A Missed Opportunity: Affirming the Section 15 Equality Argument against Physician-Assisted Death

Maneesha Deckha

2016

This paper was originally published at: https://mjlh.mcgill.ca/publications/volume-10-issue-1-101-special-issue-2016/a-missed-opportunity-affirming-the-section-15-equality-argument-against-physician-assisted-death/

Citation for this paper: Maneesha Deckha, "A Missed Opportunity: Affirming the Section 15 Equality Argument against Physician-Assisted Death" (2016) 10:1 McGill JL& Health S69.

A Missed Opportunity: Affirming the Section 15 Equality Argument against Physician-Assisted Death

*Maneesha Deckha**

In the 2012 decision of *Carter v Canada (AG)* the British Columbia Supreme Court found that Section 15 equality rights under the *Canadian Charter of Rights and Freedoms* were infringed by the blanket prohibition against assisted death in the *Criminal Code*. Madam Justice Lynn Smith's application of the substantive equality model is a critical factor in the judgment, enabling a responsive and nuanced understanding of disability, the systemic disadvantages that people with disabilities experience, and the disability rights responses to physician-assisted death. Her equality analysis also exhibits a respect for the agency of those in vulnerable positions because of their physical health. These dimensions lead to a sophisticated judicial treatment of the disability rights debate on physician-assisted death in the Section 15 portion of the trial decision. The views of disability scholars feature significantly in this portion of the decision and the diverse perspectives within the disability community about physician-assisted death are synthesized and explored. The Section

En 2012, dans l'arrêt *Carter v Canada (PG),* la Cour suprême de la Colombie-Britannique a statué que l'interdiction générale de l'aide médicale à mourir par le *Code criminel* violait le droit au traitement égal garanti par l'article 15 de la *Charte canadienne des droits et libertés*. L'application du cadre juridique de l'égalité réelle par la juge Lynn Smith est un facteur déterminant de cet arrêt et permet une compréhension nuancée et réceptive du handicap, des désavantages systémiques que les personnes avec un handicap rencontrent et des réponses possibles à l'aide médicale à mourir d'un point de vue du droit des personnes avec un handicap. Son analyse fondée sur l'article 15 illustre également un respect pour la capacité des personnes en situation de vulnérabilité due à leur santé physique. Ces dimensions supportent un traitement juridique sophistiqué du débat sur les droits des personnes avec un handicap et sur l'aide médicale à mourir, lequel est abordé dans la décision de première instance. C'est effectivement dans les portions dédiées à l'analyse fondée sur

* BA (McGill), LLB (Toronto), LLM (Columbia); Professor and Lansdowne Chair, Faculty of Law, University of Victoria. The author would like to thank the Social Sciences and Humanities Research Council of Canada for research support.

Citation: Maneesha Deckha, "A Missed Opportunity: Affirming the Section 15 Equality Argument against Physician-Assisted Death" (2016) 10:1 McGill JL & Health S69.

Référence : Maneesha Deckha, « A Missed Opportunity: Affirming the Section 15 Equality Argument against Physician-Assisted Death » (2016) 10 : 1 RD & santé McGill S69.

15 analysis also extends generous judicial recognition to the fundamental autonomy and embodied interests at stake for those wishing to pursue physician-assisted death. The combined effect of Justice Smith's Section 15 analysis, as this article will argue, is a progressive line of reasoning about access to physician-assisted death that advances judicial discourse about inequality in relation to disability. It is regrettable that neither the dissenting judgment of the British Columbia Court of Appeal nor the unanimous judgment of the Supreme Court of Canada endorsed the trial judge's Section 15 equality ruling. This article explains the positive egalitarian impulses in the trial decision's Section 15 analysis to illuminate how Justice Smith advances judicial discourse about inequality in relation to disability. In view of enhancing the critical equality impact of the decision, the article also identifies some concerns with the remedies she crafts in terms of their imbrication in biomedical power disparities that typically work to disadvantage non-normative bodies.

l'article 15 de cette décision qu'on accorde beaucoup d'importance aux points de vue des spécialistes des droits des personnes avec un handicap et que les perspectives variées sur l'aide médicale à mourir émanant de la communauté des personnes avec un handicap sont abordées et synthétisées. L'analyse fondée sur l'article 15 accorde aussi une reconnaissance juridique appréciable à l'autonomie fondamentale qui est en jeu pour celles qui désirent recourir à l'aide médicale à mourir. Le présent article démontre que l'effet cumulatif de l'analyse fondée sur l'article 15 est un raisonnement progressiste sur l'accès à l'aide médicale à mourir qui fait avancer le discours judiciaire en ce qui a trait à l'inégalité reliée au handicap. Il est désolant que ni l'opinion dissidente du jugement de la Cour d'appel de la Colombie-Britannique, ni le jugement unanime de la Cour suprême du Canada n'appuie le jugement fondé sur l'article 15 de la juge d'instance. Le présent article explique les motivations égalitaristes et positivistes qui sous-tendent l'analyse fondée sur l'article 15 de la cour d'instance pour clarifier comment la juge Smith fait progresser le discours judiciaire en ce qui a trait à l'inégalité reliée au handicap. Dans le but d'accroître l'impact crucial de cet arrêt sur l'égalité, le présent article identifie enfin des inquiétudes par rapport à l'imbrication de la réparation conçue avec les disparités de pouvoir biomédical qui tendent généralement à désavantager les corps non-normatifs.

Introduction

Section 15 of the *Canadian Charter of Rights and Freedom* (*Charter*) guarantees the right to equality.[1] Over the last decade or so, this provision has settled some long-standing social controversies as well as initiated judicial participation in other constitutional challenges.[2] While the precise legal issues diverge in Section 15 equality jurisprudence, a common feature in these cases is the Supreme Court of Canada's (Supreme Court) ability to fashion a *substantive* version of the equality right. Substantive equality, as opposed to formal equality, refers to a systemic, flexible, and contextual understanding of discrimination and oppression, i.e., one that attends "to the multiple and varied manifestations and dynamics of inequality … "[3] Articulations of substantive equality help to illuminate the unequal impacts of a law on different groups of people. This is because it allows for a focus on the *effects* of the law in precluding the mainstream recognition and inclusion of historically, socially, or culturally disadvantaged groups as human beings deserving of full respect and dignity.[4]

---

1 Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*]. For examples of other uses of the Section 15 right in constitutional jurisprudence, see Daphne Gilbert, "Time to Regroup: Rethinking Section 15 of the *Charter*" (2003) 48 McGill L J 627. For more context and critical perspective on the *Charter* see e.g. Andrew Petter, *The Politics of the* Charter*: The Illusive Promise of Constitutional Rights* (Toronto: University of Toronto Press, 2010).

2 Section 15 has guided the articulation of the legality of polygamy (*Reference Re Criminal Code of Canada*, 2011 BCSC 1588, 28 BCLR (5th) 96), same-sex marriage (*Halpern v Canada (AG)* (2003), 265 OR (3d) 161, 25 DLR (4th) 529), and prostitution (*Downtown Eastside Sex Workers United Against Violence Society v Canada (AG)*, 2011 BCCA 515, 40 BCLR (5th) 88).

3 The Honourable Claire L'Heureux-Dubé, "Preface" in Fay Faraday, Margaret Denike, & M Kate Stephenson, eds, *Making Equality Rights Real* (Toronto: Irwin Law, 2006) 3 at 4 [Faraday et al, "Making"]. For a discussion on how substantive equality relates to systemic stereotyping, see Sophie Moreau, "The Wrongs of Unequal Treatment" in Faraday et al, "Making", 31 at 36–38. For a discussion on the value placed on substantive equality in Canadian society, both in the present and historically, see Patricia Hughes, "Recognizing Substantive Equality as a Foundational Constitutional Principle" (1999) 22:5 Dal LJ at 21–27.

4 Luc B Tremblay, "Promoting Equality and Combating Discrimination Through Affirmative Action: The Same Challenge? Questioning the Canadian Substantive Equality Paradigm" (2012) 60 Am J Comp L 181 at 190–191.

Although the adoption of a substantive equality framework nowhere near guarantees that all equality interests will be vindicated in a particular dispute, the framework seeks to prevent the perpetuation of systemic disadvantage. It can thus serve as a helpful tool when marshaling a constitutional challenge to long-standing laws that impair the dignity and autonomy interests of individuals that typically imbue an equality claim.[5] It can be particularly useful, then, in legal disputes where rights to what we can do to our bodies are at stake and where the harms faced by socially stigmatized or disadvantaged bodies might not be easily perceived by mainstream society. And while there is ample room for the Supreme Court to refine its application of the substantive equality model and what the model requires,[6] an equality analysis can shine a much needed spotlight on systemic disadvantage against marginalized and non-normative bodies in invalidating traditional yet problematic legal norms.[7]

Indeed, this is what occurred at the trial level in the 2012 decision of *Carter v Canada (AG)* (*Carter* BCSC),[8] where the British Columbia Supreme Court found that Section 15 equality rights under the *Charter* were infringed by the blanket prohibition against assisted death in the *Crimin-*

---

5 Susanne Baer, "Dignity, Liberty, Equality: A Fundamental Rights Triangle of Constitutionalism" (2009) 59:4 UTLJ 417 at 427–30.

6 For indications of how the Supreme Court has fallen short of substantive equality ideals in its application of the framework, see Jennifer Koshan & Jonnette Watson Hamilton, "Meaningless Mantra: Substantive Equality after *Withler*" (2011) 16:1 Rev Const Stud 31 and generally, Faraday et al, "Making", *supra* note 3. Section 15's definition of substantive equality also does not encompass distributive justice (Tremblay, *supra* note 4).

7 For analyses of the potential of substantive equality in challenges to discrimination in health law areas, see Martha Jackman, "Health Care and Equality: Is there a Cure?" (2007) 15 Health LJ 87; Yude M Henteleff, Mary J Shariff & Darcy L MacPherson, "Palliative Care: An Enforceable Canadian Human Right" (2011) 5:1 McGill LJ 107 at 130; Estair Van Wagner, "Equal Choice, Equal Benefit: Gendered Disability and the Regulation of Assisted Human Reproduction in Canada" (2008) 20:2 CJWL 231.

8 2012 BCSC 886, 287 CCC (3d) 1 [*Carter* BCSC]. It is important to note that one Canadian province – Québec – has passed legislation legalizing physician-assisted death (PAD) along somewhat similar lines to the conditions established in *Carter v Canada (AG)*, 2015 SCC 5, [2015] 1 SCR 331 [*Carter* SCC]. See *An Act Respecting End-of-Life Care*, RSQ c S-32.0001.

al Code.[9] The main litigant, Gloria Taylor, was a competent terminally ill woman who wanted to be able to end her life with physician assistance before her natural death. Both the provincial and federal governments resisted her constitutional challenge, but she ultimately prevailed, making it the first time that a Canadian court legalized physician-assisted death (PAD). Madam Justice Lynn Smith's application of the substantive equality model is a critical factor in the judgment, enabling a responsive and nuanced understanding of disability, the systemic disadvantages that people with disabilities experience, and the disability rights responses to PAD. Her equality analysis also exhibits a respect for the agency of those in vulnerable positions because of their physical health. These dimensions lead to a sophisticated judicial treatment of the disability rights debate on PAD in the Section 15 portion of the trial decision where the views of disability scholars feature significantly and the diverse perspectives within the disability community about PAD are synthesized and explored. The Section 15 analysis also extends generous judicial recognition to the fundamental autonomy and embodied interests at stake for someone like Taylor. Her Section 15 analysis, as this article will argue, should be considered a progressive line of reasoning about access to PAD that advances judicial discourse about inequality in relation to disability.

Despite these strengths, neither the dissenting judgment of the British Columbia Court of Appeal nor the unanimous judgment of the Supreme Court endorsed the trial judge's Section 15 equality ruling that the absolute nature of the prohibition on assisted death in the *Criminal Code* was unconstitutional in violating the right to equality under Section 15.[10] Both elected to anchor their rulings in Section 7 autonomy arguments.[11] This is regrettable. Although valuable in its own right, the Supreme Court's Section 7 reasoning does not capture the egalitarian dimensions of the decision that the Section 15 equality analysis does, nor does it allow the Supreme Court to affirm the progressive orientation of the trial judgment in this regard. Justice Smith's discussion of the disability rights debate over PAD, her sophisticated understanding of how autonomy implicates equality for a marginalized social group, and the embodied nature of the decision that come through in her Section 15 equality analysis are lost in the Court of Appeal and Supreme

---

9 RSC 1985, c C-46; *Carter* BCSC, *supra* note 8 at paras 1161–62.

10 *Carter v Canada (AG)*, 2013 BCCA 435 at 7, 293 CRR (2d) 109 [*Carter* CA], rev'd by *Carter* SCC, *supra* note 8.

11 *Carter* CA, *supra* note 10 at para 5; *Carter* SCC, *supra* note 8 at para 92.

Court decisions. As the Supreme Court's Section 7 analysis is largely silent on the topic of disability rights, the disability studies orientation of the trial judgment's Section 15 analysis does not receive a broader airing and much needed juridical and social attention. This article explains the positive egalitarian impulses in the trial decision's Section 15 analysis to illuminate how Justice Smith advances judicial discourse about inequality in relation to disability. In view of enhancing the critical equality impact of the decision, the article also identifies some concerns with the remedies she crafts in terms of how these remedies are imbricated in biomedical power disparities that typically work to disadvantage non-normative bodies.

I wish to be clear that the focus of the article is not on whether Justice Smith's conclusion denouncing the absolute nature of the ban is ultimately a progressive one for the equality-seeking disability rights movement. While I do believe this to be the case, and what follows arguably supports such a conclusion, it is a position I cannot do justice to here. My argument instead is about judicial discourse. Part I of this article reviews Justice Smith's decision to explain the architecture of her doctrinal analysis with respect to the Section 15 claim that led her to hold that the criminal prohibition against PAD violates Taylor's equality rights. Part II then discusses the nuanced equality analysis on disability the decision delivers in the course of assessing the discriminatory effect of subsection 241(b) of the *Criminal Code* on those with seriously compromised physical conditions who wish to die earlier rather than later. It also considers several objections to advocating for a Section 15 analysis due to particular elements of Section 15 doctrine as well as limits to the substantive equality framework in general. While acknowledging the legitimacy of these objections, this part proceeds to explain why the trial judge's Section 15 analysis is nonetheless preferable to an analysis of PAD that foregoes a Section 15 analysis. After defending the desirability of a Section 15 analysis in *Carter*, Part III revisits the remedies provided by Justice Smith through a critical equality lens to consider how the decision promotes existing power disparities in biomedicine. Specifically, I distill the biopolitical and medicalized implications of the remedies to identify how the calibre of the remedies from a critical equality perspective could be improved. It is here that I include a brief discussion of the new federal amendments allowing for PAD, to take note of where the new law stands in relation to these remedies and critiques.[12]

---

[12] *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, RSC 2016, c 3 [*Medical Assistance in Dying Act*].

I. The *Carter* BCSC Decision

A. Overview

Carter BCSC[13] involved a *Charter* challenge to the constitutionality of subsection 241(b) of the *Criminal Code*, which prohibited PAD.[14] The plaintiffs, Gloria Taylor, Lee Carter, and three others,[15] claimed that this prohibition violated Sections 7 and 15 of the *Charter* and could not be saved under Section 1.[16] They sought an immediate constitutional exemption permitting Ms. Taylor to seek a PAD and a declaration of invalidity of the impugned provisions.[17] In relation to Section 15, the plaintiffs claimed that the prohibition had a "disproportionate impact on physically disabled persons,"[18] who, unlike those who can commit suicide on their own, cannot die without the assistance of another.[19] With respect to Section 7, the plaintiffs argued that subsection 241(b) deprived individuals of their right to life, liberty, and security of the person by precluding "competent, grievously and irremediably ill adult individuals who voluntarily seek physician-assisted

---

13 *Carter* BCSC, *supra* note 8.

14 *Ibid* at para 100. To be exact, the plaintiffs challenged sections 14, 21, 22, 222, and 241, which together make up the prohibition on PAD. The crux of the challenge addressed subsection 241(b). This section reads: "Everyone who (…) 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" (*supra* note 9, s 241(b)).

15 Gloria Taylor had the neurodegenerative disease known as "ALS" (amyotrophic lateral sclerosis) and sought relief to obtain a PAD. Lee Carter and Hollis Johnson, two other plaintiffs, assisted Lee Carter's mother in obtaining an assisted death in Switzerland. The last two plaintiffs were Dr. William Shoichet, a family physician willing to participate in PAD, and the British Columbia Civil Liberties Association.

16 Section 1 of the *Charter* is critical to the analyses of all *Charter* challenges. It is further described below. In essence, the section allows state action that has infringed a *Charter* right to nonetheless be "saved" if it meets the requirements of the doctrinal test established.

17 *Carter* BCSC, *supra* note 8 at para 27. Section 52 of the *Charter* allows the court to declare invalid legislation that infringes a *Charter* right and cannot be saved by Section 1.

18 *Carter* BCSC, *supra* note 8 at para 26.

19 *Ibid* at para 15.

dying on an informed basis from receiving such assistance."[20] Justice Smith found that both rights were infringed, that the legislation could not be saved under Section 1, and granted both remedies, albeit slightly revised, sought by the plaintiffs.

The defendants – the governments of Canada and the province of British Columbia – responded largely in unison.[21] They both argued that *Rodriguez v British Columbia (AG)*[22] was binding and thus thereby required the court to dismiss the present claim;[23] alternatively, the defendants argued that Section 1 would save any rights infringement[24] given that the sanctity of life is a fundamental Canadian value.[25] In defence of the ban's breadth, the federal government argued that the current laws were necessary to protect persons in vulnerable circumstances and nothing short of an absolute prohibition would suffice.[26] Both governments maintained that those who are ill and disabled require the law's protection against ableist attitudes that might make health care providers, substitute decision makers, and family members erroneously conclude that certain lives are not worth

---

20 *Ibid* at para 25.

21 *Ibid* at para 34. More specifically, the government of British Columbia adopted the arguments of the government of Canada.

22 [1993] 3 SCR 519, 1993 7 WWR 641 [*Rodriguez*]. *Rodriguez* involved an almost identical constitutional challenge to the criminal law against PAD. The challenge was unsuccessful and the defendants in *Carter* took the position that this finding of the Supreme Court is binding on the *Carter* BCSC court. Justice Smith disagreed with the defendants' position, concluding that although *Rodriguez* is binding, it did not severely limit the plaintiffs' claim since *Rodriguez* did not address whether subsection 241(b) infringed the right to life under Section 7 and nor did it address whether it infringed the right to equality under Section 15 (*Carter* BCSC, *supra* note 8 at para 13). Although *Rodriguez* addressed the security of the person and liberty interests under Section 7, it did not address whether the deprivation was in accordance with the principles of fundamental justice – overbreadth and gross disproportionality. In terms of equality rights, the *Rodriguez* Court only briefly discussed the possibility of a constitutional claim and stated that any infringement would be a reasonable limit and justified under Section 1.

23 *Carter* BCSC, *supra* note 8 at paras 34, 861.

24 *Ibid* at paras 33, 34.

25 *Ibid* at paras 168–69.

26 *Ibid* at paras 31, 621.

leading.[27] The defendants argued that the law, although autonomy-reducing, promotes the dignity and equality interests of vulnerable groups[28] and is in line with the "fundamental Canadian value" that is the preservation of human life.[29]

Justice Smith rejected these arguments, ruling that the effects of the provision far over-stretched its purpose of protecting vulnerable persons.[30] As discussed further below, Justice Smith concluded that it was possible to structure a regime of PAD that did not put vulnerable parties at risk and completed her reasons by delineating conditions under which one could receive such assisted death.[31] Justice Smith reached this conclusion after careful and comprehensive analysis. At almost 400 pages, the judgment meticulously canvassed both legal and ethical grounds. It began by addressing the debate on the ethical nature of medical end-of-life practices since "both legal and constitutional principles are derived and shaped by societal values."[32] Justice Smith then reviewed how opinions vary as to whether current legal end-of-life practices are ethically distinguishable from PAD,[33] noting that ethicists and medical practitioners "widely concur that current legal end-of-life practices are ethically acceptable."[34] For their part, the plaintiffs argued there is no ethical distinction between suicide and PAD. Justice Smith agreed, stating that the ethical distinction vanishes when "the patient's decision for suicide is entirely rational and autonomous, it is in

---

27 *Ibid* at para 359.

28 *Ibid* at paras 32, 1069. Canada's arguments regarding the prevention of wrongful deaths can be found at paragraphs 748–54.

29 *Ibid* at para 168.

30 *Ibid* at para 853.

31 *Ibid* at para 1393.

32 *Ibid* at para 317. The judge identified three additional reasons why the ethical debate was relevant. First, she stated it was important to know whether there is consensus among physicians that performing assisted-death would be ethical. Second, the plaintiffs argued there is no bright ethical line between current legal end-of-life practices, including suicide, and PAD. Third, the prohibition may be contrary to the societal consensus on assisted-death.

33 Current legal end-of-life practices include withholding life-sustaining treatment, palliative sedation, administering dosages to hasten death, treatment cessation, and pain management.

34 *Carter* BCSC, *supra* note 8 at para 5.

the patient's best interest, and the patient has made an informed request for assistance."[35] After canvassing the testimonies from over fifty expert witnesses on the values and principles underlying PAD,[36] and accepting the clear social consensus on the high value of human life, Justice Smith concluded that in PAD "[t]he physician provides the means for the patient to do something which is itself ethically permissible. It is unclear, therefore, how it could be ethically impermissible for the physician to play this role."[37]

When she proceeded to doctrinal analysis, Justice Smith began with Section 15 – discussed in detail below – and then addressed the Section 7 claim.[38] Section 7 of the *Charter* protects the right to life, liberty, and security of the person, and the right to only have these liberties infringed upon when such infringements are in accordance with the principles of fundamental justice (an internal requirement within Section 7).[39] Justice Smith held that the prohibition violated both the right to life and security of the person as protected under Section 7.[40] With regard to the right to life, Justice Smith accepted only one of the submissions ("that the right to life is also engaged because the provisions may cause her to end her own life earlier than she would otherwise want to"),[41] but innovatively reframed it as the "right *not* to die."[42] She found that the provision effectively shortens the lives of persons, namely those who are aware of their eventual physical incapability

---

35 *Ibid* at para 339.

36 Fifty-seven experts testified including researchers, physicians, and academics on the complexity of the ethical nature of PAD. A comprehensive list of all experts and their occupation begins at para 160 of the trial judgment.

37 *Carter* BCSC, *supra* note 8 at para 339.

38 *Ibid* at paras 1286–1383.

39 This concept has been described as "the basic values of our legal system and its constitutional traditions" (JM Evans, "The Principles of Fundamental Justice: The Constitution and the Common Law" (1991) 29:1 Osgoode Hall LJ 51 at 55).

40 *Carter* BCSC, *supra* note 8 at paras 1, 1304.

41 *Ibid* at para 1309.

42 *Ibid* at para 1322 [emphasis in original]. The plaintiffs had also argued "that Gloria Taylor's right to life is engaged by the impugned provisions because they deprive her of the right to make and carry out the decision to end her own life" (*ibid* at para 1307).

of ending their own life, by causing them to take their lives earlier than they would otherwise.[43] She further found that the plaintiffs' security interests, though varied in relation to the prohibition, were all clearly engaged.[44] The Supreme Court affirmed Justice Smith's reasoning on Section 7.[45]

Justice Smith's finding of *Charter* violations perpetrated by subsection 241(b) of the *Criminal Code* meant that it was incumbent on the government to justify these infringements under Section 1. At the core of Canada's submission on both the Section 7 principles of fundamental justice and the Section 1 proportionality analyses was the proposition that nothing short of the blanket prohibition would be sufficient to protect those who are rendered particularly vulnerable.[46] In rejecting this claim, Justice Smith relied upon evidence from permissive jurisdictions on the effectiveness of safeguards (namely, mandatory psychiatric evaluations,[47] requiring a written request,[48] imposing a waiting period,[49] and limiting the eligibility to "those patients who are grievously and irremediably ill,"[50] among others) against the risks inherent in permitting PAD ("competence, voluntariness, informed consent, ambivalence and socially vulnerable individuals"[51]), the impact of PAD on other forms of care, and the effect of PAD on physician-patient

---

43 *Ibid*.

44 Ms. Taylor's situation was comparable to that of Ms. Rodriguez's, and the liberty interests of Ms. Carter and Mr. Johnson were engaged due to the possibility of imprisonment (see *ibid* at para 17). See also *supra* note 15 for a brief description of the situations of the five plaintiffs and *Rodriguez*, *supra* note 22 and accompanying text for more on the *Rodriguez* decision.

45 *Carter* SCC, *supra* note 8 at para 86.

46 Canada stated that age or disability may increase vulnerability. Canada also argued there is a strong risk of involuntary deaths due to mental capacity, depression, incompetence, coercion, undue inducement, and psychological manipulation (*Carter* BCSC, *supra* note 8 at paras 748–54).

47 *Ibid* at para 873.

48 *Ibid* at para 874.

49 *Ibid*.

50 *Ibid* at para 877.

51 *Ibid* at para 761.

relationships.[52] After reviewing extensive evidence compiled from international studies, Justice Smith concluded that "it is possible for a state to design a system that both permits some individuals to access physician-assisted death and socially protects vulnerable individuals and groups."[53] She found that it was possible to screen out individuals who are ambivalent,[54] depressed,[55] coerced,[56] influenced, [57] or misinformed.[58] As well, Justice Smith found that the voluntariness of the decision making about PAD of vulnerable individuals such as the elderly and people with disabilities could also be confirmed by physicians properly conducting capacity assessments.[59] Further, she stated the risks inherent in permitting PAD could not only be identified but also reduced through a "carefully-designed system imposing stringent limits that are scrupulously monitored and enforced."[60] As a result, she held the absolute prohibition was not in accordance with the principles of fundamental justice[61] and, predictably, the infringement was not saved under Section 1.[62]

---

[52] Several jurisdictions allow PAD: Belgium, Netherlands, Switzerland, Luxembourg, Columbia, Montana and Oregon. For a detailed description of their practices, see *ibid* at part VIII.

[53] *Ibid* at para 667.

[54] *Ibid* at para at 843.

[55] *Ibid* at para 798.

[56] *Ibid* at para 815

[57] *Ibid*.

[58] *Ibid* at para 831.

[59] *Ibid* at paras 847, 853.

[60] *Ibid* at para 883. The plaintiffs suggested requirements such as a mandatory psychiatric evaluation, formal written request, minimum waiting period, and the option limited to those who are suffering intolerably from an illness.

[61] *Ibid* at paras 1371, 1378. The effect of the provision was held to be inconsistent with the principles of fundamental justice because it was grossly disproportionate and overbroad. The plaintiffs had also argued that the provision was arbitrary, but since the majority in *Rodriguez* held the provision was not arbitrary (see *supra* note 22 at 5), Justice Smith held that she was bound by that decision (*Carter* BCSC, *supra* note 8 at para 1331).

[62] It would be extremely difficult to save a Section 7 violation with Section 1 because of the similarity between the two concepts. For a discussion of these

The Supreme Court affirmed Justice Smith's analysis, holding that the Section 7 deprivations were overbroad and thus not in accordance with the principles of fundamental justice. The Section 7 deprivations also failed the proportionality test under Section 1 because the complete ban on PAD failed to minimally impair the right at stake.[63] To be sure, the Supreme Court's Section 7 analysis generates a forward-looking decision with respect to the right to choose what happens to one's body. It is a monumental judgment in the Canadian juridical landscape regarding autonomy rights, which, of course, are related to equality movements and social justice ends. Yet, in choosing not to address the central equality argument the case raises, the Supreme Court missed an opportunity to endorse Justice Smith's progressive approach to the equality and rights issues that are implicated by the decision. By conducting a Section 15 analysis, Justice Smith was able to distill the important equality issues at stake more closely and explicitly than a Section 7 analysis allows. To understand her equality-minded contributions, the next section summarizes her conclusions on Section 15.

B. The Section 15 equality analysis

1. General doctrinal test

The mechanics of Section 15 have been unsettled in recent years. At the time of the trial decision, a two-step test inquiring into whether the law creates a distinction based on an enumerated or analogous ground and, if so, whether this distinction creates a disadvantage or perpetuates prejudice, shaped the Section 15 analysis and remains good law to this day.[64] Also at

---

two sections, see Jacquelyn Shaw, "A Death-Defying Leap: Section 7 *Charter* Implications of the Canadian Council for Donation and Transplantation's Guidelines for the Neurological Determination of Death" (2012) 6:1 McGill JL & Health 41 at 121.

63 *Carter* SCC, *supra* note 8 at paras 86, 121.

64 The most recent authority on Section 15 is *Québec (AG) v A*, 2013 SCC 5 at 66, [2013] 1 SCR [*Québec v A*], which the Supreme Court cited most recently in *Kahkewistahaw First Nation v Taypotat*, 2015 SCC 30 at para 16, [2015] 2 SCR 548 [*Kahkewistahaw First Nation*]. In this most recent decision, the Supreme Court describes the second step of the test slightly differently than in *Québec v A*, that is, as an inquiry into whether the law "has the effect of reinforcing, perpetuating or exacerbating (systemic) disadvantage" (*ibid* at paras 17, 20). *Withler v Canada*, 2011 SCC 12, [2011] 1 SCR 396 [*Withler*] was the

the time of the trial decision, four related factors typically guided the inquiry into disadvantage and prejudice: pre-existing disadvantage, correspondence with actual characteristics, ameliorative purposes or effects, and the interests affected.[65] The Court recently affirmed these factors as constitutive of substantive inequality but clarified that there is no "rigid template."[66] Justice Smith went through all four factors in *Carter* BCSC but the guiding principle for the entire Section 15 analysis, as she reminds us, is substantive equality.[67] Thus, Justice Smith adopted a contextual approach to determine whether the law comports with the underlying anti-discrimination principle of Section 15 and, indeed, the entire *Charter*, namely the protection of human dignity.[68] She reached this determination through assessing the four factors enumerated above.

2. Application

Justice Smith found that the first step of the Section 15 analysis is easily satisfied: the criminal prohibition draws a distinction between people of

---

most recent authority on Section 15 analysis at the time of the trial decision and Justice Smith relied on its enunciation of the test (*Carter* BCSC, *supra* note 8 at paras 1022, 1026). For a discussion of the imprecision in the *Withler* articulation of discrimination, see Koshan & Hamilton, *supra* note 6 at part IV.

65 *Carter* BCSC, *supra* note 8 at para 1085. These factors were set out initially in *Law v Canada (Minister of Employment and Immigration)*, [1999] 1 SCR 497, 170 DLR (4th) 1 and were affirmed in *Withler*, *supra* note 64.

66 *Québec v A*, *supra* note 64 at para 331, Abella J citing *Withler*, *supra* note 64 at para 66. There are also cases where the "reasonable person" was used to apply an objective standard for determining discrimination. For a discussion on this tool, see Hart Schwartz, "Making Sense of Section 15 of the *Charter*" (2011) 29 NJCL 201 at 213–17, cited in *Carter* BCSC, *supra* note 8 at para 1024.

67 The Supreme Court recently affirmed this view in *Kahkewistahaw First Nation*, *supra* note 64 at para 17.

68 The philosophical notion of dignity has fallen in and out of favour with the Supreme Court; at one time it formed a part of the Section 15 test but it is currently thought to be too hard to define and apply. See Peter W Hogg, *Constitutional Law of Canada*, 5th ed (Toronto, Carswell: 2007) at 55–28 to 55–29 and 55–31 to 55–32; Schwartz, *supra* note 66 at 202–03. Now, human dignity is affirmed as the underlying principle of the entire *Charter* (*Québec v A*, *supra* note 64 at para 329, Abella J).

different abilities that creates an increased burden on people with physical disabilities.[69] She rejected the defendants' two arguments: 1) that there is no distinction because the law prohibits PAD for everyone; and 2) that people of all abilities have the option to decline hydration and nutrition. The first failed because there is evidence of a distinct impact on people with physical disabilities and the second does not succeed because it is only people with disabilities who are left with only this one undesirable option.[70]

With respect to the second step, both sides agreed that people with physical disabilities experience a disadvantaged situation relative to able-bodied individuals.[71] They disagreed as to whether the law furthers the disadvantage. Justice Smith accepted the claimant's argument that the law does not correspond to the situation of people with physical disabilities because it is founded on the "false premise" that "people with disabilities are more susceptible than others … or more likely to be suicidal."[72] Justice Smith also found that the paternalism implicit in the law affects people with physical disabilities differently than able-bodied people,[73] adversely affecting an autonomy interest that is "fundamentally important and central to personhood."[74] She concluded that the law against PAD breaches Section 15.[75]

---

69 *Carter* BCSC, *supra* note 8 at para 1077.

70 *Ibid* at paras 1075–76. This effect of the prohibitions – that physically disabled people are at a relative disadvantage in comparison to able-bodied people – is recognized in Jennifer J Llewellyn & Jocelyn Downie, "Restorative Justice, Euthanasia, and Assisted Suicide: A New Arena for Restorative Justice and a New Path for End of Life Law and Policy in Canada" (2010-2011) 48 Alta L Rev 965 at 968. In this piece, the authors argue that there are benefits to applying restorative justice principles in cases involving euthanasia and assisted death. In framing their argument, they outline the disadvantages to the current criminal approach. One of these is the disproportionate burden felt by people with physical disabilities and their families due to the ability requirements for legal suicide.

71 *Carter* BCSC, *supra* note 8 at para 1102.

72 *Ibid* at para 1110.

73 *Ibid* at para 1130.

74 *Ibid* at para 1155.

75 *Ibid* at paras 1161–62.

C. The Section 1 justification analysis

1. General doctrinal test

Having established that the law offends Section 15, Justice Smith moved on to determine whether it is nonetheless justified under Section 1. The government must show that the limit of the right is prescribed by law, i.e., the limitation must be accessible and precise,[76] which the impugned criminal provision is held to be. The government must also demonstrate that the law is justified in a free and democratic society, an element analyzed through focusing on the law's purposes and proportionality.[77]

2. Application

Justice Smith found that the purpose of the criminal ban is "to protect vulnerable persons from being induced to commit suicide at a time of weakness" and that the state interest in this goal is "the protection of life and maintenance of the *Charter* value that human life should not be taken."[78] She further found that this purpose has not changed since *Rodriguez*[79] and that she is thereby bound to find this step satisfied.[80] It is with respect to the proportionate nature of the law that the criminal ban fails.[81] Having clarified the question at this stage as to whether a "less drastic" measure is

---

[76] *Greater Vancouver Transportation Authority v Canadian Federation of Students*, 2009 SCC 31 at para 50, [2009] 2 SCR 295 citing Hogg, *supra* note 68 at 122. If the rights infringement was found to be the result of action not prescribed by law, then the infringement will necessarily fail to be justified (see Barbara Billingsley, "Justification" in Leonard Rotman, ed, *Constitutional Law: Cases, Commentary and Principles* (Toronto: Thomson Carswell, 2008) 837 at 838.

[77] *Carter* BCSC, *supra* note 8 at para 1169.

[78] *Ibid* at para 1190.

[79] *Rodriguez*, *supra* note 22 at 19–20.

[80] *Carter* BCSC, *supra* note 8 at paras 1204–05.

[81] Similar to the previous step, the court is bound by the precedent from *Rodriguez* that the prohibition of PAD is rationally connected to the objective of the legislation (*ibid* at paras 1208–09).

available for achieving the objective[82] – and not, as the defendants argued, whether the prohibition "falls within a range of reasonable alternatives"[83] – she relied on evidence from jurisdictions with legalized PAD in finding that such an alternative does exist.[84] The defendants thus failed to prove that the law minimally impairs the equality right.[85] Further, the government failed to demonstrate an adequate balance between the salutary effects and deleterious effects of the impugned legislation.[86] This step provided a crucial broad perspective on the situation, where the costs and benefits of the legislation can be weighed.[87] Justice Smith stated that the salutary effects of a prohibition of PAD include: simplicity,[88] communication of an anti-suicide message,[89] protection of vulnerable populations,[90] clarity of physicians'

---

82 *Carter* BCSC, *supra* note 8 at para 1211.

83 *Ibid* at para 1226.

84 *Ibid* at para 1243.

85 *Ibid* at para 1244.

86 *Alberta v Hutterian Brethren of Wilson Colony*, 2009 SCC 37 at paras 76–77, [2009] 2 SCR 567 [*Hutterian Brethren*]. As explained in the *Carter* SCC decision, the Supreme Court modified the Section 1 analysis after *Rodriguez* in *Hutterian Brethren*. In the *Rodriguez* decision, the Supreme Court provided direction on the deference to be granted by the judiciary towards the legislature regarding the constitutionality of laws in a Section 1 analysis, namely, that complex regulatory schemes warrant more deference than penal statutes (*Carter* BCSC, *supra* note 8 at para 1168, citing *Rodriguez*, *supra* note 22). Justice Smith found that this case involved legislation in the second category thus less deference is necessary (*Carter* BCSC, *supra* note 8 at para 1180).

87 This step was once not considered important and was used to provide a summary of the findings in the first two steps (*Carter* BCSC, *supra* note 8 at para 994). However, the Supreme Court in *Hutterian Brethren* provided clarification on the purpose of the third step, attributing a distinct purpose to it (*ibid* at paras 994, 1246, referring to *Hutterian Brethren*, *supra* note 86 at paras 76–77). This change, which the *Carter* BCSC court finds is substantive in nature, is a significant part of the reason why the British Columbia Supreme Court was not bound in this case by the Supreme Court decision in *Rodriguez* (*Carter* BCSC, *supra* note 8 at paras 994, 1003; *Rodriguez*, *supra* note 22).

88 *Carter* BCSC, *supra* note 8 at para 1268.

89 *Ibid* at para 1265.

90 *Ibid* at para 1267.

roles,[91] and the maintenance of a high value for human life.[92] She found that these could be maintained without a blanket prohibition[93] however, and are outweighed by the following deleterious effects:[94] belittlement of the wishes of the terminally ill,[95] lack of patient candour with their physicians, the denial of autonomy, and a lack of regulation for those instances of PAD that happen despite criminalization.[96]

D. Summary

Justice Smith thus concluded that the PAD prohibition violated Section 15 on grounds of disability and could not be saved under Section 1: the government failed to justify the law in failing to demonstrate that the law did not minimally impair the equality right and that the law's salutary effects outweighed its detrimental ones. With this Part having outlined the doctrinal result in Justice Smith's decision, the next Part proceeds to identify how it reflects a disability studies perspective.

II. The Disability Insights of the Equality Analysis

Justice Smith's commitment to the substantive equality model to process equality claims is the principal reason for the decision's equality-favouring outcome in favour of PAD where a competent, non-depressed, yet grievously ill individual seeks to end her life with the assistance of a physician. As she emphasized, the Supreme Court recently identified substantive equality as the "animating norm" for constitutional equality law, declaring that the norm requires close attention to context and "the law's real impact on the claimants and members of the group to which they belong."[97] Even

---

91 *Ibid* at para 1270.

92 *Ibid* at para 1275.

93 *Ibid* at para 1283.

94 *Ibid* at para 1285.

95 *Ibid* at para 1266.

96 *Ibid* at para 1282.

97 *Ibid* at para 1022, citing *Withler*, *supra* note 64 (per McLachlin CJ and Abella J at paras 1–3).

after the trial decision, the Supreme Court stressed the substantive equality undercurrent to Section 15, reaffirming it as an effects-focused and contextual doctrine aimed at preventing entrenchment of systemic disadvantage.[98] The substantive equality model enabled Justice Smith to examine the context surrounding the law, an examination that yielded multiple progressive equality insights in relation to disability.

A. A nuanced understanding of the disability studies debate on PAD

A prominent feature of Justice Smith's decision is her nuanced understanding of disability rights. Justice Smith recognized the traditional and continuing social prejudice against individuals with disabilities,[99] but her decision also offered further sophisticated analysis not found in cases from other jurisdictions that make only brief mentions of ableist discrimination.[100]

---

98 See *Québec v A*, *supra* note 64 at para 332; *Kahkewistahaw First Nation*, *supra* note 64 at para 17. Interestingly, the Canadian government did not concede an effects-based violation; instead, it emphasized the statute's purposes of protecting the vulnerable and preserving the sanctity of human life. The Canadian government argued that "persons with disabilities are treated with equal dignity and respect since they, along with the able-bodied, are equally denied access to assisted death" (*Carter* BCSC, *supra* note 8 at para 1128). Justice Smith quickly dispensed with this argument: "I think it ignores the adverse impact/unintended effects discrimination analysis central to the substantive equality approach … In this case, by Canada's admission, the legislation operates to deprive non-vulnerable people such as Ms. Taylor of the agency that they would have if they were not physically disabled. Thus, although (as Canada submits) the law is 'equally paternalistic to the able-bodied and the disabled', the paternalism does not affect them all in the same way, with very significant consequences" (*ibid* at para 1130).

99 She wrote that "[d]isabled people have experienced marginalization in Canadian society, including in connection with the delivery of health care. Health care providers may, like other people, overestimate the difficulty in living with certain kinds of disability and wrongly assume that life in some circumstances is 'not worth living'" (*ibid* at para 194).

100 The Supreme Court of the Unites States wrote in *Baxter v Montana*, 2009 MT 449 [*Baxter*]: "While the government may impugn on privacy rights, liberty interests, and other Article II rights in proper circumstances ... the individual always retains his [*sic*] right of human dignity. So too with persons suffering from mental illness or disability and involuntary commitment" (at para 86). In *Washington v Glucksberg*, 521 US 702 (USSC 1997) at 732, 117 S Ct 2258,

Perhaps as much as a judicial decision can do, the *Carter* trial decision gave a full accounting of the debate in the disability rights community about PAD.

In beginning her equality analysis by defining pre-existing disadvantage, Justice Smith affirmed the plaintiffs' position that "disabled people face pre-existing disadvantage, vulnerability, stereotyping and prejudice in Canadian society."[101] Here, the judgment also refers to affidavit evidence from a disability studies theorist noting the "direct and systemic … pervasive and persistent"[102] nature of this discrimination. Further, in assessing the risks of lifting the ban, Justice Smith canvassed in considerable detail the evidence from disability studies scholars about their objections to legalizing PAD.[103] She noted the serious concern articulated by many that physicians immersed in the mainstream medical model of disability, which views bodily variations as lamentable conditions to be corrected,[104] will be quick to endorse wishes of individuals with disabilities to seek death rather than counsel them against suicide as they would others.[105] Justice Smith presented and accepted the evidence from disability theorists who note how ableist social attitudes dehumanize those with disabilities and problematically assume that loss of bodily control and increased dependence on others equates to a life without dignity, thereby perpetuating stereotypes about the lives and experiences of those with disabilities.[106]

---

138 L Ed (2d) 772 [*Glucksberg*], the Supreme Court of the United States identified the State's interest in protecting:

> the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal difference" [footnotes omitted]. The State's assisted-suicide 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.

101 *Carter* BCSC, *supra* note 8 at 1099.

102 *Ibid*.

103 *Ibid* at paras 848–52.

104 See Alison Kafer, *Feminist, Crip, Queer* (Bloomington: Indiana University Press, 2013) at 5.

105 *Carter* BCSC, *supra* note 8 at paras 851–52.

106 *Ibid* at paras 848–50, 853.

In incorporating these insights, Justice Smith signalled her respect for disability studies perspectives. While not a uniform school of thought, disability studies as an academic discipline generally aims to challenge presumptions about normality.[107] Proponents seek to examine the degree to which impairments are socially constructed as "disability" by the material world and by widespread prejudices about productivity and participation.[108] In acknowledging these perspectives in relation to the mainstream medical model, which often situates disability as a functional limitation of the body,[109] Justice Smith legitimated the project of disability studies scholars to deconstruct entrenched Western norms of ability and normative bodies.

At the same time that Justice Smith fully validated the disability studies critique articulated by the defendants' experts, she avoided treating all individuals with disabilities as one homogeneous group. First, she was alert to the various ways disability arises.[110] Moreover, she recognized the different perspectives within the PAD debate articulated by individuals of different abilities. She acknowledged the defendants' position, supported by affidavits from disability scholars, that persons with disabilities are at risk of subtle coercion to end their lives due to ableist norms and acknowledged that disability is socially conceptualized.[111] Yet, Justice Smith also gave voice to the plaintiffs' submissions that such a position is "patronizing, and … that such an assumption infantilizes disabled people and feeds prejudice and discrimination against them."[112] She was also aware of the submissions of the intervener Ad Hoc Coalition of People with Disabilities which questioned the blanket assumption that all disabled people are vulnerable and incap-

---

107 See Anastasia Liasidou, "The Cross-Fertilization of Critical Race Theory and Disability Studies: Points of Convergence/ Divergence and Some Educational Policy Implications" (2014) 29:5 Disability & Society 724 at 726.

108 See Natasha Saltes, "'Abnormal' Bodies on the Borders of Inclusion: Biopolitics and the Paradox of Disability Surveillance" (2013) 11:1/2 Surveillance & Society 55 at 58.

109 *Ibid*.

110 She wrote: "In my view, it is important to recognize that there are many reasons why a person might be seriously physically disabled: disabilities may be congenital, acquired through trauma, or arise form disease. In that end and in their nature, physical disabilities vary widely, as do people who live with them" (*Carter* BCSC, *supra* note 8 at para 1101).

111 *Ibid* at paras 1118, 1127.

112 *Ibid* at para 1088.

able of making informed choices about their lives.[113] Indeed, Justice Smith endorsed the concern about paternalism, concluding that not all disabled people are in need of protection.[114] She also rejected the defendants' view, given the totality of evidence before her, that disabled people will seek assistance with death at a disproportionate rate to the rest of society if PAD is sanctioned and available, due to ableist social pressures from physicians, family, and caregivers.[115]

To be sure, Justice Smith was aided in this full exposition of the disability studies critique of ableism by precedent recognizing systemic discrimination in Canadian society against people with disabilities.[116] She was also

---

[113] *Ibid* at para 1125.

[114] *Ibid* at para 1129. She stated that Canada's position problematically "rests upon the assumption that even the most independent-minded, clearest-thinking person with physical disabilities needs protection from the bias of doctors and caregivers" (*ibid*).

[115] *Ibid* at para 811. She pointed to the evidence offered for the plaintiffs by disability theorists who contest the traditional paternalistic view. Justice Smith highlighted the evidence of a disability studies scholar who favoured PAD but not without stressing that "clinicians who perform such assessments would have to be aware of the risks of coercion and undue influence, of the possibility of subtle influence, and the risks of unconscious biases regarding the quality of the lives of persons with disabilities or persons of advanced age" (*ibid* at para 815).

[116] Justice Smith included in her decision a passage from *Granovsky v Canada (Minister of Employment and Immigration)*, 2000 SCC 28, [2000] 1 SCR 703 [*Granovsky*] which formed a part of the plaintiff`s arguments:

> … many of the difficulties confronting persons with disabilities in everyday life do not flow ineluctably from the individual`s condition at all but are located in the problematic response of society *to* that condition. ... Exclusion and marginalization are generally not created by the individual with disabilities but are created by the economic and social environment and, unfortunately, by the state itself. Problematic responses include, in the case of government action, legislation which discriminates *in its effect* against persons with disabilities, and thoughtless administrative oversight

(*Carter* BCSC, *supra* note 8 at 1135, citing *Granovsky* at para 30 [emphasis in original]). Also included is the following passage from *Eldridge v British Columbia (AG)*, [1997] 3 SCR 624 at para 56, 74 ACWS (3d) 41 [*Eldridge*]: "It is an unfortunate truth that the history of disabled persons in Canada is

assisted by the legal dispute before her where the parties have each used a disability rights framework to advance their divergent views on which position will best respect the rights and lives of people with disabilities. Yet, it was she who incorporated the divergence of views on this issue that the critical substantive equality framework generates. As a result, Justice Smith was able to convey a rich account of the disability rights critique – an element absent in the Supreme Court's Section 7 reasoning. Indeed, the Supreme Court's decision contains no explicit mention of disability rights or disability perspectives.

B. An expansive vision of autonomy and respect for agency

Another progressive feature of the equality judgment is the extent to which it balanced concerns about exploitation of vulnerability with the affirmation of vulnerable individuals to still make important life decisions. This is most apparent in the way the decision defined the nature of the equality interest at issue. Specifically, Justice Smith did not define it as the ability to control the timing and nature of one's own death, which is how the defendant governments defined the equality interest at issue and what they denied to be an interest protected by the Constitution.[117] In contrast, the trial decision took the following point of departure in identifying the nature of the interest:

> Autonomy with respect to physical integrity is a value of fundamental importance in the Canadian Constitution. Its place in the constitutional order is paralleled by its place in the common law. The starting point in our law – the default position – is that persons control their own physical integrity. Instances when other persons or the state are permitted to usurp that control are the exception, not the rule…. In fact, the historical direction of the law has been to limit and circumscribe the occasions when an individual's physical integrity may be

---

largely one of exclusion and marginalization. Persons with disabilities have too often been excluded from the labour force, denied access to opportunities for social interaction and advancement, subjugated to invidious stereotyping and relegated to institutions" (*Carter* BCSC, *supra* note 8 at para 1099).

[117] *Carter* BCSC, *supra* note 8 at para 1146.

> usurped, as part of the increasing recognition of full personhood in previously excluded categories of persons.[118]

Justice Smith clearly underscored the importance of autonomy to what is at stake in the litigation. She thus explicitly resisted the narrow definition that the defendant governments wanted her to adopt and which prevails, for example, in leading American PAD jurisprudence.[119] In defining the interest more broadly as one of autonomy over physical integrity, she affirmed an expansive view of the right at stake. Justice Smith also made clear the critical importance of respecting autonomy. Although she stressed a few paragraphs later that autonomy is not a constitutional trump against other values directed at protecting vulnerable groups from dehumanization, she went on to affirm that it is still "fundamentally important" and "central to personhood."[120] We are reminded that disrespecting autonomy has exclusionary consequences.

The endorsement of an expansive view of autonomy and its critical relation to personhood in the judgment leads to a recognition of the agency that individuals with compromised abilities, even at the ends of their lives, can hold and should be recognized as holding. Although autonomy and agency

---

[118] *Ibid* at paras 1149–50.

[119] *Ibid* at para 1157. See *Glucksberg*, *supra* note 100 at 727–28, which states:

> [t]hat many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected ... The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause [footnotes omitted].

[120] *Carter* BCSC, *supra* note 8 at paras 1153–55. For insight into why a liberal conception of choice should not automatically trump other considerations when attending to widespread social problems involving exploitation and vulnerability, see Janine Benedet, "Marital Rape, Polygamy, and Prostitution: Trading Sex Equality for Agency and Choice" (2013) 18:2 Rev Const Stud 161; Janine Benedet & Isabel Grant, "Sexual Assault and the Meaning of Power and Authority for Women with Mental Disabilities" (2014) 22:2 Fem Leg Stud 131 at 135 (criticizing in particular the social model of disability for the premium it ascribes to choice).

are often used interchangeably, it is helpful to appreciate that by "agency," I refer to the making of a choice with an awareness of the social relations that structure that choice. If autonomy in the classic liberal sense is captured by the concept of self-governance, we can understand agency not simply as the ability to exercise rational choice (and so deny the impact of social relations in structuring our choices),[121] but as doing so in the context of power relations and the constraints they may impose.[122] Justice Smith's decision afforded individuals with physical impairments this self-directing ability, instead of disavowing the validity of their choices to die because of the backdrop of ableism against which such choices are made.

The substantive equality framework provides a prominent place to this expansive view of autonomy by recognizing and prioritizing agency (and the corresponding need to ensure that the conditions for agency exist). It shifts the focus from abstract values concerning the protection of vulnerable citizens and the related belief in the sanctity of human life – purposes that governments both in Canada and elsewhere have identified as the reasons for the complete prohibition[123] – to a consideration of the effect of universal abstract values as concretely applied to actual human lives. This permits the judgment to highlight the fact that maintaining life at all costs is not a universally shared value,[124] and should yield to the choice not to endure prolongation of life where the quality is not desirable according to that individual.[125] In questioning the universal nature of the sanctity of human life, the judgment aligns with recent policy reports that interrogate the assumption

---

121 This is the distinction that Susan Sherwin draws in "A Relational Approach to Autonomy in Health Care" in Susan Sherwin, coordinator, *The Politics of Women's Health: Exploring Agency and Autonomy* (Philadelphia: Temple University Press, 1998) 18 at 33, cited in Jennifer Nedelsky, *Law's Relations: A Relational Theory of Self, Autonomy, and Law* (New York: Oxford University Press, 2011) at 390, n 105.

122 See Kathryn Abrams, "From Autonomy to Agency: Feminist Perspectives on Self-Direction" (1999) 40:3 Wm & Mary L Rev 805 at 806.

123 *Carter* BCSC, *supra* note 8 at para 1190; *Glucksberg*, *supra* note 100 at 728; *Vacco v Quill* [1997] 521 US 793 at paras 805–06.

124 *Ibid* at para 1268.

125 The Royal Society of Canada Expert Panel End of Life Report notes that most Canadians lack appropriate access to palliative care (*End-of-Life Decision Making* (Ottawa: RSC, 2011), online: <rsc-src.ca/sites/default/files/pdf/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf> at 12 [RSC Report]).

"that continued existence is always of benefit to the person in question."[126] By de-emphasizing the need to preserve life at all costs the judgment appropriately distances itself from the implicit religious connotations about the sanctity of human life grounded in a particular worldview that not everyone shares.[127] This position signals respect for and inclusion of different views about human life.

C. Embodying the decision

What is more, the judgment, for all its extensive legal reasoning, does not neglect the individual bodies affected by the loss of autonomy inherent in the prohibition on assisted death. All too often, even in health care decisions, the bodies that anchor the legal dispute and the question of how they should be cared for by our health care systems are absent in legal judgments.[128] This absence of the body in abstract argumentation often entails adverse results for those whose bodies are marginalized.[129] Justice Smith highlighted the physical impact on the individuals who must live in their bodies through pain and deterioration, as well as the terror, fear and emotional suffering it causes them and their families. In addition to quoting the deposition from plaintiff Gloria Taylor at multiple points to illustrate the plaintiffs' overall submission that "the interests at stake in this case are fundamental, relating to personal integrity, autonomy and fundamental choices

---

126 *Ibid* at 57.

127 See Ngaire Naffine, "Varieties of Religious Intolerance" (2006) 8 UTS Law Review 103 at 105.

128 See e.g. Annette F Street & David W Kissane, "Discourses of the Body in Euthanasia: Symptomatic, Dependent, Shameful and Temporal" (2001) 8:3 Nurs Inquiry 162; Y Michael Barilan, "The Story of the Body and the Story of the Person: Towards an Ethics of Representing Human Bodies and Body Parts" (2005) 8:2 Med Health Care Philos 193.

129 See e.g. Susan M Wolf, "Erasing Difference: Race, Ethnicity, and Gender in Bioethics" in Anne Donchin & Laura M Purdy, eds, *Embodying Ethics: Recent Feminist Advances* (Lanham, MD: Rowman & Littlefield, 1999) 65; Lisa C Ikemoto, "The Fuzzy Logic of Race and Gender in the Mismeasure of Asian American Women's Health Needs" (1996) 65 U Cin L Rev 799; Deleso Alford Washington, "Critical Race Feminist Bioethics: Telling Stories in Law School and Medical School in Pursuit of 'Cultural Competency'" (2009) 72:4 Alta L Rev 961.

about one's own body and life,"[130] the judgment gave space to affected individuals to articulate their assessment of their own health and life situations by quoting their affidavits at length.[131] Justice Smith presented the experiences of individuals living with serious illnesses in a compelling light and concluded that the prohibition produces "severe and specific deleterious effects" on them.[132]

While it would have been possible to locate such insights about the autonomy interest, including detailing the embodied nature of the interest, in the Section 7 portion of the trial judgment, it is significant that they resided instead in the Section 15 portion. Connecting autonomy over fundamental life choices with *equality* enables an understanding of how individuals are made unequal in society when autonomy is thwarted and their pre-existing disadvantage amplified. After all, the ban against PAD does not simply represent a denial of a fundamental life choice, but also represents a distinction that creates further *social disadvantage* for an already marginalized group. The impact of autonomy deficits on social experiences of equality, particularly regarding the individual right to control one's body and physical integrity, can be illustrated in various contexts. Indeed, in matters of health care, equality motivations helped generate the new norm of informed consent as a corrective to physician paternalism in the allopathic tradition. Nan D Hunter speaks to this point by reference to the American experience of the rise of the informed consent doctrine:

> The women's and racial justice movements were especially significant in the move toward recognition of patient-autonomy rights. Physician disrespect of patients had long been exacerbated by race and gender, and equality movements of the mid-twentieth century included these issues as part of their agendas. This equality-focused "master frame" of social change, and the new social meanings that resulted from it, shaped the contours, timing, and social meaning of the informed-consent doctrine.[133]

---

[130] *Carter* BCSC, *supra* note 8 at paras 1143–44. See also paragraphs 52, 54, 56, to see the extent to which the Supreme Court references Taylor's words.

[131] *Ibid* at paras 1278–79.

[132] *Ibid* at para 1281.

[133] "Rights Talk and Patient Subjectivity: The Role of Autonomy, Equality, and Participation Norms" (2010) 45 Wake Forest L Rev 1525 at 1530–31.

Hunter's statements about feminist and anti-racist mobilization to address the then prevailing norm of beneficence giving rise to paternalism as a matter of equality refer to overall health care decision making. This should not discount the application of her insight to specific kinds of health care decision making. For example, feminists have long recognized the crucial adverse effect that the inability to control one's physical integrity has on equality outcomes with respect to matters of reproduction, whether in the decision to terminate a pregnancy[134] or in the struggle to continue a pregnancy.[135] If it is reasonable to accept the connection between autonomy and equality in matters relating to initiating life then this link should also be extended to matters relating to facilitating death.

D. Objections to using Section 15

All of these elements of the Section 15 reasoning coalesce into a forward-looking decision on disability rights. Yet, at this point some may wonder if there is a downside to a Section 15 analysis such that its absence at the Supreme Court is actually a better outcome for the disability rights community and furthers the desire for more socially aware judicial discourse.

1. Problems with Section 15's doctrinal elements

This concern may begin with the insight that equality-seeking groups have not enjoyed much success with Section 15 in challenging legislation at the Supreme Court. Indeed, at least since the more progressive revision of the doctrine in *R v Kapp*,[136] there has been no favourable Section 15 judgment from the Supreme Court where the full extent of the discrimination alleged was found.[137] As Jennifer Koshan notes, recent Supreme Court

---

134 See e.g. Drucilla Cornell, *The Imaginary Domain: Abortion, Pornography, and Sexual Harassment* (New York: Routledge, 1995).

135 See e.g. Dorothy Roberts, *Race, Reproduction and the Meaning of Liberty* (New York: Vintage, 1997).

136 2009 SCC 41, [2008] 2 SCR 483.

137 See Jennifer Koshan, "Redressing The Harms of Government (In)Action: A Section 7 Versus Section 15 *Charter* Showdown" (2013) 22:1 Const Forum Const 31 at 34–35. A review of Section 15 claims brought before the Supreme Court since 2015 reveals that this situation has not changed.

decisions have productively revised equality doctrine to avoid the pitfalls of comparator groups, proof tests about dignity, and other shortcomings identified by critical equality scholars with previous Section 15 doctrine.[138] Yet, she reveals that "in spite of the Court's acknowledgement of criticisms of earlier equality rights cases, and in spite of being presented with alternative approaches that take substantive equality more seriously, the Court is making it very difficult for claimants to prove discrimination even in cases where there is strong evidence of specific harms caused by the inequality."[139]

One example of a new barrier is the Supreme Court's emphasis on stereotyping and prejudice as evidence of disadvantage. As Koshan observes, this definition of discrimination excludes "other harms of discrimination such as marginalization, oppression, and deprivation of significant benefits."[140] Another roadblock to success for equality-seeking claimants is the proclivity of the Supreme Court to legitimate government purposes as neutral when plaintiffs challenge large benefits-conferring legislation as discriminatory.[141] To add to these impediments, the Supreme Court seems to prefer basing a decision on an alternative ground to Section 15 where possible[142] – a preference witnessed in its *Carter* SCC decision. All of these factors raise the very real possibility that the plaintiffs' Section 15 claim in *Carter* BCSC would have failed at the Supreme Court. A decision from the Supreme Court denying the equality claim could have left a powerful precedent undermining or even contesting the disability and embodied perspectives the trial decision advanced. Viewed in this light, the lack of a Section 15 analysis at the Supreme Court is not so much a missed opportunity but a lucky break for equality-seeking groups.

For the sake of argument let us concede that had it addressed Section 15, the Supreme Court would have rendered a disappointing analysis that eroded or even erased the progressive elements of Justice Smith's decision. This indeed would have been unfortunate in terms of the harmful precedent that would have been established. At the same time, avoiding Section 15 for

---

138 *Ibid* at 32.

139 *Ibid* at 35.

140 *Ibid* at 32. Koshan and her co-author discuss an array of further concerns with the Supreme Court's approach to Sections 15(1) and (2) in a series of articles she cites (*ibid*, n 12).

141 *Ibid* at 32–33.

142 *Ibid* at 34.

fear of a retrograde decision is also unfortunate. Equality rights become illusory if we fear their poor enforcement and consequently avoid challenging legislation on equality grounds. It is surely no answer to deficiencies in Section 15 doctrine to render this ground obsolete in *Charter* litigation. Rather, courts should continue to articulate more robust visions for what substantive equality demands. That is why Justice Smith's Section 15 analysis is so valuable. Through the actual analysis she conducted, a nuanced account of inequality and disability emerged that arguably resulted in a progressive, equality-favouring decision in favour of people with physical disabilities. The Supreme Court should have endorsed a progressive interpretation of Section 15 in relation to the ban on PAD for persons with disabilities in order to advance judicial discussion about disability rights.

2. Disability critiques of the substantive equality model

To be sure, even a robust vision of substantive equality has its limits which prompt legal commentators in both Canada and the United States working within the framework of disability studies and what is increasingly known as critical disability studies to question the usefulness of anti-discrimination claims housed in the substantive equality model. Critical disability studies, like disability studies, objects to the medical model of disability, advocating instead for an understanding of disability as a deeply mediated site of power.[143] But critical disability studies also applies a critical filter to the premises, terms, and methodology that disability studies has employed, thus placing the latter's "conventions, assumptions and aspirations of research, theory and activism in an age of postmodernity."[144] Another notable feature of disability studies' more critical iteration is showcased by critical disability studies' intersectional orientation and desire to engage with feminist, queer, and postcolonial theory rather than privilege materialist or Marxist analyses.[145] Although the national legislative and constitution-

---

143 See Kafer, *supra* note 104 at 5–6.

144 Dan Goodley, "Dis/entangling critical disability studies" (2013) 28:5 Disability & Society 631 at 632, referencing the work of Margrit Shildrick, *Dangerous Discourses of Disability, Subjectivity and Sexuality* (London: Palgrave Macmillan, 2009); Margrit Shildrick, "Critical Disability Studies: Rethinking the Conventions for the Age of Postmodernity" in Nick Watson et al, eds, *Routledge Handbook of Disability Studies* (London: Routledge, 2012) at 30–41

145 Goodley, *supra* note 144; Simo Vehmas & Nick Watson, "Moral Wrongs, Dis-

al contexts in which the critiques of disability studies and critical disability studies operate in Canada and the United States are different, these critiques share the view that substantive equality analyses inadequately incorporate the tenets of disability studies and do not benefit judicial understandings about disability enough to counsel their continued usage. Three recurring concerns are the adherence to the medical model of disability, an underappreciation of disability stigma, and, as articulated by critical disability studies scholars, the lack of an awareness of intersectionality within the substantive equality framework.

Underlying the first concern is the claim that current substantive equality analyses are incompatible with the social model of disability and align instead with the problematic medical model. Since equality claims frequently require discrimination to be based on unchangeable characteristics, a person's disability has to be understood as fixed.[146] Biology and society are kept separate.[147] The social model of disability contests this understanding.[148] This critique leads to a second shortcoming of the substantive model: that similar to formal equality,[149] it does not adequately account for the systemic nature of disability prejudice.[150] Specifically, the able-bodied person's normative stature is not interrogated within the substantive equality model.[151] The species norm, as Ani Satz puts it, that positions disability as

---

advantages, and Disability: A Critique of Critical Disability Studies" (2013) 29:4 Disability & Society 638 at 638–40.

146 See Martha T McCluskey, "How the Biological/Social Divide Limits Disability and Equality" (2010) 33 Washington University JL & Pol'y 109 at 120 [McCluskey, "Biological"].

147 See *ibid* at 18.

148 See Daphne Gilbert & Diana Majury, "Infertility and the Parameters of Discrimination Discourse" in Dianne Pothier & Richard Devlin, eds, *Critical Disability Theory: Essays in Philosophy, Politics, Policy, and Law* (Vancouver: UBC Press, 2006) at 293–94.

149 See Gilbert and Majury, *supra* note 148 at 3.

150 See Martha T McCluskey, "Rethinking Equality and Difference: Disability Discrimination in Public Transportation" (1988) 97:5 Yale LJ 863 at 865–68, 872–73 [McCluskey, "Rethinking"]; Samuel R Bagenstos; "The Structural Turn and the Limits of Antidiscrimination Law" (2006) 94:1 Cal L Rev 1.

151 See McCluskey, "Biological", *supra* note 146 at 123–24.

abnormal remains unquestioned[152] with the result that disability is viewed as a weakness rather than a difference.[153] Finally, critical disability theorists worry that the substantive equality model reinforces a hierarchy among inequalities.[154] As critical race feminists initially illuminated,[155] the model is not designed to address intersecting grounds of discrimination and thus struggles to accept the possibility that a person might identify as part of many different "minorities" and, as such, might argue that their experiences of inequality take shape through this multiplicity.[156] Another recurring critique emphasizes the claim that any substantive equality judgment will be inefficient without state-sponsored social programs.[157]

3. Assessing the objections

These critiques are correct in suggesting that the substantive equality model is also limited in its ability to expose and remedy marginalization, exploitation, and oppression related to disability. Deficits in Justice Smith's equality analysis from a critical disability studies perspective are simple enough to spot. For example, we observe that Justice Smith did not incorporate the literature's layered insights about terminology or which model is best to understand disability. She accepted the power of biomedicine to

---

152 "A Jurisprudence of Dysfunction: On the Role of Normal Species Functioning in Disability Analysis" (2006) 6:2 Yale J Health Pol'y, L, and Ethics 221.

153 See McCluskey, "Biological", *supra* note 146 at 120, 122.

154 See *ibid* at 120.

155 See e.g. Kimberlé Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics" (1989) 140 U Chicago Legal F 139.

156 See Fiona Sampson, "Beyond Compassion and Sympathy to Respect and Equality: Gendered Disability and Equality Rights Law" in Devlin & Pothier, *supra* note 148 at 267–70. For discussions of the intersectionality of gender and disability, see e.g. Kristin Bumiller, "Quirky Citizens: Autism, Gender, and Reimagining Disability" (2008) 33:4 Signs 967; Rosemarie Garland-Thomson, "Feminist Disability Studies" (2005) 30:2 Signs 1557. Related to this critique is the concern that substantive equality models are identity-based, which leads to rigid and artificial ways of understanding discriminatory phenomena.

157 See generally Samuel R Bagenstos, "The Future of Disability Law" (2004) 114:1 Yale LJ 1; Jerome E Bickenbach, "Disability and Equality" (2003) 2:1 JL & Equality 7 at 12–15.

"know" the body and define disability (i.e., through assigning allopathic physicians the ability to determine eligibility for PAD). Nor did she contest the liberal parameters of Section 15 doctrine in general that constrain discussion of critical disability studies' many concerns about normalization, neoliberalism, and biopolitics in relation to disability.[158] Her reasoning also did not delve into the intersectional effects of the PAD ban. While Justice Smith, as noted above, highlighted the bodily effects of the legal prohibition on individuals, and in this regard "allow[s] the body to resurface as a significant element of the disability experience" in discussions of disability as some critical disability studies scholars advocate,[159] the judgment adheres to the liberal modernist limits of substantive equality doctrine. Whether these limits of the substantive equality model are so severe, however, to reject pursuing a Section 15 claim altogether is debatable. After all, such critiques could easily apply to all liberal *Charter* rights and the liberal legalism of the common law in general. Even Canadian scholars identifying as critical disability theorists are supportive of substantive equality as a model of equality rights to pursue.[160] More to the point, however, although the shortcomings inherent to current Section 15 analysis may mar the critical equality impact of Justice Smith's decision, her analysis still achieved a level of critical purchase that enriches judicial discourse about disability and systemic disadvantage.

The Supreme Court's Section 7-reliant decision does not incorporate insights and principles from disability studies or critical disability theory the way the trial decision did to explain the *systemic marginalizing* impact of the PAD prohibition. Nor might we expect it to. As Susanne Baer observes, many nations' constitutional doctrines treat autonomy and equality as dis-

---

158 For an overview of concerns regarding normalization and biopolitics, see Saltes, *supra* note 108 at 56–62.

159 Goodley, *supra* note 144 at 634. A central tenet of disability studies is that the social model of disability denies the biologically linked suffering that physical, cognitive, and sensory impairments occasion. Goodley succinctly explains the underlying rationale of this disavowal as follows: "As a direct riposte to a medicalized and psychologized hegemonies of disability – that sited disability as a personal tragedy, biological deficiency and psychical trauma – disability studies relocated disability to social, cultural, economic and political registers. Having an impaired body did not equate with disability. In contrast, disability was a problem of society" (*ibid*).

160 See e.g. Richard Devlin & Dianne Pothier, "Introduction" in Pothier & Devlin, *supra* note 148, 1 at 8.

tinct, and often antithetical, fundamental rights mandating separate analyses with different foci.[161] When liberty is the right at stake, our attentions gravitate toward whether an individual has the ability to choose as a rational, autonomous actor or whether the state constricts choice.[162] It is in the arena of equality rights where one asks whether certain *conditions* prevent certain groups from making a choice that everyone else can (as in *Carter*).[163] We see this division in the *Charter*. It is with respect to Section 15 *Charter* rights that litigants typically hope to obtain judicial recognition of a contested law's participation in fostering the often hidden but ever-present *systemic disadvantage* that actually removes choices for some but not others.

As a result, the question of what critical understanding about disability is lost without a Section 15 equality analysis of the *Criminal Code*'s prohibition on assisted death has a different answer if we pose the same question about Section 7. It is not that one has more value than the other or that a Section 7 analysis cannot also generate a progressive social justice analysis – for those critical scholars and others who agree with the decision, the ultimate outcome at the Supreme Court in *Carter* SCC clearly illustrates that it can.[164] Rather, it is the potential of a Section 15 equality analysis to shine a spotlight on questions of *whom* does a law, because of larger and systemic social conditions, *include/enable* or *exclude/marginalize*. The Section 7 doctrine does not engage this question; its focus instead is on *what* is restricted and the importance of the suffering involved.[165] At the trial level in *Carter*, this focus within Section 15 doctrine yielded a critical insight about disability and its relation to systemic disadvantage as well as an explanation of how the prohibition of PAD furthers this disadvantage by restricting choices about death.

---

161 *Supra* note 5 at 428, 435, 448. It is vital to note that Baer does not endorse this separation. Rather, she is interested in moving constitutional doctrines toward a triangulated relationship between the fundamental rights of dignity, equality and liberty. Baer argues that these rights and the work they do are best understood as indelibly inflected by one another (*ibid* at 430).

162 *Ibid* at 449.

163 As Baer succinctly puts it, "[e]quality is about who enjoys a liberty, while liberty is about what you enjoy" (*ibid* at 449).

164 See also *Canada (AG) v Bedford*, 2013 SCC 72, [2013] 3 SCR 1101 (another recent Supreme Court decisions decided on Section 7 grounds that many would argue promotes social justice).

165 Baer, *supra* note 5 at 449.

In short, Justice Smith's decision is still deserving of merit for its contribution to critical judicial discourse about disability and inequality. Neither deficiencies with the mechanics of Section 15 doctrine nor the norms of the substantive equality model diminish the value of the decision in this regard. That being said, Justice Smith's reasoning could have gone further in its critical equality and disability vision as noted above. This comment is also applicable to the remedies it delivered. The next Part explains why.

III. Revisiting the Remedies

Recall that Justice Smith invalidated subsection 241(b) of the *Criminal Code* because it is a blanket prohibition that did not "allow for a stringently limited, carefully monitored system of exemptions."[166] As a remedy for the plaintiffs, Justice Smith issued two declaratory orders that subsection 241(b) violated the Section 7 and Section 15 rights of those who qualified for PAD under the "stringent conditions" regarding competence, being informed, grievously ill, etc.[167] In devising these conditions, Justice Smith drew from the dissenting judgments in *Rodriguez* at the Court of Appeal and the Supreme Court wherein Chief Justices McEachern and Lamer respectively set out what a person would have to prove to be eligible for PAD[168] as well as several other policy and legislative considerations.[169] As these declaratory orders were suspended for twelve months, the Supreme Court also provided a constitutional exemption for Gloria Taylor that set out a series of conditions she would have to fulfill and steps she would have to follow to legally access PAD.[170] There are several ways in which these remedies may be said to reinforce problematic power relations in biomedicine and thus may not actually be all that equality enhancing. This section explains these concerns. The criticisms discussed are: 1) the biopolitical and able-mindedness implications of the remedies; 2) the medicalization of death

---

166 *Carter* BCSC, *supra* note 8 at para 124.

167 *Ibid* at paras 1233, 1393.

168 *Ibid* at paras 858, 1421, drawing from *Rodriguez v British Columbia* (1993), 76 BCLR (2d) 145, 14 CRR (2d) 34 [*Rodriguez*, BCCA] at paras 100–08 and *Rodriguez*, *supra* note 22 at 579.

169 *Carter* BCSC, *supra* note 8 at paras 862–71.

170 *Ibid* at paras 1411, 1413.

they promote; and 3) the valuation of the physician's autonomy over the patient's that they normalize.

A. Biopolitical and able-mindedness implications

Implicit within the *Carter* BCSC decision is a tolerance for a regime where the state, not the individual, is able to control life and death and manage the trajectories and experiences of bodies. Drawing from the work of Michel Foucault and Giorgio Agamben, we note that the decision exemplifies the concern that it is increasingly the state that attends to the biological processes of life and carries out the regulation and often repression of bodies.[171] These theories of biopower and biopolitics document how, since the 17th century, the traditional power of the sovereign to kill and take life has transformed into a biopolitics of the sovereign to "make live and to let die."[172] The state now approaches its subjects as biopolitical objects in need of technologies regulation to enhance and extend life. A critical exception to this approach occurs where, using Agamben's influential term, the state exercises its sovereign power to classify some individuals as "bare life" to be excluded from the normative political order.[173] In this subhuman zone presented as exceptional, accelerated death is legal.[174]

Scholars have noted how state prohibitions against PAD operate as a contemporary manifestation of biopower and biopolitics.[175] Although Jus-

---

171 See Todd F McDorman, "Controlling Death: Bio-Power and the Right-to-Die Controversy" (2005) 2:3 Communication and Critical/Cultural Studies 257 at 258–65.

172 See Michel Foucault, *"Society Must be Defended": Lectures at the College de France, 1975-1976*, translated by David Macey (New York: Macmillan, 2003) at 241, cited in Megan Foley, "Voicing Terri Shiavo: Prosopopeic Citizenship in the Democratic Aporia between Sovereignty and Biopower" (2010) 7:4 Communication and Critical/Cultural Studies 381 at 383.

173 See Kristin G Cloyes, "Rethinking Biopower: Posthumanism, Bare Life, and Emancipatory Work" (2010) 33:3 Advances in Nursing Science 234 at 236; see also 235–37 for the important ways in which Agamben's theory of biopower diverges from that of Foucault.

174 See Dinesh Wadiwel, *The War against Animals* (Amsterdam: Brill, 2015) at 72–78.

175 Foley, *supra* note 172 at 395–96; McDorman, *supra* note 171.

tice Smith declared the absolute prohibition on PAD unconstitutional, her decision does not escape participating in these fields. For one, her remedy only recognizes the legitimacy of a small fraction of persons (those who are afflicted by a serious and degenerative medical condition who express a competent, fully informed, and non-ambivalent desire to end their lives) to control their deaths.[176] In her own words, it is a "stringent exception" to state control over how people can or cannot die.

In legislating such a general prohibition, the state will foster a normalized view of the meaning of human life that individuals are expected to adopt in the care of themselves and others. The state retains the sovereign power to assert which types of intentional termination of human life are legitimate (war, defences to homicide, capital punishment, suicide etc.) and which are not. Sovereignty over the body moves from the individual to the state.[177] From this perspective, in excluding only a fraction of the population from the criminal prohibitions, one could critique the *Carter* decision for extending the traditional currents of biopower and reinforcing the problematic biopolitical configurations of (post)modern day Western democracies.[178] The government's new amendments to the *Criminal Code* to legalize

---

[176] The RSC Report notes that there are four diseases that are particularly challenging to the provision of adequate end-of-life care: dementia, kidney disease, heart disease, and chronic obstructive pulmonary disease. In light of this data, Justice Smith's ruling would have an impact on a small percentage of individuals deciding on end-of-life care due to terminal illnesses (*supra* note 125 at 12).

[177] Victor Toom, "Bodies of Science and Law: Forensic DNA Profiling, Biological Bodies, and Biopower" (2012) 39:1 JL & Soc'y 151 at 152.

[178] Llewellyn and Downie show how a criminal response to PAD is limited in what it can offer those directly involved in assisted suicide and society as a whole. But in terms of the question of biopower it can be said that their restorative justice proposal can be critiqued in the same way as the criminal law system. Even though the courts and legislatures are not as heavily involved, it is still a group of legal and health care professionals who judge the actions of those involved in assisted suicide and thus the merits of the personal decision to seek aid in dying. However, since the premise of restorative justice in the context of end-of-life decisions, as Llewellyn and Downie describe it, is that "the more one is embedded in a web of relationships of equal respect, concern, and dignity, the less likely one is to cause harm," there is the potential within this structure to acknowledge individual autonomy by not directly equating assisted death with crime (*supra* note 70 at 977). See *Criminal Code*, *supra* note 9, as amended by the *Medical Assistance in Dying*

PAD do not upset this dynamic. In fact, the amending legislation narrows the number of Canadians who can qualify by introducing the requirement that death be "reasonably foreseeable."[179]

Further, in not permitting those deemed legally incompetent (by reason of mental illness and cognitive impairment) to seek PAD – even if they had a pre-existing wish expressed when competent – the decision introduces an exception that distinguishes between mental and physical disabilities. This stance places the trial decision in *Carter* in a long line of medico-legal interventions restricting the autonomy of those exhibiting mental symptoms deemed abnormal and in need of treatment and, where possible, correction or reversal.[180] It also arguably violates Article 12 of the Convention on the Rights of Persons with Disabilities, which Canada has ratified. This Article guarantees equal recognition before the law and specifically requires states to "recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life."[181] The Committee for the Rights of

---

Act, *supra* note 12, s 3. This section creates section 241.1 as an addition to the *Criminal Code* that sets out the framework for medical assistance in dying. Subsection 241.2(1) establishes the eligibility criteria along the general lines set out by the Supreme Court in *Carter* SCC. However, in defining what constitutes a "grievous and irremediable medical condition" in subsection 241.1(2), the amending statute, in contrast to other factors that echo the *Carter* SCC decision in terms of the kind of conditions that would qualify, includes the requirement that a person's "natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining."

179 *Criminal Code*, *supra* note 9, s 241.2(2)(d), as amended by *Medical Assistance in Dying Act*, *supra* note 12, s 3.

180 For a deeper exploration of mental illness through a Foucauldian lens, see generally Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, translated by Richard Howard (Toronto: Random House of Canada Ltd, 1988); Arthur Still and Irving Velody, eds, *Rewriting the History of Madness: Studies in Foucault's "Histoire de la Folie"* (New York: Routledge, 1992); John Iliopoulos, "Foucault's Notion of Power and Current Psychiatric Practice" (2012) 19:1 Philosophy, Psychiatry, & Psychology 49; Gerald Turkel, "Michel Foucault: Law, Power, and Knowledge" (1990) 17:2 JL & Soc'y 170 at 172–75.

181 *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, UNGA, 76th Mtg, UN Doc A/Res/61/106, (2006), in force May 3, 2008 (ratification by Canada 11 March 2010) at paras 1–2 [CRPD].

Persons with Disabilities' (CRPD) formal commentary on Article 12, paragraph 2, emphasizes that those with "cognitive or psychosocial disabilities" are at particular risk of having their equality rights violated through laws that remove their legal capacity due to their disability, insisting that states take action to ensure that rights are not automatically divested for those with non-physical disabilities.[182] Whether Article 12, paragraph 2, requires that those with cognitive and psychosocial disabilities be afforded a right to PAD on equal terms with those with physical disabilities is still an unsettled question.[183] Yet, one can make the argument that a law that would maintain such a distinction, as Justice Smith's eligibility factors regarding competence and lack of depression do,[184] violates the principle of equality,[185] and runs afoul of Article 12's equality guarantee.

More clearly, Justice Smith's reliance on physician assessments to determine capacity as part of the competence assessment for PAD contradicts the CRPD's commentary that characterizes such assessments as discriminatory.[186] The CRPD states that "[m]ental capacity is not, as is commonly presented, an objective, scientific and naturally occurring phenomenon [but] is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity."[187] It further notes that "persons with cognitive or psychosocial disabilities have been, and still are, disproportionately affected by substitute decision-making regimes and denial of legal capacity" and that such regimes and denials violate the Convention's equality guarantee.[188] Health professionals' assessments of mental capacity to determine legal capacity for PAD, which trigger substitute decision making and can result in denials

---

182 Committee on the Rights of Persons with Disabilities, General Comment No 1 (Eleventh session, 2014) at para 9 [CRPD, "General Comment No 1"].

183 See Elizabeth Peel & Rosie Harding, "A Right to 'Dying Well' with Dementia? Capacity, 'Choice' and Relationality" (2015) 25:1 Fem Psychol 137 at 139.

184 *Carter* BCSC, *supra* note 8 at paras 770–98.

185 Paul T Menzel & Bonnie Steinbock, "Advance Directives, Dementia, and Physician-Assisted Death" (2013) 41:2 JL Med & Ethics 484.

186 CRPD, "General Comment No 1", *supra* note 182 at para 15.

187 *Ibid* at para 14.

188 *Ibid* at para 9.

of legal capacity, are part of the "practices that in purpose or effect violate article 12 …"[189]

The CRPD provides a specific critique of capacity assessments that exhibit a "functional approach" to determining legal capacity, i.e., an approach that consists of an inquiry into whether or not a person's ability to make decisions is compromised past a particular threshold.[190] The CRPD writes:

> The functional approach attempts to assess mental capacity and deny legal capacity accordingly. It is often based on whether a person can understand the nature and consequences of a decision and/or whether he or she can use or weigh the relevant information. This approach is flawed for two key reasons: (a) it is discriminatorily applied to people with disabilities; and (b) it presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies him or her a core human right — the right to equal recognition before the law… Article 12 does not permit such discriminatory denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity.[191]

Justice Smith accepted that "cognitive impairment and capacity are distinct; [and that] the presence of some cognitive impairment does not necessarily obviate the capacity to give informed consent."[192] Yet, she reviewed at length various medical views regarding the assessment of competence in general and, in particular, medical views with respect to manifestations of cognitive impairments and depression. She then concluded that "very careful scrutiny" would be required to ensure decisional capacity for PAD.[193] She affirmed the ability of psychiatrists – particularly contested agents of normalization[194] – and other

---

189 *Ibid*.

190 *Ibid* at para 15.

191 *Ibid*.

192 *Carter* BCSC, *supra* note 8 at para 795.

193 *Ibid*. Justice Smith discusses the evidence about incompetence as a risk to improper PAD in paras 762–98.

194 See Saltes, *supra* note 108 at 62, 64. For critiques of the practices and discourses of psychiatry as a field see Paula J Caplan & Lisa Cosgrove, eds, Bias

physicians to perform this level of scrutiny.[195] In endorsing functional capacity assessments to exclude individuals with cognitive disabilities and mental illnesses, when found incompetent pursuant to such an assessment, from accessing PAD, Justice Smith's decision may be said to contribute to a two-tier disability rights landscape that privileges physical or sensory disabilities, a privileging that the excerpts from the CRPD's commentary above clearly contest. In doing so, the judgment exhibits what critical disability studies scholars are increasingly articulating as "*able-mindedness*,"[196] a term meant to accentuate the culturally normative presumptions about mental and cognitive abilities that are discriminatory.[197]

B. Medicalization of death

Closely related to the concern about biopolitics is the medicalization of death that the specific remedy normalizes. The medicalization of life experiences is a topic that has received widespread critical academic attention.[198]

---

in Psychiatric Diagnosis (Lanham, MD: Jason Aronson, 2004); Shaindi Diamond et al, *Psychiatry Disrupted: Theorizing Resistance and Crafting the (R) evolution* (Montreal: MQUP, 2014); Ewen Speed, "Discourses of Acceptance and Resistance" in Mark Rapley, Joanna Moncrieff & Jacqui Dillon, eds, *De-Medicalizing Misery: Psychiatry, Psychology and the Human Condition* (Basingstoke: Palgrave Macmillan, 2011) at 123–140; Charles E Rosenberg, "Contested Boundaries: psychiatry, disease, and diagnosis (2015) 58:1 Perspect Biol Med 120 at 123–24. For critical appraisal of the field as well as reflections on how psychiatric practice guided by feminist analysis can benefit patients see Sally Swartz, "Feminism and psychiatric diagnosis: Reflections of a feminist practitioner" (2013) 23:1 Feminism & Psychology 41.

195 *Carter* BCSC, *supra* note 8 at para 798.

196 See e.g. Margaret Price, "The Bodymind Problem and the Possibilities of Pain" (2015) 30:1 Hypatia: a Journal of Feminist Philosophy 268 at 268 [emphasis added].

197 See Ashley Taylor, "The Discourse of Pathology: Reproducing the Able Mind through Bodies of Color" (2015) 30:1 Hypatia 181 at 185. Able-mindedness is perhaps even more problematic than able-bodiedness because, as Ashley Taylor notes, of how mental incompetence has historically been disproportionately attributed to those with marginalized race, class, and gender identities, an attribution that endures today (*ibid* at 185–88).

198 For citations to generative literature see Drew Halfmann, "Recognizing Medicalization and Demedicalization: Discourses, Practices, and Identities" (2012)

The medicalization of death is included in this literature and has been recognized as having profound effects on how individuals view end-of-life decisions.[199] Briefly, medicalization occurs when an everyday life occurrence is *defined* in medical terms/language; the medical analysis may or may not prescribe medical treatment/intervention to "fix" the problem.[200] In the case of *Carter*, both of these elements are present. The phenomenon of disability and assisted death requests are explained in medical (and medico-legal) terms relating to physical conditions, cognitive competence, and mental illnesses. The *Carter* SCC decision ultimately assigns authority to doctors to assess (diagnose?) whose death request is valid and permits only physicians to provide medical assistance in dying.[201]

Consider the medical requirements that Justice Smith set out as legal conditions for requesting PAD. First, the physician must declare that the patient is grievously ill and will not recover.[202] After ensuring the patient's decision is informed, the physician as well as a psychiatrist must attest that the patient "is competent and that her request for physician-assisted death is

---

16:2 Health 186 at 187, 201 [Halfmann, "Recognizing Medicalization"]. For a discussion of the contemporary causes of medicalization see Peter Conrad, "The Shifting Engines of Medicalization" (2005) 46:1 J Health Soc Behav 3. Scholarly attention to how certain practices once medicalized may actually become demedicalized is now emerging as a separate focus (see Halfmann, *ibid*).

199 RSC Report, *supra* note 125 at 10, citing Economist Intelligence Unit, "The Quality of Death: Ranking End-of-Life Care Across the World 2010", *The Economist* (2010) at 15–20 which stated that the "medicalization of death in Canada has engendered a culture where many people are afraid to raise the topic of death." The report also found that Canada ranked relatively high in comparison to other countries in the area of "quality of death" but lower in public awareness about options and even lower for costs.

200 See Halfmann, "Recognizing Medicalization", *supra* note 198 at 187, citing the influential definition of medicalization provided by Peter Conrad, "Medicalization and social control" (1992) 18 Annu Rev Sociol 209 at 211; Heather Hartley & Leonore Tiefer, "Taking a Biological Turn: The Push for a 'Female Viagra' and the Medicalization of Women's Sexual Problems" (2003) 31:1/2 Women's Studies Q 42 at 43.

201 The new law expands this to nurse practitioners and nurses: *Criminal Code*, *supra* note 9, s 241.1(a), as amended by *Medical Assistance in Dying Act*, *supra* note 12, s 3.

202 *Carter* BCSC, *supra* note 8 at para 1414.

voluntary and non-ambivalent."[203] If either practitioner cannot confirm this, that conclusion will be communicated to other doctors who may become involved at a later stage as well as to the court.[204] After this step, the patient's autonomy takes a back seat. She then has to seek permission of a court for the assisted death.[205] The new federal amending legislation has eliminated this step,[206] but it is worthwhile noting that Justice Smith's ruling would have permitted a court to decline an application for PAD on the basis that "at the material time" the patient is not "suffering from enduring and serious physical or psychological distress that is intolerable to her and that cannot be alleviated by any medical or other treatment acceptable to her."[207] No doubt, a court would have only felt qualified to make this assessment upon the opinion of medical experts.

In the course of this multi-step procedure, individuals' intimate decisions about their bodies are handed over to and tested by medical agents of the state. Private hopes for death become subject to public decisions that are, in turn, rendered legitimate by medical knowledge.[208] It is important to note that this model is not universal. Studies have addressed how PAD may de-medicalize death by pointing to the Swiss model for PAD and comparing it with the Oregon model from which the *Carter* BCSC decision more heavily draws.[209] In his discussion of the Swiss model, Stephen Ziegler notes that death is arguably de-medicalized since: 1) the assistance is rendered most frequently by non-physicians, which has the further de-medicalizing effect of enabling death to take place outside of hospitals and in the person's community; and 2) PAD is not restricted to the terminally ill.[210] While *Carter*'s

---

203 *Ibid*.

204 *Ibid*.

205 *Ibid* at para 1415.

206 *Criminal Code*, *supra* note 9, s 241.2(1), as amended by *Medical Assistance in Dying Act*, *supra* note 12, s 3.

207 *Carter* BCSC, *supra* note 8 at para 1415.

208 See Victor Toom, "Bodies of Science and Law: Forensic DNA Profiling, Biological Bodies, and Biopower" (2012) 39:1 JL & Soc'y 150 at 152.

209 See e.g. Stephen Ziegler, "Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance Oversight and Demedicalize the Dying Process" (2009) 37 JL Med & Ethics 318 at 322.

210 *Ibid* at 322, 325–26.

eligibility requirements at trial and at the Supreme Court did not explicitly mandate that an illness be terminal,[211] the initial procedures Justice Smith laid out for Taylor to access her constitutional exemption were immersed in a medical paradigm.

To appreciate the significance of this pathway to PAD, recall that the plaintiffs had sought a remedy that would have permitted assisted death where the suffering was *psychosocial* (and not necessarily also physical or psychological).[212] Justice Smith specifically rejected this category of suffering as a trigger for PAD eligibility.[213] She also declined to adopt the plaintiffs' suggestion that PAD could be carried out by a physician *or someone under the general control of the physician*.[214] Justice Smith restricted the assistance to physicians only.[215] She clearly invested the medical profession with trust, expertise, and authority to make the decision over who is entitled to assistance and who is not. There is ample scholarship that questions whether medicalization serves the interests of vulnerable populations,[216] in-

---

211 Views have diverged as to how to interpret the Supreme Court's stance in *Carter* SCC on whether a medical condition has to be terminal. The competing arguments were recently aired in *Canada (AG) v EF*, 2016 ABCA 155, 34 Alta LR (6th) 1 before the Alberta Court of Appeal, which held that the Supreme Court in *Carter* SCC did not require that a condition be terminal for a patient to submit a request for PAD. For discussion of the case and its interpretation of *Carter* SCC, see Jennifer Koshan, "A Terminal Dispute? The Alberta Court of Appeal Versus the Federal Government on Assisted Death" (May 26, 2016), ABlawg: The University of Calgary Faculty of Law Blog, online: <ablawg.ca/2016/05/26/a-terminal-dispute-the-alberta-court-of-appeal-versus-the-federal-government-on-assisted-death/>.

212 *Carter* BCSC, *supra* note 8 at para 24.

213 *Ibid* at para 1390.

214 *Ibid* at 1385 [emphasis added].

215 *Ibid* at 1389. The RSC Report, in contrast, explicitly includes a survey of the opinions of various medical and social assistance professionals and canvasses their roles in end-of-life care, thereby encouraging a broader societal discussion on the roles that various professionals should play in assisted death (RSC Report, *supra* note 125 at 24, 61, 95).

216 See e.g. Ann V Bell, "The Margins of Medicalization: Diversity and Context Through the Case of Infertility" (2016) 156 Social Science & Medicine 39 at 40.; Deborah Findlay, "The Good, the Normal and the Healthy: The Social Construction of Medical Knowledge about Women" (1993) 18:2 Can J of

cluding scholarship that notes the adverse effects of psychiatric understandings of mental health on these same populations.[217] None of this scholarship can be detected in Justice Smith's reasoning.

C. Respecting autonomy appropriately

Following from this deference to the medical profession, Justice Smith's reasoning also prompts the critique that it is not the eligible individual whose autonomy is respected under Justice Smith's decision, but the attending physician's. Arguably, it is scientific knowledge about physical conditions and mental health that is valued rather than the patient's decision to die irrespective of whether a physician agrees with her. One may ask whether it is the doctor's or the patient's autonomy that the law respects. Elizabeth Schneider posed the same question in relation to the conceptualization of the right to abortion in the United States noting that it is not the woman's decision to abort that the law respects but the professional judgment of her doctor who agrees with her decision.[218] In setting up a system of respecting the patient's choice only where two physicians agree with her, *Carter* BCSC may be vulnerable to the same criticisms of medicalizing what should be an individual's own choice about what happens to her body.

Indeed, there is an absence of gendered analysis in the judgment as it does not consider the stereotypes against women specifically that shape their encounters with physicians and families.[219] This is in sharp contrast to

---

Sociology 121; David Pfeiffer, "The Categorization and Control of People with Disabilities" (1999) 21:3 Disabil Rehabil 106.

217 See Sharon Cowan, "Looking Back (To)wards the Body: Medicalization and the GRA" (2009) 18:2 S & LS 247; Rachel Liebert, "Feminist Psychology, Hormones and the Raging Politics of Medicalization" (2010) 20:2 Fem & Psychol 278–83; Heather Hartley & Leonore Tiefer, "Taking a Biological Turn: The Push for a "Female Viagra" and the Medicalization of Women's Sexual Problems" (2003) 31:1/2 Women's Studies Q 42 at 43–44; Brenda A LeFrançois, Robert Menzies & Geoffrey Reaume, eds, *Mad Matters: A Critical Reader in Canadian Mad Studies* (Toronto: Canadian Scholars' Press, 2013).

218 Elizabeth M Schneider, "The Synergy of Equality and Privacy in Women's Rights" (2002) U Chicago Leg F 137 at 147.

219 For discussions on the relevance of these stereotypes, see e.g. Katerina George, "A Woman's Choice: The Gendered Risks of Voluntary Euthanasia and Physician-Assisted Suicide" (2007) 15:1 Med L Rev 1 at 16–18; Cheryl B Travis &

the decision's keen awareness of the stereotypes about the value of the lives of disabled people and the elderly that operate within the medical profession and within society at large, such that these groups are more vulnerable to being encouraged to die.[220] As an example of this absence, the decision does not query whose assisted death requests physicians are most likely to grant or how women constitute a vulnerable group within the disability community.[221] The lack of gendered information in the evidentiary record may explain this silence. Nevertheless, recent studies provide reason to suspect that the courts and medical profession will approach requests for PAD differently when these requests are made by women. As Jennifer Parks has argued, physicians are less likely to support the choices of women who wish to die, demonstrating an increased proclivity to deny their choices as competent and informed vis-à-vis the death wishes expressed by male patients. It is plausible that the increased tendency to question women's competence in decision making is influenced by long-standing systemic stereotyping of women as more irrational by the medical profession and by society at large.[222]

Conversely, as Katrina George points out, since women are socialized to be self-sacrificing caregivers rather than recipients of care, they will be more likely than men to internalize the dominant narrative that they are burdens to their families and should elect to die instead.[223] And while women

---

Dawn M Howerton, "Risk, Uncertainty, and Gender Stereotypes in Healthcare Decisions" (2012) 35:3–4 Women Ther 207; Klea D Bertakis & L Jay Helms, "Patient Gender Differences in the Diagnosis of Depression in Primary Care" (2004) 10:7 J Womens Health Gend Based Med 689; Dana Yagil & Gil Luria, "Parents, Spouses, and Children of Hospitalized Patients: Evaluation of Nursing Care" (2010) 66:8 J Adv Nurs 1793.

220 Drawing from studies in permissive jurisdictions that do not reveal a disproportionate number of the disabled or the elderly as recipients of assisted death, Justice Smith expressed confidence in the ability of physicians to reject these stereotypes (*Carter* BCSC, *supra* note 8 at para 798).

221 The decision can also be said to be missing cultural perspectives, such as those highlighted in the RSC Report, *supra* note 119 at 17–18.

222 Jennifer A Parks, "Why Gender Matters to the Euthanasia Debate: On Decisional Capacity and the Rejection of Women's Death Requests" (2000) 30:1 Hastings Cent Rep 30 at 33–36.

223 George, *supra* note 219 at 18–23. Further, as most high profile legal cases on PAD have involved women as the plaintiffs, it may be that permitting PAD as Justice Smith has for Gloria Taylor will result in more women dying than men (*ibid* at 1). George examines the available data for several jurisdictions

are typically considerably less likely to opt for suicide than men, evidence from PAD-permitting jurisdictions indicate that they are more amenable to selecting PAD or euthanasia than suicide.[224] George attributes this latter phenomenon to women's preference for death modalities that "appear 'passive and compliant' and, therefore, compatible with cultural stereotypes of femininity."[225] My point is that, as Parks and George demonstrate, there are multiple ways in which PAD may affect women specifically. In choosing not to engage with this scholarship, Justice Smith missed an opportunity to address the gender inequality that currently exists within the medical profession. As such, while it may promote equality and dignity for individuals with physical disabilities overall, the decision may be a disservice to women within this group in failing to consider the gendered effects of legalizing PAD.

D. Summary

In at least three ways, Justice Smith's decision precludes a critical disability studies treatment of PAD by reinforcing problematic biopolitical and biomedical discourses with the remedies it devises and contradicting the CPRD Committee's position on the legitimacy of capacity assessments and substitute decision-making regimes. Of course, it may be too much to expect a single trial decision to enter into an analysis of patterns of gendered differentiation in terms of whose assisted death preferences are genuinely autonomous and/or respected. Also, given everything else the decision addresses, it may also be unrealistic to expect a court to engage with the literature critiquing the phenomenon of medicalization. At the same time, it is worth noting the implicit able-mindedness of the decision by virtue of its endorsement of capacity assessments. It is equally worth locating the decision as part of the biopolitical matrix and highlighting the deference that the decision shows to the medical profession. Although the Supreme Court does not delineate the steps a person must take before they can qualify for PAD as Justice Smith's decision did, the Supreme Court does generally de-

---

regarding the gender of PAD- and euthanasia-seekers but finds the evidence inconclusive since the characteristics of those requesting PAD are not usually available (*ibid* at 7–8).

224 *Ibid* at 24–25.

225 *Ibid* at 24, citing Silvia Sara Canetto, "Elderly Women and Suicidal Behaviours" in Silvia Sara Canetto & David Lester, eds, *Women and Suicidal Behaviour* (New York: Springer Publishing Company) 215 at 227.

fine the group of people who will qualify for PAD through the existence of medical conditions. Further, the Supreme Court does not contest the overall embeddedness of the trial decision in medico-legal discourse either or express any concern about the able-mindedness presuppositions of capacity assessments.

The new federal amendments to the *Criminal Code* legalizing PAD, which received Royal Assent on June 17, 2016, also do not question these central elements.[226] The steps that must be followed pursuant to the new federal amending legislation for individuals to access what the legislation terms "medical assistance in dying" or "MAID" do vary somewhat from those Justice Smith mandated (most notably, a court order is no longer required).[227] The new provisions regarding eligibility, safeguards, and the steps that must be followed, however, do not disturb the deference that Justice Smith accorded to the medical profession other than to extend the power to provide medical assistance in dying to nurse practitioners along with physicians (after two independent physicians have confirmed the eligibility of a patient request).[228] The legislative history indicates the federal government extended the scope of health providers who could provide MAID to ensure access in geographic areas where MAID-performing physicians would not be readily available.[229] Where the provisions refer to physicians alone, it is important to note that, unlike Justice Smith's specifications, the amending legislation does not require that psychiatrists be involved – the statute uses the general term of "medical practitioner," defining it as "a person who is entitled to practise medicine under the laws of a province."[230] While this certainly diminishes the power of psychiatrists as specialist medical practitioners to evaluate the legitimacy of MAID requests, it entrusts physicians in general with the ability to do so – a clear expression of deference

---

226 *Medical Assistance in Dying Act*, *supra* note 12, amending *Criminal Code*, *supra* note 9.

227 *Criminal Code*, *supra* note 9, s 241.1, as amended by *Medical Assistance in Dying Act*, *supra* note 12, s 3.

228 *Criminal Code*, *supra* note 9, s 241.2(3) as amended by *Medical Assistance in Dying Act*, *supra* note 12, s 3.

229 Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying: A Patient-Centred Approach* (February 2016) [Joint Committee, *Report*].

230 *Criminal Code*, *supra* note 9, ss 227(5), 241.1, as amended by *Medical Assistance in Dying Act*, *supra* note 12, s 2.

to their profession as a whole. Expected provincial and territorial health-related regulation regarding the logistics and administration of MAID in each jurisdiction will very likely reinforce the presence of physicians and health care practitioners working with or under them as essential components of the regulatory frameworks that jurisdictions develop for the practice of MAID.[231] Entrenching the medicalization of the MAID framework further is, as mentioned earlier, the inclusion of the requirement that a person's death be "reasonably foreseeable."[232]

The new law also establishes capacity assessments as an important safeguard in determining who can access MAID and thus adopts the distinction both judgments maintained between physical and mental disabilities in rendering those with mental disabilities ineligible for MAID if found incapable. It remains to be seen, however, whether the new law will backtrack from even this modest position by denying MAID to individuals who submit a request in order to put an end to suffering caused by mental illness. The House of Commons and the Senate passed a bill that did not reflect the advice the federal government received on how to handle requests rooted in psychiatric conditions from the Special Joint Committee on Physician-Assisted Dying ("the Committee") appointed by Parliament in December 2015 to undertake further consultation and study but also to make recommendations to the federal government as to the legislative framework it should institute in this area.[233]

---

[231] See Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, *Final Report* (November 30, 2015) at 6, 24–26 [Provincial-Territorial Advisory Group, *Final Report*]. The Advisory Group affirms that PAD should only be available after a request is assessed by two physicians and should be carried out by a health practitioner – either a physician or nurse practitioner or a registered nurse or physician assistant acting under the direction of a physician or nurse practitioner (*ibid* at 25–26, 28–29). It is important to note, however, that the Advisory Group has also recommended that "self-administered physician-assisted dying," where a physician does not have to be present, be a legal option as well (*ibid* at 23). It remains to be seen whether future legislation will permit this.

[232] *Criminal Code*, s 241.1(2)(d), *supra* note 14, as amended by *Medical Assistance in Dying Act*, s 3, *supra* note 12.

[233] The Committee was struck soon after an expert panel charged with consultations with the public, the interveners in *Carter* SCC, and medical and other stakeholders, delivered its findings to Parliament on December 15, 2015. The External Panel on Options for a Legislative response to *Carter* was established on July 17, 2015. It was originally tasked, as its title suggests, with providing guidance for a legislative response to the Supreme Court's ruling but that por-

The Committee recognized that the presence of a mental illness does not necessarily preclude legal capacity[234] and concluded that disallowing individuals with mental illnesses from accessing PAD would constitute a *Charter* violation.[235] It thus recommended "[t]hat individuals not be excluded from eligibility for medical assistance in dying based on the fact that they have a psychiatric condition."[236] Although the federal government did not adopt this position in drafting the Act, it did mandate in the final version that the Ministers of Justice and Health within 180 days of the Act's Royal Assent "initiate one or more independent reviews of issues relating to requests by mature minors for medical assistance in dying, to advance requests and to requests where mental illness is the sole underlying medical condition."[237] There is thus some scope for some of the able-mindedness of the current law to be redressed in the near future. Still, the legislative debate that has occurred with respect to the possible inclusion/exclusion of those suffering from a mental condition in the MAID framework has shown no inkling of challenging the legitimacy of capacity assessments along the lines exempli-

---

tion of the mandate was removed by the newly elected Ministers of Justice and Health following the Fall 2015 federal election. The Committee's mandate, critically, did include this legislative component (see Joint Committee, *Report*, *supra* note 228 at 2, 7). For a link to the External Panel findings see *External Panel, Options for a Legislative Response to* Carter v Canada, *Consultations on Physician-Assisted Dying – Summary of Results and Key Findings* (December 15, 2015), online: <www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/toc-tdm.html>. Also created before the Committee was the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, in which all provinces and territories except Quebec participated (British Columbia acted as an observer only). This body issued its Provincial-Territorial Advisory Group, *Final Report*, *supra* note 231, on November 30, 2015.

234 Joint Committee, *Report*, *supra* note 229.

235 *Ibid* at 14. This understanding was also shared by the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying. See Provincial-Territorial Expert Advisory Group, *Final Report*, *supra* note 231 at 15 where it states that "[t]he Court's declaration is also not restricted to physical illnesses, diseases or disabilities, and includes mental illness."

236 Joint Committee, *Report*, *supra* note 228 at 14–15.

237 *Medical Assistance in Dying Act*, *supra* note 12, s 9.1(1), amending *Criminal Code*, *supra* note 9.

fied by the CPRD Committee's concerns about rendering people incapable rather than supporting them in making decisions.[238]

Conclusion

For the first time in its history, Canada's highest court has held that an absolute ban on assisted death is unconstitutional under Section 7 of the *Charter* as it violates the rights to life, liberty, and security of the person for those individuals who are suffering intolerably from a "grievous and irremediable" medical condition, are mentally competent, informed, and non-ambivalent about their wish to die, but cannot commit suicide without the assistance of someone else. Since the Supreme Court decided the matter definitively under Section 7, the unanimous Supreme Court did not address the Section 15 equality argument raised by the plaintiffs. Although understandable, the equality lacuna is regrettable. In omitting a discussion of Section 15, the Supreme Court foreclosed a fuller discussion of whether banning PAD for individuals with physical disabilities enhances or detracts from such individuals' opportunities for autonomy and expression of personhood.

Justice Smith's interpretation of the equality interests at stake did address these important points and also vindicated the plaintiffs' equality claim. To be sure, the *Carter* trial decision is the product of multiple doctrinal tests, empirical assessments, and lines of reasoning. Central to the equality analysis, however, is the trial court's commitment to substantive equality. This equality model facilitates an effects-based focus that encourages judicial discussion of the social context in which laws operate. Through Justice Smith's progressive interpretation, the substantive equality model yielded a complex understanding of the disability rights debate on PAD as well as a generous conceptualization of the autonomy interests at stake for someone like Gloria Taylor. Justice Smith's substantive equality analysis on the disparate impact of prohibiting PAD on disadvantaged groups also served to foreground the embodied nature of the legal dispute. This foregrounding was accomplished in part through the narratives presented by Gloria Taylor and other affected individuals as to how the PAD prohibition would materially affect their health and bodies. For these reasons, and despite the

---

238 See e.g. House of Commons, *Journals*, 42nd Parl, 1st Sess, No 74 (16 June 2016) at 645–47 (the amendments made by the Senate to Bill C-14 and returned to the House of Commons); *House of Commons Debates*, 42nd Parl, 1st Sess, No 74 (16 June 2016) at 4602–29 (the House of Commons' consideration of the Senate's amendments).

critiques that could nonetheless apply to certain aspects of the Section 15 analysis due to the doctrine's limits, including the limits of the substantive equality framework, it would have been desirable for the Supreme Court to endorse Justice Smith's Section 15 analysis as strongly as it did her Section 7 analysis. At the very least, it is hoped that concerns about critical disability and discrimination can inform the interpretation of the new law and its scheduled review such that questions of biopolitics, able-mindedness, medicalization, and patient autonomy become central to the emerging regulatory framework.