Grievous and Irremediable in Bill C-14:
Why "advanced state of irreversible decline" and death being "reasonably foreseeable"
are both consistent with *Carter* and *Charter* compliant

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Bill C-14, in the proposed s. 241.2(2), provides the following definition of grievous and irremediable medical condition:

(2) A person has a grievous and irremediable medical condition if
(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.

Subsections (b) and (d) are very contentious, and there will undoubtedly be amendments proposed to delete them. I am writing to urge Parliament NOT to delete them because they are both consistent with *Carter v Canada (Attorney General)*, [2015] 1 SCR 331, and compliant with the *Charter* as being required to protect the vulnerable.

Consistency with *Carter*

The language in proposed subsections 241.2(2)(b) and (d) is not incorporated into the suspended declaration of invalidity in *Carter*. Jocelyn Downie concludes: "Access through the Bill therefore falls below the bare minimum established by *Carter*."[1] It is an extraordinary claim that judicial silence ties Parliament's hands, a claim that does not withstand careful scrutiny.

Subsection (b) parallels the language incorporated by Justice Smith at trial in her declaration of invalidity, stipulating "advanced weakening capacities with no chance of improvement" (2012 BCSC 886, para. 1393(a) and (b)). Although this language was not explicitly adopted by the SCC judges, they did not disavow it either. Indeed, the SCC judges did not even acknowledge that she said it. In not commenting at all, the SCC cannot be said to have pronounced on the issue. The SCC was at the very least leaving it open to Parliament to adopt such a limitation, which one presumes Justice Smith included to cover people such as Kay Carter.

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[1] Jocelyn Downie, "Bouquets and brickbats for the proposed assisted dying legislation" April 20, 2016, *Policy Options*, http://policyoptions.irpp.org/magazines/april-2016/bouquets-and-brickbats-for-the-proposed-assisted-dying-legislation/.

Similarly, although the SCC *Carter* suspended declaration of invalidity does not include any language stipulating "natural death has become reasonably foreseeable" as in proposed s. 241.2(2)(d), the Court made no pronouncement against such a limitation. In canvassing the international and Quebec experience with regimes of medical assistance in dying, which vary as to whether a patient must in any sense be dying to be eligible, the SCC did not weigh the pros and cons of such a limitation. The SCC's suspended declaration of invalidity is not a declaration at large – it is a declaration against an absolute ban on physician-assisted suicide. It is not a declaration against any future regime of assisted death with safeguards. The SCC specifically limited the scope of its declaration:

> The scope of the declaration is intended to respond to the factual circumstances of this case. We make no pronouncements on other situations where physician-assisted suicide may be sought. (para. 127)

The SCC prefaced its declaration of invalidity by noting "that the impugned laws infringe the rights of people like Ms. Taylor" (para. 126). The Court did not specify which factual circumstances were relevant. It is clear that neither Gloria Taylor's gender nor race was relevant to her right to physician-assisted death, but one would be hard-pressed to say that the fact the she was dying was not a relevant circumstance.

In its January 15, 2016 decision on the extension of the suspended declaration of invalidity, the SCC made a point to "not be taken as expressing any view as to the validity of the [Quebec] *ARELC* [*Act Respecting End-of-Life Care*]" (2016 SCC 4, para. 4) which includes the stipulation of "advanced state of irreversible decline in capability" and is limited to "end of life" situations. The Court's lack of comment is unsurprising, given that the Quebec legislation was not squarely before it, but it does underscore that such limitations are an open question.

Protection of the Vulnerable

In suspending the declaration of invalidity initially for twelve months, and ultimately for sixteen months, the SCC recognized that "Complex regulatory regimes are better created by Parliament than by the courts" (*Carter* 2015, para. 125). The SCC recognized in *Carter 2015* that deference is owed to Parliament, especially in the circumstance where, as with physician-assisted death, the objective pursued by Parliament implicates constitutionally protected rights (para. 95). The protection of the vulnerable "from being induced to commit suicide at a time of weakness" (*Carter* 2015, para. 74) is the protection of rights of those who, by definition, are not well placed to advance their own rights. The SCC did not elaborate on what Parliament would need to do to meet its constitutional obligations to protect the vulnerable from error and/or abuse, beyond saying that an absolute ban on physician-assisted death was not a proportionate balance between competing constitutional rights.

In *Carter* 2015 the absolute ban on physician-assisted death was found to run afoul of overbreadth as a principle of fundamental justice because the challenged provision "bears no relation to the purpose" or has "no connection with the mischief contemplated by the legislation" (*Carter 2015*, para. 85). In contrast, the proposed subsections 241.2(2)(b) and (d) are important in designing safeguards against error and abuse. If there is no state of irreversible decline in capability and death by natural causes is not reasonably foreseeable, the consequences of potential error are substantially magnified compared to hastening death by a relatively short time.

Without the limitations of subsections (b) and (d), physician-assisted death will foreclose over a long period the possibility of the person changing their mind. The odds of a transitory suicidal wish being determinative increase. The opportunities escalate for assessments being distorted by notions of a disabled life not being worth living. Thus vulnerability concerns are substantially magnified if physician-assisted death is not limited as in subsections (b) and (d), and thus would weigh more heavily in the balance. Challengers would not be able to say that subsections (b) and (d) bear "no relation" or "no connection" to the objective of protecting the vulnerable so as to be contrary to the principles of fundamental justice as overbroad. Nor could these stipulations be considered grossly disproportionate.

In the alternative, moving to s. 1 of the *Charter* respecting reasonable limits, where the focus shifts away from the individual claimant, the difficulty in identifying the vulnerable was recognized in *Carter 2015* as an important consideration (para. 88). The SCC said "theoretical or speculative fear cannot justify an absolute prohibition" (para. 119). Moving from an absolute ban to the stipulation in the proposed s. 241.2(2) is the type of "less harmful means" that are "reasonably tailored to the objective" (para. 102) so as to pass the minimal impairment step under s. 1. The greater concerns about vulnerability would also preclude deleterious effects from outweighing salutary effects. Thus proposed s. 241.2(2) would be a proportionate balancing.

It is argued that "reasonably foreseeable" is too vague.[2] However, that term incorporates the flexibility necessary[3] to deal with the reality that predictions as to the timing of death are notoriously unreliable. The basic question is whether medical assistance in dying should be limited to those who are in some sense dying from natural causes.

If subsections 241.2(2)(b) and (d) were deleted, physician-assisted dying would be so wide open that the chances increase substantially of people dying who would not choose death if they fully appreciated other options. It is one thing to say that the person is dying and wants state sanctioned help to choose the manner and exact timing of death. It is quite another to say that someone is in no sense dying, who probably has a long life ahead of them during which any current wish to die could change, should get state sanctioned help to die early. Vulnerability is potentially a concern for any physician-assisted death (hence the need for other safeguards), but those concerns go way up for people who are not in any sense dying. Thus subsections (b) and (d) are necessary in furthering the important public policy of suicide prevention.

Conclusion

Carter puts the onus on Parliament to craft a regime that provides equitable access to physician-assisted death. At the same time, it places on Parliament a responsibility to incorporate sufficient safeguards to protect the constitutional rights of the vulnerable. With competing constitutional rights, it is not open to Parliament to pursue one to the exclusion of the other – that was ultimately the downfall of an absolute ban on physician-assisted death.

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[2] *Ibid.*

[3] As an exception to what would otherwise be a crime, doubt should be resolved in favour of those claiming the applicability of the provision.