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Carter, Medical Aid In Dying, and Mature Minors

Constance MacIntosh

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The Supreme Court of Canada's decision in *Carter v Canada (AG)* decriminalized medical aid in dying in certain defined circumstances. One of those circumstances is that the person seeking assistance be an "adult." This article argues that the regulatory response to this decision must approach the idea of "adult" in terms of the actual medical-decisional capacity of any given individual, and not rely upon age as a substitute for capacity. This article surveys jurisdictions where minors are included in physician-assisted dying regimes, and identifies what little empirical evidence exists regarding requests from minors. The heart of the article considers the jurisprudence on mature minors and when they are deemed to have the right to require the withdrawal of, or refuse to receive, life-sustaining treatment, and compares the reasoning in these cases with that in *Carter*. A particular focus of this article is on how the jurisprudence approaches decisional capacity when the individual in question may be particularly

La décision de la Cour suprême du Canada dans *Carter v Canada (PG)* a décriminalisé l'aide médicale à mourir dans certaines circonstances définies. Une de ces circonstances concerne le statut d' « adulte » de la personne cherchant à obtenir cette aide. Cet article soutient que la réponse règlementaire à cette décision doit considérer l'idée du patient « adulte » sur le plan de la capacité décisionnelle de chaque individu, plutôt que de se fier à l'âge comme substitut de la capacité. Cet article étudie les juridictions où les requêtes des mineurs sont incluses dans les régimes règlementaires d'aide médicale à mourir et identifie le peu de données empiriques qui existent concernant les requêtes provenant de mineurs. Au cœur de cet article se trouve la jurisprudence sur les mineurs matures et les circonstances considérées comme étant suffisantes pour leur accorder le droit de refuser ou de cesser de recevoir les traitements de maintien de la vie. On y retrouve également une comparaison du raisonnement de ces décisions au raison-

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vulnerable. It finds that a blanket exclusion of mature minors from a physician-assisted dying regime likely violates the *Canadian Charter of Rights and Freedoms*, and calls out for considered debate on these issues instead of forcing a minor and their family to bring the issues forward through litigation.

nement dans *Carter*. Dans cet article, une attention particulière est portée à l'approche de la jurisprudence concernant la détermination de la capacité décisionnelle d'un individu lorsque celui-ci peut être particulièrement vulnérable. Enfin, cet article constate qu'une exclusion généralisée des mineurs matures dans le régime règlementaire d'aide médicale à mourir est probablement contraire à la *Charte canadienne des droits et libertés* et conclut à la nécessité d'un débat de qualité sur ces problèmes au lieu de forcer un mineur et sa famille à mettre ces enjeux de l'avant au moyen de procédures judiciaires.

INTRODUCTION

The Supreme Court of Canada's decision in *Carter v Canada (AG)* (*Carter* SCC) de-criminalized physician-assisted death in certain defined circumstances.[1] The court was not asked, directly, to consider the situation of requests from mature minors. In this paper, I draw upon the leading decision concerning the rights of mature minors to refuse life-sustaining treatment as a touchstone for considering whether the reasons in *Carter* SCC are persuasive in the context of minors. In particular, I draw upon Justice Abella's reasons in the Supreme Court of Canada decision in *AC v Manitoba (Director of Child and Family Services)*.[2] In *AC*, the court had to assess what weight should be placed upon a minor's express refusal to consent to a blood transfusion, without which she was expected to die. The focus in *AC*, like that in *Carter* SCC, was determining the *Canadian Charter of Rights and Freedoms*[3] compliance of a regime that was enacted to address medical decision making in situations where the subject of the decision may be vulnerable. Both cases involved fact situations where the requested medical treatment decision was expected to result in the death of the requestor. In each case, the conclusion about *Charter* compliance turned on whether the regime had mechanisms for considering whether the individual may not, in fact, be vulnerable. After closely comparing these cases, I ultimately conclude that the blanket exclusion of mature minors from a physician-assisted dying regime likely violates Section 7 of the *Charter*.

The layout of the paper is as follows. In Part I, below, I flesh out aspects of the *Carter* SCC decision, and its use of the term "adult" as a descriptive criterion for the *Criminal Code*[4] exemptions. I also survey data on requests from minors in permissive regimes. In Part II, I canvass the recommendations, conclusions, and actions of various bodies that were struck to consider medical aid in dying in Canada, for their approaches to requests from minors. I then, in Part III, survey provincial statutory regimes and their interaction with the common law to illustrate how the capacity of minors to make medical treatment decisions is assessed and weighed for the purpose of consent to, and refusal of, treatment. Next, in Part IV, I turn to the *Carter*

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1 2015 SCC 5 at para 147, [2015] 1 SCR 331 [*Carter* SCC].

2 2009 SCC 30, [2009] 2 SCR 181 [*AC*].

3 Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

4 RSC 1985, c C-46.

decisions at both the trial level and at the Supreme Court of Canada to consider whether some of the principles and arguments that led to the Supreme Court carving out the declaration are persuasive in the context of mature minors. Finally, in Part V, I offer a brief discussion of the legal regimes which have mechanisms for considering requests for medical aid in dying from minors and the safeguards which they have put in place.

I. The *Carter* Decision and Mature Minors

The *Carter* case specifically considered whether two provisions of the *Criminal Code* offended the *Charter*. These provisions were subsection 241(b), which makes aiding or abetting a person to commit suicide an indictable offense, and section 14, which states that consent to death does not affect criminal responsibility for causing death.[5] The court found that the *Criminal Code* provisions violated all aspects of Section 7 of the *Charter*. Section 7 provides that "[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[6] The prohibition was found to deprive some persons of life, because it resulted in individuals taking their own lives prematurely, out of fear that they would be physically incapable of doing so without assistance when their situation became intolerable to them. The right to liberty was violated because the prohibition denied individuals the right to make decisions about their bodily integrity and medical care. Security of the person was also violated because the prohibition left some individuals to endure intolerable suffering. These infringements were found not to be in accordance with the principles of fundamental justice. This was because the objective of the *Criminal Code* prohibition was not to preserve life, regardless of the circumstances, but to protect vulnerable persons from being induced, at a moment of weakness, to commit suicide. However, the prohibition impacted not only this identified group, but also the rights of those who were not in fact vulnerable.

The conclusion that the prohibition was not saved by Section 1[7] similarly turned on the prohibition's blanket character. In particular, the prohibi-

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5 *Ibid*.

6 *Charter, supra* note 3.

7 *Ibid*, s 1. Section 1 imposes limits on *Charter* rights. In particular, it states that "[t]he *Canadian Charter of Rights and Freedoms* guarantees the rights and

tion was not proportionate to the law's objective because a blanket prohibition was not necessary to protect the vulnerable. This conclusion turned on evidence that physicians are able to assess vulnerability and already do so when assessing decisional capacity and informed consent in the context of medical decision making. It also turned on evidence regarding how other countries have developed physician-assisted dying regimes with safeguards for protecting vulnerable persons.

The court declared the *Criminal Code* provisions of no force and 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.[8]

This declaration reads down *Criminal Code* offences that would otherwise be triggered by physician-assisted death. The declaration's requirement that the requesting person be an adult creates challenges. The term "adult" is not defined in *Carter* SCC. In some legislation regarding medical-decisional capacity, the term "adult" is defined to align with the age of majority and is further defined as creating a presumption of capacity.[9] However, persons under the age of majority, or minors, may also have decisional capacity. In some provinces, the presumption of capacity is legislatively granted to

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freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." In determining whether a rights-infringing law is saved by this limitation, courts apply a test which was identified in *R v Oakes*, [1986] 1 SCR 103. The court will first ask whether the law's goal has a "pressing and substantial" objective. If so, the court then conducts a proportionality analysis, which assesses whether the law's limitation on a *Charter* right is rationally connected to its purpose, whether the law minimally impairs the right in question, and whether there is proportionality between the benefits of the limit and its deleterious effects.

8 *Carter* SCC, *supra* note 1 at para 147.

9 See e.g. *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181. Section 1 defines "adult" as "anyone who has reached 19 years of age," and section 3 states that anyone who is an adult is presumed to be capable of "giving, refusing or revoking consent to health care" (*ibid,* s 3(1)(a)).

minors aged 16 and 17.[10] In most provincial regimes, factors relating to a minor's actual decisional capacity play a significant role in determining the weight to be assigned to their wishes for medical treatment including refusal of life-sustaining care, and the concept of a "mature minor" [11] is used. Regulatory reform in response to *Carter* SCC does not reflect these regimes. Instead, it imports an age limit, 18, as a threshold criteria for eligibility.[12] As a result, a physician would not be criminally liable for granting a request from a mature minor to withdraw life-saving treatment but would potentially face a murder charge and sentence of life in prison if a physician agreed to grant such a youth a request to administer a lethal medication[13] in a context where the other elements of the declaration are present. On its face, this seems to be an incongruous and arbitrary outcome that requires closer scrutiny.

There is no evidence to suggest that the court was asked to consider requests from mature minors, or the consistency of the prohibitions with the rights of mature minors. Rather, from reviewing the trial decision, it seems the legal questions revolved around how the *Criminal Code* prohibitions were inconsistent with the *Charter* rights of the particular plaintiffs – none of whom were minors. The evidence and arguments concerning regimes that permit physician-assisted death, and how those regimes address coercion, comprehension, and capacity, similarly did not consider how such regimes approach requests from minors.[14] It is appropriate that the court did not extend its declaration beyond the legal questions that were expressly argued and the evidentiary record before it. However, given that all Canadian jurisdictions recognize mature minors as having full or qualified rights to make medical treatment decisions, including withdrawal of life-sustaining treatment, it is disappointing that the court did not flag the need for policy-makers to engage with the question of how these rights will have to be reconciled with the *Carter* SCC declaration.

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10 See *Medical Consent of Minors Act*, SNB 1976, c M-6.1, s 2; *The Health Care Directives Act*, SM 1992, c 33, CCSM c H27, s 4(2)(a) [*Directives*, Manitoba].

11 The concept of a "mature minor" is explained in Part IV, below.

12 *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* SC 2016, c 3, amending *supra* note 4, s 241.2(1)(b).

13 *Criminal Code*, *supra* note 4, ss 229, 231, 235. For a concise discussion of terminology related to assisted death, see *Carter v Canada (AG)*, 2012 BCSC 886 at paras 36–43, 218 ACWS (3d) 824 [*Carter* BCSC].

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

There is scant empirical evidence on minors' requests for physician-assisted death in general,[15] let alone in Canada. One of the few studies on minors' requests for physician-assisted dying that included Canadian data took place in 1997. It involved sending confidential surveys to all members of the American Society of Clinical Oncologists located in Canada, the US, and the UK. A total of 228 pediatric oncologists (or 55% of the pediatric oncologist membership at the time) took part in the survey.[16] Unfortunately the responses are not reported by country, but rather are merged in the survey's findings. According to the survey, 20.1% of pediatric oncologists reported receiving between 1 to 10 requests for physician-assisted suicide during the course of their careers. Moreover, 26.1% reported receiving requests for euthanasia.[17] The survey revealed that in some instances pediatric oncologists complied with these requests: 4.2% reported having provided a prescription to enable assisted death on 1 to 10 occasions, and 8.6% reported having performed euthanasia for between one to five patients.[18] Though this data set is small, and old, it would seem to suggest that Canadian physicians likely already receive and may grant such requests – despite the granting of these requests being unlawful. Regardless of the limits of what one can conclude from this study, it is simply naïve to assume that minors will not make such requests now that the *Criminal Code* has been amended to permit requests for medical aid in dying from adults.

While the number of requests from minors is extremely small even in jurisdictions where minors are included in physician-assisted dying regimes,[19] the numbers do not undermine the importance of fulsomely con-

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15 Bernard Dan, Christine Fonteyne & Stéphan Clément de Cléty, "Self-Requested Euthanasia for Children in Belgium" (2014) 383:9918 Lancet 671 at 671. The authors note that there is little reliable data that has been collected on requests from minors.

16 Joanne Hilden et al, "Attitudes and Practices among Pediatric Oncologists Regarding End-of-Life Care: Results of the 1998 American Society of Clinical Oncology Survey" (2001) 19:1 J Clin Oncol 205 at 205.

17 *Ibid* at 208. The authors of the report caution that those pediatric oncologists who indicated they had performed euthanasia were also almost all willing to use high-dose opioids to control pain, and may have "believed that adequate pain control in those cases was the equivalent of euthanasia" (*ibid* at 210).

18 *Ibid* at 208.

19 A study on pediatric end-of-life decisions in the Netherlands inquired into 129 reported deaths of children between the ages of 1 and 17, over a four-month

sidering whether the *Carter* SCC exemptions ought to be, or legally must be, extended to mature minors before we are faced with the foreseeable situation of a mature minor seeking certainty on the issue. To wait and force a minor to put themselves forward and live out this test case role, in a situation where the minor otherwise meets the onerous *Carter* SCC criteria of living with a grievous and irremediable medical condition that causes intolerable and enduring suffering, is cruel. This paper is intended to contribute to this foreseeable conversation.

II. Reports on Medically Assisted Death and Children, and Legislative Responses

There have been three national reports in Canada on physician-assisted death and several reports submitted to or commissioned by the Québec government. The first national report was prepared by the Special Senate Committee on Euthanasia and Assisted Suicide, which submitted its report to Parliament in 1995. Their mandate was "to examine and report on the legal, social, and ethical issues relating to euthanasia and assisted suicide" so as to support Parliament engaging in a "full and open national debate" on these matters.[20] Despite the breadth of this mandate, the report was utterly silent on the situation of minors. Given that the Committee recommended that even for competent adults assisted suicide and euthanasia should remain prohibited, it is likely that they thought it unnecessary to engage with the more complex issue of mature minors.

Fifteen years later, in 2010, the public policy questions were revisited by an Expert Panel of the Royal Society of Canada. This Panel discussed the situation of mature minors in the debate on assisted suicide and euthanasia.

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period. The study revealed that 0.7% of the deaths followed a request made by a minor to the physician to administer drugs to hasten death. Astrid Vrakking et al, "Medical End-of-Life Decisions for Children in the Netherlands" (2005) 159:9 Arch Pediatr Adolesc Med 802 at 804 [Vrakking et al, "Medical End-of-Life Decisions"]. Belgian pediatricians predicted that the number of requests from minors would be quite small. See Linda Pressly, "Belgium Divided on Euthanasia for Children", *BBC News* (9 January 2014), online: BBC <www.bbc.com/news/magazine-25651758>.

20 Parliament of Canada, The Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death – Final Report* (June 1995), online: Parliament of Canada < www.parl.gc.ca/content/sen/committee/351/euth/rep/lad-e.htm>.

The Panel referred to a number of legal sources as relevant for determining the legal situation of mature minors, including "the common law mature minor rule, the courts' overall jurisdiction to protect the vulnerable, provincial/territorial child and family services legislation, provincial/territorial consent legislation, and the *Canadian Charter of Rights and Freedoms*"[21] as well as the jurisprudence interpreting these various instruments and doctrines. The Panel observed that given the unclear interaction between the above instruments and doctrines, as well as controversy surrounding the instruments/doctrines themselves, the law on mature minors remains an area of confusion.[22] Regardless, the Panel ultimately reached a straight-forward recommendation – that the law on mature minors for making medical treatment decisions should apply to decisions about assisted suicide and euthanasia. However, they also noted that this solution required provincial and territorial governments to clarify mature minor consent law for end-of-life decision making through their consent and child protection legislation.[23]

Provinces and territories never acted on either recommendation. As will be discussed below, we continue to have a patchwork of legislation for assessing and giving weight to the decisional capacity of mature minors generally, although there are some commonalities. As well, no provincial or territorial government appears to have considered whether or with what modifications the law on mature minors applies (or should apply) to assisted death, with the exception of Québec. As the only province to enact physician-assisted death legislation, Québec declined to authorize physician-assisted death for mature minors.[24] This decision ran contrary to the explicit recommendations of Québec's *Commission des droits de la personne et des droits de la jeunesse*. The Commission found both that the absolute exclu-

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21 The Royal Society of Canada Expert Panel, *End-of-Life Decision-Making in Canada* (Ottawa: November 2011) at 32 [footnotes omitted].

22 *Ibid*.

23 *Ibid* at 92.

24 An expert panel provided a review for Québec and surveyed the law on minors. While it identified the right of children over 14 with capacity to make medical treatment decisions, it did not make a recommendation about whether to extend the regime to minors. Québec, Comité de juristes experts, *Mettre en oeuvre les recommandations de la Commission spéciale de l'Assemblée nationale sur la question de mourir dans la dignité : rapport du comité de juristes experts* (January 2013), online: Ministère de la Santé et des Services sociaux <www.msss.gouv.qc.ca/documentation/salle-de-presse/medias/rapport_comite_juristes_experts.pdf>.

sion of minors from the regime violated their rights, and that this rights violation could not likely be justified. The Commission wrote:

> Les balises qui rendent inaccessible l'aide médicale à mourir aux personnes mineures risquent de porter atteinte à leurs libertés et droits fondamentaux en l'occurrence le droit à la vie, le droit à l'intégrité, le droit à la sûreté, le droit à la liberté de sa personne, la liberté de conscience, le droit à la sauvegarde de sa dignité et le droit au respect de sa vie privée. La Commission doute que ces atteintes puissent être sauvegardées en vertu de l'article 9.1 de la Charte. Des règles plus en phase avec les règles actuelles de consentement aux soins pour les personnes mineures, mais qui tiennent compte de caractère spécifique et irréversible de l'aide médicale à mourir, seraient mieux à même de satisfaire au critère de l'atteinte minimale. La Commission invite donc le législateur à ouvrir la possibilité de recourir à l'aide médicale à mourir aux personnes mineures, moyennant le développement de mécanismes de consentement appropriés.[25]

The Commission's recommendation, that the legislative regime for physician-assisted death be extended to minors, and that the regime identify appropriate mechanisms to determine how requests from mature minors are considered, were not acted upon by Québec.

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[25] Québec, Commission des droits de la personne et des droits de la jeunesse, *Mémoire à la Commission de la santé et des services sociaux de l'Assemblée nationale* : Project de Loi No 52, Loi concernant les soins de fin de vie (September 2013) at 22, online: <www.cdpdj.qc.ca/publications/memoire_PL52_soins-fin-de-vie.pdf> [Mémoire, Projet de loi No 52]. An unofficial translation of this passage, provided by Brenna Noble, is:

> The rules that render medical aid in dying unattainable to minors may jeopardize their fundamental rights and freedoms in this case the right to life, the right to integrity, the right to security, the right to liberty, one's freedom of conscience, the right to the safeguard of one's dignity, and the right to privacy. The Commission doubts that such attacks can be saved under section 9.1 of the *Charter*. Rules more in line with the current rules of consent to care for minors, but that take the specific and irreversible nature of medical aid in dying into account, would be better able to satisfy the minimal impairment test. The Commission therefore invites the legislature to open the possibility of permitting medical aid in dying to minors, through the development of appropriate mechanisms to consent.

Mature minors were also mentioned in proposed charging guidelines for exercising prosecutorial discretion in situations of physician-assisted death in Canada. This detailed set of guidelines was put forward by two scholars, who published it shortly after the trial judge in *Carter* struck down the *Criminal Code* prohibitions but suspended the declaration for one year.[26] These guidelines are highly detailed and nuanced. In general, they recommend not prosecuting where the request is an expression of autonomous choice and public confidence would not be eroded by a failure to prosecute. The authors describe their guidelines as intended to apply to "competent adults and minors alike,"[27] while noting that decisional capacity for minors is determined with regard to their individual level of maturity.[28]

Most recently, the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying issued its Final Report on November 30, 2015.[29] This Advisory Group's members were appointed by eleven provinces and territories, consulted nationally, and were mandated to give non-binding advice to participating provinces and territories regarding implementation of the *Carter* SCC decision. The group considered the meaning of the reference to "adult" in *Carter* SCC. They ultimately recommended that the regulatory framework for physician-assisted dying in Canada avoid using an age limit and effectively interpreted the reference to "adult" in *Carter* SCC as meaning having competence.[30] This recommendation was in part a response to requests for a consistent national approach to eligibility, and to recognize that age is an arbitrary factor, which does not create a safeguard against risk and vulnerability. Instead, the Advisory Group posited that a decision about eligibility should turn on "the context of each request to determine whether the person has the information needed, is not under coercion or undue pressure, and is competent to make such a decision."[31]

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26 Jocelyn Downie & Ben White, "Prosecutorial Discretion in Assisted Dying in Canada: A Proposal for Charging Guidelines" (2012) 6:2 McGill JL & Health 113.

27 *Ibid* at 134.

28 *Ibid* at 143.

29 Online: Ontario Ministry of Health and Long-Term Care <www.health.gov.on.ca/en/news/bulletin/2015/docs/eagreport_20151214_en.pdf>.

30 *Ibid* at 34.

31 *Ibid*.

A federal panel was also struck to advise on implementing *Carter* SCC. That panel did not make any recommendations. Rather, its deliverable was a summary of findings based on public consultations regarding issues raised by the *Carter* decision. The panel received comments from private individuals regarding minors, which reflected mixed support for including minors within a physician-assisted dying regime. Comments from medical ethicists, a College of Physicians and Surgeons, and legal scholars, on the other hand, were consistent in rejecting age as a criterion for access and in supporting a capacity-based approach, sometimes in conjunction with a mandatory consultation with parents or legal guardians.[32]

The next Part explains the law on minors and medical decision making. It illustrates that provinces, like the Provincial-Territorial Expert Advisory Group, have largely recognized that older youth may have competency and capacity to make life-and-death medical treatment decisions.

III. Minors and Capacity to Make Medical Treatment Decisions

The law treats adults differently than minors in many instances. One of the areas of law where their rights differ is the law surrounding consent to medical interventions, where without informed consent an intervention may constitute an assault.[33] Adults are presumed to possess decisional capacity to consent to medical treatment. As a result of this presumption, concerns about their consent are more likely to turn on questions such as whether the adult was sufficiently informed for the consent to be valid.[34] This presumption about decisional capacity does not – in most cases – hold for minors.[35]

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[32] Canada, External Panel on Options for a Legislative Response to *Carter v Canada*, *Consultations on Physician-Assisted Dying: Summary of Results and Key Findings – Final Report* (15 December 2015) at 54–55, online: Department of Justice <www.justice.gc.ca/eng/rp-pr/other-autre/pad-amm/pad.pdf>.

[33] *Reibl v Hughes*, [1980] 2 SCR 880, 114 DLR 3(d) 1.

[34] See e.g. Patricia Peppin, "Informed Consent" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham: LexisNexis Canada, 2011) 153 at 153–54 [Downie, Caulfield & Flood, 4th ed].

[35] For a comprehensive discussion of medical decision making in the context of minors, including the rights and roles of parents and the thresholds for state intervention, see Joan M Gilmour, "Legal Considerations in Paediatric Patient and Family-Centred Healthcare" in Randi Zlotnik Shaul, ed, *Paediatric Pa-*

In practice, the question of capacity and consent to medical treatment for minors usually only becomes relevant where there is some sort of dispute about treatment. For example, a minor may wish to have a treatment, such as an abortion, against the wishes of their parents and so the parents claim the physician may not lawfully proceed on the basis of the minor's consent alone.[36] Alternately, physicians may disagree with the treatment decisions of the minor and/or the minor's family, and so inform child welfare authorities, who in turn make a decision whether or not to seek a court order granting authorization to impose treatment.[37] The new legislation presents a variation on this situation. Indeed, it forces us to contemplate a situation where, for example, there is a consensus between the mature minor, their family, and their physician that physician-assisted death is an appropriate treatment decision.[38] However, pursuant to the medical assistance in dying legislation, it would be unlawful to grant this treatment choice until the day the minor reaches the age of 18.

Why 18? The reasoning behind this age bar being set at 18 is not clear. It may be influenced by the fact that the age of majority, when a person ceases

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tient and Family-Centred Care: Ethical and Legal Issues (New York: Springer, 2014) 115 at 115–21.

[36] An early case in this area considered whether a 16-year-old could consent to an abortion, against the wishes of her parents. See *C (JS) v Wren*, 76 AR 115, [1986] 35 DLR (4th) 419 (ABCA).

[37] Many cases in this area have concerned treatment decisions regarding children who are Jehovah's Witnesses. In these cases, the parents and child rejected physician advice to undergo a blood transfusion, despite such a decision rendering recovery unlikely. See e.g. *AC*, *supra* note 2; *B(SJ) v British Columbia (Director of Child, Family and Community Service)*, 2005 BCSC 573, [2005] BCJ No 836; *Alberta (Director of Child Welfare) v BH*, 2002 ABPC 39, [2002] AJ No 356 [*BH*]; *U(C) (Next Friend Of) v McGonigle*, 2000 ABQB 626, [2000] AJ No 1067; *Re Kennett Estate v Manitoba (AG)*, [1998] MJ No 131, 78 ACWS (3d) 1114 (MBQB); *Walker (Litigation Guardian of) v Region 2 Hospital Corp* (1994), 150 NBR (2d) 366, 116 DLR (4th) 477 (NBCA) [*Walker*].

[38] Obviously, other permutations are possible, including one where only the mature minor seeks assisted death, and the family and health care team disagree, or one where the dispute is between the parents and the child. See e.g. *BH*, *supra* note 37, where the parent had consented to a blood transfusion that would likely save the life of the minor, but the 16-year-old Jehovah's Witness minor refused. The scenario described in the body of the paper is the one which would most likely lead to this issue being litigated.

being a legal minor, is 18 in six Canadian provinces,[39] although it is 19 in four provinces and the three territories.[40] That being said, the age of majority plays a shifting role vis-à-vis the right of minors to consent to other forms of medical treatment. Importantly, being a minor – or being below the age of majority – is not an absolute bar to a person being recognized as having a right to determine their own medical treatments. Both statutory law and the common law provide guidance on whether a child can provide consent or, in the alternative, whether their parent or guardian presumptively retains this authority.[41] In some instances statutory law codifies the common law. In other instances, it compliments or overrides it.[42] As a result, the law on consent varies across the country.

The common law recognizes that while minors are not presumed to have decisional capacity, this presumption can be rebutted. The common law approaches the issue on an individualized basis that focuses on the minor's level of maturity.[43] Joan Gilmour summarizes the common law as follows: "For children and adolescents who have the capacity to understand information and appreciate the consequences of making specific decisions, the consensus is that they should make their own treatment decisions."[44] Legis-

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39 These provinces are Alberta, Manitoba, Ontario, Prince Edward Island, Saskatchewan, and Québec. See *Age of Majority Act*, RSA 2000, c A-6, s 1; *The Age of Majority Act*, RSM 1987, c A7, s 1; *Age of Majority and Accountability Act*, RSO 1990, c A.7, s 1; *Age of Majority Act*, RSPEI 1988, c A-8, s 1; *The Age of Majority Act*, RSS 1978, c A-6, s 2(1); art 153 CCQ.

40 This is the case in British Columbia, New Brunswick, Newfoundland, Nova Scotia, Northwest Territories, Nunavut, and Yukon. See *Age of Majority Act*, RSBC 1996, c 7, s 1(a); *Age of Majority Act*, RSNB 1973, c A-4, s 1(1); *Age of Majority Act*, SNL 1995, c A-4.2, s 2; *Age of Majority Act*, RSNS 1989, c 4, s 2(1); *Age of Majority Act*, RSNWT 1988, c A-2, s 2; *Age of Majority Act*, RSY 1986, c 2, s 1(1).

41 *B(R) v Children's Aid Society of Metropolitan Toronto*, [1995] 1 SCR 315, [1994] SCJ No 24.

42 For a summary of the relationship between statutory law and the common law, see Joan Gilmour, "Children, Adolescents and Health Care" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds, *Canadian Health Law and Policy*, 2nd ed (Toronto: Butterworths, 2002) 202 at 210–21.

43 *Ibid* at 211.

44 Joan Gilmour et al, "Pediatric Use of Complementary and Alternative Medicine: Legal, Ethical, and Clinical Issues in Decision-Making" (2011) 128:S4

lation varies across the country in terms of how it interacts with the common law or otherwise approaches decisional capacity in minors. Manitoba and New Brunswick provide examples of jurisdictions where legislation has deemed an age less than majority as the age at which a child is presumptively recognized as having decisional capacity for medical treatment decisions. In these provinces, children 16 years of age and older are presumed to have capacity,[45] and thus can consent to medical treatment, including the withdrawal from or refusal of life-sustaining treatment. The *Carter* SCC declaration, with its reference to the patient being an "adult" as a threshold criterion, is strikingly at odds with these regimes if "adult" is interpreted to mean the age of majority. The new legislation is similarly inconsistent. Just as with adults who lack capacity, these laws contemplate the state or a third party having discretion to intervene if decisional capacity is in fact lacking. For example, the Manitoba legislation permits intervention if the 16- or 17-year-old minor is unable, in fact, to "understand the information that is relevant to making a decision to consent or not consent" to treatment, or is unable "to appreciate the reasonably foreseeable consequences of making a decision to consent or not consent" to the medical treatment.[46] The legislation in New Brunswick and Manitoba also addresses the role of a minor's views when the minor is under 16 years of age. In particular, where a minor is between 12 and 16, and there is a dispute over treatment, Manitoba gives the minor the opportunity to have their opinion heard in a court proceeding. The judge may also consider the preferences of a minor under the age of 12 if the minor is deemed by the judge to be able to understand

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Pediatrics S149 at S151–52. See also Joan M Gilmour, "Children, Adolescents and Health Care", *supra* note 42 at 212, where Gilmour similarly writes: "a minor who can fully understand and appreciate the nature and consequences of a proposed medical procedure can give legally valid consent to the treatment."

45 See *Medical Consent of Minors Act*, *supra* note 10, s 17(3); *Directives*, Manitoba, *supra* note 10, s 4(2)(a).

46 *The Child and Family Services Act*, SM 1985–86, CCSM c C80, ss 25(9)(a)–(b) [*Child and Family Services Act*]. Two common requirements for consent, arising under the common law but reified into legislation in many instances, are that the patient have capacity to make the treatment decision and the consent be informed. Decisional capacity is defined as being present where "an individual has sufficient ability to understand and appreciate the nature and consequences of treatment and its alternatives to be able to make a decision about whether to proceed with it or not" (Joan M Gilmour, "Death, Dying and Decision-Making about End of Life Care" in Downie, Caulfield & Flood, 4th ed, *supra* note 34, 385 at 387–89 [Gilmour, "Death, Dying and Decision-Making"]).

the proceeding and if the treatment would not be harmful to the minor.[47] New Brunswick permits any child under 16 to give consent if the minor is found "capable of understanding the nature and consequences of a medical treatment" and the treatment is in "the best interests of the minor and his continuing health."[48] Thus for both jurisdictions, minors 16 years of age and younger are already recognized as potentially having the capacity and right to consent to the withdrawal of life-sustaining treatment, although this right is limited to circumstances where the treatment enables "continuing health" or is "not harmful." On the face of it, medical aid in dying would cause the identifiable "harm" of certain death. However, one must bear in mind the larger context, and in particular the elements of the declaration, and ask whether it is conceivable that there are circumstances in which a decision-maker would find that certain death is "not harmful" if the alternative is to force the minor to experience enduring intolerable suffering. This conclusion is all the stronger in light of the legislative regime, which added the further requirement that the natural death of the requesting individual be reasonably foreseeable.[49]

The statutory regime in British Columbia, on the other hand, makes no reference to age. Unlike New Brunswick and Manitoba, it has adopted a capacity approach for all minors. Its terms for a minor's consent to be considered legally effective are twofold. First, the minor must be found to understand "the nature and consequences and the reasonably foreseeable benefits and risks of the health care." Second, the health care provider must have "made reasonable efforts to determine and [must have] concluded that the health care is in the infant's best interests."[50] Thus the mature minor's decision is not deferred to without a concurring opinion from a physician, and unlike New Brunswick, no legal presumption is made that minors 16 to 18 years of age have decisional capacity. Just as some physicians agreed with the patient litigants in *Carter* SCC that a request for a physician-assisted death ought to be granted to those individuals, it is entirely conceivable that a British Columbian physician may concur with a capable minor that physician-assisted dying is in their best interests.

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47 *Child and Family Services Act*, *supra* note 46, ss 2(2)–(3). It was the Manitoba regime that was at issue in *AC*, *supra* note 2, and so it is returned to again, below.

48 *Medical Consent of Minors Act*, *supra* note 10, s 3(1)(b).

49 *Criminal Code*, *supra* note 4, s 241.2(2)(d).

50 *Infants Act*, RSBC 1996, c 223, s 17(3)(a).

The scholarship on mature minor regimes often adopts a critical tone, taking the position that in refusal of treatment cases, capacity assessments may be artificial. Mosoff, for example, notes that where there is a dispute about capacity and the matter goes to court, a youth will be found to lack capacity if "death is likely without treatment and the treatment is likely to be successful."[51] That is, the decision about whether to respect the minor's wishes turns not on the capacity assessment, but on the alignment of the prognosis with the minor's decision. Gilmour surmises that a positive prognosis influences whether a court believes that the minor understands the consequences of refusing the treatment, and thus whether the minor has capacity.[52]

Where minors' decisions to refuse potentially life-sustaining treatment have been assessed in court and respected, the fact situations have indeed tended to be ones where the odds of a favourable outcome were low, or the child's life was unlikely to be appreciably prolonged. These poor prognoses were often accompanied by undesirable side effects associated with the treatment, including emotional distress due to religious beliefs being violated.[53] Despite this pattern, the Supreme Court of Canada concluded that – in

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[51] See Judith Mosoff, "'Why Not Tell It Like It Is?': The Example of P.H. v. Eastern Regional Integrated Health Authority, a Minor in a Life-Threatening Context" (2012) 63 UNBLJ 238 at 239. See also Gilmour, "Children, Adolescents and Health Care", *supra* note 42 at 213:

> The argument that a minor can only consent to care that would be of benefit is sometimes referred to as 'the welfare principle'. It suggests that a mature minor can only make those decisions about medical care that others would consider to be in his or her interests; as such it challenges the extent of the commitment in law to mature minors' interests in self-determination and autonomy.

[52] Gilmour, "Death, Dying and Decision-Making", *supra* note 46 at 392–93. In *AC*, *supra* note 2, Justice Abella noted a similar trend, without going so far as to suggest that unspoken factors are at play. In her survey of the jurisprudence in 2009, she noted that at that time no court in Canada or the UK had allowed a child under 16 to refuse treatment that was likely to jeopardize the child's "potential for a healthy future" (*ibid* at paras 56–57). In these cases, courts found that the decision to refuse treatment was not voluntary (e.g., due to influence from parents) or else that "the [child] was not mature enough to make the decision to die" (*ibid* at para 61).

[53] *AC*, *supra* note 2 at paras 62–63. See also *Walker*, *supra* note 37; *Re K(LD)*, (1985), 23 CRR 337 at paras 19, 27, 33, ACWS (2d) 417 (Ont Prov Ct); *Sas-*

theory – the coupling of Manitoba's legislation with the common law could result in upholding a 15-year-old's decision to not undergo a life-saving treatment despite a good prognosis.[54] While the jurisprudence may exhibit a certain capriciousness, this is no cause to avoid considering the implications of *Carter* SCC for mature minors. Any older adolescent who met the remainder of the onerous criteria set out in the *Carter* SCC declaration and the additional statutory requirement – a grievous and irremediable medical condition that causes enduring suffering that is intolerable and whose death is reasonably foreseeable – would be unlikely to be in a situation where the prognosis is favourable. As a result, some of the concerns which Mosoff and Gilmour identify would be unlikely to influence the integrity of the capacity assessment. In sum, while the tests and criteria vary, all jurisdictions recognize that minors may be sufficiently mature to consent to medical treatment including the withdrawing of life-sustaining treatment. In some instances, third party affirmation that the decision is in the minor's best interest is also required.

Recall that the *Carter* SCC declaration brings the law on physician-assisted suicide or voluntary euthanasia more in line with existing law on the determinative role of consent where a person refuses to receive, or withdraws from, life-sustaining treatment[55] – but only for someone who is a "competent adult."[56] A pivotal question, then, is whether the medical aid in dying regime enacted to implement *Carter* SCC, and in particular the regime's exclusion of mature minors, would withstand a *Charter* challenge. That is, is the reasoning in *Carter* SCC persuasive in the case of a mature minor? I turn now to comparing the *Carter* SCC decision with Justice Abella's reasons in *AC*.

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katchewan (Minister of Social Services) v P(F), [1990] 69 DLR (4th) 134, [1990] 4 WWR 748 (Sask Prov Ct).

54 *AC*, *supra* note 2.

55 For an overview of the determinative role of consent in such health care decisions, see Gilmour, "Death, Dying and Decision-Making", *supra* note 46 at 387.

56 Another continuing inconsistency is that substitute decision-makers, and advance directives, can provide full consent for the withdrawal of life-sustaining treatment from persons who, at the time when the decision to withdraw is actually made, lack capacity. See *Personal Directives Act*, SNS 2008, c 8, ss 3(b), 9, 15.

IV. APPLYING THE REASONING IN *CARTER* TO MATURE MINORS

The legal question in *Carter* SCC was framed as whether a statutory regime which has the "narrow goal of preventing vulnerable persons from being induced to commit suicide at a time of weakness"[57] was *Charter*-compliant. The trial judge, Justice Smith, remarked on similarities between the matters before her and the leading case on mature minors' right to not have medical treatment imposed without their consent, *AC*.[58] The discussion below will take the majority reasons written by Justice Abella in *AC*[59] as a touchstone for considering the persuasiveness of aspects of the *Carter* SCC decision in the context of mature minors. It will focus, in particular, on the analysis of the rights that are protected under Section 7 of the *Charter*.

AC involved the interaction of the common law with Manitoba's child welfare legislation. A 15-year-old Jehovah's Witness had refused to consent to blood transfusions, a decision that put her life directly at risk. The minor's family supported this decision. The Manitoba Director of Child and Family Services intervened and sought a court order under provincial legislation to authorize the life-saving treatment without the consent of the minor and/or her family. As the minor was under 16, the legislative presumption of capacity was not present. Instead, as discussed above, the minor only had the right to have her views made known to

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57 *Carter* SCC, *supra* note 1 at para 78.

58 *AC*, *supra* note 2.

59 There were three sets of reasons in *AC* (*supra* note 2). Justice Abella wrote the majority judgment, for herself and three other judges, and upheld the regime as lawful. Chief Justice McLachlin and Justice Rothstein concurred in the result. Both Justice Abella and Chief Justice McLachlin found the regime to be constitutionally sound. However, Justice Abella found that the common law continued to play a role, a conclusion which Chief Justice McLachlin rejected. Justice Abella and Chief Justice McLachlin also had different findings on elements of the *Charter* analysis. Justice Binnie wrote in dissent and found the regime violated the *Charter*. For discussion of these reasons, see Shawn HE Harmon, "Body Blow: Mature Minors and the Supreme Court of Canada's Decision in *AC v Manitoba*" (2010) 4:1 McGill JL & Health 83. The approach to autonomy which the court endorsed has also attracted considerable criticism. Alternatives, such as supported decision making, have been presented as preferable approaches. See e.g. Mona Paré, "Of Minors and the Mentally Ill: Re-Positioning Perspectives on Consent to Health Care" (2011) 29:1 Windsor YB Access Just 107.

the decision-maker.[60] The family argued that their child's refusal to consent to treatment ought to be definitive. In particular, they argued that the child's *Charter* rights to equality,[61] life, liberty, security of the person,[62] and to religious freedom[63] were violated by the legislation because they claimed it effectively created "an irrebuttable presumption of incapacity."[64]

Early in her reasons, the trial judge in *Carter v Canada (AG)* (*Carter* BCSC), Justice Smith, reflected on how the legal questions that she had to decide were similar to those that were considered in *AC* and adopted its language. She wrote:

> [In *AC* Justice Abella] framed the issue in a way that echoes the issue in the case before me (at para 30):
>
> > The question is whether the statutory regime strikes a constitutional balance between what the law has consistently seen as an individual's fundamental right to autonomous decision making in connection with his or her body and the law's equally persistent attempts to protect vulnerable children from harm.[65]

Justice Smith returned to *AC* throughout her analysis. She ultimately drew many of her conclusions, which were subsequently adopted by the Supreme Court, from *AC*, as well as from other cases that discussed the conditions under which minors could refuse life-saving treatment.[66]

As noted above, both these decisions concerned regimes enacted to address decision-making contexts where the subject of the decision may be vulnerable and where that vulnerability required considering whether or

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60 *Child and Family Services Act*, *supra* note 46, ss 2(2)–(3).

61 *Charter*, *supra* note 3, s 15.

62 *Ibid*, s 7.

63 *Ibid*, s 2(a).

64 *AC*, *supra* note 2 at para 25.

65 *Carter* BCSC, *supra* note 13 at para 962, citing *AC*, *supra* note 2 at para 30.

66 See e.g. *AC, supra* note 2, was cited in *Carter* BCSC, *supra* note 13 at paras 218, 955–56, 958–70, 1234, 1298, 1300–03, 1350.

how protections may be required. In *AC*, the relevant vulnerability is that which is presumed to be inherent to childhood and which is also presumed to gradually dissipate with the development of maturity. In *Carter* SCC, the relevant vulnerability is characterized as a "time of weakness" that a suffering person may experience. In each case, the conclusion about *Charter* compliance turned on whether the regime recognized that vulnerability may not, in fact, be present in the circumstances, or alternatively that a level of vulnerability does not necessarily undermine autonomous decisional capacity.

To look at the cases more closely, both *AC* and *Carter* SCC considered how an individual's Section 7 rights[67] were impacted upon by the regime in question. In *Carter* SCC, the Supreme Court of Canada found that the right to life was engaged because "the prohibition on physician-assisted dying had the effect of forcing some individuals to take their own lives prematurely, for fear they would be incapable of doing so when they reached the point where suffering was intolerable."[68] Justice Abella did not discuss the right to life in *AC*. But the reasoning in *Carter* SCC is on its face compelling with regard to mature minors. It is entirely conceivable that a 16-year-old may choose to commit suicide "prematurely" rather than face living with a medical condition that has become intolerable to them past the moment when they still have the power to take their own life. Both decisions do discuss the right to liberty and security of the person. In *AC*, the court considered minors' interests in liberty and security of the person and found that these interests were implicated by orders imposing treatment against the wishes of a minor. The court found that such orders denied minors the ability to determine their own medical treatment, thereby depriving them of their rights as guaranteed under the *Charter*.[69]

Revisiting these *Charter* rights in *Carter* SCC, the court observed that these rights are underwritten by a concern for "individual autonomy and dignity."[70] The court affirmed that security of the person encompasses "a notion of personal autonomy involving … control over one's bodily integ-

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67 *Charter*, *supra* note 3, s 7. Section 7 protects the rights to "life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

68 *Carter* SCC, *supra* note 1 at para 57.

69 *AC*, *supra* note 2 at para 102.

70 *Carter* SCC, *supra* note 1 at para 64.

rity free from state interference"[71] and that "it is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering."[72] As to liberty, they defined this interest as "the right to make fundamental personal choices free from state interference."[73] The court in *Carter* SCC analyzed the right to liberty and security of the person together, finding that the prohibition interfered with individuals' "ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty. And, by leaving people … to endure intolerable suffering, it impinges on their security of the person."[74] In its summative comments on autonomy, the *Carter* SCC court essentially found that the reasoning in *AC*, which supported mature minors having the right to refuse treatment, also determined its conclusions about the claimed right of the individual plaintiffs to choose physician-assisted death:

> In *A.C. v. Manitoba (Director of Child and Family Services)*, ... a majority of this Court, per Abella J. (the dissent not disagreeing on this point), 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" (para. 39). This right to "decide one's own fate" entitles adults to direct the course of their own medical care (para. 40): it is this principle that underlies the concept of "informed consent" and is protected by s. 7's guarantee of liberty and security of the person.[75]

Given *Carter* SCC's reasoning, and the findings in *AC*, it is likely that a physician-assisted death regime that completely excludes mature minors, without regard to their actual circumstances, will impair their Section 7 rights.

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71 *Ibid*, citing *Rodriguez v British Columbia (AG)*, [1993] 3 SCR 519 at 587–88, [1993] SCJ No 94.

72 *Carter* SCC, *supra* note 1 at para 64.

73 *Ibid*, citing *Blencoe v British Columbia (Human Rights Commission)*, 2000 SCC 44 at para 50, [2000] 2 SCR 307, citing *R v Morgentaler*, [1988] 1 SCR 30 at 166, 44 DLR (4th) 385, Wilson J.

74 *Carter* SCC, *supra* note 1 at para 66.

75 *Ibid* at para 67.

Laws that infringe on life, liberty, or security of the person will stand if they are consistent with the principles of fundamental justice, which include the principle that a law should not being arbitrary.[76] The court in *Carter* SCC found that a total ban on assisted death was not arbitrary because there was a rational connection between the legal prohibition and its object, to protect the vulnerable from ending their lives in times of weakness.[77] If the question with regard to mature minors is framed as whether it is arbitrary to assume that a continued prohibition on assisted death will protect them, then, like the discussion in *Carter* SCC about adults, the answer must be no. However, if the question is whether it is arbitrary to assume that a mature minor can never have the capacity to make a medical treatment decision that adults have the capacity to make, then the answer must be yes. As discussed above, mature minors are defined by a finding that they have this very capacity vis-à-vis the specific decision at issue in any given instance. In *AC* the court affirmed that a regime which ignored this fact would be arbitrary:

> Given the significance we attach to bodily integrity, it would be arbitrary to assume that no one under the age of 16 has capacity to make medical treatment decisions. It is not, however, arbitrary to give them the opportunity to prove that they have sufficient maturity to do so.[78]

The finding that the legislative regime in *AC* did in fact provide an opportunity to prove capacity was pivotal for determining that although the regime violated a minor's Section 7 rights to liberty and security of the person, it was nonetheless compliant with Section 7.

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[76] The principles of fundamental justice are also offended if a law is overbroad or has consequences that are grossly disproportionate. The decision in *Carter* SCC turned on the prohibition being overbroad, and taking "away rights in a way that … goes too far by denying the rights of some individuals in a way that bears no relation to its object" (*Carter* SCC, *supra* note 1 at para 85). In particular, the prohibition was overbroad because it caught people who are not, in fact, vulnerable, but rather seeking to exercise an autonomous and informed choice. Overbreadth was not considered in *AC* (*supra* note 2) – but one would expect a similar assessment. In principle, an age restriction results in minors who are capable and can consent being treated as incapable and lacking capacity. The court in *Carter* SCC also briefly discussed the principle of gross disproportionality but did not reach a conclusion on that issue (*ibid* at paras 89–90).

[77] *Ibid* at 83–84.

[78] *AC*, *supra* note 2 at para 107.

In her analysis, Justice Abella found that the potential for vulnerability, in the form of lack of maturity, justified the state holding a power to assess life decisions for their alignment with the child's best interests:

> [T]he ineffability inherent in the concept of "maturity" … justifies the state's retaining an overarching power to determine whether allowing the child to exercise his or her autonomy in a given situation actually accords with his or her best interests.[79]

However, the protective legislative regime at issue in *AC* was nuanced by the fact that it did not create an irrebuttable presumption of incapacity. Rather, Justice Abella found it required an inquiry into maturity, with the overarching power of the state to act without the consent of the minor fading in light of growing maturity, even where the minor is refusing life-sustaining treatment. On this point, Justice Abella wrote:

> The more a court is satisfied that a child is capable of making a mature, independent decision on his or her own behalf, the greater the weight that will be given to his or her views when a court is exercising its discretion under [the legislation]. … If … the court is persuaded that the necessary level of maturity exists, it seems to me necessarily to follow that the adolescent's views ought to be respected.[80]

In other words, the minor's *Charter* rights were respected because the regime did not create an absolute bar to their treatment wishes being respected. Rather, it required an assessment on the facts and recognized the possibility of finding that in individual cases a child may be found to have the decisional rights of a competent adult due to having mature decisional capacity. This set of facts also supported the court's conclusion that the regime's reliance on age did not violate Section 15 – because capacity, not age, was the true determinant of whether the child would have the right to make their own treatment decision.[81]

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79 *Ibid* at para 86.

80 *Ibid* at para 87.

81 The court in *AC*, *ibid*, considered whether the reference to age offended Section 15, the equality provisions of the *Charter*. The court found Section 15 was not offended. Although noting that the presumption as to a distinction between "promoting autonomy and protecting welfare" is presumed to collapse at age 16, in all cases weight will be allocated to a child's views in accordance with

In summarizing her reasons, Justice Abella commented that "[a] rigid statutory distinction that completely ignored the actual decision-making capabilities of children under a certain age would fail to reflect the realities of childhood and child development."[82] To place a stark red line between adults and minors with regard to physician-assisted dying would clash with the very reasons our approaches to mature minors and medical-decisional capacity are *Charter*-compliant. The court's reasons in *AC*, coupled with those in *Carter* SCC, would seem to support extending the regime which operationalizes the declaration in *Carter* SCC to mature minors, or risk being found unconstitutionally arbitrary.

In *AC* there was no *Charter* violation, and so there was no Section 1 analysis. This differs from *Carter* SCC, where because the provision in question was found to violate Section 7 rights and be inconsistent with the principles of fundamental justice because the *Criminal Code* did not provide an opportunity to rebut the presumption of vulnerability, the court had to consider whether the violation was justified by the government.[83] The Supreme Court shaped its discussion on Section 1 as an answer to the following question:

> [W]hether a regime less restrictive of life, liberty and security of the person could address the risks associated with physician-assisted dying, or whether Canada was right to say that the risks could not adequately be addressed through the use of safeguards.[84]

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a court's conclusions about the child's maturity and capacity. Justice Abella writes: "their ability to make treatment decisions is ultimately calibrated in accordance with maturity, not age, and no disadvantaging prejudice or stereotype based on age can be said to be engaged" (*ibid* at para 111).

82 *Ibid* at para 116.

83 As stated by the Supreme Court of Canada in *Carter* SCC, the Section 1 justification analysis centrally asks the following questions about an impugned regime: "In order to justify the infringement of the appellants' s. 7 rights under s. 1 of the *Charter*, Canada must show that the law has a pressing and substantial object and that the means chosen are proportional to that object. A law is proportionate if (1) the means adopted are rationally connected to that objective; (2) it is minimally impairing of the right in question; and (3) there is proportionality between the deleterious and salutary effects of the law: *R. v. Oakes*, [1986] 1 S.C.R. 103" (*supra* note 1 at para 94).

84 *Ibid* at para 103.

This is a re-phrasing of how the trial judge in *Carter* BCSC positioned the issue. She stated, more generally, that the "real question is whether a prohibition with exceptions would, in practical application, place patients at risk because of the difficulty in designing and applying the exceptions."[85] It is hard to imagine that this question would not be asked if a challenge was brought regarding mature minors. One would expect that this issue would sit at the heart of public concerns.

This portion of *Carter* SCC is particularly interesting for considering the situation of mature minors, as the Supreme Court of Canada answered this question with reference to its reasoning and findings in *AC*. In particular, *AC* was relied upon to illustrate that safeguards can be designed and implemented to protect those who ask for physician-assisted death and who are potentially vulnerable:

> As the trial judge noted, the individual assessment of vulnerability (whatever its source) is implicitly condoned for life-and-death decision making in Canada. In some cases, these decisions are governed by advance directives, or made by a substitute decision-maker. Canada does not argue that the risk in those circumstances requires an absolute prohibition (indeed, there is currently no federal regulation of such practices). In *A.C.*, Abella J. adverted to the potential vulnerability of adolescents who are faced with life-and-death decisions about medical treatment (paras. 72–78). Yet, this Court implicitly accepted the viability of an individual assessment of decisional capacity in the context of that case. We accept the trial judge's conclusion that it is possible for physicians, with due care and attention to the seriousness of the decision involved, to adequately assess decisional capacity.[86]

In short, it was the court's confidence that physicians can assess adolescent decisional capacity in the context of life-and-death decisions that gave the court confidence that physicians can assess adult decisional capacity to consent to physician-assisted dying.[87] It follows that we should have confidence that our tests for adolescents will also capture their capacity in this context.

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85 *Carter* BCSC, *supra* note 13 at para 1235.

86 *Carter* SCC, *supra* note 1 at para 116.

87 Justice Abella wrote in *AC*, *supra* note 2 at para 78: "the factors that may affect an adolescent's ability to exercise *independent*, mature judgement in making

V. THE QUESTION OF SAFEGUARDS: PRACTICES AND EXPERIENCES IN BELGIUM AND THE NETHERLANDS

The Section 1 analysis in *Carter* SCC, which focuses on proportionality and what was necessary to protect the vulnerable, turned in part on evidence concerning how other regimes address risks and concerns about vulnerability associated with physician-assisted death. Based on this evidence, both the trial judge and the Supreme Court concluded that it was possible to limit the risks "through a carefully designed and monitored system of safeguards."[88] The Supreme Court, of course, left it to policy-makers to determine what this system would look like.

In the context of mature minors' capacity to consent, Courts and medical treatment teams have already recognized that when considering the weight to be placed on a mature minor's request "the degree of scrutiny will inevitably be most intense in cases where a treatment decision is likely to seriously endanger a child's life or health."[89] However, it may be that further and specific protocols, safeguards, or terms for evaluating requests for medical aid in dying from mature minors are appropriate. This issue should certainly be discussed and considered if provinces and the federal government include mature minors in physician-assisted dying regimes. While the Expert Panel suggested that the same regime that is used for adults should be used for minors, the Québec Commission suggested that the rules for consent for minors should be supplemented by rules that take the specific and irreversible nature of medical aid in dying into account.[90]

Both Belgium and the Netherlands, where minors are included in a physician-assisted dying regime, have chosen routes which align more closely with the Commission's suggested approach. Belgium's regime did not originally extend to minors. Its 2002 legislation, which legalized euthanasia where the patient was experiencing a "hopeless medical condition and complains of constant and unbearable physical *or mental* pain that cannot be relieved and is the result of a serious and incurable accidental or pathologic-

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maximally autonomous choices are numerous, complex, and difficult to enumerate with any precision" [emphasis in original].

88 *Carter* SCC, *supra* note 1 at para 117.

89 *AC*, *supra* note 2 at para 86.

90 Mémoire, Project de Loi No 52, *supra* note 25 at 22.

al condition,"[91] required patients to be of the age of majority in Belgium, 18, or an "emancipated minor."[92]

In 2014, Belgium amended its law to extend the exception to minors. It removed all reference to age, and instead made "the capacity for discernment" (*la capacité de discernement*) the key threshold for minors.[93] Belgium adopted this amendment, in part,[94] because age was seen "as less important than the capacity for discernment" and a recognition that this capacity "var-

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91 Raphael Cohen-Almagor, "Belgian Euthanasia Law: A Critical Analysis" (2009) 35 J Med Ethics 436 at 438 [emphasis in original].

92 *Ibid*. See *Loi relative à l'euthanasie*, Moniteur Belge [MB], 22 June 2012, 28515 [*Loi euthanasie*]. An unofficial version of this original legislation is available online: Dalhousie Health Law Institute <eol.law.dal.ca/wp-content/uploads/2015/06/Belgian-Euthanasia-Act.pdf>. For an unofficial translation of the legislation into English, see Dale Kidd, "The Belgian Act on Euthanasia of May 28th 2002" (2002) 9:2-3 Ethical Perspectives 182. The term "emancipated minor" is not defined in the legislation. The term was described to Raphael Cohen-Almagor as intended to refer to "boundary cases of 16-17 year-old patients" and to "an autonomous person capable of making decisions" (Cohen-Almagor, *supra* note 91 at 437). Others have asserted that the term only referred to "minors who are independent of their parents (e.g. due to marriage)" and thus "does not apply to other 'mature minors' between the ages of twelve and eighteen." See Wayne Sumner, *Assisted Death: A Study in Ethics and Law* (Oxford University Press, 2011) at 157. Given changes to the legislative regime in 2014, the question of the proper interpretation of the term has been rendered moot.

93 *Loi euthanasie*, *supra* note 92, art 3(1), as amended by *Loi modifiant la loi du 28 mai 2002 relative à l'euthanasie, en vue d'étendre l'euthanasie aux mineurs*, Moniteur Belge [MB], 22 February 2014, 21053. An unofficial English translation is available online: Dalhousie Health Law Institute <eol.law.dal.ca/wp-content/uploads/2015/06/Law-of-28-May-2002-on-Euthanasia-as-amended-by-the-Law-of-13-February-2014.pdf>.

94 Other key factors for not restricting minors' access to euthanasia in controlled circumstances include strong public and physician support: Andrew M Siegel, Dominic A Sisti & Arthur L Caplan, "Pediatric Euthanasia in Belgium: Disturbing Developments" (2014) 311:19 JAMA 1963 at 1963. A 2011 survey found that 69.4% of Belgium physicians supported extending the then current law on euthanasia to minors: Geert Pousset et al, "Attitudes and Practices of Physicians Regarding Physician-Assisted Dying in Minors" (2011) 96:10 Arch Dis Child 948 at 950.

ies widely with children."[95] This change brought their medical aid in dying laws in line with their existing consent legislation, which turns on a factual assessment of capacity.[96]

While all children with decisional capacity can consent to euthanasia, one safeguard is that their decision is not determinative as parental consent is also required. Describing the criteria of the 2014 amendment, Bernard Dan et al write:

> This bill rests on the same fundamentals as the 2002 Act on Euthanasia, including specifics of the request, responsibility of the physician, and the notions of serious and incurable disorder, hopeless situation, and unbearable suffering. Although it extends its application to children, it restricts its scope by excluding psychiatric disorders and, more importantly, by specifically addressing the issue of capacity for discernment, which should be assessed carefully by a multidisciplinary pediatric team, including a clinical psychologist. The parents must agree to the request.[97]

Thus, this regime recognizes the family as the decision-making unit. As well, the whole regime was passed in conjunction with legislation that "provided the basis for a steep increase in the means that were already available for palliative care,"[98] as one of their measures to reduce risk and address vulnerability.

Legislation authorizing physician-assisted death in the Netherlands, on the other hand, was crafted to address requests from minors from the start. The 2002 *Termination of Life on Request and Assisted Suicide (Review Pro-*

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95 Dan, Fonteyne & de Cléty, *supra* note 15 at 671 [footnotes omitted].

96 Article 12 of the *Loi relative aux droits du patient*, Moniteur Belge [MB], 26 September 2002, 43719 grants minors "'who are deemed to be capable of reasonable judgment of their needs' the right to exercise their patient rights autonomously, independently of chronological age." See Pousset, *supra* note 94 at 952.

97 Dan, Fonteyne & de Cléty, *supra* note 15 at 672.

98 Cohen-Almagor, *supra* note 91 at 437.

cedures) Act has some terms that apply whenever a physician receives a request, and additional terms that apply when the request is made by a minor.[99]

In all cases, the legislation permits physicians to agree to grant requests for assisted death in circumstance of "due care." The "due care" criteria include the patient being convinced there is no other reasonable solution for him or her, the physician being convinced that the request is voluntary and well-considered, and that the patient's suffering is lasting and unbearable. The physician must also have informed the patient about his or her options, and an independent written opinion must be obtained from another physician, where that second physician has seen the patient and agrees that the above criteria are met.[100] The granting physician must report on how the due care criteria were met, and the report is in turn evaluated by a Regional Euthanasia Review Committee. If the Committee is of the opinion that the due care criteria were not met, the file is referred to the Healthcare Inspectorate and the Public Prosecution Service, who may prosecute the physician.[101]

Additional requirements arise when the requesting individual is a minor. These requirements are calibrated by age and mirror Dutch laws on a minor's consent to medical treatment.[102] In particular, older minors who are 17 and 18 years of age can independently request assisted death, but their parents are required to be consulted about and involved in the decision-

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99 *Termination of Life on Request and Assisted Suicide (Review Procedures) Act* (entered into force April 2002), art 2.

100 André Janssen, "The New Regulation of Voluntary Euthanasia and Medically Assisted Suicide in the Netherlands" (2002) 16:2 Intl JL Pol'y & Fam 260 at 262–63. See also Government of the Netherlands, "Is Euthanasia Allowed?" (14 February 2016), online: <www.government.nl/issues/euthanasia/is-euthanasia-allowed>. For a detailed description of how the due care criteria are interpreted, see Regional Euthanasia Review Committees, "Annual Report 2011" (August 2012) at 8–26. An English translation of the Dutch law can be found at World Federation of Right to Die Societies, "Termination of Life on Request and Assisted Suicide (Review Procedures) Act", online: <www.euthanasia.ws/documentos/Leyes/Internacional/Holanda%20Ley%202002.pdf>.

101 Government of the Netherlands, "Euthanasia, Assisted Suicide and Non-Resuscitation on Request" (14 February 2016), online: <www.government.nl/issues/euthanasia/euthanasia-assisted-suicide-and-non-resuscitation-on-request>. For a more detailed description of the process for reviewing reports, see Regional Euthanasia Review Committees, *supra* note 100 at 27–28.

102 Janssen, *supra* note 100 at 265.

making process.[103] For younger minors, the legislation is similar to that in Belgium, and while children who are 12 to 16 years of age can request assisted death, their parents must also consent to the request.[104]

The legislation also makes the physician responsible for the ultimate decision about whether to grant the request.[105] Intriguingly, a survey of pediatric physicians working in specializations where the majority of child deaths occur (oncology, hematology, intensivists and neurologists) found that while 62% had received requests for physician-assisted dying, only 24% had ever granted such a request.[106] Unfortunately the publication describing the survey results did not provide the reasons why the requests were not granted, so it is not clear, for example, whether the decision turned on a capacity assessment, medical criteria not being met, or the physician concluding that there were other reasonable options. Another study has found that, although only consultation is required by the legislation, in practice physicians are less likely to grant requests from older minors without parental consent.[107] Overall, while Dutch minors can initiate the decision-making process, it appears that their family and the whole treatment team are robust participants in such decisions. In many ways, this model is closer to a supported decision-making model, which some have argued ought to be generally adopted

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103 *Ibid*.

104 The legislation does not extend to children under 12 years of age. Vrakking et al, "Medical End-of-Life Decisions", *supra* note 19 at 803. According to recent interviews reported in the Daily Telegraph, the Dutch Paediatric Association objects to the age-based approach. The Association's ethics committee is petitioning for a commission to be struck to consider an approach under which "[e]ach child's ability to ask to die [is] evaluated on a case-by-case basis" according to Eduard Verhagen, a member of the ethics committee and professor of paediatrics at Groningen University, as cited in Justin Huggler, "Give Children under 12 the Right to Die, Say Dutch Paediatricians", *The Telegraph* (19 June 2015), online: <www.telegraph.co.uk/news/worldnews/europe/netherlands/11686716/Give-children-under-12-the-right-to-die-say-Dutch-paediatricians.html>.

105 Vrakking et al, "Medical End-of-Life Decisions", *supra* note 19 at 807. Vrakking et al explain that this is pursuant to the *Dutch Medical Treatment Act* (1995).

106 Vrakking et al, "Medical End-of-Life Decisions", *supra* note 19 at 807.

107 *Ibid* at 807, citing Astrid M Vrakking et al, "Physicians' Willingness to Grant Requests for Assistance in Dying for Children: A Study of Hypothetical Cases" (2005) 146:5 J Pediatr 611 at 611–17.

in Canada for minors. Mona Paré, for example, suggests such approaches are better at respecting the protection needs and autonomy rights of minors than our current approach to consent and capacity, because they engage the circle of care.[108]

If Canada chooses to include minors in a physician-assisted dying regime, which legally I believe we must, the regimes in Belgium and the Netherlands offer us some models to consider when assessing whether additional safeguards should be in place when requests come from minors. They also identify some issues that we must address in our conversations about minors and physician-assisted death. These include the roles for family members and treatment teams in end-of-life decisions, as well as the need to pay attention to the adequacy of palliative care. The Netherlands model is also provocative in that while a request must be made by the minor, the state continues to assert a protective role and the ultimate decision does not rest with the minor but with a physician.

Conclusion

This article has not engaged with many of the spectres that hover around discussions of medical aid in dying. It has not, for example, considered the adequacy of the funding of pediatric palliative care and the quality of hospice care for minors in Canada. Any deficiency in these factors ought not to play a role in any request for physician-assisted death in Canada. This article has also not suggested how provinces ought to go about addressing the outstanding matter of bringing clarity and consistency to the law regarding mature minors and medical decision making generally. It has instead focused on the general and consistent principles in this area, which force us to recognize that we need to grapple with how minors are to be included in Canada's medical aid in dying regime.

This article calls out for a lot of work. It calls upon the public and policy makers to engage with the fact that minors will request physician-assisted death, and to think through the best answers to such a request. At the moment, the range of responses seems to include telling a minor who is 17 years and 10 months old to make a choice between either waiting it out for two months and hoping that they do not lose capacity during that time period, or else choosing to have their feeding tube removed and starving to

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108 Paré, *supra* note 59.

death while heavily sedated. Another choice is to tell a family that they can serve as a litigation test case that will likely last far longer than the life of their child. These responses are not satisfactory, and they do a disservice to our youth.

This conversation requires engagement with what the law demands, with close attention and honesty about the impact and consequences of our decisions. The analysis above, of *Carter* SCC and *AC*, indicates that the complete exclusion of minors from a physician-assisted death regime will likely fall if challenged under Section 7. The focus of the discussion moving forward should be to identify the terms under which our legal regime is clearly *Charter*-compliant, and under which there is public confidence that protections are in place where vulnerability is present.