CARTER V. CANADA (ATTORNEY GENERAL):

CANADIAN COURTS REVISIT THE CRIMINALIZATION OF ASSISTED SUICIDE

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I. INTRODUCTION

In 1993, the Supreme Court of Canada, by a vote of 5-4, rejected a challenge to the Criminal Code of Canada's prohibition on assisted suicide.[1] The challenge, brought by a woman suffering from ALS (Lou Gehrig's disease), claimed that her rights under the Charter of Rights and Freedoms of the Canadian Constitution, to dignity of the person and equal benefit of the law, were violated by a statute that had the effect of denying the disabled the right to terminate their lives while leaving attempted suicide by those who could proceed unaided unpunished.[2]

A few years later, the United States Supreme Court came to the same conclusion in a factually similar case challenging the prohibition of assisted suicide on Fourteenth Amendment grounds.[3] Both decisions found that the prohibition was justified by the difficulty of assuring, under anything less than an absolute prohibition, that vulnerable persons would not be pressured into a suicide that was not fully voluntary.

In the last twenty years, two American states and several European nations have liberalized their approach to assisted suicide. With the experience of those jurisdictions as background, in June 2012 the

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1. Rodriguez v. British Columbia, [1993] 3 S.C.R. 519 (Can.).
2. *Id.*
3. Washington v. Glucksberg, 521 U.S. 702 (1997).

Supreme Court of British Columbia (a trial court) handed down a judgment in *Carter v. Canada (Attorney General)*.[4] Finding sufficient reasons to distinguish the Supreme Court's 1993 decision, Justice Lynn Smith held that insofar as it prohibited a competent, terminally ill patient from obtaining assisted suicide, it violated Charter rights. The decision will no doubt make its way back to the Supreme Court of Canada.

Part II of this Article discusses the Supreme Court of Canada's 1993 decision.[5] Part III discusses the legislative changes that have taken place in American and European jurisdictions with respect to assisted suicide in the last twenty years.[6] These will provide the background for Part IV, which summarizes and discusses Justice Smith's judgment in *Carter*.[7] Along the way, it will highlight some differences in Canadian and American approaches to analyzing constitutional claims that government has infringed fundamental rights or denied equal protection. Finally, Part V will briefly discuss the possible future of Justice Smith's analysis in claims challenging statutes such as the Canadian assisted suicide law, either in Canada or the United States.[8]

II. *RODRIGUEZ V. BRITISH COLUMBIA*

The Supreme Court of Canada confronted the question of constitutional protection for physician-assisted suicide in the 1993 case of *Rodriguez v. British Columbia (Attorney General)*.[9] Sue Rodriguez, a 42-year old woman, was afflicted with ALS.[10] Her condition was deteriorating, and she was given a life expectancy of two to fourteen months.[11] In the interim, she was expected to lose the ability to walk, move, speak, and swallow without assistance.[12] Anticipating a time when she was no longer able to enjoy life, she desired the assistance of a physician to set up "technological means" which would allow her to end her life.[13]

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4. Carter v. Canada (Att'y Gen.), [2012] B.C.S.C. 886 (Can. B.C.), *available at* http://www.canlii.org/en/bc/bcsc/doc/2012/2012bcsc886/2012bcsc886.html.

5. *See infra* Part II.

6. *See infra* Part III.

7. *See infra* Part IV.

8. *See infra* Part V.

9. [1993], 3 S.C.R. 519 (Can.).

10. *Id.* at 530 (Lamer, C.J., dissenting).

11. *Id.*

12. *Id.*

13. *Id.*

Although Canada had decriminalized attempted suicide in 1972,[14] the Criminal Code Section 241 continues to prohibit anyone from counseling, aiding or abetting another to commit suicide.[15] Rodriguez claimed that the application of Section 241 in cases similar to hers violated several of her rights under the Canadian Charter of Rights and Freedoms,[16] specifically the right to "life, liberty and security of the person,"[17] the right "not to be subject to any cruel and unusual treatment or punishment,"[18] and the right "to the equal protection and equal benefit of the law."[19]

A five-justice majority rejected Rodriguez's claims. Justice Sopinka, writing for the majority, first turned to the Section 7 claim.[20] In protecting the right to life, liberty and security of the person, the provision contains its own limiting principle, stating that such right cannot be infringed "except in accordance with the principles of fundamental justice."[21] While Justice Sopinka found that Section 241(b) did infringe Rodriguez's security of the person (and perhaps her liberty interest), "any resulting deprivation is not contrary to the principles of fundamental justice."[22]

In the 1988 case of *R. v. Morgentaler*,[23] the Court invalidated Code provisions that prevented women from obtaining access to abortion "unless they complied with an administrative scheme found to be contrary to the principle of fundamental justice."[24] In Justice Sopinka's view, the several opinions of the justices in *Morgentaler* had established "that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and

14. Criminal Law Amendment Act, 1972, S.C. 1972, c. 13, s. 16 (Can.). *See also* SPEC. S. COMM. ON EUTHANASIA AND ASSISTED SUICIDE, PARLIAMENT OF CAN., FINAL REPORT OF LIFE AND DEATH APPENDIX D (1995), *available at* http://www.parl.gc.ca/content/sen/committee/351/euth/rep/lad-a2-e.htm.

15. Criminal Code, s. 241(b), R.S.C. 1985, c. C-46. This provision states, "Every one who . . . (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years."

16. *Rodriguez*, 3 S.C.R. at 520.

17. Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, § 7 (U.K.).

18. *Id.* § 12.

19. *Id.* § 15.

20. *Rodriguez*, 3 S.C.R. at 583 (Sopinka, J.).

21. *Id.*

22. *Id.*

23. R. v. Morgentaler, [1988] 1 S.C.R. 30 (Can.).

24. *Rodriguez*, 3 S.C.R. at 586 (Sopinka, J.).

psychological integrity, and basic human dignity are encompassed within security of the person."[25]

Whether the application of Section 241(b) to cases such as Ms. Rodriguez was contrary to principles of fundamental justice required far more analysis. Justice Sopinka began by noting that the analysis called for "a balancing of the interest of the state and the individual."[26] The state interest in Section 241(b) is "the protection of the vulnerable who might be induced in moments of weakness to commit suicide."[27] While noting that the criminal offense of attempted suicide had been repealed in 1972,[28] Justice Sopinka maintained that this did not diminish the state interest in protecting life, but rather was merely a recognition that the criminal prohibition was of little value in deterring suicide.[29]

Although Canadian courts had recognized the right of a patient to refuse treatment, or demand that it be discontinued, even where the lack of treatment would result in death,[30] Justice Sopinka maintained the distinction between such refusal and active third-party assistance in suicide for two reasons.[31] "[F]irst, 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."[32] In reviewing the law of other Western democracies, Justice Sopinka noted that "[n]owhere is assisted suicide expressly permitted,"[33] although some jurisdictions mitigated guilt depending on particular circumstances,[34] and the Netherlands, while maintaining the offense on the statute books, would decline to prosecute if the act had occurred consistent with "medically established guidelines."[35] In 1983, the European Commission on Human Rights rejected the contention that the U.K. prohibition on assisted suicide violated the European Convention for the Protection of Human Rights and Fundamental Freedoms.[36]

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27. *Id.* at 595.

27. *Id.* at 595.

27. *Id.* at 595.

28. *See supra* note 14.

29. *Rodriguez*, 3 S.C.R. at 522 (Sopinka, J.).

30. *See* Ciarlariello v. Schacter, [1993] 2 S.C.R. 119 (Can.); Nancy B. v. Hotel-Dieu de Quebec, [1992] 86 D.L.R. 4th 385 (Can. Que. S.C.); Malette v. Shulman, [1990] 72 O.R. 2d 417 (Can. C.A.).

31. *Rodriguez*, 3 S.C.R. at 598 (Sopinka, J.).

32. *Id.* at 601.

33. *Id.* at 601-02.

34. *Id.* at 603.

35. *Id.*

36. *Id.* at 602 (citing Application No. 10083/82 R. v. United Kingdom, July 4, 1983 D.R. 33).

In light of this general consensus in favor of a distinction between withdrawal of treatment and active assistance in suicide, and the position of the Canadian Medical Association, the British Medical Association and the World Medical Association against legalization of assisted suicide, Justice Sopinka found that Section 241(b) did not violate any principle of fundamental justice.[37]

Justice Sopinka then considered Rodriguez's contention that Section 241(b) violated her right under Section 12 of the Charter "not to be subjected to any cruel and unusual treatment or punishment."[38] The key question here was whether the prohibition could constitute "treatment" for purposes of the Charter provision. While agreeing that the section could extend to some situations beyond the imposition of criminal sentences, Justice Sopinka rejected the position that the mere criminalization of the act by the Criminal Code could constitute "treatment" by government.[39] A finding of "treatment" requires that "the individual is in some way within the special administrative control of the state."[40] Here, there was no "active state process in operation, involving an exercise of state control over the individual"[41] beyond the generally applicable criminal prohibition.

Finally, Justice Sopinka turned to the contention that the prohibition violated Section 15 of the Charter by discriminating against disabled persons with respect to a "benefit or burden" of the law.[42] Justice Sopinka assumed without deciding that Section 15 was infringed, but found that the provision was "clearly saved" under Section 1.[43] There was no doubt that Section 241(b) was grounded in a pressing and substantial government interest, and that the legislation was rationally related to that purpose.[44] The key question was whether the provision could be seen as impairing the Section 15 right only to the minimal degree necessary to achieve the government's pressing goals.[45] In other words, was the legislation overbroad or disproportionate?

Citing the "substantial consensus" of western governments, medical societies and the Canadian Law Reform Commission that he discussed in his Section 7 analysis, Justice Sopinka found that a legislative decision that any attempt to create exceptions would create a "slippery slope" that

37. *Rodriguez*, 3 S.C.R. at 608 (Sopinka, J.).
38. *Id.*
39. *Id.* at 611.
40. *Id.*
41. *Id.* at 612.
42. *Id.*
43. *Rodriguez*, 3 S.C.R. at 612-13.
44. *Id.* at 613.
45. *Id.*

would threaten the purpose of protecting the vulnerable was defensible, and that Section 1 balancing justified any Section 15 discrimination inherent in the prohibition.[46]

Four justices dissented. Justice McLachlin (now the Chief Justice of Canada) writing for herself and Justice L'Heureux-Dubé, maintained that the application of Section 241(b) infringed the § 7 right to security of the person, and that it could not be justified as consistent with the principles of fundamental justice.[47] Justice McLachlin contended that the 1988 decision in *R. v. Morgentaler*[48] was controlling. In *Morgentaler*, the Supreme Court of Canada invalidated Criminal Code provisions regulating abortion on the ground that the system, under which women could gain authorization for abortion, had the effect of denying some women the right to security of the person in a way inconsistent with principles of fundamental justice.[49] While facially neutral, the abortion regulation system made access to authorization depend to a great extent on a woman's place of residence and the number of local physicians available to serve on the board authorizing abortions.[50] Justice McLachlin saw this as similar to a legal regime that, while facially neutral, interferes with the right of the disabled person to terminate her life, while removing the legal prohibition or attempted suicide for those able to act without assistance.[51]

To Justice McLachlin, the societal interests relied upon by Justice Sopinka, while relevant in Section 1 balancing, were not appropriate considerations in determining whether principles of fundamental justice would support the conclusion that there was no Section 7 violation at the outset:

> The principles of fundamental justice require that each person, considered individually, be treated fairly by the law. The fear that abuse may arise if an individual is permitted that which she is wrongly denied plays no part at this initial stage. In short, it does not accord with the principles of fundamental justice that Sue Rodriguez be disallowed what is available to others merely because it is possible that other people, at some other time, may

46. *Id.*
47. *Rodriguez*, 3 S.C.R. at 616-17 (McLachlin, J., dissenting).
48. R. v. Morgentaler, [1988] 1 S.C.R. 30 (Can.).
49. *Id.* at 66-69.
50. *Id.*
51. *Rodriguez*, 3 S.C.R. at 619-20 (McLachlin, J., dissenting).

> suffer not what she seeks, but an act of killing without true consent.[52]

Sue Rodriguez had, in Justice McLachlin's view, satisfied the Section 7 burden of demonstrating that the application of Section 241(b) to her case was inconsistent with principles of fundamental justice.[53] Societal interests were relevant only at the stage of determining whether the Section 7 violation was justified under Section 1 as "demonstrably justified in a free and democratic society," an inquiry in which the burden of proof falls upon the government.[54]

In Justice McLachlin's opinion, the government could not meet that burden. The absolute prohibition on assisted suicide, she maintained, went beyond any safeguards necessary to prevent euthanasia of those not truly consenting or vulnerable to undue influence in consenting.[55]

Chief Justice Lamer also dissented, but focused entirely upon the Section 15 guarantee of equal protection and equal benefit of the law.[56] Finding a violation of Section 15 that was not justified under Section 1, he found no need to address the Section 7 issue.[57]

At the outset, the Chief Justice noted that Section 15 stood as a prohibition not merely against facial or deliberate discrimination "but also against incidental or indirect discrimination."[58] Thus, "a distinction based on a prohibited ground, even where made without the intent to disadvantage or deprive of a benefit some person or class of persons, could therefore be discriminatory."[59] That Section 241(b) does not, on its face, create a distinction based upon disability, nor was it Parliament's intention to do so, does not settle the matter.[60]

The facial neutrality of Section 241(b) nevertheless created "an unequal effect on persons who are or will become unable to commit suicide."[61] Since, the Chief Justice maintained, the inequality was based on the "personal characteristics" of those individuals,[62] and had the effect of depriving them of a benefit of the law—that is, the right to choose

52. *Id.* at 621.
53. *Id.* at 624.
54. *Id.* at 624-25.
55. *Id.* at 626-27.
56. *Id.* at 530 (Lamer, C.J., dissenting).
57. *Rodriguez*, 3 S.C.R. at 544.
58. *Id.* at 547.
59. *Id.* at 548.
60. *Id.* at 550.
61. *Id.* at 552 (Lamer, C.J., dissenting).
62. *Id.* at 557.

suicide[63]—a violation of Section 15 of the Charter had been established.[64]

The Chief Justice then concluded that the Section 15 violation was not justified under Section 1 balancing. The purpose of Section 241(b)—which "may properly be characterized as the protection of vulnerable people, whether they are consenting or not, from the intervention of others in decisions respecting the planning and commission of the act of suicide"[65]—qualified as a pressing and substantial legislative objective, and Section 241 was rationally connected to that goal.[66]

But the provision, in the Chief Justice's opinion, failed the proportionality test by failing to impair Section 15 rights "as little as reasonably possible."[67] The absolute prohibition of Section 241(b) makes no distinction between "a person who is aided in his or her decision to commit suicide and the situation where the decision itself is a product of someone else's influence."[68] A more narrowly drawn prohibition could, wrote the Chief Justice, include safeguards that would protect the vulnerable "and still ensure the equal right to self-determination of persons with physical disabilities."[69] Section 1, then, could not save the infringement of Section 15.[70]

In a brief dissenting opinion, Justice Cory agreed with both Justice McLachlin's analysis of the claim under Section 7 and Chief Justice Lamer's analysis under Section 15.[71] When the "right to choose death is open to patients who are not physically handicapped," he stated, "[t]here is no reason for denying that choice to those that are."[72] The state interest in protection of the vulnerable could be sufficiently protected by conditions placed by a less absolute prohibition.

III. DEVELOPMENTS SINCE *RODRIGUEZ*

When the Supreme Court considered *Rodriguez*, courts and legislators in Western democracies had little experience in considering the question of assisted suicide. Justice Sopinka noted that Canadian courts had recognized a Charter-based right of a competent individual to

63. *Rodriguez*, 3 S.C.R. at 557 (Lamer, C.J., dissenting).
64. *Id.*
65. *Id.* at 561.
66. *Id.*
67. *Id.* at 563.
68. *Id.* at 568-69.
69. *Rodriguez*, 3 S.C.R. at 569 (Cory, J., dissenting).
70. *Id.*
71. *Id.* at 629-31 (Cory, J., dissenting).
72. *Id.* at 631.

refuse or withdraw medical treatment,[73] and such a right was strongly suggested by the opinions of the United States Supreme Court in its 1990 *Cruzan* decision.[74]

In *Cruzan*, a five-justice majority upheld a Missouri statute that insisted that relatives seeking to terminate treatment for a comatose patient establish that termination was consistent with the now unable-to-speak patient's wishes by a standard of clear and convincing evidence rather than a mere preponderance.[75] As significant as the holding of the case, however, was the seemingly clear endorsement by a majority of the justices of the position that a competent patient had a constitutionally guaranteed right to discontinue treatment and that such a right might well extend to the right to have wishes set forth in a properly executed "living will," or appointment of a proxy decision-maker.[76] Missouri's higher burden of proof was justified as necessary to assure that treatment would not be withdrawn against the wishes of a patient unable to speak for herself.[77]

Two years after the Canadian Supreme Court decision in *Rodriguez*, the United States Supreme Court unanimously upheld the Washington State prohibition on assisted suicide in a case factually similar to *Rodriguez*.[78] In perhaps a more forceful rejection of the substantive due process claim, the Court found that the absolute prohibition was justified by the state's "unqualified interest in the preservation of human life" as well as its interest in "protecting vulnerable groups . . . from abuse, neglect and mistakes."[79] The "fear that permitting assisted suicide will start . . . down the path to voluntary and perhaps even involuntary euthanasia" was sufficient to justify an absolute prohibition.[80]

Four justices concurring in the judgment expressed some reservations about how the statute might be applied in situations where a patient sought to avoid "intolerable pain and the indignity of living one's final days incapacitated and in agony."[81] Specifically, Justice O'Connor

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73. *See supra* note 30.

74. Cruzan v. Mo. Dep't of Health, 497 U.S. 261 (1990).

75. *Id.* at 285-87.

76. *Id.* at 278 (stating "that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions"). *See id.* at 287 n.12 (noting that the case did not present "the question whether a State might be required to defer to the decision of a surrogate" appointed by the patient while competent). *See also id.* at 289-90 (O'Connor, J., concurring).

77. *Id.* at 283.

78. Washington v. Glucksberg, 521 U.S. 702 (1997).

79. *Id.* at 728-31.

80. *Id.* at 732.

81. *Id.* at 789-92 (Breyer, J., concurring).

and Justice Breyer noted that were the statute applied to prevent palliative care intended to reduce pain at the end of life, but that may have the effect of shortening life, it would present a more difficult question.[82] Whether legal protection for palliative care, combined with recent advances in the medical profession's pain management capabilities, is sufficient to address the claim of the terminally ill without the further step of permitting acts intended to, rather than merely having the likely effect of, shortening life, remains a central question relating to the legal status of assisted suicide.[83]

While *Glucksberg* rejected a constitutional right to assisted suicide, American federalism permitted states to address the issue through either legislative or judicial means.[84] In 1994, by a narrow majority, Oregon voters approved by initiative the "Oregon Death with Dignity Act," permitting a physician to prescribe a lethal medication to an adult patient suffering from a terminal illness after taking steps to assure that the request was voluntary and not the product of depression or any other psychological disorder.[85] The patient would then be free to self-administer the drug.[86]

Legal challenges delayed the implementation of the Act, and a 1997 referendum question seeking repeal of the Act was defeated.[87] In 2001, the Bush administration declared that physicians acting pursuant to the Act would be in violation of federal statutes prohibiting the distribution of controlled substances, but in 2006, the United States Supreme Court held that the federal Controlled Substances Act[88] could not be enforced against physicians acting under the procedures set forth in the Oregon statute.[89]

The Oregon statute requires physicians acting pursuant to it to report detailed information to the Oregon Health Division, which has compiled statistics concerning the prescriptions and resulting deaths since 1998.[90] From enactment of the Act through the end of 2010, 525 Oregon

82. *Id.* at 792. *See also id.* at 736-38 (O'Connor, J., concurring).

83. Amicus briefs filed in *Glucksberg* described the increasing attention given to palliative care by the medical profession. *See, e.g.*, Brief of the American Medical Ass'n, the American Nurses Ass'n, and the American Psychiatric Ass'n, et al., as Amicus Curiae in Support of Petitioners, Washington v. Glucksberg, 521 U.S. 702 (1997) (No. 96-110), 1996 WL 656263. *See also Glucksberg*, 521 U.S. at 792 (Breyer, J., concurring).

84. *Glucksberg*, 521 U.S. at 792 (Breyer, J., concurring).

85. Oregon Death With Dignity Act, OR. REV. STAT. ANN. §§ 127.800-.897 (West 2003).

86. *Id.*

87. Gonzales v. Oregon, 546 U.S. 243, 249 (2006).

88. Controlled Substances Act, 21 U.S.C.A. § 801 *et seq.* (West 2014).

89. *Gonzales*, 546 U.S. at 274-75.

90. Oregon Death With Dignity Act, OR. REV. STAT. ANN. § 127.865 (2003).

residents died from prescriptions under the Act, a number representing a percentage of deaths in Oregon ranging from 5.5/10,000 (0.055%) in 1998 to 20.9/10,000 (.209%) in 2010.[91]

Eleven years after the United States Supreme Court upheld the State of Washington's absolute prohibition on assisted suicide, the state's voters approved by initiative the "Washington Death with Dignity Act,"[92] which is substantially similar to the Oregon Act.[93] In the first two years of the Washington Act's operation, 150 prescriptions were issued under the Act, and patients used 87 of those prescriptions to hasten death.[94]

The State of Montana has taken no legislative action to permit assisted suicide, but a recent decision of the Montana Supreme Court held that, as a matter of statutory interpretation rather than constitutional right, the consent of a terminally ill patient to physician assistance in dying would serve as a defense to homicide charges against the physician.[95] With the exception then of Oregon, Washington, and Montana, assisted suicide remains illegal within the United States with the possible proviso, suggested by concurring justices in *Glucksberg*, that these statutes may not be enforceable against physicians who merely provide palliative care that may have the unintended consequence of shortening life.[96]

Justice Sopinka noted in *Rodriguez* that the Netherlands, while retaining laws against euthanasia, had permitted physicians to raise the defense of necessity in cases of voluntary euthanasia.[97] In 2001, the Netherlands codified the exception to the prohibition of assisted suicide.[98] The Act, which makes no distinction between euthanasia and assisted suicide,[99] sets forth criteria that require a voluntary, fully informed decision by a patient undergoing unbearable suffering with no prospect of improvement[100] and consultation with a second, independent physician.[101] Significantly, there is no requirement that the patient be

91. The Oregon statistics are set out in *Carter v. Canada (Attorney General)*, [2012] B.C.S.C. at para. 398-400 (Can. B.C.).

92. Washington Death with Dignity Act, WASH. REV. CODE ANN. § 70.245 (West 2009).

93. *See Carter*, [2012] B.C.S.C. at para. 402.

94. *Id.* at para. 402-03.

95. Baxter v. Montana, 224 P.3d 1211 (Mont. 2009).

96. Washington v. Glucksberg, 521 U.S. 702, 792 (1997) (Breyer, J., concurring).

97. Rodriguez v. British Columbia, [1993] 3 S.C.R. 519, 581-82 (Can.).

98. Termination of Life on Request and Assisted Suicide (Review Procedures) Act, Stb. 2002, p. 194.

99. *Id.* at art. 2.

100. *Id.* at art. 2(1)(a)-(c).

101. *Id.* at art. 2(1)(e).

terminally ill, and Dutch courts have held that both physical and mental suffering can qualify under the statute.[102]

Studies conducted since 1990 show that physician-assisted deaths in the Netherlands have ranged from 2.2% to 3.5% of all deaths.[103] A large majority of these deaths resulted from euthanasia rather than assisted suicide.[104] While less than 1% of all deaths, there has been a significant number of cases of euthanasia without an express request by the patient; some of these cases involved previously expressed wishes by the patient, some others involved consultation with relatives of incompetent patients, and some involved neither.[105] Courts have held that the necessity defense was still available after enactment of the 2001 Act in cases lacking express consent, but where the defense is not made out, euthanasia is still a criminal act.[106]

In 2002, Belgium enacted a statute on euthanasia largely modeled on the Dutch Act.[107] The Belgian Act provides somewhat more detailed procedural requirements for physicians, particularly in cases where the unbearable suffering is not the consequence of a terminal illness.[108] Officially reported euthanasia cases in Belgium from 2002-2008 represented less than 1% of all deaths.[109] Interestingly, at least one study concluded that the incidence of euthanasia prior to the 2002 Act was actually higher than the post-Act years.[110] A second study concluded that cases of euthanasia without explicit request by the patient were actually fewer after enactment of the Act.[111]

Switzerland criminalizes euthanasia, but its Penal Code makes "death on request" subject to a lower sentence than murder or manslaughter.[112] With respect to assisted suicide, the Penal Code makes a distinction based upon the motives of the person assisting the suicide.

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102. The cases are cited and discussed in *Carter v. Canada (Attorney General)*, [2012] B.C.S.C. at para. 469 (Can. B.C.).

103. *Id.* at para. 475.

104. *Id.*

105. *Id.* at para. 483-86.

106. *Id.*

107. 28 May 2002 Act on Euthanasia of 22 June 2002, BELGISCH STRAATSBLAD [B.S.] [Official Gazette of Belgium].

108. *Id.* at para. 509-11.

109. The statistics are set forth in *Carter*, [2012] B.C.S.C. at para. 518-520.

110. Luc Deliens et al., *End of Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey*, 356 LANCET 1806 (2000).

111. Johan Bilsen et al., *Changes in Medical End-of-Life Practices During the Legalization Process of Euthanasia in Belgium*, 65 SOC. SCI. MED. 803 (2007). The article is discussed in *Carter*, [2012] B.C.S.C. at para. 525-527.

112. SCHWEIZERISCHES STRAFGESETZBUCH [StGB] [CRIMINAL CODE] Dec. 21, 1937, SR 757 (1938), art. 114-15 (Switz.).

The Code punishes anyone "who for selfish motives incites or assists another to commit or attempt to commit suicide."[113] In other words, assisting suicide for unselfish reasons is not a criminal offense. While there are no statutory procedures similar to those provided by the Dutch or Belgian Acts, several Swiss "right-to-die" organizations which assist those seeking assisted suicide have developed protocols incorporating some of the requirements of those statutes, such as the presence of unbearable suffering and a deliberate and stable decision by a competent patient.[114] A ten-year study found that the incidence of assisted death in Switzerland has increased significantly, but remains under 1% of all deaths.[115]

The most recent European statute on the subject of assisted suicide and euthanasia is the 2009 Law on Euthanasia and Assisted Suicide of Luxembourg.[116] The Act draws on the Belgium Act in its requirement that where a competent adult patient has made a voluntary written request for either euthanasia or assisted suicide while suffering from "constant and unbearable physical or mental suffering without prospects of improvement," a physician providing such assistance will not be prosecuted.[117] The statute sets out further procedures for the physician to follow to ensure that the patient's request is fully informed and voluntary.[118] An additional provision allows physicians to provide euthanasia to a patient who is irreversibly unconscious and suffering from a serious incurable condition if such an act would be consistent with an "end of life provision" registered by the patient with the National Control and Assessment Commission when the patient was competent.[119]

When the Canadian Supreme Court decided *Rodriguez*, it had little foreign experience with the issue of assisted suicide to consider. While the Netherlands had recognized necessity as a defense that might excuse assisted suicide, no nation had expressly permitted it, and the consequences of such permission could only be the subject of speculation.[120] However, statutes and court decisions after 1995 from European and American jurisdictions provide more empirical basis for assessing the potential benefits and dangers of a more permissible legal approach to end-of-life issues, and they would provide much of the

113. *Id.* at art. 115.

114. *See Carter*, [2012] B.C.S.C. at para. 594.

115. *Id.* at para. 595-97.

116. Law of 16 March 2009 on Euthanasia and Assisted Suicide, Memorial A – No. 46 (Lux.).

117. *Id.* at art. 2.3.

118. *Id.* at art. 2.1-2.2.

119. *See Carter*, 2012 B.C.S.C. at para. 609-10.

120. *See supra* Parts II, III.

evidence considered by the Supreme Court of British Columbia in *Carter v. Canada.*[121]

IV. *CARTER V. CANADA (ATTORNEY GENERAL)*

In April 2012, Justice Lynn Smith of the Supreme Court of British Columbia handed down her judgment in *Carter v. Canada (Attorney General).*[122] In commencing the case, the plaintiffs renewed the claims first heard in *Rodriguez* that Section 241(b) of the Criminal Code unjustifiably infringed the life, liberty, security rights, and equality rights of the plaintiffs.[123] Plaintiff Gloria Taylor suffered from ALS and sought the right to assistance in ending her life at the point she found life unbearable.[124] Other plaintiffs included a family physician who was willing to assist patients in ending their lives if the laws permitted him to do so.[125]

After several weeks of hearing evidence, Justice Smith delivered her judgment and summarized the evidence and her legal conclusions in her Reasons for Judgment, a document over 300 pages in length.[126] Her summary of the permissible end-of-life decision-making in Canada in 2012 was as follows:

> (a) "Patients [were] not required to submit to medical interventions (including artificial provision of nutrition and hydration), even where their refusal of or withdrawal from treatment would hasten their deaths, and physicians must respect their patients' wishes about refusal of or withdrawal from treatment."[127]
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> (b) Competent patients may make "decisions about refusal or withdrawal of treatment . . . either in the moment or by way of advance directives." In the case of incompetent patients, "substitute decision-makers" may make these decisions.
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> (c) "Physicians may legally administer medications even though they know that the doses of medication in question may

121. *See infra* Part IV.
122. *Carter*, [2012] B.C.S.C. 886.
123. *Id.* at para. 13-14.
124. *Id.* at para. 46-56.
125. *Id.* at para. 72-76.
126. *Id.*
127. *Id.*

> hasten death, so long as the intention [was] to provide palliative care by easing the patient's pain."[128]
>
> (d) "It is unclear whether a patient's substituted decision-maker can require the maintenance of life-sustaining treatment against medical advice."[129]

With respect to the ethical issues presented by physician assisted death, Justice Smith found that there were "experienced and reputable Canadian physicians" who would consider it ethically permissible to assist patients in hastening death in some circumstances.[130] She further found that while current Canadian law drew a bright line distinction between hastening death through withdrawal of treatment (or perhaps through providing palliative care) on one hand[131] and assisted suicide on the other, such a distinction was difficult to maintain as a matter of ethics.[132] Examining both professional and general public opinion, she found no "clear societal consensus" either in favor or against assisted suicide when the assistance was "clearly consistent with the patient's wishes and best interests and in order to relieve suffering."[133]

After summarizing the legal changes in other jurisdictions with respect to assisted suicide described in Part III of this article,[134] she then examined evidence from studies seeking to determine the effectiveness of the procedures contained in those statutes in preventing abuse of vulnerable patients.[135]

Initially, Justice Smith found that compliance with the safeguards and reporting requirements in jurisdictions including Oregon, the Netherlands, and Belgium was at a high but not "at an ideal level."[136] From the data reported in these jurisdictions, she concluded that the availability of assisted suicide had "not inordinately impacted persons who might be seen as 'socially vulnerable': elderly, female, uninsured, of low educational status, poor, members of racial or ethnic minorities, physically disabled, or chronically but non-terminally ill."[137] Less evidence exists on the possible impact on those who might be

128. *Carter*, [2012] B.C.S.C. 886.
129. *Id.* at para. 231.
130. *Id.* at para. 319.
131. *Id.* at para. 327-28
132. *Id.* at para. 335-39.
133. *Id.* at para. 358.
134. *See supra* Part III. *See also Carter*, [2012] B.C.S.C. at para. 359-620.
135. *Carter*, [2012] B.C.S.C. at para. 646-85.
136. *Id.* at para. 653-56.
137. *Id.* at para. 662.

"situationally vulnerable" due to emotional distress, depression, coercion, or the desire not to be a burden to others.[138] Overall, Justice Smith concluded that these systems "work well in protecting patients from abuse while allowing competent patients to choose the timing of their deaths."[139]

One contention of opponents of assisted suicide is that acceptance of this option would reduce the incentives for physicians and insurers to provide palliative care as an alternative.[140] Reviewing the evidence from other jurisdictions, Justice Smith concluded that any such negative consequences would be entirely speculative.[141] She found it "difficult to imagine that Canadian politicians, public officials or health care providers, if physician-assisted death were legal, would reduce resources for palliative care for that reason."[142]

Finally, Justice Smith reviewed evidence of the risks cited by opponents of assisted suicide: the alleged inadequacy of safeguards to assure competence, voluntariness and informed consent, and to protect socially vulnerable individuals and the ambivalent.[143] She concluded that "the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced."[144]

Having summarized the evidence, Justice Smith turned to her legal analysis. She initially dealt with the impact of *Rodriguez*.[145] The position of the Attorneys General of Canada and British Columbia was that *stare decisis* required that Gloria Taylor's claim, essentially identical to the earlier claim of Sue Rodriguez, be rejected.[146] The plaintiffs contended, in response, that the record in this case reflected "a significant material change from the evidence available when *Rodriguez* was decided,"[147] and that the Supreme Court of Canada had also developed analytical tools for the analysis of a Charter claim under Section 7, Section 15, and the balancing of interests under Section 1 that were unavailable to the Court in 1993.[148]

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138. *Id.* at para. 663.
139. *Id.* at para. 685.
140. *Id.* at para. 314(l).
141. *Carter*, [2012] B.C.S.C. at para. 736.
142. *Id.* at para. 735.
143. *Id.* at para. 1192.
144. *Id.* at para. 883.
145. *Id.* at para. 885-1008.
146. *Id.* at para. 891, 898.
147. *Carter*, [2012] B.C.S.C. at para. 896.
148. *Id.*

Examining Section 7 jurisprudence since 1993, Justice Smith concluded that two additional principles for analysis of the question of whether a limit on life, liberty, or security was justified had emerged.[149] The first was a concern for overbreadth, the use of "means . . . too sweeping in relation to the objective" of the legislation.[150] The second was concern for gross disproportionality between the negative effect on the individual and the benefits to the legitimate government action.[151] While Canada and British Columbia maintained that those principles, while not expressly labeled as such, were implicit in *Rodriguez*,[152] Justice Smith saw them as sufficiently new to justify the need to reexamine Section 7 analysis in a case factually similar to *Rodriguez*.[153]

Consistent with Justice Sopinka's analysis in *Rodriguez*, Justice Smith found that the plaintiffs' rights to liberty and security of the person were infringed, but she found that the absolute prohibition of Section 241(b) was inconsistent with the principles of fundamental justice, applying the principles of overbreadth and gross disproportionality.[154] Canada and British Columbia argued that nothing short of an absolute prohibition could achieve 100% success in avoiding the inducement of vulnerable persons to commit suicide.[155] Justice Smith, however, noting that the goal of 100% success was "unrealistically exacting,"[156] found that "evidence supports the conclusion that a system with properly designed and administered safeguards could, with a very high degree of certainty, prevent vulnerable persons from being induced to commit suicide while permitting exceptions for competent, fully-informed persons acting voluntarily to receive physician-assisted death."[157] Thus, by violating the principles limiting overbreadth and gross disproportionality, Justice Smith concluded the absolute prohibition of Section 241(b) violated the plaintiffs' Section 7 rights.[158]

Justice Smith's analysis of the plaintiffs' equal protection claims under Section 15 began with the observation that the repeal in 1972 of the Criminal Code prohibitions on suicide and attempted suicide permitted those physically able to end their lives without assistance to do

149. *Id.* at para. 1002.
150. *Id.* at para. 975.
151. *Id.* at para. 976.
152. *Id.* at para. 977.
153. *Carter*, [2012] B.C.S.C. at para. 985.
154. *Id.* at para. 1378.
155. *Id.* at para. 1349.
156. *Id.* at para. 1360.
157. *Id.* at para. 1367.
158. *Id.* at para. 1378.

so.[159] Section 15 includes physical disability as a prohibited ground for discrimination.[160] Does criminalizing assisted suicide result in illegal discrimination against those unable to act without assistance?

In contrast to the position of the United States Supreme Court in applying the Fourteenth Amendment,[161] the Supreme Court of Canada has held that a statute can violate Section 15 based on its discriminatory effect, without a showing of either facial discrimination or discriminatory intent.[162] Canada and British Columbia maintained that Section 214(b) did not violate Section 15 because both its purpose and effect were to protect vulnerable populations, including the very disabled persons allegedly discriminated against.[163] Justice Smith found that the statute did violate Section 15, and that the beneficial purposes and effects, if any, were only appropriate to consider in discussing the next issue: whether the Section 15 violation could be justified under Section 1 balancing.[164]

Both Section 7 violations and Section 15 violations may be justified under Section 1 of the Charter, which makes Charter rights "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."[165] Section 1 balancing requires the court to address the following questions, on which the government bears the burden of proof:[166]

> (1) Is the purpose for which the limit is imposed pressing and substantial?
>
> (2) Are the means by which the legislative purpose is furthered proportionate?
>
> (a) Is the limit rationally connected to the purpose?
>
> (b) Does the limit minimally impair the Charter right?
>
> (c) Is the law proportionate in its effect?[167]

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159. *Carter*, [2012] B.C.S.C. at para. 1011.
160. *Id.*
161. *See* Washington v. Davis, 426 U.S. 229 (1976).
162. *See* Andrews v. Law Society, [1989] 1 S.C.R. 143 (Can.).
163. *Carter*, 2012 B.C.S.C. at para. 1160.
164. *Id.* at para. 1161.
165. Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, § 1 (U.K.).
166. *Carter*, [2012] B.C.S.C. at para. 1169.
167. *Id.*

Justice Smith accepted, on the authority of *Rodriguez*, that the purpose of Section 241(b) is pressing and substantial and that the statute is rationally connected to its purpose, which she characterized as "protecting vulnerable persons from inducement to commit suicide."[168] On the question of minimal impairment, however, Justice Smith rejected the arguments of Canada and British Columbia that deference to legislative judgment was called for where that judgment reasonably concluded that anything less than an absolute prohibition would create unacceptable risk of abuse.[169] The appropriate question, Justice Smith stated, was whether there is "an alternative, less drastic, means of achieving the objective in a real and substantial manner."[170] She concluded:

> [1232] The question, then, is whether there is an alternative means for the legislature to achieve its objective in a real and substantial way that less seriously infringes the *Charter* rights of Gloria Taylor and others in her situation.
>
> [1233] Clearly, it is theoretically possible for the legislature to do so. Parliament could prohibit assisted death but allow for exceptions. The exceptions could permit physician-assisted death under stringent conditions designed to ensure that it would only be available to grievously ill, competent, non-ambivalent, voluntary adults who were fully informed as to their diagnosis and prognosis and who were suffering symptoms that could not be treated through means reasonably acceptable to those persons.[171]

Finally, Justice Smith turned to the proportionality question.[172] Going beyond the question of minimal impairment, this inquires "whether the benefits of the impugned law are worth the costs of the rights limitation."[173]

Canada argued that the availability of palliative care to relieve suffering for most terminal patients reduced the costs to the point where they were outweighed by the risks of wrongful death.[174] Justice Smith,

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168. *Id.* at para. 1183-1205.
169. *Id.* at para. 1229-31.
170. *Id.* at para. 1226 (citing Alberta v. Hutterian Brethren of Wilson Colony, [2009] 1 S.C.R. 37, para. 55 (Can.)).
171. *Id.* at para. 1232-33.
172. *Carter*, [2012] B.C.S.C. at para. 1245-85.
173. *Id.* at para. 1246.
174. *Id.* at para. 1250.

however, found that some patients cannot be helped by palliative care, that others suffer the mental anguish of being deprived of their autonomy, and that the benefits of the absolute prohibition could be substantially achieved by an alternative prohibition that permitted "stringently-limited exceptions."[175] She concluded that the government had failed to satisfy its burden of establishing proportionality between the rights violation and the promotion of the substantial government interests.[176]

Justice Smith concluded that Section 241(b) violated the Charter in "its application to competent, fully-informed, non-ambivalent adult persons who personally (not through a substituted decision-maker) request physician-assisted death, are free from coercion and undue influence and are not clinically depressed."[177] While conceding that "it is the proper task of Parliament, not the courts, to determine how to rectify legislation that has been found unconstitutional,"[178] Justice Smith found it "incumbent on the Court" to specify the specific application of Section 241(b) that rendered it unconstitutional and required legislative attention.[179] Accordingly, she entered the following declaratory orders:

> (a) A declaration that the impugned provisions unjustifiably infringe [Section] 15 of the *Charter,* and are of no force and effect to the extent that they prohibit physician- assisted suicide by a medical practitioner in the context of a physician-patient relationship, where the assistance is provided to a fully-informed, non-ambivalent competent adult patient who: (a) is free from coercion and undue influence, is not clinically depressed and who personally (not through a substituted decision-maker) requests physician-assisted death; and (b) is materially physically disabled or is soon to become so, has been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury), is in a state of advanced weakening capacities with no chance of improvement, has an illness that is without remedy as determined by reference to treatment options acceptable to the person, and has an illness causing enduring physical or psychological suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person.

175. *Id.* at para. 1283.
176. *Id.* at para. 1285.
177. *Id.* at para. 1388.
178. *Carter,* [2012] B.C.S.C. at para. 1386.
179. *Id.*

> (b) A declaration that the impugned provisions unjustifiably infringe [Section] 7 of the *Charter,* and are of no force and effect to the extent that they prohibit physician-assisted suicide or consensual physician-assisted death by a medical practitioner in the context of a physician-patient relationship, where the assistance is provided to a fully-informed, non-ambivalent competent adult person who: (a) is free from coercion and undue influence, is not clinically depressed and who personally (not through a substituted decision-maker) requests physician-assisted death; and (b) has been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury), is in a state of advanced weakening capacities with no chance of improvement, has an illness that is without remedy as determined by reference to treatment options acceptable to the person, and has an illness causing enduring physical or psychological suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person.[180]

In order to allow Parliament time to consider an acceptable alternative to Section 241(b), Justice Smith suspended the effect of the declarations for one year.[181] She also, to assure Gloria Taylor an effective remedy, entered a "constitutional exemption" permitting Ms. Taylor to obtain physician-assisted death during the period of suspension of the declaration of invalidity provided that Ms. Taylor complies with conditions similar to those set forth in the declaratory orders.[182]

V. THE FUTURE OF *CARTER* FOR END-OF-LIFE JURISPRUDENCE

The government of Canada has announced that it will appeal Justice Smith's decision in *Carter.*[183] Thus, the future impact of the decision on Canadian law is uncertain. On March 18, 2013, the B.C. Court of Appeal heard the government's appeal in *Carter.*[184] Ultimately, the Supreme Court of Canada must decide whether its commitment to *stare decisis* and the arguments in favor of deference to legislative judgment in

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180. *Id.* at para. 1393.

181. *Id.* at para. 19.

182. *Id.*

183. *See* Alison Crawford, *How 20 Years Has Changed the Debate over Assisted Suicide*, CBC NEWS (Mar. 9, 2013), http://www.cbc.ca/news/politics/how-20-years-has-changed-the-debate-over-assisted-suicide-1.1334158.

184. *Id.*

maintaining the absolute prohibition of Section 241(b)[185] are outweighed by post-*Rodriguez* developments in both Charter jurisprudence and evidence of the effect of permitting highly regulated assisted suicide from other jurisdictions.[186] Given the close vote in *Rodriguez*,[187] and the changes in the membership of the Court in the last two decades,[188] it seems safe to say only that neither outcome would be shocking.

Carter is not the only case that will allow the Supreme Court of Canada to consider end-of-life issues in the immediate future. On December 10, 2012, the Court heard an appeal from the Court of Appeal for Ontario in *Cuthbertson v. Rasouli*.[189] In *Rasouli*, the Court of Appeal for Ontario interpreted the authority under statutory law of physicians to withdraw life-sustaining treatment and substitute palliative care, when they have determined that a patient is in a state of "permanent and irreversible unconsciousness," without the consent of the patient's substitute decision-maker.[190]

Under the Ontario Health Care Consent Act,[191] a health practitioner must obtain the consent of a patient, or the substitute decision-maker for an incapable person, for any treatment.[192] Should that consent be refused, the practitioner may apply to the Consent and Capacity Board for a decision whether the treatment proposed for a patient incapable of giving consent is in the patient's best interest.[193] In *Rasouli*, physicians contended that "treatment" under the Act did not include the withdrawal of life support in the case such as *Rasouli*, where there was no chance of recovery.[194]

The court of appeal accepted the argument that the Act did not require consent to withdraw treatment that was considered "medically

185. *See supra* Part II.

186. *See supra* Part IV.

187. *See supra* text accompanying note 1.

188. *See* Steven Ertelt, *Expert: Canada Supreme Court Will Uphold Assisted Suicide Ban*, LIFENEWS.COM (Sept. 5, 2012), http://www.lifenews.com/2012/09/05/expert-canada-supreme-court-will-uphold-assisted-suicide-ban/ (stating that seven of nine Justices would have changed).

189. Cuthbertson v. Rasouli, [2013] S.C.R. 53 (Can.). *See also Rasouli Case Chance for Supreme Court to Put Forward Guidelines on End-of-Life Treatment*, GLOBE AND MAIL (Dec. 10, 2012), http://theglobeandmail.com/commentery/editorials/rasouli-case-chance-for-supreme-court-to-put-forward-guidelines-on-end-of-life-treatment/article6114255/.

190. Rasouli v. Sunnybrook Health Sci. Ctr., [2011] O.N.C.A. 482, para. 6 (Can. Ont. C.A.).

191. Ontario Health Care Consent Act, S.O. 1996, c.2, § 1 *et seq.* The relevant sections are set forth in *Rasouli*, [2011] O.N.C.A. 482, para. 19.

192. Ontario Health Care Consent Act, S.O. 1996, c.2, § 10.

193. *Id.* § 37(1).

194. *Rasouli*, [2011] O.N.C.A. 482, para. 46.

ineffective or inappropriate,"[195] but held that the substitution of palliative care for the patient's ventilator was a "treatment package" and does fall within the Act.[196] This, the court stated, was different than a physician withdrawing, for example, a course of chemotherapy determined to be ineffective, since that decision would not be necessarily connected to the introduction of palliative or any other form of care.[197]

In interpreting the Act to place limitations on involuntary passive euthanasia, the court stated:

> [62] In sum, while the recourse available to a doctor who disagrees with the decision of a substitute decision-maker in an end-of-life case may not be perfect from the doctor's perspective, the process seems to have worked well since the Act came into existence some 15 years ago. End-of-life situations are always emotionally laden. The process created under the Act provides doctors with a safety valve in cases where the patient has not expressed a prior wish under [Section] 21(1) of the Act. Most doctors, we believe, would see that as a good thing rather than viewing it as an impediment to their professional independence and autonomy.
>
> . . . .
>
> [64] We do not believe that by interpreting palliative care to include the withdrawal of life support measures, the floodgates will open and intensive care units will be deluged with patients who have no chance of improvement but who require life-sustaining measures to survive. If that proves to be the case, then the legislature can, and no doubt will review the situation.[198]

The end-of-life issues in *Rasouli* are clearly different from those presented by *Carter*. Yet the degree to which each case raises issues of patient autonomy, the distinction between passive and active physician assistance in ending life, and the degree to which these are appropriate issues for judicial, as opposed to legislative, resolution suggests that the Supreme Court of Canada's decision in each case will have some relevance to the disposition of the other.

Will the reasoning in *Carter* have any relevance to the resolution of similar issues in United States' courts? The short answer would appear to

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195. *Id.*
196. *Id.* at para. 52.
197. *Id.* at para. 53.
198. *Id.* at para. 62, 64.

be no. The United States Supreme Court's decision in *Glucksberg*[199] was unanimous in upholding Washington's absolute prohibition on assisted suicide, and there is surely no reason to imagine that the current Court has become more expansive in its protection of privacy and autonomy rights.[200] Still, there are at least two aspects of *Carter* that are of some interest to American constitutionalists.

The first concerns federalism. Canada's federalism assigns criminal law to Parliament rather than the provinces.[201] Thus, in this case, and others presenting issues demanding balancing individual autonomy against the social benefits of criminal statutes, Canada is faced with an all-or-nothing decision. Either Section 241(b) will continue to govern throughout Canada, or it will be replaced with an alternative, which is also applicable nationwide.[202]

In contrast, *Glucksberg* did not preclude states from making their own decisions on the acceptability of assisted suicide.[203] Indeed, the very state whose prohibition was sustained in *Glucksberg* became the second American jurisdiction to move toward a more permissive position on assisted suicide.[204] When the consequences of a proposed social change are highly contested and largely speculative, Oregon and Washington can act as "laboratories of democracy,"[205] providing some empirical basis for debate in other states.[206]

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199. Washington v. Glucksberg, 521 U.S. 702 (1997).

200. *See, e.g.*, Gonzales v. Carhart, 550 U.S. 124 (2007) (upholding restrictions on late-term abortions).

201. Constitution Act, 1867, 30 & 31 vict., c.3 (U.K.) § 91 (27).

202. This was also the case in R. v. Morgentaler, [1988] 1 S.C.R. 30 (Can.). *See also supra* text accompanying note 23. Since the decision in *Morgentaler* invalidated the then existing restrictions on abortion, Parliament has failed to act to substitute a constitutionally acceptable alternative. The government of Quebec has introduced a bill to liberalize assisted suicide in the province. If enacted, the constitutionality of the measure under Canadian federalism is questionable. *See* Joseph Brean, *"There Is a Battle Ahead": Advocates Hope Quebec Bill the First Step in Changing Canada's Assisted Suicide Laws*, NAT'L POST (June 14, 2013) http://news.nationalpost.com/2013/06/14/there-is-a-battle-ahead-advocates-hope-quebec-bill-the-first-step-in-changing-canadas-assisted-suicide-laws/.

203. *Glucksberg*, 521 U.S. 702.

204. *See supra* Washington Death with Dignity Act, WASH REV. CODE ANN. § 70.245 (West 2009).

205. This well-known phrase derives from the discussion by Justice Brandeis in *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (Brandeis J., dissenting).

206. In May 2013, Vermont ended legal penalties for doctors prescribing medication to terminally ill patients seeking to end their lives. *See* Jason McLure, *Vermont Passes Law Allowing Doctor-Assisted Suicide*, NBC NEWS HEALTH, (May 20, 2013), http://www.nbcnews.com/health/vermont-passes-law-allowing-doctor-assisted-suicide-6C10003656. Other state legislatures have considered similar legislation in recent years. *Id.* For a comprehensive list of American state laws touching on assisted suicide, see

Perhaps the most interesting analytical tool discussed in *Carter* is the concept of "gross disproportionality."[207] Even when statutes or government acts produce substantial social benefits, at some point the cost of the individual burdened by the practice becomes so great that it requires that the burden on this individual be lifted. While this does overlap with the concept of overbreadth, a relevant consideration in both Canadian and American constitutional analysis,[208] it more sharply focuses on the burden on the individual. At some point, social welfare considerations cannot justify imposing pain on the individual.

There are echoes here of the second formulation of Immanuel Kant's Categorical Imperative, his ultimate moral principle.[209] The Formula of Respect for the Dignity of Persons directs that we "[a]ct in such a way that you treat humanity, whether in your own person or in the person of another, always . . . as an end and never . . . as a means."[210] Respect for this formula would presumably invalidate any government action that uses the individual as no more than a means to achieve a social benefit, a benefit that the individual will not share. When Justice Smith finds that the acknowledged government interest in preventing suicides that are not truly voluntary cannot excuse the infliction of great suffering on an individual whose desire to terminate her life is fully consensual, she is employing a version of this principle.

This concept of gross disproportionality has not been formally incorporated into American constitutional analysis, but there are traces of this commitment in some Supreme Court opinions. In *Glucksberg*, several concurring Justices noted that the state of Washington interpreted its statute to permit the administration of palliative care despite the possibility that the pain-killing drugs might have the side effect of shortening the patient's life.[211] Were this not the case, as those Justices suggested, the statute might have gone too far. To require a terminal patient not only to continue to live but also to do so without pain relief, in the interest of preventing possible misuse of the drugs by others, would be to use the patient as entirely a means to a social good and not

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Assisted Suicide Laws in the United States, PATIENTS RIGHTS COUNCIL (Feb. 6, 2012), http://www.patientsrightscouncil.org/site/assisted-suicide-state-laws/.

207. *See supra* notes 150-58 and accompanying text.

208. *See* R. v. Malmo-Levine, [2003] 3 S.C.R. 571, para. 142-43 (Can.) (gross disproportionality); R. v. Clay, [2003] 3 S.C.R. 735 (Can.) (overbreadth and gross disproportionality); Schad v. Borough of Mt. Ephraim, 452 U.S. 61 (1981) (overbreadth).

209. IMMANUEL KANT, GROUNDING FOR THE METAPHYSICS OF MORALS 14 (James W. Ellington trans., 3d ed. 1993).

210. *Id.*

211. *See* Washington v. Glucksberg, 521 U.S. 702, 736-38 (1997) (O'Connor, J., concurring); *id.* at 780 (Souter, J., concurring); *id.* at 791-92 (Breyer, J., concurring).

as an end. In the terms of Canadian jurisprudence, this would constitute "gross disproportionality."[212]

Similarly, in *Sell v. United States*,[213] while the Supreme Court held that a criminal defendant may sometimes be forcibly medicated to make the defendant competent to stand trial, the use of the medication itself must be in the best interest of the defendant.[214] Forced medication is permissible here where a social good is sought, but only if the government act also takes individual welfare into account.[215]

Proportionality, like all balancing tests, can be criticized as unacceptably indeterminate. Still, whether explicitly or implicitly, proportionality tests have become commonplace in American constitutional law.[216] For example, the Supreme Court has adopted explicit proportionality limits on the imposition of punitive damages[217] and land use regulations[218] and has implicitly used proportionality analysis in a range of constitutional criminal procedure cases.[219] Something resembling proportionality analysis seems to be present in the "undue burden" standard adopted by the joint opinion of Justices O'Connor, Kennedy and Souter in *Planned Parenthood v. Casey*[220] for assessing abortion restrictions.

A more explicit recognition of proportionality analysis by American courts in cases involving privacy and autonomy claims would hardly be, then, a shocking development. Borrowing the concept of "gross disproportionality," as elaborated in *Carter*, as a situation where the extreme burden on the individual is imposed entirely for social benefits, with none flowing to that individual, might be a step in providing some degree of predictability to such a proportionality test.

Needless to say, the debate over whether and to what extent United States courts should consult foreign law sources, even those from nations with reasonably similar legal and cultural traditions for guidance, is not

212. *See supra* notes 150-58 and accompanying text.

213. Sell v. United States, 539 U.S. 166 (2003).

214. *Id.* at 169.

215. *Id.* at 181.

216. *See generally* E. THOMAS SULLIVAN & RICHARD S. FRASE, PROPORTIONALITY PRINCIPLES IN AMERICAN LAW (2009).

217. BMW v. Gore, 517 U.S. 559 (1996); State Farm Mut. Aut. Ins. Co. v. Campbell, 538 U.S. 408 (2003).

218. Nollan v. Cal. Coastal Comm'n, 483 U.S. 825 (1987); Dolan v. City of Tigard, 512 U.S. 374 (1994).

219. *See* SULLIVAN & FRASE, *supra* note 216, at 91-169.

220. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 873-79 (1992).

settled.[221] Still, it would seem foolish to ignore the attempts of neighbors to deal with the same contentious legal issues facing the United States. Regardless of the fate of *Carter* on appeal, the likelihood that this will lead the United States Supreme Court to reconsider *Glucksberg* is probably nil. Given that criminal law in American federalism is primarily a state concern,[222] however, the evidence and arguments presented in *Carter* may be of great assistance to legislatures and state court judges in the United States.

221. *See, e.g.*, *The Relevance of Foreign Legal Materials in U.S. Constitutional Cases: A Conversation Between Justice Antonin Scalia and Justice Stephen Breyer*, 3 INT'L J. CONST. L. 519 (2005).

222. Washington v. Glucksberg, 521 U.S. 702 (1997).