The parameters of a *Charter* compliant response to *Carter v. Canada (Attorney General)*, 2015 SCC 5

Dianne Pothier[1]
Professor Emeritus
Schulich School of Law at Dalhousie University
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Introduction

The Supreme Court of Canada's remedy in *Carter* was a declaration of invalidity:

> Section 241(b) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and 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 suffering that is intolerable to the individual in the circumstances of his or her condition. (paras. 127 and 147)

The Court suspended its declaration of invalidity in *Carter*, initially for twelve months, and ultimately for sixteen months, because it recognized the complexity of the issues to be resolved. What the SCC found unconstitutional, and needs to be replaced, is an absolute ban on physician-assisted death.[2] This leaves significant room for Parliament to choose what safeguards are necessary to protect the vulnerable. As the Court said: "Complex regulatory regimes are better created by Parliament than by the courts." (para. 125) As the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying said in its *Final Report* (November 30, 2015): "Although the Supreme Court did not outline the framework for such a system [of safeguards] in the *Carter* decision, it expressed confidence that such a system could be implemented in Canada." (p. 15)

The overlap of federal criminal law jurisdiction and provincial health jurisdiction raises the possibility of conflicting legislation. If the *Criminal Code* is stricter than provincial legislation, reliance on provincial legislation will not avail in a criminal prosecution.[3] If the

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[1] Dianne Pothier, BA. (Dalhousie, 1975), MA (Carleton, 1978), LLB (Dalhousie, 1982) is a Professor Emeritus of the Schulich School of Law at Dalhousie University, having been a member of the law faculty from 1986 to 2012. Areas of specialization include: constitutional, public, labour, human rights, equality, and disability. Previous employment includes being legal counsel to the Canada Labour Relations Board (1984-1986), a Supreme Court of Canada law clerk (1983) and a Parliamentary Intern (1975-76). Publications include being the co-editor, along with Richard Devlin, of Critical Disability Theory: Essays in Philosophy, Politics, Policy and Law, published by UBC Press in 2006.

[2] An absolute ban on physician-assisted suicide could be maintained through the use of a s. 33 override, the *Charter's* notwithstanding clause, but I understand that such is not currently in the contemplation of Canadian legislators.

[3] Hence the significance of Quebec being exempted from the four month extension of the suspended declaration of invalidity in *Carter* (January 15, 2016). While the *Criminal Code* absolute prohibition on assisted suicide remained in force during the suspension of the declaration of invalidity, an act of physician-assisted death in accordance with Quebec's *An Act respecting end-of-life care*, S.Q. 2014, c. 2, in force 10 December 2015, would be subject to

provincial legislation is stricter than the criminal law, the lack of criminal liability would not preclude professional discipline under provincial legislation, meaning the access contemplated under the criminal law would be thwarted. There is thus a high premium on harmonizing federal and provincial law.[4]

The *Final Report* of the External Panel on Options for a Legislative Response to *Carter v. Canada* (15 December 2015) set out the vastly divergent positions of a broad range of stakeholders; many choices have to be made. There is significant pressure to amend the *Criminal Code* by 6 June 2016, when the suspension of the declaration of invalidity will expire, in order that a system of safeguards under the criminal law be in place. However, nothing done as of 6 June 2016 is cast in stone. Adjustments based on reconsideration and/or experience will always be possible. Legislating in stages is also an option.

In what follows I will explain why, in my assessment, it is consistent with *Carter* to (1) limit physician-assisted death to end-of-life conditions; (2) include a mechanism of prior review beyond doctors` assessments; (3) preclude reliance on advance directives; and (4) limit availability to those 18 and over.

Some Preliminary Observations

One mistake that is commonly made, even by Supreme Court of Canada judges, relates to the legality of suicide and attempted suicide. In commenting on *Rodriguez v. Canada (Attorney General)*, [1993] 3 S.C.R. 519, Justice La Forest said that the "prohibition against assisted suicide …was upheld despite the fact that suicide itself was, and is at present, not illegal in this country; *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199, at 263. To describe suicide as "at present, not illegal" suggests that it could become illegal, but such a notion is illogical. If suicide is successful, the person is dead, and we do not prosecute dead people. Suicide never has been, nor could ever be, illegal. What used to be illegal, but no longer is, is attempted suicide. The decriminalization of attempted suicide should not, however, be seen as embracing a legal right to die. Rather it represents compassionate recognition that if things are bad enough that someone is attempting suicide, they do not need the extra burden of a criminal prosecution. The decriminalization of attempted suicide has not diminished the significance of suicide prevention as important public policy. For example, the fact of disproportionately high suicide rates among Aboriginal youth or gay, lesbian, and transgender youth, does not lead anyone to celebrate that they are exercising their legal right to die. It is in that context that it must be appreciated that the basis for a constitutional right to physician-assisted death is a constrained right, not an unqualified right to autonomy over life and death. The involvement of third parties, and the sanction of the state, raise issues beyond individual autonomy.

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criminal prosecution. The majority's lifting of the suspension in Quebec effective January 15, 2016 avoids any conflict. The dissent on the January 15, 2016 motion decision, in not lifting the suspension for Quebec, thought it was sufficient to rely on the province`s public commitment to prosecutorial discretion not to prosecute.

[4] One manner of avoiding conflict is for the federal criminal law to referentially incorporate provincial law, such that compliance with provincial law would not constitute a crime. See, e.g. *R. v. Furtney*, [1991] 3 S.C.R. 89.

Competing Constitutional Rights

The SCC recognized in *Carter* 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 is the protection of rights of those who, by definition, are not well placed to advance their own rights. Thus Parliament needs to design safeguards with care. As the Supreme Court of Canada said: "We agree with the trial judge that the risks associated with physician-assisted death can be limited through a carefully designed and monitored system of safeguards." (end of para. 117)

At the outset the Supreme Court of Canada identified the issues at stake in *Carter*: "This is a question that asks us to balance competing values of great importance. On the one hand stands the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable." (para. 2) Because the only issue before it was the constitutional validity of an absolute ban on assisted suicide, the Court 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 was not a proportionate balance between competing constitutional rights.

In responding to *Carter*, Parliament and legislatures need to be mindful of possible future constitutional challenges. If it is alleged that there is insufficient access to physician-assisted death, individual claimants seeking physician-assisted death can come forward. On the other hand, a challenge that physician-assisted death is too easily available is a more complex claim to bring. A claim that the constitutional rights of the vulnerable are being violated would not likely properly be brought by an individual. Individuals opposed to physician-assisted death for themselves would not need litigation to vindicate that position; under any system of physician-assisted death an individual can just say no. Where the challenge is on behalf of the vulnerable who are not in a position to just say no, it would need to be public interest litigation.[5] Nonetheless, the problem in identifying individual litigants does not make the constitutional rights of the vulnerable any less real.

The fact that competing constitutional rights are at stake in the context of physician-assisted death makes it different from *R. v. Morgentaler*, [1988] 1 S.C.R. 30. In 1988 the SCC did not say there could be no criminal prohibition of any sort against abortion. All who found a

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[5] A disability organization should have no difficulty meeting the test for public interest standing set out in *Canada (Attorney General) v. Downtown Eastside Sex Workers United Against Violence Society*, [2012] 2 S.C.R. 524:

> [37] In exercising the discretion to grant public interest standing, the court must consider three factors: (1) whether there is a serious justiciable issue raised; (2) whether the plaintiff has a real stake or a genuine interest in it; and (3) whether, in all the circumstances, the proposed suit is a reasonable and effective way to bring the issue before the courts:

s. 7 *Charter* breach assumed there could be some criminal prohibitions against abortion to advance a state interest in the protection of the foetus. But there is no requirement to do so, because of the implicit assumption, in cases such as *Borowski v. Canada (Attorney General)*, [1989] 1 S.C.R. 342 and *Tremblay v. Daigle*, [1989] 2 S.C.R. 530, that the foetus does not count within everyone under s. 7, and so the foetus has no *Charter* rights. The fact that we have had no criminal prohibition against abortion for almost 30 years has not been susceptible to constitutional challenge because a woman's reproductive choice is the only constitutional claim at stake. Continuing problems related to access to abortion beyond the criminal law likewise do not have any *Charter* claims competing with a woman's reproductive choice. (Conscientious objections by those opposed to performing abortions are not the source of access problems.) In contrast to the abortion context, those vulnerable under a regime of physician-assisted death do have constitutional rights that Parliament cannot ignore. If Parliament were to ignore the vulnerable by having insufficient safeguards, that becomes open to a constitutional challenge from the other end compared to *Carter*.

Where s. 1 limitations have been upheld in the pursuit of non-constitutional objectives, legislatures are at liberty to later abandon pursuit of such non-constitutional interests. For example, in *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713 Sunday closing requirements were upheld, despite infringement of the freedom of religion of those observing a Saturday Sabbath, in the interests of a common pause day (employees having the same day off as family and friends). Since then the interests of retailers and shoppers in Sunday opening have prevailed, with the pursuit of a common pause day giving way. With no constitutional right to a common pause day, that change in legislative policy has been not been susceptible to challenge. In contrast, failing adequately to protect vulnerable persons in a physician-assisted death regime would be susceptible to constitutional challenge.

In *Carter*, the constitutional challenge was based on both s. 7 and s. 15 of the *Charter*. Having found a violation of s. 7, a deprivation of life, liberty, and security of the person not in accordance with the principles of fundamental justice, the SCC did not deal with the s. 15 equality claim (para. 93). A challenge based on the constitutional rights of the vulnerable could likewise be based on either s. 7 or s. 15. The arguments based on s. 15 are more compelling. Reliance on s. 15 is preferable because of the comparative nature of an equality claim, i.e. that the law is more burdensome on some compared to others. That is the essence of a claim on behalf of the vulnerable. The claim is discrimination on the basis of the enumerated grounds of age, mental or physical disability, as well as the analogous ground of vulnerability. Moreover an equality claim is more amenable to a systemic approach, incorporating the collective responsibility of society, beyond an individual autonomy analysis.

The context of competing constitutional claims means there are two kinds of questions in the aftermath of *Carter* concerning the safeguards in a regime of physician-assisted death. One type of question is what kinds of safeguards are <u>permissible</u>, consistent with *Carter*. The other type of question is what kinds of safeguards are <u>required</u> to protect the rights of the vulnerable. The SCC to some extent dealt with the former in *Carter*, but, given the nature of the claim before it, did not address the latter. Anything that would be required to protect the vulnerable must be permissible, consistent with *Carter*. Things not absolutely required to protect the vulnerable could still be permissible.

Given that *Carter* only analysed a claim by those seeking a constitutional right to physician-assisted death, I will not pursue the details of a counter constitutional claim on behalf of the vulnerable. However, the context of competing constitutional claims underscores the importance of safeguards to protect the vulnerable, even where only analysed as the objective underlying limits on the right to life, liberty and security of the person.

Assessing Safeguards

A proportionate balance between competing *Charter* claims clearly requires that physician-assisted death be available. Any safeguards cannot make access to physician-assisted death illusory (Dickson C.J. in *Morgentaler*). In assessing safeguards, both the principles of fundamental justice and the stipulations of s. 1 of the *Charter* need to be scrutinized carefully. It must be remembered that the Supreme Court of Canada's analysis was in the context of an absolute ban on assisted suicide, and it made no effort to detail what a constitutionally valid regime of safeguards could entail, leaving that determination to Parliament. That is typical. When the Court finds legislation to be unconstitutional, the analysis of the flaws of the legislation will give some hints as to how it can properly be drafted, but not provide detailed prescriptions. An exception was *Charkaoui v. Canada (Citizenship and Immigration)*, [2007] 1 S.C.R. 350, where the SCC gave quite detailed indications of how a security certificate regime could pass muster under s. 1 of the *Charter*. *Carter* does not offer such detailed prescriptions. Nonetheless, *Charkaoui* is an important reminder that s. 7 breaches can be justified under s. 1 "in extraordinary circumstances where concerns are grave and the challenges are complex" (para. 66). Physician-assisted death aptly fits that description.

The remedy in *Carter*, the declaration of invalidity contained in paragraphs 127 and 147 of the 2015 decision, is a s. 52[6] remedy against the statute, not a s. 24[7] personal remedy for any litigant. But it 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 assessment of *Charter* compliant safeguards in an assisted death regime raises many questions. In particular, the following issues are addressed in the Vulnerable Persons Standard, http://www.vps-npv.ca: (1) end-of-life conditions; (2) prior review; (3) advance directives; and (4) mature minors.

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[6] Section 52(1) of the *Constitution Act, 1982* reads as follows:

> 52. (1) The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

[7] Section 24(1) of the *Charter* reads as follows:

> 24. (1) Anyone whose rights or freedoms, as guaranteed by this *Charter*, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.

(1) End-of-life conditions

The External Panel offered the following snapshot:

> All jurisdictions that regulate assisted dying through legislation have some form of medical eligibility criteria. The definitions of these criteria vary considerably. For example, in the four U.S. states with legislation permitting assisted death, the person making the request must have an incurable disease and be expected to die within six months. In Québec, the person must be at the end of life in an advanced state of irreversible decline in capability. In the Netherlands, the person must have unbearable suffering with no prospect of improvement and no reasonable alternative in light of their situation. (p. 57)

Belgium's regime is likewise not limited to end-of-life conditions. In the assessment of the international evidence, neither Justice Smith at trial nor the Supreme Court of Canada suggested that the jurisdictions with regimes limited to terminal illness be discounted. Indeed the opposite is true. In not giving weight to the fresh evidence about Belgium, the Supreme Court of Canada relied on the different history in Belgium (para. 112) and concluded that the Belgian cases "offer little insight into how a Canadian system might operate" (para. 113).

The Provincial-Territorial Expert Advisory Group observed that: "It is notable that the Supreme Court did not limit its [*Carter*] ruling to … cases of terminal illness, or to people near death." (p. 15)[8] While it is true that the SCC's declaration of invalidity is not expressly limited to end-of-life conditions, it does not follow that Parliament is precluded from so doing.

At trial and on appeal to the Supreme Court of Canada the focus was on Gloria Taylor, since Kay Carter had travelled to Switzerland to avail herself of physician-assisted death. While suspending the general declaration of invalidity, Justice Smith at trial gave a constitutional exemption to Gloria Taylor that included the stipulation (uncontested in her case) that she was terminally ill; 2012 BCSC 886, para. 1414(b). Justice Smith's general analysis included repeated references to "hastened death." She did not define this term, nor provide any specific time parameters, given the notorious difficulty in precisely predicting the timing of death from natural causes. But she was clearly contemplating the difference between death that was hastened from quite soon to very soon, not death that was expected to be possibly decades away being hastened to very soon. That was reflected in the limiting language included in her declaration of invalidity stipulating "advanced weakening capacities with no chance of improvement" (para. 1393(a) and (b)). Although this language of "advanced weakening capacities" was not explicitly adopted by the SCC judges, they did not disavow it either. In not commenting, the SCC was at the very least leaving it open to Parliament to adopt such a limitation, as proposed in the Vulnerable Persons Standard.

The Report of the Special Joint Committee on Physician-Assisted Dying, *Medical Assistance in Dying*: *A Patient Centred Approach* (February 2016) recommended against a limitation to terminally ill patients (p. 12). In support of that recommendation, it referred to the testimony of Peter Hogg: "Prof. Hogg argued that, while it was not impossible for Parliament to

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[8] It is important to note that Quebec was not part of the Provincial-Territorial Group, since Quebec has already passed its own medical aid in dying legislation (note 2, *supra*) that is limited to end-of-life situations.

require that the condition be terminal, such a law would be more susceptible to constitutional challenge." (p. 12) It is important to note that Professor Hogg said this in the context of challenges by those seeking physician-assisted death, without considering a possible counter challenge on behalf of the constitutional rights of the vulnerable. Moreover, even limiting the focus to a challenge by those seeking physician-assisted death, he did not elaborate on whether a limitation to terminal illness could be in accordance with the principles of fundamental justice or pass muster under s. 1 of the *Charter*. Of course greater limitations require more work to defend or justify than fewer limitations, but that does not mean that a limitation to end-of-life conditions would not, at the end of the day, be valid.

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*" (para. 4) which is limited to end-of-life conditions. The Court's lack of comment is unsurprising, given that the Quebec legislation was not squarely before it, but it does underscore that this is still an open question.

As a matter of overbreadth as a principle of fundamental justice, the issue is whether the challenged provision "bears no relation to the purpose" or has "no connection with the mischief contemplated by the legislation"; *Carter (2015)* para. 85. The Joint Committee noted that "Margaret Somerville, professor at McGill University, expressed the view that only individuals with less than four weeks to live should qualify." (p. 12) I have little doubt that such a short time frame would be seen as a thinly disguised attempt to all but preclude physician-assisted death, and would therefore run afoul of the principles of fundamental justice, and not pass muster under s. 1. The six month time frame in American states would be less problematic, but could still raise concerns, especially given the difficulty in accurately predicting when death will ensue. The Quebec legislation avoids this problem in not having a specific time frame, while limiting to end-of-life conditions. Quebec's legislation also avoids the perhaps vague term of "terminally ill".

> 26. Only a patient who meets all of the following criteria may obtain medical aid in dying:
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> (1) be an insured person within the meaning of the *Health Insurance Act* (chapter A-29);
> (2) be of full age and capable of giving consent to care;
> (3) be at the end of life;
> (4) suffer from a serious and incurable illness;
> (5) be in an advanced state of irreversible decline in capability; and
> (6) experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.

As noted above, at the end of the paragraph setting out the declaration of invalidity in *Carter*, the Supreme Court of Canada concluded by saying: "The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought." (para. 127). 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.

The Joint Committee thought otherwise, citing Professor Jocelyn Downie:

> [Terminal illness] was not included by the Supreme Court in *Carter*. It is too vague and indeterminate. It is arbitrary and it has no moral justification as a barrier to access.
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> …
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> Furthermore, limiting MAID [medical aid in dying] in this way would result in Canadians with grievous and irremediable conditions faced with enduring and intolerable suffering having to continue suffering against their will. (p. 12)

What this conclusion by the Joint Committee does not acknowledge is where protection of the vulnerable fits into the analysis. The limitation to end-of-life conditions is important in designing safeguards against error and abuse. If death by natural causes is potentially decades away, the consequences of potential error are substantially magnified compared to hastening death by a short time. If the person is not at the end of life, 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 to end-of-life conditions, and thus would weigh more heavily in the balance. Challengers would not be able to say that an end-of-life stipulation bears "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 the end-of life stipulation be considered grossly disproportionate.

In the alternative, moving to s. 1, where the focus shifts away from the individual claimant, the difficulty in identifying the vulnerable was identified in *Carter* as an important consideration (para. 88). At trial, Justice Smith made the following comments in the course of her s. 1 analysis:

> [1226] ... The question is whether there is "an alternative, less drastic, means of achieving the objective in a real and substantial manner" (*Hutterian Brethren* at para. 55).
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> [1227] I do accept the defendants' submission that considerable deference is due to Parliament. The choice whether to permit any form of physician-assisted death implicates fundamental social values. Further, complex and difficult predictions about human behaviour are inherent in weighing the possible means of preventing the inducement of vulnerable people, including grievously ill people, to commit suicide.
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> [1228] However, recognizing the need for deference does not allow a court to down tools and end the analysis. This Court must fulfill its constitutional duty to decide whether Parliament's choice of an absolute prohibition, which infringes constitutional rights, is justified in comparison with other possible measures which would avoid infringement.
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> [1229] I also note that the absolute prohibition is not a set of tailored regulations of the nature contemplated in some of the jurisprudence regarding deference (for example in *Hutterian Brethren* at para. 56).

In analysing s. 1 in *Carter*, the SCC said "theoretical or speculative fear cannot justify an absolute prohibition" (para. 119) Moving from an absolute ban to an end-of-life stipulation 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 beyond

end-of-life conditions would also preclude deleterious effects from outweighing salutary effects. Thus an end-of-life stipulation would be a proportionate balancing.

The issue of end-of-life conditions is intertwined with the issue of whether there should be specified medical conditions. The Joint Committee indicated "There was a strong consensus in the testimony and briefs that there should be no list of included conditions." (p .12) By itself, a list of conditions would likely be problematic, as some appropriately included conditions would likely be left out. However, there is a connection between types of conditions and end-of-life situations. Moreover, in the context of dealing with the fresh evidence about the Belgian experience, the Supreme Court of Canada specifically carved out psychiatric disorders as conditions that "would not fall within the parameters suggested in these reasons" (para. 111),

Following upon this stipulation, the Vulnerable Persons Standard indicates that, on their own, conditions such as psychiatric illness, mental anguish, and developmental, intellectual or cognitive disabilities should not give rise to a right to physician-assisted death. This is because none of these conditions is, on their own, life-threatening. Thus there is no claim that mental suffering is any less serious than physical suffering. Rather the point is that any suffering (whether physical or mental) not associated with end-of-life conditions is not appropriate for physician-assisted death.

If the *Criminal Code* were amended to exempt physician-assisted death from criminal prohibition only for end-of-life conditions, it is quite predictable that, sooner or later, such a limitation would be challenged as contrary to the *Charter*. However, in my assessment, the chances are strong that the limitation would be upheld. There would either be no breach of the principles of fundamental justice, or, in the alternative, the government would succeed in a s. 1 defence.

(2) prior review

Given the accepted objective of protecting the vulnerable, a *bona fide* mandatory vulnerability assessment is at the core of what would be connected to the objective. But there are many questions about what that could or should involve.

During the initial twelve months of the suspended declaration of invalidity, the SCC did not authorize individual relief through s. 24 remedies. However, in its January 15, 2016 decision, the Court authorized individual exemptions for the extended four months of the suspended declaration, as an interim measure pending Parliament's intervention.

> We would, as a result, grant the request for an exemption so that those who wish to seek assistance from a physician in accordance with the criteria set out in para. 127 of our reasons in *Carter*, may apply to the superior court of their jurisdiction for relief during the extended period of suspension. Requiring judicial authorization during that interim period ensures compliance with the rule of law and provides an effective safeguard against potential risks to vulnerable people. (para. 6)[9]

[9] It would seem to be significant that the Court refers to para. 127, rather than para. 147. Para. 147 is the formal declaration at the end of the judgment, repeating the text in the body of the judgment from para. 127. However para. 127 adds the qualifier set out above:

Accordingly, for the four month extension, there is a prior review by a judge before physician-assisted death is authorized. In the first such decision, Justice Martin, of the Court of Queen's Bench of Alberta, carefully canvassed the criteria in para. 127, and specifically concluded that the claimant "is not a vulnerable person who requires the protection of those sections of the *Criminal Code* impugned in *Carter 2015*." *Re HS*, 2016 ABQB 121, para. 118. Is there scope for some sort of prior review in the legislated regime that Parliament will enact?

The criteria in para. 127 include competence and clear consent as an expression of autonomy. An autonomous decision requires non-ambivalent and informed consent, free of external pressure, with knowledge of options available. Options may include medical treatment as well as non-medical supports that would make life worth living. Vulnerability can compromise autonomy, and make individuals susceptible to seek suicide at moments of weakness, and/or for reasons beyond the medical condition underlying the legal basis for physician-assisted death.

Vulnerability, competence and clear consent will sometimes be easy to determine, but other times will pose significant challenges to discern. The Quebec regime (s. 29) places the responsibility on two doctors to determine these issues. There are reporting requirements after the fact (s. 37), to enable assessment of the experience of regulating physician-assisted death. But there is no decisional stage before death beyond the doctors assessing eligibility. Both the Provincial-Territorial Expert Advisory Group (Recommendations 22 and 29) and the Joint Committee (Recommendations 12, 15, and16) favour such a structure.

The Supreme Court of Canada in *Carter* expressed confidence in the ability of doctors to make these determinations:

> [115] The evidence accepted by the trial judge does not support Canada's argument [that a blanket prohibition is necessary]. 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 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.

These comments should not, however, be seen as determinative.

> 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.

Superior court judges hearing applications during the four month extension are presumably meant to heed this qualifier.

These remarks cannot be taken in isolation or out of context. The context is the assessment of an absolute ban on physician-assisted death, and the Court's emphasis throughout the judgment that the design of a system of safeguards is Parliament's responsibility. It cannot be a principle of constitutional law that only doctors can assess vulnerability, competence, and consent. Equally, one could not conclude from the interim relief contained in the SCC's January 15, 2016 decision, extending by four months the suspension of the declaration of invalidity, that only superior court judges can make such determinations. It is ultimately for Parliament to determine who can best make such determinations.

The parallel to withholding/withdrawal decisions has its limits. If physician-assisted death is not limited to end-of-life situations, and covers medical conditions that are not life-threatening, it substantially diminishes the similarity between physician-assisted death and withholding/withdrawal decisions. Whether or not confined to end-of-life situations, the "more active assistance in dying" represented by physician-assisted death heightens the need to consider alternatives. Although doctors may be well-versed in alternative medical treatments, they may not be in the best position to fully inform about, or provide access to, supports of a primarily non-medical nature that could persuade the patient not to access physician-assisted death. Professionals beyond doctors could be tasked on a prior review panel to expand the consideration to include a broader social responsibility to the patient. An added level of decision-making before physician-assisted death is authorized could provide an opportunity to better identify, and address, unmet needs. To require prior review in all cases would ensure that the appropriate questions were always asked, even if in some cases the answers would quickly become obvious.

Such an element of prior review would need to expeditious. It could not be used as a mechanism to preclude physician-assisted death from practically being available. This is clear from *Morgentaler*. However, *Morgentaler* does not stand for the proposition that no prior review system could be valid. The therapeutic abortion committee structure was invalid because it had multiple elements that bore no relation to the state interest supposedly being pursued. Moreover, as noted above, the state interest in *Morgentaler* was not a constitutionally protected one. An expeditious prior review process for physician-assisted death, tightly directed toward assessing vulnerability, competence, and consent, would have a very close relationship to the state objective of protecting the vulnerable. It would therefore not run afoul of either overbreadth or gross disproportionality as principles of fundamental justice. In the alternative, for reasons parallel to those in the previous section, a s. 1 defence would avail.

An expeditious prior review is important to enable full opportunity to assess options other than suicide, in order to ensure the patient makes a fully autonomous choice.

(3) advance directives

Advance directives were not an issue in *Carter*. The SCC was only considering the situation of competent adults able to consent both at the time of initial request for physician-assisted death and at the time of implementation. It cannot be said that *Carter* requires the effectiveness of advance directives.

Quebec's legislation does not authorize advance directives for medical aid in dying (s. 51). Both the Provincial/Territorial Expert Advisory Group (Recommendation 12) and the Joint Committee (Recommendation 7) recommend that an advance directive after a diagnosis of the grievous and irremediable condition should be effective under the *Criminal Code*.

The argument in favour of advance directives is primarily autonomy. The argument against is primarily that it precludes a change of mind after loss of competence.

Where the issue is choice, it seems difficult to say that insisting on informed consent throughout is contrary to the principles of fundamental justice. That would not preclude Parliament from embracing advance directives,[10] but Parliament would not be required to do so.

Parliament has been held to have precluded advance consent as effective for sexual intimacy in the context of an unconscious person; *R. v. J.A.*, [2011] 2 S.C.R. 440. All the more so should Parliament be able to preclude advance directives for physician-assisted death.

(4) mature minors

The Supreme Court of Canada's declaration of invalidity was confined to adults (paras. 127 and 147). The situation of adults was all that was before it, with no claimant or affiant being anywhere close to the cusp. The SCC did not therefore define adult for this purpose. The *Criminal Code* could referentially incorporate the various provincial/territorial ages of majority (18 or 19) or could set a single age, presumably 18 as the federal age of majority, e.g. for voting. The latter would seem to be preferable, to have consistent law across the country for assisted death.

More contentious is the question of whether mature minors should be eligible for physician-assisted death. The Expert Panel commented as follows:

> Few individuals or groups to appear before the Panel specifically advanced arguments regarding access for mature minors, perhaps understandably, since the issue was not raised in *Carter*. The Panel did not actively seek out expert opinion or perspectives on this issue, nor did it speak with professionals in fields focused on child and adolescent-related issues (e.g. pediatrics or child and adolescent psychology). (p.55)

The Quebec legislation does not make mature minors eligible for medical aid in dying (s. 26(2)). Although the Provincial-Territorial Expert Advisory Group recommended that mature minors be eligible under the *Criminal Code* (Recommendation 17), the Joint Committee concluded that such a step be postponed, pending further study (Recommendation 6).

Carter itself clearly does not require that mature minors be eligible for physician-assisted death. The extra vulnerability of youth warrants at least some pause. At some point there is likely to be a *Charter* challenge if physician-assisted death is not extended to mature minors, but the outcome of such a challenge is by no means certain.

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

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[10] Subject to a constitutional challenge on behalf of the vulnerable.

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.