BENCHMARK

INVITED SUBMISSION

# *Carter v. Canada (Attorney General)*: Will the Supreme Court of Canada's Decision on Physician-assisted Death Apply to Persons Suffering from Severe Mental Illness?

**Barbara Walker-Renshaw LLB***
**Margot Finley LLB****
**Borden Ladner Gervais LLP**
**Toronto, Canada**

*Barbara Walker-Renshaw is a partner in the Health Law Practice Group of Borden Ladner Gervais LLP, with a specialty practice in mental health law;

**Margot Finley is an associate in the Commercial Litigation Practice Group at Borden Ladner Gervais LLP, who was co-counsel to an intervener in Carter v. Canada (Attorney General) at the Supreme Court of Canada.

In February 2015, the Supreme Court of Canada found that the criminal prohibition on physician-assisted death is unconstitutional, in that it deprives competent adults who clearly consent to the termination of life, and who are suffering from a grievous and irremediable medical condition, of such assistance. The question has been asked whether the Court's decision will open the door to physician-assisted death only for those with physical illnesses, such as terminal cancer or neurodegenerative diseases, or whether those suffering from major mental illnesses, such as clinical depression, bipolar disorder, or schizophrenia, will also be able to access physician-assisted death.

In the mental health care context, will health care providers need to rise to the challenge of distinguishing between suicidal ideation and intent that is a symptom of pathology, of a treatable mental illness, on the one hand and suicidal ideation and intent that is, perhaps, a capable and thoughtful response to a "grievous and irremediable" condition, on the other?

Below we provide some context for that question and will outline in more detail what the Supreme Court of Canada decided in *Carter v. Canada (Attorney General),* and the possible ramifications of that decision for physicians and other healthcare providers working with those suffering from mental illness.

## Suicide and Mental Illness

According to Statistics Canada, mental illness is the most important risk factor for suicide. More than 90% of people who commit suicide have a mental or addictive disorder.[1] Even among those generally supportive of a right to physician-assisted death for those with a terminal illness, in which death is a natural or inevitable outcome of a treatment refractory disease process, there may be some reluctance to see an extension of assisted death to those suffering from treatment resistant mental illness, particularly because of the importance placed on suicide prevention in modern mental health treatment.[2] Psychiatrists trained to prevent suicide, for example, may be deeply reluctant to accept a patient's wish to end his or her life.

Some statistics include:

- Depression is the most common illness (60%) among those who die from suicide.[3]
- According to the Canadian Mental Health Association, from 20% to 60% of deaths by suicide occur among people who have a mood disorder.[4]
- There is a very high prevalence of suicide attempts in people with bipolar affective disorder (50%).[5] For those with bipolar depression, suicide risks are approximately 15 times higher than the general population.
- It is estimated that there is a 4 to 10% lifetime risk for suicide among persons with schizophrenia and a 40% lifetime risk of suicide attempts. A 1986 World Health Organization study found the most common cause of death in those with schizophrenia was suicide.[6] More recent studies suggest that the contribution of suicide to mortality for those with schizophrenia varies widely dependent on the age of the study cohort, length of follow up and type of study and may be underestimated.[7]


 (ISSN: 1916-2405)

- In recent years, the most common method of suicide in Canada has been hanging (44%), which includes strangulation and suffocation, poisoning (25%), and firearm use (16%).[8]

In Canada, we have yet to develop the legal framework governing physician-assisted death that will flow from the *Carter v. Canada* decision. However, in Belgium, where euthanasia was legalized in 2002,[9] it has been reported that people suffering from the following illnesses have been euthanized: autism, anorexia, borderline personality disorder, chronic-fatigue syndrome and manic depression.[10] In 2015, "thirteen percent of the Belgians who were euthanized did not have a terminal condition, and roughly three percent suffered from psychiatric disorders."[11] It is difficult to predict how many persons suffering from severe, treatment refractory mental illness will approach their attending psychiatrists to discuss a physician-assisted death, if such assistance was available to them. In the paragraphs that follow, we discuss whether the decision in *Carter v. Canada* could apply to persons suffering from severe mental illness.

## Decision of the Supreme Court of Canada in *Carter v. Canada (Attorney General)*

The *Criminal Code* prohibits anyone from consenting to death being inflicted upon them (section 14) and also prohibits anyone from aiding or abetting a person to commit suicide (section 241(b)). In 1993, the Supreme Court of Canada upheld the constitutionality of these provisions in *Rodriguez v. British Columbia* (Attorney General),[12] finding that the prohibition on assisted dying accorded with the principles of fundamental justice.

In *Carter v. Canada (Attorney General) ("Carter")*,[13] the plaintiffs also challenged the constitutional applicability and validity of these provisions. The plaintiffs were individuals who suffered from intractable and progressive diseases, specifically a fatal neurodegenerative disease, amyotrophic lateral sclerosis (ALS) and spinal stenosis, as well as those who sought to assist them in dying. They claimed that the criminal prohibitions on assisted death violated section 7 (the right to life, liberty, and security of the person) and section 15(1) (equality) of the *Charter of Rights and Freedoms.*[14]

After success before the B.C. Supreme Court [15] and disappointment in the B.C. Court of Appeal,[16] the plaintiffs, or appellants, were ultimately successful at the Supreme Court of Canada. The Supreme Court held that the absolute prohibitions on assisted dying in sections 14 and 241(b) of the *Criminal Code* deprive competent adults of their right to life, liberty, and security of the person, as guaranteed by section 7 of the *Charter,* in a manner that is not in accordance with the principles of fundamental justice, nor saved by section 1 of the *Charter* (the "reasonable limits" test). The Court held that these provisions are of no force or effect to the extent that 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 physical or psychological suffering that is intolerable to the individual in the circumstances of his or her condition.[17]

The Court held that the right to "life" in section 7 is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly.[18] The prohibition on assisted dying deprives some individuals of life, as it has the effect of forcing some individuals to take their own lives prematurely, often by dangerous or violent means, for fear that they will be incapable of doing so when they reach the point where suffering is intolerable.[19] The Court held that the absolute prohibition essentially creates a "duty to live" rather than a "right to life" and opined that this could call into question the legality of any consent to the withdrawal or the refusal of lifesaving or life-sustaining treatment. [20] Consequently, the Court concluded that the prohibition deprived some individuals of the right to life.

With respect to the "liberty and security of the person" interests under section 7, the Court stated that anyone who suffers intolerably as a result of a grievous and irremediable medical condition and pursues physician-assisted dying does so out of a deeply personal response to pain and suffering.[21] Such "fundamentally important and personal medical decision-making" is a matter critical to the values of dignity, personal integrity, and autonomy.[22] By denying the individual the opportunity to make that choice, the prohibition on assisted death impinges on liberty and security of the person.

The Court recognized that the law has long protected patient autonomy in medical decision making, and endorsed the "tenacious relevance in our legal system of the principle that competent individuals are – and should be – free to make decisions about their bodily integrity."[23] At the same time, the Court recognized that debate about this issue in the "public arena reflects the ongoing debate in the legislative sphere"; further, "[s]ome medical practitioners see legal change as a natural extension of the principle of patient autonomy, while others fear derogation from the principles of medical ethics."[24] Nonetheless, the Court ultimately ruled in favour of patient autonomy.

Having found that the appellants' section 7 rights were infringed, the Court determined that the infringement was not in accordance with the principles of fundamental justice, as required by section 7 of the Charter. The Court found that the prohibition on physician-assisted death was overbroad in that it catches people outside the class of persons the prohibition was designed to protect – namely, vulnerable individuals who may be induced to commit suicide in a time of "weakness."[25] In other words, the Court found that the prohibition not only affected the protected class, but also affected people who have reached a considered, rational, and persistent wish to end their own lives due to intractable suffering.[26]

The Court also held that the prohibition's breach of section 7 could not be justified under section 1 of the *Charter*. Section 1 of the *Charter* provides that a law may limit an otherwise guaranteed *Charter* right if that the limit is reasonable and demonstrably justified in a free and democratic society. At this stage of the analysis, the law requires the Government whose law has been found to violate a Charter right, to show that the law has a pressing and substantial object and that the means chosen to obtain that object are proportional to the object. [27]

In Carter, the Court found that the prohibition is rationally connected to the pressing and substantial objective of preventing people from taking their life at a time of weakness.[28] Nevertheless,

the Court again accepted the trial judge's factual findings that physicians are able to assess reliably the patient's competence and voluntariness of decision-making in this context.[29] Further, the Court accepted the trial judge's conclusion that it would be possible for physicians to apply the informed consent standard to patients who seek assistance in dying, adding the caution that physicians should ensure that patients are properly informed of their diagnosis and prognosis and the range of available options for medical care.[30] As a result, the absolute prohibition did not minimally impair the section 7 rights with which it interfered and could not be justified.

When the Supreme Court of Canada considered physician-assisted death in the 1993 case of *Rodriguez v. British Columbia*, there was no other Western democracy that expressly permitted assistance in dying. When the trial judge heard the *Carter* case in late 2011 and early 2012, the evidentiary record confirmed that by 2010, there were eight jurisdictions that permitted some form of assisted dying: the Netherlands, Belgium, Luxembourg, Switzerland, Colombia, and three US states: Oregon, Washington, and Montana.[31] The evidentiary record at trial in the Carter case was substantial. There were 116 affidavits filed, including the affidavits of 57 medical and academic experts. Some of the affidavits were hundreds of pages in length and attached secondary sources as exhibits. In addition, 18 witnesses were cross-examined on their affidavits, including 11 witnesses who were cross-examined on their affidavits before the trial judge.[32] Accordingly, the Supreme Court found that the "matrix of legislative and social facts in the [*Carter*] case differed from the evidence before the Court in *Rodriguez,*"[33] allowing the Court to depart from its earlier decision in *Rodriguez*.

## Will the *Carter* decision make physician-assisted death accessible for the Mentally Ill?

Although the Supreme Court opined that "euthanasia for … persons with psychiatric disorders" would not fall within the parameters for physician-assisted death suggested in its reasons,[34] the test articulated in the *Carter* decision leaves open the possibility that those suffering from severe mental illness may be eligible for physician-assisted death.

The Court's ruling makes it clear that, before assisted death may be accessible in any context, it must be confirmed that the capable adult seeking death (1) clearly consents to the termination of life; (2) has a grievous and irremediable condition; and (3) is enduring suffering that is intolerable to the individual in the circumstances of his or her condition.[35] Below we will consider whether these requirements can be met in the circumstance of individuals suffering from severe mental illness and make some additional comments on a particular remedy (4) that was made available to one of the plaintiffs at trial, insofar as that may provide guidance on how a legal framework for providing physician-assisted death may evolve in Canada.

### (1) Capacity to Consent

In order for an adult to "clearly consent to the termination of life", as required by *Carter*,[36] it is essential that the individual has the capacity to consent to the termination of his or her own life. Though mental illnesses may be characterized by alterations in thinking, mood, or behaviour associated with significant distress and impaired functioning,[37] an individual with mental illness is not necessarily incapable of making treatment or other decisions about his or her life. The well-established processes and practices for determining an individual's decision-making capacity with respect to treatment are analogous to the processes that may be required to assess capacity to consent to physician-assisted death.

In Ontario, the statutory test for capacity to consent to treatment has two branches: (1) the ability to understand information relevant to make a treatment decision and (2) the ability to appreciate the foreseeable consequences of a decision or of making no decision regarding the proposed treatment.[38] The Supreme Court affirmed this test in *Starson v. Swayze* and commented on it as follows: "the determination of capacity should begin with an inquiry into the patient's actual appreciation of the parameters of the decision being made: the nature and purpose of the proposed treatment; the foreseeable benefits and risks of treatment; the alternative courses of action available; and the expected consequences of not having the treatment." [39]

While the legal framework governing assisted death is yet to be established, we anticipate that individuals who have been found incapable of making treatment decisions are unlikely to meet a legal test that would determine capacity to "consent" to assisted death. It is possible, however, for an individual to be deeply depressed, for example, and also capable of making treatment decisions. That an individual suffers from a mental illness does not automatically mean he or she cannot "clearly consent to the termination of life", as required in the *Carter* decision.

### (2) Grievous and Irremediable Condition

The Court uses the phrase "grievous and irremediable" without defining those terms except to say that an "irremediable" condition does not require the patient to undertake treatments that are not acceptable to the individual.[40]

The majority of psychiatric disorders are, generally, not in and of themselves terminal.[41] It is possible, however, that certain symptoms of severe mental illness may lead to death by means other than suicide. For example, severe paranoia or hallucinations may interfere with the person's ability to maintain nutrition or hydration adequate to sustaining life. However, those consequences of the symptoms of mental illness are generally reversible with treatment. Accordingly, the disease process of mental illness may be distinguished from physical illnesses or diseases, such as incurable cancer or ALS, which will inevitably result in death. It is therefore important to consider whether the Supreme Court's decision in *Carter* incorporated an assumption as to the proximity or inevitability of death in its use of a "grievous and irremediable" condition as part of the test for when physician-assisted death would be accessible.

In their submissions at trial, the plaintiffs defined "grievous and irremediable" as follows:

1. A person is "grievously and irremediably ill" when he or she has a serious medical condition that has been diagnosed as such by a medical practitioner and which:

a. is without remedy, as determined by reference to treatment options acceptable to the person; and

b. causes the person enduring physical, psychological, or psychosocial suffering that:

i. is intolerable to that person; and

ii. cannot be alleviated by any medical treatment acceptable to that person.

2. A "medical condition" means an illness, disease, or disability, and includes a disability arising from traumatic injury.[42]

The Supreme Court adopted the term "grievous and irremediable" and did not distinguish its use of the term from that of the plaintiffs. This understanding of a "grievous and irremediable" illness suggests that the illness, disease, or disability referred to in *Carter* does not need to be terminal to the individual for physician-assisted death to be available. It appears to focus more on whether the medical condition can be remedied by means acceptable and tolerable to the individual rather than whether the medical condition will result in death. It is arguable that this subjective component of the grievous and irremediable test could arise with some frequency in the mental health care context, where pharmacological treatment can be life long and impose a significant side effect burden on the patient.

The "irremediable" requirement means that the individual's condition must be one that cannot be improved. It could be argued that "it is essentially impossible to describe any psychiatric illness as incurable"[43] given the evolving state of mental health research and the difficulty predicting whether therapy will produce a response or whether a patient will undergo remission. As with individuals suffering from cancer or a degenerative illness, decisions in the mental health context will have to be made on an individual basis based on the state of clinical knowledge at the time the decision is made and the history of the individual patient with respect to the efficacy and tolerability of treatment options.

**(3) Intolerable Suffering**

The Supreme Court's decision covers those persons with 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."[44] It is obvious that mental illness can cause considerable, enduring suffering.

The Court does not distinguish physical suffering from psychological suffering or elevate one kind of pain over another. This is consistent with the Court's past jurisprudence, referenced in *Carter*, in which the Court has found that the right to "security of the person" under section 7 of the *Charter* is "engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering". [45]

**(4) Remedy**

In addition to finding the current Criminal Code provisions prohibiting physician-assisted death to be unconstitutional, it is interesting to consider a remedy provided by the trial judge to one of the litigants at trial. For a plaintiff who was suffering from ALS, the trial judge carved out a constitutional exemption that would allow her to obtain a physician-assisted death if certain conditions were met, one of which was that her attending physician and a consulting psychiatrist would each attest that she was competent and that her request for physician-assisted death was voluntary and non-ambivalent. If the conditions were met, the plaintiff could apply to a judge for a court order for a physician-assisted death at the time of her choosing, provided that at the material time, she is:

i. 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; and

ii. competent, and voluntarily seeking a physician-assisted death, in the opinion of the assisting physician and a consulting psychiatrist.

Finally, the trial judge ordered that if the plaintiff were to seek and obtain a physician-assisted death, the assisting physician would be authorized to complete her death certificate indicating that her underlying illness – ALS – was the cause of her death.[46] The appellants asked the Supreme Court to create a mechanism for further exemptions during the period in which the finding of constitutional invalidity was suspended. The Court declined to do so as the plaintiff who had asked for and received a constitutional exemption at trial had since passed away and none of the other individual appellants had sought one. [47]

## Conclusion

The stated goal of the criminal prohibition on assisted death is to protect vulnerable persons from being induced to commit suicide at a time of "weakness".[48] Indeed, some disability advocates have opposed the legalization of assisted dying on the basis that it "implicitly devalues their lives and renders them vulnerable to unwanted assistance in dying, as medical professionals assume that a disabled patient 'leans towards death at a sharper angle than the acutely ill — but otherwise non disabled — patient'". [49] If assisted death is made accessible to those suffering from grievous and irremediable mental illness, the same argument could be made that such individuals may feel that it is more acceptable to choose death. No less than a person suffering from a physically degenerative illness, however, the vulnerability of a person suffering from a severe mental illness can be assessed on an individual basis, using the procedures that physicians apply in their assessment of informed consent and decision making capacity in the context of medical decision making more generally. [50]

If physician-assisted death becomes an accepted practice in mental health care, how will that be reconciled with the well-established impetus in mental health care to prevent suicide? Under Ontario's *Mental Health Act*, a physician performing a psychiatric assessment "shall admit" the person to a psychiatric facility on an involuntary basis if the person meets certain criteria, including risk of serious bodily harm to the person, often demonstrated by suicidal ideation or intent.

The underlying policy rationale of suicide prevention through involuntary admission to a psychiatric facility is essentially one of compassion and beneficence; that is, promoting what is best for the patient in order to protect the patient's risk of death, to relieve their mental suffering, and to improve the patient's quality of life over the long term. By providing for involuntary admission, the mental health care system has valued beneficence over autonomy where there is a likelihood that the patient's mental disorder is of a nature or quality that will result in serious bodily harm to the patient.[51] Balancing beneficence with respect for a patient's autonomy is a familiar and frequent tension in mental health and a key issue in considering whether physician-assisted death should be accessible to those suffering from psychiatric disorders.

As the trial judge in the *Carter* decision noted, "[e]thics is a discipline consisting of rational inquiry into questions of right and wrong; in this case, whether it is right, or wrong, to assist persons who request assistance in ending their lives and if it is right to do so, in what circumstances."[52] The trial judge expressly recognized that the ethical debate about physician-assisted death is relevant given that "both legal and constitutional principles are derived from and shaped by societal values." [53]

If the goals of assisted death are to prevent suffering and value patient autonomy in medical decision-making, it may be difficult to find a principled basis to distinguish those suffering from a mental illness from those experiencing illnesses such as terminal cancer or ALS. It is well-established that current palliative care practice aimed at pain relief often has the effect of hastening death, where death is inevitable. Can it be said that death is inevitable in cases of severe mental illness? Should the inevitability of death be a criteria in Canada's future legal framework governing physician-assisted death, or will that deny those suffering from severe, treatment resistant mental illness relief from what they might genuinely experience as unbearable suffering?

The "recovery principle" has been accepted as a guiding framework for mental health care in Canada.[54] It promotes patient autonomy and choice, and also seeks to ensure that persons with mental disorders have the same rights and access to care as persons with other conditions. The Mental Health Commission of Canada notes that the concept of recovery also refers to living a satisfying, hopeful, and contributing life, even when mental health problems and mental illnesses cause ongoing limitations.[55] It is challenging to reconcile the concept of a hopeful and contributing life with a request for physician-assisted death, but insofar as the recovery movement embodies patient autonomy, dignity, and inclusion, it is arguable that recovery includes accessibility to all forms of assistance and care. If physician-assisted death becomes part of the continuum of care for persons suffering from physical conditions such as terminal cancer or ALS, on what ethical basis can that care be denied to those capable patients suffering intolerably from a grievous and irremediable mental illness? Would prohibiting the availability of physician-assisted death for capable persons suffering intolerably from severe, treatment refractory mental illness be just another form of stigmatizing mentally ill persons?

In some jurisdictions where physician-assisted death has been legalized, regulations prohibit the practice where the patient may be suffering from a psychiatric or psychological disorder, such as depression, which may impair judgment,[56] and thus affect capacity to consent to physician-assisted death. Indeed, as noted above, the Supreme Court of Canada stated that "persons with psychiatric disorders" "would not fall within the parameters" suggested by the reasons in *Carter*. [57]

Despite that comment in the *Carter* decision and given its focus on grievous, irremediable conditions and intolerable suffering, the test formulated by the Supreme Court of Canada in *Carter* leaves open the possibility that it would be unconstitutional to bar a capable adult from making the fundamentally important and personal medical decision that he or she can no longer tolerate the irremediable suffering of a treatment-resistant, severe mental illness.

***Footnotes***

1. Statistics Canada Catalogue no. 82-624-X, Tanya Navaneelan, Modified 2012-07-25; http://www.statcan.gc.ca/pub/82-624-x/2012001/article/11696-eng.htm (accessed September, 2015) ("Statistics Canada")

2. Mental Health Commission of Canada, Changing Directions, Changing Lives: The Mental Health Strategy for Canada, http://www.mentalhealthcommission.ca/English/system/files/private/MHStrategy_Strategy_ENG_0.pdf, p. 17 (accessed September, 2015)

3. Statistics Canada, *supra*

4. Canadian Mental Health Association, The Relationship between Suicide and Mental Illness, http://toronto.cmha.ca/mental_health/the-relationship-between-suicide-and-mental-illness/ (accessed September 2015) ("CMHA")

5. CMHA, *supra*

6. CMHA, supra

7. Chris J. Bushe et al., "Mortality in schizophrenia: a measurable clinical endpoint" J Psychopharmacol. 2010 Nov; 23 (4 supplement): 17-25; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2951589/ (accessed September 2015). Studies that recruit first-episode patients will measure suicide mortality with greater accuracy whereas studies that include populations aged over 40–50 years are more likely to detect cancer cases. In contrast, studies that follow patients outside these age parameters may underestimate these causes of mortality (Bushe et al.)

8. Statistics Canada, *supra*

9. Jan L. Bernheim et al. "Development of palliative care and legalisation of euthanasia: antagonism or synergy?", BMJ 2008 Apr 19; 336 (7649): 864-867

10. Rachel Aviv, "The Death Treatment: When should people with a non-terminal illness be helped to die?" *The New Yorker*, June 22, 2015, http://www.newyorker/com/magazine/2015/06/22/the-death-treatment. (accessed September 2015)("Aviv")

11. Aviv, *supra*

12. [1993] 3 SCR 519

13. [2015] 1 SCR 331 ("*Carter*")

14. The Supreme Court did not find it necessary to consider the s. 15 argument, having concluded that the prohibition violates s. 7.

15. 2012 BCSC 886 ("*Carter*, BCSC")

16. 2013 BCCA 435 ("*Carter*, BCCA")

17. *Carter*, para. 147

18. *Carter*, para. 62; This is consistent with the Court's consideration of the right to life in *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791 and *Canada (Attorney General) v. PHS Community Services Society*, [2011] 3 S.C.R. 134

19. *Carter*, paras. 1, 57

20. *Carter*, para. 63

21. *Carter*, para. 68

22. *Carter*, paras. 30, 65-66

23. *Carter*, para. 67

24. *Carter*, para. 10

25. *Carter*, para. 76, citing *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, at 595; this purpose is restated at paras. 78, 84, 86, 99, and 101. In our view, the Court uses the word weakness to connote vulnerability related to impaired decision making arising from the person's medical or mental condition.

26. *Carter*, para. 86

27. *Carter*, para. 94

28. *Carter*, paras. 74, 84

29. *Carter*, paras. 27, 104, 106

30. *Carter*, paras. 27, 104, 106

31. *Carter*, para. 8; see also *Carter BSCS*, paras. 389-620 for a detailed review of the eight jurisdictions that the court considered, where some form of physician assisted death was permitted. Note that in the US state of Montana, there is no legislation expressly governing physician assisted suicide, rather its Montana's Supreme Court has recognized that the consent of a terminally ill patient can constitute a statutory defence to a charge of homicide against an aiding physician (*Carter, BCSC*, paras. 613-6170). Since 2010, the US state of Vermont legalized assisted dying in 2013 (see Aviv, *supra* note 10), and in October 2015, the state of California passed legislation providing for physician-assisted death for treatment capable adults who have been diagnosed with a terminal disease: the *End of Life Options Act*. The Act defines "terminal disease" as an "incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months".

32. *Carter BCSC*, paras. 113 and 160.

33. *Carter*, para. 47

34. *Carter*, para. 111

35. *Carter*, para. 147

36. *Carter*, paras. 4, 127

37. Public Health Agency of Canada, Mental Illness, http://www.phac-aspc.gc.ca/cd-mc/mi-mm/index-eng.php (accessed September, 2015)

38. *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch. A, s. 4.

39. *Starson v. Swayze*, [2003] 1 S.C.R. 722, para. 80

40. *Carter*, para. 127

41. Eating disorders such as bulimia nervosa and anorexia nervosa, for example, can lead to death if untreated.

42. *Carter BCSC*, para. 24; emphasis added

43. Brendan D. Kelly and Declan M. McLoughlin, "Euthanasia, Assisted suicide and psychiatry: a Pandora's box", The British Journal of Psychiatry Oct 2002, 181 (4) 278-279

44. *Carter*, para. 147

45. *Carter*, para. 64

46. *Carter BCSC*, paras. 1413- 1415

47. *Carter*, para. 129

48. *Carter*, para. 74; *supra* note 25

49. *Carter*, para. 10

50. *Carter*, para. 106

51. *Mental Health Act*, R.S.O. 1990, c. M.7, ss. 20(1.1) and 20(5).

52. *Carter BCSC*, para. 164

53. *Carter BCSC*, para. 317

54. See, e.g. Canadian Mental Health Association, https://ontario.cmha.ca/mental-health/mental-health-conditions/recovery/ (accessed September, 2015)

55. Mental Health Commission of Canada, Guidelines for Recovery-Oriented Practice, http://www.mentalhealthcommission.ca/English/issues/recovery (accessed September 2015).

56. *Carter BCSC*, at para. 681, referring to Oregon's law on physician-assisted death.

57. *Carter*, para. 111

---

***Acknowledgements:***

*The authors are grateful to the following persons for their helpful comments on an earlier draft of this article:* Daphne Jarvis, Partner, Borden Ladner Gervais LLP; Dr. Phil Klassen, Vice-President Medical Services, Ontario Shores Centre for Mental Health Sciences; and Dr. Ian Dawe, Physician-in-Chief, Ontario Shores Centre for Mental Health Sciences. All opinions, errors, and omissions are the authors' own.

***Competing interests:*** *none*

***Address for correspondence:*** *bwalkerrenshaw@blg.com*

***Date of publication:*** *November 20, 2015*