman be entitled to judicially-approved mutilation?

Justice Smith asserted that, "The starting point in our law—the default position—is that persons control their own physical integrity."[117] Persons may indeed control their own physical integrity, but within limits. The law recognizes our physical integrity, our lives, and our autonomy as goods we have the right to safeguard. It does not follow that we may lawfully consent to the amputation of healthy limbs, to be killed, or sell ourselves into slavery, conduct which undermines these goods. The judgment proceeds that "[a]n example with direct relevance to this case is the evolution of the doctrine of informed consent to medical treatment."[118] The relevance is not obvious. The legal requirement of consent to medical treatment provides a shield against unwanted touching, not a sword to demand interventions. It does not follow from the fact that physicians may not *treat* patients *without* their consent that they can *terminate* them *with* their consent. Moreover, the killing of patients has never been regarded by the law as a medical treatment but as a serious crime (and by the medical profession as a whole as inconsistent with the physician's role as healer). Reflecting such reasoning, Section 14 of the Criminal Code provides, it will be recalled,[119] that no person is entitled to have death inflicted upon him.

Finally, if, as Justice Smith held, the law discriminates against those unable to commit suicide, why did the judgment impose conditions (such as 'grievous illness') on those who need of assistance to kill themselves, conditions which do not apply to those who are physically able to kill themselves? Why are such conditions not discriminatory?

III. Evading the Logical "Slippery Slope" Argument

Justice Smith claimed[120] that the purpose of the prohibition on assisting suicide is protection of the "vulnerable." This overlooks the distinct purpose of affirming the principle of the inviolability of life, of discouraging anyone, "vulnerable" or not, from committing (to echo the British government minister quoted above[121]) "self murder." The crime of assisting suicide is committed irrespective of the vulnerability of the suicide.

In *Rodriguez*, Justice Sopinka observed that the purpose of the prohibition was not confined to protection of the vulnerable. Early in his judgment he asked: "As members of a society based upon respect for the intrinsic value of human life and on the inherent dignity of every

117. *Carter*, [2012] B.C.S.C. at para. 1149.
118. *Id.* at para. 1151.
119. *See supra* text accompanying note 6.
120. *Carter*, [2012] B.C.S.C. at para. 16.
121. *See supra* text accompanying note 113.

human being, can we incorporate within the Constitution which embodies our most fundamental values a right to terminate one's own life in any circumstances?"[122] The sanctity of life had, he added, long been understood to exclude freedom of choice in the self-infliction of death.[123] He noted that Section 241(b), which was "grounded in the respect for and the desire to protect human life,"[124] fulfilled "the government's objectives of preserving life *and* protecting the vulnerable."[125] At one point he did state that the section has as its purpose the protection of the vulnerable,[126] but he continued that 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."[127]

The purpose was not only a policy of the state but was part of Canada's "fundamental conception of the sanctity of human life."[128] The Law Reform Commission of Canada had noted, in its working paper on euthanasia, aiding suicide, and the cessation of treatment, that "[p]reservation of human life is acknowledged to be a fundamental value of our society" and that in general the criminal law endorsed the principle of the sanctity of human life.[129] Moreover, while bodies such as the Commission had great sympathy for those who wanted to end their lives in order to end significant suffering, they refused to condone euthanasia and assisting suicide. Justice Sopinka added: "The basis for this refusal is twofold it seems—first, the active participation by one individual in the death of another is *intrinsically morally and legally wrong*, and second, there is no certainty that abuses can be prevented by anything less than a complete prohibition."[130] There was no halfway measure that could be relied upon with assurance to fully achieve the legislation's purpose:

> [F]irst, because the purpose extends to the protection of the life of the terminally ill. Part of this purpose . . . is to discourage the

122. Rodriguez v. British Columbia (Att'y General), [1993] S.C.R. 519, 585 (Can.).

123. *Id.*

124. *Id.* at 613.

125. *Id.* at 590 (emphasis added). He concluded that the blanket ban was grounded on a substantial consensus among western countries, medical organizations, and the Canadian Law Reform Commission that "in order to effectively protect life and those who are vulnerable" an exceptionless prohibition was the best approach. The formulation of safeguards had been unsatisfactory and had failed to allay fears that a relaxation of the clear standard set by the law "will undermine the protection of life and will lead to abuses of the exception." *Id.* at 613.

126. *Id.* at 595.

127. *Id.*

128. *Id.*

129. *Id.*

130. *Id.* at 601 (emphasis added). He also stated that to the extent that there was a consensus, it was that "human life must be respected" and we must be careful not to undermine the institutions that protect it. The consensus was reflected in the prohibition of capital punishment, a prohibition supported, in part, on the basis that allowing the state to kill would cheapen human life. The prohibition on assisting suicide served a similar purpose, and to permit a physician lawfully to participate in taking life would send a signal that there were circumstances in which the state approved of suicide. *Id.* at 608.

> terminally ill from choosing death over life. Secondly, even if the latter consideration can be stripped from the legislative purpose, we have no assurance that the exception can be made to limit the taking of life to those who are terminally ill and genuinely desire death.[131]

Justice Smith concluded, in relation to the protection of the vulnerable, that an alternative means of protecting the vulnerable would be to keep an "almost absolute" prohibition in place, allowing "grievously and irremediably ill adult persons who are competent, fully-informed, non-ambivalent and free from coercion or duress" to receive a lethal injection or assistance in suicide.[132]

However, her judgment nowhere answered the cardinal objection, raised in expert evidence for Canada, that once the principle of the inviolability of life is abandoned by endorsing voluntary euthanasia in some circumstances, the bright line grounded in the intrinsic and ineliminable dignity of each patient is usurped by an arbitrary line dependent on subjective judgments about which patients would be "better off dead" and that, in particular, the endorsement of voluntary euthanasia *logically* entails the endorsement of non-voluntary euthanasia, that is, the killing of incompetent patients. There are three reasons why all this is so.

First, the criteria for euthanasia set out in the judgment[133] are vague. What, precisely, is meant by a "serious illness, disease or disability", and a "state of advanced weakening capacities"? Would arthritis, or impaired hearing or sight, qualify? The conditions are also arbitrary. Why exclude someone who *almost* meets them (whatever they mean) or someone who feels that their life is no longer worth living for other reasons, whether or not health-related? And why reject the plaintiffs' argument that "psychosocial" suffering should count? And is suffering, especially "psychological" suffering, which is "intolerable" to the patient, not an inherently subjective criterion?

Secondly, the judgment accepted that the criminal law draws no distinction between intentionally bringing about a prohibited consequence and doing something knowing that the prohibited consequence is virtually certain to result.[134] It also agreed with the arguments advanced by three experts for the plaintiffs—Professors Battin and Sumner (philosophers) and Dr. Angell (a physician)—that there is no ethical distinction between "physician-assisted death" and other end of

131. *Id.* at 614. Similarly, in *Washington v. Glucksberg*, Chief Justice Rehnquist, delivering the judgment of the U.S. Supreme Court, listed several state interests justifying the prohibition on assisting suicide. First, Washington had an unqualified interest in the preservation of human life. The interests in the sanctity of life represented by the laws against homicide were threatened by one willing to participate in taking another's life. The interest was symbolic and aspirational as well as practical. 521 U.S. 702, 728 (1997). *Another* interest was the protection of vulnerable groups including the poor, elderly, and disabled from abuse, neglect and mistakes. *Id.* at 731-32 .

132. Carter v. Canada (Att'y General), [2012] B.C.S.C. 886, para. 16 (Can. B.C.).

133. *See supra* text accompanying notes 9–11, and note 12.

134. *Carter*, [2012] B.C.S.C. at 327–28.

life practices, such as palliative treatment, "whose outcome is highly likely" to be death.[135] However, if there is no legal and ethical distinction between administering a poison like potassium chloride with intent to end a patient's life, and administering morphine to ease pain, foreseeing it will shorten life as a side-effect, and it is lawful and ethical to do the latter when a dying patient is incapable of consenting to it (which it undoubtedly is), why is it not ethical to do the former and why should it not be lawful to do so if the dying patient is incapable of requesting it?

Thirdly: there is the formidable logical "slippery slope" argument.[136] This argument runs that even in cases of voluntary euthanasia it is the *doctor* who decides whether to grant the patient's request, and no responsible doctor would grant the request unless he or she judged that death would benefit the patient, because the patient's life was no longer "worth living." Once a doctor is prepared to make such a judgment in the case of patient capable of requesting death, the judgment can, logically, equally be made in the case of a patient incapable of requesting death. If respect for autonomy and beneficence are thought to justify voluntary euthanasia, why is beneficence alone not thought to justify non-voluntary euthanasia? If a doctor thinks death would benefit the patient, why should the doctor deny the patient that benefit merely because the patient is incapable of asking for it? If denying assistance in suicide to those physically incapable of committing it, and for whom death is thought a benefit, amounts to discrimination, why does denying euthanasia to those mentally incapable of requesting it, and for whom death is thought a benefit, not amount to discrimination? The logical "slippery slope" argument is unanswerable.[137]

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135. *Id.* at para. 335, 1336.

136. Although the focus here is on the *logical* argument, the *empirical* "slippery slope" argument (which the judgment also failed to address adequately) should not be overlooked. The empirical argument holds that, given the intractable difficulties of *drafting* and *policing* exceptions to the law against medical killing, safeguards cannot be made effective. It challenges advocates of relaxation of the law to show that such safeguards *can* be made effective, something which (as well shall see in Part IV, *infra*) defenders of relaxation of the law, whether in the Netherlands, Oregon, or elsewhere, have failed to show. The argument does *not* require opponents of reform to show that the incidence of euthanasia and physician-assisted suicide has increased wherever the law has been relaxed. Although such an increase is indeed to be expected (unless we believe that the law against murder, and professional sanctions, have no deterrent effect) statistical evidence of practice before legalization may well be non-existent. For a persuasive argument, based on the "law of demand," about the likely increase of euthanasia and physician-assisted suicide after their decriminalization, see NEIL M. GORSUCH, THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA 132–38 (2006).

137. For an attempt to answer it, see Hallvard Lillehammer, *Voluntary Euthanasia and the Logical Slippery Slope Argument*, 61 CAMBRIDGE L.J. 545 (2002). Lillehammer asserts that the law could require both beneficence and autonomy. So it could. But he omits to explain *why* it should so limit the "benefit" of euthanasia.

One possible argument is that the law does sometimes distinguish between consensual and non-consensual conduct, as in relation to sexual intercourse. The response to this argument is that, while a rapist could hardly invoke beneficence to justify intercourse with an incompetent woman, a doctor could well (as doctors do in the Netherlands) invoke beneficence to justify ending the life of an incompetent patient to end their suffering.

Tellingly, arguments thought to justify voluntary euthanasia, which were adduced by the plaintiff's two lead ethical experts, Professors Battin and Sumner, and quoted at some length by the judge, offer no answer to the logical argument. Indeed, they are obviously vulnerable to it. The judgment quotes Sumner as stating:

> *Treatment cessation, pain management, and terminal sedation can. . .all be justified when they are the outcome of an informed choice (whether request or refusal) on the part of a decisionally capable patient, and they serve the best interest of the patient by preventing or avoiding needless suffering.* This justification holds even when the result of any of these measures is the hastening of the patient's death. Indeed, these measures may in many circumstances better serve both patient autonomy and patient well-being by hastening death, if that is the outcome that the patient seeks and that will help to minimize suffering.[138]

He added: "It is obvious that either assisted suicide or voluntary euthanasia can be justified in exactly the same way by reference to exactly the same values."[139] As for the counter-argument that assisted suicide and voluntary euthanasia involve an intent to kill, and that other end-of-life practices need not, the judgment simply reports that Sumner rejects it.[140]

Sumner's argument prompts at least two obvious questions. First, if there is no difference between intending death and foreseeing death, and if treatment cessation is justified in the case of incompetent patients (a proposition Sumner would surely accept, unless he subscribes to the absurd proposition that life-preserving measures should never be withheld or withdrawn from incompetent patients), why should euthanasia be denied to incompetent patients? Secondly, if he thinks the best interests of an incompetent patient would be served by euthanasia, why should the doctor stay his or her hand merely because the patient is unable to request it? What if the patient no longer has, in his words, "a life worth living"?[141] It comes as no surprise that, in a book published the same year *Carter* was heard, Sumner openly endorsed non-voluntary euthanasia.[142]

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138. *Carter*, [2012] B.C.S.C. 886 at 234 (emphasis added by Justice Smith).

139. *Id.*

140. *Id.* at para. 235.

141. *Id.* at para. 351. He states: "If the goods of further life would outweigh the evils then it would be better for the person to continue living, and death would therefore be a harm to him since it would deprive him of this good future." *Id.* Is not the corollary that if the evils of further life would outweigh the goods then it would be better for the person *not* to continue living and that death would *not* be a harm to him?

A third question: if Sumner agrees that competent patients have a right to refuse life-saving treatment for any reason, and if he thinks the doctor's foresight of the patient's hastened death is ethically equivalent to intentionally hastening the patient's death, why does he not subscribe to a right to demand euthanasia for any reason?

142. *See* L.W. SUMNER, ASSISTED DEATH: A STUDY IN ETHICS AND LAW (2011). "In the case of severely disabled newborns, the best interest standard can therefore lead to the result that (a) no corrective treatment will be undertaken for the infant's condition and (b) euthanasia will instead be administered. In short, it can justify nonvoluntary euthanasia as an outcome." *Id.* at 125. "There are circumstances under which nonvoluntary

Similarly, the evidence of Professor Battin provides no answer to the logical slope argument. The judgment quotes her as saying that the core principles in the debate are autonomy and mercy (or "the right to be free from pain and suffering").[143] It is one thing to argue that, in the case of an autonomous patient, voluntary euthanasia can be justified by autonomy and mercy, but why should mercy be denied the non-autonomous patient? Her quoted evidence reads that because, in her view, autonomy and mercy must work in tandem and do not operate independently:

> [I]t cannot be claimed that permitting physician-assisted dying would require assisting lovesick teenagers who are not suffering from a serious medical condition to die; likewise it cannot be claimed that permitting physician-assisted dying on the basis of the principle of mercy would require involuntary euthanasia for someone who is in pain but nevertheless desires to stay alive.[144]

However, the logical slippery slope argument is not that acceptance of voluntary euthanasia logically involves acceptance of *involuntary* euthanasia (euthanasia against the wishes of a competent patient). It is that acceptance of voluntary euthanasia logically involves acceptance of *non-voluntary* euthanasia (euthanasia of the incompetent). Why should the incompetent patient who is suffering intolerably be denied a merciful release? The judgment does not say. Moreover, in her published work, Battin, like Sumner, endorses non-voluntary euthanasia.[145]

It is worth adding that, contrary to Battin, it can indeed be argued that, if voluntary euthanasia is to be allowed, it should be available to the lovesick teenager, or at least to a much wider range of candidates than those suffering from a serious illness. It is arbitrary to confine euthanasia to those whose suffering is caused by illness, let alone illness of a particular degree. Battin states that the principle of "mercy" means that "No one should be . . . forced to suffer, without adequate cause."[146] How, then, can mercy be confined to suffering due to illness, let alone "grievous" illness? There are many sources of suffering. There is, for example, grief, which was the cause of the mental suffering endorsed as an acceptable ground for hastened death by the Dutch Supreme Court in the *Chabot* case.[147] And what of "existential suffering," being "tired of life," which, though hitherto rejected by the Dutch courts as an acceptable ground, is thought by many in the Netherlands, including

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euthanasia offers the best outcome for decisionally incapable persons in the dying process." *Id.* at 126.

143. *Carter*, [2012] B.C.S.C. 886 at 239. The principle of the inviolability of life is, of course, notably absent from her list.

144. *Id.* at 241.

145. Margaret Pabst Battin, The Least Worst Death: Essays in Bioethics on the End of Life 120–23 (1994).

146. *Carter*, [2012] B.C.S.C. 886 at para. 239.

147. *Chabot*, Nederlandse Jurisprudentie 1994, no 656. The Supreme Court stated that the suffering resulted from a "depression in a particular sense without psychotic characteristics in the context of a complicated grieving process." Hoge Raad der Nederlanden [HR] [Supreme Court of the Netherlands], 21 June 1994 (Neth.), Strafkamer, n. 96 972, para. 4.5.

the Dutch Minister of Health who introduced the Dutch euthanasia legislation,[148] to justify a hastened death. And Dr. Philip Nitschke, one of the world's leading advocates of euthanasia, has reportedly supported its availability to the "troubled teen."[149] At one point,[150] Professor Battin states that euthanasia should only be available to avoid "suffering that is either intolerable or about to be so." But why should mercy be denied to those who *could* tolerate their suffering but do not wish to do so? The next plaintiff's expert quoted in the judgment, Dr. Upshur, states: "I do not believe that assisted suicide and euthanasia should only be available to those who are diagnosed as terminally ill, *but rather should be available to those for whom life has become not worth living to them.*"[151]

Clearly, once the law abandons the bright line prohibition on any intentional ending of patients' lives, it enters a fuzzy world of arbitrary judgments about whose lives are, or are not, "worth living." It is not surprising that disability groups in general strongly oppose legalization. A letter from disability groups in the United Kingdom and United States which opposed a proposal to relax the law stated: "We are like society's 'canaries in the coalmine' who can often see the dangers of potentially discriminatory legislation before others, as it impacts on us even before the deed is done. We are scared now; we will be terrified if assisted suicide becomes state-sanctioned."[152]

Justice Smith found that there is a strong consensus in Canada that if it is ever ethical for physicians to engage in euthanasia "it would be only in limited and exceptional circumstances, where it is clearly consistent with the patient's wishes and best interests, and in order to relieve suffering."[153] But the principles underlying the reasoning of the leading ethicist experts for the plaintiffs, Professors Sumner and Battin,[154] would appear to justify euthanasia, both voluntary and non-voluntary, in a wide range of cases.[155]

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148. *Dutch Minister Favors Suicide Pill*, CNN.COM (Apr. 14, 2001), www.cnn.com/2001/world/europe/04/14/netherlands.suicide/index.html.

149. Kathryn Jean Lopez, *Euthanasia Sets Sail: An Interview with Philip Nitschke, the Other "Dr. Death,"* NAT'L REV. ONLINE (June 5, 2001), http:/old.nationalreview.com/interrogatory/interrogatory060501.shtml.

150. *Carter*, [2012] B.C.S.C. 886 at para. 240. *Cf. id.* at para. 239.

151. *Id.* at para. 242 (emphasis added).

152. *Open Letter from Leaders of Disabled People's Movement in UK and USA*, DISABILITY ARTS ONLINE CRIPPEN BLOG (July 7, 2009), http://www.disabilityartsonline.org.uk/crippen-cartoon-blog?item=446.

153. *Carter*, [2012] B.C.S.C. 886 at para. 342.

154. *See supra* text accompanying notes 138–45.

155. In one of her books, Battin asks whether we are witnessing "the first breaking waves of a sea-change from one perspective on death and dying to another, a far more autonomist and directive one much as we have seen changes in reproduction?" Margaret Pabst Battin, *Physician-Assisted Suicide: Safe, Legal, Rare?*, *in* PHYSICIAN-ASSISTED SUICIDE: EXPANDING THE DEBATE 63, 71 (Margaret Pabst Battin et al. eds., 1998). If, she adds, we are, then the assumption that physician-assisted suicide "would or should be rare" collapses. *Id.* Another essay in the same volume (an essay which takes no side in the ethical debate) suggests that decriminalization will bring about profound changes in the way that death and dying are viewed and that social and economic considerations will impact individual decision-making such that "[a] lingering death may come to seem an extravagance,

Remarkably, Justice Smith's judgment simply *evades* the logical "slippery slope" argument. It states that the argument "requires speculation and arises only tangentially in connection with the issues in this case."[156] Earlier, the judgment had observed:

> The plaintiffs do not argue that physician-assisted death should be imposed on patients who do not, themselves, request it. Therefore, the ethical debate relevant to this case focuses on a limited class of patients: those who are competent adults (decisionally capable); fully informed as to their diagnosis, prognosis and all options for treatment or palliative care; persistently and consistently requesting assistance with death (that is, non-ambivalent); and not subject to coercion or undue influence.[157]

But the fact that the plaintiffs' arguments do not (for the present) seek to justify non-voluntary euthanasia surely does not relieve the court of the duty to consider the *obvious implications* for incompetent patients (and other vulnerable patients) of those arguments. The evidence of the plaintiffs' own experts indicates the absence of any clear or coherent limits to euthanasia, whether voluntary or non-voluntary, once the current bright, ethically coherent line offered by the inviolability of life is abandoned.

Justice Smith, then, dodged the logical "slippery slope" from voluntary to non-voluntary euthanasia. No less remarkably, in the British Columbia Court of Appeal, Chief Justice Finch's dissent dismissed the relevance of the *incidence* of non-voluntary euthanasia. Responding to the submission of counsel for Canada that the evidence of non-voluntary euthanasia from jurisdictions with relaxed laws indicated the insufficiency of their safeguards, Chief Justice Finch wrote that as non-voluntary euthanasia does not involve the consent of the patient it is "not relevant to considering safeguards for voluntary euthanasia."[158]

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a frivolous indulgence." Patricia S. Mann, *Meanings of Death, in* PHYSICIAN-ASSISTED SUICIDE: EXPANDING THE DEBATE 11, 23 (Margaret Pabst Battin et al. eds., 1998).

156. *Carter*, [2012] B.C.S.C. 886 at para. 365.

157. *Id.* at para. 313. By contrast, the U.S. Supreme Court was alert to the implications of accepting what was presented as a limited right to physician-assisted suicide. Chief Justice Rehnquist noted that if suicide was a right, it was a right enjoyed by every man and woman and could not be limited to competent, terminally ill adults, and the decision of a duly appointed surrogate decision-maker was for legal purposes the decision of the patient. Such a right, he observed, "is likely, in effect, a much broader license, which could prove extremely difficult to police and contain." Washington v. Glucksberg, 521 U.S. 702, 733 (1997). Delivering the judgment of the Supreme Court of Ireland in *Fleming* (a case discussed in Part V, *infra*), Chief Justice Denham noted that the right to assistance in suicide claimed by the appellant in that case "would sweep very far indeed." Fleming v. Ireland, [2013] I.E.S.C. 19 at para. 113. The Chief Justice added:

> In general, the Constitution guarantees rights of general application for the benefit of every citizen and person entitled to assert such rights. The Court accordingly does not accept the submission that there exists a constitutional right for a limited class of persons, which in this case would include the appellant, deducible from their particular personal circumstances.

Id. at para. 115.

158. Carter v. Canada [Att'y General], [2013] B.C.C.A. 435, at para. 154. (Can. B.C.).

But if a major argument against relaxing the law is that it would not be possible to frame and police safeguards to prevent euthanasia without request, and the evidence from jurisdictions which permit voluntary euthanasia discloses widespread non-voluntary euthanasia, why is that not relevant?

Moreover, the judgment of Chief Justice Finch also tends to reinforce concerns about the likelihood of decriminalization promoting non-voluntary euthanasia both in principle and in practice. Rejecting Canada's submission that "life" in Section 7 of the Charter means physical life, he concluded:

> The meaning of the term "life" in the context of s.7 includes a full range of potential human experiences. The value a person ascribes to his or her life may include physical, intellectual, emotional, cultural and spiritual experiences, the engagement of one's senses, intellect and feelings, meeting challenges, enjoying successes, and accepting or overcoming defeats, forming friendships and other relationships, cooperating, helping others, being part of a team, enjoying a moment, and anticipating the future and remembering the past. Life's meaning, and by extension the life interest in s.7, is intimately connected to the way a person values his or her lived experience.[159]

He added:

> The point at which the meaning of life is lost, when life's positive attributes are so diminished as to render life valueless, when suffering overwhelms all else, is an intensely personal decision which "everyone" has the right to make for him or herself.[160]

But how is the law to define and determine when "the meaning of life is lost" and to police such an "intensely personal decision," and why should euthanasia not be applied to incompetent patients whose "positive attributes are so diminished as to render life valueless . . ."? Rightly, Justices Newberry and Saunders rejected Chief Justice Finch's interpretation of "life." They observed that those with only a limited ability to enjoy the experiences listed by him were no less "alive" and had no less a right to "life" than persons who were able-bodied and fully competent.[161] They concluded:

> If "life" were regarded as incorporating various qualities which some persons enjoy and others do not, the protection of the *Charter* would be expanded far beyond what the law can "guarantee," while conversely, a slippery slope would open up for those who are unable to enjoy the blessings described by the Chief Justice.[162]

159. *Id.* at para. 86.
160. *Id.*
161. *Id.* at para. 280.
162. *Id.*

IV. Factual Findings or Wishful Thinking?

Justice Smith concluded that the empirical evidence from jurisdictions where euthanasia and/or physician-assisted suicide is permitted shows "differing levels of compliance" with the safeguards.[163] This is some understatement. The reality is that of the few jurisdictions which have relaxed their laws, none has demonstrated anything even approaching effective control. The best available evidence, that from the Netherlands, shows that key safeguards have long been widely breached, and with virtual impunity. Since 1984, when voluntary, active euthanasia was declared lawful by the Dutch Supreme Court, the evidence generated by several Dutch government-sponsored surveys has shown that thousands of patients have been killed without the required explicit request, and that thousands of euthanasia deaths have been illegally certified by doctors as death by "natural causes."[164] The first official survey disclosed that in 1990 there were 2,300 cases of voluntary, active euthanasia and 400 cases of physician-assisted suicide; that over 80% of these cases went unreported; and that there were a further 1,000 cases of active euthanasia without explicit request (mostly, but by no means all, involving incompetent patients).[165] The evidence from Belgium paints a similar picture: the common performance of non-voluntary, active euthanasia and a frequent failure to report.[166] The evidence from Oregon is much more limited: there have been no comprehensive surveys like those in the Netherlands. Moreover, the safeguards in Oregon are in significant respects, not least the absence of review committees, even laxer than those in the Netherlands and Belgium. The Oregon law's safeguards have been aptly described by leading health lawyer Professor Alexander Capron as "largely illusory."[167]

It is therefore odd that Justice Smith should have concluded that the evidence shows that the risks "can be very largely avoided through carefully-designed, well-monitored safeguards."[168] First, *no* jurisdiction which permits euthanasia or assisting suicide has "carefully-designed, well-monitored safeguards." The judgment appears to offer no response to the evidence[169] that control in the Netherlands, Belgium and Oregon cannot be effective because they rely on self-reporting by

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163. *Id.* at para. 9.

164. On the Dutch experience in general see C. Gomez, Regulating Death: Euthanasia and the Case of The Netherlands (1991); Herbert Hendin, Seduced by Death: Doctors, Patients and Assisted Suicide (1998); John Keown, Euthanasia, Ethics and Public Policy Part III (2002); R. Cohen-Almagor, Euthanasia in The Netherlands: The Policy and Practice of Mercy Killing (2004): John Griffiths et al., Euthanasia and Law in Europe (2008) Part I .

165. 14% of the 1,000 patients were "totally" competent and a further 11% "partly" competent. *See* Keown *supra* note 164, at 104–05, 113. For the results of later surveys see Griffiths et al., *supra* note 164 at 180, 199.

166. *See* Griffiths et al., *supra* note 164 at 332; 341.

167. Alexander M. Capron, *Legalizing Physician-Aided Death*, Cambridge Q. Healthcare Ethics 10 (1996); *see also* Gorsuch *supra* note 136, at chapter 7.2.

168. Carter v. Canada (Att'y General), [2012] B.C.S.C. 886, at para. 10 (Can. B.C.).

169. *Id.* at para. 374.

doctors. Nor do the guidelines require all candidates for euthanasia or assisted suicide to consult a psychiatrist or a specialist in palliative care.[170]

Secondly, the *undisputed* empirical evidence from the Netherlands and Belgium shows widespread breach of the safeguards, not least the sizeable incidence of non-voluntary euthanasia and of non-reporting.[171] The judgment's handling of the Dutch experience[172] is particularly unreliable, failing to give adequate attention to the widely-acknowledged and widespread breaches of the Dutch safeguards since 1984.

Thirdly, the judgment skates over the official *condonation* of non-voluntary euthanasia of disabled infants by the Dutch courts and medical profession,[173] and fails even to mention (despite it being cited in evidence) the repeated criticism of the Dutch by the United Nations Human Rights Committee.[174] The judgment also fails to give anything like adequate attention to important expert committee reports which have taken full account of the Dutch experience in their unanimous and considered rejection of euthanasia, not least the reports of the House of Lords Select Committee on Medical Ethics[175] and of the New York State Task Force.[176] The judgment states that there is now much greater compliance with the requirement to report than there was "pre-legalization."[177] However, voluntary euthanasia was declared lawful by the Dutch Supreme Court in 1984—in 2002 the legal guidelines were essentially translated into statutory form. The low rate of reporting in 1990 (18%) was, therefore, discovered six years *after* legalization. The fact that the reporting rate rose to 80% in 2005 (three years after the enactment of the statute) is an improvement, but from a low base, and obviously had nothing to do with "legalization." That 20% of euthanasia cases in 2005 year were still being falsely and illegally certified by physicians as deaths by natural causes,[178] and that some 550 patients

170. For other concerns noted in the judgment *see id.* at para. 405, para. 406, para. 429.

171. For example, evidence from the plaintiff's own Belgian expert disclosed a reporting rate of only 52.8% there. *Id.* at para. 560, para. 564. The evidence also disclosed a substantial incidence of non-voluntary euthanasia: 1.8% of all deaths in Flanders. *Id.* at para. at 567. *See also id.* at para. 657.

172. *Id.* at para. 455–504.

173. *Id.* at para. 484. In two cases in 1996 Dutch appellate courts held lethal injections for disabled infants lawful in certain circumstances. KEOWN *supra* note 164, at 119-20. In 2005 the Dutch Association for Pediatrics adopted the 'Groningen Protocol' for infanticide. GRIFFITHS ET AL., *supra* note 164, at 231-233.

174. U.N. Human Rights Comm., *Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant*, para. 7, U.N. DOC. CCPR/C/NLD/CO/4 (Aug. 25, 2009). *See also* U.N. Human Rights Comm., *Concluding Observations of the Human Rights Committee: Netherlands*, para. 5–6, U.N. DOC. CCPR/CO/72/NET (Aug. 27, 2001).

175. House of Lords, Report of the Select Committee on Medical Ethics, H.L. Paper No. 21-I (1994). (U.K.).

176. N.Y. STATE TASK FORCE ON LIFE & THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994)

177. Carter v. Canada (Att'y General), [2012] B.C.S.C. 886, para. 655 (Can. B.C.).

178. *See* J. GRIFFITHS ET AL., EUTHANASIA AND LAW IN EUROPE 199 (2008).

were euthanized without the required explicit request,[179] is hardly evidence of effective control. Again, the judge's conclusion that law reform in the Netherlands has made considerable progress in achieving its goals[180] depends on what she means by "law reform." After legalization in 1984, a high incidence of non-voluntary euthanasia and of non-reporting was detected. The fact that the numbers have improved since then is hardly evidence that the relaxation of the law in the Netherlands has been accompanied by effective control. It is simply evidence that matters seem less bad than they were in the half dozen or so years after legalization. But the Dutch regime still falls far short of demonstrating effective control. If control were so effective, why the criticisms by the U.N. Human Rights Committee in 2001 and again in 2009?[181] The assertion by Battin that the empirical data from the Netherlands "demonstrates that no or little substantive abuse has occurred"[182] bears little relation to the disturbing reality disclosed by the Dutch surveys, unless she entertains the peculiar view that non-voluntary euthanasia is not a "substantive abuse."

Fourthly, the judgment attaches considerable significance to a paper by Battin et al purporting to show no statistical evidence of heightened risk to "vulnerable groups" in the Netherlands and Oregon.[183] However, to show that the proportion of, say, elderly people who were euthanized or assisted in suicide was no greater than the proportion of elderly dying naturally does not show that those euthanized or assisted in suicide were not pressured or depressed. Moreover, as Battin et al. properly recognize, "full examination of practice in Oregon would require studies of the complexity, duration and comprehensiveness of the four Dutch nationwide studies."[184] The judge, despite recognizing the limitations of self-reporting, and the doubts about compliance with the requirement of referral to a mental health professional of patients suspected to be suffering from mental disorder or depression,[185] concluded that the Oregon law is working "fairly well."[186] Given the absence of comprehensive surveys, such a judgment is surely unwarranted. And even if there were an absence of reported abuse, absence of evidence of abuse is not evidence of absence of abuse. The judge also observed that the Oregon data supported the evidence of a Dutch expert, Dr. van Delden, that it is possible to design a system that protects vulnerable individuals and groups.[187] The evidence from Oregon is, again, insufficient to support that conclusion, and the evidence from the Netherlands and Belgium goes the other way.

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179. *Id.* at 180.
180. *Carter*, [2012] B.C.S.C. 886 at para. 660.
181. *See supra* note 174.
182. *Carter*, [2012] B.C.S.C. 886 at para. 661.
183. *Id.* at para. 621–36; Margaret Pabst Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable Groups"*, 33 J. MED. ETHICS 591 (2007).
184. *Carter*, [2012] 886 B.C.S.C. at para. 635.
185. *Id.* at para. 649; *see also infra* text accompanying note 209.
186. *Carter*, [2012] B.C.S.C. 886 at para. 653.
187. *Id.* at para. 667.

The judge concluded that the experience in Oregon is more likely to be predictive of what would happen in Canada if a permissive regime were put in place, though she acknowledged that even in relation to Oregon "only a weak inference can be drawn."[188] Moreover, if only a weak inference can be drawn from the experience in Oregon, a jurisdiction which does not permit voluntary euthanasia, what is the supposed basis of the judge's conclusion that the empirical evidence shows that the risks associated with euthanasia "can be very largely avoided through carefully-designed, well-monitored safeguards?"[189] The judge concluded that, "the expert opinion evidence from persons who have done research into the question is that, with respect to all three jurisdictions, the predicted abuse and disproportionate impact on vulnerable populations has not materialized."[190] This ignores expert evidence to the contrary which was placed before the court, and which is consistent with the concerns raised by other researchers who were not called as experts.[191] The judge also concluded that empirical researchers and practitioners with experience in those jurisdictions conclude that their systems work well in protecting patients from abuse.[192] But how can any system be said to "work well" when it relies on self-reporting or is associated with a sizeable incidence of non-voluntary euthanasia and of non-reporting? Or when, like the Dutch, its failings are recognized by bodies including the United Nations Human Rights Committee? The judgment does not say.

V. *Fleming v. Ireland*

In *Fleming v Ireland*,[193] a case broadly similar to *Carter*, a woman with multiple sclerosis wanted to avail herself of assisted suicide at a time of her choosing. She challenged the constitutionality of Ireland's prohibition on assisting suicide, contained in section 2(2) of the Criminal Law (Suicide) Act 1993, and sought a declaration of incompatibility pursuant to section 5 of the European Convention on Human Rights Act 2003.[194] Mirroring the Suicide Act 1961 in England, the Criminal

188. *Id.* at para. 683.

189. *Id.* at para. 10.

190. *Id.* at para. 684.

191. *See e.g.,* R. Cohen-Almagor, Euthanasia in the Netherlands: The Policy and Practice of Mercy Killing (2004);

192. *Carter,* [2012] B.C.S.C. 886 at para. 685.

193. Fleming v. Ireland [2013] I.E.H.C. 2 (H. Ct.) (Ir.), *aff'd*, Supreme Court [2013] I.E.S.C. 19.

194. In the alternative, she sought an order directing the third defendant, the Director of Public Prosecutions, to issue guidelines stating the factors taken into account in deciding whether to prosecute or consent to prosecute anyone who assisted the plaintiff to commit suicide. *Id.* at 3(3). The court, distinguishing R. (Purdy) v. Dir. of Pub. Prosections, [2010] 1 A.C. 345 (Eng.), rejected this claim. *See Fleming,* [2013] I.E.H.C. at para. 126–75. For criticism of *Purdy* see Keown, *supra* note 22, at 301–07.

The challenge to the law in *Fleming* was narrower than that in *Carter* in that the plaintiff did not challenge the prohibition on euthanasia, but wider in that she challenged the law prohibiting anyone, physician or layperson, from assisting suicide. The essence of her claim was distilled by Chief Justice Denham in the Supreme Court: that disabled persons suffering severe pain from a terminal and degenerative illness, and who were able to

Law (Suicide) Act 1993 abolished the crime of suicide but punishes, with a maximum of fourteen years' imprisonment, aiding, abetting, counseling, or procuring suicide or an attempt by another to commit suicide.[195] The plaintiff invoked Article 40.3.2 of the Irish Constitution, which provides: "The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen."[196] She argued that insofar as it protected her "person" this necessarily embraced decisions concerning her personal welfare, including medical treatment.[197] The State could not prescribe an orthodoxy in respect of life choices of this fundamental nature, and individual choices of this kind taken by competent adults must normally be respected absent compelling reasons to the contrary.[198]

The Divisional Court of the High Court[199] considered that insofar as the plaintiff advanced a conscientious and considered decision to seek the assistance of others to take active steps to end her own life "in the face of a terminal illness which has ravaged her body and rendered her life one of almost complete misery," that such a decision "is *in principle* engaged by the right to personal autonomy which lies at the core of the protection of the person by Article 40.3.2."[200] However, the court said it chose the words "in principle" carefully, as there were "powerful countervailing considerations" which fully justified the legislature in prohibiting assisting suicide. It added:

> Like Rehnquist C.J. in *Glucksberg*, the Court believes there is a real and defining difference between a competent adult making the decision not to continue medical treatment on the one hand—even if death is the natural, imminent and foreseeable consequence of that decision—and the taking of *active steps by another* to bring about the end of that life of the other. The former generally involves the passive acceptance of the natural process of dying, a fate that will ultimately confront us all, whereas the latter involves the *active* ending of the life of *another*—a totally different matter.[201]

It went on:

> *If* this Court could be satisfied that it would be possible to tailor-make a solution which would address the needs of Ms. Fleming *alone* without any *possible* implications for third parties or society at large, there might be a good deal to be said in favour of her case.

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express their wishes, should not be prevented from being assisted to commit suicide. *Fleming*, [2013] I.E.S.C. at para. 23.

195. *Fleming*, [2013] I.E.H.C. at para. 4.

196. Ir. Const., 1937, art. 40, *available at* http://www.taoiseach.gov.ie/eng/Historical_Information/The_Constitution/.

197. *Fleming*, [2013] I.E.H.C. at para. 49.

198. *Id.* at para. 50.

199. Comprising the President of the High Court (Kearns) and Justices Carney and Hogan.

200. *Fleming*, [2013] I.E.H.C. at para. 52 (emphasis in original).

201. *Id.* at para. 53 (emphasis in original).

> But this Court cannot be so satisfied. It certainly cannot devise some form of legislative solution which would be an impermissible function for the Court. Further, the Court is mindful that any legislative solution would have to be of *general* application and this is true *a fortiori* of any judicial decision which the Court might be called upon to make.[202]

Even with legislative safeguards "serious objections and concerns remain."[203] There was the risk of misdiagnosis of terminal illness;[204] of mistaken prognosis;[205] the subjective nature of the 'intolerability' of pain;[206] and that pain ranked low in the motivational hierarchy of those seeking assisted suicide.[207] Although the study by Battin et al. concluded that the evidence from the Netherlands and Oregon did not show that potentially vulnerable groups were in fact vulnerable to pressure, the relevance of some of those groups in the context of physician-assisted suicide was open to question. The court noted that, in their reply to that study, Professors Ilora Finlay and Rob George had argued that socioeconomic categories are not necessarily a proxy for vulnerability.[208] The court could not, moreover, overlook the fact that one of the co-authors of the Battin study, Professor Ganzini, had herself expressed doubts about the absence of appropriate safeguards in the Oregon law. Moreover, Professor George had given evidence, as an expert for Ireland, that the 2011 report from the Oregon Department of Public Health had shown that the referral rate for psychiatric evaluation for those who had ended their lives by physician-assisted suicide was just 1.4%.[209]

Moreover, Ganzini's study found that of eighteen patients who had received physician assistance in suicide, three had been suffering from clinical depression which had not been diagnosed or been the subject of independent psychiatric evaluation.[210] Just as importantly, the court continued, the Battin study did not address the concerns powerfully expressed by the two expert witnesses led by the State—palliative care physicians Dr. Tony O'Brien and Professor Rob George—that under a relaxed regime certain categories of patients with no visible sign of depression and who did not belong to any of the traditional categories of vulnerable patients would place *themselves* under pressure to hasten their death in this fashion in a subtle manner that might often escape detection.[211] George had observed that, while overt pressure on individuals to end their lives would likely be uncommon, much more common were the signals that relatives and others can send, albeit

202. *Id.* at para. 55 (emphasis in original).
203. *Id.* at para. 57.
204. *Id.*
205. *Id.* at para. 59.
206. *Id.* at para. 60.
207. *Id.*
208. *Id.* at para. 61.
209. *Id.* at para. 62.
210. *Id.* at para. 63.
211. *Id.* at para. 64.

unconsciously, to a seriously ill family member that he or she has become a burden on the family or that family life has become disrupted by their illness. There was such a thing as "care fatigue" even in loving family environments, and it was easy for seriously ill people to feel a sense of obligation to remove themselves from the scene.[212] The court concluded: "Of the evidence given in this case, the Court prefers that offered by the State."[213] It added:

> The predominant thrust of the expert evidence offered by Dr. O'Brien and Professor George to the effect that relaxing the ban on assisting suicide would bring about a paradigm shift with unforeseeable (and perhaps uncontrollable) changes in attitude and behavior to assisted suicide struck the Court as compelling and deeply worrying. The Court was particularly impressed by the evidence given by these two witnesses based as they are on many years of clinical experience in dealing with and treating terminally ill patients. The Court finds the evidence of these witnesses, whether taken together or separately, more convincing than that tendered by Professor Battin, not least because of the somewhat limited nature of the studies and categories of person studied by Professor Battin but also because the views of the State's witnesses are rooted in their solid clinical experience of dealing with literally thousands of terminally ill patients and both gave their evidence in a manner which greatly impressed the Court.

It concluded:

> The Court finds that the State has provided an ample evidential basis to support the view that any relaxation of the ban on assisted suicide would be impossible to tailor to individual cases and would be inimical to the public interest in protecting the most vulnerable members of society.[214]

The court noted that a further point of some importance was that relaxation of the law would compromise, perhaps in a fundamental and far-reaching way, that which was rightly regarded as an essential ingredient of a civilized society committed to the protection of human life and dignity. It might well send out a subliminal message to particular vulnerable groups, such as the disabled and the elderly, that in order to avoid consuming scarce resources in an era of shrinking public funds for healthcare, physician-assisted suicide was a normal option which any rational patient faced with terminal or degenerative illness should consider.[215] And this was quite apart from other considerations to which the legislature could properly attach great weight, such as the preservation of the integrity of the medical profession as healers, and of deterring suicide and anything that smacks of the "normalisation" of suicide.[216] It was idle to suggest that even the consensual taking of

212. *Id.* at para. 66.
213. *Id.* at para. 67.
214. *Id.*
215. *Id.* at para. 68.
216. *Id.* at para. 69.

another's life would not involve the risk of the physician becoming accustomed to the new paradigm, and the risks of complacency with regard to the maintenance of safeguards could not be discounted as negligible.[217] In that regard, one had to have regard to the Dutch data, which showed a lack of control, and that non-voluntary euthanasia was a serious problem.[218] The Dutch experience showed that the risks were real and could not be dismissed as speculative, and, just as seriously, the dilution of the statutory ban might over time lead to the unintentional erosion of moral and legal standards among medical practitioners.[219]

It was true, added the court, that under the law's proportionality analysis, a complete statutory ban which overrode or significantly interfered with a constitutional right required compelling justification, especially in the case of intimate choices in relation to profound issues touching on personal autonomy. Nevertheless, the court thought the legislature "fully entitled" to enact the ban on assisting suicide, not least when regard was had to the wider public policy considerations and to the duty imposed by Article 40.3.2 to safeguard the right to life.[220] The State had a "profound and overwhelming interest in protecting the sanctity of all human life": this was an express and solemn commitment contained in Article 40.3.2. In conjunction with the equality guarantee in Article 40.1, "it commits the State to valuing *equally* the life of *all* persons."[221] The court continued:

> In the eyes of the Constitution, the last days of life of an elderly, terminally ill and disabled patient facing death have the same value, possess the same intrinsic human dignity and naturally enjoy the same protection as the life of the healthy young person on the cusp of adulthood and in the prime of their life. These are, of course, concerns which any free and democratic society must strive to protect and uphold.[222]

The prohibition on assisting suicide was rationally connected to this fundamental objective of protecting life and was "not remotely based on arbitrary, unfair or irrational considerations."[223] If the court were to unravel a thread of the law by even the most limited constitutional adjudication in the plaintiff's favor, it would, or at least might, open a Pandora's Box, placing the lives of others at risk. Such might well be the effect of relaxation,

> specifically because of the inability of even the most rigorous system of legislative checks and balances to ensure, in particular, that the aged, the disabled, the poor, the unwanted, the rejected, the lonely, the impulsive, the financially compromised and the emotionally vulnerable would not disguise their own personal prefer-

217. *Id.*
218. *Id.* at para. 70.
219. *Id.* at para. 71.
220. *Id.* at para. 72.
221. *Id.* at para. 74 (emphasis in original).
222. *Id.*
223. *Id.* at para. 75.

> ences and elect to hasten death so as to avoid a sense of being a burden on family and society.[224]

The safeguards built into any liberalized system would, furthermore, be vulnerable to laxity and complacency and might well prove difficult or even impossible to police adequately.[225] For all these reasons, the court held that the blanket ban satisfied the requirement of proportionality.

The court proceeded to consider the comparative legal authorities. It observed that, apart from the judgment of Justice Smith in *Carter*, there was "near judicial unanimity" on the constitutionality of blanket bans on assisting suicide.[226] In particular, every appellate court had stressed as compelling the considerations which had persuaded the Irish Divisional Court to uphold the law.[227] The U.S. Supreme Court in *Glucksberg* had noted the State's interest in protecting vulnerable groups, including the poor, the elderly, and the disabled from abuse, neglect, and mistakes, and in protecting the disabled and dying from prejudice, negative stereotypes, and societal indifference.[228] It had observed that the blanket ban "reflects and reinforces its policy that the lives of terminally ill, disabled and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's."[229] The U.S. Supreme Court had also noted that the state may fear that permitting assisted suicide would start it down the path to euthanasia with and even without consent. If suicide was a right, it was a right enjoyed by every man and woman and could not be limited to competent, terminally ill adults, and the decision of a duly appointed surrogate decision maker was for legal purposes the decision of the patient.[230] A limited right to physician-assisted suicide was likely, in effect, a much broader license, which could prove extremely difficult to police and contain.[231] This concern was further supported, the U.S. Supreme Court had added, by evidence from the Netherlands, where the Dutch government's own survey had disclosed 1,000 cases of euthanasia without explicit request, and the euthanasia of disabled neonates and demented elderly.[232] The Irish Divisional Court also noted that in the companion case of *Vacco v. Quill*, the U.S. Supreme Court had rejected the argument that the distinction between refusing lifesaving treatment and assisted suicide was arbitrary: by permitting everyone to refuse unwanted treatment, while prohibiting everyone from assisting

224. *Id.* at para. 76.
225. *Id.*
226. *Id.* at para. 78.
227. *Id.*
228. *Id.* at para. 81. *See supra* note 131.
229. *Id.* at para. 81.
230. *Id. See supra* note 157.
231. *Fleming*, [2013] I.E.H.C. at para. 81.
232. *Id.*

suicide, the law was, the Supreme Court had noted, following a long-standing and rational distinction.[233]

Turning to the decision of the Canadian Supreme Court in *Rodriguez*, the Irish Divisonal Court noted that Justice Sopinka had held that the blanket ban had a "clearly pressing and substantial legislative objective grounded in the respect for and the desire to protect human life, a fundamental Charter value."[234] On the question of proportionality, he had observed that to introduce an exception would create inequality, and that attempts to create exceptions had tended to support the theory of the "slippery slope": "The formulation of safeguards to prevent excesses has been unsatisfactory and has failed to allay fears that a relaxation of the clear standard set by the law will undermine the protection of life and will lead to abuses of the exception."[235] There was no halfway house, he had concluded, which would achieve the legislation's purpose because the purpose extended to the protection of the lives of the terminally ill, partly by discouraging them from choosing death, and because there was no assurance that the exception could be made to limit the taking of life to those who are terminally ill and genuinely desire death.[236] The Irish court observed that Justice Sopinka's analysis of the proportionality issue concurred with its own.[237]

It noted also that the European Court of Human Rights had affirmed, in *Pretty*, the U.K.'s blanket ban on assisting suicide, concluding that "[c]lear risks of abuse do exist, notwithstanding arguments as to the possibility of safeguards and protective procedures,"[238] and that in *Haas v. Switzerland*[239] it had observed that "the risks of abuse inherent in a system that facilitates access to assisted suicide cannot be underestimated."[240]

What of *Carter*? The Irish Divisional Court noted that Justice Smith had given two reasons for holding the Canadian ban to be unconstitutional: subsequent development in the proportionality analysis, and evidence from jurisdictions with relaxed laws which had not been available to the Supreme Court in *Rodriguez*.[241] While the Irish court thought it would be inappropriate to comment on the first, it did address the second. In light of the evidence that had been presented to Justice Smith, and to it, the court disagreed with her analysis and conclusions.[242]

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233. *Id.* at para. 83. The Irish Divisional Court expressed its entire agreement with the views of the U.S. Supreme Court it quoted from *Glucksberg* and *Vacco*. *Id.* at para. 84.

234. *Id.* at para. 87.

235. *Id.*

236. *Id.*

237. *Id.*

238. *Id.* at para. 109.

239. 53 Eur. Ct. H.R. 33 (2011).

240. *Fleming*, [2013] I.E.H.C. at para. 118.

241. *Id.* at para. 90. Evidence about the failure of Dutch control, including the first Dutch survey disclosing the 1,000 cases of non-voluntary euthanasia in 1990, was available well before *Rodriguez* was decided, and amply warranted Justice Sopinka's concern about the "worrisome" trend the evidence revealed. Rodriguez v. British Columbia (Att'y Gen.) [1993] 3 S.C.R. 519, 603 (Can.). And, as we shall see, the subsequent evidence persuaded the Irish Divisional Court to agree not with Justice Smith but with Justice Sopinka.

242. *Fleming*, [2013] I.E.H.C. at para. 92.

First, it was true that similar issues of informed consent attended, on the one hand, the decision of a seriously ill patient to refuse life-sustaining treatment and, on the other, physician-assisted suicide. However, the similarity ended there, since for the reasons the Divisonal Court had set out, there was an "enormous and defining" difference between the two.[243] The latter involved active participation in the intentional killing of another, even if freely consensual.[244] Secondly, the Divisional Court could not agree that the accumulated evidence from other jurisdictions supported Justice Smith's conclusion that "the risks inherent in legally permitted death have not materialized in the manner that may have been predicted."[245] It added:

> Neither the evidence tendered at the hearing before us or the evidence given before Lynn Smith J. regarding contemporary practice in either the Netherlands or Belgium can be regarded as encouraging or satisfactory. After all, it was not in dispute but that in 2005—the year for which the latest data is available for the Netherlands—560 patients (some 0.4% of *all* deaths) were euthanized without having given their explicit consent.[246]

Moreover, the corresponding figure for Belgium was apparently higher, "as 1.9% of *all* deaths which took place in the entirety of Flanders between June and November 2007 were without explicit request."[247] The corresponding figure for Switzerland was also high: "almost 1% of *all* deaths."[248] Justice Smith had also noted that evidence was given that in some cases euthanasia without request is lawful in the Netherlands.[249] In short, observed the Divisional Court, the evidence showed that the incidence of non-voluntary euthanasia in the Netherlands, Belgium, and Switzerland is "strikingly high."[250] Further, the evidence before Justice Smith also showed that "family burden" was more often cited as a reason for non-voluntary euthanasia, and that non-voluntary euthanasia predominated in respect of the elderly who were in a coma or demented, that is, "precisely one of the vulnerable groups most at risk."[251] Her finding that relaxation of the law did not disproportionately impact vulnerable groups such as the elderly or those with disabilities had to be measured against this evidence, as well as the evidence (apparently accepted by her) that disabled neonates were not infrequently euthanized in the Netherlands.[252] The Divisional Court concluded, "Against that general background, the Court cannot at all agree with [Justice Lynn Smith's] finding that the risks inherent in legally permitted assisted death have not materialized in jurisdictions such as

243. *Id.* at para. 93.
244. *Id.*
245. *Id.* at para. 94.
246. *Id.* at para. 96 (emphasis in original).
247. *Id.* at para. 99 (emphasis in original).
248. *Id.* (emphasis in original).
249. *Id.* at para. 97.
250. *Id.* at para. 102.
251. *Id.* at para. 103.
252. *Id.*

Belgium and the Netherlands."[253] The court went on that, while it agreed with her that scrutiny of physician-assisted suicide would have to be "at the highest level," she herself acknowledged that, more than thirty years after relaxation of the law, compliance with essential safeguards in the Netherlands was "not yet at an ideal level."[254] The Divisional Court added:

> In fact, it might well be said that this is altogether too sanguine a view and that the fact that such a strikingly high level of legally assisted deaths without explicit request occurs in countries such as Belgium, Netherlands and Switzerland without any obvious official or even popular concern speaks for itself as to the risks involved in any such liberalisation.[255]

The Divisional Court preferred the reasoning of Justice Sopinka in *Rodriguez*.[256]

The Divisional Court noted that the preponderance of judicial opinion in the United States, Canada, the United Kingdom, and the European Court of Human Rights had been to uphold a blanket ban for the same or substantially the same reason as it had set out. "Specifically, experience has shown that it would be all but impossible effectively to protect the lives of vulnerable persons and to guard against the risks of abuses were the law to be relaxed."[257] No appellate court had upheld the claims of a litigant in the plaintiff's position because it was impossible to craft a solution specific to the needs of a plaintiff such as Ms. Fleming without jeopardizing an essential fabric of the legal system, namely, respect for human life, and compromising these protections for others and other groups of individuals who sorely need such protections.[258] The court was "prepared to allow" that insofar as the blanket ban failed to make separate provision for persons in the plaintiff's position by creating no exception to take account of the physical disability which prevented her from taking the steps which the able-bodied could take, the precept of equality in Article 40.1 was engaged.[259] However, for all the reasons it had given for rejecting her claim under Article

253. *Id.* at para. 104. Even if it is true, the court added, that the incidence of non-voluntary euthanasia has significantly declined since the law was relaxed. *Id.* For criticism of the claim that the incidence has in fact declined since legalization. *See supra* notes 177–81.

254. *Fleming*, [2013] I.E.H.C. at para. 104.

255. *Id.* Although this Article is concerned with the evidence presented in *Carter* and *Fleming*, it is worth noting that the euthanasia experience in Belgium has since been attracting increasing publicity, concerning the use of organs from euthanized patients; the euthanasia of deaf twins; of a transsexual person; and the enactment of legislation to permit euthanasia for children. *See* Simon Caldwell, *Organs of those killed by euthanasia being used*, DAILY TELEGRAPH (June 14, 2011); *Deaf Belgian twins end lives as they start going blind*, BBC (Jan. 16, 2013), http://www.bbc.com/news/world-europe-21039064; *Belgian helped to die after three sex change operations*, BBC (Oct. 2, 2013), http://www.bbc.com/news/world-europe-24373107; *Belgian parliament votes through child euthanasia*, BBC (Feb. 13, 2014), http://www.bbc.com/news/world-europe-26181615.

256. *Fleming*, [2013] I.E.H.C. at para. 105.

257. *Id.* at para. 119.

258. *Id.* at para. 120.

259. *Id.* at para. 122. *Cf.* the judgment of the Irish Supreme Court, *supra* note 116.

40.3.2, it considered the differential treatment amply justified. There was, moreover, a profound difference between the law permitting an adult to take their own life and sanctioning another to assist that person to take their own life.[260] The decision of the Divisional Court was affirmed by the Supreme Court of Ireland.[261]

Demonstrating an impressive familiarity with the comparative legal authorities and with the empirical evidence, the judgment of the Divisional Court in *Fleming* confirms the eccentric and erroneous nature of the judgment of Justice Smith in *Carter*. This is not to suggest that *Fleming* is itself free from difficulty. First, it held that the plaintiff's rights under Article 40.3.2 were engaged by the State's prohibition on assisting suicide, which prohibition then required justification.[262] However, the ban on assisting suicide *implements* the requirements of that Article. Article 40.3.2 provides, it will be recalled,[263] that the State shall "protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen." The ban *protects* the lives of citizens from unjust attack, not only those who may not freely wish to die (for whom the court showed a commendable concern) but even those who may. The court did not appear to appreciate that, while autonomy is indeed an important human capacity, and part of our dignity, not *all* exercises of autonomy engage constitutional protection, and certainly not those aimed at self-destruction (or self-mutilation, or selling oneself into slavery . . .). Indeed, not only *may* the State prohibit assisting suicide, there is a strong argument that it *must* do so, at least if it is to comply with Article 40.3.2 and protect the life of each citizen from unjust attack; with Article 40.3.1, by which the State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen; and with Article 40.1 which guarantees the equality of each person before the law. In its review of the comparative authorities, the court cited the decision of the U.S. Supreme Court in *Cruzan v. Director, Missouri Department of Health*.[264] In that case, the Supreme Court assumed that there is a liberty to refuse unwanted medical treatment. The law rightly protects such exercises of autonomy. But an

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Article 40.1 provides, "All citizens shall, as human persons, be held equal before the law. This shall not be held to mean that the State shall not in its enactments have due regard to differences of capacity, physical and moral, and of social function."

260. *Fleming*, [2013] I.E.H.C at para. 122.

261. Fleming v. Ireland [2013] I.E.S.C. 19.

262. *See supra* text accompanying note 200. Similarly, the European Court of Human Rights reasoned in *Pretty* that because the United Kingdom's ban on assisting suicide prevented the applicant from exercising her choice to avoid what she considered would be an undignified end to her life, the court was "not prepared to exclude "that the ban interfered with her right to respect for her private life under Article 8(1) of the European Convention. Pretty v. United Kingdom, 35 Eur. Ct. H.R. 1, para. 67 (2002). The Law Lords were on surer ground in holding that there was nothing in Article 8(1) to suggest that it protected the choice to live no longer. R. (Pretty) v. Dir. of Pub. Prosecutions, [2001] U.K.H.L. 61, para. 23 [2002] 1 A.C. 800.

263. *See supra* note 196.

264. *Fleming*, [2013] IEHC 2 at para. 54 (citing Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990)).

autonomous choice to refuse treatment which is futile or too burdensome (a choice historically protected by the law) is quite different from a choice to be helped to kill oneself (a choice historically prohibited by the law). *Cruzan* is authority for the former, not the latter. A legal prohibition on refusing treatment would conflict with a long-recognized right; a prohibition on assisting suicide conflicts with no right, long-recognized or otherwise.

A second and overlapping criticism of *Fleming* is that the Divisional Court treated the distinction between the right to refuse treatment and the claimed right to assistance in suicide in terms of "the taking of active steps" by a third party to bring about the death of another.[265] This was mistaken. For the key to understanding the law relating to the protection of human life is the distinction between intention and foresight, not the distinction between acts and omissions. Assisting suicide (and euthanasia) often involve the taking of active steps, but not always. The court should have held that the claim in *Fleming* failed not because it would have involved *active* assistance in suicide, but because it would have involved *intentional* assistance in suicide.

A third criticism is that the court was "prepared to allow" that insofar as the blanket ban failed to make separate provision for persons in the plaintiff's position by creating no exception to take account of the physical disability which prevented her from taking the steps which the able-bodied could take, the precept of equality in Article 40.1 was engaged.[266] The fragile nature of such reasoning was explained in Part II of this Article.

Conclusions

The judgment of Justice Lynn Smith in *Carter* is profoundly flawed. It fails accurately to articulate or to affirm the fundamental legal principle of the inviolability of life, a principle which has long provided an ethical, intelligible, and workable bright line, historically endorsed by the criminal law and by professional medical ethics, prohibiting the intentional shortening of patients' lives and the intentional assistance or encouragement of suicide. By blurring the key distinction between trying to shorten life and merely foreseeing the shortening of life, the judgment both misunderstands and undermines that principle. Moreover, the principles the judgment adopts at its expense—an exaggerated deference to autonomy and an understanding of beneficence which holds that some lives are "not worth living," that some patients would be "better off dead"—would justify the ending of the lives of patients, both competent and incompetent, in a broad range of cases. The judgment's cursory dismissal of the logical "slippery slope" argument is particularly difficult to defend.

The judgment's analysis of the regulation of euthanasia and assisting suicide, in those few jurisdictions with relaxed laws, is no sounder

265. *See supra* text accompanying notes 201, 244.
266. *See supra* text accompanying note 259.

than its analysis of legal and ethical principle. The experience of the Netherlands and Belgium discloses widespread breach of key guidelines, with virtual impunity, not least the frequent practice of non-voluntary euthanasia. The safeguards in Oregon are in significant respects even laxer, and Oregon awaits the sort of comprehensive surveys carried out by the Dutch, surveys which have exposed the persistent failure of their guidelines to cabin voluntary euthanasia. Justice Smith's key finding that the evidence shows that the risks of decriminalization "can be very largely avoided through carefully-designed, well-monitored safeguards"[267] is very wide of the mark. In short, *Carter* rejects a foundational ethical principle of the criminal law and misrepresents the disturbing and widely-recognized reality of practice in those few jurisdictions which have abandoned it.

In *Bland* Lord Goff stated:

> It is of course well known that there are many responsible members of our society who believe that euthanasia should be made lawful: but that result could, I believe, only be achieved by legislation which expresses the democratic will that so fundamental a change should be made in our law, and can, if enacted, ensure that such legalised killing can only be carried out subject to appropriate supervision and control.[268]

Reflecting this proper and prudent approach, the highest courts in Canada, the United States, England, and Ireland, together with the European Court of Human Rights, have deferred to legislatures to resolve a matter—involving as it does questions of ethics, clinical judgment, and social policy—that is paradigmatically suited to legislative deliberation. *Carter* illustrates the dangers of judges, not least in expedited hearings,[269] making mistaken factual findings, findings at odds with those of expert committees. Legislatures are not constrained by the circumstances, not least the possible urgency of an individual case and the expertise of individual counsel. They are also able to appoint expert committees to assist their deliberations. The dangers of judges deciding the issue are only compounded by the reluctance of appellate courts to review a trial judge's findings of fact. Chief Justice Finch

267. *See supra* text accompanying note 2.

268. Airedale N.H.S. Trust v. Bland, [1993] A.C. 789, 865 (H.L.) (Eng.). Similarly, in Washington v. Glucksberg, 521 U.S. 702, 720 (1997), Chief Justice Rehnquist noted the judicial need for the utmost care in accepting a right to physician-assisted suicide; that such acceptance would place the matter outside the arena of public debate and legislative action, and that the court's rejection of such a right permitted the debate to continue, "as it should in a democratic society." *Id.* at 735. Delivering the judgment of the Supreme Court of Ireland in *Fleming*, Chief Justice Denham stated that the legislation prohibiting assisting suicide called for "a careful assessment of competing and complex social and moral considerations." She added: "That is an assessment which legislative branches of government are uniquely well placed to undertake." Fleming v Ireland, [2013] I.E.S.C. 19, para. 96. *See also id.* at para. 107.

269. Both *Carter* and *Fleming* were fast-tracked. *Carter* proceeded by way of a summary trial application and counsel were required to operate under "fairly short timelines." Carter v. Canada (Att'y Gen.), [2012] B.C.S.C. 886, para. 114 (Can. B.C.). The proceedings in *Fleming* were instituted on October 25, 2012, and the case was heard on December 5, 2012. *Fleming*, [2013] I.E.H.C. at para. 2.

observed in *Carter* that, while findings based on social and legislative facts together with the testimony of live witnesses are not subject to the ordinary "palpable and overriding error" standard on review, they are owed some level of deference.[270] The erroneous nature of the key factual finding in *Carter* is palpable and overriding but, had it been less so, and had Justice Smith's judgment not been reversed because of her misunderstanding of disproportionality, it is not difficult to imagine an appellate court granting it deference. A single judge's flawed interpretation of the empirical evidence could then have had the most profound consequences for Canadian law, medicine, and society.

In the Court of Appeal, Justices Newberry and Saunders briefly considered *obiter* the possibility of granting a constitutional exemption in the case of "a generally sound law that has an extraordinary, even cruel, effect on a small number of individuals."[271] They remarked that the issue of physician-assisted suicide has surfaced repeatedly in Parliament "without result one way or another."[272] While one shares their sympathy for those whose suffering cannot be completely alleviated by modern palliative medicine and social support, their suggestion that this might justify a constitutional exemption is highly problematic.

First, would it be proper for a statute enacted by the democratically-elected legislature, and upheld as constitutional by the courts, to be nullified by the courts, even in a "small number" of cases? Moreover, what would qualify the courts to make exceptions, not least when any exception has grave implications for society, implications an adequate understanding of which requires familiarity with the arguments and evidence canvassed by expert bodies, in Canada and beyond, which have exhaustively considered the issue and which have overwhelmingly decided against the making of any exception? Further, although Justices Newberry and Saunders claimed that the issue has been repeatedly raised in the legislature "without result one way or another," does not this claim simply close its eyes to the plain fact that there *has* been a result: the repeated rejection of attempts to create exceptions?[273]

Secondly, Justices Newberry and Saunders claimed that the prohibition against assisting suicide is concerned with the protection of the vulnerable and that "[l]ifting the prohibition for those who are clear-minded, supported in their life-expectancy by medical opinion, rational and without outside influence, and protected by a court process, might not undermine the legislative intention. . . ."[274] But, as we will recall, the purpose of the prohibition on assisting suicide is not only to protect

270. Carter v. Canada (Att'y Gen.) [2013] B.C.C.A. at para. 151.

271. *Id.* at para. 326.

272. *Id.* at para. 334.

273. As recently as 2010, "Bill C-384," a private member's bill to decriminalize euthanasia and physician-assisted suicide, was rejected by the Canadian Parliament by 228 votes to 59. *Assisted suicide voted down by MPs*, CBCNEWS (Apr. 21, 2010, 11:42 PM), http://www.cbc.ca/news/canada/assisted-suicide-voted-down-by-mps-1.910839.

274. *Carter*, [2013] B.C.C.A. at para. 333.

the vulnerable: it is to affirm the inviolability of the lives of all, "vulnerable" or not.[275]

Thirdly, could a constitutional exemption be limited to a "small number" of individuals? Are there not numerous individuals, with suffering of various types and degrees, and with varying degrees of life-expectancy (suffering will be more protracted the longer one's life-expectancy), who might claim an exemption? According to what criteria would the judges distinguish between the "deserving" and the "undeserving"? And, if certain individuals who requested an exemption on account of their suffering were accommodated, why deny an exemption to an incompetent person suffering to the same (or greater) extent, whose representative applied for an exemption on their behalf?

Fourthly, leaving aside the problem of defining the limits of any exemption, would euthanasia in practice be performed only when sanctioned by a court? If many Dutch doctors ignore even the "light touch" regulation required of them, why should we expect many Canadian doctors to subject themselves, and their patients, to the more formal, time-consuming, and arduous process of euthanasia by constitutional exemption? The mechanism of a constitutional exemption escapes none of the key objections to relaxing the law which have been identified by expert committees, objections which ground statutory blanket bans on euthanasia and assisting suicide, bans which have been repeatedly upheld by appellate courts.

In conclusion, nothing in the judgment of Justice Smith in *Carter* (or in the dissenting judgment of Chief Justice Finch in the Court of Appeal) should give the Supreme Court of Canada cause to overrule its decision in *Rodriguez*, a decision the soundness of which has been repeatedly affirmed, and whose soundness is significantly reinforced by the manifest unsoundness of the argumentation in *Carter* for overruling it.

275. *See supra* text accompanying notes 120–31.