



Submissions of the British Columbia Civil Liberties Association

Regarding *Carter v. Canada* and the unconstitutional exclusion of “mental illness”
from Bill C-7

To the Standing Committee on Legal and Constitutional Affairs

In view of its study on Bill C-7,
An Act to amend the Criminal Code
(medical assistance in dying)

December 1, 2020

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Bill C-7's exclusion of "mental illness" does not respect the *Carter* decision

Overview

Bill C-7 is a critical piece of legislation that contains many legislative changes that we have long been fighting for. However, Bill C-7 is flawed in a fundamental way. Bill C-7 must be amended to remove the absolute prohibition against permitting people whose sole underlying condition is "mental illness" from having the choice of medical assistance in dying ("MAID"). Mental illness should not be excluded from the definition of "serious and incurable illness, disease or disability" as proposed by section 241.2(2.1).

This absolute prohibition does not comply with the Supreme Court of Canada's decision in *Carter v. Canada (Attorney General)*, 2015 SCC 5 ("*Carter*"), and is therefore unconstitutional. Excluding all "mentally ill" people from choosing assistance in dying, no matter how extreme their suffering, no matter how grievous and irremediable their condition, and irrespective of the competence and voluntariness of their decision, takes away a human right that was granted by the Supreme Court of Canada. In sum, the government should support human rights in mental health care – not stigmatize and abandon those suffering from mental health issues.

Brenda's Story

Brenda is a key example of a person Bill C-7 will leave behind. Brenda shared her story with the BC Supreme Court in Julia Lamb's case in order to help Julia challenge the current MAID law's prohibition on MAID for people whose natural deaths were not reasonable foreseeable.

Brenda has been married for 48 years, has three children and is a retired teacher. She suffers from severe myalgic encephalomyelitis, which is also called chronic fatigue syndrome. She also suffers from chronic pain. Everyday Brenda suffers debilitating pain and fatigue.

For well over a decade, Brenda has tried every prescription and treatment that has been offered to her, but no doctor has been able to determine a cause for her pain and fatigue. She has consulted

with a long list of doctors, including specialists in neurology, gynecology, rheumatology and internal medicine. She has tried over 80 different medications.

Brenda requested an assisted death, but her doctor informed her she would not qualify because her natural death is not “reasonably foreseeable.” Brenda’s story is important because even though the proposed legislation removes the requirement that a person’s natural death be reasonably foreseeable, Brenda could be excluded from the law by virtue of being deemed to have a sole underlying mental disorder. Indeed, one of her physicians diagnosed her as having a somatoform disorder, meaning a mental illness in which her physical symptoms have no identifiable cause. Although most of her doctors determined she suffered from a medical condition (as opposed to a psychiatric disorder) – there is significant disagreement amongst medical practitioners as to how to diagnose the ambiguous pattern of symptoms experienced by Brenda.

What is clear is that Brenda feels helpless that there is no way out from under her pain and suffering. She states in her affidavit that she has recently considered death by suicide:

I recently began reading about how to take my own life and I believe I have accumulated enough medication to do it. I fear, however, that I might not succeed and could somehow end up in an even worse situation that I am now. That possibility deters me. Although I do not fear death, I am terrified by the thought of life with additional pain.

One thing Brenda’s story underscores is the arbitrariness for some patients as to whether they receive a medical or a psychiatric diagnosis. Further, Brenda’s story highlights how it is often unhelpful to divide illness into psychiatric and medical diagnoses given that neither diagnosis provides relief from suffering. Unfortunately, Bill C-7 reifies this dualistic view of illness.

Brenda points out the cruel injustice of being denied the right to choose a gentle death. She stated:

Although clearly there must be some limits on who can access MAID, I find it incomprehensible that someone like me – who, despite best efforts, endures daily, debilitating pain with no hope of improvement – is ineligible. My conditions may not fit neatly within a category, and may not yet be well understood in the way some other illnesses such as cancer are, but my symptoms are real and torturous. How can we can ourselves a humane society when I – and others like me – are forced to suffer.

With Brenda's permission, we attach her affidavit in its entirety as an attachment to this submission. Although the information contained in her affidavit is deeply personal – Brenda shared her story in the hopes that she could make positive change in the law for herself and others.

The term “mental illness” in C-7 is undefined and will lead to uncertainty

The term “mental illness” is not defined in Bill C-7 – yet there is no clearly accepted lay or clinical definition of “mental illness.” This lack of clarity in the law will lead to uncertainty – and will threaten the rights of many Canadians who are currently permitted to receive MAID if they meet the strict eligibility criteria.

The proposed legislation states that to be eligible for MAID, a person must have a “grievous and irremediable medical condition,” and it then offers the following criteria for eligibility:

- (2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:
 - (a) they have a serious and incurable **illness, disease or disability**;
 - (b) they are in an advanced state of irreversible decline in capability;
 - (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
 - (d) their 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.

The proposed amendment further states: “(2.1) For the purposes of paragraph (2)(a), **a mental illness is not considered to be an illness, disease or disability**” [emphasis added].

The Expert Panel Working Group on MAID Where a Mental Disorder is the Sole Underlying Medical Condition was charged with examining the unique considerations relevant to individuals

living with “mental illness” with respect to MAID.¹ The panel chose to use the term “mental disorder,” finding the term to be consistent with clinical medical and legal practice. The panel noted that “mental disorder” is the term used in the two primary classification systems in psychiatry: the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems (ICD10) and the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-5).²

On the other hand, the term “mental illness” does not have a clinical medical or legal definition.

There are a significant number of mental disorders that could be deemed “mental illness” that could be captured by the law, including, for example:

- a. Huntington’s disease;
- b. Somatoform disorders;
- c. Alzheimer’s disease;
- d. Dementia;
- e. Autism; and
- f. Anxiety, mood, psychotic, personality and eating disorders.

Bill C-7 offers no guidance to physicians and patients as to which disorders are disqualifying in terms of being able to choose MAID, which will lead to confusion and uncertainty. The evidence before the court in Carter included evidence from people with whose sole underlying condition was a mental disorder, such as Nagui Marcos, who suffered from Huntington’s disease.

Currently, individuals who suffer from Alzheimer’s disease and dementia are widely viewed by medical professionals as *not* being flatly barred from MAID if they meet the rigorous, upfront safeguards. Bill C-7 throws their eligibility into question.

Carter v. Canada sets the “floor” of what is constitutionally required

¹ Council on Canadian Academies, 2018. *The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder Is the Sole Underlying Medical Condition*. Ottawa (ON): The Expert Panel Working Group on MAID Where a Mental Disorder Is the Sole Underlying Medical Condition.

² Ibid. p. 6

The Supreme Court of Canada's decision in *Carter* set the “floor” and not the “ceiling” of what is constitutionally required to respect the rights of all Canadians. This means that while Parliament may extend the rights to physician assisted dying beyond what the Court required (for example, by permitting nurse practitioners to provide MAID), it cannot restrict those rights.

The first paragraph of *Carter* is instructive, as it sets out the context for its decision:

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

In the *Carter* proceedings, the plaintiffs challenged, and the court declared unconstitutional, the criminal law's absolute prohibition against physician-assisted dying. This prohibition was absolute in the sense that it applied to all persons suffering from medical conditions – whether terminal or non-terminal, disabled or non-disabled, adult through to elderly, early stage illness or late stage illness, irremediable or remediable only by means personally unacceptable – regardless of whether they were decisionally capable individuals.

The law's prohibition was “absolute” because it did not permit patients the benefit of being individually assessed for eligibility for physician-assisted dying. It was “absolute” because it did not distinguish between those who were “vulnerable” and those who were entitled to choose for themselves.

Canada defended against that proposition, arguing both that no one could be reliably vetted for eligibility and, further, that some groups (e.g., the disabled, the elderly) were especially incapable of being so vetted and thus would be at particular risk under a permissive law. It further asserted that a law permitting assisted dying would have various negative social consequences.

On a full evidentiary record, the Supreme Court of Canada found that all persons could be individually assessed to determine whether they were eligible to make, for themselves, a medical decision to die. The court further found that Canada's alleged negative social consequences were

either not established on the evidence or, where accepted, were speculative and non-compelling. A declaration of unconstitutionality was issued accordingly.

Parliament responded to that declaration of unconstitutionality by enacting Bill C-14, *An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying)*. This law permits only a subclass of affected persons to be individually assessed – leaving those outside the statutorily permitted subclass still subject to an absolute prohibition, in that the excluded persons continue to be deemed “decisionally vulnerable” and not entitled to an individual eligibility assessment.

The express basis for the exclusion of the subclass was certain of the social consequences that had been specifically raised and addressed in *Carter* (see Legislative Background: Medical Assistance in Dying (Bill C-14) – Addendum: “Rationale for the approach in Bill C-14”).³

In 2016, the BCCLA filed a constitutional challenge to the new assisted dying law, Bill C-14, *Lamb v. Canada* (“*Lamb*”).⁴ The BCCLA launched the challenge with Julia Lamb, a now 28-year-old B.C. woman who has spinal muscular atrophy, a progressive, degenerative disease, on the basis that the law limited assistance in dying to Canadians whose natural death has become “reasonably foreseeable.”

Shortly thereafter, in 2017, Quebecers Jean Truchon and Nicole Gladu, two Canadians with serious health conditions which cause them intolerable suffering, filed a similar challenge to the law. Their challenge resulted in a 2019 decision by the Quebec Superior Court, in *Truchon v. Canada* (“*Truchon*”),⁵ that Canada and Quebec’s assisted dying laws are unconstitutional because they were incompatible with *Carter* and violated the *Charter* rights of Mr. Truchon and Ms. Gladu.

Less than two weeks later, Julia Lamb and the BCCLA adjourned their medical assistance in dying case. Julia requested the adjournment after the Government of Canada’s expert witness admitted

³ "Department of Justice, "Legislative Background: Medical Assistance in Dying (Bill C-14) – Addendum," *Government of Canada*, July 15, 2016. <https://www.justice.gc.ca/eng/rp-pr/other-autre/addend/index.html>

⁴ *Lamb v. Attorney General of Canada*, SCBC (File No. S165851, Registry: Vancouver)

⁵ *Truchon c. Procureur general du Canada*, 2019 QCCS 3792.

that Julia would now qualify for an assisted death if she requests MAID. According to the uncontradicted government expert, medical practitioners across Canada who help patients end their lives have reached a clear understanding that the law does not in fact require a person to be near death.

In reaction to the *Truchon* decision, and following on the heels of the *Lamb* adjournment, the federal government once again tabled responsive legislation: Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, the current legislation under review. The federal government takes the position that this time its new replacement law will pass *Charter* scrutiny. We do not agree. The new law does not comport with the constitutional minimums established in *Carter*.

When the federal government enacted Bill C-14 in June 2016, government officials took the position that the scope of the *Carter* decision was limited to persons in “factual circumstances” that parallel those of Gloria Taylor, the lead plaintiff in *Carter*, a woman who suffered from ALS. Now the government asserts that the *Carter* decision does not apply to those with “mental illness.”⁶ These assertions rest on a particular interpretation of *Carter* – one that has been rejected multiple times by multiple courts.

In individual exemptions hearings following *Carter v. Canada (Attorney General)*, 2016 SCC 4, (“*Carter 2016*”), the Attorney General of Canada (“AGC”) opposed exemption applications by asserting that the scope of the declaration in *Carter* was narrowly limited to a subset of persons (i.e. those who were eventually permitted access to MAID under C-7.) In one such application, the AGC argued that the scope of the *Carter* declaration, and therefore the *Carter 2016* exemption relief, was limited to those with terminal illnesses and expressly precluded those with psychiatric conditions.

⁶ See for example: Department of Justice, “Charter Statement: *An Act to amend the Criminal Code (medical assistance in dying)* (C-7),” *Government of Canada*, October 21, 2020. <https://www.justice.gc.ca/eng/csj-sjc/pl/charter-charte/c7.html>

It lost that argument before the Court of Queen's Bench of Alberta and the Alberta Court of Appeal.⁷ That legal challenge was brought by E.F., a woman who received MAID when a mental disorder was her sole underlying medical condition (E.F. had conversion disorder, also known as functional neurological symptom disorder).⁸ The motions judge determined that although she suffered from a mental disorder, E.F. was capable of making an informed, voluntary request to receive physician assistance in dying and came within the criteria established by *Carter*.

The Alberta Court of Appeal unanimously rejected the AGC's argument that psychiatric conditions were excluded. The Court of Appeal interpreted the *Carter* decision as extending to individuals with a mental disorder as a sole underlying condition who otherwise complied with *Carter* criteria. In paragraph 59, the Court wrote:

As can be seen, in *Carter* 2015 the issue of whether psychiatric conditions should be excluded from the declaration of invalidity was squarely before the court; nevertheless the court declined to make such an express exclusion as part of its carefully crafted criteria. Our task, and that of the motions judge, is not to re-litigate those issues, but to apply the criteria set out by the Supreme Court to the individual circumstances of the applicant. The criteria in paragraph 127 and the safeguards built into them are the result of the court's careful balancing of important societal interests with a view to the Charter protections we all enjoy. Persons with a psychiatric illness are not explicitly or inferentially excluded if they fit the criteria.”

The AGC chose not to appeal this decision.

It then advanced the same argument that scope of the declaration in *Carter* was narrowly limited to a subset of persons before the Ontario Superior Court of Justice.⁹ It lost there too - and, again, it did not appeal. It also lost the argument in *Truchon* – and again it did not appeal. Significantly, as it is something that Canada is uniquely able to do, Canada also did not refer the issue of the proper scope of *Carter* to the Supreme Court of Canada for an opinion.¹⁰ Instead it continues to press its argument in the court of public opinion and before Senators and Members of Parliament.

⁷ *Canada (Attorney General) v. E.F.*, 2016 ABCA 155 [*E.F.*]

⁸ *Ibid*, para. 7.

⁹ *I.J. v. Canada (Attorney General)*, 2016 ONSC 3380 [*I.J.*]

¹⁰ *Supreme Court Act*, R.S.C. 1985, c. S-26, s. 53

The federal government continues to take that position that *Carter* excludes psychiatric disorders from the parameters of its reasons.¹¹ This precise argument was rejected by the Alberta Court of Queen's Bench and the Alberta Court of Appeal in *E.F.*¹² Those courts determined that, rather than seeking to exclude psychiatric conditions from its reasons, the Supreme Court of Canada explicitly refused to do so. Rather, the court concluded that decisional capacity and vulnerability can be assessed on an individual basis using the procedures that physicians apply in their assessment of informed consent and decisional capacity in the context of medical decision-making more generally. On this point, the unanimous Alberta Court of Appeal concluded: "Persons with a psychiatric illness are not explicitly or inferentially excluded if they fit the [*Carter*] criteria."¹³

What was in Dispute in *Carter*

The issue of whether those suffering from mental disorders should be excluded from the parameters of its reasons was very much a part of the debate and the record before the Supreme Court of Canada. Whether vulnerable persons can be reliably assessed for eligibility; the impact denial of access has on suffering individuals; and whether evidence about regimes in foreign jurisdictions provides a basis for inferring how a Canadian system would operate – were fully and forcefully litigated.

In April 2011, the BCCLA and four directly affected individuals launched a challenge to the provisions of the *Criminal Code* which, at that time, imposed an absolute prohibition against medically assisted dying which was applicable to all persons in Canada.

The BCCLA was given standing as an institutional plaintiff, on the basis that the issue of whether there was a constitutional right to physician-assisted dying was relevant to all Canadians, including the BCCLA's thousands of members, and that it was not reasonable to expect those with grievous

¹¹ Department of Justice, "Charter Statement: *An Act to amend the Criminal Code (medical assistance in dying)* (C-7)," *Government of Canada*, October 21, 2020. <https://www.justice.gc.ca/eng/csj-sjc/pl/charter-charte/c7.html>

¹² *E.F.* paras. 47 – 59.

¹³ *E.F.* para. 59.

and irremediable medical conditions, those with what were often terminal illnesses, to attempt to carry out such litigation for themselves.¹⁴

The *Carter* Plaintiffs were and represented people with terminal and non-terminal medical conditions. Kay Carter had a medical condition (spinal stenosis) that was neither “incurable” (but in respect of which she had declined surgery) nor terminal (in that she could have survived indefinitely). Dr. Shoichet’s position was that he faced a deprivation of liberty for helping any grievous and irremediable ill person from ending their life.

The evidence before the court in *Carter* included evidence from people with terminal and non-terminal medical conditions, including people for whom a natural death was not “reasonably foreseeable,” including Tony Nicklinson (Locked In Syndrome) and Elayne Shapray (Multiple Sclerosis), as well as people whose sole underlying condition was a mental disorder, such as Nagui Marcos (Huntington’s disease).¹⁵

i. *Carter* Trial

The *Carter* Plaintiffs claimed that:

- a. to the extent the criminal law prohibited competent, grievously and irremediably ill adults who are voluntarily seeking physician-assisted dying on an informed basis from receiving assistance, they were contrary to s. 7 of the *Charter*; and
- b. to the extent the criminal law prohibits competent, materially physically disabled, grievously and irremediably ill adults who are voluntarily seeking physician-assisted dying on an informed basis from receiving assistance and thereby disproportionately impact the disabled, they were contrary to s. 15 of the *Charter*.¹⁶

¹⁴ Reasons for Judgment, *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (File No. S112688, Registry: Vancouver), June 15, 2012, paras. ¶¶86-87 and 98-99. [Trial Reasons]

¹⁵ See, for example, *ibid*, para. ¶1041.

¹⁶ Amended Notice of Civil Claim, *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (File No. S112688, Registry: Vancouver), August 15, 2011.

Thus, the core¹⁷ *Charter* claimant group in *Carter* consisted of all individuals meeting the “*Carter* Criteria” – individuals who are:

- a. competent (to make a medical care decision to die);
- b. informed;
- c. adult;
- d. suffering intolerably from a grievous and irremediable (by reference to treatments acceptable to them) medical condition (illness, disease or disability); and
- e. acting voluntarily.

The respondents in the *Carter* Proceedings were the AGC and the Attorney General British Columbia.

The evidence at trial in this matter was extensive. The expert evidence, in particular, was voluminous and detailed. The AGC’s key experts were cross-examined by the appellants, with much of that examination being conducted before the BC Supreme Court. The evidence was comprehensively addressed by the trial judge, who carefully considered the body of evidence before her in the context of the entire record and made findings based on, *inter alia*, her assessments of impartiality and relative expertise.

The *Carter* Plaintiffs took the position that it was possible to reliably vet the *Carter* Criteria for individuals seeking access to assisted dying as a medical treatment and, accordingly, that the law could and should provide for access subject to such vetting.

¹⁷ With the s. 15 claimants needing to meet all the *Carter* Criteria, and also to be materially physically disabled such that they could not terminate their lives without assistance.

In response to the *Carter* Plaintiffs' position, the AGC, *inter alia*:

- a. disputed that reliable assessment for compliance with the *Carter* Criteria was possible (especially regarding the physically disabled and those with psychiatric conditions); and
- b. asserted that a permissive regime would, *inter alia*, convey negative messages about suicide as a solution and about the values of the lives of the disabled.

In particular, in its filed Response in the *Carter* Proceedings, the AGC asserted, *inter alia*, the following (Part 1, Division 3):

- a. people suffering from illness or disability are vulnerable to being persuaded to choose death,¹⁸ and such persuasion may be extremely subtle and unintentional;¹⁹
- b. it is difficult or impossible to assess the voluntariness or quality of decisions to choose assisted dying made by disabled people;²⁰
- c. the legalization of assisted death would suggest that “the government condones and/or encourages people suffering from illness or disability to choose death;”²¹ and,
- d. there is a risk that people may seek assisted death on the basis of a misdiagnosis or an inaccurate treatment.²²

Extensive evidence was placed before the *Carter* trial court with respect to the factual issues in dispute.

¹⁸ Amended Response to Amended Civil Claim, *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (File No. S112688, Registry: Vancouver), September 16, 2011, p. 30, ¶12.

¹⁹ Ibid, pp. 30-31, ¶¶ 13-14.

²⁰ Ibid, p. 31, ¶¶ 15.

²¹ Ibid, para. 19.

²² Ibid, para. 20.

Notably, *inter alia*, the AGC put into evidence:

- a. testimony from multiple experts in suicide and suicide prevention: Drs. Mishara,²³ Heisel,²⁴ and Hendin²⁵;
- b. evidence intended to demonstrate that the disabled were especially vulnerable to being encouraged to, or improperly permitted to, end their lives contrary to their true wishes if physician-assisted dying was permitted and, in particular, the evidence of Professor Frazee;²⁶ and
- c. evidence intended to demonstrate that cognitive impairments, including psychiatric conditions and depression, render competence assessments ineffectual: Dr. Sheldon.²⁷

It is also noteworthy that at trial, the AGC asserted that the objective of the *Carter* Laws was as follows:

... Canada argues these objectives for the legislation: (1) preserving life by not condoning the taking of life; and (2) preventing harm to individuals and society including: (a) protecting vulnerable individuals from being induced to commit suicide in moments of weakness; (b) preventing damage to the doctor-patient relationship; (c) preventing a negative impact on palliative care; and (d) preventing negative messages about the value of human life, particularly the value of the lives of individuals with disabilities.²⁸

In the AGC's Written Submissions at trial dated November 14, 2011, the AGC:

- a. argued that allowing physician assisted dying was inconsistent with the governmental objective of reducing suicide;²⁹

²³ Trial Reasons, paras. 766, 800.

²⁴ Ibid, paras. 768, 812.

²⁵ Ibid, paras. 794, 796.

²⁶ Ibid, paras. 848-53.

²⁷ Ibid, para. 776.

²⁸ Ibid, para. 1187 (emphasis added); see Attorney General of Canada's Written Submissions, *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (File No. S112688, Registry: Vancouver), December 8, 2011, pp. 329-30, ¶¶577-79.

²⁹ Attorney General of Canada's Written Submissions, *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (File No. S112688, Registry: Vancouver), December 8, 2011, p. 178, ¶¶94-95.

- b. asserted a need to protect especially vulnerable populations “such as Aboriginal communities and the elderly” from the risk of suicide;³⁰
- c. asserted that some populations were especially vulnerable to wrongful deaths because of their personal circumstances, such as physical and mental disabilities, age-related illnesses, or social indifference and isolation;³¹
- d. argued that the diagnosis of cognitive impairment and competency is more complex if the person is living with concurrent physical and psychiatric conditions or several psychiatric conditions;³²
 - a. recognized that the case was *not* restricted to the terminally ill;³³
 - b. argued that pre-conceived perceptions about persons with disabilities could impact the reliability of eligibility assessments for the disabled;³⁴
 - c. argued that assisted dying should not be made available to persons with treatable conditions;³⁵
 - d. argued that the *Carter* Laws were required to protect vulnerable people from inaccurate eligibility assessments and the harms of negative messaging,³⁶ and in particular to protect: (i) the elderly,³⁷ and (ii) individuals with disabilities;³⁸ and
 - e. argued that the *Carter* Laws were required to prevent “negative messaging”, including that suicide was an appropriate solution to problems.³⁹

³⁰ Ibid, pp. 183-84, ¶¶106-08.

³¹ Ibid, pp. 219, ¶¶207.

³² Ibid, pp. 255, ¶¶336.

³³ Ibid, pp. 211-13, 215, ¶¶187-90, 196.

³⁴ Ibid, pp. 261-62, ¶¶359-60.

³⁵ Ibid.

³⁶ Ibid, p. 275, ¶402.

³⁷ Ibid, pp. 275-81, ¶¶403-17.

³⁸ Ibid, pp. 281-87, ¶¶418-37.

³⁹ Ibid, pp. 287-91, ¶¶438-50.

The AGC then relied on all the above points and evidence again in its s. 1 justification argument,⁴⁰ including asserting that “vulnerable people could be induced to commit suicide or consent to euthanasia” and that “no safeguard can address the negative social messaging that some lives are less valuable than others”.⁴¹

The *Carter* Plaintiffs argued, *inter alia*, that the evidence before the court established individuals could be (and in other life and death medical contexts were already being) assessed in accordance with the *Carter* criteria, and, further, that government was well-placed to carry out “positive messaging” or conduct general public education in order to allay any concerns about “negative messaging” arising from legalized assisted dying.

The trial judge canvassed the evidence and made extensive, detailed findings of fact and set out her legal reasoning at length, including: (a) as to negative messaging resulting from permitting assisted dying;⁴² and (b) as to the feasibility of assessing the eligibility of people from marginalized communities and those at a higher risk for suicide – including AGC’s assertion that disabled people should not be permitted access to assisted dying because of their particular vulnerability.⁴³

The trial judge found the *Carter* Laws breached ss. 7 and 15 of the *Charter*, and that neither breach was justified under s. 1.⁴⁴

ii. *Carter* Appeal Proceedings

The BCCA allowed the appeal on the basis of the doctrine of *stare decisis*. Finch C.J., dissenting: *Carter v. Canada (Attorney General)*, 2013 BCCA 435, ¶¶171-77.

The Supreme Court of Canada granted leave to appeal. It also granted the AGC’s motion to enter new evidence.

⁴⁰ Ibid, pp. 329-34, ¶¶577-601.

⁴¹ Ibid, p. 334, ¶598.

⁴² Trial Reasons, ¶¶1191, 1252-53, 1265.

⁴³ Ibid, ¶¶848-53, 1118-20, 1126-27, 1129.

⁴⁴ Ibid, ¶¶16-18, 1393.

The AGC filed an affidavit purporting to update the trial record about assisted dying cases in Belgium since the trial regarding the impact of assisted dying on marginalized populations, including persons with psychiatric conditions.⁴⁵ The *Carter* Plaintiffs filed a response affidavit.

The AGC's factum before the Supreme Court of Canada acknowledged that:

- a. the trial declaration of invalidity was not limited to the terminally ill nor to persons whose conditions were "incurable";⁴⁶
- b. The AGC had put evidence and argument before the trial judge about vetting disabled individuals and about negative social messaging about the disabled;⁴⁷ and
- c. continued to argue that the objectives of the *Carter* Laws included preventing negative social messaging about the value of some lives (particularly of disabled lives), and to guard against social messaging condoning suicide as a solution to suffering.⁴⁸

The Supreme Court of Canada issued its decision in February 2015.

The Supreme Court of Canada rejected the AGC's position that the *Carter* Laws were justified because there were persons for whom the risk of being allowed to decide for themselves involved too many possible sources of error. The Court agreed with the trial judge that individual assessments for decisional capability in life and death contexts were not only feasible, they were already being carried out in respect of other end-of-life decisions.⁴⁹

The Court noted the trial judge's factual findings at length and dismissed all of the AGC's challenges to those findings, including of social and legislative fact.⁵⁰

⁴⁵ Affidavit of Professor Etienne Montero, *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (File No. S112688, Registry: Vancouver), June 8, 2017, pp. 129-37.

⁴⁶ Respondent's Factum, *Carter v. Canada (Attorney General)*, 2016 SCC 4 (File No. 35591), July 8, 2014, p. 28, ¶24.

⁴⁷ Ibid, pp. 29, 33, ¶¶43-44, 156.

⁴⁸ Ibid, pp. 30, 34, ¶¶147, 162, .

⁴⁹ *Carter*, ¶¶114-16

⁵⁰ Ibid, ¶¶104-109.

As the AGC had sought and obtained the right to put additional evidence before the Supreme Court of Canada, the Court was called upon to make an important finding of first instance. The Court rejected the AGC's claim that its new evidence was significant to the issues of compliance or expansion in permitting regimes. The Court found that none of the new evidence undermined the trial judge's findings. It further specifically noted that one of the reasons the new evidence was insignificant was because evidence about practices in foreign jurisdictions offered little insight into how a Canadian regime would operate.⁵¹

The specific issue of whether those suffering from psychiatric conditions should be excluded from the declaration of invalidity was squarely before the Supreme Court of Canada. For example, at paragraph 114, the court discussed Canada's position regarding the risks associated with the decriminalization of physician assisted dying as follows:

In [Canada's] view, there are many possible sources of error and many factors that can render a patient "decisionally vulnerable" and thereby give rise to the risk that persons without a rational and considered desire for death will in fact end up dead. It points to cognitive impairment, depression or other mental illness, coercion, undue influence, psychological or emotional manipulation, systemic prejudice (against the elderly or people with disabilities), and the possibility of ambivalence or misdiagnosis as factors that may escape detection or give rise to errors in capacity assessment. Essentially, Canada argues that, given the breadth of this list, there is no reliable way to identify those who are vulnerable and those who are not. As a result, it says, a blanket prohibition is necessary.

In the next paragraph the Court stated:

The evidence accepted by the trial judge does not support Canada's argument. Based on the evidence regarding assessment processes in comparable end-of-life medical decision-making in Canada, the trial judge concluded that vulnerability can be assessed on an individual basis, using the procedures that physicians apply in their assessment of informed consent and decisional capacity in the context of medical decision-making more generally. Concerns about decisional capacity and vulnerability arise in all end-of-life medical decision-making. Logically speaking, there is no reason to think that the injured, ill and disabled who have the option to refuse or to request withdrawal of lifesaving or life-sustaining treatment, or who seek palliative sedation, are less vulnerable or less

⁵¹ Ibid, ¶¶110-113.

susceptible to biased decision-making than those who might seek more active assistance in dying. The risks that Canada describes are already part and parcel of our medical system.

The court concluded, at paragraph 116, “ ... the individual assessment of vulnerability (whatever its source) is implicitly condoned for life and death decision making in Canada”, and accepted that “it is possible for physicians, with due care and attention to the seriousness of the decision involved, to adequately assess decisional capacity”.

The Supreme Court of Canada unanimously declared that the absolute prohibition under the *Carter* Laws unjustifiably infringed s. 7 of the *Charter*:

127 The appropriate remedy is therefore a declaration that s. 241(b) and s. 14 of the *Criminal Code* are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. “Irremediable,” it should be added, does not require the patient to undertake treatments that are not acceptable to the individual....⁵²

The Court found it unnecessary to decide whether the laws also violated s. 15. The Court suspended its declaration of invalidity.⁵³

Summary

In summary, Supreme Court of Canada’s decision in *Carter* set the “floor” and not the “ceiling” of what is constitutionally required to meet the s. 7 rights of all Canadians. The “floor” is defined for a group of persons: those who are competent (to make a medical care decision to die); informed; adult; suffering intolerably from a grievous and irremediable (by reference to treatments acceptable to them) medical condition (illness, disease or disability); and acting voluntarily.

Parliament cannot now exclude a whole category of such persons – for example, the “mentally ill” – from their *Charter* right to physician assisted dying.

⁵² Ibid, ¶127.

⁵³ Ibid, ¶¶127-128.

Parliament is constitutionally entitled to require certain processes, such as the requirement for two or more doctors, and other safeguards to assess decisional capability for a defined group such as the “mentally ill”. However, it is unconstitutional for Parliament to redefine the group of persons who are constitutionally entitled to request MAID in such a way as to deny or exclude the persons that the Court included as having the right to assisted dying.

About the BC Civil Liberties Association

The objects of the British Columbia Civil Liberties Association ("BCCLA") include the defense and promotion of civil liberties and human rights in British Columbia and Canada.

In addition to the BCCLA’s long-standing interest in matters of patients’ rights and health policy, the BCCLA has been extensively involved in advocacy and education in respect to end of life choices, including MAID. The BCCLA was the institutional plaintiff in *Carter*, which successfully struck down ss. 241(b) and 14 of the *Criminal Code* as unjustifiably violating the *Charter*. One week after Bill C-14 was passed, the BCCLA challenged the new law on behalf of Julia Lamb. Joseph Arvay was lead counsel in both cases.

The BCCLA has consistently opposed the criminalization of assistance in dying, arguing that the principles of liberty, autonomy and equality, as well as the humanitarian commitment to preventing unnecessary suffering and to preserving the dignity of the individual, justify decriminalization.

BC Civil Liberties Association Contact Information:

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Attachment to BCCLA Brief (December 1, 2020): Affidavit of Brenda

This is the 1st affidavit
of Brenda [REDACTED] in this case
and it was made on 13 Dec 2018

No. S-165851
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

JULIA LAMB AND BRITISH COLUMBIA CIVIL LIBERTIES
ASSOCIATION

PLAINTIFFS

AND:

ATTORNEY GENERAL OF CANADA

DEFENDANT

AFFIDAVIT

I, **BRENDA** [REDACTED] retired teacher, of [REDACTED], Province
of [REDACTED], SWEAR (OR AFFIRM) THAT:

1. I have personal knowledge of the facts and matters hereinafter deposed to, save and except where same are stated to be made on information and belief, and so where stated, I verily believe them to be true.
2. I was born on [REDACTED] I have been married for 48 years to my husband [REDACTED], and we live in [REDACTED] [REDACTED]. We have three adult children. Before I had to stop working due to my illness, I was a teacher.
3. I have severe myalgic encephalomyelitis, which is also called chronic fatigue syndrome ("CFS") or systemic exertion intolerance disease ("SEID"). I also have chronic pain, although doctors who have treated me disagree as to how it should be classified.

First Symptoms and Progression

4. My chronic fatigue symptoms first appeared in January 2007, in the middle of a nine month road trip around North America with my husband and another couple. At the time we were in Florida visiting Disney World, I experienced a sudden and total loss of energy. I stopped dead in my tracks and was unable to move any further. It felt as though I had completely lost the energy to move the muscles in my legs. I sat down on a bench and waited about 30 minutes before getting up. When I did, I was only able to manage a walking shuffle. This experience repeated itself in subsequent days – it was as if I was completely running out of energy. For the remaining four months of the trip, I felt as though I could only move in slow motion, often choosing to stay behind the group in the hopes that the problem would resolve itself. It never did.

5. When I got back to [REDACTED] in April 2007, I went to my family physician, Dr. [REDACTED]. He was reluctant to make a diagnosis without further observation and assessment. I prepared to return to my teaching job in August 2007, but when school started I was only able to work for two weeks before overwhelming exhaustion forced me to take a leave of absence. I was on leave for the remainder of the semester. I tried to return to work in January 2008, but only managed one week. In April 2008, I was advised by Dr. [REDACTED] that I had CFS and I might never be able to return to teaching.

6. The pain began about a year later, sometime in March of 2009. The first type of pain I experienced was pelvic pain. At first, the pain would occur whenever I was sitting. Soon I could not sit for more than a few minutes before being forced to lie down. Then the pain became constant, such that it was there even when I was lying down. Over the last 10 years, pelvic pain has been my most persistent and predominant pain. I have not been able to sit for more than a few minutes since 2009. When I am in my wheelchair or in an appointment, and am required to sit, I sit on cold packs, which I store in the freezer.

7. In the spring of 2009, I began to experience facial pain. It started inside my mouth but then migrated to the outside of my cheeks. In the summer of 2009, I had to go to the emergency room with extreme stomach pain. Eventually various other parts of my body began to be affected. In 2012, I experienced for the first time a burning pain on the backs of my legs. This pain remitted, but then returned later, in 2016. In 2013, I developed a pressure sore on my right ear and began

using a foam pillow to sleep on. Shortly after that, pain in my neck and shoulders began. In 2014, I developed hip pain. In 2016, I started getting headaches behind my left eye. In February 2018, I developed a new pain in the right side of my scalp.

8. Although these different areas of pain have varied in their presence and intensity, I can safely say that since 2009, I have been struggling with some combination of pelvic, facial, stomach, back, neck, shoulder, leg, and/or foot pain at all times. From the moment I wake up in the morning to the time I go to sleep, there is always at least one – and usually more than one – part of my body that is affected with pain.

9. I rate my pain as either low, medium or high. I wake up every morning with pain on at least a low level, but it very rarely remains like that. On most days, by mid-afternoon, the pain has increased to a high level. Once the pain reaches a high level, it usually does not subside until I go to sleep. I take sleeping pills to fall asleep, as sleep is often my only source of relief.

Efforts at Treatment and Pain Management

10. Since the onset of my CFS symptoms in 2007, and my pain symptoms in 2008, I have consulted a long list of doctors to try to ascertain the cause of my symptoms. The process has been grueling and exhausting. The following is a list of the physicians or clinics I have seen along with the time period(s) during which I was under their care:

- a. General practitioner, Dr. [REDACTED] (1990s – present);
- b. Seattle Fibromyalgia and Fatigue Clinic (March and May 2009);
- c. Gastroenterologist, Dr. [REDACTED] (2008 – 2014);
- d. Neurologist, Dr. [REDACTED] (2009 - 2018);
- e. Gynecologist, Dr. [REDACTED] (October 2010);
- f. Internal medicine, Dr. [REDACTED] (October 2010);
- g. Pain Clinic, [REDACTED] [REDACTED] Hospital, 3 week program (November – December 2010);

- h. Lyme disease specialist, Dr. [REDACTED] (June – October 2011);
 - i. CFS specialist, Dr. [REDACTED] (December 2012 – November 2013);
 - j. Dr. [REDACTED], Complex Chronic Diseases Program (“CCDP”), B.C. Women’s Hospital (May 2013 – January 2014);
 - k. Rheumatologist, Dr. [REDACTED] (January 2016);
 - l. Neurosurgeon, Dr. [REDACTED] (May 2016);
 - m. Anaesthesiologist, Dr. [REDACTED], Pain Clinic, [REDACTED] Hospital (August 2016);
 - n. Internal medicine, Dr. [REDACTED], Vancouver General Hospital (April 2017);
 - o. Anaesthesiologist, Dr. [REDACTED], Helmcken Pain Clinic (June – July 2017);
 - p. Neurologist, Dr. [REDACTED], [REDACTED] Hospital (July 2017);
 - q. Urologist, Dr. [REDACTED] (May 2018);
 - r. Sexual medicine, Dr. [REDACTED] (May 2018);
 - s. Gynecologist, Dr. [REDACTED] (June 2018);
 - t. Urologist, Dr. [REDACTED] (June 2018); and,
 - u. Medical Assistance in Dying provider, Dr. [REDACTED], (November 2018).
11. I have tried every prescription and treatment that has been offered to me, with no significant results. By my count, I have tried over 80 different medications since 2007, including, but not limited to the following:
- a. Ciprofloxacin and metronidazole;
 - b. Oxycodone and hydromorphone;

- c. Tinidazole;
- d. Biaxin;
- e. Electroconvulsive therapy;
- f. Verapamil;
- g. Morphine;
- h. Tecta;
- i. Constella;
- j. BuTrans patches;
- k. T3 and T4 thyroxine;
- l. Gabapentin;
- m. Cortisone epidural (nerve block);
- n. Medical marijuana (CBD/THC);
- o. Xylocaine cream;
- p. Seroquel;
- q. Trazadone;
- r. Ativan;
- s. Venlafaxine; and,
- t. Zopiclone.

12. I have also sought treatment from various wellness practitioners, including physiotherapists, naturopaths, a chiropractor, a Chinese medicine practitioner, a psychologist and

counsellors, and massage therapists. Although I have experienced some minor relief from some of the treatments, my pain and fatigue have persisted on a daily basis.

13. No doctor has been able to determine a cause for my pain, despite numerous tests and trials to rule out various possibilities. For example, various doctors have ruled out the following possibilities as the source of my pelvic pain: an abscessed fistula, a swelling of my sit bones, pudendal nerve pain, arthritis, a gynecological issue, or a urology issue. MRIs have shown no visible explanation for the pain.

14. In June 2011, I was seen by Dr. [REDACTED] for a psychiatry consult. Dr. [REDACTED] told me she believed I have a somatoform disorder, meaning a mental illness in which my physical symptoms have no identifiable cause.

15. In May and June 2012, I agreed to be admitted to [REDACTED] Hospital for 47 days in order to try and rule out possible causes for my symptoms, including psychiatric causes. Among other things, I voluntarily underwent 11 sessions of electroconvulsive therapy ("ECT"), a drastic and extremely invasive procedure. Nothing was identified as a cause of my symptoms, and I was also found not to show any signs of major depressive disorder, anxiety disorder, or any other mood disorder.

16. In May and June 2013, I was assessed by Dr. [REDACTED] at the Complex Chronic Diseases Program at B.C. Women's Hospital in Vancouver. Dr. Bested diagnosed me with severe myalgic encephalomyelitis and with fibromyalgia.

17. In 2017, I returned to Dr. [REDACTED], a neurologist in [REDACTED] that I had consulted with in 2009. She was of the view that my chronic pain is neuropathic, and that my pelvic pain might be caused by a problem with the pudendal nerve. She referred me to Dr. [REDACTED], an anaesthesiologist who administered two pudendal nerve blocks. The effect of these was negligible, and my pain has persisted.

18. Although there is disagreement between my doctors about whether I have fibromyalgia, or some other type of pain condition, the reality is that I live each day with real pain, for which no cause or cure has been identified.

My Quality of Life

19. It has always seemed to me as though the term “chronic fatigue” does not accurately capture the debilitating symptoms of the disease, at least in the way that I experience it. My symptoms involve much more than just fatigue, at least in the ordinary sense of that word. “Fatigue” seems such an inappropriately benign word for the cause of such suffering.

20. Although I was never a “high energy” person, CFS makes it feel as though my body is thoroughly devoid of energy, making it impossible to accomplish most tasks. It is a challenge for me to walk, talk, and move. I gave up driving eight years ago, and it has been years since I was able to go to the store and buy groceries. I rely on my husband to do all of the cooking, kitchen cleanup and laundry. Any efforts I spend on simple tasks require vastly disproportionate time to recover from. If I exert myself, for example, by cleaning up after dinner, I will suffer the next day from extra exhaustion and extra pain. Accordingly, I spend the majority of every day lying flat on my back in bed, listening to audio books.

21. While I have never been depressed, the effort required to complete normal activities, even short phone conversations, seems to trigger a stress response in my body, which brings with it pain that seems quite unjustified. I take anti-anxiety medications like Ativan and Trazadone to avoid the pain by managing the stress.

22. Over the last 10 years, my most predominant pain has been my pelvic pain. If I try to sit up from my lying position, the pain returns quickly as a harsh, throbbing pain, beginning in the area of my lower pelvis and radiating down my left leg. I am currently also suffering very intense pain in my feet which is present at all times of the day, regardless of whether I am standing or lying down. When I walk, each step is painful. Stomach pain has also been a longstanding symptom of mine, and for the last week or so I have been experiencing it in a particularly severe form. I have also recently been suffering from breakthrough migraine headaches, despite taking the maximum dose of Verapamil every day.

23. I am exhausted by the pain that every day brings. Although I try to get up from bed once an hour to walk through the house, the attempts exacerbate my foot pain, which becomes unbearable very quickly and forces me to lie down again. I almost never leave the house, and if I

do have an appointment, my husband drives while I lie down in the back seat of the car. I almost never have company over, as I find the stress of visitors increases my pain for the remainder of the day. Even the effort required to be interviewed by phone for the purposes of this affidavit, in increments of 20 minutes, was very difficult for me and caused my pain to worsen afterwards.

24. Despite my condition, I have been told by my doctors that there is no reason to think that I will die any time soon.

My Request for Medical Assistance in Dying ("MAID")

25. Although my CFS makes my life extremely difficult, the pain is worse. After a decade of consultations, tests and treatments, all of my attempts have only proven that no one has any hope to offer me. I have reached my limit in terms of how much I am prepared to suffer, and have felt that way for about a year now. Having tried everything that has been offered to me by the worlds of medicine and alternative medicine, I can see no way around the pain. The thought of "living" even a few more months with my pain is absolutely overwhelming.

26. Although I knew there was a foreseeability of death requirement that would make me ineligible for MAID, I made a request to be assessed in November 2018. I felt that I needed to know for sure. Dr. [REDACTED] visited me at my home and, after assessing me, told me that I do not qualify because my natural death is not "reasonably foreseeable." Although her answer did not surprise me, it did reinforce the helpless feeling I have that there is no way out from under my suffering. I feel that the most that I can hope for at this point is to perhaps discover some new coping strategies to deal with my fatigue and pain.

27. I was recently referred to a neuropsychiatrist, Dr. [REDACTED]. Because of the number of other specialists I have already seen, the prospect of a new physician opinion at this point poses little more than an opportunity for disappointment.

28. I recently began reading about how to take my own life and I believe I have accumulated enough medication to do it. I fear, however, that I might not succeed and could somehow end up in an even worse situation than I am now. That possibility deters me. Although I do not fear death, I am terrified by the thought of life with additional pain.

29. Although clearly there must be some limits on who can access MAID, I find it incomprehensible that someone like me – who, despite best efforts, endures daily, debilitating pain with no hope of improvement - is ineligible. My conditions may not fit neatly within a category, and may not yet be well understood in the way some other illnesses such as cancer are, but my symptoms are real and are torturous. How can we call ourselves a humane society when I – and others like me – are forced to suffer?

SWORN (OR AFFIRMED) BEFORE ME)

at [REDACTED], British Columbia, on)

Dec 2018

A Commissioner for taking Affidavits for
British Columbia.

British Columbia.