IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Carter v. Canada (Attorney General),*
2012 BCSC 886

Date: 20120615
Docket: S112688
Registry: Vancouver

Between:

Lee Carter, Hollis Johnson, Dr. William Shoichet,
The British Columbia Civil Liberties Association and Gloria Taylor

Plaintiffs

And

Attorney General of Canada

Defendant

And

Attorney General of British Columbia

Defendant

And

Farewell Foundation for the Right to Die
-and-
The Christian Legal Fellowship
-and-
Canadian Unitarian Council
-and-
Euthanasia Prevention Coalition and
Euthanasia Prevention Coalition – British Columbia
-and-
Ad Hoc Coalition of People with Disabilities
Who are Supportive of Physician-Assisted Dying

Intervenors

Before: The Honourable Madam Justice Lynn Smith

Reasons for Judgment

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Place and Date of Hearing:	November 14-18, 21-25, 28, December 1-2, 5-9, 12-14, 16, 2011, April 16, 2012 Vancouver, B.C.
Place and Date of Judgment:	Vancouver, B.C. June 15, 2012

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I. SUMMARY

[1] The plaintiffs have challenged the *Criminal Code of Canada* provisions prohibiting physician-assisted dying, relying on the *Canadian Charter of Rights and Freedoms*. In the Reasons for Judgment that follow, I describe the evidence and legal arguments that have led me to conclude that the plaintiffs succeed in their challenge. They succeed because the provisions unjustifiably infringe the equality rights of Gloria Taylor and the rights to life, liberty and security of the person of Gloria Taylor, Lee Carter and Hollis Johnson.

[2] Under s. 52 of the *Constitution Act*, the provisions are declared invalid, but the operation of that declaration is suspended for one year. During the period of suspension, a constitutional exemption will permit Ms. Taylor the option of physician-assisted death under a number of conditions.

[3] I will summarize, in brief, my findings of fact and legal reasoning.

[4] Palliative care, though far from universally available in Canada, continues to improve in its ability to relieve suffering. However, even the very best palliative care cannot alleviate all suffering, except possibly through sedation to the point of persistent unconsciousness (palliative sedation).

[5] Currently accepted and legal end-of-life practices in Canada allow physicians to follow patients' or substitute decision-makers' instructions to withhold or withdraw life-sustaining treatment from patients. Accepted practices also allow physicians to administer medications even in dosages that may hasten death, and to administer palliative sedation. Ethicists and medical practitioners widely concur that current legal end-of-life practices are ethically acceptable. Some of these currently accepted practices bear similarities to physician-assisted death, but opinions differ as to whether they are ethically on a different footing.

[6] Medical practitioners disagree about the ethics of physician-assisted death. There are respected practitioners who would support legal change. They state that

providing physician-assisted death in defined cases, with safeguards, would be consistent with their ethical views. However, other practitioners and many professional bodies, including the Canadian Medical Association, do not support physician-assisted death.

[7] Despite a strong societal consensus about the extremely high value of human life, public opinion is divided regarding physician-assisted death. The substantial majority of committees that have studied the question, in Canada and elsewhere, oppose physician-assisted death but a minority support it.

[8] The most commonly expressed reason for maintaining a distinction between currently accepted end-of-life practices and physician-assisted death is that any system of safeguards will not adequately protect vulnerable people.

[9] Most Western countries do not permit physician-assisted dying or assisted dying, but a few do (Netherlands, Belgium, Luxembourg and Switzerland). Three of the United States permit physician-assisted dying, in the case of Oregon and Washington through legislation. The jurisdictions that permit physician-assisted dying have created safeguards to ensure that only defined categories of patients are involved, and that protocols including second opinions and reporting requirements are followed. Research findings show differing levels of compliance with the safeguards and protocols in permissive jurisdictions. No evidence of inordinate impact on vulnerable populations appears in the research. Finally, the research does not clearly show either a negative or a positive impact in permissive jurisdictions on the availability of palliative care or on the physician-patient relationship.

[10] The defendants identify a number of areas of risk for patients if physician-assisted death is permitted, for example relating to the patients’ ability to make well-informed decisions and their freedom from coercion or undue influence, and to physicians’ ability to assess patients’ capacity and voluntariness. The evidence shows that risks exist, but that they can be very largely avoided through carefully-designed, well-monitored safeguards.

[11] I turn to the legal issues.

[12] The Supreme Court of Canada *Rodriguez* decision from 1993 is a binding authority with respect to certain aspects of the plaintiffs' claims.

[13] *Rodriguez* decides that s. 241*(b)* of the *Criminal Code* (the assisted suicide prohibition) engages Ms. Taylor's rights to security of the person and liberty under s. 7 of the *Charter*, and that the legislation is not arbitrary. It leaves open whether the legislation infringes Ms. Taylor's right to life. Further, it does not decide whether any of the plaintiffs has been deprived of s. 7 rights through legislation that is not in accordance with two principles of fundamental justice that had not yet been identified as such when *Rodriguez* was decided. Those are the principles that laws must not be overbroad, and that laws must not be grossly disproportionate.

[14] *Rodriguez* does not determine whether s. 241*(b)* of the *Criminal Code* infringes Ms. Taylor's equality rights under s. 15 of the *Charter*. The majority in *Rodriguez* concluded that, if there was an infringement of s. 15 (a question it did not decide), the infringement constituted a reasonable limit and was demonstrably justified under s. 1 of the *Charter*. Because the analytical approach to s. 1 of the *Charter* has been modified since *Rodriguez*, I have addressed the question of s. 1 justification on the evidentiary record in this case.

[15] The claim that the legislation infringes Ms. Taylor's equality rights begins with the fact that the law does not prohibit suicide. However, persons who are physically disabled such that they cannot commit suicide without help are denied that option, because s. 241*(b)* prohibits assisted suicide. The provisions regarding assisted suicide have a more burdensome effect on persons with physical disabilities than on able-bodied persons, and thereby create, in effect, a distinction based on physical disability. The impact of the distinction is felt particularly acutely by persons such as Ms. Taylor, who are grievously and irremediably ill, physically disabled or soon to become so, mentally competent, and who wish to have some control over their circumstances at the end of their lives. The distinction is discriminatory, under the

test explained by the Supreme Court of Canada in *Withler*, because it perpetuates disadvantage.

[16] The legislation's infringement of s. 15 equality rights is not demonstrably justified under s. 1 of the *Charter*. The purpose of the absolute prohibition against physician-assisted suicide, as determined by *Rodriguez*, is to prevent vulnerable persons from being induced to commit suicide at times of weakness. That purpose is pressing and substantial and the absolute prohibition against assisted suicide is rationally connected to it. However, a less drastic means of achieving the legislative purpose would be to keep an almost-absolute prohibition in place with a stringently limited, carefully monitored system of exceptions allowing persons in Ms. Taylor's situation – grievously and irremediably ill adult persons who are competent, fully-informed, non-ambivalent and free from coercion or duress – to access physician-assisted death. Thus, the legislation does not impair Ms. Taylor's equality rights as little as possible. Further, the legislation has very severe adverse effects on Ms. Taylor and others in her situation, that are not outweighed by its benefits. For those reasons, and despite affording due deference to Parliament, I conclude that the legislation's absolute prohibition falls outside the bounds of constitutionality.

[17] The claimed infringement of s. 7 rights differs as among the plaintiffs. With respect to Ms. Taylor, the legislation affects her rights to liberty and security of the person, as was found in *Rodriguez*. In addition, the legislation affects her right to life because it may shorten her life. Ms. Taylor's reduced lifespan would occur if she concludes that she needs to take her own life while she is still physically able to do so, at an earlier date than she would find necessary if she could be assisted. With respect to Ms. Carter and Mr. Johnson, the legislation affects their rights to liberty because they are at risk of incarceration, at least in theory, for having helped a loved one who obtained assisted death in Switzerland.

[18] The legislation deprives the plaintiffs of their s. 7 rights inconsistently with the principles of fundamental justice. First, the legislation is overbroad. Second, the legislative response – an absolute prohibition – is grossly disproportionate to the

objectives it is meant to accomplish. As with the s. 15 infringement, the s. 7 infringement would not be justified under s. 1.

[19] The declaration of invalidity is suspended for one year in order to permit Parliament to take whatever steps it sees fit to draft and consider legislation. For one of the successful plaintiffs, Gloria Taylor, to have an effective remedy, she must be granted a constitutional exemption during the period of suspension. She will be permitted to seek, and her physician will be permitted to proceed with, physician-assisted death under specified conditions.

[20] The parties may return to make submissions as to costs or to seek clarification, if necessary, of the Court's Order.

[21] I wish to acknowledge the excellent counsel work for all sides, which was of great assistance to the Court.

II. INTRODUCTION

A. Nature of the Claim

[22] The plaintiffs challenge the assisted suicide prohibition in s. 241*(b)* of the *Criminal Code*, R.S.C. 1985, c. C-46, together with a number of related provisions. They argue that, to the extent that those provisions prohibit physician-assisted dying (as they define the term), they unjustifiably infringe ss. 7 and 15 of the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act, 1982* (U.K.), 1982, c. 11 [*Charter*].

[23] The plaintiffs define "physician assisted dying" as follows:

> For purposes of this claim, "physician-assisted suicide" means an assisted suicide where assistance to obtain or administer medication or other treatment that intentionally brings about the patient's own death is provided by a medical practitioner, as that terms is defined in s 29 of the *Interpretation Act*, R.S.B.C. 1996, c. 238, or by a person acting under the general supervision of a medical practitioner, to a grievously and irremediably ill patient in the context of a patient-physician relationship.
>
> For purposes of this claim, "consensual physician-assisted death" means the administration of medication or other treatment that intentionally brings about

> a patient's death by the act of a medical practitioner, as that term is defined in s. 29 of the *Interpretation Act*, or by the act of a person acting under the general supervision of a medical practitioner, at the request of a grievously and irremediably ill patient in the context of a patient-physician relationship.
>
> For purposes of this claim, "physician-assisted suicide" and "consensual physician-assisted death" will be collectively defined as "physician-assisted dying".

[24] They say that "grievously and irremediably ill" means the following:

> 1. A person is "grievously and irremediably ill" when he or she has a serious medical condition that has been diagnosed as such by a medical practitioner and which:
>
> a. is without remedy, as determined by reference to treatment options acceptable to the person; and
>
> b. causes the person enduring physical, psychological or psychosocial suffering that:
>
> i. is intolerable to that person; and
>
> ii. cannot be alleviated by any medical treatment acceptable to that person.
>
> 2. A "medical condition" means an illness, disease or disability, and includes a disability arising from traumatic injury.

[25] The plaintiffs claim that to the extent that the impugned provisions prohibit competent, grievously and irremediably ill adult individuals who voluntarily seek physician-assisted dying on an informed basis from receiving such assistance, they deprive the plaintiffs of their rights to life, liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice, contrary to s. 7 of the *Charter*.

[26] Arguing that the impugned provisions have a disproportionate impact on physically disabled persons, the plaintiffs say that they infringe s. 15 of the *Charter* to the extent that they prohibit competent, materially physically disabled, grievously and irremediably ill adult individuals who voluntarily seek physician-assisted dying on an informed basis from receiving such assistance.

[27] The plaintiffs seek declarations of invalidity under s. 52 of the *Charter*, suspended for six months. They also seek a constitutional exemption for Ms. Taylor

and her physician during the period of suspension, and costs (including special costs).

[28] The plaintiffs say that if the Court makes the declarations of invalidity that they seek, it will then be the proper institutional role of Parliament to draft legislation addressing the specific infringements in a constitutional manner. To that end, they suggest that it would be helpful if the Court were to indicate with some specificity the basis upon which it finds the provisions unconstitutional, as well as what might make them constitutional.

[29] Originally, the plaintiffs also advanced a claim for declaratory relief in reliance on the doctrine of interjurisdictional immunity, but did not argue that claim.

[30] The defendant Canada opposes the granting of any of the relief sought by the plaintiffs. It pleads that there is no reason to depart from the Supreme Court of Canada's decision in *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 [*Rodriguez*] which affirms the constitutionality of s. 241*(b)* of the *Criminal Code*. Further, it says that the plaintiffs are claiming a constitutionally protected right that is broader than that which was rejected by the Supreme Court of Canada in that decision, in the following ways:

(a) The plaintiffs' claim includes a right to both assisted suicide and euthanasia.

(b) The plaintiffs' claim may not be limited in a meaningful way to physician-assisted suicide or euthanasia because the plaintiffs' definitions contemplate someone "acting under the general supervision of a medical practitioner" and there is nothing in the plaintiffs' pleadings that limit who that person might be, or define what "acting under the general supervision of a medical practitioner" means.

(c) The plaintiffs' claim challenges not only s. 241*(b)*, but also s. 241*(a)*, the prohibition on counselling suicide. Thus, Canada says, the plaintiffs' claim would allow physicians to counsel a patient to commit suicide.

(d) The plaintiffs' claim relates not to individuals who are terminally ill, but rather to persons who are "grievously and irremediably ill".

(e) The plaintiffs' claimed right is not limited to individuals who are experiencing intractable suffering; rather, the pleadings require only that the person be suffering "enduring physical, psychological or psychosocial suffering" that is intolerable to that person. Canada says the test is thus entirely subjective and the plaintiffs' pleadings do not require that all reasonable efforts, or even any efforts, have been made to try to relieve the person's suffering.

(f) The plaintiffs' claim includes individuals who could commit suicide without assistance, and is not limited to persons who are or will become unable to end their own lives without assistance.

[31] Canada submits that protecting against death does not infringe the right to life, liberty or security of the person, although it concedes that insofar as the individual plaintiffs' actions may expose them to prosecution, their liberty interests are engaged. Canada pleads that the individual plaintiffs' life or security of the person interests are not affected, but submits that if they are, such effect is in accordance with the principles of fundamental justice. Canada submits that the current laws are necessary to protect people in vulnerable circumstances, and that nothing short of the existing laws would achieve that goal.

[32] With respect to the equality claim, Canada says that s. 15 of the *Charter* "is not engaged by the facts of this case". It argues that the laws do not draw a distinction in a manner contrary to s. 15, but rather uphold and promote human dignity; further, it says that persons who are ill and disabled require the protection of the laws against assisted suicide.

[33] Finally, Canada submits that if the laws are found to infringe the rights of any individuals, then such infringement is justifiable in a free and democratic society and is saved by s. 1.

[34] British Columbia responds to the plaintiffs' claim in similar terms to those of Canada. It argues that *Rodriguez* is binding and determinative. Further it submits that there is no infringement of the plaintiffs' rights under ss. 7 or 15, and that if there is, such infringement is justified pursuant to s. 1. In general throughout, British Columbia adopts Canada's submissions.

[35] Of the intervenors, the Farewell Foundation for the Right to Die, the Canadian Unitarian Counsel and the Ad Hoc Coalition of People with Disabilities who are Supportive of Physician-Assisted Dying are supportive of the plaintiff's claim. The Euthanasia Prevention Coalition and the Christian Legal Fellowship support the defendants' position and oppose the plaintiffs' claim.

B. Terminology

[36] It is important to define the terms related to assisted dying. These Reasons will use the following definitions.

[37] "Assisted suicide" means the act of intentionally killing oneself with the assistance of another person who provides the knowledge, means or both. "Physician-assisted suicide" means the act of intentionally killing oneself with the assistance of a medical practitioner, or person acting under the direction of a medical practitioner, who provides the knowledge, means, or both.

[38] "Euthanasia" means the intentional termination of the life of a person, by another person, in order to relieve the first person's suffering. According to the *Shorter Oxford English Dictionary,* it is derived from the Greek *eu*, meaning good, and *thanatos* meaning death, and so means "a quiet and easy death". Although the Nazi use of "euthanasia" to refer to some of their atrocities has led some to avoid the term, others continue to utilize it in its original sense and I will do so in these Reasons. In the context of the issues in this case, I will use "euthanasia" to mean

the intentional termination of the life of a patient by a physician, or someone acting under the direction of a physician, at the patient's request, for compassionate reasons. Euthanasia can be voluntary, non-voluntary or involuntary. "<u>Voluntary euthanasia</u>" means euthanasia performed in accordance with the wishes of a competent individual, whether those wishes have been made known personally or by a valid, written advance directive. "<u>Non-voluntary euthanasia</u>" means euthanasia performed without knowledge of the wishes expressed by a competent person or through a valid advance directive. "<u>Involuntary euthanasia</u>" means euthanasia performed against the wishes expressed by a competent person or through a valid advance directive.

[39] "<u>Assisted dying</u>" and "<u>assisted death</u>" are generic terms used to describe both assisted suicide and voluntary euthanasia. "<u>Physician-assisted death</u>" and "<u>physician-assisted dying</u>" are likewise generic terms that encompass physician-assisted suicide and voluntary euthanasia that is performed by a medical practitioner or a person acting under the direction of a medical practitioner. Other medical practices that physicians employ at the end of a patient's life do not fall within the terms "assisted death" or "assisted dying" as used in these Reasons.

[40] "<u>Withdrawal of potentially life-sustaining treatment</u>" means ceasing treatment that has the potential to sustain a person's life. "<u>Withholding potentially life-sustaining treatment</u>" means intentionally refraining from commencing treatment that has the potential to sustain a person's life.

[41] "<u>Palliative care</u>" means care provided to people of all ages who have a life-limiting illness, with little or no prospect of cure, and for whom the primary treatment goal is quality of life. The treatment is aimed at alleviating suffering – physical, emotional, psychological, or spiritual – rather than curing. It aims neither to hasten nor to postpone death, but affirms life and regards dying as a normal process. It recognizes the special needs of patients and families at the end of life, and offers a support system to help them cope.

[42] “Palliative sedation” means the intentional administration of sedative medication to reduce a patient’s level of consciousness, with the intent to alleviate suffering at the end of life. It includes both intermittent and continuous sedation, as well as both superficial and deep sedation. It may be accompanied by the withdrawal of artificial hydration and nutrition. The phrase “terminal sedation” is occasionally used synonymously with palliative sedation.

[43] Terms related to consent and capacity are also central to any discussion of assisted dying. In the health law context, “informed consent” means an intelligent choice as to treatment options made after the patient has been provided with sufficient information to evaluate the risks and benefits of the proposed treatment and other available options (*Malette v. Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.) [*Malette*] at 327). “Competence” and “capacity” mean the ability to understand the subject-matter in respect of which a decision must be made, and the ability to appreciate the consequences of that decision. When a patient is competent, he or she is said to have “decisional capacity”, which means the ability to make a subjective treatment decision based on an understanding of the medical facts provided by the doctor and on an assessment of one’s own personal circumstances (*Malette* at 327-28).

III. THE PLAINTIFFS

[44] Gloria Taylor has a fatal neurodegenerative disease. She would like to know that she can have a physician-assisted death if and when continued life becomes unbearable to her. Lee Carter and her husband, Hollis Johnson, helped Ms. Carter’s mother, Kathleen Carter, to arrange an assisted death in Switzerland. Dr. William Shoichet is a family physician in British Columbia who would be willing to participate in physician-assisted dying if it were no longer prohibited.

[45] The British Columbia Civil Liberties Association (“BCCLA”) is also a plaintiff. The BCCLA has had a long-standing interest in matters of patients’ rights and health policy, and has conducted advocacy and education with respect to end-of-life choices, including assisted suicide and voluntary euthanasia.

A. Gloria Taylor

[46] Gloria Taylor is the divorced mother of two grown sons. She has an 11-year-old granddaughter with whom she is extremely close.

[47] Ms. Taylor has amyotrophic lateral sclerosis (“ALS”), also known as Lou Gehrig’s disease. ALS is a neurodegenerative disorder that causes progressive muscle weakness and eventually progresses to near total paralysis. As neurologists Dr. Sharon Cohen and Dr. Scott Meckling explain, while cognition and sensation remain generally intact, ALS patients become increasingly incapacitated. They lose the ability to use their hands and feet; the ability to walk, to chew and to swallow; the ability to make their speech intelligible to others; and, ultimately, the ability to breathe. The average time from diagnosis to death is three years.

[48] Ms. Taylor began to experience cramping in her hands, feet and limbs in 2003. It was not until December 2009 that she was diagnosed with ALS. By that time, her muscles had begun to atrophy. She had difficulty walking and suffered generalized body weakness. In January 2010, her neurologist told her that she would likely be paralyzed in six months and would likely die within the year.

[49] However, Ms. Taylor fared better than predicted, and her condition plateaued for a period. Nevertheless, in most respects, her condition has continued to deteriorate steadily since diagnosis. Muscle atrophy in her hands and wrists makes fine motor tasks very difficult. Muscle atrophy in her feet makes walking a challenge. She uses a walker but requires a wheelchair for anything more than a short distance. She cannot move the wheelchair herself due to the loss of strength in her arms and hands, and her inability to use her hands effectively. She has pain from muscle deterioration for which she takes medication.

[50] Home support workers assist Ms. Taylor with daily tasks every morning and evening. Having strangers assist her with personal matters such as showering every day is something she experiences as an assault on her privacy, dignity and self-esteem.

[51] Ms. Taylor has been a strong and independent person throughout her life. True to form, she continues to live on her own and as independently as possible despite her illness. She is able to fulfil her role as part-time property manager for the mobile home park where she lives and continues to have a busy life, visiting family and friends or communicating with them using the telephone or a special voice-activated computer. Ms. Taylor is committed to a number of causes and remains actively involved in them. For example, she is a board member of the Interior BC Chapter of the Association for Injured Motorcyclists, which she set up years earlier while an avid motorcyclist. She also belongs to a support group for people living with ALS and their caregivers, which she founded upon discovering that no such group existed in Kelowna where she lives.

[52] Nevertheless, Ms. Taylor's illness is steadily impacting her ability to do these things. She is fearful about the progression of her disease and about which of her body's functions will be affected next. She says that one of her greatest fears is to be reduced to a condition where she must rely on others for all of her needs. She does not wish "to live in bedridden state, stripped of dignity and independence". She states:

> I want to be very clear: I do not believe that my family considers me a burden. Nor am I concerned that as I get more and more ill they will begin to do so. When I told my family and friends that I wanted a physician-assisted death, my concern was that they might be disappointed in me for not trying to hold on and stay with them until the last possible moment. But I do want to express the fact that I, myself, will be greatly distressed by living in a state where I have no function or functionality that requires others to attend to all of my needs and thereby effectively oblige my family to bear witness to the final steps of the process of my dying with the indignity a slow death from ALS will entail. I do not, in particular, want to be the cause of my 11 year old granddaughter's sitting vigil as I die an ugly death, and I believe that is what she will do, because she loves me. I do not want to be a burden, not because I fear my family does or would resent me – I do *not* think that – rather, I do not want to be a burden because I *know* they love me.

[53] Ms. Taylor has informed her family and close friends of her desire to have a physician-assisted death. She says her sons, granddaughter, mother, sisters and closest friends all strongly support her right to make the decision to die, and have told her that they do not wish to see her suffer. Although she is aware that assisted

suicide is legal in Switzerland, she is not financially able to travel and obtain the services there. Moreover, it is important to her to have her family around her when she dies.

[54] In her affidavit, Ms. Taylor describes some of her hopes and fears regarding her death, as follows:

> I do not want my life to end violently. I do not want my mode of death to be traumatic for my family members. I want the legal right to die peacefully, at the time of my own choosing, in the embrace of my family and friends.
>
> I know that I am dying, but I am far from depressed. I have some down time – that is part and parcel of the experience of knowing that you are terminal. But there is still a lot of good in my life; there are still things, like special times with my granddaughter and family, that bring me extreme joy. I will not waste any of my remaining time being depressed. I intend to get every bit of happiness I can wring from what is left of my life so long as it remains a life of quality; but I do not want to live a life without quality. There will come a point when I will know that enough is enough. I cannot say precisely when that time will be. It is not a question of "when I can't walk" or "when I can't talk". There is no pre-set trigger moment. I just know that, globally, there will be some point in time when I will be able to say – "this is it, this is the point where life is just not worthwhile". When that time comes, I want to be able to call my family together, tell them of my decision, say a dignified good-bye and obtain final closure – for me and for them.
>
> My present quality of life is impaired by the fact that I am unable to say for certain that I will have the right to ask for physician-assisted dying when that "enough is enough" moment arrives. I live in apprehension that my death will be slow, difficult, unpleasant, painful, undignified and inconsistent with the values and principles I have tried to live by. I am proud to be dedicating the final days of my life trying to change the law in this respect. It is my hope that my actions in being a plaintiff in this case will bring others the peace of mind and sense of control that the law is presently denying me.

[55] Ms. Taylor finds the idea of palliative sedation to be repugnant and does not consider it a viable alternative to physician-assisted dying.

[56] In conclusion, Ms. Taylor deposes:

> I am dying. I do not want to, but I am going to die; that is a fact. I can accept death because I recognize it as a part of life. What I fear is a death that negates, as opposed to concludes, my life. I do not want to die slowly, piece by piece. I do not want to waste away unconscious in a hospital bed. I do not want to die wracked with pain. It is very important to me that my family, and my granddaughter in particular, have final memories that capture me as

> I really am – not as someone I cannot identify with and have no desire to become.
>
> I have pre-arranged my cremation. I have chosen songs I would like played at my service and am designing a memorial program. I am working on a eulogy, which my cousin has agreed to read aloud for me at the service. We create ourselves through our lives. These acts are part of my creation of the person I want to be and the person I want others to see and remember me as. I want my death to be part of that creation as well. As Sue Rodriguez asked before me – whose life is it anyway?

B. Lee Carter and Hollis Johnson

[57] In 2008, Lee Carter's mother, Kathleen ("Kay") Carter, was diagnosed with spinal stenosis, a condition involving progressive compression of the spinal cord. Kay was advised that surgery could relieve some of the compression of her spine, but she declined due to the significant operative risks.

[58] Kay's physical condition deteriorated steadily over the ensuing months, though her mental faculties remained intact. By August 2009, she required assistance for virtually all of her daily activities, including eating and toileting. She had extremely limited movement in her hands. She was confined to a wheelchair, and could not move it herself. If lying flat, she required assistance to sit up. Kay suffered chronic pain, and was prescribed medication at increasing levels as her condition deteriorated.

[59] Hollis Johnson describes his mother-in-law as intellectually curious and an independent thinker. However, with her failing body, she was no longer able to hold a newspaper, change television channels or turn on the radio. Her physical limitations deprived her of the intellectual and social stimulation that had previously given her great pleasure.

[60] Ms. Carter states that her mother, a strong-willed and independent person, repeatedly expressed how her condition made her feel trapped in her own body and stripped of her independence. On a number of occasions, Kay told her daughter that she did not wish to live her life in that condition, as an "ironing board" lying flat in a bed.

[61] In late July 2009, Kay decided that she wished to terminate her own life as soon as possible by means of physician-assisted suicide.

[62] Kay informed each of her children separately of her wish. Ms. Carter deposes that given the way Kay had lived her life, she was not surprised that her mother found complete dependence and loss of control to be intolerable indignities. Mr. Johnson also was not surprised at his mother-in-law's decision, as it was consistent with the values and principles she had always espoused.

[63] Kay wanted to end her life in Canada but was aware that assisting suicide was a criminal offence. She asked Ms. Carter and Mr. Johnson to support and assist her in arranging an assisted suicide in Switzerland and to travel there with her for that purpose. Although aware that assisting Kay could expose them to prosecution in Canada, they both resolved without hesitation to assume that risk and to assist Kay to end her life in the manner she wished.

[64] Ms. Carter undertook the necessary research at Kay's direction. Kay decided that she wished to apply to DIGNITAS, a Swiss organization that offers its "death with dignity" services to non-residents. Ms. Carter and Mr. Johnson then proceeded with the extensive preparatory work entailed in an application to DIGNITAS.

[65] The application and approval process took considerable time, causing Kay increasing concern that she might not physically be able to travel to Switzerland given her rapidly deteriorating condition. Eventually, in November 2009, the date of January 15, 2010 was determined. Ms. Carter and Mr. Johnson made the arrangements necessary for Kay to travel to Switzerland.

[66] Both Ms. Carter and Mr. Johnson found the planning and arrangement process extremely trying. Because their activities possibly constituted an offence in Canada, they had to take considerable care to keep the plan and arrangements covert. Kay's care facility, for example, was misled about the nature of her departure, which deprived staff, residents and Kay of the opportunity to say final goodbyes to one another.

[67] Ms. Carter, two of her siblings and Mr. Johnson accompanied Kay to Switzerland and to the DIGNITAS clinic.

[68] At the clinic, a staff member gave Kay medication to settle her stomach. After about 30 minutes, she was moved from her wheelchair to a bed. The members of Kay's family positioned themselves around her, entwining their arms around Kay and each other. The staff member brought the prescribed dose of sodium pentobarbital to Kay in a small glass, and assisted her to drink the medication with a straw. Kay became unconscious within minutes, and after about 20 minutes, she passed away. She was 89 years of age.

[69] Ms. Carter deposes that she believes her mother died exactly as she wanted and that, as a result, she (Ms. Carter) was happy for her and at peace.

[70] The financial costs incurred in travel, accommodations, medical consultations and the services of DIGNITAS totalled approximately $32,000. Kay paid this amount from her remaining life's savings.

[71] Ms. Carter and Mr. Johnson express the view that Kay ought to have been able to obtain a physician-assisted suicide in Vancouver, surrounded by as many of her family and friends as she wished, and that she ought not to have been required to go through the gruelling stress and uncertainty involved in arranging for the procedure in Switzerland. They both also wish to have the option of legally obtaining physician-assisted dying in Canada for themselves, each other, and others they love.

C. Dr. William Shoichet

[72] Dr. William Shoichet is a family physician practising in Victoria.

[73] In the course of his practice, Dr. Shoichet has provided medical care to a number of patients suffering from grievous and irremediable illnesses, such as cancer and certain degenerative neurological conditions. Some of these patients suffered greatly from the effects of their illnesses, and experienced severe or chronic

pain, inability to take care of their own basic physical needs and desires, inability to act independently, and severe loss of dignity and privacy.

[74] Dr. Shoichet says that palliative care has not always been a viable option for his patients. Some have told him that, in their view, palliative care involves unduly prolonging a fate that cannot be avoided. Further, while palliative care can eliminate most physical pain, it cannot always do so.

[75] Dr. Shoichet considers end-of-life care to be an important part of his compassionate, moral, ethical and professional duty as a physician treating grievously and irremediably ill patients. He further considers the ability to participate in physician-assisted dying on request, in appropriate circumstances and with necessary safeguards in place, to be an important component of the provision of health care to grievously and irremediably ill patients.

[76] In the event the current prohibition of physician-assisted suicide were to be changed or struck down, Dr. Shoichet would be willing to assist a patient who requested such end-of-life care where he was satisfied that it constituted appropriate medical care in the circumstances.

D. Standing of Dr. Shoichet and BCCLA

[77] Both defendant governments challenge the standing of the BCCLA. British Columbia challenges the standing of Dr. Shoichet.

[78] The plaintiffs answer that neither government pleaded that Dr. Shoichet lacks standing. Further, they say that Dr. Shoichet qualifies for both private and public interest standing, and that the BCCLA qualifies for public interest standing.

[79] The plaintiffs also submit that, given that the claim has been fully argued and that the BCCLA and Dr. Shoichet could have applied for and likely would have been granted intervenor standing, the question of standing is moot, academic and unnecessary to decide in this case.

[80] I note that a similar question arose in *Bedford v. Canada (Attorney General)*, 2010 ONSC 4264 [*Bedford SC*], varied on appeal in *Canada (Attorney General) v. Bedford*, 2012 ONCA 186 [*Bedford*], where the private interest standing of one plaintiff was conceded, while the standing of two others was disputed by Canada. The Court of Appeal majority wrote at para. 50:

> There is a simple reality here. Ms. Lebovitch has private interest standing to challenge the three *Criminal Code* provisions. Neither appellant says otherwise. This placed all the constitutional issues squarely before the application judge and now places them before this court. Accordingly, the issue of Ms. Bedford's and Ms. Scott's standing is irrelevant. We decline to address it.

[81] Although I believe that there is some relevance to the question of public interest standing for the BCCLA, because of the plaintiffs' argument that the BCCLA should remain part of this litigation in order to see it through, I can see no relevance to the question of Dr. Shoichet's standing. The plaintiffs Gloria Taylor, Lee Carter and Hollis Johnson all indisputably have private interest standing; the constitutional issues are before the Court and all have been fully argued. Neither defendant pleaded that Dr. Shoichet lacked standing. For those reasons, I decline to address the question of Dr. Shoichet's standing.

[82] With respect to the standing of the BCCLA, I will begin with a brief review of the legal principles governing public interest standing.

[83] The Supreme Court addressed public interest standing in *Canadian Council of Churches v. Canada (Minister of Employment and Immigration)*, [1992] 1 S.C.R. 236 [*Canadian Counsel of Churches*]. Justice Cory, writing for the Court, observed that the purpose of public interest standing is to prevent the immunization of legislation or public acts from challenge. Accordingly, public interest standing is not required when, on a balance of probabilities, it can be shown that the measure in question will be challenged by a private litigant. The decision whether to grant public interest standing is a discretionary one. Nevertheless, when exercising the discretion, the court should interpret the applicable principles in a liberal and generous manner.

[84] The principles that guide the exercise of the court's discretion are these (at 253):

(a) Is there a serious issue raised as to the invalidity of the legislation in question?

(b) Has it been established that the plaintiff is directly affected by the legislation or, if not, does the plaintiff have a genuine interest in its validity?

(c) Is there another reasonable and effective way to bring the issue before the court?

[85] This third aspect of the test lies at the heart of the discretion to grant public interest standing: *Hy and Zel's Inc. v. Ontario (Attorney General)*, [1993] 3 S.C.R. 675 at 692.

[86] The BCCLA is a large, well-established organization. It has been extensively involved in advocacy and education regarding end-of-life choices, including assisted suicide and voluntary euthanasia. It says that the issue of whether there is a constitutional right to physician-assisted dying is relevant to all Canadians. In addition, the BCCLA says that it has thousands of members who may wish to have physician-assisted dying services.

[87] The BCCLA says that it is unreasonable to expect grievously and irremediably, and often terminally, ill persons to bring on and carry through to completion a lengthy and involved constitutional challenge.

[88] The affidavit of John Dixon, a board director of the BCCLA, expands upon these points:

> Both my personal experience and my experience as a BCCLA board director have underscored my understanding that it is critically important to have the involvement of an institutional litigant in *Charter* cases. Indeed, it has been my experience, through my nearly 30 years of active involvement in the work of the BCCLA, that the BCCLA often ends up being the institutional "anchor" in *Charter* cases, because mortality, financial considerations, or the loss of

> emotional energy and commitment often ends the continued participation of individuals.
>
> Dying patients who desire medical assistance in easing their passing have a limited ability to litigate for years on end to secure the right to a physician-assisted death. Such persons are by their very nature vulnerable, and due to their illness may lack the physical and emotional resources necessary for litigation. Most importantly, they often lack sufficient time before death to litigate the predictably long march of a case through the appellate courts.

[89] Mr. Arvay, counsel for the plaintiffs, adds that in the event Ms. Taylor's death should occur during the course of these proceedings, it is important that the BCCLA be a party so that it may continue representing her interests. Further, he says that the presence of the BCCLA as a named plaintiff can reasonably be said to have attracted the participation of witnesses, both lay and expert, as well as interest from the media (and allowed the fundraising necessary to cover legal costs and, thus, access to justice, in this case). Finally, Mr. Arvay submits that there is no evidence to suggest that the individual plaintiffs in this case could, or would, have pursued this claim without the BCCLA's participation.

[90] With respect to the first criterion for public interest standing, British Columbia concedes that a serious issue has been raised with respect to the invalidity of the impugned provisions, by the other plaintiffs who have standing. Canada, on the other hand, says that no serious issue exists since the constitutionality of the assisted suicide prohibition was decided in *Rodriguez*.

[91] For the reasons I set out in the section of these Reasons addressing the impact of *Rodriguez* and *stare decisis*, I find there is a serious issue to be tried.

[92] As for the second criterion, the defendants both concede, properly in my view, that the BCCLA has a genuine interest in the validity of the impugned legislation.

[93] As for the third criterion, both defendant governments submit that the claims of the individual plaintiffs amply bring the case forward, and that the BCCLA's claims add nothing to their challenge. Accordingly, the defendants say, the BCCLA's participation is not necessary in order to have the constitutional validity of the impugned legislation tested before the court.

[94] In my view, timing matters in this case in assessing whether there is another reasonable and effective way to bring the issue before the court. The defendants did not apply at the outset of the proceedings to have the BCCLA struck from the claim for want of standing. Now that the case is closed, it is easy to say, as the defendants do, that the claims of the individual plaintiffs reasonably and effectively bring the issue before the court. What is less clear is whether the individual plaintiffs would ever have initiated their claims without the participation of the BCCLA.

[95] In deciding how to exercise my discretion, I am guided by the rationales for restricting public interest standing and the need to strike a balance between ensuring access to the courts and preserving judicial resources, as stated in *Canadian Council of Churches* (at 252).

[96] The support of an organization such as the BCCLA may be necessary, in practical terms, to permit individuals to mount challenges to legislation such as this, and to have access to justice. I note the comments in *Chaoulli v. Québec (Attorney General)*, 2005 SCC 35 [*Chaoulli*] of Binnie and LeBel JJ. (Fish J. concurring), in dissent but not on this point. They referred to the unlikelihood that seriously ill persons would bring a systemic challenge to legislation affecting them (at para. 189).

[97] Further, to the extent that concerns about preserving judicial resources, especially from marginal or redundant suits, animate the principles that guide the granting of public interest standing, those concerns simply do not arise here. All of the evidence has been tendered and the claim fully argued; there is, accordingly, no judicial economy to be found in striking the BCCLA as a party at this late stage.

[98] Finally, and most importantly, the BCCLA is involved as a co-plaintiff, in support of plaintiffs who have private standing. The issue is very different than it would be if the BCCLA were attempting to bring a separate action; in that case, the existence of an action by Ms. Carter, Mr. Johnson and Ms. Taylor might provide a strong argument that the BCCLA lacked standing to advance its own separate claim.

[99] Ultimately, public interest standing is a matter of judicial discretion. In my view, this is an appropriate case in which to exercise my discretion to grant public interest standing to the BCCLA.

IV. CRIMINAL CODE PROVISIONS AND THEIR HISTORY

A. The Impugned Provisions

[100] The plaintiffs challenge the constitutionality of ss. 14, 21, 22, 222 and 241 of the *Criminal Code* [the impugned provisions], which collectively prohibit physician-assisted dying.

[101] The impugned provisions are as follows:

- Section 241 of the *Criminal Code* provides:

> Every one who
>
> (a) counsels a person to commit suicide, or
>
> (b) aids or abets a person to commit suicide,
>
> whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

- Section 22(3) of the *Criminal Code* defines “counsel” to include “procure”.

- Section 14 provides that no person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

- Section 21(1)(b) renders a person who does or omits to do anything for purposes of aiding any person to commit an offence, a party to the offence.

- Section 21(2) renders persons acting with a common intention to carry out an unlawful purpose and to assist each other in carrying out that purpose, parties to any offence if they knew or ought to have known that the commission of the offence would be a probable consequence of carrying out the common purpose.

- Section 22(1) provides that where a person counsels another person to be a party to an offence and that other person is otherwise a party to that offence, the person who counseled is also a party to that offence, notwithstanding that the offence was committed in a way different from that which was counselled.

- Section 22(2) provides that a person who counsels another person to be a party to an offence is a party to every offence that the other commits in consequence of the counselling that the person who counselled knew or ought to have known was likely to be committed in consequence of the counselling.

- Section 222 of the *Criminal Code* defines homicide, and states:

> 222. (1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.
>
> (2) Homicide is culpable or not culpable.
>
> (3) Homicide that is not culpable is not an offence.
>
> (4) Culpable homicide is murder or manslaughter or infanticide.
>
> (5) A person commits culpable homicide when he causes the death of a human being,
>
> > *(a)* by means of an unlawful act;
> >
> > *(b)* by criminal negligence;
> >
> > *(c)* by causing that human being, by threats or fear of violence or by deception, to do anything that causes his death; or
> >
> > *(d)* by wilfully frightening that human being, in the case of a child or sick person.
>
> (6) Notwithstanding anything in this section, a person does not commit homicide within the meaning of this Act by reason only that he causes the death of a human being by procuring, by false evidence, the conviction and death of that human being by sentence of the law.

B. Legislative History

[102] The common law considered suicide to be a form of homicide that offended against both God and the King's interest in the life of his citizens. As explained in *Rodriguez* (at 596-597), until 1823, English law provided that the property of the suicide would be forfeited and his body placed at the cross-roads of two highways with a stake driven through it. Given the practical difficulties of prosecuting a successful suicide, most prosecutions centred on attempted suicide.

[103] When Canada enacted its first comprehensive criminal code in 1892 (*Criminal Code*, S.C. 1892, c. 29), the offences of assisting suicide and attempting suicide were codified as ss. 237 and 238:

> 237. Every one is guilty of an indictable offence and liable to imprisonment for life who counsels or procures any person to commit suicide, actually committed in consequence of such counselling or procurement, or who aids or abets any person in the commission of suicide.
>
> 238. Every one who attempts to commit suicide is guilty of an indictable offence and liable to two years' imprisonment.

[104] These two provisions remained substantially the same, aside from renumbering, until 1954 when the *Criminal Code* underwent a general overhaul. At that time, the maximum penalty for assisting suicide was reduced from life imprisonment to 14 years. Attempted suicide was converted to a summary conviction offence with a maximum penalty of six months imprisonment.

[105] The most significant change to the suicide provisions occurred in 1972 when Parliament passed Bill C-2, an omnibus criminal law amendment bill. Among other changes, it abolished the offence of attempted suicide. As the Minister of Justice, the Honourable Otto Lang, explained when introducing the bill for Second Reading in the House of Commons:

> We have removed, as well, the offence of attempted suicide, again on the philosophy that this is not a matter which requires a legal remedy, that it has its roots and its solutions in sciences outside of the law and that certainly deterrent under the legal system is unnecessary.

> [*House of Commons Debates*, 28th Parl., 4th Sess., Vol. 2 (27 April 1972), at 1699]

[106] The only other change of any substance saw “counsels and procures” in s. 241*(a)* amended to “counsels” in 1985.

[107] Section 241 of the *Criminal Code* has not been amended since that time.

C. Private Members’ Bills and Senate Reports Since Rodriguez

[108] Assisted suicide and euthanasia have been the subject of substantial Parliamentary debate and study over the past 20 years.

[109] Since 1991, nine private member’s bills have been introduced in the House of Commons seeking to amend the *Criminal Code* to decriminalize assisted suicide or euthanasia. Three of these bills died with the prorogation of Parliament. The remaining six, however, were debated in either the House of Commons or committee.

[110] The most recent was Bill C-384, *An Act to Amend the Criminal Code (right to die with dignity)*, 2nd Sess., 40th Parl., which was introduced in the House of Commons in May 2009. The bill proposed to amend s. 222 of the *Criminal Code*, the homicide prohibition, by adding a provision stating that a medical practitioner does not commit homicide if he aids a person who is at least eighteen, and who meets a number of other conditions, to die with dignity. It would also have amended s. 241*(b)* to permit a medical practitioner to assist in suicide under certain conditions.

[111] Bill C-384 was debated at Second Reading (*House of Commons Debates*, 40th Parl., 2nd sess., No. 89, (2 October 2009) at 5518). Its proponents spoke of the profound and fundamental importance of dignity, the legalization of the practice of physician-assisted death in other jurisdictions, and the limits of palliative care. Among the concerns cited by its opponents were the inadequacy of safeguards and the inevitability of mistakes, the “slippery slope”, the potential for pressure on vulnerable Canadians, and the devaluing of human life. Members of both sides of

the debate related the personal stories of family members or constituents who had been seriously ill.

[112] On April 21, 2010, the motion to advance Bill C-384 to Committee was defeated by a vote of 228 to 59.

[113] The Senate, too, has considered assisted suicide and euthanasia. In the wake of the *Rodriguez* decision, in 1994 a Special Senate Committee was appointed to examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide. The Committee heard testimony from over 130 non-governmental witnesses over 30 days of hearings and received and considered thousands of letters and briefs. It issued its final report – *Of Life and Death* (Ottawa: The Special Senate Committee on Euthanasia and Assisted Suicide) (Chair: Joan B. Neiman) [the Special Senate Committee Report] – in June 1995. That report is described later, in the section on Medical Ethics and End-of-Life Decision Making.

V. EVIDENTIARY AND PROCEDURAL RULINGS

A. Evidence

1. The Record

[114] Although the parties were required to operate under fairly short timelines, they managed to assemble a very considerable evidentiary record. It includes some 36 binders of affidavits, transcripts and documents entered through admission. There were 116 affidavits filed. Some of these run to hundreds of pages in length and attach as exhibits many secondary sources. In addition, 18 witnesses were cross-examined on their affidavits, including 11 witnesses who were cross-examined on their affidavits before the Court.

[115] The parties did a thorough and detailed job of reviewing the materials in their submissions. Because of the extensive nature of the record, I will not refer to every affidavit or to every witness. However, I have reviewed the entire record, and my conclusions are based upon all of the evidence before me, taken as a whole.

[116] Where objection was taken to evidence and I ruled that it was admissible but would consider the objections in assessing its weight, I have done so. Further, I have assessed the weight to be given to the expert opinion evidence, taking into consideration the particular expertise of the witness, whether the opinion was within that expert's scope of expertise, the consistency of the opinion with that of other experts, and the apparent impartiality or partiality of the expert in question.

[117] There was essentially no challenge to most of the evidence of the non-expert witnesses, and I have by and large taken that evidence at face value.

[118] Finally, where there was objection to evidence on the basis that it came from secondary sources and was hearsay, I have taken those objections into account and have not accepted what was related for the truth of its contents.

2. Evidence Admitted Past the Deadlines

[119] The parties had deadlines for providing evidence to the other side. In a few instances, evidence became available outside those deadlines, either during the hearing or after the hearing. These are my rulings with respect to that evidence.

a) The Royal Society Expert Panel Report and the Report of the Canadian Parliamentary Committee on Palliative and Compassionate Care

[120] On November 23, 2011, the plaintiffs introduced, through cross-examination of one of the defendants' witnesses, a recently-delivered report from an Expert Panel of the Royal Society of Canada: *End-of-Life Decision Making* (Ottawa: Royal Society of Canada, 2011) (Chair: Udo Schuklenk) [the RSC Report].

[121] The plaintiffs sought to have the RSC Report admitted in evidence.

[122] Canada opposed its admission, essentially on two grounds.

[123] First, in Canada's view, the report is essentially argument on one side of the debate (and largely legal argument), rather than a balanced or comprehensive review of the issues.

[124] Second, Canada urged, admission of the report would be unfair because three of the authors were expert witnesses for the plaintiffs (Dr. Johannes van Delden, Professor Sheila McLean and Dr. Ross Upshur), and a fourth author (Professor Jocelyn Downie) had been assisting the plaintiffs with instructing expert witnesses. Ms. Nygard submitted that those witnesses were advancing their views a second time through the RSC Report, in addition to the opinion evidence set out in their affidavits. Canada might have elected to cross-examine those witnesses, counsel argued, if this second version of the witnesses' views had been available.

[125] Counsel for the plaintiffs submitted that the RSC Report constituted completely new evidence, previously unavailable. Counsel compared it to the Report of the Canadian Parliamentary Committee on Palliative and Compassionate Care (House of Commons, *Not to be Forgotten: Care of Vulnerable Canadians* (November 2011) (Co-chairs: Harold Albrecht, Joseph Comartin and Frank Valeriote) [the Canadian Parliamentary Committee Report]) which was also released during the hearing, and provided to the Court by Canada.

[126] Plaintiffs' counsel advised the Court that they had no information whatsoever as to the contents of the RSC Report until it was released to the public. Counsel also described to the Court the process that the Royal Society of Canada uses to develop its expert panels, and to have expert panel reports peer reviewed.

[127] The plaintiffs' position was that the inability to cross-examine the authors of the RSC Report should go to its weight rather than its admissibility.

[128] At the hearing, I admitted the evidence provisionally. Canada then elicited comments about the report from one of its witnesses, Dr. Harvey Chochinov, who is a Fellow of the Royal Society of Canada. In his view, the RSC Report reads as though it was written with a pre-ordained conclusion. He further commented on the rapidity with which the panel had proceeded, and noted that the membership of the expert panel lacked representation from the palliative care community, and included persons who had previously expressed views supportive of physician-assisted dying.

[129] I have now reviewed the RSC Report and have concluded that it will be admitted in evidence, in the main for the fact that the expert panel made the recommendations that it did. I have not relied upon it as evidence on any contentious matters such as the efficacy of safeguards in jurisdictions that permit physician-assisted dying. Its review of the legal landscape regarding end-of-life care in Canada is not evidence, but the equivalent of a law review article or a legal text.

[130] I will also admit in evidence the Report of the Parliamentary Committee on Palliative and Compassionate Care, and similarly have not relied upon it as evidence with respect to any contentious matters, but as evidence that the Committee made certain recommendations.

b) The Select Committee of the Assemblée Nationale de Québec

[131] After the hearing, the plaintiffs applied to adduce further evidence. They asked the Court to receive into the record the recommendations portion of the Report of the Select Committee of the Assemblée Nationale of Québec on "Dying with Dignity, *Mourir dans la Dignité* (March 2012) (Chair: Maryse Gaudreault) [the Québec Select Committee Report]. This is my ruling on that application.

[132] The plaintiffs provided evidence as to the composition of the Committee, its mandate, and its consultation document. However, the plaintiffs request only that the Court receive evidence that the Select Committee made the recommendations it did. They submit that the evidence is relevant, in part because of the defendants' evidence regarding numerous committee reports and recommendations opposing a change in the law regarding assisted suicide and euthanasia. They submit that the Québec Select Committee Report was not available earlier and that the Court should be aware that a committee of the legislative assembly of one Canadian province has recently considered the matter and made recommendations for change.

[133] Both Canada and British Columbia are opposed to the reception of this evidence. British Columbia submits that these are non-binding recommendations, constituting the opinion of the Committee alone. It submits that other organizations

have stated opinions with respect to the contents of the report that are not reflected in the recommendations; therefore, admitting only the recommendations would fail to provide the Court with a balanced picture.

[134] Canada’s position is that if the plaintiffs’ case is to be reopened, it should be only for the limited purpose of adducing the fact that the Select Committee made certain recommendations and not for the truth of any of the materials considered by the Committee.

[135] I conclude that the evidence should be received. It was not available earlier and bears directly on the question of “societal consensus”, which was the subject of considerable evidence at the trial.

[136] I will admit the recommendations for the fact that they were made by a Select Committee of the Assemblée Nationale. I will also admit in evidence the affidavit of Ms. Nancy Reimer made on April 11, 2012, tendered by British Columbia. It attaches pieces of commentary on the Select Committee recommendations. Again, these are received not for the truth of their contents but for the fact that these comments were made.

B. Summary and Expedited Trial

[137] This matter proceeded by way of a summary trial application pursuant to Rule 9-7 of the *Supreme Court Civil Rules*, B.C. Reg. 168/2009, based on affidavit evidence. However, all parties were able to require the attendance of deponents for the other side for cross-examination, either outside court or before the Court, and counsel had some opportunity to elicit evidence from their own deponents through examination in chief before the Court.

[138] The timelines for the provision of evidence were, with counsel for the parties, developed at Case Management Conferences.

[139] Counsel for the defendants submitted that the subject matter and the complexity of the issues meant that the matter was not suitable for summary trial

under Rule 9-7 on short timelines, and that there should be a conventional trial with witnesses.

[140] Rule 9-7(15) provides discretion for the Court to decline to grant judgment following a summary trial where the matter has proved unsuitable for summary trial:

> (15) On the hearing of a summary trial application, the court may
>
> (a) grant judgment in favour of any party, either on an issue or generally, unless
>
> (i) the court is unable, on the whole of the evidence before the court on the application, to find the facts necessary to decide the issues of fact or law, or
>
> (ii) the court is of the opinion that it would be unjust to decide the issues on the application,
>
> (b) impose terms respecting enforcement of the judgment, including a stay of execution, and
>
> (c) award costs.

[141] The plaintiffs' position was that the mode of summary trial, or a petition based on affidavit evidence, is commonly used in *Charter* cases where the record largely consists of legislative facts and expert opinion evidence. They asked to proceed with a summary trial, taking the risk that at the end of the day the Court would conclude that it was not possible to find the facts necessary to decide the issues of fact or law, or that it would be unjust to decide the issues on this application. As for the timing of the trial, counsel for the plaintiffs advanced two main reasons for proceeding on a relatively expedited basis: (1) Ms. Taylor's deteriorating physical condition; and (2) limits on counsel's ability to represent the plaintiffs *pro bono* in an extended conventional trial.

[142] The plaintiffs prevailed on this point, and the Court heard a summary trial, although one with the significant modifications I have described.

[143] In their closing submissions, the defendants maintained their position that it is not in the interests of justice to determine the constitutional issues in this matter by way of a summary trial on short timelines, given both the nature and the importance of the issues as well as the volume and complexity of the evidence.

[144] There is no doubt that the timelines under which all counsel worked were challenging. Despite the timelines, in my view, a remarkably comprehensive and complete record was provided to the Court.

[145] Significantly, counsel for the defendants did not point to any specific evidence that they would have provided to the Court, but for the timelines.

[146] Having heard all of the evidence and submissions, I find that I am able, on the whole of the evidence, to find the facts necessary to decide the issues in this case. There was no issue as to the credibility of any witness of fact. Although some issues arose as to the reliability of expert witnesses and the weight that should be given to their opinions, none of those issues, in my view, was difficult or impossible to decide, particularly given that the parties had the opportunity to cross-examine the key witnesses on their affidavits before the Court, and did so.

[147] In my opinion, it is not unjust to decide the issues on this application.

C. Scope of Reply

[148] At the conclusion of the hearing, an issue arose about the scope of the plaintiffs' reply. I considered the submissions and decided to receive the reply submissions. These are my reasons for that decision.

[149] Canada argued that the plaintiffs' submissions did not constitute proper reply. Canada submitted that the plaintiffs have split their case, making new arguments and new references to evidence in their reply, to which the defendants had no opportunity to respond.

[150] In Canada's submission, a plaintiff must make submissions in chief concerning arguments and issues that were or ought to have been anticipated. Canada relies on *Owners, Strata Plan LMS 1816 v. B.C. Hydro*, 2002 BCSC 313 [*Strata Plan LMS 1816*] at para. 11 for the proposition that a reply is meant only to address new issues that the presenting party had no reason to anticipate, and must be responsive to the other party's final submission. Canada also argues that a

plaintiff is required to exhaust its evidence in first instance, citing *Allcock Laight & Westwood Ltd. v. Patten, Bernard and Dynamic Displays Ltd; Patten and L.A. Corney Commercial Deliveries Ltd. v. Bernard and Dynamic Displays Ltd.* , [1967] 1 O.R. 18 (Ont. C.A.).

[151] Canada proposes that the appropriate response would be to disregard the improper submissions, citing *Froom v. Canada (Minister of Justice)*, 2003 FC 1299 at paras. 11-13. In the alternative, Canada requests the opportunity to provide the Court with a brief sur-reply.

[152] The plaintiffs argue that they anticipated and addressed the defendants' argument to the extent reasonably possible in their detailed argument in chief. However, they submit, they are entitled to reply to Canada's submissions, including the ways in which Canada relies upon and interprets the evidence.

[153] The plaintiffs further submit that it is proper both to address the respondent's characterization of the evidence and to offer affirmative factual responses, relying on *Strata Plan LMS 1816* at para. 7. They note that addressing the evidence is particularly important in this case because the Court made it clear that it expected the parties to provide assistance in negotiating the extensive factual record.

[154] The plaintiffs argue that the theory of reply advanced by Canada would require the plaintiffs to anticipate the defendant's entire theory of the case and rebut it in advance of hearing it. This, they say, would be unfair and unrealistic. They cite *Merck-Frosst v. Canada*, 2009 FC 914 at paras. 29-30, for the proposition that the plaintiffs cannot be expected to deal with every argument they can anticipate because they cannot know which of the possible arguments the defendants will in fact advance.

[155] The plaintiffs rely on *Strata Plan LMS 1816* at paras. 4-5, 10-11 and 15-19 for the proposition that sur-reply is much narrower than reply, and should not be granted in this case; moreover, it would not further "the just, speedy and inexpensive

determination of a proceeding on its merits" (Rule 1-3 of the *Supreme Court Civil Rules*) to allow the defendants to file a sur-reply.

[156] I note that *Strata Plan LMS 1816* in fact related to the propriety of filing sur-reply pleadings, rather than reply submissions as is the issue in this case.

[157] In their reply submissions, the plaintiffs did not tender any new evidence, though they did draw to the Court's attention aspects of the existing evidence that, in their view, responded to specific pieces of the evidence upon which Canada relied. Nor did the plaintiffs advance new theories of the case or make arguments that were not responsive to arguments raised by the defendants. For example, one aspect of the plaintiffs' reply to which Canada objected was a section in which the plaintiffs set out what they said would be safeguards responding to the defendants' submissions raising concerns about risks. In my view, the plaintiffs could not have been expected to anticipate Canada's very thorough and detailed argument about risks, and it was appropriate for them to respond with specific reference to the evidence.

[158] Though the plaintiffs' reply is lengthy and detailed, in my view it is proper reply under the Rules and practice of this Court, in the context of this case.

[159] I have reviewed, and noted, Canada's submissions regarding specific points as to which they say that the plaintiffs in their reply misstated Canada's position.

VI. EXPERT OPINION EVIDENCE

[160] The Court had the benefit of expert opinion evidence from many academics, researchers and medical practitioners. For convenience, the table below sets out, with respect to the expert witnesses, their names, a summary of their qualifications, and the identity of the party tendering their evidence. I have adopted the convention, in these Reasons, of referring to medical doctors as "Dr." and to university researchers (including those who hold doctorates) as "Professor".

Witness	**Summary of Qualifications**	**Evidence tendered by**
Dr. Marcia Angell	A physician, Senior Lecturer on social medicine in the Division of Medical Ethics at Harvard Medical School in Boston, Massachusetts, and former Editor-in-Chief of the New England Journal of Medicine. She specializes in medical ethics and social medicine.	Plaintiffs
Dr. Michael Ashby	A practicing specialist and Professor in palliative and pain medicine with the University of Tasmania in Australia. He is also a consultant in palliative and pain medicine with the Department of Health and Human Service in Tasmania.	Plaintiffs
Professor Margaret Pabst Battin	A philosopher, bioethicist and Distinguished Professor of the Department of Philosophy at the University of Utah. Her research focuses on physician-assisted death and related ethical, philosophical and empirical issues.	Plaintiffs
Dr. David Bell	A physician with a family practice with hospital privileges in Victoria, British Columbia. He has more than 30 years experience caring for patients at the end of their lives.	Plaintiffs
Dr. Charles Bentz	A practicing physician specialising in internal medicine, and Medical Director and Associate Professor at the School of Physician Assistant Studies at Pacific University, College of Health Professions in Oregon. He previously served as Director of the End-of-Life Care Curriculum and member of the End-of-Life Quality Improvement Committee at St. Vincent Hospital, and the Program Chair for five state-wide palliative care conferences.	AG Canada
Dr. Eugene Bereza	A Montréal-based physician, clinical ethicist and Director of the Biomedical Ethics Unit at the McGill Faculty of Medicine; the Neuroethics Program at Montreal Neurological Institute and Hospital; the Medical Ethics Program, McGill Department of Family Medicine, and the Ethics Program at CSSS de la Montagne. He practices in applied clinical ethics, research ethics and organizational ethics.	AG Canada

Witness	**Summary of Qualifications**	**Evidence tendered by**
Dr. Jean Bernheim	A retired oncologist, researcher and Professor Emeritus of medicine at the Free University of Brussels in Oostende, Belgium. His research focuses on the design and application of methods to evaluate "quality of life", and epidemiological and conceptual end-of-life research.	Plaintiffs
Dr. Marcel Boisvert	An Associate Professor with the Department of Medicine at McGill University and a retired palliative care physician in Québec. He has presented on palliative care to numerous conferences and government committees.	Plaintiffs
Dr. Georg Bosshard	A family physician, geriatrician and Associate Professor of clinical ethics at the University of Zurich in Switzerland. He previously served as a research associate for medical law and ethics and has done research into end-of-life issues in Europe.	Plaintiffs
Dr. David Boyes	A retired physician who practiced in obstetrics, gynaecology and oncology in Vancouver, British Columbia. He retired in 1987 as Director of the Cancer Control Agency of British Columbia, having become one of the world's leading authorities on cervical cancer.	Plaintiffs
Professor Anne Bruce	A registered nurse and an Associate Professor in the Faculty of Human and Social Development with the School of Nursing at the University of Victoria in British Columbia. She authored a paper concerning palliative sedation.	Plaintiffs
Dr. Ryan Bystrom	A family physician in Westbank, British Columbia with active privileges at the Kelowna General Hospital. He is also a clinical instructor with the University of British Columbia. Dr. Bystrom is Ms. Taylor's family physician.	Plaintiffs

Witness	Summary of Qualifications	Evidence tendered by
Dr. Eric Cassell	A retired internist and palliative care physician in Miniskink Hills, Pennsylvania, and current Emeritus Professor of public health at Weill Medical College of Cornell University and Adjunct Professor of medicine at McGill University. He has provided care to the dying and written on the subject for 40 years, and has held numerous commission and committee appointments in the area of bioethics and palliative care.	Plaintiffs
Dr. Harvey Chochinov	A Distinguished Professor of psychiatry at the University of Manitoba and Director of the Manitoba Palliative Care Research Unit, CancerCare Manitoba. He holds the only Canada Research Chair in palliative care, and has published extensively in the psychosocial dimensions of palliation.	AG Canada
Dr. Sharon Cohen	A behavioural neurologist and Assistant Professor in the Division of Neurology at the University of Toronto, with a cross-appointment in the Graduate Department of Speech Language Pathology. Her practice focuses on disorders of cognition, mood and behaviour, including dementia and Huntington's disease	Plaintiffs
Mr. Mark Connell	An attorney in Missoula, Montana who has served as Director of the Montana Trial Lawyers Association and the American Civil Liberties Union of Montana. He represented the plaintiffs in a case that resulted in the Supreme Court of Montana holding that a terminally ill patient's consent to physician-assisted death constitutes a statutory defence to homicide charges against a physician.	Plaintiffs
Dr. Deborah Cook	A physician and Professor in the Departments of Medicine and Clinical Epidemiology & Biostatistics, and Academic Chair in Critical Care Medicine at McMaster University in Hamilton, Ontario. She specialises in critical care medicine, including end-of-life care.	Plaintiffs

Witness	Summary of Qualifications	Evidence tendered by
Professor Luc Deliens	A Belgium-based medical sociologist, Professor of public health and palliative care at Vrije Universiteit Amsterdam, and Professor and Director of the End-of-Life Care Research Group at Ghent Universiteit and Vrije University, Brussels. He has published extensively on end-of-life care.	Plaintiffs
Dr. Martha Donnelly	A geriatric psychiatrist and Associate Professor at the University of British Columbia in Vancouver, where she is the Director of the Geriatric Psychiatry Program. She has had extensive practical experience doing competency assessments, and teaches in that area.	Plaintiffs
Dr. G. Michael Downing	A palliative care physician and Research Director of Vancouver Island Health Authority's Victoria Hospice, an internationally recognized centre for expertise in palliative pain and symptom management, education and research in palliative care in Victoria, British Columbia.	AG BC
Baroness Ilora Finlay of Llandaff	A palliative care physician who was involved in establishing palliative medicine as a recognized speciality in the United Kingdom, as well as an Honorary Professor of palliative medicine at Cardiff University and Groningen University. She has served in the United Kingdom House of Lords since 2001, where she has been active in health-related legislation.	AG Canada
Professor Catherine Frazee	A Professor Emerita at the School of Disability Studies at Ryerson University in Ontario. She served as a Commissioner for Human Rights, and later as Chief Commissioner for the Ontario Human Rights Commission. She has done extensive work in human rights and disability rights, including research into the risks that physician-assisted dying poses for people with disabilities.	AG Canada

Witness	Summary of Qualifications	Evidence tendered by
Dr. Romayne Gallagher	A Vancouver-based physician specializing in palliative care and chronic pain, and a Clinical Professor in the Division of Palliative Care at the University of British Columbia. She is currently the Head of the Divisions of Palliative and Residential Care in the Department of Family and Community Medicine, and Physician Program Director of the Palliative Care Program, for Providence Health Care.	AG Canada
Dr. Linda Ganzini	A geriatric psychiatrist, and Professor of psychiatry and medicine and Director of the Division of Geriatric Psychiatry at the Oregon Health and Science University. She holds a Masters of Public Health degree with an emphasis in epidemiology and biostatistics. Over some 15 years, Dr. Ganzini has co-authored numerous studies regarding different aspects of physician-assisted dying in Oregon.	Plaintiffs
Dr. N. Gregory Hamilton	A practicing psychiatrist who is a co-founder, past board member and past President of Physicians for Compassionate Care, a non-profit organization in Portland, Oregon that promotes compassionate care for severely ill patients without sanctioning or assisting their suicide.	AG Canada
Professor Marnin Heisel	A clinical psychologist, research scientist and Associate Professor at the Schulich School of Medicine and Dentistry, University of Western Ontario. He has expertise in suicidology, with particular expertise in suicide prevention among older adults.	AG Canada
Dr. Herbert Hendin	A New York-based psychiatrist and researcher who studies and treats people who wish to end their lives, some of whom are terminally ill. He has served as CEO and Medical Director of the American Foundation for Suicide Prevention and has done research into the effects of legalizing physician-assisted dying in Oregon and the Netherlands.	AG Canada

Witness	Summary of Qualifications	Evidence tendered by
Ms. Ann Jackson	A consultant to not-for-profit boards of directors who retired as the Executive Director and Chief Executive Officer of the Oregon Hospice Association in 2008. She has been a primary spokesperson about end-of-life choices in Oregon and currently works with individuals and organizations on end-of-life decision making.	Plaintiffs
Professor John Keown	A Professor of law who holds the Rose Kennedy Chair of Christian Ethics at Georgetown University in Washington D.C. He has specializes in medical ethics, and has spent more than 20 years researching, teaching, presenting and publishing on end-of-life issues.	AG Canada
Dr. Gerrit Kimsma	A Dutch family practitioner, and an Extern Associate Professor of medical ethics and philosophy at the Radbout University Medical Center in Nijmegen, the Netherlands. He has been a program developer and instructor for the program in the Netherlands that provides support and consultation to physicians in connection with patient requests for euthanasia ("SCEN").	Plaintiffs
Dr. Michael Klein	A family physician, paediatrician, neonatologist, maternity care researcher and maternity, primary care and organizational consultant in Vancouver who served as the head of family practice departments at several medical institutions, including the Children's and Women's Health Centre of British Columbia.	Plaintiffs
Professor Thomas Koch	A Toronto-based gerontologist specializing in chronic conditions and diseases, and an Adjunct Professor of medical geography at the University of British Columbia. He is a consulting medical ethicist to Alton Medical Centre (Toronto), Copeman Healthcare (Vancouver) and Perram House Hospice (Toronto). He has written and presented on issues of medical ethics and care.	AG Canada

Witness	Summary of Qualifications	Evidence tendered by
Professor Johan Legemaate	A Professor of health law at the University of Amsterdam in the Netherlands who has served as legal counsel to several medical organizations and health-related advocacy groups. He has published on a wide range of health law issues, including patients' rights, the regulation of care and end-of-life decisions.	Plaintiffs
Professor Penney Lewis	A Professor of law at the King's College London School of Law and Centre of Medical Law and Ethics in the United Kingdom. She has conducted comparative legal research in multiple jurisdictions, including comparative work on assisted dying.	Plaintiffs
Dr. S. Lawrence Librach	A Canadian palliative care physician and Director of the Joint Centre for Bioethics, and the Head of the Division of Palliative Care in the Department of Family and Community Medicine, at the University of Toronto. He is a member of the board of directors and past President of the Canadian Hospice Palliative Care Association.	Plaintiffs
Dr. Douglas McGregor	A palliative care specialist, Clinical Assistant Professor in the Department of Family Practice at the University of British Columbia and the Regional Medical Director, Palliative Care for the Vancouver Coastal Health Authority. He has been active in developing guidelines on general approaches for physicians in various aspects of end-of-life care.	AG BC
Professor Sheila McLean	An Emeritus Professor of law and ethics in medicine at the University of Glasgow in Scotland, who also serves as a member and former Vice-Chairperson of the International Bioethics Committee of UNESCO. She has researched and published in the area of medical law and ethics for more than 30 years.	Plaintiffs
Dr. Scott K. Meckling	A practising neurologist in Kelowna, British Columbia, who is the Head of the Division of Neurology and Director of the Multiple Sclerosis Clinic at the Kelowna General Hospital.	Plaintiffs

Witness	**Summary of Qualifications**	**Evidence tendered by**
Professor Sabine Michalowski	A Professor of law at the University of Essex, United Kingdom where she is director of the LL.M. in Health Care Law and Human Rights. She has developed an expertise in Colombian law, including the practice of physician-assisted death in that country.	Plaintiffs
Professor Brian Mishara	A Québec-based Professor of psychology at the Université de Québec à Montréal, and the Director of the Centre for Research and Intervention on Suicide and Euthanasia. He has served as a special consultant to the World Health Organization to work with governments in the development of national suicide prevention strategies and policies.	AG Canada
Professor Richard Glynn Owens	A practicing psychologist and Professor of psychology at the University of Auckland in New Zealand with expertise in forensic psychology, health psychology and the psychology of death and dying. He has provided clinical care to dying patients, and is a former member of the board of trustees of the South Auckland Hospice.	Plaintiffs
Dr. José Pereira	An Ottawa-based palliative care physician who has practiced in Canada and Switzerland, and the Head and Professor of palliative care in the Department of Medicine at the University of Ottawa. He is also Medical Chief of the Department of Palliative Medicine at two Ottawa medical centres. He has a particular interest in medical education research around palliative care competencies and the use of palliative sedation.	AG Canada
Dr. Thomas Preston	A retired practicing cardiologist and Professor of medicine at the University of Washington, who now serves as Medical Director of Compassion & Choices in Seattle, Washington. In that capacity, he was involved with the coalition that passed the ballot initiative that legalised physician-assisted dying in Washington.	Plaintiffs
Dr. Peter Rasmussen	A retired Oregon palliative care physician who formed the first hospital-based palliative care team in Oregon. He was a plaintiff in the United States Supreme Court decision that allowed Oregon's assisted death legislation to take effect.	Plaintiffs

Witness	Summary of Qualifications	Evidence tendered by
Dr. Gary Rodin	A Professor at the University of Toronto, Department of Psychiatry, and Head of the Department of Psychosocial Oncology and Palliative Care at the Princess Margaret Hospital, University Health Network. He holds a University of Toronto/University Health Network Chair in psychosocial oncology and palliative care and has conducted research into the psychological aspects of advanced cancer and the quality of death and dying.	AG Canada
Professor Mary Shariff	An Assistant Professor with the Faculty of Law at the University of Manitoba who has conducted research on assisted death from a comparative law perspective, with particular focus on the construction of the principle of autonomy in the regulation of assisted death in the Netherlands, Belgium, Luxembourg, Switzerland and the United States.	AG Canada
Dr. Leslie J. Sheldon	A practising geriatric psychiatrist and Assistant Clinical Professor in the Geriatric Psychiatry Program and Instructor with the Faculty of Pharmaceutical Sciences at the University of British Columbia in Vancouver, who has extensive experience assessing cognitive capacity.	AG Canada
Ben Shimshon	A public opinion researcher who is a founding director of BritainThinks, a strategy and research agency that provides high-level communication and strategy advice to clients. His agency conducted a poll on public opinion on "Dying in Dignity" in the United Kingdom in 2011.	Plaintiffs
Dr. Derryck Smith	A practising psychiatrist and a Clinical Professor of psychiatry at the University of British Columbia who has been involved in assessing and treating individuals with a broad range of psychiatric disorders including depressive disorders. He is experienced in assessing cognitive functioning and competence.	Plaintiffs

Witness	Summary of Qualifications	Evidence tendered by
Professor Helene Starks	An Associate Professor and researcher at the University of Washington School of Medicine's Department of Bioethics and Humanities in Seattle, with a Ph.D. in Health Services Research. Much of her professional research has concerned decision-making around end-of-life care, including medically-assisted dying.	Plaintiffs
Professor Wayne Sumner	A Canadian philosopher and retired University Professor at the University of Toronto who specialized in ethical theory, applied ethics and bioethics. During his teaching career, he served as Chair of the Department of Philosophy and was cross-appointed to the Faculty of Law, and was a founding member of the university's Centre for Bioethics.	Plaintiffs
Dr. Rodney Syme	A Melbourne, Australia urologist who has knowingly provided advice to people about end-of-life decisions, and provided assistance that some have used to end their own lives. He has written and spoken widely on those matters, and published a book about his experience: *A Good Death* (Carlton, Australia: Melbourne University Press, 2008).	Plaintiffs
Dr. Ross Upshur	A physician and Professor at the Department of Family and Community Medicine and Dalla Lana School of Public Health at the University of Toronto. He is also the former Director of the University of Toronto Joint Centre for Bioethics and a Canada Research Chair in primary care research. His research interests and teaching credentials include public health ethics, epidemiology and the philosophy of medicine.	Plaintiffs
Dr. Johannes J.M. van Delden	A Professor of medical ethics at the Medical School of Utrecht University and Director of Education at the Julius Center for Health Sciences and Primary Care at the University Medical Center in Utrecht, the Netherlands. He has been involved in all of the major empirical studies into end-of-life care that have taken place in the Netherlands since 1990.	Plaintiffs

Witness	Summary of Qualifications	Evidence tendered by
Dr. Philip Welch	A physician and medical geneticist at Dalhousie University in Halifax, Nova Scotia. He specialises in treating and researching genetic disorders including Huntington's Disease and Muscular Dystrophy.	Plaintiffs
Professor James Werth	A Professor of psychology and Director of the Doctor of Psychology Program in Counseling Psychology at Radford University in Virginia, and a licensed psychologist specializing in counselling persons with HIV/AIDS and other chronic and terminal illnesses. He has served on all three of the American Psychological Association's major groups addressing end-of-life issues.	Plaintiffs
Professor Laura Williamson	The Wellcome Trust Research Fellow at the Institute for Applied Health Research, Glasgow Caledonian University in Glasgow, Scotland. Her research interests lie in the area of public health ethics.	Plaintiffs

VII. MEDICAL ETHICS AND MEDICAL END-OF-LIFE PRACTICES

A. Introduction

[161] The ethics of physician-assisted suicide and euthanasia have been vigorously debated by individual citizens, politicians, lawyers, philosophers and ethicists. Canadian and international physicians and health-care providers who are closely affected by the issue have struggled with it too, both in theory and in practice. The ethical debate, broadly speaking, is about two questions: (1) If the law permitted it, would it ever be ethical, in an individual case, for a physician to assist a competent and informed patient who requests hastened death? (2) Even if it were ethical to provide such assistance in an individual case considered in isolation, would a change in the existing law or policy pose a threat to other persons (particularly those who are vulnerable due to age or disability) or to broader societal values (such as general respect for human life, building a strong palliative care system and maintaining appropriate relationships between physicians and patients)?

[162] In this section, I concentrate mainly on the first question regarding the ethics of physician-assisted death in an individual case. With respect to the second question, evidence is available from jurisdictions where assisted death is permitted about the effectiveness of safeguards against abuse and the impact legalization has had on palliative care and physician-patient relationships. As well, evidence is available from Canada that bears on the feasibility of systems of safeguards. I will discuss that evidence in the next two sections.

[163] The plaintiffs argue that the absolute prohibition against assisted death is arbitrary and infringes s. 7 because, among other reasons, it is ethically indistinguishable from currently accepted end-of-life practices. Because *Rodriguez* held that the legislation is not arbitrary, I do not address the parties' submissions about arbitrariness. However, in this section I will review the evidence that the parties provided regarding the ethical debate and end-of-life medical practices. Such a review also logically entails a brief description of the governing legal principles with respect to the informed consent requirement. I do so both in order to create a record for higher courts and because this body of evidence and law has some relevance to other issues that are necessary for me to address.

B. Relevance of the Ethical Debate

[164] Ethics is a discipline consisting of rational inquiry into questions of right and wrong; in this case, whether it is right, or wrong, to assist persons who request assistance in ending their lives and, if it is right to do so, in what circumstances. Since this case concerns arguments for physician-assisted death, a central question is whether it is ethical for physicians to provide such assistance.

[165] Ethical principles have shaped both the law and medical practice. Ethical principles, similarly, enter into constitutional analysis (for example, Justice Sopinka referred to the positions of medical associations regarding the ethics of assisted suicide and euthanasia in his Reasons in *Rodriguez* (at 608)).

1. Positions of the Parties

[166] All of the parties and several of the intervenors address ethical principles and the role that they ought to play in resolving the issues in this case.

[167] The plaintiffs argue that the ethical position can inform, but not determine, the legal analysis. They submit, however, that in this case the legal resolution should mirror the ethical one. They suggest that there is no societal consensus supporting a principle of the absolute sanctity of human life but that there is a societal consensus supporting the principle of a person's autonomy over his or her own body.

[168] Canada says that whatever one might conclude about the ethical position is irrelevant to the legal questions before the Court. It criticizes the plaintiffs' argument for attempting to raise one ethical view to the status of a principle of fundamental justice. Nevertheless, Canada says that the preservation of human life is a fundamental value in Canadian society and that respect for life transcends individual, religious and diverse cultural values. Canada does not assert a state interest in the absolute protection of all human life. It says, however, that respect for this fundamental value is reflected in the state's interest in not condoning the taking of human life, and embodied in the criminal law.

[169] British Columbia, similarly, argues that the sanctity of life is a fundamental principle in our society. It refers to *United States of America v. Burns*, 2001 SCC 7 [*Burns*] at para. 71, where the Court stated:

> The distinction between "general public policy" on the one hand and "the inherent domain of the judiciary as guardian of the justice system" is of particular importance in a death penalty case. The broader aspects of the death penalty controversy, including the role of retribution and deterrence in society, and the view that capital punishment is inconsistent with the sanctity of human life, are embedded in the basic tenets of our legal system, but they also reflect philosophic positions informed by beliefs and social science evidence outside "the inherent domain of the judiciary". ...
>
> [Emphasis added.]

[170] The Canadian Unitarian Council submits that there are many perspectives on how the sanctity of our lives is best honoured. It submits that the only ethical principle with a broad consensus is informed consent which it says is “the touchstone of medical ethics and of the law pertaining to medical decision-making”. It also argues that our society does regard some decisions to end one’s life intentionally (through termination or refusal of treatment) as worthy of respect and protection, even where the assistance of a physician is required.

[171] The Christian Legal Fellowship (“CLF”) argues that the intentional taking of innocent human life is always wrong and that the principle of inviolability of life is a cornerstone of Western civilization. It distinguishes this principle from “vitalism”, or the goal of preserving life at all costs. Counsel for this intervenor argues that the strong medico-legal culture against killing needs this inviolability principle: what prevents killing is the law, along with the internalized medical culture that draws a clear line against directly taking life. Further, the CLF argues, physician-assisted death entails a conclusion by the physicians in question that a life is not worth living. Thus, “what looks like patient autonomy is, in reality, a greatly expanded discretionary power over life and death to be given to physicians.” It says that refusal or voluntary withdrawal of treatment is consistent with the inviolability principle because where the physician’s intention is to comply with a patient’s wishes to withdraw treatment, rather than to kill, the act is ethical and lawful.

[172] The Euthanasia Prevention Coalition and the Euthanasia Prevention Coalition – British Columbia (“EPC”) similarly submit that human life is intrinsically valuable and inviolable. They suggest that decisions about life should be seen both as individual and collective, and that personal autonomy is not absolute but is linked to interdependence. These intervenors refer to the Hippocratic Oath which, they say, dictates as a matter of ethics that doctors are first to do no harm, and supports a distinction in end-of-life treatment based upon intention. Their position is that a shift in medical ethics would adversely impact the fiduciary relationship between doctors and patients. Pointing out that persons with disabilities have historically relied on principles of choice, autonomy and self-determination to fight devaluing stereotypes

and prejudices, it says that those principles are inverted, without regard to the harmful consequences, when invoked to support a right for disabled people to die.

2. Analysis

[173] Actions may be ethical but not legal, and, conversely, may be legal but not ethical. The question in this case, in any event, is not what is ethical or legal, but whether specific provisions of the *Criminal Code* are constitutional. However, because the three realms (ethical, legal and constitutional) tend to converge even though they do not wholly coincide, my view is that the ethics of physician-assisted death are relevant to, although certainly not determinative of, the assessment of the constitutional issues in this case.

[174] The ethical debate may bear on the issues in this case for at least three additional reasons.

[175] First, the plaintiffs argue that their constitutional rights are infringed because physician-assisted death is not permitted. It is therefore important to know whether at least some physicians believe that it would be ethical to respond positively to patients' requests for assisted death if the law permitted them to do so.

[176] Second, the plaintiffs argue that the current line drawn between permissible and impermissible end-of-life care is based upon distinctions that in reality have no practical ethical or moral force. They also argue that there is no ethical distinction between the laws that permit suicide and those that prohibit physician-assisted suicide.

[177] Third, the plaintiffs say that if the purpose of the law is to uphold a particular religious conception of morality (about which there is not a consensus in Canadian society), it is an invalid purpose. They suggest that there is a societal consensus supportive of their claim.

[178] For those reasons as well, though bearing in mind that the ethical and constitutional questions are distinct, it seems worthwhile to review the parameters of the ethical debate.

[179] The plaintiffs' claim in this matter relates to physician-assisted death.

[180] In the context of the ethical debate about physician-assisted death, the focus is not on whether it is ethical for persons to make a request for assistance in death. The ethics of suicide *per se* are not at issue, and it is clear that requesting assistance in death does not in and of itself contravene any law.

[181] Rather, the relevant ethical debate is specifically focused on the ethics of physicians and on existing end-of-life practices.

[182] I also recognize that other providers of health care, particularly palliative care, have ethical views that matter, as do family members and other persons, but because of the way in which this case is framed the focus is on physicians.

[183] At this stage, I am reviewing the arguments for and against the proposition that it can ever be right for a physician to assist a patient with her own death, leaving aside (for the moment) the questions whether a legal system permitting such assistance might cause harm to vulnerable persons or to society, and whether our current legal prohibition against physician-assisted death is consistent with the *Charter*.

[184] I will begin by reviewing Canadian law and medical practices as they pertain to end-of-life care, and will then turn to the evidence pertaining to the ethics of physician-assisted death.

C. Current State of the Law and Practice in Canada Regarding End-Of-Life Care

[185] End-of-life care for seriously ill patients very frequently involves decisions about whether to prolong life or instead to permit the patient's disease to take its course. Death of a patient may follow a decision by the patient or a surrogate

decision-maker to withdraw life-sustaining treatment from the patient. According to Dr. Deborah Cook, a specialist in critical care medicine, approximately 90% of deaths among critically ill patients in Canada occur following the withdrawal of some form of life-support, most commonly the withdrawal of medical ventilation, dialysis or inotrope medications.

[186] One of the main arguments for the proposition that physician-assisted death can be an ethical practice is that physician-assisted death is ethically indistinguishable from conventionally ethical end-of-life practices such as withholding or withdrawing treatment or administering palliative sedation.

[187] I will begin my analysis, for that reason, with a summary of what the evidence reveals regarding current end-of-life practices, and their legal and ethical status, in Canada.

1. Palliative Care Practice

[188] Palliative care has improved considerably in the past few decades, including with respect to pain management.

[189] Adequate palliative care can reduce requests for euthanasia or lead to their retraction (according to Dr. Jean Bernheim in his cross-examination, and Dr. Chochinov, both palliative care specialists). Expressions of a wish to die, even persistent expressions, may in fact reflect a wish for better treatment, in the experience of Dr. Romayne Gallagher (another palliative care specialist). Indeed, Dr. Gallagher deposes that some recent studies suggest that palliative care lengthens life.

[190] However, despite the best possible palliative care, some patients suffer pain that cannot be alleviated, according to expert witnesses called by both the plaintiffs and the defendants. As well, symptoms can cause suffering other than pain (such as nausea, vomiting, and shortness of breath) that cannot be alleviated even by the best palliative care. Some patients experience what is called “existential suffering”, meaning, for example, a profound sense of loss of dignity.

[191] The defendants do not take the position that all pain or suffering can be alleviated for all patients and concede that palliative care is not a panacea.

[192] Further, high quality palliative care is far from universally available in Canada. Dr. Gallagher states that, in her opinion:

> While standards and norms exist there is not the same degree of standardization of access. The Canadian Hospice Palliative Care Association estimates that up to 90% of people who die could benefit from palliative care (the 10% are sudden deaths and accidental deaths). Unfortunately only 16-30% of Canadians receive palliative care as part of their life-threatening illness. Palliative care services across Canada have often been referred to as a patchwork of services across the country because there is little strategic planning of palliative care. There are many places in Canada, particularly in rural or remote areas, where there is little or no access to palliative care specialist nurses or physicians. If we could guarantee that every medical student or nursing student received adequate palliative care training we could assume that all primary care providers were capable of providing palliative care meeting the Canadian standards. However, the curricula and standards have only been developed in the last 10 years in Canada and there are many other countries that lag behind Canada in palliative care training.
>
> [Footnotes omitted.]

[193] Dr. José Pereira and Dr. Harvey Chochinov give evidence to similar effect. Their opinions are consistent with the conclusions in the Special Senate Committee Report, and subsequent Senate reports on the state of palliative care.

[194] Patients' experience with the medical system, including palliative care, may be affected by factors such as their age and disability. Disabled people have experienced marginalization in Canadian society, including in connection with the delivery of health care. Health care providers may, like other people, overestimate the difficulty in living with certain kinds of disability and wrongly assume that life in some circumstances is "not worth living" (according to the evidence of Professor Catherine Frazee, Rhonda Wiebe and David Martin).

[195] Palliative care may include administering medications for pain management in high doses. The weight of the evidence currently suggests that it is very unlikely that opioids will hasten death where properly used. However, a belief that aggressive

pain management through opioids will hasten death is still fairly widely held, even among physicians.

[196] For example, Dr. Michael Ashby says that “[a]nalgesic and sedative use, if done in accordance with international standards for good palliative care, do not cause death. ... However, like any class of drugs, opioids are dangerous if used inappropriately”.

[197] Dr. Pereira deposes:

> Studies are demonstrating that using strong opioids such as morphine carefully and then gradually increasing their doses (titration) to effect (good symptom control) is safe and effective in managing dyspnea related not only to cancer but also ALS and end-stage heart and lung failure”.

[198] To the extent that practitioners continue to believe that opioids sufficient to relieve pain may hasten death, that phenomenon may tend to confound the ethical debate. This is because some practitioners may believe that they are administering opioids which have a double effect (managing pain but incidentally hastening death), when in fact they simply have the single effect of managing pain. Some evidence suggests that as a result, pain management has not been as effective as it could be. Dr. Gallagher states:

> One of the long-standing myths that we are working to change is the one that opioids shorten life because they cause respiratory depression which can cause death. In the last 10 years there have been many studies in a number of countries and across a variety of health care settings showing that opioids used in appropriate doses to control pain and shortness of breath do not cause respiratory depression and do not hasten death. ... Since this article was published even more studies have come out demonstrating the safety of opioids when used appropriately for the treatment of pain and shortness of breath.
>
> One of the barriers to adequate pain and symptom control at the end of life is the persistence of this myth. Doctors do not wish to cause harm to people and are hesitant to increase the dose beyond their familiarity. This is part of the work that palliative care practitioners do on a daily basis is to educate and mentor physicians in proper prescribing in order to control pain and shortness of breath. Many patients also believe that these drugs are harmful and hesitate to use them, causing suffering for themselves and those who love them. Palliative care practitioners often spend time educating the patient and

> family about the safety and benefits of using these medications to control pain and shortness of breath.

[199] In summary, while the weight of the evidence is that proper use of opioids in palliative care does not cause death, opioids can have that effect if used inappropriately.

[200] In the context of palliative care, it is fairly widely accepted that when a patient is close to the end of life, and is experiencing symptoms that are severe and refractory (that is, resistant to treatment), it is ethical practice for her physician to sedate her and maintain her in a state of deep, continuous unconsciousness to the time of death, with or without providing artificial hydration or nutrition ("terminal sedation" or "palliative sedation"). Deponents who discussed this practice included Dr. Pereira, Dr. Michael Downing and Professor Anne Bruce.

[201] Palliative sedation remains somewhat controversial and is typically made available only when the patient is thought to be near death (normally, within one week), although it is not always possible to be accurate in such assessments. No legislated standards for palliative sedation exist in Canada of which I am aware, but some guidelines have recently been developed or are still under development, according to Dr. Downing, Dr. McGregor and Professor Bruce. For example, the Fraser Health Authority *Refractory Symptoms and Palliative Sedation Therapy Guidelines* (Surrey: Fraser Health, 13 January 2011) state that the criteria for implementing palliative sedation therapy include that the patient: is terminally ill and near death (within hours to days) with no hope of recovery; is in a palliative program or has a palliative care treatment plan; is suffering refractory symptoms which the palliative sedation is intended to relieve; is fully informed and involved in the decision-making or the substitute decision-maker is acting in accordance with the patient's values and beliefs; a "Do Not Resuscitate" order is in effect; and the degree of sedation is proportionate to relief of the refractory symptoms.

[202] Dr. Douglas McGregor provides an account of how he has occasionally incorporated palliative sedation into his own practice. In cross-examination,

Dr. McGregor stated that palliative sedation can sometimes hasten death. However, it cannot be assumed that palliative sedation, even accompanied by withdrawal of hydration, necessarily hastens death when it is administered to patients who are already in the final stages of dying.

2. Assisted Suicide and Voluntary Euthanasia Practice

[203] Assisted suicide and voluntary euthanasia (as well as non-voluntary and involuntary euthanasia) are criminal offences: *Criminal Code*, ss. 241, 229. The defence of necessity is likely not available: *R. v. Latimer*, [2001] 1 S.C.R. 3.

[204] Most physicians who consider provision of assisted death to be ethical practice in some circumstances are deterred from providing it by the current state of the law. (I refer to the evidence of Dr. David Bell, Dr. David Boyes, Dr. Michael Klein, Dr. William Shoichet, Dr. Derryck Smith and Dr. Philip Welch.) It is likely, however, and I find on a balance of probabilities, that a few physicians in Canada, as in other countries, provide assistance in suicide or euthanasia despite the criminal prohibition against doing so. (I refer to the evidence of Dr. Lawrence Librach and Dr. Eugene Bereza in this regard.) I also note the evidence of Dr. Rodney Syme that, despite the prohibition of assisted death in Australia, 36% of Australian surgeons reported administering medication in doses greater than necessary to relieve symptoms, with the intention of hastening death, in order to relieve suffering.

[205] Some Canadians travel to Switzerland in order to obtain assistance in hastening their deaths, doing so at a time when they are still well enough to travel, at considerable financial cost and with some possible risk of criminal prosecution for relatives or others who assist them (I refer to the evidence of the plaintiffs Lee Carter and Hollis Johnson). According to statistics provided by the Swiss “death with dignity” organization DIGNITAS, of 97 assisted suicides facilitated by that organization in 2010, five were of Canadians.

[206] A Canadian organization called Dying with Dignity provides information and support on hastening death. Its Executive Director, Wanda Morris, deposes that Dying with Dignity provides support for individuals at the end of their lives, including

support at the bedside of those who wish to determine the nature and timing of their death. The organization offers information and emotional support. Ms. Morris states that Dying with Dignity does not encourage anyone to end their life, does not provide the means to do so, and does not actively assist in a person's death.

3. The Law

a) The Informed Consent Requirement

[207] Patient decision-making is central to all medical care. The doctrine of informed consent protects a patient's right to accept or refuse medical treatment. No medical procedure may be undertaken unless a medical practitioner has obtained the patient's consent after providing her with information sufficient to enable her to evaluate the risks and benefits of the proposed treatment and other available options. Informed consent presupposes the patient's capacity to make a subjective treatment decision based on her understanding of the necessary medical facts provided by the doctor and on her assessment of her own personal circumstances.

[208] The foregoing description of the doctrine of informed consent is taken from *Malette*. Justice Robins, writing for the Court, further explained (at 328):

> The right of self-determination which underlies the doctrine of informed consent also obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment.

[209] *Malette* arose when a physician, aware that his severely injured and unconscious patient was carrying a card identifying herself as a Jehovah's Witness and requesting that she not be given a blood transfusion under any circumstances, nevertheless administered a blood transfusion to save her life. The Court concluded that the effect of the plaintiff's card was to restrict the treatment which could be provided to her, and that the physician's administration of the transfusions therefore constituted a battery. On the basic principle, the Court stated (at 336):

> At issue here is the freedom of the patient as an individual to exercise her right to refuse treatment and accept the consequences of her own decision. Competent adults ... are generally at liberty to refuse medical treatment even at the risk of death. The right to determine what shall be done with one's own body is a fundamental right in our society. The concepts inherent in this right are the bedrock upon which the principles of self-determination and individual autonomy are based.
>
> [Emphasis added.]

[210] In *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (Ont. C.A.) [*Fleming*], the Public Trustee, on behalf of two mentally incompetent patients who were involuntarily detained in a psychiatric facility, sued to enforce their rights to refuse the administration of certain neuroleptic drugs their treating psychiatrist considered beneficial to their mental conditions. When they were competent, the patients had expressed their wish not to receive those drugs which could have significant and unpredictable side effects.

[211] The Court (*per* Robins J.A.) cited *Malette*, and said the following with regard to the general principles applying to the physician-patient relationship at 85-86:

> The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination. The doctrine of informed consent ensures the freedom of individuals to make choices about their medical care. It is the patient, not the doctor, who ultimately must decide if treatment – any treatment – is to be administered.
>
> A patient, in anticipation of circumstances wherein he or she may be unconscious or otherwise incapacitated and thus unable to contemporaneously express his or her wishes about a particular form of medical treatment, may specify in advance his or her refusal to consent to the proposed treatment. A doctor is not free to disregard such advance instructions, even in an emergency. The patient's right to forgo treatment, in the absence of some overriding societal interest, is paramount to the doctor's obligation to provide medical care. This right must be honoured, even though the treatment may be beneficial or necessary to preserve the patient's life or health, and regardless of how ill-advised the patient's decision may appear to others.
>
> [Emphasis added.]

[212] The Court concluded that provisions of the Ontario *Mental Health Act*, R.S.O. 1980, c. 262, granting a physician the authority to override the competent wishes of a patient where deemed to be in the patient's best interests, unjustifiably infringed the security of the person guarantee in s. 7 of the *Charter*.

[213] These principles were brought into sharp focus in *Nancy B. v. Hôtel Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. S.C.) [*Nancy B.*], where the patient was not simply refusing treatment but requiring that previously-initiated treatment be withdrawn. The 25-year old plaintiff was afflicted with Guillain Barré Syndrome, an irreversible neurological disorder which in her case had led to total and permanent paralysis, and to complete dependence on mechanical respiration. She sought an injunction requiring the hospital to withdraw the respiratory support upon her request. The plaintiff was pronounced mentally competent by the hospital's psychiatrist, and it was accepted that her request was freely given and informed.

[214] Justice Dufour characterized the issue in these terms (at 392):

> What Nancy B. is seeking, relying on the principle of personal autonomy and her right of self-determination, is that the respiratory support treatment being given her cease so that nature may take its course; that she be freed from slavery to a machine as her life depends upon it. In order to do this, as she is unable to do it herself, she needs the help of a third person. Then, it is the disease which will take its natural course.

[215] Having reviewed both the Québec civil law and the common law regarding informed consent, the Court found that "[t]he logical corollary of this doctrine of informed consent is that the patient generally has the right not to consent, that is the right to refuse treatment and to ask that it cease where it has already been begun" (at 390). Justice Dufour then considered whether this right was limited by the criminal law, ultimately concluding that the *Criminal Code* (specifically, ss. 45, 216, 217 and 219) did not impede the withdrawal of the treatment keeping the plaintiff alive. He held that an individual who terminated Nancy B.'s respiratory support was letting nature take its course, and was not in any way offending the criminal law.

[216] In the result, Dufour J. granted the order permitting the plaintiff's physician to terminate respiratory support upon her request.

[217] The Supreme Court of Canada in *Rodriguez* confirmed that patients have the right to refuse or discontinue treatment, citing the *Nancy B.* decision. Sopinka J. summarized the state of the common law as follows (at 598):

> Canadian courts have recognized a common law right of patients to refuse consent to medical treatment, or to demand that treatment, once commenced, be withdrawn or discontinued [*Ciarlariello*]. This right has been specifically recognized to exist even if the withdrawal from or refusal of treatment may result in death ([*Nancy B*]; and [*Malette*]).

[218] The Supreme Court of Canada confirmed in 2009 that these remain the common law principles regarding informed consent, in *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30 [*A.C.*], at paras. 39-45. Justice Abella wrote, for the majority, at paras. 39-40:

> The legal environment for adults making medical treatment decisions is important because it demonstrates 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.
>
> At common law, adults are presumptively entitled to direct the course of their own medical treatment and generally must give their "informed consent" before treatment occurs, although this presumption of capacity can be rebutted by evidence to the contrary. (See Lucinda Ferguson, "The End of an Age: Beyond Age Restrictions for Minors' Medical Treatment Decisions", paper prepared for the Law Commission of Canada (October 29, 2004), at p. 5.) When competency is not in question, this right "to decide one's own fate" (*Re T (adult: refusal of medical treatment)*, [1992] 4 All E.R. 649 (C.A.), at p. 661) includes the unqualified right to refuse life-saving medical treatment.

[219] In *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119 [*Ciarlariello*], the Supreme Court affirmed the foundational importance of individual autonomy and self-determination in the common law principles. Justice Cory, for the Court, wrote (at 135):

> It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the

> right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent. This concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient. If, during the course of a medical procedure a patient withdraws the consent to that procedure, then the doctors must halt the process. This duty to stop does no more than recognize every individual's basic right to make decisions concerning his or her own body.
>
> [Emphasis added.]

[220] Since *Rodriguez*, the common law principles relating to competent adult patients have been clear. Individual autonomy gives competent, informed patients the right to consent to treatment, including the right to withdraw consent to life-sustaining treatment.

[221] However, many patients are not competent to make medical decisions.

[222] To provide for those situations, most Canadian provinces and territories have legislation regarding advance directives. In British Columbia, it is the *Representation Agreement Act*, R.S.B.C. 1996, c. 405, ss. 2 and 7. Where an individual does not have a representation agreement, the *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 11 allows a health care provider to provide treatment with the consent of a personal guardian or representative. Section 16(1) prescribes a list of third parties from whom a health care provider may obtain substitute consent. In the absence of legislation of this nature, the common law will continue to govern. As both *Malette* and *Fleming* make clear, an individual's known preferences regarding future treatment will prevail in the event that he or she later becomes incompetent.

[223] Where a patient is incompetent and her treatment preferences are not known, both at common law and under applicable statutory regimes, medical decisions will be made in the patient's best interests: see, for example, *Conway v. Jacques* (2002), 214 D.L.R. (4th) 67 (Ont. C.A.).

[224] In some cases, this may allow the withdrawal of life-sustaining treatment from an incompetent patient. In *Rodriguez*, the majority referred (at 598-99) with seeming

approval to the decision of the House of Lords in *Airedale N.H.S. Trust v. Bland*, [1993] 2 W.L.R. 316 [*Bland*], where such a procedure was approved in the case of a boy who, as a result of injuries, was in a persistent vegetative state. His parents and treating physicians sought and obtained court approval to cease life-sustaining treatment.

b) Potentially Life-Shortening Symptom Relief

[225] Since *Rodriguez*, it has been clear that potentially life-shortening symptom relief is permissible where the physician's intention is to ease pain. As Sopinka J. explained (at 607):

> The administration of drugs designed for pain control in dosages which the physician knows will hasten death constitutes active contribution to death by any standard. However, the distinction drawn here is one based upon intention – in the case of palliative care the intention is to ease pain, which has the effect of hastening death, while in the case of assisted suicide, the intention is undeniably to cause death. ... In my view, distinctions based upon intent are important, and in fact form the basis of our criminal law. While factually the distinction may, at times, be difficult to draw, legally it is clear.

c) Palliative Sedation

[226] So far as I am aware, palliative or terminal sedation has not been the subject of judicial consideration in Canada. It seems, however, to be a practice that may fall within the principles already described with regard to informed consent and potentially life-shortening symptom relief.

d) Withdrawal of Treatment against the Consent of Substitute Decision-Makers

[227] The law makes clear that consent is a sufficient condition for the withdrawal or withholding of treatment. But is consent also a necessary condition? Whether a physician or hospital can legally withhold or withdraw potentially life-sustaining treatment without the consent of either the patient or the patient's substituted decision-maker, is currently under much debate.

[228] In some decisions, Canadian courts have held that it is not appropriate for a court to interfere with medical practitioners acting unilaterally in the best interests of

a patient: for example, *Child and Family Services of Manitoba v. R.L.* (1997), 154 D.L.R. (4th) 409 (Man. C.A.); and *Re: I.H.V. Estate*, 2008 ABQB 250.

[229] More commonly, however, courts faced with such issues have concluded that the law in Canada is not settled: for example, *Sawatzky v. Riverview Health Centre Inc.* (1998), 167 D.L.R. (4th) 359 (Man. Q.B.); *Jin v. Calgary Health Region*, 2007 ABQB 593; *Golubchuk v. Salvation Army Grace General Hospital*, 2008 MBQB 49; and *Rotaru v. Vancouver General Hospital Intensive Care Unit*, 2008 BCSC 318.

[230] The question whether a patient's family can require maintenance of life-sustaining treatment against medical advice is central in a case to be heard in the Supreme Court of Canada, *Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONCA 482 (leave to appeal to S.C.C. granted, [2011] S.C.C.A. No. 329).

e) Summary

[231] To summarize, the law in Canada is that:

(a) Patients are not required to submit to medical interventions (including artificial provision of nutrition and hydration), even where their refusal of or withdrawal from treatment will hasten their deaths, and physicians must respect their patients' wishes about refusal of or withdrawal from treatment.

(b) Decisions about refusal or withdrawal of treatment may be made by competent patients either in the moment or by way of advance directives, and may be made by substitute decision-makers in the case of incompetent patients.

(c) Physicians may legally administer medications even though they know that the doses of medication in question may hasten death, so long as the intention is to provide palliative care by easing the patient's pain.

(d) It is unclear whether a patient's substituted decision-maker can require the maintenance of life-sustaining treatment against medical advice.

D. Evidence

1. Opinions of Ethicists

[232] Each side tendered evidence regarding the ethics of physician-assisted death. Before turning to the evidence of practising physicians, I will review the evidence of professional ethicists.

[233] The plaintiffs rely upon the evidence of Professor Wayne Sumner, Dr. Marcia Angell, Professor Margaret Battin, Dr. Upshur, and Dr. Gerrit Kimsma. The defendants counter with the evidence of Professor John Keown, Professor Thomas Koch and Dr. Bereza. Those witnesses refer in turn to the writings of others, and to the reports of various bodies that have analyzed the issues.

[234] Professor Sumner is a philosopher and retired Professor of ethics. In his opinion evidence, he addresses the ethical position regarding a request for assistance with death from a person who is: decisionally capable (competent); fully informed of her diagnosis and prognosis, and of treatment or palliative care options; exercising individual will free of undue influence or coercion; and expressing the request on a consistent and continuing basis. He states this opinion:

> Treatment cessation, pain management, and terminal sedation can … all be justified when they are the outcome of an informed choice (whether request or refusal) on the part of a decisionally capable patient, and they serve the best interest of the patient by preventing or avoiding needless suffering. This justification holds even when the result of any of these measures is the hastening of the patient's death. Indeed, these measures may in many circumstances better serve both patient autonomy and patient well-being by hastening death, if that is the outcome that the patient seeks and that will help to minimize suffering.
>
> It is obvious that either assisted suicide or voluntary euthanasia can be justified in exactly the same way by reference to exactly the same values. These measures as well can be both the outcome of a patient's informed request and serve the patient's best interest. There cannot be an ethical bright line between the three conventionally accepted measures and these further ones, since they all serve exactly the same core values. If these widely accepted measures are justified, under conditions of patient informed choice and patient best interest, then so is assisted death. Which measures will be appropriate in a given case will depend on the particularities of the case, and especially on what the patient wants and what will best serve his interest. In many cases, perhaps most, the conventionally accepted options

> will suffice. But there will be cases in which a decisionally capable patient will make a rational, considered, and stable request for one or another form of assisted death and in which that will serve their best interest. <u>The ethical framework that will justify treatment cessation, pain management, and terminal sedation will therefore equally justify assisted death.</u>
>
> [Emphasis added.]

[235] Professor Sumner refers to searches for an ethical bright line distinguishing among end-of-life measures. He describes arguments that attempt to distinguish: acts from omissions; a patient's request for treatment which will hasten death from refusal of a treatment which will prolong life; killing from letting die; and death as an intended outcome from death as an unintended though foreseen outcome. He concludes that there is simply no way to show that, of the four treatment options (treatment cessation, pain management, terminal sedation and assisted death), assisted death is uniquely ethically impermissible. He says that if it is impermissible then so are some of the others; if they are all permissible, then so is assisted death.

[236] Thus, according to Professor Sumner, the ethical framework which justifies the conventionally accepted options will equally justify assisted suicide and voluntary euthanasia.

[237] Professor Sumner also refers to attempts to distinguish suicide from assisted suicide on an ethical basis:

> The two acts in question – suicide and assistance with suicide – are different, and there is no simple entailment relation between the moral status of the first and that of the second. To make the obvious point, in committing suicide the patient causes his own death while in assisting the physician enables, and therefore to that extent plays a causal role in, the death of another. While suicide remains within personal boundaries (leaving aside spillover effects on others), assistance crosses those boundaries: it is action not by a person on herself but by one person upon another. Therefore, at least in principle there is room here for an ethical distinction. However, in practice it is difficult to see what the ground of the distinction might be. We are imagining that the patient's decision for suicide is entirely rational and autonomous, that it is in the patient's best interest, and that he has made an informed request for assistance. The role of the physician is limited to providing the means for the patient to do something which is itself ethically permissible. It is unclear, therefore, how it could be ethically impermissible for the physician to play this role. The ethical burden of justifying assistance with suicide is discharged by justifying suicide itself.

[238] Dr. Angell, a physician and Senior Lecturer of social medicine at Harvard University, argues that physician-assisted suicide and euthanasia may be ethically permissible. She deposes:

> One of the most important ethical principles in medicine is respect for each patient's autonomy, and when this principle conflicts with others, it should almost always take precedence. This premise is incorporated into our laws governing medical practice and research, including the requirement of informed consent to any treatment. In medicine, patients exercise their self-determination most dramatically when they ask that life-sustaining treatment be withdrawn. Although others may sometimes consider the request ill-founded, we are bound to honor it if the patient is mentally competent – that is, if the patient can understand the nature of the decision and its consequences.

[239] Professor Battin, a philosopher and Professor of bioethics, provided evidence about what she says are the core principles central to the debate: liberty (also referred to as freedom, self-determination or autonomy) and mercy (compassion, or the right to be free from pain and suffering). She asserts: "No one should be deprived of liberty or forced to suffer, without adequate cause." Professor Battin then refers to a third core value for physicians, non-abandonment, stating:

> A third central value, non-abandonment, is more precisely a norm of practice for physicians, and follows from the two philosophical principles. Physicians are under an ethical obligation to try to respond to autonomous requests from their patients, especially when those requests revolve around extremes of suffering in those who are otherwise dying.

[240] Professor Battin says that assistance in death should not be solely a matter of patient choice:

> Autonomy focuses on the values and wishes of the particular patient who finds himself or herself in an untenable situation. But assistance in dying, if it is also to involve physicians, cannot be solely a matter of patient choice. The nature of the patient's suffering and why it is intolerable to the patient must also be understood by the physician, who then is obliged to try to respond as a matter of mercy and in fulfilment of his or her commitment not to abandon the dying patient. Thus autonomy and mercy go hand in hand: for the physician to offer assistance in dying, it must be the patient's choice and it must also be done to help the patient avoid suffering that is either intolerable or about to be so.

[241] She also argues that the principles of autonomy and mercy do not stand alone. In her view, in order to support physician-assisted dying, the principles of autonomy and mercy must work in tandem:

> Physician assistance in bringing about death is to be provided only when the patient voluntarily seeks it (autonomy) and only where it serves to avoid pain or suffering or the prospect of them (mercy). Because these principles do not operate independently, it cannot be claimed that permitting physician-assisted dying would require assisting lovesick teenagers who are not suffering from a serious medical condition to die; likewise it cannot be claimed that permitting physician-assisted dying on the basis of the principle of mercy would require involuntary euthanasia for someone who is in pain but nevertheless desires to stay alive. Both principles must be in play; but when they are in play, they jointly provide a powerful basis for permitting and respecting physician aid in dying.
>
> Those who oppose physician aid in dying must show that the principles of liberty and freedom from suffering that are basic to an open, liberal and democratic society should be overridden. This is the point of slippery-slope assertions about the potential for corrupting physicians and widespread abuse in the Netherlands and perhaps Oregon. Yet there is no empirical evidence that supports these claims, and substantial evidence to the contrary.

[242] Dr. Upshur, a physician and Professor of public health ethics, states:

> Based on my review of the empirical, psychological, and philosophical literature and my experience as a clinician, I believe that, under certain conditions, providing assistance with suicide or euthanasia can be an ethically appropriate course of conduct for a physician. The conditions that I support, on the same professional foundation, are that the request be free and informed and made by an individual when competent. I do not believe that assisted suicide and euthanasia should only be available to those who are diagnosed as terminally ill, but rather should be available to those for whom life has become not worth living to them. There are times when even the best palliative care is not sufficient and where a competent and uncoerced patient wishes to die. Within a carefully regulated regime, in my professional opinion as a clinician and ethicist, it can be clinically and ethically appropriate for a physician to provide that patient with assistance (either through assisted suicide or euthanasia).

[243] Dr. Kimsma, a Netherlands physician and Extern Associate Professor of ethics, deposes as follows:

> Based on my practical experience as a medical practitioner and SCEN consultant: ... I believe that practicing PAD [physician-assisted death] is consistent with the goals of medicine. However, I am fully aware of the

> ambivalence and complexity and bias incorporated in these issues, both from points of view of religion, law and medicine. The real significance of the "Oath of Hippocrates" as an argument against physician-aid-in-dying is difficult to defend from a historical point of view. PAD, throughout modern Western medicine seems to be occurring in fact, but being dealt with under a veil of confusion, ambiguity and lack of truth/disclosure. That said, it remains true that at all time PAD is difficult and emotionally burdening for physicians, given the medical ideology of the absolute protection of life and the alleviation of suffering.

[244] On the other side of the debate, we find Professor Keown, a Professor of law and medical ethicist, whose position is that any intentional taking of life is unethical and should not be permitted. He says that the principle of the inviolability of life has historically informed both the criminal law and the ethics of the medical profession. He argues against physician-assisted suicide and euthanasia, both because he supports the principle of the sanctity of life and because he is of the view that it will be impossible to avoid abuse without a legal bright line prohibiting intentional killing (the "practical slippery slope") and extension of the circumstances in which assisted death is permitted (the "logical slippery slope").

[245] On cross-examination, Professor Keown was asked about his book, *Euthanasia, Ethics and Public Policy: An argument against legalization* (New York: Cambridge University Press, 2002). He agreed that he is strongly opposed to the reasoning in the *Bland* decision of the House of Lords (referred to with seeming approval in *Rodriguez*) since it amounted to permission to intentionally cause the death of an incompetent patient by omission. He confirmed his view of the *Bland* case as a move away from the traditional values of autonomy and inviolability of life, and towards the use of quality of life as an ethical legal marker.

[246] Professor Koch, a gerontologist and Adjunct Professor of medical geography, was asked by Canada to comment on the evidence of Dr. Angell, Professor Battin and Dr. Kimsma, and to provide an opinion regarding the concept of autonomy in the context of physician-assisted suicide and hastened death. He suggests that it is simplistic to define autonomy as the ability to choose freely for oneself regardless of the consequences (a definition he attributes to Dr. Angell), and says "relational autonomy" would reflect the sense of patient allegiance and mutuality argued by

Dr. Kimsma. He says the simplistic definition of autonomy would lead to absurd consequences such as liposuction on demand, even if it would likely cause the death of the patient. He urges that nobody in practice subscribes to such a definition. He opines, in his affidavit, that:

> By insisting society should approve and then facilitate the death of a citizen, advocates of simple autonomy are asking for not simply communal and medical tolerance but communal support and medical support. That is not autonomy but something very different.
>
> To assume the autonomous will of the individual should in these situations take precedence over both social cautions and medical cautions is to assume the person choosing has all knowledge and the perspective to employ it. But this is precisely what differentiates these complicated medical realities from the normal consumer mode of choice in our society. This was the point made by Nobel prize-winning economist Kenneth Arrow in his article on medicine as a distinct entity in the modern marketplace (Kenneth Arrow, "Uncertainty and the Welfare economics of medical care." *The American Economic Review* 53:5 (1963), 981-9732). Medicine, unlike many other areas, is one in which the knowledge of the person is necessarily limited when compared to the knowledge of the professional. They are not commensurate and thus demand a degree of trust and faith in the medical professionals to do what is right.

[247] Professor Koch asserts that the Hippocratic Oath in one or another form remains a mainstay of medical if not biomedical ethics. He says that the covenant in that oath not to "give a lethal drug to anyone if asked" reflects a belief in the value of life generally and specifically in the lives the physician undertakes to serve. In his opinion, patients' fears (such as the fear of incontinence) cannot be accepted as a reason for termination of life because that would be to agree that a life with incontinence is a life that is insupportable, and would feed into a view of medicine as a consumerist practice in which special knowledge has little value. He deposes as follows:

> This claim isn't about individual choice and autonomy. We cannot stop but we need not applaud suicide in the face of adversity. Ms. Taylor may kill herself. She seeks not the right to do that but instead the obligation of us to agree her life is so insufficient that we will assist or direct her termination. This claim is about whether we honour each other irrespective of individual characteristics or set up a sliding scale by which some conditions devalue life until the point where its termination is appropriate. It is about whether we place our priorities in the arenas of rehabilitation, palliation, and social service or agree with the simplistic assumption that state-supported, physician-assisted or directed

> termination is or should be a reflexive response to restrictive medical conditions.

[248] The defendants also rely on the evidence of Dr. Bereza, a physician and Director of clinical ethics programs. Dr. Bereza states that the ethical debate in the context of this litigation ought to extend beyond normative ethics to applied medical ethics – a discipline that requires "the careful and comprehensive deliberation and management of complex, real-life situations, where morally significant details can vary profoundly even within groupings of similar clinical cases." He suggests that ultimately judgments must be made based on not only rational, but also moral, emotional, psychological and spiritual elements. He frames the ultimate question this way: "Do the ethically relevant considerations of individual liberty, self-determination, relief of suffering (presumably of an increasingly small minority), and tolerance of perspectives in a pluralist society, outweigh the risks of ethically unwarranted, premature deaths for some (possibly many)?"

[249] Dr. Bereza's evidence, particularly his formulation of the ultimate question, illustrates the strong connection between the ethical question in individual cases and the broader ethical question that takes into account the consequences for society.

[250] Dr. Bereza believes that there is a legitimate distinction between withholding or withdrawing life-sustaining treatment as opposed to physician-assisted death, in that:

> Physician-assisted suicide and euthanasia, on the other hand, can be characterized as acts that require additional, active interventions that will necessarily accelerate the dying process. This does not represent a *consent* or *refusal* of care, but rather a *request* or *demand* for additional intervention to accelerate the dying process.
>
> [Emphasis in original.]

[251] However, he adds that "while these ethical distinctions are very powerful, and can probably be invoked persuasively in a large majority of cases, it may be difficult to claim that they constitute a categorical, clear line that will allow for absolute differentiation in all cases."

[252] Dr. Bereza notes that patients sometimes invoke practices such as palliative sedation and the withholding or withdrawal of life-sustaining technologies “not as refusals of burdensome medical technology, but rather as an accelerated means to death”.

[253] In the end, Dr. Bereza allows that there may be morally persuasive arguments for physician-assisted death in some cases. Nevertheless, he concludes as follows:

> The best medical care is personalized care. While the patient’s best interests are the *sine qua non* of such care, it does not necessarily follow that patient preferences be viewed as some kind of ethical trump card that supersede all other considerations. Professional integrity and communitarian perspectives are but two other considerations, among many others, that have considerable moral weight.
>
> I believe there is a risk of unjustifiable death to vulnerable individuals if the *status quo* is changed. There are some rare examples of physicians who have violated the law in this regard. I also believe there are credible anecdotes that cannot be substantiated, of physicians who may be performing euthanasia, albeit unwittingly, where this approach is masquerading as palliative care. Whether this is a result of ignorance of the law, of standards of practice in pain control and palliation, of advocacy of individual patient’s best interests, of passive complicity with family members’ personal agendas, of acts of civil disobedience based on conscience, or merely professional hubris, is probably impossible to ascertain.
>
> From a normative perspective, I would find it problematic to accept a change in the laws before our society has firstly demonstrated a commitment to providing timely and universal access to quality palliative care.

2. Evidence of Practitioners

[254] The plaintiffs also rely upon the evidence of Canadian medical practitioners who state that based on their clinical experience and their understanding of medical ethics, they would consider it ethical in some circumstances to assist a patient who wishes to hasten death. Those practitioners include: the plaintiff Dr. William Shoichet, Dr. Bell, Dr. Marcel Boisvert, Dr. Boyes, Dr. Eric Cassell, Dr. Cohen, Dr. Klein, Dr. Librach, Dr. Meckling, Dr. Smith, Dr. Upshur and Dr. Welch.

[255] I note that Canada challenges the evidence of Dr. Boyes and Dr. Boisvert as possibly based on outdated experience with palliative care options.

[256] The evidence of three of these witnesses, which is fairly representative of the others, is as follows:

[257] Dr. Klein, a family physician and paediatrician, states these views:

> When I was still in clinical family practice, I worked under the present legal regime where it is criminally prohibited to intentionally assist a grievously and irremediably ill adult patient to die under any circumstances. Under this regime, there is a great need to find solutions that address patient comfort. Often decisions are made in palliative care, and I personally have made these decisions innumerable times, to provide a treatment with the intent of securing the patient's comfort and the known outcome is that the patient's death will be hastened as a result of that treatment. However, I have not been allowed to administer analgesics with the intent of hastening a patient's death as a means of relieving their suffering, even if that is their competent, informed and lasting wish. As a physician, I felt concern and was anxious about participating in end-of-life decision making in these circumstances because I knew that I was at risk of criminal and professional censure depending on outside interpretations of my actions.
>
> As a practicing physician, I was also required to withhold or withdraw life sustaining treatment at the request of a competent patient, including discontinuation of the use of a ventilator in circumstances where the withdrawal of such will certainly result in suffocation, and the discontinuation of tube feeding and hydration in circumstances where discontinuation will results in starvation and dehydration resulting in death. I was required to undertake such conduct at the request of a patient where the patient's specific goal for the instruction is to achieve death.
>
> I understand that the law currently draws a legal distinction, but as a physician, I see no ethical distinction between withholding and/or withdrawing life sustaining treatment and/or administering analgesics for the purpose of alleviating pain in circumstances where I know that death will certainly ensue or certainly ensue more quickly than it would otherwise on the one hand, and acting to intentionally bring about a patient's death in order to relieve suffering in circumstances I outline below on the other.
>
> ...
>
> Nevertheless, the current blanket prohibition against this form of treatment circumscribes ethically supportable medical treatment that would be more aligned with a patient's informed wishes and that I would otherwise ethically prescribe to patients in certain circumstances and under certain conditions.
>
> I think physician-assisted dying is a form of medical treatment, albeit one that should be carefully regulated.

[258] With particular reference to the situation of patients with neurological disease, Dr. Cohen, a behavioural neurologist and Assistant Professor of neurology, states:

> I have witnessed a number of patients with grievous and irremediable neurological diseases who have already experienced prolonged suffering, die slow and terrible deaths. I have witnessed patients with grievous and irremediable neurological conditions at the end of life gasping for breath as they slowly drowned in their own secretions or choked on their own saliva. These patients appeared extremely uncomfortable, agitated and restless. Some patients explicitly told me that they were experiencing discomfort and pain. I have seen patients turn blue because they cannot get enough air. Some appeared terrified. For some of these patients, this slow and painful march to death lasted days. Some patients experienced multiple episodes of choking and a feeling of suffocation over a period of weeks. These deaths were extremely traumatic for both the patient and their family. Sometimes patients are provided sedation to the point of semi-consciousness so they are made more comfortable as they struggle for breath. Nonetheless, they may linger in a state of dying for hours to days with families standing by in distressed states that may take years to recover from. In my opinion, physician-assisted dying should have been an available treatment option in these situations. With all my training as a physician, I cannot accept that it is right to allow patients to die in this immeasurably cruel and useless fashion if to do so is against the patients' wishes.
>
> Nor do I think it is right to allow grievously and irremediably ill patients to suffer against their wishes if they are far from death but their suffering is protracted over time and life is no longer bearable to them as may be the case for bedridden individuals or those facing major loss of autonomy.
>
> It is my opinion that physicians must respect patients' autonomy, including patients' decisions about the timing and manner of death. Competent adults with grievous and irremediable neurological diseases should be allowed to determine for themselves the line between acceptable and unacceptable levels of suffering. It is not for me to say when a patient's suffering has become unbearable and life has lost all meaning; this is a deeply personal and private choice. Many patients find satisfaction and pleasure in their lives even though it is not the more ideal life they expected or hoped for themselves. Many patients carry on through great adversity and suffering, and find meaning even in a protracted disease and death. However, many patients reach a threshold with their disease beyond which life is no longer gratifying for them. Many of these patients have told me that they look forward to their deaths.
>
> ...
>
> As a physician, I do not believe there is any ethical distinction between withdrawing, at a patient's direction, life-sustaining treatment with the knowledge that death will result and acting, at a patient's informed request, to bring about death in order to alleviate suffering. Either way, the patient is making an independent choice to die. Competent patients have the legal right to refuse treatment that will prolong their deaths. For patients who are suffering but who are not dependent on life support, such as respirators or dialysis, refusing treatment will not hasten death quickly. To treat these patients equitably and compassionately we should offer physician-assisted dying as it is their only option to hasten death.

[259] The plaintiffs also tendered evidence from Dr. Librach, a palliative care physician and Director of a centre for bioethics. Dr. Librach does not state explicitly that he considers physician-assisted dying to be ethical, but it is a fair inference from his evidence that he does.

[260] He was asked to respond to this question: "In your opinion as a palliative care physician, could there be a need for physician-assisted dying in Canada in certain circumstances?" His answer was: "Yes but only in exceptional circumstances and with stringent legal and professional safeguards in place as I explain in the following paragraphs." Dr. Librach states the opinion that there is always some suffering associated with dying, but much unnecessary suffering can be dealt with effectively. However, he says, despite the best of palliative care, some patients want their death hastened by assisted suicide or euthanasia, even when free of significant depression or pressure or coercion from others. He states that, although the number of such patients is small, it is necessary to listen to their wishes and protect them in their decision making. He then states:

> After careful reflection I have come to the personal opinion that the issue of physician-assisted dying will not go away, that the provision of quality palliative care will not answer the wishes of all persons who are dying and that we as a society need to deal with this issue through the courts and through Parliament. Law reform needs to be considered so that the process of physician-assisted dying if approved is protective and open, not a hidden process.

[261] In addition, the plaintiffs tendered the evidence of physicians from other countries who believe that assisting patients who wish to hasten death can be ethical: Dr. Ashby (Australia), Dr. Nancy Crumpacker (Oregon, U.S.A.), Dr. Kimsma (the Netherlands), Dr. Thomas Preston (Washington, U.S.A.), Dr. Peter Rasmussen (Oregon, U.S.A.); and Dr. Syme (Australia).

[262] For example, Dr. Preston, a retired cardiologist and Director of the organization Compassion and Choices in Washington State, deposes:

> The principle of autonomy is a fundamental principle in support of physician aid in dying although it is not the only principle at stake. The autonomy argument for physician aid in dying can be stated as follows: There is a

> moral reason to respect others' autonomous choices, and this reason gains strength as the importance of the choice under consideration increases. An autonomous decision to hasten one's death is a profoundly important decision for a terminally ill person that involves his or her most significant values. There is therefore an extraordinarily strong moral reason not to restrict such a decision. This reason becomes even stronger when provisions are in place to ensure that the choice is indeed highly autonomous and not coerced. Opponents argue that autonomy cannot support physician aid in dying, citing concerns that patients desiring such an option have impaired autonomous decision-making capacity, extreme individualism, or that physician aid in dying would actually undercut individual autonomy.

[263] In response, the defendants have provided evidence from Canadian practitioners who believe that assistance in hastening death is inconsistent with sound ethical practice: Dr. Chochinov, Dr. Downing, Dr. Herbert Hendin, Dr. Gallagher, Dr. McGregor, Dr. Pereira, and Dr. Leslie Sheldon. I again provide a sample of those opinions.

[264] Dr. McGregor, a palliative care specialist and Regional Medical Director, Palliative Care for Vancouver Coast Health, provided an affidavit describing the practice of palliative care in British Columbia and in particular in the lower mainland. He deposes that the team with which he is involved has carried out palliative sedation perhaps six or seven times over eight years, and that guidelines for the practice are under development.

[265] He was cross-examined on his affidavit before the Court, and testified:

> Q Dr. McGregor, I want to ask you this question, if the – this Court was to say that the laws which make any kind of physician-assisted dying a crime are unconstitutional, in other words, if through this process physician-assisted dying was made legal and subject to all the appropriate safeguards would you not agree that these same four principles [beneficence, non-malfeasance, autonomy and justice] that are traditional health care ethical principles could be complied with by a physician if an adult with full consent and no mental illness made the request for physician-assisted dying?
>
> A I think – I think the answer to your question is yes but I'm not sure that that's the right thing to be doing in our society.

[266] In re-examination, he testified:

> Q And then finally one last question. My friend took you to what is now Exhibit 11, the extract from "Medical Care of the Dying" which was authored in part – well, co-authored and edited by Dr. Michael Downing, and took you to page 104 and asked a question with respect to the traditional health care ethical principles of beneficence, non-malfeasance, autonomy and justice. And my note of his question was if the Court was to say that the laws prohibiting physician-assisted dying are unconstitutional then subject to all the appropriate safeguards would you say that these guidelines could be complied with by an adult patient – an adult capable patient. Your answer was I think the answer to your question is yes, but I'm not sure it's right. Could you please explain why it's not right?
>
> A So I think that – I think as physicians particularly we set out to value, esteem life above everything else. I think that's a value held in society. I personally feel that that is a value that I will continue to hold and I don't think that many of my colleagues would differ from that.

[267] Dr. Downing gave evidence in his cross-examination to similar effect.

[268] Dr. Chochinov is a psychiatrist and Canada Research Chair in palliative care. His team has developed a model called "dignity therapy" which relates to practices intended to maintain an intact sense of dignity in palliative care patients. A patient's sense of autonomy, he says, can be maintained by thoughtful practices. Therapeutic options include practices such as being more vigilant and attentive to physical domains of suffering, and addressing psychological and spiritual discomfort. He provided an affidavit and was cross-examined before the Court.

[269] Dr. Chochinov was asked whether, in his opinion, the legalization of physician-assisted suicide or intentional hastened death by a medical practitioner is required to achieve good outcomes in palliative care. He responded in his affidavit as follows:

> In the vast majority of instances, palliative care is able to mitigate suffering. As such, even in the absence of death hastening options, good outcomes in palliative care are regularly achieved. Palliative care has made great gains over the last few decades and can now attend to most sources of symptom distress. In some instances, managing physical distress may involve having to sacrifice conscious awareness. ... However, palliative care should no more be seen as the perfect foil to suffering, than medicine should be pitched as the perfect foil to death.

[270] As to whether a change in the law is necessary in order to provide appropriate care for seriously ill and injured patients, given professional and ethical obligations, he referred to his previous answer and added: "At this point in time, I would not be prepared to participate in a scheme permitting physician-assisted or intentional death by medical practitioner." He gives as his reasons for holding that position the following: health system inadequacies (only a minority of Canadians have access to comprehensive, quality end-of-life care); potential harms (because in his view the data are not convincing that safeguards can protect against such harms); subjectivity in evaluation (referring to research suggesting that a health care provider's willingness to provide assisted death may be mediated by various personal factors, including religious beliefs, diminished empathy, and lesser knowledge of symptom management); and unknown changes in the health care provider-patient dynamic (he asks whether supporting a patient's wish to die could unwittingly undermine the patient's sense of worth and dignity).

[271] Dr. Gallagher, a specialist and Clinical Professor of palliative care, states in her expert report:

> *Is there a need for a change to the law prohibiting assisted suicide in order for me to provide appropriate care for patients?*
>
> In my opinion there is no need to change the law prohibiting assisted suicide in order for me to provide appropriate end of life care for my patients.
>
> *Assisted suicide by medical practitioners – is it a violation of my professional or ethical obligations to the patient?*
>
> The goals of medicine are prolonging life, relieving suffering and improving or maintaining function and have been so since the Hippocratic Oath was written thousands of years ago. Even then there was the strong pronouncement about not doing harm and not administering a deadly drug nor counseling a patient to take a deadly drug. The Canadian Medical Association Code of Ethics notes the core activities of a physician as health promotion, advocacy, disease prevention, diagnosis, treatment, rehabilitation, palliation, education and research.
>
> In no way is administering a drug with the intent to end the life of the patient consistent with the goals or core activities of medicine. While drugs administered to treat patients can result in death, that is considered an adverse outcome and not the intention of the treatment. Giving a drug with the intention of causing the death of the patient does not relieve suffering but moves the patient to a state where we presume they are beyond suffering.

> In my opinion changing the law to allow physicians to administer a deadly drug would be to radically change the concept of what a physician is that has been held for over two thousand years. I believe it would also seriously undermine the trust that patients have in a physician to do what is in their best interest.
>
> There is no medical skill required to administer a drug that results in death.

[272] The evidence of Dr. Hendin, a psychiatrist and researcher of end-of-life decisions, largely relates to the effectiveness of safeguards in the Netherlands and Oregon. With relevance to the ethical issues for physicians, however, he deposes:

> Despite the fact Oregon physicians report that depression is the best predictor and most common correlate of physician-assisted suicide, patients, their families and their physician report that not depression but a need for control is the primary concern that patients express in discussing their desire for a hastened death. This need is usually related to patients' fears of future suffering and presents the physician with an opportunity to address their specific concerns and to develop interventions that will relieve the anxiety of most patients. Oregon researchers have described these patients, noting that they were inflexible and "dreaded the thought of being dependent on others." (Ganzini 2009).
>
> The need for control, however, is characteristic of most suicidal patients. They make absolute conditions on life: "I won't live . . . without my husband," "if I lose my looks, power, prestige, or health," or "if I am going to die soon" (Hendin 1999). Depression, often precipitated by discovering a serious illness, exaggerates their tendency to see life in black and white terms, but for many such people the need for control has been a dominant feature of their lives. In any case, the good practice of medicine obliges doctors to relieve distress rather than to assume that hastening death is the best or only way of doing so.
>
> Patients are not alone in their inability to tolerate situations they cannot control. Lewis Thomas has written insightfully about sense of failure and experience in dealing with dying patients (Thomas 1984). This feeling helps to explain both the doctors' tendency to use excessive measures to maintain life and their need to make death a medical decision. By deciding when patients die, by making death a medical decision, the physician preserves the illusion of mastery over the disease and the accompanying feelings of helplessness. Assisted suicide and providing euthanasia become ways for physicians of dealing with the frustration of being unable to cure the disease.

3. Positions of Professional Bodies

[273] The Attorney General for British Columbia provided evidence regarding the positions taken by medical associations on euthanasia and assisted suicide.

[274] The Canadian Medical Association is a voluntary professional organization that has 75,000 members and represents the majority of Canadian physicians. Its policy document, *Euthanasia and Assisted Suicide*, (Ottawa: CMA, 2007) most recently revised in 2007, states in part:

> Euthanasia and Assisted Suicide
> (Update 2007)
>
> This policy replaces two previous policies, *Physician-Assisted Death 1995* and *Euthanasia and Assisted Suicide (1998)*. Euthanasia and assisted suicide, as understood here, must be distinguished from the withholding or withdrawal of inappropriate, futile or unwanted medical treatment or the provision of compassionate palliative care, even when these practices shorten life. The CMA does not support euthanasia or assisted suicide. It urges its members to uphold the principles of palliative care. ...
>
> ...
>
> **Background**
>
> Euthanasia and assisted suicide are opposed by almost every national medical association and prohibited by the law codes of almost all countries. A change in the legal status of these practices in Canada would represent a major shift in social policy and behaviour. For the medical profession to support such a change and subsequently participate in these practices, a fundamental reconsideration of traditional medical ethics would be required.
> ...
>
> **CMA policy on physician participation in euthanasia and assisted suicide**
>
> Canadian physicians should not participate in euthanasia or assisted suicide.
>
> **Physician concerns about legalization of euthanasia and assisted suicide**
>
> The CMA recognizes that it is the prerogative of society to decide whether the laws dealing with euthanasia and assisted suicide should be changed. The CMA wishes to contribute the perspective of the medical profession to the examination of the legal, social and ethical issues.
>
> Before any change in the legal status of euthanasia or assisted suicide is considered, the CMA urges that the following concerns be addressed.
>
> 1. Adequate palliative-care services must be made available to all Canadians. The 1994 CMA General Council unanimously approved a motion that Canadian physicians should uphold the principles of palliative care.
>
> The public has clearly demonstrated its concern with our care of the dying. The provision of palliative care for all who are in need is a mandatory precondition to the contemplation of permissive legislative change. Efforts to broaden the availability of palliative care in Canada should be intensified.

2. Suicide-prevention programs should be maintained and strengthened where necessary. Although attempted suicide is not illegal, it is often the result of temporary depression or unhappiness. Society rightly supports efforts to prevent suicide, and physicians are expected to provide life-support measures to people who have attempted suicide. In any debate about providing assistance in suicide to relieve the suffering of persons with incurable diseases, the interests of those at risk of attempting suicide for other reasons must be safeguarded.

3. A Canadian study of medical decision making during dying should be undertaken. We know relatively little about the frequency of various medical decisions made near the end of life, how these decisions are made and the satisfaction of patients, families, physicians and other caregivers with the decision-making process and outcomes. Physicians are involved in making decisions concerning whether to withhold or withdraw treatment and whether to administer sedatives and analgesics in doses that may shorten life. It is alleged that some Canadian physicians are providing euthanasia or assistance in suicide. Hence, a study of medical decision making during dying is needed to evaluate the current state of Canadian practice. This evaluation would help determine the possible need for change and identify what those changes should be. If physicians participating in such a study were offered immunity from prosecution based on information collected, as was done during the Remmelink commission in the Netherlands, the study could substantiate or refute the repeated allegations that euthanasia and assisted suicide take place.

4. The public should be given adequate opportunity to comment on any proposed change in legislation. The law should be determined by the wishes of society, as expressed through Parliament, rather than by court decisions.

5. Consideration should be given to whether any proposed legislation *[FN2 – E.g., Oregon Revised Statutes. The Oregon Death with Dignity Act. §127.800 – §127.995.]* can restrict euthanasia and assisted suicide to the indications intended. Research from the Netherlands and Oregon demonstrate that a large percentage of patients who request aid in dying do so in order to maintain their dignity and autonomy.

If euthanasia or assisted suicide or both are permitted for competent, suffering, terminally ill patients, there may be legal challenges, based on the Canadian Charter of Rights and Freedoms, to extend these practices to others who are not competent, suffering or terminally ill. Such extension is the “slippery slope” that many fear. Courts may be asked to hear cases involving euthanasia for incompetent patients on the basis of advance directives or requests from proxy decision makers. Such cases could involve neurologically impaired patients or newborns with severe congenital abnormalities. The “Groningen protocol,” which sets out five criteria for the provision of euthanasia to incurably ill babies, was adopted in Holland. Psychiatrists recognize the possibility that a rational, otherwise well person may request suicide. Such a person could petition the courts for physician-assisted suicide.

[275] The defendants also referred to the positions of the World Medical Association, Australian Medical Association, American Medical Association, British Medical Association, and New Zealand Medical Association, all of which are opposed to physician-assisted death.

[276] The plaintiffs argue that the official bodies do not necessarily represent the views of all of their members, and that (according to Dr. Angell) in the case of the American Medical Association, only a minority of physicians are members of that association. The plaintiffs also refer to the contrary or neutral positions taken by other organizations, including the American Academy of Hospice and Palliative Medicine, the Swiss Academy of Medical Sciences, and the American Medical Women's Association.

[277] I also note the position of the Canadian Hospice Palliative Care Association, which takes a neutral stance with respect to the legalization of physician-assisted death, according to its *Issues Paper on Euthanasia, Assisted Suicide and Quality End-of-Life Care* (Ottawa: CHPCA, 24 April 2010).

4. Public Opinion

[278] The plaintiffs led evidence regarding the results of a 2010 public opinion survey in Canada and a similar survey in Great Britain.

[279] Both surveys were conducted by Angus Reid Public Opinion, using online polling of representative samples of the Canadian and British populations. Mario Canseco, Vice President of Angus Reid, deposes that the Canadian survey was conducted on a representative sample of 1,005 Canadian adults from December 1-2, 2010. The margin of error was +/- 3.1%, 19 times out of 20. The survey results were statistically weighted according to the most current education, age, gender and region Census data to reflect the Canadian population. The British survey was conducted on a representative sample of 2,015 British adults from October 27-28, 2010. Its margin of error was +/- 2.2%, 19 times out of 20. Its results, too, were statistically weighted.

[280] The survey results for Canadians showed that, when asked “Generally speaking, do you support or oppose legalizing euthanasia in Canada?”, with no definition of “euthanasia” being provided, 63% said that they supported legalization, 24% opposed, and 13% were not sure. Results varied significantly among regions of the country, with respondents in Québec showing the highest level of support (78%) and those in Alberta the lowest (48%). When provided with some specific scenarios under which a patient might ask for a doctor’s help in ending his or her life, the responses broke down as follows:

Euthanasia

Below are some specific scenarios under which a patient might ask for a doctor’s help in ending his or her life. Do you support or oppose allowing the doctor to end the patient’s life under each one of these scenarios?

	Support	**Oppose**	**Not sure**
A patient is in a coma with little or no hope of waking. The patient had previously specified they wished to have their life terminated if they were ever to find themselves in this condition	81%	13%	6%
A patient is terminally ill and will die in less than six months. The patient is expected to suffer a great deal of physical and mental anguish during that time	78%	15%	7%
A patient has a lifelong, but non-life threatening condition such as being quadriplegic and wishes to end his or her life	36%	55%	9%
A patient wishes to die at the same time as their spouse or other loved one	13%	79%	8%

[281] The survey of Britons showed 67% supported legalizing euthanasia, 19% opposed and 14% were not sure.

[282] The plaintiffs acknowledge the limitations of opinion polls, but suggest that the evidence shows that social consensus has shifted from 1993 to the present and that there is broad public support for assisted dying in Canada and in other Western democracies.

[283] On the other hand, Canada submits that the polls are unreliable and do not assist the Court, among other reasons because the questions asked were left open to interpretation, and 20% of the population was excluded from the poll due to lack of

internet access. Canada argues that what the polls show, if anything, is that public support for euthanasia in Canada fluctuates.

[284] British Columbia's position is that public opinion polls are not relevant to the determination of societal consensus, referring to *Suresh v. Canada (Minister of Citizenship and Immigration)* 2002 SCC 1 at para. 50:

> In *Burns*, the then Minister of Justice, in his decision on the order to extradite the respondents Burns and Rafay, emphasized that "in Canada, Parliament has decided that capital punishment is not an appropriate penalty for crimes committed here, and I am firmly committed to that position" (para. 76). While we would hesitate to draw a direct equation between government policy or public opinion at any particular moment and the principles of fundamental justice, the fact that successive governments and Parliaments have refused to inflict torture and the death penalty surely reflects a fundamental Canadian belief about the appropriate limits of a criminal justice system.
>
> [Emphasis added.]

[285] Instead, it argues, Canadian consensus is to be found in the refusal of successive governments and Parliaments to legalize assisted dying, in the Special Senate Committee Report (described in the next section), and in the position of the Canadian Medical Association, statutory and judicial pronouncements, and the views of individual palliative care physicians. It says that international consensus is to be found in the overwhelming majority of Western democracies that prohibit the practices.

[286] British Columbia agrees with Canada that the polling evidence provided by the plaintiffs is unreliable. Counsel points to the cross-examination of Mr. Canseco, in which he agreed that the survey respondents may not have understood what the term "euthanasia" includes. Mr. Canseco also agreed that, taking into account two previous Angus Reid surveys, one reasonable inference could be that there has been a trend of decreasing support for the legalization of euthanasia.

[287] As to the suggestion that the polling results support a shift in consensus, Mr. Copley points out that there was evidence in the *Rodriguez* record of a public opinion poll done by Gallup Canada Inc., using a somewhat differently-worded question. That question asked, "When a person has an incurable disease that

causes great suffering, do you, or do you not think that competent doctors should be allowed by law to end the patient's life through mercy killing, if the patient has made a formal request in writing?" The poll results at that time were that 77% of Canadians believed that euthanasia should be permitted.

5. Public Committees

[288] As already described, a Special Committee of the Senate of Canada undertook in 1994 to examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide in light of ongoing public debate on the topic of assisted death. Over the course of 14 months, the Committee heard testimony from witnesses across Canada, and received hundreds of additional letters and briefs.

[289] The Special Senate Committee Report, published in June 1995, was the last comprehensive review of the question of assisted dying by a Canadian public body until 2012 when the Québec Select Committee made its report.

[290] The Senate Committee was unable to achieve unanimity with respect to assisted suicide and euthanasia. The entire Committee recommended that the offence of counselling suicide under s. 241*(a)* of the *Criminal Code* remain intact. While a majority of members recommended no amendments to the *Criminal Code* s. 241*(b)*, aiding and abetting suicide, a minority recommended that an exemption be added to permit persons to assist in a suicide under clearly defined conditions (described later, in subsection IX (C), "Addressing the Risks").

[291] The entire Senate Committee recommended that both involuntary and non-voluntary euthanasia remain criminal offences. However, the Committee recommended amendments to the *Criminal Code* that would provide for less severe penalties in cases of non-voluntary euthanasia where the essential elements of compassion or mercy are present. To that end, they suggested either the creation of a third category of murder that would not carry a mandatory life sentence, or the creation of a separate offence of compassionate homicide. In either case, the

Committee advised that the essential elements of compassion and mercy be clearly and narrowly defined.

[292] A minority of the Committee recommended amendments to the *Criminal Code* to permit voluntary euthanasia for competent individuals who are physically incapable of committing assisted suicide, subject to the same or similar safeguards recommended for assisted suicide. As an alternative, the minority recommended *Criminal Code* amendments to create a less severe penalty.

[293] Thereafter, Senate focus shifted to palliative care. A Subcommittee to update the Special Senate Committee Report was subsequently established to examine progress on implementing the unanimous recommendations made in that report. I refer to those developments when discussing the state of palliative care in Canada in subsection VIII (E), “Impact on Palliative Care”, below.

[294] In November 2011, a six-member Expert Panel of the Royal Society of Canada published the RSC Report (*End-of-Life Decision Making*) in response to national and international changes to the landscape of end-of-life care. Noting the recommendations in the Special Senate Committee Report in 1995, the Panel asked whether a careful reconsideration of the same issues would result in the same conclusions in the present day.

[295] The Expert Panel unanimously recommended that the prohibitions on assisted suicide and voluntary euthanasia in the *Criminal Code* be modified to allow both practices in carefully circumscribed and monitored circumstances. (As lesser options for reform, the Panel recommended prosecutorial charging guidelines that would be explicit as to the circumstances in which a prosecution for assisted suicide or voluntary euthanasia would not be in order, and the implementation of diversion programs and restorative justice processes for cases of this nature.)

[296] The Expert Panel identified a number of core elements of a permissive regime, to which I will refer later, in subsection IX (C), “Addressing the Risks”.

[297] The Canadian Parliamentary Committee on Palliative and Compassionate Care, an *ad hoc*, all party committee of Members of Parliament, released *Not to be Forgotten: Care of Vulnerable Canadians* in November 2011. The Canadian Parliamentary Committee Report did not address physician-assisted dying, but focused on palliative care, suicide prevention and elder abuse. However, in the context of a broader discussion on suicide prevention, the Report examined the issue of suicide prevention and mental illness amongst the elderly. The Committee recommended that the federal government establish a suicide prevention secretariat and an elder abuse awareness and prevention office with similar mandates of developing and implementing national strategies to address these concerns.

[298] In March 2012, the Québec National Assembly's Select Committee on Dying with Dignity issued the Québec Select Committee Report, which included a number of recommendations concerning palliative care, palliative sedation and advance medical directives, as well as assisted death. With regard to assisted death, the committee recommended amendments to relevant legislation to recognize medical aid in dying as appropriate end-of-life care when a physician assesses the person making the request as meeting certain conditions that I will describe later.

6. Prosecution Policies

[299] The plaintiffs led evidence about policies in British Columbia and the United Kingdom governing prosecutors' exercise of discretion in proceedings regarding assisted suicide or euthanasia.

[300] The evidence about the British Columbia policy is relevant for three reasons. First, the policy may shed some light on social consensus about the ethics of assisted suicide or euthanasia. Second, the British Columbia policy incorporates by reference accepted medical ethical standards. Finally, the plaintiffs suggest that the prosecution policy marks a significant change since *Rodriguez*. The plaintiffs characterize the B.C. policy as "remarkable" because, they say, it appears to allow for the exercise of discretion not to prosecute a person who has violated the assisted

suicide provision and thus to contradict the principle of sanctity of life espoused in the *Rodriguez* decision.

[301] The current version of the British Columbia prosecution policy provided in evidence is dated March 15, 2004, and it was admitted that the policy was made effective on that date. However, it appears that the Ministry of the Attorney General initially stated its policy on November 3, 1993, not long after the *Rodriguez* case was decided: see the Special Senate Committee Report, Appendix F, "Chronology of Major Canadian Developments and Events".

[302] The policy sets out guidelines for cases where a Report to Crown counsel reveals that a person, motivated by compassion for another person, participated in causing that person's death. It states: "Given the complex nature of the legal issues and the evolution of palliative care, charging decisions will be made on a case-by-case basis following an examination of the facts and circumstances of each case." The policy directs Crown counsel to consider a list of factors, which are said to be consistent with the overall policy on charge assessment, reflecting two requirements for a prosecution to proceed: (1) that there is a substantial likelihood of conviction; and (2) that prosecution is required in the public interest. Charge assessment decisions are to be made by Regional Crown counsel in consultation with the Director, Policy and Legislation.

[303] In the policy, "palliative care" is defined as "a qualified medical practitioner, or a person acting under the general supervision of a qualified medical practitioner, administering medication or other treatment to a terminally ill patient with the intention of relieving pain or suffering, even though this may hasten death". The policy states that that conduct, "when provided or administered according to accepted ethical medical standards, is not subject to criminal prosecution".

[304] Finally, "withholding or withdrawing treatment" is defined and the policy states that that conduct, "when provided or administered according to accepted ethical medical standards, is not subject to criminal prosecution".

[305] Crown counsel are directed to consider a number of factors in characterizing the conduct of the person involved in a death, including: the provable intention of the person, recognizing the criminal intent necessary for the offences in question; where the conduct "involves a physician and a patient, the position of the Canadian Medical Association and expert medical opinions as to generally recognized and accepted medical practices"; whether the acts of a qualified medical practitioner constitute withholding or withdrawing treatment, with reference to the law on informed consent, and indicia of capacity; and whether the act of a qualified medical practitioner or a person acting under their supervision constitutes palliative care.

[306] In considering whether the acts of a qualified medical practitioner constitute palliative care, Crown counsel are to take into account, among other matters, the *Rodriguez* decision – in particular Justice Sopinka's comments at 607 about the administration of drugs for pain control in dosages that the physician knows will hasten death. They are also to take into account whether the patient was terminally ill and near death with no hope of recovery, whether the patient's condition was associated with severe and unrelenting suffering, whether accepted ethical medical practices were followed, and whether the patient was participating in a palliative care program or palliative care treatment plan.

[307] Turning to the second branch of the charging decision, the policy states that if Crown counsel has determined that there is a substantial likelihood of conviction, then counsel must determine whether the public interest requires a prosecution. The factors to be considered include those set out in the general charge assessment policy and the following additional factors: the importance of supporting proper professional and ethical standards within the health care professions; society's interest in the protection of vulnerable persons; and society's interest in protecting the sanctity of human life, recognizing this does not require life to be preserved at all costs.

E. Analysis

1. Summary of the Ethical Debate

[308] In describing the ethical debate, it is useful to begin on common ground.

[309] First, there is no disagreement about the facts set out above, relating to existing clinical end-of-life practices and the understood legal and ethical justification for them, the non-universal availability of palliative care in Canada, and the inability of palliative care to alleviate all suffering of all patients.

[310] Second, there is little dispute that the principles described by Professor Battin (autonomy, compassion and non-abandonment) play a central role in the formation of medical ethics. As well, there is little dispute that a central precept for physicians continues to be "do no harm", that physicians set out to esteem and value life and that intentionally ending the life of a patient is either ethically inconceivable to them or conceivable only in stringently defined exceptional circumstances.

[311] Third, it is common ground that physicians are ethically required to act in the best interests of their patients, but not to break laws in order to do so. There was some reference in the evidence, and in submissions, to physicians' right to refuse to perform services that they view to be unethical, and that right appears to be recognized in permissive jurisdictions such as the Netherlands and Oregon. It is unnecessary to address this point further because the plaintiffs do not assert that a physician should be compelled to assist in suicide or perform euthanasia.

[312] Finally, there remains some controversy about the ethics of palliative sedation, at least in connection with the relief of existential suffering (as opposed to physical pain or other physical symptoms). However, I was not made aware of significant ethical disputes about other end-of-life practices when performed with the informed consent of a competent patient. The evidence (I refer to Professor Keown in particular) does show that the ethics of withdrawing or withholding treatment from a patient who is unable to give informed consent remain controversial, at least when the patient has not made his wishes known through an advance directive.

[313] The plaintiffs do not argue that physician-assisted death should be imposed on patients who do not, themselves, request it. Therefore, the ethical debate relevant to this case focuses on a limited class of patients: those who are competent adults (decisionally capable); fully informed as to their diagnosis, prognosis and all options for treatment or palliative care; persistently and consistently requesting assistance with death (that is, non-ambivalent); and not subject to coercion or undue influence.

[314] As I understand the evidence, the debate encompasses the following main ethical and practical arguments <u>against</u> making physician-assisted death available to such patients. I begin with arguments that relate solely to the individual patient, but include as well those relating to the social aspects of the debate, that is, the possible impact on persons other than the patient:

(a) The sanctity of human life is a fundamentally important ethical principle, central to our society.

(b) Physicians are committed to the preservation of life as their highest value and that commitment should not be eroded. The Hippocratic Oath is inconsistent with providing assistance in death; it explicitly forbids terminating the lives of patients.

(c) Physician-assisted death is ethically different, because of the intention of the physician, from currently permissible end-of-life practices. The "double effect" doctrine – that taking a step with knowledge it may hasten death is appropriate if the intent is to alleviate suffering – permits physicians to take steps that will possibly hasten death.

(d) Whether or not suicide may be ethical, assistance in suicide can never be ethical as it requires society to agree that a person's life is not valuable.

(e) Unfettered autonomy to request and receive treatment, including a hastened death, presupposes an undesirably consumerist model of medicine.

(f) While individual autonomy is an important value, it does not take precedence over all other values, including concern for society as a whole. Individual autonomy should be understood as “relational”, taking into account that individuals are part of society and their decisions affect others and are influenced by others. Suicide affects many people, and particularly the deceased’s family or others close to him.

(g) Risks to the individual patient who is requesting assisted death cannot be eliminated. Persons who, at one point in the trajectory of their illness, wish only to die, may find later that they are happy that they lived a while longer.

(h) The availability of physician-assisted death puts at risk patients who are depressed, not truly competent, not fully informed, or subject to coercion or undue influence, including patients who are vulnerable due to age, disability or other similar factors. It also puts at risk patients who are misdiagnosed or given an inaccurate prognosis.

(i) Even if there is nothing ethically problematic in an isolated single case of physician-assisted death for the paradigmatic competent, fully informed, terminally ill and suffering person, legal permission for such assistance puts other persons at risk.

(j) Disabled persons would be at particular risk in a system that allowed for physicians to assist in hastening death, because of the risk that requests for death by disabled people would be more likely viewed as reasonable.

(k) If physicians become involved in assisting death, that will compromise the physician-patient relationship.

(l) Physician-assisted death should not be considered until there is universal access to high-quality palliative care because (a) such care can, in almost all cases, alleviate patients' suffering; and (b) moving to physician-assisted death will undermine incentives to provide high-quality palliative care.

(m) The availability of physician-assisted death for a limited category of patients will lead to pressure to make it available to ever-wider categories of patients.

[315] On the other hand, my review of all the evidence shows that the ethical and practical arguments in favour of making physician-assisted death available to the limited category of patients described are:

(a) The sanctity of life is a principle that is not absolute in our society (it is subject to exceptions such as self-defence) and, while it is central to the value system of a number of religions, that does not settle its place in a secular society.

(b) The Hippocratic Oath derives from ancient Greece, but has been modified in modern times; a physician may not be harming a patient by assisting the patient to end a life of unbearable suffering.

(c) The harm caused by death is to the individual who loses some time in life; but, for some individuals, death which brings an end to suffering is not a harm but a benefit.

(d) No-one should be deprived of liberty, or forced to suffer, without adequate cause. Failing to respect an autonomous choice to die risks paternalism.

(e) Individuals may experience such suffering (physical or existential), unrelievable by palliative care, that it is in their best interests to assist them in hastened death. Physicians are required to respect patient autonomy, to act in their patients' best interests and not to abandon them. Where those principles co-exist, assistance in hastened death may be ethically permitted.

(f) If a patient's decision to hasten her own death by suicide is ethical, it may be ethical to provide assistance to that patient.

(g) Medical ethics already permit practices that amount to assisting with hastened death (refraining from administering or discontinuing life-sustaining treatment, administering medication in doses which may hasten death and palliative sedation). The difference between those practices and physician-assisted suicide or voluntary euthanasia is ethically insignificant.

(h) Some patients may find death while under palliative sedation repugnant or unacceptable, and may find other forms of palliative care unacceptable. Patients should not be required to submit to treatment against their wishes.

(i) Decisions to give or withhold care are routinely made on the basis of medical prognoses and diagnoses, which have varying levels of accuracy. Physicians routinely assess whether their patients are competent and informed and whether their decisions to accept or reject treatment are influenced by depression, coercion or undue influence. The risks of error already accepted in end-of-life practice are low, and can be further reduced through stringent safeguards and monitoring.

(j) The possibility of assisted death if continued life becomes unbearable may in itself alleviate suffering, even if a patient does not in the end take that course.

(k) The availability of assisted death enables patients who believe that they will come to wish to end their lives, to prolong their lives because they will be able to postpone that choice to a time after they lose the physical ability to end their own lives.

(l) It is unethical to refuse to relieve the suffering of a patient who requests and requires such relief, simply in order to protect other hypothetical patients from hypothetical harm.

(m) Disabled people should not be deprived of the same degree of autonomy as others, and should not be presumed to be less likely to be competent and more likely to be susceptible to coercion or undue influence.

(n) The physician-patient relationship is enhanced when a patient knows that her physician will not abandon her. It should not be assumed that physicians and other health-care providers will discard their focus on assisting patients and preserving life simply because assisted death becomes a legal option in limited circumstances.

(o) Palliative care and physician-assisted death are not mutually exclusive; the former should be universally provided at a high level, and the latter should be available as a last resort option.

(p) That there may be arguments for expansion of circumstances permitting physician-assisted death does not mean that those arguments will succeed.

2. Conclusions about the Ethical Debate

[316] I will reiterate the reasons why the ethical debate is relevant, and, with reference to those reasons, attempt to draw some conclusions about the ethics of physician-assisted death. I will leave aside, for the moment, the legal and constitutional ramifications of those conclusions.

[317] The overarching reason why the ethical debate is relevant is that both legal and constitutional principles are derived from and shaped by societal values.

[318] Additionally, the ethical debate bears on these questions: (1) Would Canadian physicians be willing to assist patients with hastening death if it were legal to do so? (2) Does current medical practice with respect to end-of-life care make distinctions that are ethically defensible, and is the distinction between suicide and assisted suicide ethically defensible? (3) Does the law attempt to uphold a conception of morality inconsistent with the consensus in Canadian society?

a) Would Canadian physicians be willing to assist patients with hastening death if it were legal to do so?

[319] The first question above can be answered concisely. The evidence reveals that there are experienced and reputable Canadian physicians who, in some circumstances, would find it consistent with their ethical principles to assist patients with hastening death if it were legal to do so.

b) Does current medical practice with respect to end-of-life care make distinctions that are ethically defensible and is the distinction between suicide and assisted suicide ethically defensible?

[320] The second question, which looks to the ethical distinction between permissible and impermissible end-of-life practices, and between suicide and assisted suicide, is complex.

[321] The plaintiffs say that there is no relevant ethical distinction between physician-assisted dying on the one hand and end-of-life practices which are lawful, such as refraining from treatment, ceasing treatment or administering palliative sedation, on the other. Their position is supported by ethicists such as Professor Sumner, Dr. Angell and Professor Battin. In brief, the argument is that withdrawing a ventilator tube or maintaining a patient under sedation without hydration or nutrition are acts that will result in death, just as much as the act of providing a lethal prescription or administering lethal medications. To perform those acts, knowing of their inevitable consequences, is to hasten death. Similarly, refraining from life-

saving treatment may result in the death of the patient, and is a passive form of hastening death. If those practices are ethical, then so is physician-assisted dying.

[322] The plaintiffs' position is that the accepted practices of respecting patients' wishes to withhold or withdraw life-sustaining treatment are both legal and ethical. Therefore, the plaintiffs say, physician-assisted death must also be ethical, and should be legal.

[323] The defendants do not argue that the legally approved end-of-life practices in Canada are unethical. They claim, however, that those practices are ethically distinguishable from physician-assisted death.

[324] Canada submits that the majority in Rodriguez found a distinction between assisted suicide and other end-of-life practices based on intention, as have some medical ethicists. At 607, Sopinka J. stated:

> The fact that doctors may deliver palliative care to terminally ill patients without fear of sanction, it is argued, attenuates to an even greater degree any legitimate distinction which can be drawn between assisted suicide and what are currently acceptable forms of medical treatment. The administration of drugs designed for pain control in dosages which the physician knows will hasten death constitutes active contribution to death by any standard. However, the distinction drawn here is one based upon intention – in the case of palliative care the intention is to ease pain, which has the effect of hastening death, while in the case of assisted suicide, the intention is undeniably to cause death. The Law Reform Commission, although it recommended the continued criminal prohibition of both euthanasia and assisted suicide, stated, at p. 70 of the Working Paper, that a doctor should never refuse palliative care to a terminally ill person only because it may hasten death. In my view, distinctions based upon intent are important, and in fact form the basis of our criminal law. While factually the distinction may, at times, be difficult to draw, legally it is clear. The fact that in some cases, the third party will, under the guise of palliative care, commit euthanasia or assist in suicide and go unsanctioned due to the difficulty of proof cannot be said to render the existence of the prohibition fundamentally unjust.
>
> [Emphasis added.]

[325] British Columbia submits that that distinction based on intention "provides legal clarity and draws a bright line between the lawful and the unlawful for the physician providing medical treatment".

[326] Differing from British Columbia on this point, Canada submits that while the *Rodriguez* majority's conclusion that there is a difference between permissible and impermissible end-of-life practices was ultimately correct, there are two inaccuracies in the distinctions drawn by the majority.

[327] The first alleged inaccuracy is legal. Canada says that the criminal law does <u>not</u> appear to recognize a distinction between intentionally bringing about a prohibited consequence and doing something knowing that the prohibited consequence is virtually certain to result. The second inaccuracy is factual. Canada submits that palliative pain control, including palliative sedation, does not necessarily have the effect of hastening death.

[328] With respect to the legal point, I think that Canada is correct. However, I note that Sopinka J. was drawing a line between acceptable end-of-life practices and criminal acts in the context of a constitutional challenge. The Court did not have a criminal case before it. The specific constitutional and factual context of the *Rodriguez* case, in particular its focus on the implications of the requirement for informed consent to medical treatment and on the legality of existing end-of-life practices, may explain why the majority's comments about intention do not perfectly track criminal law doctrine regarding intention and causation in homicide cases.

[329] Further, I note that Justice Sopinka acknowledges the difficulty in drawing a bright-line factual distinction (at 607, quoted above).

[330] In short, *Rodriguez* was clearly focussed on a legal, rather than a factual or ethical distinction.

[331] I turn to the second alleged inaccuracy referred to by Canada. The majority in *Rodriguez* assumes that effective pain control may hasten death. The majority states that even if it does, if the physician's intention is to care for a patient in pain, potentially lethal pain control may nevertheless be legally administered.

[332] Canada submitted that pain control or palliative sedation does not necessarily hasten death, and therefore is legally distinguishable from physician-assisted death

on the basis of causation. Whether or not that position is consistent with principles of criminal law, and I express no opinion in that regard, the majority in *Rodriguez* indicates that potentially lethal medications may be legally administered if the physician's intention is to care for a patient in pain. Thus, it seems immaterial whether or not the majority in *Rodriguez* was correct in its understanding of the effect of opioids administered as part of appropriate palliative care. (The majority in *Rodriguez* did not refer to palliative sedation.)

[333] In other words, that possibly incorrect assumption about the effect of pain control medications seems to me to leave unaffected the logic of the ethical argument based upon the *Rodriguez* decision.

[334] As I have suggested, *Rodriguez* addressed where to draw the line for legal purposes, rather than tackling the ethical question *per se*. The evidence shows that within the medical and bioethical community the question still remains open whether an ethical distinction is maintainable between withholding or withdrawing life-sustaining treatment and palliative sedation on the one hand, and physician-assisted death on the other.

[335] The preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death. I find the arguments put forward by those ethicists, such as Professor Battin, Dr. Angell and Professor Sumner, to be persuasive.

[336] In addition, the plaintiffs have provided evidence from a number of practitioners who doubt the existence of a valid ethical distinction.

[337] Some of the witnesses called by the defendants expressed similar doubts about an ethical distinction in individual cases, but opposed change in the law or in medical ethics because of the possible impact on other persons, on palliative care, on the physician-patient relationship or on society in general.

[338] In an individual case, whether based on a distinction between foreseeing and intending, on a distinction between acts and omissions, or on other grounds, a bright-line ethical distinction is elusive.

[339] I also find persuasive the arguments of Professor Sumner with respect to the absence of an ethical distinction between suicide and assisted suicide, if suicide is ethical. I agree that a distinction vanishes in the circumstances he specifies: the patient's decision for suicide is entirely rational and autonomous, it is in the patient's best interest, and the patient has made an informed request for assistance. The physician provides the means for the patient to do something which is itself ethically permissible. It is unclear, therefore, how it could be ethically impermissible for the physician to play this role.

c) Does the law attempt to uphold a conception of morality inconsistent with the consensus in Canadian society?

[340] I begin with the apparently strong consensus that the currently legal end-of-life practices are ethical. None of the Canadian ethicists and practitioners took issue with the ethical foundations of those practices, except possibly with respect to some aspects of palliative sedation. Further, the Canadian Medical Association and the B.C. Prosecution Policy seem firmly to adopt the position that current legal practices are ethical.

[341] Such consensus is not surprising; the requirement for informed consent to medical treatment that underpins current end-of-life practices is in turn founded on the very widely shared view that individuals have a veto right with respect to impingement on their own bodies. In short, the value of individual autonomy underpins the consensus.

[342] Similarly, there is a strong consensus that if it is ever ethical in an individual case for a physician to assist in death, it would be only in limited and exceptional circumstances, where it is clearly consistent with the patient's wishes and best interests, and in order to relieve suffering. The concern about imposing stringent

limits stems from the consensus that unlimited physician-assisted death would pose serious risks.

[343] The evidence shows that thoughtful and well-motivated people can and have come to different conclusions about whether physician-assisted death can be ethically justifiable. The major medical associations in Canada, the United Kingdom, some other Commonwealth countries and the United States have all taken positions opposed to physician-assisted death. On the other hand, some individual physicians in those countries take a different view, as do some medical associations, physicians and politicians in jurisdictions where physician-assisted death is permitted.

[344] The Canadian physicians who deposed that they would provide assistance with hastened death if it were legal to do so were unchallenged with respect to their standing in the medical community or their understanding of and respect for medical ethics. Their evidence shows that the view that a physician can never ethically participate in terminating life is not universally held by reputable, experienced physicians, despite the position taken by the Canadian Medical Association and similar bodies.

[345] In the RSC Report, the Expert Panel of the Royal Society of Canada unanimously recommended legal change to permit assisted death after a lengthy discussion of the ethics of that position. Similarly, the Québec Select Committee recommended legislative amendments that would allow adults with capacity to request medical aid in dying.

[346] On the other hand, the Parliament of Canada, which no doubt took into account ethical considerations, declined in 2010 to change the existing law by defeating Bill C-384. The majority of the Special Senate Committee in 1995 was not persuaded that change was appropriate, although a minority would have recommended an exemption to the *Criminal Code* to permit assisted death under clearly defined safeguards.

[347] Public opinion polls provide some indication as to societal values overall, and the polling evidence suggests that 63% of Canadians are supportive of physician-assisted death in some circumstances.

[348] Professional medical ethicists and medical practitioners also manifest a difference of opinion. As I see it, the divergence is with respect to the questions that I identified at the outset: (1) Does a physician have an overriding duty to support the inviolability of life and refrain from intentionally causing death, or can it be ethical, in an individual case, for a physician to assist a competent and informed patient who requests hastened death? (2) Even if it were ethical to provide such assistance in an individual case, should physicians refrain from doing so because of a threat to other persons (particularly those who are socially vulnerable) or to values such as respect for human life, building a strong palliative care system and maintaining appropriate relationships between physicians and patients?

[349] These points are reflected, for example, in the 1995 Special Senate Committee Report, which states:

> The members opposed to changing the existing legislation with respect to assisted suicide are <u>primarily concerned with maintaining the fundamental social value of respect for life.</u> They feel that legalizing assisted suicide could undermine respect for life which they believe is the most universally accepted value in society. Few democratic societies permit assisted suicide. In a pluralistic society, respect for life is a societal value that transcends individual, religious or diverse cultural values.
>
> These members are <u>also concerned about the risks</u> associated with changes to the present law. In their view, legalization could result in abuses, especially with respect to the most vulnerable members of society. ...
>
> There was also <u>some concern over the issue of the “slippery slope”.</u> Changes in the law with respect to competent persons could lead the way to possible changes in the law for incompetent persons. ...
>
> [Emphasis added.]

[350] With respect to the first question, I think that the real difference of opinion is not about the value of human life; no-one questions that the preservation of human life has a very high value in our society. Rather, the difference of opinion is about

whether the preservation of human life is an absolute value, subject to no exceptions.

[351] Professor Sumner explores this point:

> Normally we assume that death is one of the worst fates that can befall us, which is why in both ethics and law the causing of death is taken to be such a serious matter. But what makes death such a bad thing in the normal case is what it takes away from us – the continuation of a life worth living. The disvalue of death is therefore a direct function of the value of the life thereby lost. This is the *deprivation account* of the badness of death: death is bad for us by virtue of depriving us of the goods of continued life. On this account showing that death would be bad for a person requires a comparison between two possible futures for that person: the one in which he dies and the one in which he lives on. If the goods of further life would outweigh the evils then it would be better for the person to continue living, and death would therefore be a harm to him since it would deprive him of this good future.
>
> [Emphasis in original.]

[352] In any event, many of the expert witnesses called by the defendants do not base their opinions upon the need to uphold the sanctity of human life, or on that alone. Instead, they refer to the issues identified in the second question: the risks that legalization would pose – to vulnerable patients, to palliative care, to the physician-patient relationship in general, or to respect for human life.

[353] For example, Dr. Chochinov deposes, "[a]t this point in time I would not be prepared to participate" in physician-assisted death. He gives as his reasons: health system inadequacies; potential harms and inadequate safeguards; the subjective element in evaluating patients' requests; and potential changes in the health care provider-patient dynamic.

[354] Dr. McGregor testified that while, possibly, medical ethical principles could permit assistance in death, he was not sure that it was the right thing for society because of the potential for it to undermine the value of human life.

[355] I note as well the British Columbia Prosecution Policy. It seems to allow for the possibility that even if there is a substantial likelihood of conviction, the public interest may not always require prosecution of a case of assisted suicide or

euthanasia. One possible reading of the policy is that it is meant to discourage prosecutions in cases involving end-of-life practices where the hastening of death is a foreseeable result. Another is that it goes further and potentially encompasses cases of assisted suicide or euthanasia. At a minimum, the policy suggests an absence of societal consensus that life must always be preserved at all costs.

[356] The defendants emphasize the number of occasions on which legislatures and learned committees, both in Canada and elsewhere in the world, have looked at the question whether assisted suicide and euthanasia should be prohibited. In many of the published reports, the conclusion that these practices should be prohibited is largely driven by the view that their risks cannot be adequately addressed through safeguards, and less by the view that it would always be unethical, in an individual case, to relieve suffering. The predominant concern is about the impact on society as a whole if the prohibition against intentionally causing death were to be lifted. One way to measure whether that concern has merit is to look at the effectiveness of safeguards in jurisdictions where assisted death is permitted, and I do so in the next section of these Reasons.

[357] In summary, there appears to be relatively strong societal consensus about the following: (1) human life is of extremely high value, and society should never, or only in very exceptional circumstances, permit the intentional taking of human life; and (2) current end-of-life practices, including administering palliative sedation to relieve physical suffering and acting on patients’ or substituted decision-makers’ directions regarding withholding or withdrawal of life-sustaining treatment, are ethically acceptable.

[358] As to physician-assisted death, weighing all of the evidence, I do not find that there is a clear societal consensus either way, in an individual case involving a competent, informed, voluntary adult patient who is grievously ill and suffering symptoms that cannot be alleviated. However, there is a strong consensus that if physician-assisted dying were ever to be ethical, it would be only be with respect to

those patients, where clearly consistent with the patient's wishes and best interests, and in order to relieve suffering.

VIII. EVIDENCE FROM OTHER JURISDICTIONS

[359] Canada's response to the plaintiffs' constitutional claims rests in large measure on the proposition that nothing short of a blanket prohibition against assisted dying is sufficient to protect vulnerable individuals from what it terms "wrongful death". The population Canada has in mind includes anyone who is rendered vulnerable by his or her circumstances; Canada says circumstances like age or disability may render some people particularly susceptible. Canada submits:

> Even assuming that, in theory, assisted suicide or euthanasia is allowed only in the case of a competent adult who voluntarily requests to die, the evidence shows that it is impossible in practice to guarantee that every person helped to die is, in fact, competent to make the request, that the request is not the result of undue influences, internal or external, perhaps subtle and well-intentioned, and that the person's desire to die is not simply transitory.

[360] In contrast, the plaintiffs say that it is possible to screen out people who should not be assisted to die. They say that empirical evidence collected in jurisdictions that permit assisted dying demonstrates that the safeguards in those jurisdictions are generally effective in preventing the deaths of persons who are incompetent, subject to undue influence or unsettled in their desire to end their lives. The plaintiffs also point to evidence that the experience in the Netherlands and Oregon does not show a disproportionate number of elderly people or people with disabilities receiving assistance in death.

[361] Assisted suicide and euthanasia are criminal offences in most western countries, including the United Kingdom, Australia, New Zealand, France, Germany and most parts of the United States.

[362] Legislative bodies in a number of jurisdictions have considered and rejected legislative change with respect to euthanasia or assisted suicide. Canada tendered the reports of a number of those bodies, including:

- from the United States, The New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (New York State Department of Health, 1994);
- from the United Kingdom House of Lords, The Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL]*, (HL paper 86-I) (London, The Stationary Office Lt., 4 April 2005);
- from Australia, Senate Standing Committee on Legal and Constitutional Affairs, *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* (Report) (Canberra: Senate Printing Unit, June 2008); Joint Standing Committee on Community Development, *Report on the Dying with Dignity Bill 2009* (Report No. 36) (Hobart, Tas.: Government Printer, 2009); and
- from Scotland, *End of Life Assistance (Scotland) Bill Committee Report* (SP paper 523) (Scottish Parliament Publications, 2010).

[363] However, a small number of jurisdictions permit one or both of these practices, most notably Oregon and Washington in the United States, and in Europe, the Netherlands, Belgium, Luxembourg and Switzerland.

[364] In this section, I will summarize, and make findings of fact with regard to the extensive evidence that has been tendered with respect to permissive jurisdictions and their safeguards. I will focus on three questions: (1) What level of compliance have the permissive jurisdictions achieved with respect to their safeguards? (2) Do the safeguards effectively prevent abuse of vulnerable individuals? (3) What inferences can be drawn with respect to the likely effectiveness of comparable safeguards in Canada?

[365] Those three questions relate to what is sometimes called the “practical slippery slope”: the concern that even carefully crafted criteria will, over time, be reinterpreted or ignored, leading to euthanasia or assisted suicide of people never contemplated at the outset. A fourth question arises as well: would granting legal

permission for physician-assisted death in some circumstances create a foundation for future claims to extend legal permission beyond those contemplated circumstances? That question relates to what is called the “logical slippery slope”. It requires speculation and arises only tangentially in connection with the issues in this case. Accordingly, I will not address it in this section.

[366] I begin by reviewing briefly the opinion evidence of some of Canada’s expert witnesses who are of the view that existing safeguards in other jurisdictions have not been effective in addressing the practical slippery slope. Their evidence highlights the main concerns about the efficacy of safeguards.

[367] The plaintiffs called evidence from a number of experts who share the opinion that, generally speaking, the safeguards have been effective in limiting physician-assisted dying to those who satisfy the requisite criteria, and that there is no evidence that vulnerable groups have been adversely affected. As many of the plaintiffs’ experts have undertaken empirical studies in the Netherlands, Oregon or Belgium (which I review below), I will refer to their evidence later.

[368] I will refer only briefly to Switzerland because the practice there is quite different (assisted suicide, with no medical precondition and no requirement for a physician to be involved).

[369] After summarizing the evidence relating to the various jurisdictions, I will review a multi-jurisdictional study specifically addressing the impact of legal physician-assisted dying on vulnerable populations.

[370] I will then return to the practical slippery slope questions and set out my conclusions on those questions, based on the evidence.

A. The Major Challenges to the Effectiveness of Safeguards

[371] In the view of Dr. Hendin, a psychiatrist and researcher of end-of-life decisions in the Netherlands, virtually every protective guideline there has been violated or modified with negative consequences for patients. Under-reporting, for

instance, is a serious concern. An even greater cause for alarm he says, is the number of cases of life-ending acts without explicit request ("LAWER"), approximately 1,000 per year in each of the years for which there are data.

[372] With respect to Oregon, it is Dr. Hendin's position that due to problems with the legislation and monitoring practices, safeguards are being circumvented with unintended harmful consequences for patients.

[373] In cross-examination, it was put to Dr. Hendin that a book he wrote about assisted death, which recounts the issues he observed in the Dutch regime, has been criticized with respect to its methodology and accuracy, including by some of the doctors in the Netherlands whom he interviewed and described as major sources for his research. Dr. Hendin disagreed with the merits of those criticisms.

[374] Professor Keown, a Professor of law and medical ethicist, opposes assisted death in part because of his concerns about safeguards. He is of the opinion that laws and guidelines regarding assisted suicide and euthanasia in the Netherlands and Oregon are not effectively controlling those practices and protecting patients. By "effectively", he means sufficiently to achieve the degree of control and protection warranted by the importance of the rights and interests to be protected. The basis of his opinion is that the regimes rely on self-reporting by physicians, making control ineffective. He further says that patients are inadequately protected because neither jurisdiction requires that each patient be referred for psychiatric evaluation, nor do they require consultation with specialists in palliative care or in the patient's medical condition. Thus, he says, the safeguards protect doctors more than patients.

[375] Professor Keown attaches an excerpt from his forthcoming book relevant to these matters, *Debating Euthanasia*. One of his three main points in the book is that decriminalization would pose grave risks to the vulnerable, especially the dying, the disabled and the disadvantaged. In particular, he says that decriminalization would expose competent but vulnerable individuals to pressure to request an early death, and incompetent persons to death without request.

[376] While much of the evidence of Dr. Pereira, a specialist and Professor of palliative care, concerns palliative care, he also addresses the effectiveness of safeguards in physician-assisted suicide regimes.

[377] Dr. Pereira's views on safeguards are set out in a paper he authored entitled "Legalizing Euthanasia or Assisted Suicide: The illusion of safeguards and controls" (April 2011) 18 Curr Oncol 2. He agreed on cross-examination that he had not done original research and that his paper was wholly reliant on a review of secondary sources. He also testified on cross-examination that his interest in the topic of assisted suicide and euthanasia is of recent origin; he has not made a lengthy study of the effectiveness of safeguards. He agreed that his paper was published in a journal with a low ranking among medical journals in terms of its impact within the medical community.

[378] In Dr. Pereira's opinion, safeguards in jurisdictions that permit physician-assisted dying or euthanasia have been ineffective and actually pose a significant risk to many individuals.

[379] By way of example, Dr. Pereira states that voluntary, written consent is a safeguard in many jurisdictions. Nevertheless, he cites the fact that, in the Netherlands in 2005, 560 patients (0.4% of all deaths) were euthanized without having given their explicit consent. He states that the rate in Belgium is three times higher.

[380] Similarly, the requirement that a second physician be consulted in physician-assisted dying cases is a purported safeguard in most systems. However, according to Dr. Pereira, there is evidence of non-compliance in Belgium, the Netherlands and Oregon. Moreover, he claims that second opinions provided by members of "pro-euthanasia lobby groups" raise questions about the objectivity of these assessments.

[381] Dr. Pereira also describes what he sees as evidence of a slippery slope. The evidence he cites includes changes to laws, definitions and criteria over time so that

they begin to allow practices that had previously been deemed unacceptable. He also observed a lack of prosecution of cases where the laws have been broken and safeguards circumvented. Finally, he says that euthanasia and assisted suicide have become options available on demand rather than as a last resort.

[382] Baroness Ilora Finlay of Llandaff, a palliative care physician and member of the House of Lords, states that she has not come across safeguards within a physician-assisted suicide scheme that, in her view, are sufficiently effective. Her concerns relate to the influence of the physician on the patient and the fallibility of diagnosis and prognosis.

[383] She says that while some jurisdictions rely on diagnosis and prognosis of a terminal illness or a progressive life-threatening disease as a safeguard, medical diagnosis and prognosis are both notoriously fallible. Further, she takes the position that “unbearable suffering”, which is a safeguard in some jurisdictions, is too subjective to be effective. While type of illness or disability is sometimes proposed as a safeguard, Baroness Finlay notes that relating a safeguard to specific illnesses or disabilities is discriminatory.

[384] Mental capacity is another purported safeguard, but Baroness Finlay urges that there is no absolute test for undertaking that complex assessment. Similarly, it can be difficult to detect cognitive impairment or coercive influences on a person, which can often be very subtle. “Cooling off” periods do not adequately recognize the potential for coercive influences, nor do they take into account the reality that the desire for hastened death fluctuates greatly over time and across patients.

[385] Some jurisdictions require that patients be told of alternatives to physician-assisted dying, including palliative care. However, in Baroness Finlay’s submission, simply being told of palliative care is quite different from actually experiencing it.

[386] The requirement for a second opinion is another common safeguard. However, Baroness Finlay says that it is human nature for a physician to seek a second opinion from a like-minded physician likely to concur with his own

assessment. Further, she fears that "doctor shopping" raises the spectre of superficial assessments validating requests for physician-assisted dying. Baroness Finlay also fears that patients who request physician-assisted dying can become locked into the process, and find it difficult to alter course if they change their minds or have doubts.

[387] (I note that in the preceding paragraph, I am referring to evidence of Baroness Finlay to which objection was taken. I have concluded, however, that it is within her expertise as an experienced palliative care physician.)

[388] I now turn to review some of the evidence regarding the effectiveness of safeguards in the jurisdictions that permit physician-assisted dying.

B. Review by Jurisdiction

1. Oregon and Washington

[389] The regimes in Oregon and Washington are detailed in the evidence of Professor Penney Lewis and Professor Mary Shariff, both law professors.

[390] Oregon's *Death With Dignity Act*, Oregon Rev. Stat. §70.245 (1994) [*ODDA*] was a citizen's initiative first passed by Oregon voters in November 1994 by a 51% majority. The *ODDA* permits only one specific form of physician assisted dying: the provision of a prescription for lethal medication to be self-administered by the patient. Implementation was delayed by an injunction enjoining the *ODDA*'s operation. That injunction was subsequently vacated, and the United States Supreme Court denied *certiorari*.

[391] In 1997, the Oregon legislature referred a measure which sought to repeal the *ODDA* to the general election ballot. Voters defeated the measure by a 60% margin, thus retaining the Act. Opponents, however, lobbied for federal intervention against the state initiative. In 2001, the United States Attorney General issued an interpretive rule which essentially declared that physician-assisted suicide violated the *Controlled Substances Act of 1970*, 21 U.S.C. §801-904, thus criminalizing conduct specifically authorized by the *ODDA*. In 2006, the United States Supreme

Court held that the *Controlled Substances Act* could not be enforced against physicians who prescribed drugs for the purpose of assisted suicide as permitted by the *ODDA*: *Gonzales v. Oregon*, 546 U.S. 243 (2006).

[392] The *ODDA* permits a physician to prescribe "medication for the purpose of ending [the patient's] life in a humane and dignified manner" (s. 2.01). The patient self-administers the medication. The *ODDA* does not permit euthanasia, expressly stipulating that nothing in the Act "shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia" (s. 3.14).

[393] Section 2.01 specifies the criteria that qualify a patient to make a request for medication. The patient must:

(a) be over the age of 18;

(b) be a resident of Oregon;

(c) be capable (defined as having the ability to make and communicate health care decisions);

(d) be diagnosed by the attending and consulting physician to be suffering from a terminal disease (a "terminal disease" being defined as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months) (s. 1.01); and

(e) have voluntarily expressed in writing his or her wish to die.

[394] The *ODDA* includes the following procedural safeguards to ensure the foregoing criteria are satisfied:

(a) The patient must make two oral requests and one written request over 15 days (s. 3.06), the latter signed by two witnesses attesting that the patient is capable, acting voluntarily and is not being coerced to sign the request. One of the witnesses must be a person who is not related to the patient and has no material interest in the patient's death (s. 2.02).

(b) The attending physician must (s. 3.01):

(i) confirm that the patient has a terminal disease, is capable and has made the request voluntarily;

(ii) inform the patient of: his or her medical diagnosis and prognosis; the potential risks and probable results of taking the medication to be prescribed; and, feasible alternatives, including comfort care, hospice care and pain control (all with the aim of ensuring the patient is making an informed decision);

(iii) refer the patient to a consulting physician for medical confirmation of the diagnosis and for a determination that the patient is capable and acting voluntarily;

(iv) refer the patient to counselling if appropriate;

(v) recommend that the patient notify next of kin of his or her request for medication (though a patient who declines will not have his or her request denied for that reason);

(vi) counsel the patient about the importance of having another person present when the patient takes the prescribed medication and of not taking the medication in a public place;

(vii) inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15-day waiting period;

(viii) verify, immediately prior to writing the prescription, that the patient is making an informed decision;

(ix) document in the patient's medical record the fulfillment of all of the statutory conditions.

(c) If either the attending or consulting physician is of the view that the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, he or she must refer the patient for counselling. No medication will be prescribed until the individual prescribing the counselling determines that the patient is not suffering from such impaired judgment (s. 3.03).

(d) No less than 48 hours must elapse between the patient's written request and the writing of a prescription under the *ODDA*.

[395] The patient may rescind the request at any time and in any manner (s. 3.08).

[396] Death pursuant to the *ODDA* is not considered suicide for other purposes (s. 3.07).

[397] The Oregon Health Division ("OHD") monitors compliance with the Act. All physicians who prescribe under the *ODDA* are required to notify the OHD and provide documentation that legal requirements are met. If the legal requirements are not met, the physician is reported to the state licensing board. Pharmacists are also required to file a dispensing report with the OHD.

[398] According to data from the OHD, the following numbers of prescriptions have been issued and deaths have occurred under the *ODDA*:

Year	**No. of prescriptions under the *ODDA***	**No. of *ODDA* Deaths (includes deaths of patients with earlier prescriptions)**	**No. of *ODDA* deaths per 10,000 Oregon deaths**
1998	24	16	5.5
1999	33	27	9.2
2000	39	27	9.1
2001	44	21	7.1
2002	58	38	12.2
2003	68	42	13.6
2004	60	37	12.3
2005	64	38	12.0
2006	65	46	14.7
2007	85	49	15.6
2008	88	60	19.4
2009	95	59	19.3
2010	96	65	20.9

[399] Between the time the *ODDA* was enacted in 1997 through 2010, 525 individuals have died from ingesting prescribed medications.

[400] The following table, published by the OHD, sets out the characteristics of the 525 individuals who have died under the Act, 1998–2010:

Characteristics	***2010 (N=65)***	***1998-2009 (N=460)***	***Total (N=525)***
Sex	**N (%)***	**N (%)***	**N (%)***
Male (%)	38 (58.5)	244 (53.0)	282 (53.7)
Female (%)	27 (41.5)	216 (47.0)	243 (46.3)
Age			
18-34 (%)	0.00. (0.00)	6 (1.3)	6 (1.1)
35-44 (%)	1 (1.5)	12 (2.6)	13 (2.5)
45-54 (%)	5 (7.7)	34 (7.4)	39 (7.4)
55-64 (%)	13 (20.0)	94 (20.4)	107 (20.4)
65-74 (%)	19 (29.2)	127 (27.6)	146 (27.8)
75-84 (%)	15 (23.1)	136 (29.6)	151 (28.8)
85+ (%)	12 (18.5)	51 (11.1)	63 (12.0)
Median Years (range)	72 (44-95)	71 (25-96)	71 (25-96)
Race			
White (%)	65 (100.0)	449 (97.6)	514 (97.9)
Asian (%)	0 (0.0)	7 (1.5)	7 (1.3)
American Indian (%)	0 (0.0)	1 (0.2)	1 (0.2)
African American (%)	0 (0.0)	1 (0.2)	1 (0.2)
Hispanic (%)	0 (0.0)	2 (0.4)	2 (0.4)

Characteristics	*2010 (N=65)*	*1998-2009 (N=460)*	*Total (N=525)*
Other (%)	0 (0.0)	0 (0.0)	0 (0.0)
Marital Status			
Married (%)	33 (50.8)	212 (46.1)	245 (46.7)
Widowed (%)	14 (21.5)	101 (22.0)	115 (21.9)
Never married (%)	4 (6.2)	38 (8.3)	42 (8.0)
Divorced (%)	14 (21.5)	109 (23.7)	123 (23.4)
Education			
Less than high school (%)	4 (6.3)	33 (7.2)	37 (7.1)
High school graduate (%)	13 (20.3)	117 (25.5)	130 (24.9)
Some college (%)	20 (31.3)	105 (22.9)	125 (23.9)
Baccalaureate or higher (%)	27 (42.2)	204 (44.4)	231 (44.2)
Unknown	*1*	*1*	*2*
Underlying illness			
Malignant neoplasms (%)	51 (78.5)	373 (81.1)	424 (80.8)
Lung and bronchus (%)	8 (12.3)	88 (19.1)	96 (18.3)
Pancreas (%)	3 (4.6)	35 (7.6)	38 (7.2)
Breast (%)	3 (4.6)	38 (8.3)	41 (7.8)
Colon (%)	3 (4.6)	31 (6.7)	34 (6.5)
Prostate (%)	1 (1.5)	24 (5.2)	25 (4.8)
Other (%)	33 (50.8)	157 (34.1)	190 (36.2)
Amyotrophic lateral sclerosis (%)	7 (10.8)	35 (7.6)	42 (8.0)
Chronic lower respiratory disease (%)	2 (3.1)	18 (3.9)	20 (3.8)
HIV/AIDS (%)	0 (0.0)	8 (1.7)	8 (1.5)
Other illness (%)[Ψ]	5 (7.7)	26 (5.7)	31 (5.9)
End of life care			
Hospice			
Enrolled (%)	50 (92.6)	404 (88.2)	454 (88.7)
Not enrolled (%)	4 (7.4)	54 (11.8)	58 (11.3)
Unknown	*11*	*2*	*13*
Insurance			
Private (%) [Ω]	36 (60.0)	315 (69.1)	351 (68.0)
Medicare, Medicaid or Other Governmental (%)	22 (36.7)	135 (29.6)	157 (30.4)
None (%)	2 (3.3)	6 (1.3)	8 (1.6)
Unknown	*5*	*4*	*9*
End of life concerns[#]			
Losing autonomy (%)	61 (93.8)	414 (90.8)	475 (91.2)
Less able to engage in activities making life enjoyable (%)	61 (93.8)	398 (87.3)	459 (88.1)
Loss of dignity (%)[§]	51 (78.5)	282 (85.2)	333 (84.1)
Losing control of bodily functions (%)	30 (46.2)	264 (57.9)	294 (56.4)
Burden on family, friends/caregivers (%)	17 (26.2)	167 (36.6)	184 (35.3)
Inadequate pain control or concern about it (%)	10 (15.4)	101 (22.1)	111 (21.3)
Financial implications of treatment (%)	1 (1.5)	12 (2.6)	13 (2.5)
DWDA process			
Referred for psychiatric evaluation (%)	1 (1.5)	38 (8.4)	39 (7.5)
Patient informed family of decision (%)**	62 (95.4)	361 (93.5)	423 (93.8)
Patient died at			
Home (patient, family or friend) (%)	63 (96.9)	435 (94.6)	498 (94.9)
Long term care, assisted living or foster care facility (%)	2 (3.1)	19 (4.1)	21 (4.0)
Hospital (%)	0 (0.0)	1 (0.2)	1 (0.2)
Other (%)	0 (0.0)	5 (1.1)	5 (1.0)
Lethal medication			
Secobarbital (%)	60 (92.3)	261 (56.7)	321 (61.1)
Pentobarbital (%)	5 (7.7)	195 (42.4)	200 (38.1)
Other (%)[ΔΔ]	0 (0.0)	4 (0.9)	4 (0.8)
Health-care provider present**			
When medication was ingested			
Prescribing physician (%)	6 (30.0)	88 (23.8)	94 (24.2)
Other provider, prescribing physician not present (%)	10 (50.0)	218 (59.1)	228 (58.6)
No provider (%)	4 (20.0)	63 (17.1)	67 (17.2)
Unknown	*45*	*21*	*66*

Characteristics	***2010 (N=65)***	***1998-2009 (N=460)***	***Total (N=525)***
At time of death			
Prescribing physician (%)	6 (9.4)	77 (20.3)	83 (18.7)
Other provider, prescribing physician not present (%)	19 (29.7)	233 (61.5)	252 (56.9)
No provider (%)	39 (60.9)	69 (18.2)	108 (24.4)
Unknown	*1*	*11*	*12*
Complications[‡‡]			
Regurgitated (%)	1 (3.6)	20 (4.5)	21 (4.4)
Seizures (%)	0 (0.0)	0 (0.0)	0 (0.0)
Awakened after taking prescribed medications	2[§§]	1[§§]	3[§§]
None (%)	27 (96.4)	429 (95.5)	456 (95.6)
Unknown	*37*	*11*	*48*
Emergency Medical Services			
Called for intervention after lethal medication ingested (%)	0 (0.0)	0 (0.0)	0 (0.0)
Calls for other reasons (%)[##]	0 (0.0)	4 (0.9)	4 (0.8)
Not called after lethal medication ingested (%)	28 (100.0)	451 (99.1)	479 (99.2)
Unknown	*37*	*5*	*42*
Timing of DWDA event			
Duration (weeks) of patient-physician relationship			
Median	18	10	10
Range	0-1905	0-1440	1-1905
Unknown	*0*	*20*	*20*
Duration (days) between 1st request and death			
Median	64	43	46
Range	16-338	15-1009	15-1009
Minutes between ingestion and unconsciousness[‡‡]			
Median	5	5	5
Range	1-20	1-38	1-38
Unknown	*33*	*38*	*71*
Minutes between ingestion and death[‡‡]			
Median	35	25	25
Range (minutes-hours)	5min–53hrs	1min-104hrs	1min-104hrs
Unknown	*33*	*33*	*66*

Notations:

[*] Unknowns are excluded when calculating percentages.

[Ψ] Includes alcoholic hepatic failure, corticobasal degeneration, diabetes with renal complications, hepatitis C, organ-limited amyloidosis, scleroderma, Shy-Drager syndrome, multiple sclerosis, meningioma, pulmonary disease, chronic heart failure, diseases of the heart, cerebrovascular disease, Parkinson's disease and Huntington's disease

[Ω] Private insurance category includes those with private insurance alone or in combination with other insurance

[#] Affirmative answers only ("Don't know" included in negative answers) Available for 17 patients in 2001

[§] First asked in 2003

[**] First recorded beginning in 2001. Since then, 20 patients (4.4%) have chosen not to inform their families and 8 patients (1.8%) have had no family to inform. There was one (1) unknown case in 2009.

[ΔΔ] Other includes combinations of Secobarbital, pentobarbital and/or morphine.

[++] The data shown are for 2001-2010 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001 Procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire The new procedure only collects information on health care providers present at ingestion when the physician or another health care provider is present at time of death This resulted in a larger number of unknowns in 2010

[§§] In 2005, one patient regained consciousness 65 hours after ingesting the medication, subsequently dying from their illness 14 days after awakening In 2010, two patients regained consciousness after ingesting medications One patient regained consciousness 88 hours after ingesting the medication, subsequently dying from their illness three months later The other patient regained consciousness within 24 hours, subsequently dying from their illness five days following ingestion.

[##] Calls included three to pronounce death and one to help a patient who had fallen off a sofa.

‡‡ Procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire The new procedure accepts information about time of and circumstances surrounding death only when the physician or another health care provider is present at the time of death This resulted in a larger number of unknowns in 2010.

[401] In November 2008, Washington State voters passed their *Death With Dignity Act*, Wash. Rev. Code §70.245 (2009) [the Washington Act], through a ballot initiative by a vote of 58% to 42%. The Act came into the effect in March 2009.

[402] The Washington Act is substantially similar to the *ODDA* upon which it was modelled. One area in which it differs is by making express that the patient must self-administer the medication. The reporting requirements are also virtually identical to *ODDA*.

[403] In 2009, medications were dispensed under the Washington Act to 63 individuals. At least 36 of those individuals died after ingesting the medication. In 2010, medications were dispensed to 87 individuals; at least 51 died after ingesting the medication.

[404] Because the legislative change took place in Washington so recently, there is not much information available as to the experience there, and most of the discussion in this section relates to Oregon.

[405] The OHD publishes data regarding deaths under the *ODDA*. One of the plaintiffs' witnesses, Professor Lewis, a Professor and researcher of comparative law, is critical of the data provided in the annual reports. She states that the quality has significantly declined between 1998 and 2010, and that the reports from 2007 onwards provided considerably less detail than earlier reports. Further, she says, data which would have been helpful in evaluating implementation of the *ODDA* have ceased to be collected; for example, whether individuals received a prescription from the first physician they approached, or the amount of barbiturates prescribed.

[406] Dr. Hendin, a psychiatrist and researcher of end-of-life decisions, levels similar criticisms against data collection in Oregon. He deposes that the OHD does not collect the information it needs to effectively monitor the *ODDA*, and restricts its

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annual reports to general epidemiological data. In the absence of surveys and interviews of physicians of the sort conducted in the Netherlands, he says that officials in Oregon have no way of knowing how many physician-assisted deaths go unreported, why some physicians decline a request while others may decide to proceed, or what transpired in any particular case.

[407] Compassion & Choices is a non-profit organization that promotes informed end-of-life decision-making by educating the public and advising health care professionals. George Eighmey was the Executive Director of Compassion & Choices of Oregon from 1998 to September 2010. Jason Renaud has held the position since January 2011. Both witnesses, who give evidence for the plaintiffs, say that based on their own observations and experiences in collectively advising over 1,700 terminally ill individuals and their physicians regarding aid-in-dying issues, the *ODDA* does not cause harm to vulnerable persons.

[408] Robb Miller is Executive Director of Compassion & Choices of Washington, a position he has held since 2000. He has counselled approximately 1,200 terminally ill patients and their physicians in regard to aid-in-dying issues since the Washington Act came into effect. Mr. Miller's experience and evidence mirrors that of Mr. Eighmey and Mr. Renaud.

[409] Ann Jackson, the former Executive Director of the Oregon Hospice Association, initially opposed the *ODDA* and voted against the Act and later for its repeal. She gives this evidence with respect to her current opinion regarding the *ODDA*:

> I now believe that it was cavalier of me to even consider that hospice and palliative care professions could indeed meet all the needs of people who were dying – or that some needs, such as the need to control one's own life and death, was an unworthy need.
>
> Today I would vote in favour of physician-assisted dying, and "yes", if ODDA were on the ballot. I am convinced that physician-assisted dying can be, and is, practiced responsibly in Oregon, and that the ODDA was very well crafted. I say this based on my personal experience and on the basis of my knowledge of the data that is now regularly published by the Oregon Health Authority. I am satisfied that the bar is high enough that people who are

> clinically depressed, for instance, and whose judgment is questionable are not likely to seek it or obtain it. The bar is, however, not so high, that motivated terminally-ill Oregonians are unduly deterred or restricted from participation. The safeguards in place are not merely meaningless obstacles.
>
> I have also seen the positive impact the ODDA has on patients in palliative care who, in the end, do not use their prescription. For those patients, it provides peace of mind that they have an option in the event of a worst case scenario. I have also seen the positive impact of merely a promise of a prescription on Oregonians who are well, on those who are newly diagnosed with life-threatening diseases or conditions, on family members and loved ones. This is significant because in hospice in the United States, the patient and the family, by federal law, is the unit of care.
>
> ...
>
> Until 2008, when I retired from the Oregon Hospice Association, I met with front-line hospice workers twice a year to discuss their experiences. Whether they supported or did not support the concept of physician-assisted dying or the ODDA, it is clear to me that conversations with patients and families and other health care professionals about death and dying had improved significantly once the ODDA, literally, put the topic on the table. When one can respond openly to a request for help in dying, the likelihood of successfully addressing fears or reasons behind the request is much greater.

[410] Providing a contrasting opinion is Dr. Charles Bentz, an internal medicine physician in Oregon. In his view, the regime in Oregon allows patients’ lives to be cut short by physicians who do not address the issues underlying patient suicidality at the end of life.

[411] Dr. Bentz bases his conclusion upon his experience with a patient who had incurable cancer. He referred the patient to radiation and medical oncology. When his patient completed the radiation therapy, the radiation oncologist recorded in the medical record her opinion that the patient was depressed due to his circumstances, which included diminished physical stamina. After the patient completed chemotherapy, he asked the medical oncologist for a lethal prescription. The oncologist contacted Dr. Bentz to confirm the diagnosis and prognosis prior to issuing the prescription. Dr. Bentz declined to be the second physician required under the *ODDA*, advising the oncologist that the course of action was not appropriate and that they should be addressing the issues underlying the patient’s suicidality rather than directly causing his death. The patient was dead two weeks later from a lethal overdose prescribed by the oncologist; a second opinion had been

sought and obtained elsewhere. Dr. Bentz states that the oncologist had only known and been treating his patient for a few weeks. Moreover, the death certificate, he says, "untruthfully" recorded the cause of death as cancer.

[412] Prior to this experience, Dr. Bentz had been of the view that "we were doing well with assisted suicide in Oregon". However, after looking into the circumstances surrounding his patient's death, he saw some concerning problems with the *ODDA*, specifically, inaccurate records about patients' deaths, the destruction of such records after one year, and no or insufficient review or sanctions for physicians when patients' lives are taken unnecessarily.

[413] Dr. Bentz says that since assisted suicide was legalized in Oregon, roughly half a dozen patients have raised the issue with him. For none of the patients was physical suffering the motivating factor. He writes, "[w]hy those patients have wanted to die varies but common to each case is that once I have assisted the patient in addressing whatever their concern was, they no longer want to die."

[414] Dr. Nancy Crumpacker, a retired oncologist whose evidence was tendered by the plaintiffs, responds to Dr. Bentz's evidence that his patient's death certificate was "untruthfully" completed. She says that it is the common, if not invariable, practice of physicians who fill out the death certificates of persons who hasten their deaths under the *ODDA* to record the underlying illness as the cause of the death. This is done to protect patient confidentiality and to avoid any confusion with settlements from insurance companies. Completing the death certificate in this manner is not inconsistent with the legislation, as s. 3.14 of the *ODDA* provides that actions taken in accordance with it do not constitute suicide or homicide for any purposes. Section 3.13 additionally provides that "[n]either shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy."

[415] Dr. Linda Ganzini, a geriatric psychiatrist and Professor of psychiatry and medicine, has over some 15 years co-authored numerous studies regarding different aspects of physician-assisted dying in Oregon. She states that a number of those

studies involved confidential surveys carefully designed to detect abuse, and none has revealed any such abuse.

[416] Based on her research and analysis, Dr. Ganzini states the following conclusions in her affidavit:

> Patients do not primarily make requests for assisted suicide because of physical symptoms, such as pain or fatigue, though fear of future physical symptoms may impact the request. Lack of social support, financial concerns and depressed mood are rated by patients, family members and health care providers as unimportant reasons for requesting assisted death. Patients appear to request assisted suicide for psychological and existential reasons; that is they value control, dread dependence on others, are ready to die, or assess their quality of life as poor.
>
> It does not appear that patients who die by assisted suicide lack adequate palliative care – 98% have health care insurance, and most are enrolled in hospice before death. As reported by hospice professionals and physicians there have been measurable improvements in end-of-life care since the initial passage of the ODDA. Most hospice professionals in Oregon do not believe that assisted suicide and hospice enrolment are mutually exclusive alternatives. Substantive palliative care interventions can lead some – but not all – patients to change their minds about assisted suicide.
>
> Across a broad range of Oregon health care professionals, the majority support assisted suicide. A core third consistently morally oppose it and object to legalization of this option.
>
> In Oregon, there is no current evidence for the claim that legalised PAS has had a disproportionate impact on patients often considered vulnerable (the elderly, women, the uninsured, people with low educational status, the poor, minors, or racial or ethnic minorities). Although there is no evidence that persons with psychiatric illnesses are disproportionally impacted by this law, some patients with MDD have lethal prescriptions without being referred for a mental health evaluation.

[417] One of the studies that Dr. Ganzini co-authored surveyed Oregon physicians regarding their experiences with requests for assistance with suicide: L. Ganzini et al., “Physicians’ Experiences with the Oregon Death With Dignity Act” (2000) 342:8 New Engl J Med 557 [the Ganzini et al. Physicians’ Experience Study]. Physicians eligible to prescribe lethal medications under the *ODDA* were sent a questionnaire in 1999 (approximately two years after the legislation came into effect). 2,649 physicians (65%) returned the survey. According to Dr. Ganzini,

anything over a 60% response rate is considered generalizable. The results provide a useful snapshot.

[418] In brief, 144 physicians (5% of respondents) reportedly received a total of 221 requests for lethal prescriptions after November 1997. The mean age of the patients was 68 years; 76% had an estimated life expectancy of less than six months. Cancer was the most common diagnosis. Physicians granted approximately one in six requests for a prescription for lethal medication; one in 10 requests actually resulted in suicide.

[419] According to the physicians' assessments, 20% of the patients making a request had symptoms of depression; none of these patients received a lethal prescription. Also according the physicians' assessments, 93% of the patients were competent to make medical decisions, 2% were not competent, and physicians were uncertain in 5% of the cases. Patients' reasons for requesting prescriptions included (some patients gave more than one reason): loss of independence (57%); poor quality of life (55%); readiness to die (54%); a desire to control the circumstances of death (53%); physical pain (43%); loss of dignity (42%); viewed self as a burden (38%); and lack of social support (6%).

[420] Of the patients, 35% had previously requested a prescription from a physician other than the responding physician and 27 patients (12%) were referred to 17 of the respondents specifically because of the patients' interest in receiving a prescription. Reflecting this referral process, 27% of respondents (38 of 143) had known the patient for less than one month at the time of the request. Of the referred patients, 15 of the 27 (55.5%) received prescriptions, and seven (26%) died after taking the medication. In this group of 27 patients, substantive interventions were recommended for 20 (74%) and implemented for seven (26%). Despite the interventions, five of the seven died by physician-assisted suicide.

[421] Physicians reported the outcomes for 165 patients who requested physician-assisted suicide. Of 29 patients who received prescriptions, 17 died from taking the prescribed medication; 11 died from other causes; and one was still alive at the time

of the survey. A total of 136 patients did not receive prescriptions. The physician was not willing to provide a prescription to the particular patient in 30 cases and was not willing to provide a prescription to any patient in 40. In 27 cases, the patient died before meeting all of the requirements of the *ODDA*. Finally, 21 patients did not meet the legal requirements of the *ODDA* and 21 patients changed their minds before completing the requirements (in some cases more than one response was chosen).

[422] Respondents provided further information about 28 patients who received prescriptions, including 16 who died after administering the medications. In all cases, the physician obtained an opinion from another physician with respect to the patient's prognosis and treatment options. At the time the prescription was written, 13 patients were thought to have 1-6 months to live and 15 were thought to have less than one month to live. Of the patients, 22 were confined to bed or a chair during more than 50% of their waking hours. In the case of 18 patients, less than four weeks elapsed between the request for a prescription and its receipt.

[423] For 68 patients, including 11 who received prescriptions and 8 who died by taking the prescribed medication, the physician implemented at least one substantive intervention, such as control of pain or other symptoms, referral to a hospice program, a consultation or a trial of anti-depressant medication. Among those patients for whom substantive interventions were made, 46% changed their minds about assisted suicide, as compared with 15% of those for whom no substantive interventions were made. In 28 instances, patients received medications for depression or anxiety, or were evaluated by a mental health practitioner; three of the 28 changed their minds about obtaining a prescription.

[424] In their discussion of the results, the authors state that the demographic characteristics of the patients who requested assisted suicide were almost identical to those of members of the general population who died in Oregon. Moreover, patients rarely cited concerns about finances or lack of social support as the reasons for making their requests. The authors further note that more than one third of the

patients requested assistance with suicide because they perceived themselves as a burden to others, but that only three of these patients received prescriptions for lethal medications, suggesting that the physicians were reluctant to accede to requests for assistance under those circumstances.

[425] With respect to depression, the authors write (at 562):

> Twenty percent of the patients had symptoms of depression, a finding that is similar to the reported prevalence of depression in patients with terminal illness. Depression has been reported in 59 to 100 percent of terminally ill persons interested in assisted suicide or other means of hastening death and in 80 percent of patients with cancer who committed suicide. We could not determine whether depression was in fact less common in persons in Oregon who requested a prescription for a lethal medication or whether the physicians failed to detect depression in some instances. Nonetheless, most of the respondents reported that they had made efforts to improve their ability to recognize depression in terminally ill patients. Only 11 percent of the patients who either received a trial of medication for depression or anxiety or were evaluated by a mental health expert changed their minds about obtaining a prescription for a lethal medication.

[426] The authors acknowledge several sources of bias and potential error, including: lack of information about the 35% of physicians who did not respond; that physicians who were opposed to or uncertain about the *ODDA* were less likely to provide complete information about patients than physicians who favoured it; and, the survey asked physicians for patients' reasons for requesting death under the *ODDA*, which is less reliable than surveying the patients themselves.

[427] Dr. Ganzini co-authored a study that looked specifically at the issue of depression: L. Ganzini, E.R. Goy and S.K. Dobscha, "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey" (2008) 337 Brit Med J a1682 [the Ganzini Depression Study].

[428] The authors surveyed 58 Oregonians, most terminally ill with cancer or ALS, who had either requested assistance in dying from a physician or had contacted an aid in dying advocacy organization. The outcomes measured depression and anxiety according to the hospital anxiety and depression scale and the structured clinical interview for the Diagnostic and Statistical Manual of Mental Disorders.

[429] The authors found that 15 participants met their pre-defined criteria for major depressive disorder, and 13 met the criteria for anxiety. By the end of the study, 42 participants had died; 18 of those participants received a prescription for a lethal drug under the *ODDA*, and nine died by the lethal ingestion. Of the participants who received a prescription, 15 did not meet their criteria for a major depressive disorder. However, three did. All three depressed participants died by lethal ingestion within two months of the research interview. None had been evaluated by a mental health professional before their participation in the study.

[430] The authors described their findings, as follows (at 3):

> Among patients who requested a physician's aid in dying, one in four had clinical depression. However, more than three quarters of people who actually received prescriptions for lethal drugs did not have a depressive disorder. Our findings also indicate that the current practice of legalised aid in dying may allow some potentially ineligible patients to receive a prescription for a lethal drug; two of those who ultimately died by lethal ingestion had depression at the time they received a prescription for a lethal drug and died by ingesting the drug. A third patient was depressed at the time that she requested a physician's aid in dying and probably received her prescription; she was successfully treated for her depression before she died by lethal ingestion.

[431] The authors note the possibility that these three individuals may have satisfied the requirements of the *ODDA* despite their depressive disorders, as the attending physicians may have determined that the depression was not influencing the patients' judgment. They further indicate that while diagnosing depression can be relatively straightforward, determining its role in influencing decision making is more difficult, even by expert assessment. In this regard, they cite an earlier study co-authored by Dr. Ganzini which found that of a sample of 321 psychiatrists in Oregon, only 6% were very confident that they could adequately determine in a single evaluation whether a psychiatric disorder was impairing the judgment of a patient requesting suicide: L. Ganzini et al., "Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide" (1996) 153:11 Am J Psychiatry 1469.

[432] This earlier study, which was also included in Dr. Ganzini's expert report, found that 95% of the psychiatrists were somewhat or very confident that they could

determine, in a long-term relationship with the patient, whether a mental disorder such as depression was influencing the decision for physician-assisted suicide. Psychiatrists who favoured the *ODDA* were significantly more confident of their ability to adequately assess the patient in the context of both a single evaluation and a long-term relationship than those who were opposed to the legislation.

[433] The authors of the Ganzini Depression Study conclude that while most terminally ill Oregonians who receive assistance in dying do not have a major depressive disorder, current practice under the *ODDA* may fail to protect some patients with mental illness. Increased vigilance and systematic examination for depression among patients who may access aid in dying are therefore needed. They recommend the use of depression screening tools to determine which patients should be referred on for mental health evaluation.

[434] The authors recognize a number of limitations of the study, among them the fact that only 28% of invited patients agreed to participate. This low rate of participation leads to uncertainty regarding the extent to which the data are generalizable to the entire population of Oregonians who request physician assistance in dying.

[435] Dr. Ganzini acknowledges in her affidavit that no medical practices are without risk. She states that despite the extensive safeguards in the *ODDA*, it is impossible to say that there is no risk that a psychologically influenced or depressed patient will slip through. Indeed, she says, her study demonstrates that three patients with major depressive disorder did access lethal prescriptions.

[436] Nevertheless, Dr. Ganzini states the opinion that these risks are minimized in a number of ways:

> First, as noted above, two physicians are required to comment on the presence of depression, voluntariness and decisional capacity. Oregon hospices responded to our study regarding depressed patients accessing lethal prescriptions with renewed emphasis on screening patients for depression. Second, there are neutral observers built into the process. For example, most patients are cared for by a hospice association (85-90% of all PAS [Physician-Assisted Suicide] deaths in recent years) and the hospice

> personnel are aware of the request for PAS. As reported in study 16, patients who request PAS are routinely discussed among hospice workers and reviewed in the interdisciplinary team meeting. Third, the amount of time, dedication and effort required to get the lethal prescription is substantial and labour intensive. Only people who are determined and effective are likely to proceed successfully through all of the hoops. The length and nature of the vetting process itself creates a system that works to winnow out those who are less than fully and genuinely committed to obtaining PAS. In other words, patient inertia and indifference is likely sufficient, in itself, to thwart the process. In my opinion, many depressed patients are unable to access these prescriptions, not because they are ultimately screened out, but because they are unable to mount the effort needed to get through this process. In study 13, we reported that only one in 10 explicit requests to a physician in Oregon result in death by lethal prescription. These system safeguards and processes, in my opinion, substantially decrease the risk of an involuntary, non-decisional or mood-dependent death by lethal ingestion.

[437] In Dr. Ganzini’s opinion, patients with major depressive disorder who desire physician-assisted suicide should be given a trial of depression treatment instead of a lethal prescription, even if they do have adequate decision-making capacity. The persistence of the depressive disorder should disqualify the patient from receiving a lethal prescription.

[438] As to voluntariness, Dr. Ganzini states:

> Among the over 50 patients [pursuing] PAS who I have interviewed, I was concerned about undue influence in three. In two cases, further interviewing allayed my concerns. The third was disqualified based on undue influence and depression. In contrast, the vast majority of persons who pursue PAS do so with single-minded determination, at times in opposition to the views of family members. Although many worry about being a burden, in fact, their families would appreciate the opportunity to give greater care. These are very independent people who do not want more care.

[439] From 1996 to 2001, Professor Helene Starks, an Associate Professor of bioethics and humanities, was Research Manager/Co-Investigator of the “Insights into Hastened Death” study, the objective of which was to explore physician-assisted dying from the perspective of the patients and families who pursued this as an option regardless of its legality. A number of papers resulted from this study.

[440] Professor Starks opines that one of the limitations of the Ganzini Depression Study is the fact that the researchers did not use narrative methods to assess the

relationship between depressive symptoms and the patients' rationales for assisted death, nor which factors contributed to their determination of a quality of life threshold. She co-authored a qualitative study which did take this approach, A.J. Bharucha et al., "The Pursuit of Physician-Assisted Suicide: Role of Psychiatric Factors" (2003) 6:6 J Palliat Med 873.

[441] The researchers conducted multiple qualitative, in-depth, semi-structured interviews with 35 families. Patients and family members were interviewed concerning 12 prospective cases (12 patients and 20 family members) and 23 retrospective cases (28 family members). These individuals were predominantly from Washington but some were from Oregon. Transcripts of the interviews were reviewed by a psychiatric consultant (who did not interview participants) who formed an independent forensic psychiatric assessment for each patient using a checklist containing the standard (DSM-IV) criteria for major depressive order, as well as other symptoms of psychopathology. The consultant also provided impressions of the subject's decisional capacity.

[442] The researchers found that no patient met the criteria for a probable major depressive disorder during the planning phase of physician-assisted suicide. Three patients (9%) were described as possibly experiencing a major depressive episode during the planning phase; however, none appeared to be, or were described as being cognitively or functionally compromised. Only one patient (3%) was decisionally incapacitated during the planning phase, due to advanced vascular dementia. However, this patient had openly communicated an enduring interest in physician-assisted suicide to her spouse and family over many years prior to the onset of dementia. Three patients (9%) who had actively sought and planned their physician-assisted suicide over many months were decisionally incapacitated on the day of death due to advanced dementia and/or superimposed delirium.

[443] Professor Starks states that the most significant findings of the study include: (1) the planning phase for physician-assisted suicide was long and unfolded over months to years; (2) major depressive episodes were relatively absent during the

planning phase, meaning that depression did not appear to be the primary motivation or influence for patients seeking physician-assisted suicide; (3) the overwhelming majority of patients seeking physician-assisted suicide maintained their decisional capacity; and (4) some of the individuals who sought physician-assisted suicide may have had unreported psychiatric co-morbidities, such as alcohol abuse. While these co-morbidities have the potential to impair decisional capacities, none of the participating patients exhibited any such signs. Professor Starks says that the findings demonstrate that the decision to seek physician-assisted suicide was not impulsive, and patients openly communicated their intent with family members over significant periods of time. Depressive symptoms, when present, were not described by the patients or their families as influential factors in their pursuit of physician-assisted suicide.

[444] She opines, based on her research, that “it is possible to have co-morbid depressive symptoms and still have decisional capacity to choose assisted dying and not have depression as the driving factor.”

[445] The authors acknowledge that the generalizability of the findings is limited, primarily by the small and self-selected nature of the sample. Other limitations include the illegality of physician-assisted suicide (when some of the suicides took place) and the resulting need for secrecy, and the possibility that depressed people with terminal illnesses pursuing physician-assisted suicide chose not to participate in the study. In cross-examination, Professor Starks agreed that there could have been recall bias in the interview subjects, and that some of the sources used to recruit families for the study were patient advocacy organizations. She also agreed that because the patients were not given standardized psychopathology instruments, the study may have failed to detect depressed individuals. As well, the population, which included patients who were assisted in suicide extra-legally, may not be representative.

[446] Professor Starks opines that the Washington system would be improved if it required palliative care consultations and systematic narrative assessments.

[447] In arguing that the safeguards in the Oregon regime do not sufficiently protect vulnerable individuals, a number of Canada's experts – such as Professor Keown and Dr. Pereira – cite the findings of the Ganzini Depression Study. A physician is not required to refer a patient for counselling under the Oregon regime unless he or she believes there is a concern as to the patient's competence. However, Dr. Hendin says, studies show that physicians are not reliably able to diagnose depression or to determine whether depression is impairing judgment.

[448] Canada's experts also point out that the available data indicate that the vast majority of patients in Oregon have not been referred for psychiatric evaluation, and that the percentage of referrals has decreased over the years.

[449] According to the latest data from the OHD, which appears earlier in this section, one patient of the 65 who died under the *ODDA* in 2010 (1.5%) was referred for a psychiatric evaluation. Of the 460 patients who died between 1998 and 2009, 38 were referred for a psychiatric evaluation (8.4%).

[450] Dr. Ganzini opines that the primary reason for the decline in psychiatric referrals in Oregon is that multi-disciplinary hospice medical teams, which include clinical social workers with mental health expertise, have become more confident in their own ability to assess depression accurately. Palliative care physicians have also now gained experience in evaluating patients under the *ODDA*. Dr. Ganzini suggests that the decrease may also reflect the research findings that most patients who seek access to physician-assisted death are not depressed. However, she agrees that mental health evaluation is underutilized, and that some patients who are depressed might be screened out following mental health evaluations.

[451] Some of the other concerns that Canada's experts raise with respect to the situation in Oregon include the fact that physicians recommended a palliative care consultation in only 13% of the first 142 requests for prescriptions after the *ODDA* came into effect (citing the Ganzini et al. Physicians' Experience Study); and, the absence of any enforcement mechanism in the event physicians fail to comply with the reporting requirements.

[452] Professor Keown notes that the three most common reasons for seeking a lethal prescription in Oregon have been losing autonomy (91.2%), a decreasing ability to engage in activities which make life enjoyable (88.1%) and loss of dignity (84.1%). He points out that these reasons are some distance from the "unbearable suffering" standard used to illustrate the need for physician-assisted dying. He also says that the majority of patients have been guided through the process by Compassion & Choices, which he describes as the "pressure group" that promoted the legislation.

[453] A further concern that Dr. Hendin raises is that unlike the regime in the Netherlands, the *ODDA* does not require the physician to inquire into the patient's suffering, as the relevant criterion is that the patient is terminally ill and has less than six months to live. The unintended consequence, he says, is that physicians do not necessarily inquire into the source of the medical, psychological, social and existential concerns that usually underlie requests for assisted dying. Such inquiry produces the kind of discussion that itself often leads to relief for patients, and provides an opportunity for physicians to suggest more moderate measures. Further, while physicians are required to indicate to a requesting patient that palliative and hospice care are feasible alternatives, they are not required to be knowledgeable about relieving physical or emotional suffering in patients. The focus, Dr. Hendin says, thus shifts away from relieving the distress of dying patients considering a hastened death to meeting the statutory requirements of the *ODDA*.

[454] With respect to Washington, Professor Starks states that the publically available data suggest that all patients who get as far as receiving a prescription have met the eligibility criteria. Professor Starks further deposes that satisfying the requirements of the Washington Act requires effort and dedication. This reflects a common characteristic of the participants in the "Insights into Hastened Death" study, and published descriptions of the individuals who use the *ODDA*, namely, that they are organized and able to direct their lives.

2. Netherlands

[455] Euthanasia and assisted suicide are governed in the Netherlands by the *Termination of Life on Request and Assisted Suicide (Review Procedures) Act*, *2002, Stb.* 2001, 194 [the Dutch Act], which came into force in 2002. While both practices are offences under the *Penal Code* (Art. 293-294, Sr.), the Dutch Act creates an exception for physicians who comply with the due care and reporting requirements it prescribes. In describing the regime, I draw on the evidence of Dr. Kimsma, Professor Legemaate, Professor Lewis and Professor Shariff.

[456] The Dutch Act does not differentiate between euthanasia and assisted suicide. “Euthanasia” is used as a compendious term that encompasses both practices. Much of the research concerning the Dutch regime uses the word euthanasia in this way. In order to describe Dutch law and practice accurately, in this section the word “euthanasia” is used as it is in the Netherlands – as a term that includes both euthanasia and physician-assisted suicide.

[457] The Dutch Act is in part the codification of a permissive regime that had developed through a series of judicial decisions and professional guidelines issued over the preceding three decades.

[458] The *Postma* decision (District Court, Leeuwarden, 21 February 1973, N.J. 1973, No. 183), concerned the case of a physician who had administered a lethal dose of morphine to her 78-year old mother who was deaf and partially paralyzed, and had pleaded with her daughter repeatedly to end her life. The doctor was convicted of “death on request” but was sentenced to one week of probation instead of a possible 12-year term of imprisonment. The decision provoked legal discussion regarding the acceptability of active physician involvement in death. Subsequent court decisions confirmed that, under certain circumstances, euthanasia and assisted suicide could be justifiable even though they were offences under criminal law.

[459] The underlying legal reasoning for accepting active physician involvement in death remained unclear until 1984 when the first voluntary euthanasia decision

reached the Dutch Supreme Court: *Schoonheim*, Supreme Court, 27 November 1984, N.J. 1985, No. 106. The Court reasoned that notwithstanding the prohibition of the practice in the *Penal Code*, a physician was able to invoke the defence of necessity when confronted with a conflict between his or her duties to preserve life on the one hand and to relieve suffering on the other. If, faced with such conflict, the physician chose a course of action that was objectively justifiable, he or she was not guilty of an offence. The Court held that the criteria for accepting the defence of necessity were to be derived from medical-ethical opinions formulated by the medical profession.

[460] This reasoning provided the foundation for voluntary euthanasia in the Netherlands until the Dutch Act was enacted in 2002. As earlier noted, the Act largely codified the due care criteria which had developed in the jurisprudence. Generally speaking, the criteria were that the patient’s wish to die had to be informed and voluntary, and expressed clearly and repeatedly; the patient had to be suffering intolerably and with no hope of relief, though he or she did not have to be terminally ill; the physician had to consult with at least one other physician; and, the physician had to report the death to the medical examiner.

[461] Unlike many jurisdictions which draw a moral or legal distinction between euthanasia and assisted suicide, the Netherlands treats both alike. “Euthanasia” refers to the termination of life upon request, thus encompassing both practices. Professor Legemaate explains that both the Dutch Act and the case law that preceded it treat euthanasia and assisted suicide the same way, and that the same requirements and procedures apply to each. A physician and patient may choose one or the other, depending on the circumstances at hand, the characteristics of the patient and his medical condition. In cases where a choice can be made, the Royal Dutch Medical Association advises physicians to favour assisted suicide for psychological reasons, but this is not a binding rule.

[462] Under Article 2 of the Dutch Act, a physician who carries out euthanasia is exempt from prosecution under the *Penal Code* if he or she complies with a number of due care criteria. Specifically, the physician must:

(a) be satisfied that the patient's request is voluntary and carefully considered;

(b) be satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement;

(c) have informed the patient about his or her situation and prospects;

(d) have come to the conclusion, together with the patient, that there is no reasonable alternative in light of the patient's condition;

(e) have consulted at least one other independent physician who must have seen the patient and provided a written opinion on the requirements of due care referred to in (a) to (d) above; and

(f) have terminated the patient's life or assisted with suicide with due medical care and attention.

[463] Regional Review Committees ("RRC"), which review all cases of euthanasia, have fleshed out some of these legislative requirements. For example, they have identified that there must be a sufficient physician-patient relationship to allow the physician to form a judgment concerning the requirements of due care. Similarly, criterion (f) has been interpreted to require the use of the appropriate method, substance and dosage as recommended by professional guidelines, and that the physician stay with the patient until death occurs, or, in the case of physician-assisted suicide, that the physician hand the medication to the patient and remain until the patient is pronounced dead (in case complications should arise).

[464] The requirement for an independent consultation increasingly is being satisfied by consultations with specialized physicians participating in the SCEN (Support and Consultation Regarding Euthanasia in the Netherlands) Project. These physicians are available to advise doctors who are faced with a request for

physician-assisted death, and to act as the independent consultant required by the Act. A non-binding best practices protocol has been implemented among SCEN physicians.

[465] The Dutch Act establishes certain reporting requirements. A physician must report an assisted death to the medical examiner using a prescribed form indicating that he or she has complied with the due care criteria. The medical examiner, in turn, is required to conduct an examination of the deceased patient and ascertain the completeness and accuracy of the physician's report. He or she then notifies the relevant RRC.

[466] Five regional RRCs review and evaluate all cases of physician-assisted dying. Each RRC comprises an uneven number of members and must include a physician, a legal expert and an ethicist. The RRC must decide whether the reported instance of physician-assisted dying is within the limits of the Dutch Act or should be referred to the criminal authorities. It is only where the RRC has determined that the due care requirements have not been met that such a referral will be made. According to Dr. Kimsma, the conclusions of the RRCs are published online in the interests of transparency and public accountability.

[467] The RRCs are required to issue a joint annual report which includes information related to number and nature of reported cases, and the opinions and considerations involved.

[468] The Dutch Act is limited to the termination of life upon a patient's request. It does not extend to termination of life without request. A physician is not obligated to comply with a request for euthanasia.

[469] Jurisprudence from Dutch courts remains relevant in defining the permissible scope of euthanasia. Two Supreme Court decisions of note are *Chabot*, Supreme Court, 21 June 1994, N.J. 1994, No. 656, and *Brongersma*, 24 December 2002, Supreme Court, N.J. 2003, No. 167. In the former, the Court confirmed that mental, as well as physical, suffering can justify physician-assisted dying. It cautioned,

however, that in such cases, the physician must be “extremely cautious”. In *Brongersma*, the Court held that neither the previous rules nor the Dutch Act (the death occurred in 1998 but the case did not reach the Supreme Court until 2002) cover “tired of life” situations. Rather, physicians must limit themselves to requests for physician-assisted dying from patients suffering from a medically classifiable physical or psychiatric sickness or disorder.

[470] Dr. van Delden, a physician and Professor of medical ethics, has been involved in all of the major empirical studies into end-of-life care in the Netherlands since 1990.

[471] As Dr. van Delden explains, in 1990, the Dutch government appointed what came to be known as the Remmelink Commission to conduct nationwide research into the frequency and characteristics of euthanasia, physician-assisted suicide and other medical end-of-life decisions in the Netherlands. To enhance physicians’ co-operation, information provided by physicians cannot be accessed by the public prosecutor. The Commission appointed a research group, of which Dr. van Delden was a member. Similar studies were conducted in 1995, 2001 and 2005. Data were collected in 2010 but the results have yet to be published.

[472] The studies (which are known as the “death certificate studies”) used stratified samples of death cases drawn from the central death registry of Statistics Netherlands. The researchers sent a questionnaire to all physicians attending a death for which the cause of death did not preclude an end-of-life decision (such as a motor vehicle accident causing instant death). The anonymity of physicians and their patients was guaranteed, and 76% responded in 1990, 77% in 1995, 74% in 2001, and 78% in 2005.

[473] The questionnaire focused on the characteristics of the end-of-life decisions preceding the patients’ deaths. Terms such as “euthanasia” and “physician-assisted suicide” were not used out of concern they might be subject to varied interpretations by responding physicians. The key questions posed were:

- Did you withhold or withdraw medical treatment
    - while taking into account the possibility or certainty that this would hasten the patient's death, or
    - with the explicit intention of hastening the patient's death?
- Did you intensify the alleviation of pain and symptoms
    - while taking into account the possibility or certainty that this would hasten the patient's death, or
    - partly with the intention of hastening the patient's death?
- Was death the result of the administration, supply, or prescription of drugs with the explicit intention of hastening the patient's death?

[474] When the third question was answered "yes", the researchers classified the case as either: euthanasia (when the drug was administered by the physician at the explicit request of the patient); physician-assisted suicide (when the patient ingested the drug him- or herself); and, as a life-ending act without an explicit request (when there was no explicit patient request).

[475] The frequency of euthanasia and physician-assisted suicide across the four studies in the Netherlands reveal the following statistics:

	1990	1995	2001	2005
Annual number of deaths	128,824	135,675	140,377	136,402
Voluntary euthanasia	1.7%	2.4%	2.6%	1.7%
Assisted suicide	0.2%	0.2%	0.2%	0.1%
Life-terminating acts without explicit request of the patient	0.8%	0.7%	0.7%	0.4%
Total	2.7%	3.3%	3.5%	2.2%

[476] Dr. van Delden elaborates with respect to the data for 2005 in his affidavit, stating that physicians received 8,400 requests for euthanasia in 2005. 2,325 requests for euthanasia and 100 requests for assisted suicide, or 3/10 of all requests, were granted. Of those patients whose requests were not granted, half had died before the decision was made. The other half either withdrew their requests or had their requests refused because the physician was of the view that the request was not well-considered or the patient's suffering was not unbearable.

[477] According to their treating physicians, patients who accessed either euthanasia or physician-assisted suicide gave the following reasons for their requests: no prospect of improvement (85%); loss of dignity (50%); severe symptoms, excluding pain (58%); pain (47%); and, expected suffering (46%). In all cases, the reporting physicians stated there were no indications that the patient's request had been made under pressure from others.

[478] Dr. van Delden provides the following table setting out the demographic characteristics of individuals who died by euthanasia or assisted suicide in 2001 and 2005:

	2001 (%)	**2005** (%)
Total	2.8	1.8
Age (years)		
0-64	5.0	3.5
65-79	3.3	2.1
80 or over	1.4	0.8
Sex		
Male	3.1	2.0
Female	2.5	1.5
Cause of death		
Cancer	7.4	5.1
Cardiovascular disease	0.4	0.3
Other/unknown	1.2	0.4
Type of physician		
General practitioner	5.8	3.7
Clinical specialist	1.8	0.5
Nursing home physician	0.4	0.2

[479] Dr. van Delden explains that the high incidence of physician-assisted dying among cancer patients accounts, in part, for the higher frequency of the practice in the under-64 age group.

[480] In addition to the data obtained in the "death certificate studies" through questionnaires, the researchers obtained data from the public prosecutors, and later the RRCs, as to the number of reported cases of euthanasia and physician-assisted suicide.

[481] The rate of reporting by physicians has increased steadily over the four studies. In 1990, an estimated 18% of cases were reported to the appropriate authorities; in 1995, 41%; in 2001, 54%; and, in 2005, 80%. According to Dr. van Delden, changes in notification procedures account for the increase. In earlier periods, physicians were required to notify the public prosecutor or, later, the local medical examiner, who would then advise the public prosecutor. No criminal proceedings would be initiated if the prosecutor was satisfied that the due care criteria had been met. The government subsequently put in place a notification procedure that shifted the assessment of physician conduct from the legal system to the RRCs.

[482] The 2005 study revealed that the predominant reason for not reporting cases of using drugs with the explicit intention to end the patient’s life at his request was that the physician did not regard the course of action as euthanasia or physician-assisted suicide, and therefore did not consider reporting to be necessary. In those cases where physicians used drugs officially recommended for euthanasia or physician-assisted suicide, reporting was at 99%; where other drugs were used, mainly opioids, the reporting rate was 2%.

[483] All four studies revealed cases of LAWER in the Netherlands. In absolute numbers, there were 1,000 in 1990; 900 in each of 1995 and 2001, and 550 in 2005. In a substantial percentage of cases, the decision had either been discussed with the patient or the patient had, during a previous phase of the illness, expressed a wish for euthanasia in the event suffering became unbearable; these were not discussions, however, that satisfied the due care requirement of an explicit request. This was the situation in 60% of the cases in 1990; 53% in 1995; 36% in 2001; and 60% in 2005.

[484] In other cases, the patients were incompetent. Professor Lewis deposes that the judicially developed necessity defence continues to apply outside the scope of the Dutch Act to LAWER cases involving incompetent persons, including neonates.

Thus, in some cases, she says, termination of life without request is legally justified in the Netherlands.

[485] According to Dr. van Delden, in 95% of the LAWER cases, the decision to perform euthanasia had been discussed with colleagues, nursing staff or relatives (on average, two out of three of these categories). In approximately two-thirds of the cases, morphine was the only drug administered. The percentage of cancer patients was considerably lower than in cases of euthanasia. Further, the LAWER patients were closer to death as compared with patients whose requests for euthanasia or assisted suicide were granted; in 88% of LAWER cases, life was shorted by at most one week. Dr. van Delden states that the most recent studies show that about one-third of the LAWER cases can also be described as terminal sedation.

[486] In Dr. van Delden's view, although the LAWER cases are a serious matter, and remain a criminal offence, they are not necessarily proof of a slippery slope from physician-assisted dying on explicit request to non-voluntary euthanasia. He points out that the occurrence of LAWER in the Netherlands decreased between 1991 and 2005. Further, he says, other studies show that the prevalence of LAWER is considerably higher in other countries (Australia and Belgium) that do not permit euthanasia. He notes that the ratio of cases-on-request to LAWER cases in Belgium in 1998, prior to legalization, was 1:3 – the inverse of the same ratio in the Netherlands.

[487] Dr. van Delden opines that given the due care criteria and the procedural protections built into the Dutch system, there is no risk of a patient receiving physician-assisted dying following a mistaken diagnosis or prognosis. He also believes that in light of the nature of the diseases that precipitate requests for physician-assisted dying, there is no risk that a treatment would become available during the period that would otherwise have extended their life-expectancy. There are no reported cases of either risk having materialized.

[488] Based on his 20 years of experience with euthanasia and assisted suicide in the Netherlands, it is Dr. van Delden's opinion that the slippery slope arguments

raised by opponents of the practice are demonstrably false. He opines that it is demonstrably true that it is possible for a state to design a system that both permits some individuals to access euthanasia or assisted suicide and enables the state to protect vulnerable individuals and groups.

[489] Two of the plaintiffs' witnesses – Professor Battin and Dr. Kimsma – co-authored a study with Frances Norwood which casts light on the practice of end-of-life care in the Netherlands.

[490] In F. Norwood, G. Kimsma and M.P. Battin, "Vulnerability and the 'slippery slope' at the end-of-life: a qualitative study of euthanasia, general practice and home death in The Netherlands" (2009) 26:6 Fam Prac 472, the authors note the presence of the LAWER cases in the Dutch statistics, and observe that some commentators cite these cases as showing the existence of a slippery slope in action in the Netherlands.

[491] To obtain better insight into the complexity and multi-faceted nature of the trajectory of discussions and behaviours that occur at the end of life, the authors undertook a 15-month study of home death in the Netherlands based on observation and interviews with 15 physicians and 650 of their patients, 192 of whom were living with a terminal or life-threatening illness.

[492] The authors examined these cases for evidence of life-terminating treatment where the patient was capable of making a request for euthanasia but did not; life-terminating treatment where the patient was not capable of making an explicit request; euthanasia used instead of palliative care alternatives; and euthanasia that was predominantly the intention of the physician as opposed to the patient. With one exception, they did not find such cases. In that particular instance, an 81-year-old patient with inoperable cancer died after an increase in morphine by a physician intending to hasten his death and alleviate his suffering at the request of his family; the case fell outside accepted boundaries of euthanasia or terminal sedation under Dutch law. Prior to his illness, the patient had discussed with both his general physician and his family his desire for euthanasia in the event it ever became

necessary. However, there was no consultation with a second physician and it was not clearly established that the patient's prior request had been "well considered".

[493] Norwood et al. state that the study revealed that the daily practice of euthanasia in the home and nursing home typically involves extensive deliberations, the majority of which do not end in a euthanasia death. They said that physicians typically stall the development of the discussions, leaving the option of euthanasia open to the patient while at the same time putting the onus on the patient to continue discussions towards that end. The authors cite this finding that the euthanasia process most often occurs as part of an ongoing discussion, and not as a singular event, as evidence against the existence of abuse in the Netherlands. They say that their finding is substantiated by figures obtained in statistical studies regarding the prevalence of euthanasia in that jurisdiction. Those data indicate, for example, that of those individuals who initiated a request for euthanasia with their physician after a life-threatening illness was diagnosed, less than two-fifths died by euthanasia or assisted suicide in 2001. In 2005, that figure was one third.

[494] The researchers note that general practitioners in the Netherlands continue a strong tradition of making house calls, tend to treat multiple members of the same family, and accept family participation in end-of-life discussions.

[495] Norwood et al. conclude (at 479):

> Opponents and proponents of euthanasia who suggest that euthanasia practices can be condensed and understood in terms of the 'explicitness' of the request or by the intention of a physician are missing critical nuances and patterns revealed in the day-to-day practice of euthanasia. This study focused on the contexts and interactions that structure daily practices around euthanasia, using a small sample of patients, families and GPs in the greater Amsterdam region. A study of this type cannot disprove the presence of abuse related to euthanasia practices in The Netherlands, but it does offer evidence that the day-to-day practice of euthanasia discussion is much more conducive to maintaining life than previously understood.

[496] The limitations of a small qualitative study necessarily influenced by Dutch cultural and medical practices are apparent. Nevertheless, the study adds some context to the statistical data regarding euthanasia and LAWER in the Netherlands.

[497] Dr. Kimsma, a Netherlands physician and Extern Associate Professor of ethics, is one of the co-authors of that study. Based on his research and experience, Dr. Kimsma is of the view that the Dutch system has sufficient safeguards in place to protect vulnerable patients. The basis for his conviction in this regard is that physician-assisted dying is only possible where there is a voluntary and well-considered request. He states that such a request is checked and evaluated with patients on a constant basis “because there never can and should be any doubt regarding the integrity and stability of such a grave request”.

[498] In his affidavit, Dr. Kimsma deposes that since physician-assisted dying is “against the grain of medicine”, it is difficult and emotionally destabilizing for physicians to enter into these euthanasia discussions with patients. Physicians must convince themselves to overcome these negative emotions, and since the patient essentially has to convince the physician that that the patient-related aspects of the due care criteria are met, a vulnerable patient runs no risk.

[499] Dr. Kimsma deposes that the empirical studies examining the incidence of depression among those seeking and receiving physician-assisted death in the Netherlands and Oregon show that the prevalence of depressive orders in patients requesting physician-assisted dying is lower than expected. Nevertheless, the issue remains a serious one since there are patients, albeit a small number, who are depressed and request to be helped to die. He says that the inescapable conclusion is that in cases where signs of depression manifest, a serious diagnostic assessment must take place. He endorses the concern that patients requesting physician-assisted death might have a major depressive disorder that goes untreated. He states that, in case of the least doubt about depression, a psychiatric assessment is professionally mandatory in the Netherlands. He adds that the diagnosis “depression” is the reason for refusal in 31% of the non-granted requests.

[500] A number of Canada’s experts give evidence with respect to the difficulties facing physicians in assessing whether patients satisfy the necessary criteria, drawing on the experience in the Netherlands.

[501] Professor Keown observes that criteria such as voluntariness and unbearable suffering are not precisely defined and are open to subjective interpretation.

[502] Demonstrating this point more concretely, Professor Brian Mishara, a Québec-based Professor of psychology and suicide prevention consultant, cites a Dutch study, H.M. Buiting et al., "Dutch criteria of due care for physician-assisted dying in medical practice: a physician perspective" (2008) 34:9 J Med Ethics e12. He summarizes its findings in his affidavit:

> A study published in 2008 by Buiting and colleagues randomly selected a stratified sample of 2,100 physicians in the Netherlands and asked them about decision-making related to requests for euthanasia or assisted suicide. They found that 75% of the physicians who responded (56% response rate) had received such requests and 25% of the physicians who received requests had experienced problems in their decision-making with regard to at least one of the requirements for access to euthanasia and assisted suicide. Of the physicians who experienced problems, 79% had difficulties concerning their determination of whether or not the patient's suffering was unbearable and hopeless and 58% had problems determining whether or not the request was voluntary or well considered. The authors of this article questioned whether the subjective opinions of physicians, who often report difficulties in determining if the patients meet requirements for access to physician assisted death, should be the basis of determining who should live or die according to the Dutch Euthanasia Act.

[503] The authors of the study also indicate that experiencing problems in applying the criteria should not necessarily be interpreted as a negative finding since, by their very nature, decisions related to euthanasia may be difficult. Requests for physician-assisted dying typically result in several discussions with the patient, family and other care givers about the due care criteria. The authors say that the fact that some criteria are more difficult to assess than others suggests they are taken seriously in the decision-making process and receive considerable attention. The authors recommend that, because physicians have to make difficult decisions in applying the due care criteria, their roles and responsibilities should be clarified. They question whether physicians can play a major role with respect to the subjective aspects of the decision and argue that they should focus more on the requirement for the absence of reasonable alternatives.

[504] Dr. Hendin, however, states that since the nation-wide Dutch studies are primarily numerical and categorical, they do not examine the interaction between physicians, patients and families, which ultimately determines the decision for euthanasia. Other studies, he says, have in fact shown that voluntariness is compromised, alternatives are not presented, and the criterion of unrelievable suffering is bypassed. Dr. Hendin provides examples of how he says this occurs. On cross-examination, Dr. Hendin's evidence regarding those examples was significantly weakened. For instance, he agreed that his knowledge of the cases was second-hand, and based in one instance on an article written in Dutch; in another on his viewing of a film.

3. Belgium

[505] The Belgian *28 May 2002 Act on Euthanasia*, B.S. 22 June 2002 [the Belgian Act] came into effect in September 2002. Its contours are similar to the Dutch Act upon which it is based, though its provisions are more detailed. The description of the legal regime is drawn from the evidence of Professor Luc Deliens, Professor Lewis and Professor Shariff.

[506] Professor Lewis deposes that although neither suicide nor assisting suicide is a criminal offence under the Belgian penal code, someone who intentionally provides assistance could be prosecuted for failing to assist a person in danger, or involuntary homicide. She adds, however, "as no criminal charges have ever been prosecuted in relation to physician-assisted dying under the Belgian criminal law, it is unclear whether the defence of necessity would be available in such circumstances".

[507] According to Professor Luc Deliens, a medical sociologist and Professor of palliative care in Belgium, new legislation regarding patients' rights and palliative care was implemented in Belgium in 2002 at the same time as the Belgian Act. The patients' rights legislation stressed the right of all patients to be informed of diagnosis and prognosis, and to consent to treatment decisions. The palliative care legislation provided that every patient has a right to palliative care, and contained measures for the development of palliative care services in Belgium.

[508] The Belgian Act defines euthanasia as "intentionally terminating life by someone other than the person concerned, at the latter's request" (s. 2). Although assisted suicide is not explicitly included in this definition, the Belgian euthanasia oversight body – the Federal Control and Evaluation Commission ("FCEC") – has determined that it encompasses physician-assisted suicide. Because of this framework the experts on the Belgian regime use "euthanasia" as a compendious term including euthanasia and physician-assisted death. This should be kept in mind when considering the evidence concerning Belgium.

[509] Section 3(1) of the Belgian Act provides that a physician who performs euthanasia does not commit a criminal offence when he or she ensures that:

> (a) the patient is over the age of majority, and is conscious and competent when making the request;
>
> (b) the request is voluntary, well-considered, repeated and not the result of external pressure (the request must also be in writing (s. 4)); and
>
> (c) the patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.

[510] Section 3(2) sets out a number of procedural requirements for the physician. In each case, he or she must:

> (a) Inform the patient about his or her condition and life expectancy, and discuss with the patient his or her request for euthanasia, as well as possible therapeutic and palliative options. Together with the patient, the physician must come to the belief that there is no reasonable alternative to the patient's situation and that the patient's request is completely voluntary.
>
> (b) Be certain of the patient's constant physical or mental suffering, and the durability of the euthanasia request. To this end, the physician is to

have several conversations with the patient spread out over a reasonable period of time, taking into account the progress of the patient's condition.

(c) Consult with another physician about the serious and incurable character of the medical condition, and inform him or her about the reasons for the consultation. The consulting physician must be independent of both the patient and attending physician, and must be competent to give an opinion about the medical condition in question. The consulting physician must review the medical record, examine the patient and be certain of the patient's constant and unbearable physical or mental suffering that cannot be alleviated. The attending physician must inform the patient about the results of the consultation.

(d) If there is a nursing team that has regular contact with the patient, discuss the patient's request with the team.

(e) If the patient so desires, discuss his or her request with relatives appointed by the patient.

(f) Be certain that the patient has had the opportunity to discuss his or her request with the persons he or she wishes.

[511] The Belgian Act imposes additional safeguards where the physician is of the view that the patient is clearly not expected to die in the near future, that is, is not in the terminal phase. In such circumstances, s. 3(3) requires that the physician must also:

(a) Consult a third physician, who is either a psychiatrist or a specialist in the medical condition in question. The consulting physician must be independent of the patient and the attending physician. The consulting physician must review the medical record, examine the patient and be certain of the patient's constant and unbearable physical or mental suffering that cannot be alleviated, and of the voluntary, well-considered and repeated character of the euthanasia request. The attending physician must inform the patient about the results.

(b) Allow at least one month to elapse between the patient's written request and the act of euthanasia.

[512] The Belgian Act establishes the FCEC, which is comprised of 16 members including doctors, lawyers and individuals from groups that routinely deal with issues relating to the terminally ill.

[513] A physician who has performed euthanasia must complete and deliver to the FCEC a prescribed registration form which includes such information as the biographical details of the patient; the nature of the patient's condition, the suffering and why it could not be alleviated; the elements underlying the assurance that that the request was voluntary, well-considered and repeated, and not the result of any external pressure; and, the manner in which euthanasia was performed and the pharmaceuticals used.

[514] The FCEC determines whether the euthanasia was performed in accordance with the Belgian Act. If a two-thirds majority of the committee is of the opinion that the required conditions have not been fulfilled, it will turn the case over to the public prosecutor.

[515] For the benefit of the Belgian Parliament, the FCEC is required to prepare biennial reports setting out statistical information derived from the registration forms submitted to the committee; an evaluation of the implementation of the law; and if required, recommendations that could lead to new legislation or other measures concerning the execution of the Belgian Act.

[516] Section 14 of the Belgian Act provides that no physician may be compelled to perform euthanasia. Should the physician consulted refuse to perform euthanasia, then he or she must inform the patient of this fact in a timely manner, and explain her reasons for refusing. If the refusal is based on medical reasons, then those reasons are noted in the patient's medical record.

[517] Section 15 states that any person who dies as a result of euthanasia performed in accordance with the Belgian Act is deemed to have died of natural causes for the purposes of contracts that he or she has entered into, in particular, insurance contracts.

[518] Data drawn from the databases of officially reported euthanasia cases in Belgium indicate the following frequency of the practice between implementation of the Belgian Act and December 31, 2007:

Year	**No. Deaths**	**No. Reported Cases of Euthanasia**	**All Deaths**
2002*	105,642	24	N/A**
2003	103,278	235	0.23%
2004	101,946	347	0.34%
2005	103,278	388	0.38%
2006	101,587	428	0.42%
2007	100,658	495	0.49%
2008	N/A**	705	N/A**
Total		2622	

* Cases reported from September 22 up to and including December 31.

** N/A denotes not available

[519] The foregoing data are from T. Smets et. al., “Legal Euthanasia in Belgium: Characteristics of All Reported Euthanasia Cases” (February 2010) 48:2 Med Care 187 [the Smets et al. Characteristics Study].

[520] The following table summarizes the characteristics of patients who have made a request for euthanasia since implementation of the Belgian Act in 2002 (Y. Van Wesemael et al., “Process and Outcomes of Euthanasia Requests under the Belgian Act on Euthanasia: A Nationwide Survey”, J Pain Symptom Management (forthcoming) [the Van Wesemael et al. Process and Outcomes Study].

Characteristics of Patients Who Have Made a Request for Euthanasia Since Enactment of the Law

	Euthanasia Requested	Euthanasia Performed	Euthanasia Request Rejected	Patient Withdrew Euthanasia Request	Patient Died Before Administration	Patient Still Alive
Patient Characteristics	*n* (Column %)	Row %	Row %	Row %	Row %	Row %
Total	355[a] (100)	48.3	5.0	10.4	23.0	13.2
Gender						
Female	171 (48.7)	44.4	5.8	9.9	22.2	**17.5**
Male	180 (51.3)	52.2	4.4	10.6	23.9	8.9
Age, years						
<40	13 (3.7)	38.5	7.7	7.7	15.4	30.8
40-49	26 (7.4)	38.5	3.8	7.7	23.1	26.9
50-59	48 (13.7)	54.2	4.2	10.4	18.8	12.5
60-69	75 (21.4)	52.0	5.3	8.0	25.3	9.3
70-79	113 (32.3)	54.0	3.5	8.0	23.0	11.5
80 or older	75 (21.4)	**33.3**	8.0	**17.3**	26.7	14.7
Diagnosis[b]						
Cancer	226 (63.7)	61.1	2.7	8.4	24.3	17.0
Chronic obstructive pulmonary disease	16 (4.5)	62.5	0.0	12.5	12.5	12.5
Multiple sclerosis / amyotrophic lateral sclerosis	12 (3.4)	33.3	0.0	8.3	25.0	33.3
Heart failure	10 (2.8)	20.0	0.0	20.0	50.0	10.0
Psychiatric disorder	19 (5.3)	**0.0**	15.8	15.8	**0.0**	**68.4**
General deterioration	25 (7.0)	**16.0**	20.0	8.0	32.0	21.0
Other[c]	37 (10.4)	32.4	10.8	16.2	13.5	27.0
Reasons for requiring euthanasia[d]						
Suffering without prospect of improvement	252 (71.6)	55.2	2.8	7.1	22.6	12.3
Deterioration/ loss of dignity	154 (43.9)	55.8	4.5	5.2	23.4	11.0
Pain	120 (34.0)	56.7	0.8	7.5	27.5	7.5
General weakness/ fatigue	113 (32.2)	52.2	6.2	9.7	24.8	7.1
Not wanting to be a burden on family/ environment	113 (32.0)	**39.8**	8.0	13.3	22.1	16.8
Dependence	78 (22.2)	43.6	1.3	**16.7**	23.1	15.4
Tired of living	92 (26.0)	**34.8**	8.7	13.0	23.9	**19.6**
Invalidity	50 (14.2)	50.0	4.0	10.0	22.0	14.0
Fear of suffocating	46 (13.1)	60.9	0.0	6.5	23.9	8.7
Depression	43 (12.2)	**16.3**	**20.9**	11.6	23.3	**27.9**
Dyspnoea	24 (6.8)	**70.8**	0.0	8.3	20.8	**0.0**
Vomiting	11 (3.1)	**81.8**	0.0	0.0	18.2	0.0
Suffering as most important reason for requesting euthanasia	139 (40.6)	61.2	2.9	5.0	19.4	11.5
Written request (*n* = 302)	219 (62.9)	63.0	2.3	5.5	19.6	9.6

Notations

Significance tested with Stat Xact and Fisher's exact test for statistically significant differences between categories versus all other categories within the variable. Significant differences are in bold.

a For eight cases, the information on the outcome was missing. Percentages are calculated for valid cases.
b Physicians indicated multiple diagnoses in 11 cases. These are not shown in the table.
c Other diagnoses include acquired immunodeficiency syndrome (1), cerebrovascular accident (7), (beginning) dementia (4), Parkinson's (2), quadriplegia (1), multiple system atrophy (1), myopathy (1), and non-specified diagnoses (19)
d More than one answer possible.

[521] Professor Deliens deposes that considerable empirical research has been conducted in Belgium with respect to all forms of end-of-life decisions before, during

and after the 2002 legalization of physician-assisted dying. He attaches to his affidavit numerous studies of which he is co-author.

[522] Prior to the legalization of euthanasia in 2002, Professor Deliens co-authored "End of Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey" (2000) 356 Lancet 1806. It reported the results of a study based upon a 20% sample randomly selected out of all 3,999 deaths recorded between January 1 and April 30, 1998.

[523] The study revealed that the strict Belgian law did not prevent physicians from practicing euthanasia and other end-of-life decisions, with end-of-life decisions explicitly intended to shorten life being involved in about 10% of deaths. Professor Deliens said that he and his co-authors estimated that 1.3% of deaths resulted from euthanasia or physician-assisted suicide and that, in 3.2% of cases, lethal drugs were given without the explicit request of the patient. They found that alleviation of pain and symptoms with opioids in doses with a potential life-shortening effect preceded death in 18.5% of cases and non-treatment decisions in 16.4% of cases, of which 5.8% were with the explicit intention of ending the patient's life.

[524] He stated that the results showed the difficulty of obtaining reliable data on euthanasia and other end-of-life medical practices in a country with no formal registration and authorization procedure for end-of-life decisions, and where criminal prosecution of some end-of-life decisions is a possibility.

[525] Professor Deliens also co-authored a study looking at "Changes in medical end-of-life practices during the legalization process of euthanasia in Belgium" (J. Bilsen et al., (2007) 65 Soc Sci Med 803. The researchers found that the overall incidence of end-of-life decisions did not change, but the incidence of euthanasia decreased (1.1% to 0.3%), as did the incidence of LAWER (3.2% to 1.5%) and alleviation of pain and symptoms with life-shortening co-intention (5.3% to 2.8%).

[526] On the basis of his own empirical research, his review of the data collected by others, his review of the relevant literature and his experience as a medical

sociologist, Professor Deliens is of the opinion that, in practice, the Belgian Act is successful in limiting the availability of euthanasia to individuals who meet the requirements it imposes, and effectively protecting vulnerable individuals.

[527] Professor Deliens was co-author of the Smets et al. Characteristics Study, which provides the following information about all cases reported to the FCEC between 2002 and 2007.

[528] A total of 1,917 euthanasia cases were reported. The breakdown of patient ages was:

(a) 18-39: 3% of all euthanasia cases; 2% of all deaths in Belgium;

(b) 40-59: 26% of all euthanasia cases; 9.5% of all deaths in Belgium;

(c) 60-79: 53.1% of all euthanasia cases; 37.9% of all deaths in Belgium;

(d) > 79: 17.9% of all euthanasia cases; 50.2% of all deaths in Belgium.

[529] A second independent physician was consulted in 99.8% of cases. Of the patients, 93.4% were terminally ill, and 87.6% of the terminally ill patients had cancer. Of the non-terminal patients, 90.8% suffered from other illnesses, including progressive neuromuscular disease. Psychological suffering was reported significantly more often for non-terminal patients (89.7% v. 66.5%), whereas the reverse was true for physical suffering (96% v. 89.7%).

[530] Of all cases, 0.7% (13) concerned non-terminally ill patients who did not suffer physically; six of those patients had a neuropsychiatric disease and eight had a somatic disease. All of the patients reported psychological suffering.

[531] The authors of the study advance a number of possible explanations for the annual increase in the incidence of euthanasia. They say it is plausible that patients increasingly see euthanasia as an acceptable end-of-life option or that physicians may have become more willing to perform euthanasia in a climate where it is no longer illegal. It is also possible that physicians may have become more willing to

report cases, likely, in part, because the Federal Control and Evaluation Commission has never sent a reported case to the judicial authorities.

[532] The authors state that no evidence was found to support the fear that legalization of euthanasia would increase the likelihood of elderly patients ending their lives with the assistance of a physician. Patients 80 years of age or older were under-represented among euthanasia cases compared with all deaths, even controlling for diagnosis and place of death. Further, the number of reported cases in this age group did not increase significantly over time.

[533] The authors conclude (at 192):

> Based on these reported cases, we can conclude that euthanasia is most often chosen as a last resort at the end of life by younger patients and by patients with cancer. Developments over time do not show any indication to support the slippery slope hypothesis. Furthermore, requests for euthanasia from nonterminal patients, some suffering from nonsomatic diseases, can and are being granted under the Belgian euthanasia law, albeit in small and not increasing numbers and under the same strict due care criteria as for terminally ill patients. Further research should focus on estimating the notification rate for euthanasia and should give attention to the unreported practice as well.

[534] The authors note a number of limitations of their study. Because they relied on secondary data collected as part of the anonymous notification procedure, the authors could not obtain complete insight into some areas of the practice, such as palliative interventions. Further, the data only reflect the officially reported cases; the authors could not exclude the possibility that physicians do not always report their cases, and that unreported cases differ from reported ones.

[535] Professor Deliens also co-authored the Van Wesemael J. et al. Process and Outcomes Study, mentioned earlier. The study aimed to describe which euthanasia requests were granted, withdrawn and rejected since the enactment of the Belgian Act, focusing on the characteristics of the patient, treating physician, and the consultation with a second physician. A representative sample of 3,006 Belgian physicians likely to be involved in end-of-life care received a questionnaire seeking

details on their most recent euthanasia request. 914 physicians responded, a response rate of 34% when non-practising physicians were accounted for.

[536] In the responses to the questionnaires, 363 post-2002 requests for euthanasia were described. Of all the requests, 171 (48%) eventually ended in euthanasia; 18 (5%) were rejected; 37 (10%) were withdrawn by the patient; 81(23%) patients died before euthanasia was carried out; and, 47 (13%) patients were still alive at the end of the study.

[537] In 248 (71%) cases, the attending physician's initial position toward the request was positive, meaning that he or she had already decided to probably or certainly grant the request; in 75 (21%) cases, it was negative, meaning that he or she had already decided to probably or certainly refuse the request.

[538] In 235 (65%) cases, the attending physician consulted with an independent second physician. The second physician gave positive advice in 180 (77%) cases, negative advice in 45 (19%), and no advice (yet) in seven (3%).

[539] In the 45 cases where the second physician gave negative advice, he or she judged that there was no unbearable suffering in 12 (26%) cases; no medically hopeless situation in 14 (31%) cases; no well-considered request in five (10%) cases; and that there were palliative options available in 12 (26%) cases.

[540] Of the 180 cases in which the second physician gave positive advice, euthanasia was performed in 140 (78%) cases; there were no cases in which the request was rejected; the patient withdrew the request in seven (4%) cases; the patient died before euthanasia was performed in 26 (14%) cases, and the patient was still alive at the time of the study in seven (4%) cases.

[541] Of the 45 cases in which the second physician gave negative advice, euthanasia was performed in four (10%) cases; the request was rejected in seven (16%) cases; the patient withdrew the request in 11 (25%) cases; the patient died before euthanasia was performed in 13 (30%) cases; and the patient was still alive at the time of the study in nine (20%) cases.

[542] Of the seven cases in which the second physician gave no advice, euthanasia was performed in four (59%) cases; the request was rejected in one (14%) case; there were no cases in which the request was withdrawn; the patient died before the euthanasia was performed in one (14%) case, and the patient was still alive at the time of the study in one (14%) case.

[543] In the 123 cases in which there was no consultation with a second physician, euthanasia was performed in 20 (17%) cases; the request was rejected in 10 (9%) cases; the patient withdrew the request in 19 (16%) cases; the patient died before euthanasia was performed in 41 (34%) cases; and the patient was still alive at the time of the study in 29 (24%) cases.

[544] For 10 of the 18 patients whose requests were rejected, a different end-of-life decision with a possible life-shortening effect was made. Such a decision was made in the cases of 23 of the 37 patients who withdrew their requests.

[545] No requests from patients with a psychiatric disorder were granted, and for those patients whose main diagnosis was general deterioration, requests were granted less often compared with those from patients with other diagnoses. Requests were also rejected significantly more often when depression was given as a reason.

[546] The authors make the following points in their discussion of the results.

[547] Reasons for requesting euthanasia are medical, social and psychological but suffering without prospect of improvement is the most important. This is consistent with results from studies conducted in the Netherlands. Pain is an important reason for requesting euthanasia in more than one-third of cases, which is also consistent with other studies. Only 5% of all requests for euthanasia were actually rejected, which is considerably lower than in the Netherlands where the rate of rejection is 12%. The authors posit that this may indicate that postponing the decision or trying to convince the patient to choose a different option are more acceptable forms of rejection for some physicians.

[548] With respect to concerns for the vulnerable, the authors write (at 11):

> The repeatedly expressed concern that vulnerable people (older people, disabled people, those with psychiatric disorders) would more easily receive euthanasia is not supported by our data. On the contrary, we found that requests for euthanasia from patients 80 years and older are granted less often and withdrawn more often. Requests from patients with a psychiatric disorder were never granted, and those from people with general deterioration were granted less often. The chances of receiving euthanasia are lower when depression is one of the reasons for requesting euthanasia and when the patient is 80 years or older. This may be reassuring on the one hand, but may, on the other hand, also be an indication of possible "discrimination" toward certain patient groups in granting euthanasia requests.

[549] The authors note various limitations to the study. These include the fact that the low response rate makes it difficult to generalize the results; a survey of the non-responders indicated they were slightly less supportive of euthanasia than responders, indicating a slight response bias; there may be a recollection bias on the part of the physician, particularly with respect to requests from more than a year earlier; and, the information on the circumstances of the euthanasia only reflected the physician's point of view.

[550] A qualitative study regarding adherence to safeguards was co-authored by Professor Deliens, T. Smets et al., "Euthanasia in patients dying at home in Belgium: interview study on adherence to legal safeguards" (April 2010) Brit J Gen Pract e163. The study aimed to investigate the degree of adherence to the due care requirements imposed by the Belgian Act with respect to patients dying at home under the care of general practitioners, and to explore possible reasons for non-adherence. The study entailed in-depth interviews of physicians (under a guarantee of anonymity) identified as having performed euthanasia at a patient's personal residence within a defined two year period. The process resulted in a study of nine deaths. All nine patients were adults and none had a low level of education. None was estimated as being of low income, and seven lived with a regular partner at the time of death. Four were between 18-64 years of age; three were between 65-79; and two were 80 or older. In seven of nine cases, the principal diagnosis was cancer.

[551] While limited, the study provides information regarding actual euthanasia cases taking place at home under the care of a general practitioner. It revealed that all nine patients had made a voluntary and well-considered request for euthanasia. Eight put their request in writing. One made only a verbal request; the physician did not consider it necessary to have it in writing based on the relationship of trust between the physician, the patient and the family. All nine patients were in a condition for which medical treatment was achieving little or nothing, and there was no prospect of improvement. Eight had lasting and unbearable physical and/or psychological suffering; one was in a situation in which unbearable suffering was expected in the future.

[552] In all cases, the physician informed the patient about his or her health condition and life expectancy, and in all cases, they had together come to the conclusion that no reasonable alternatives were possible. In seven cases, the physicians indicated that either life-prolonging or palliative treatments were still possible, but they were not applied because the patient refused further treatment or did not want to prolong his or her life, or because the physician or patient deemed the chance of improvement too small.

[553] In one of the nine cases, a nurse administered the final drug; in the rest, the general practitioners did so.

[554] In three cases, the physician did not consult a second physician as required by the Belgian Act. One physician did not see the consultation as necessary since he did not consider the matter to be a clear case of euthanasia. Another did not consult because it "was a case of euthanasia outside the euthanasia law. No lethal drug was used". Nevertheless, both physicians consulted other physicians who, while not performing the tasks required by the Belgian Act, gave advice and information. A third physician did not consult another physician because he or she found the consultation procedure too burdensome and not useful; he or she believed it was up to the patient and physician alone to make the decision.

[555] Of the six cases in which there were consultations, in two cases the consulting physician was not independent of the attending physician and patient. In one, the attending and consulting physicians knew each other because they had taken classes in palliative care together. In the other, the consulting and attending physicians were friends.

[556] Five of the cases were reported to the FCEC as required. The reasons given as to why the other four cases were not reported were: (1) the physician had forgotten; (2) the physician did not see the case as one of euthanasia but of terminal sedation with the intent to hasten death, which does not have to be reported; (3) the physician found the procedure burdensome and not useful (as noted in (e) above; and (4) the physician mistakenly believed that the Belgian Act required him or her to wait an additional 15 days.

[557] The authors state that the cases were identified by means of a large-scale retrospective mortality study representative of all deaths in Belgium, and are therefore likely to be representative of home euthanasia cases in the country. Nevertheless, the conclusions are based on a very small number of cases. Further, given that the interviews were conducted with the physicians about their own adherence and non-adherence to the law, the possibility of social desirability bias cannot be excluded.

[558] The authors conclude (at e169):

> This study found that while most GPs adhered to the substantive requirements, some demonstrated limited adherence to the procedural requirements. Although legalisation of euthanasia in Belgium has changed it from a covert practice to a more societally controlled one, legalisation alone does not seem sufficient to guarantee due care. It seems warranted that legalisation of euthanasia, rather than being a final destination, should be seen as a starting point for further debate about standards and guidelines for careful end-of-life practice, and should go together with the proper education of, and provision of information to, all physicians potentially involved. Incorporation in medical education, feedback from the Federal Review Committee to reporting GPs about their medical actions, and accessible, adequate support for GPs who are confronted with an explicit request for euthanasia could help them in understanding which practices are regarded as

> euthanasia, and could help overcome their limited knowledge of the euthanasia law.

[559] With respect to the issue of reporting, Professor Deliens was also co-author of T. Smets et al., “Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases” (2010) 341 Brit Med J c5174 [the Smets et al. Reporting Study]. The methodology entailed a review of all death certificates in Flanders, Belgium regarding deaths between June 1 and November 30, 2007. Based on the underlying causes of death, physicians were sent a questionnaire focusing on the characteristics of the end-of-life decision-making that preceded the patients’ deaths. Total anonymity of physicians and patients was guaranteed. Terms such as “euthanasia” were not used, and instead the questions posed were designed to assess whether the acts corresponded to the legal definition of euthanasia. The legal definition of euthanasia includes only acts done at the explicit request of the patient; thus LAWER cases were excluded from those classified as euthanasia for the purposes of the study. The response rate for the survey was 58.4%, which the authors say leaves room for doubt that results might have differed with a higher response rate.

[560] The results indicate that the incidence of euthanasia was estimated at 1.9% of all deaths. Only 52.8% of all estimated cases of euthanasia were reported to the Committee. Physicians who perceived their cases to constitute euthanasia reported 93.1% of the time.

[561] Of the unreported cases, 92.2% involved acts of euthanasia as defined by the study but were not perceived as “euthanasia” by the physicians. Physicians who had not reported a case that the study defined as euthanasia gave these reasons for not reporting: they did not perceive their act as euthanasia, 76.7%; reporting was too much of an administrative burden, 17.9%; the legal due care requirements had possibly not been met, 11.9%; euthanasia is a private matter between physician and patient, 8.7%; and possible legal consequences, 2.3%.

[562] Unreported cases were generally dealt with less carefully than reported cases. A written request was absent in the majority of unreported cases; 87.7% had a verbal request only. Other physicians and caregivers specialised in palliative care were consulted less often. The life ending act was more often performed with opioids or sedatives, and the drugs were more often administered by a nurse. In about half of the unreported cases in which opioids were used with the explicit goal of hastening death, physicians indicated that the dose was no higher than necessary for pain and symptom alleviation. Consultation with another physician occurred in almost all reported cases but only half of the unreported cases.

[563] There was a significant relation between reporting of euthanasia and the patient's age, with deaths of patients 80 years or older reported significantly less often than deaths of younger patients. Cases were also reported less often where the time by which life was shortened was less than one week.

[564] The authors offer this interpretation of the study's results (at 5):

> Five years after the enactment of the euthanasia law in 2002, half of all euthanasia cases in Flanders were reported to the review committee. A similar reporting procedure exists in the Netherlands, where the current reporting rate is estimated at 80.2%. However, the Netherlands had already experienced two decades of relatively open euthanasia practice before euthanasia was officially legalised in 2002, and a reporting procedure has been in place since the early 1990s. Compared to the Netherlands, bringing life ending acts into the open is a relatively new experience for physicians in Flanders (and in Belgium as a whole) because physicians have only been required to report cases since the enactment of the euthanasia law. This may, at least in part, explain the lower reporting rate in Flanders compared with in the Netherlands. [Footnotes omitted.]

[565] They also offer some hypotheses that might explain the seeming gap between the legal definition of euthanasia and physicians' perceptions. They state this conclusion (at 7):

> The quality of medical practice at the end of life needs monitoring in any kind of society, and certainly in countries that have legalized euthanasia. To provide better societal control over euthanasia and to safeguard the quality of the practice, it is necessary that all cases of euthanasia are reported. The transparency in reporting that was envisaged by the architects of the euthanasia law in Belgium extends especially to those cases in which the

> time by which life is shortened is greater than one week and to those cases in which it is more certain that life is shortened by the drugs administered. However, this study estimated that in 2007, only half of all cases of euthanasia in Flanders and around three in four where life was shortened by more than one week were reported to the review committee.
>
> As such legalisation alone does not seem sufficient to reach the goal of transparency ("total" or a 100% transparency seems to be a rather utopian ideal) and to guarantee the careful practice of euthanasia. It seems warranted that a policy be developed to facilitate physicians in complying correctly with a request for euthanasia, including their obligation to report. Education in medical schools and adequate support for treating physicians who are confronted with an explicit request for euthanasia will be pivotal in reaching this goal.

[566] In K. Chambaere et al., "Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey" (June 15, 2010) 182:9 Can Med Assoc J 895 [the Chambaere et al. Population Study], the authors, who include Professor Deliens, describe the practices of euthanasia and assisted suicide, and the use of LAWER in Flanders, Belgium between June and November 2007. They observe at the outset that euthanasia opponents frequently argue that legalization will lead to a rise in LAWER, particularly among vulnerable groups.

[567] The analysis is based upon the same 2007 death certificate study and questionnaire as that used for the Smets et al. Reporting Study described above. The response rate was 58.4%. Overall, 208 deaths involving the use of life-ending drugs were reported: 142 were upon an explicit patient request (137 euthanasia and five assisted suicide); 66 were without an explicit request (LAWER). Euthanasia and assisted suicide cases predominantly involved patients under 80 years of age (79.6%), those with cancer (80.2%) and those dying at home (50.3%). LAWER cases mostly involved patients who were 80 or older (52.7%), those without cancer (67.5%) and those who died in hospital (67.1%). The LAWER cases represented 1.8% of the deaths in Flanders during the study period.

[568] Of the LAWER cases, the decision was not discussed with the patient in 77.9% of the cases. The reasons given by the physicians included (respondents could choose more than one option): the patient was comatose (70.1%); the patient had dementia (21.1%); the decision was clearly in the patient's best interest (17%);

and the discussion would have been harmful to the patient (8.2%). In 40.4% of the cases, the physician indicated that although the decision had not been discussed, the patient had previously expressed a wish for ending life. In 4% of cases, the patient had a written advance directive.

[569] LAWER was discussed less often with other caregivers but as often with the patient's family in comparison with euthanasia or assisted suicide. Pain and the patient's wish for ending life were more often reasons for carrying out euthanasia or assisted suicide, whereas family burden and the consideration that life not be needlessly prolonged were more often cited as reasons for LAWER.

[570] In most cases of euthanasia or assisted suicide, the patients had been treated for their terminal illness for more than six months (80.3%), the goal of treatment in the last week was patient comfort (94.3%) and life was shortened by one week or more (44.5%). Cases of LAWER were more likely to have shorter length of treatment of the terminal illness (less than one month in 46.1% of cases), to have cure as the goal of treatment in the last week (14.6% as opposed to 1.2%), to have shorter estimated time by which life was shortened (less than 24 hours in 47.9% of cases), and to involve the administration of opioids.

[571] The authors say that the differences in demographic and clinical characteristics between the LAWER patients and those who died of euthanasia or assisted suicide likely reflect differences in the patients' illness trajectory. For instance, cancer has a generally predictable trajectory, allowing decision-making to occur in the period between diagnosis and death. In contrast, most of the patients in the LAWER cases had diseases with less predictable end-of-life trajectories, such as cardiovascular disease. The authors also believe that LAWER cases often involved chronically ill patients whose general conditions suddenly and drastically deteriorated to point that they were left permanently unable to communicate. In these situations, the authors say, physicians need to decide on a course of action together with the patient's family, which may result in a conflict of interest. This underscores the importance of advance care planning with family and caregiver, and

of communication regarding the patient's wishes should he or she become comatose or incompetent. They opine that such measures will undoubtedly limit the number of LAWER cases.

[572] At 899, the authors write:

> Our finding that euthanasia and assisted suicide were typically performed in younger patients, patients with cancer and patients dying at home is consistent with findings from other studies. Our finding that the use of life-ending drugs without explicit patient request occurred predominantly in hospital and among patients 80 years or older who were mostly in a coma or had dementia fits the description of "vulnerable" patient groups at risk of life-ending without request. Attention should therefore be paid to protecting these patient groups from such practices. However, when compared with all deaths in Flanders, elderly patients and patients dying of diseases of the nervous system (including dementia) were not proportionately at greater risk of this practice than other patient groups.

[573] They further comment, at 900:

> We found that the use of life-ending drugs without a patient's explicit request occurred more often in Flanders, Belgium, than in other countries, including the Netherlands, where euthanasia is also legal. Flemish physicians have been shown to be more open to this practice than physicians elsewhere, which suggests a larger degree of paternalistic attitudes. This being said, its occurrence has not risen since the legalization of euthanasia in Belgium. On the contrary, the rate dropped from 3.2% in 1998 to 1.8% in 2007. In the Netherlands, the rate dropped slightly after legalization, from 0.7% to 0.4%. Although legalization of euthanasia seems to have had an impact, more efforts are needed to further reduce the occurrence of life-ending drug use without an explicit request from the patient. [Footnotes omitted.]

[574] Professor Deliens agreed on his cross-examination that a possible explanation for the reduction in LAWER, physician-assisted suicide and euthanasia between 1998 and 2001 was that, during the period of the debate about legislation, criminal investigations were initiated. He said, however, that the 2001 data were collected at a time when the medical profession was in turmoil because of the debate and the data may not be reliable. He suggested that the significant comparison is between 1998 and 2007, which showed a drop in LAWER cases from 3.2% to 1.8%.

[575] He was asked on cross-examination about whether the research he had done permitted him know whether the persons receiving euthanasia had disabilities. He testified that although the question is not specifically addressed in the published papers, and there was not a specific question about disabilities in the questionnaire, it was possible to know from the death certificates, which include codes for the kind of disease patients had prior to their deaths. He said that it is possible to link the data and, from the codes, to tell whether there were people with disabilities. He said that they found no cases.

[576] Finally, I note that Professor Deliens was asked about the comment in the Chambaere et al. Population Study that “the use of life-ending drugs without explicit patient request occurred predominantly in hospital and among patients 80 years or older who were mostly in a coma or had dementia and fits the description of ‘vulnerable’ patient groups at risk of life ending without request”.

[577] His responses to this line of questioning suggested that possibly he did not wish to admit that he had said that patients who are 80 years or older are vulnerable and at risk of LAWER. I take into account that Professor Deliens was ill, and was being cross-examined by videolink, in English (not his first language). Perhaps for those reasons, or perhaps because of a lack of impartiality, his responses in this one area did not seem wholly straightforward.

[578] One final study co-authored by Professor Deliens is K. Chambaere et al., “Trends in Medical End-of-Life Decision Making in Flanders, Belgium 1998-2001-2007” (May-June 2011) 31 Med Decis Making 500 [the Chambaere et al. Trends Study]. The objective of this study was to examine trends with respect to the occurrence and decision-making process of end-of-life practices in different patient groups, using the 2007 death certificate study and questionnaire data in comparison with those from similar previous studies.

[579] The authors summarize the trends at 501:

> In 2001, which was a period of intense debate concerning legalization of euthanasia in Belgium, a sharp decline in both euthanasia and lethal drug

> use without explicit patient request was recorded in comparison with 1998. This was probably related to the legalization debate during which legal inquiries into the involvement of physicians and nurses in life-ending acts were undertaken, making physicians more reluctant to carry out such end-of-life practices or to report them. When such acts did take place, physicians conferred more often with patients, nurses, and relatives than they had done in 1998. In 2007, we conducted a third large-scale, population based study to assess the effects of the 2002 legislation on euthanasia, palliative care, and patient rights on end-of-life practices. The study found that the total prevalence of medical end-of-life practices, defined as the administration of drugs or the forgoing of treatment where life shortening was intended or taken into account, had increased considerably to nearly half (47.8%) of all Flemish deaths. Performance of euthanasia had increased from 1.1% in 1998 and 0.3% in 2001 to 1.9% in 2007. The use of life-ending drugs without the patient's explicit request remained stable compared with 2001, at 1.8% of all deaths, whereas the prevalence of intensified alleviation of pain and symptoms (26.7%) and nontreatment decisions (17.4%) had risen significantly since 1998 and 2001. [Footnotes removed.]

[580] Professor Deliens summarizes his conclusions about the results in his affidavit:

> We found that in patient groups in which the prevalence of life-ending drug use without explicit patient request had dropped, performance of euthanasia and assisted suicide had increased. The consistent increase in intensified pain and symptom alleviation was found in all patients groups except cancer patients. In 2007, competent patients were slightly more often involved in the discussion of end-of-life practices than in previous years. Over the years, involvement of the patient in decision making was consistently more likely among younger patients, cancer patients and those dying at home. Physicians consulted their colleagues more often than in previous years for euthanasia and non-treatment decisions. The euthanasia law and emerging palliative care culture have substantially affected the occurrence and decision making for end-of-life practices in Belgium. Efforts are still needed to encourage end-of-life decision making, as some patients would benefit from advance care planning.

[581] The authors conclude that the findings do not suggest a slippery slope in which legalized euthanasia will lead to more LAWER. They say, to the contrary, that legalization of euthanasia in Belgium has led to less LAWER and is likely to have provided a platform for open physician-patient communication on end-of-life issues.

[582] Dr. Ashby, a specialist and Professor of palliative and pain medicine in Australia, states that, provided opinion evidence for the plaintiffs. Based on his review of the empirical evidence available in the peer-reviewed literature and on

personal communications with researchers in Europe, he is of the opinion that the societal harms proposed by opponents of euthanasia and physician-assisted suicide are not substantiated in jurisdictions where the practices are legal. In particular, he does not believe there is evidence that euthanasia without the patient's consent has increased in the Netherlands or Belgium since the changes to the law.

[583] Dr. Ashby attaches the Chambaere et al. Population Study to his affidavit. He opines that the methodology for the collection of data used in the study was sound and appropriate, and that the conclusions that the authors drew were reasonable and supported by the data.

[584] Dr. Bernheim, a retired oncologist and Professor Emeritus of medicine in Belgium, states his opinion with respect to the effectiveness of safeguards in Belgium in his affidavit:

> On the basis of my own empirical research, my review of the data collected by others, my review of the relevant literature and my experience as a medical oncologist, I have reached the following conclusions. The legalisation of euthanasia has enhanced, as opposed to undermined, palliative care. Euthanasia is (in Belgium) an integral component of palliative care. In my opinion, the Belgian law is, in practice, being complied with in terms of limiting the availability of euthanasia to persons meeting the qualifications imposed under the Act and is effectively better protecting the vulnerable in the context of a permissive regime than was the case under the previous repressive regime. In my opinion concerns of the "slippery slope" were understandable and legitimate, but they have been assuaged by the empirical evidence, and – if anything – Belgium has climbed up the "slippery slope" since the legalization and regulation of euthanasia.

[585] He observes that since legalization of euthanasia in Belgium, the overall incidence of the practice has changed little but that the care with which it is carried out has improved markedly (physicians now more frequently discuss such decisions with patients, their relatives, colleagues and nurses), and that the previously relatively high incidence of what he describes as "paternalistic life termination without explicit request" (LAWER) decreased to a larger extent than the extent to which (by definition, voluntary) euthanasia increased. In other words, he says, the major effect of the law was a shift from unrequested to requested assisted dying. In addition, he indicates that the Belgian euthanasia bill was passed together with a

palliative care bill extending palliative care to all hospitals and doubling public funding, and that there has been a marked increase in palliative care practices.

[586] Dr. Bernheim deposes that a review of published historical, regulatory and epidemiological evidence in Belgium indicates that there is no evidence of a slippery slope resulting in harm to vulnerable patients such as the elderly and disabled persons. Further, he says that there is no evidence that euthanasia and palliative care are antagonistic forces nor that legalization of the former has impeded the development of palliative care by appearing as an alternative; rather, there are many indications of reciprocity and synergistic evolution. He also explains that a substantial proportion of Belgian caregivers seem to consider euthanasia as a medical act which, performed with due care, is consistent with their commitment to palliative care.

[587] Dr. Bernheim acknowledges that the studies provide incomplete information on the “still too large minority” of unreported cases, but adds that the situation has improved since 1998 when the research suggested that three-quarters of life terminations were without request and none were reported.

[588] In cross-examination, Dr. Bernheim agreed that the death certificate studies in Belgium did not include information provided by physicians who gave second opinions or by other caregivers, and that the studies had other methodological limitations.

4. Switzerland

[589] Unlike the other European countries which have decriminalized euthanasia or assisted suicide, Switzerland does not have a specific statute on this point. Rather, the matter is governed by the Swiss *Penal Code*, S.R. 311.0. In describing the Swiss legal regime and practice, I rely on the evidence of Dr. Georg Bosshard, Professor Lewis and Professor Shariff.

[590] Euthanasia is not permitted in Switzerland. It is punishable under Article 114 of the *Penal Code* as “death on request”, an offence which carries a lower minimum sentence than murder or manslaughter.

[591] Article 115 of the *Penal Code* provides that “[a]ny person who for selfish motives incites or assists another to commit or attempt to commit suicide shall, if that other person thereafter commits or attempts to commit suicide, be liable to a custodial sentence not exceeding five years or to a monetary penalty.” Thus, assisting a person to commit suicide is not an offence when done for unselfish motives.

[592] Dr. Georg Bosshard explains the implications of Article 115 further:

> As a basis for an open practice of assisted suicide, article 15 is interesting for two reasons. First, it makes no mention of doctors – the legality of assisting suicide, in the absence of self-interest, holds good for any person. Second, there is no mention of any medical precondition. The only prerequisite is implicit; namely, that the individual wanting help to commit suicide must have decisional capacity, since otherwise he would not be “handlungsfähig” (have legal capacity) and his act could not be considered suicide.

[593] Assisted suicides must be reported as unnatural deaths to the local authorities.

[594] There are four right-to-die organizations in Switzerland: EXIT Deutsche Schweiz; EXIT Association pour le Droit de Mourir dans la Dignité; DIGNITAS; and Exit International. (The latter two organizations offer assistance to people who are not resident in Switzerland.) Almost all physician-assisted suicides (92% according to Dr. Bosshard) take place within the frameworks set up by these organizations. Dr. Bosshard describes the regime at EXIT Deutsche Schweiz:

> EXIT Deutsche Schweiz (“EXIT DS”) provides assistance only after an evaluation process which requires that the wish to die is deliberate and stable, the member suffers from a disease with a hopeless prognosis, and the suffering in unbearable or unreasonable disability is present. EXIT DS workers follow a protocol and use a checklist to document what was discussed at the initial visit and all subsequent contacts. Most members who are considered eligible for help are close to death, and EXIT DS routinely recommends both hospice care and notification of the family. Difficult cases

> are referred to EXIT DS's ethics committee for review. Everyone who seeks assisted suicide must be examined by a doctor, who will not prescribe the lethal dose of barbiturates until he or she has assessed the patient's medical condition and decisional capacity. If the member is eligible but their own doctor declines to participate, EXIT DS can refer the member to a collaborating physician who would consider assessing the patient and prescribing the lethal drugs. The prescription will be obtained at a local pharmacy by an EXIT DS volunteer and stored at EXIT DS headquarters until the day of use, when a volunteer will again assess the member's decisional capacity. If the member continues to assert a desire to die, the volunteer will mix the drugs in liquid or food and hand it to the person to swallow. If the person is incapable of swallowing, the drugs can be self-administered through a percutaneous endoscopic gastronomy catheter or intravenously. Most suicides occur in the person's home, with only a few taking place in nursing homes or a dedicated room at EXIT DS in Zurich. At the time of death, the volunteer notifies the police, who attend with a medical officer. Provided that there are no indications that the assistance violated Swiss law, the case will be closed. The body is usually released to coroner at the scene, although the rules and procedures vary between cantons.
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> ...
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> EXIT DS controls quality through screening and training of volunteers, adherence to eligibility and practice guidelines, retrospective review of cases (to review all assisted suicides), and ethics consultations (to deal with difficult cases). It will refuse to provide consultation or support for an assisted death if the person does not meet their eligibility criteria (in which case the person is referred to counselling, hospice or other appropriate agency).

[595] According to Dr. Bosshard, assisted suicide in Switzerland accounted for 0.36% of all deaths in 2001.

[596] Dr. Bosshard co-authored a retrospective analysis of all case files of assisted suicide kept during the 1990–2000 period by EXIT DS, the largest of Switzerland's right-to-die organizations: G. Bosshard, E. Ulrich and W. Bär, "748 cases of suicide assisted by a Swiss right-to-die organisation" (2003) 133 Swiss Med Wkly 310. During this period, EXIT DS assisted in 748 suicides among Swiss residents, or 0.1% of total deaths and 4.8% of total suicides. The data revealed that the deceased were between 18 and 101 years of age, with a mean age of 72 years. Women accounted for 54.4% of the deceased, a significant over-representation in comparison with all other deaths.

[597] Over the ten-year study period, the number of deaths tripled from 110 in the first three years studied to 389 in the last three. This was a highly significant

increase in relation to both total deaths in Switzerland (which remained constant), and total suicides (which decreased slightly over the same period).

[598] In Canton Zurich, EXIT DS assisted in 331 deaths during this period. Of these, 78.9% of the deceased were principally suffering from fatal diseases, particularly cancer but also cardiovascular/respiratory disease, HIV/AIDS and neurological diseases.

[599] The remaining 70 persons (21.1%) had primarily non-fatal diagnoses such as musculoskeletal disorders, chronic pain syndrome and diagnoses such as blindness and general weakness. The wish to die was related to mental disorder in nine cases: eight of depression and one of psychosis. The authors note that 76% of people in the non-fatal diagnosis groups were women. This high proportion cannot be explained simply by their longer life expectancy since amongst the 331 cases the men were older than the women.

[600] In his affidavit, Dr. Bosshard refers to the finding in a recent international study that Swiss doctors carry out euthanasia and termination of life without explicit request of the patient in almost 1% of all deaths, and that the finding “provoked no reaction from Swiss public prosecutors”.

[601] He also opines, on the basis of the data, that all cases of assisted suicide are being reported when right-to-die societies such as EXIT or DIGNITAS are involved.

[602] Under the heading “Exit Deutsche Schweiz on the slippery slope?”, the authors write (at 315-316):

> There was a striking increase – tripling – in the number of Exit deaths over the 11-year study period. However, sociodemographic factors (age, gender distribution) and medical factors (diagnoses) relating the deceased remained relatively unchanged. Since the quality of the records improved, we conclude that this increase stems more from a growing number of requests than from relaxation of the indications for assisted suicide or from progressive laxity in decision-making. Concern remains whether the persistence of the death wish was tested adequately in those cases where the prescribing physician was not the attending or family doctor, particularly when Exit membership was of short duration (sometimes less than a week). Such practice stands in contrast to Emanuel and co-workers’ finding that, among terminally ill patients

> who were seriously considering euthanasia or physician-assisted suicide, half changed their minds over the next few months.

[603] Professor Mishara deposes that the absence of legal controls in Switzerland has resulted in 50% more cases of assisted dying in that country (0.45% of deaths) as compared to the Netherlands (0.3%). Assisted deaths in Switzerland are five times more common than in Oregon; there they account for only 0.09% of deaths.

[604] The intervenor Farewell Foundation for the Right to Die supports adoption of a model similar to that in Switzerland. It emphasizes the benefits of that model which, it says, successfully regulates assisted dying without imposing a general supervisory role on the medical profession.

5. Luxembourg

[605] Euthanasia is treated as a form of murder under Article 397 of Luxembourg's *Penal Code* (Law of 16 June 1879), Mémorial 1879, 589 – Pas. 1879, 231. However, as a result of Art. 397.1, the criminal prohibition does not apply to a physician who has complied with the conditions of the *Law of 16 March 2009 on Euthanasia and Assisted Suicide*, Mémorial A-No. 46, 16 March 2009 [the Luxembourgish Act]. The Luxembourgish Act draws heavily from the Belgian Act. In describing the regime in Luxembourg, I rely on the evidence of Professor Lewis and Professor Shariff.

[606] Article 1 defines both euthanasia and assisted suicide. Euthanasia is an act, performed by a physician, which intentionally ends the life of a person at his or her express and voluntary request. Assisted suicide occurs where a physician intentionally assists a person to commit suicide or provides the means to that end on the person's express and voluntary request.

[607] Pursuant to Art. 2.1, a physician will not prosecuted for euthanasia or assisted suicide where the following conditions are met:

(a) the patient is an adult, capable and conscious at the time of the request;

(b) the request is made voluntarily, after reflection, repeatedly, and is not the result of external pressure;

(c) the patient suffers constant and unbearable physical or mental suffering without hope of recovery, arising from a pathological illness or accident; and

(d) the request is in writing.

[608] Article 2.2 requires the physician to comply with following conditions of form and procedure:

(a) Inform the patient of his or her condition and life expectancy, and discuss with the patient his or her request for euthanasia and the therapeutic measures which could still be considered, including the availability and consequences of palliative care. The physician must believe that, in the patient's view, there is no other acceptable solution. These conversations must be recorded in the patient's medical file.

(b) Ensure the persistence of the patient's suffering and of his or her request. To this end, the physician will conduct several interviews with the patient at reasonable intervals.

(c) Consult with another physician, independent of both the patient and the treating physician, and competent in regards to the patient's condition. The consulting physician will review the medical file, examine the patient, confirm the patient's suffering, and prepare a report to this effect. The treating physician will inform the patient of the outcome of this consultation.

(d) Discuss the patient's request with the patient's medical team unless the patient opposes.

(e) Discuss the patient's request with people designated in his or her living will unless the patient opposes.

(f) Ensure the patient has the opportunity to discuss his or her request with those persons he or she wishes.

(g) Ascertain whether the patient has registered an “end of life provision” with the National Control and Assessment Commission.

[609] If a patient in a state of irreversible unconsciousness and suffering from a serious and incurable condition has drafted and registered an “end of life provision” with the National Control and Assessment Commission (“NCAC”), a physician may provide euthanasia to the person (Article 4.3).

[610] Physicians must submit a registration document in the appropriate form to the NCAC within four days of performing euthanasia (Article 5). The NCAC is composed of nine members including physicians (including one specialized in pain management), legal professionals and members representing organizations defending patients’ rights. The NCAC will determine whether the conditions of the Luxembourgish Act have been met. If it rules by a two-thirds majority that the physician has not complied with the due care requirements, it will notify the Medical College. Where it rules that the physician has not complied with the requirements of Article 2.1, it will notify the public prosecutor.

[611] The NCAC prepares a biennial report.

[612] Article 15 states that no physician no physician may be compelled to perform euthanasia. Should the physician consulted refuse to perform euthanasia, then he or she must inform the patient of this fact within 24 hours, and explain his or her reasons for refusing.

6. Montana

[613] While Montana has not legalized assisted suicide, its Supreme Court has recognized that the consent of a terminally ill patient can constitute a statutory defence to a charge of homicide against an aiding physician. Evidence concerning

the legal status of assisted death in Montana was provided by Mark Connelly, a lawyer in Montana, and Professor Shariff.

[614] In *Baxter v. Montana*, a terminally ill man, four physicians and a non-profit organization challenged the constitutionality of the application of Montana's homicide statutes to physicians who provide aid in dying to mentally competent, terminally ill patients. The District Court held that under Montana's *Constitution*, a competent, terminally ill patient had the constitutional right to die with dignity based on the rights to dignity and privacy (Cause No. ADV-2007-287 (Montana First Judicial District Court), Decision and Order 5 December 2008). The District Court further held that none of the state interests advanced by Montana was sufficiently compelling or narrowly tailored to justify the limitation of that right. These interests included preserving human life, protecting vulnerable groups from potential abuses, and protecting the integrity and ethics of the medical profession.

[615] While the District Court found the homicide statutes to be unconstitutional as they applied to terminally ill patients and their physicians, it concluded that implementation of the right to death with dignity and medical assistance was properly left to the legislature.

[616] On appeal, the Montana Supreme Court affirmed the result but vacated the District Court's ruling on the constitutional issues (2009 MT 449). The Supreme Court found as a matter of statutory interpretation that there was nothing in Montana statutes or jurisprudence indicating that physician assistance in dying was against public policy. It held that a terminally ill patient's consent to physician assistance in dying constituted a statutory defence to the charge of homicide against the aiding physician when no other consent exceptions apply.

[617] The Supreme Court's ruling represents the current state of the law in Montana, according to Professor Shariff.

7. Colombia

[618] I draw on the evidence of Professor Sabine Michalowski, a Professor of law, with respect to Colombia.

[619] As a result of a May 1997 decision of Columbia's Constitutional Court (Sentencia C-239/97), assisted death is permitted so long as it is performed by a medical professional with the consent of a patient who is experiencing intense suffering as a consequence of a terminal illness. Mercy killing remains an offence if these conditions are not met. The penalty for mercy killing is considerably lower than that of other homicides.

[620] The Constitutional Court in its decision urged Congress to enact legislation to regulate assisted death in line with the constitutional principles developed in its decision and provided recommendations to that end. This has yet to happen. In 2006, a bill to this effect was introduced but subsequently withdrawn when it became clear that it would be rejected.

C. Impact of Legal Physician-Assisted Dying on Vulnerable Populations

[621] In the preceding sections, I have described a few of the many studies which have been undertaken to assess different aspects of the physician-assisted dying regimes in those jurisdictions that permit the practice. Because of the issues in this case, one particularly relevant study is M.P. Battin et al., "Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on 'vulnerable' groups" (2007) 33 J Med Ethics 591 [the "Battin et al. Study"]. This study squarely addresses whether legalized physician-assisted dying places vulnerable groups at risk. As I have noted, it is Canada's position that no measures short of a blanket prohibition against assisted dying are sufficient to protect vulnerable individuals, including the elderly and persons with disabilities.

[622] Of the co-authors of this study, both Professor Battin and Dr. Ganzini provided evidence tendered by the plaintiffs in this proceeding; the other three co-authors are Dutch epidemiologists.

[623] Battin et al. refer to the warnings about potential abuse given by many task forces, courts and medical organizations. They say that concerns about the practice of physician-assisted death disproportionately affecting vulnerable groups must be taken seriously, not only because of the frequency with which these concerns are raised, but also because of their gravity. To assess these concerns, the authors examined data from Oregon and the Netherlands with an eye to determining "whether there is evidence that where assisted dying is already legal, the lives of people in groups identified as vulnerable are more frequently ended with assistance from a physician than those of the background population" (at 592).

[624] The groups upon which Battin et al. focussed are those which are usually identified as vulnerable in the public, political and professional debates over physician-assisted dying: the elderly; women; uninsured persons; persons with AIDS; persons with low educational status; the poor; racial and ethnic minorities; persons with physical or mental disabilities or chronic non-terminal illnesses; minors and mature minors; and persons with psychiatric illnesses, including depression.

[625] The authors examined the Oregon data from the annual and cumulative Department of Human Services reports for the 1998-2006 period, and three independent surveys of Oregon physicians and hospice professionals. (The Department of Human Services reports include all legal cases reported under the *ODDA*.) The Dutch data came from the national death certificate studies for 1990, 1995, 2001 and 2005, as well as from a number of smaller, focused Dutch studies.

[626] Battin et al. conclude on the basis of these data that, with one exception, the rates of assisted dying in both Oregon and the Netherlands show no evidence of heightened risk to any of the identified vulnerable groups as compared with background populations. People with AIDS are the only group that exhibited a heightened risk. Professor Battin suggests in her affidavit that an explanation for that heightened risk may be found in the fact that the data largely predate the development of highly active antiretroviral therapies that substantially minimize the likelihood of death from AIDS.

[627] With respect to the elderly, the authors explain that 10% of patients who died by physician-assisted suicide were 85 or older, whereas 21% of all deaths in Oregon were among persons in this age category. Persons aged 18-64 were over three times more likely than those over 85 to receive assisted dying. With respect to the Netherlands, they write that rates of assisted dying were lowest among people over 80 (0.8% in 2005), next lowest in the age range 65-74 years (2.1%) and higher below 65 (3.5%). Individuals over 80 comprised 30% of the group of patients whose requests were refused and 13% of those whose requests were granted and carried out.

[628] As for individuals with pre-existing non-terminal physical disabilities or chronic non-terminal illnesses, the authors note that the Oregon data do not specifically indicate whether a person had a disability before becoming terminally ill. Nevertheless, they point out that no one received assisted dying under the *ODDA* who was not determined by two physicians to be terminally ill; that is, no one received such assistance for disability alone.

[629] As previously explained, terminal illness is not required under the Dutch Act, and an individual who faces unbearable suffering, in his own view, and who has been offered all forms of treatment but has no hope of improvement may request assistance in dying. The authors used physicians' estimates of the amount of life foregone as an approximation of disability or chronic illness status, and found that approximately 0.2% of patients who received assistance were estimated to have foregone more than six months of life; this was less than 10 of the approximately 2,400 assisted dying cases in 2005. They also state that Dutch general practitioners infrequently grant and frequently refuse assistance in dying to patients whose diagnosis is “old age/general deterioration” or “other”; this latter category includes patients with no terminal illness and no ALS or multiple sclerosis. The authors conclude that there is thus no evidence that physician-assisted dying poses heightened risk to people with disabilities who are not also seriously ill.

[630] With respect to individuals with psychiatric illness, including depression, the study found that approximately 20% of requests for death under the *ODDA* were from depressed patients but that none progressed to physician-assisted dying. None of the 292 patients who died under the *ODDA* was determined to have a mental illness influencing his or her decision, though there have been three disputed cases among the nine-year total of 456 patients who received prescriptions. The authors acknowledge the following limitation with respect to this aspect of the study (at 596):

> Because not all patients who requested assistance were specifically evaluated by mental health professionals and because many cases of depression are missed in primary care, it is possible that some depressed patients received lethal prescriptions; it is also possible that a patient without a mental disorder at the time of receiving the prescription became depressed by the time they ingested it. There is, however, no direct evidence that depressed patients are at higher risk for receiving assistance in dying under the ODDA.

[631] As for the Netherlands, about two-thirds of explicit requests for assistance in dying are not granted. Accordingly to the 1995 study, in 31% of all requests not granted, the physician gave the presence of psychiatric illness as at least one reason for not complying. Physicians in the interview portion of the 1995 study mentioned depression as the predominant symptom of patients who died with physician assistance in 3% of all cases, compared with “loss of dignity” in 60%, pain as an associated complaint in 45% and debility in 43%.

[632] Battin et al. cite one study in which cancer patients with depressed mood were four times more likely to request euthanasia: M.L. Lee et al., “Euthanasia and depression: a prospective cohort study among terminally ill cancer patients” (2005) 23 J Clin Oncology 6607. However, that study did not address how often the request was granted. (Dr. Kimsma also refers to this study in his evidence.)

[633] The authors of the Battin et al. Study indicate that in the 2001 Dutch national death certificate study, about 3% of all requests for physician-assisted dying in the previous year were from patients with predominantly psychiatric or psychological illness, but that none of those was granted. In the 1995 Dutch nationwide sub-study

on end-of-life decision-making in psychiatric practice, there appeared to be about two to five physician-assisted deaths on request per year, mostly, but not always, in patients with a concurrent serious illness, often in the terminal phase.

[634] In her affidavit, Dr. Ganzini states that although “extralegal cases” (those performed contrary to legal requirements) were not the focus of the study, none was uncovered in Oregon, and among extralegal (LAWER) cases in the Netherlands, there was no evidence of higher rates in vulnerable groups,

[635] Battin et al. offer this conclusion (at 597):

> Thus, we found no evidence to justify the grave and important concern often expressed about the potential for abuse – namely, the fear that legalised physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups. The evidence available cannot provide conclusive proof about the impact on vulnerable patients, and full examination of practice in Oregon would require studies of the complexity, duration and comprehensiveness of the four Dutch nationwide studies. Nevertheless, the joint picture yielded by the available data in the two jurisdictions shows that people who died with a physician’s assistance were more likely to be members of groups enjoying comparative social, economic, educational, professional and other privileges. This conclusion does not directly speak to the moral issues in physician-assisted dying; it does not argue whether physician-assisted dying would be more or less appropriate for people in some groups; and it does not show that people in vulnerable groups could not be disproportionately affected in the future or in other jurisdictions. It also does not show whether low rates of physician-assisted dying among vulnerable persons reflect a protective effect of safeguards or, rather, are evidence of unequal access to assistance. But it does show that there is no current factual support for so-called slippery-slope concerns about the risks of legalisation of assisted dying – concerns that death in this way would be practised more frequently on persons in vulnerable groups.

[636] In 2008, Professor Battin updated the data and affirmed the conclusions in the Battin et al. Study in a further, more detailed article (“Physician-Assisted Dying and the Slippery Slope: the Challenge of Empirical Evidence” (2008) 45 Willamette L Rev 91).

[637] The Battin et al. Study has been the subject of criticism, including by Canada’s witness, Baroness Finlay. Baroness Finlay co-authored a critique with Professor Robert George entitled “Legal physician-assisted suicide in Oregon and

the Netherlands: evidence concerning the impact on patients in vulnerable groups – another perspective on Oregon's data" (2001) 37 J Med Ethics 171. As the title suggests, the critique focussed on the findings with respect to Oregon, and called into question both the study's methodology and its conclusions. Among the primary criticisms were that Professor Battin et al.'s conclusion regarding the elderly is at variance with official OHD data. The authors argue that the traditional threshold for old age is 65, and 85 is far too high to use as the beginning of old age. They say that 12 OHD annual reports issued between 1998 and 2009 show that of the 460 individuals who died under the *ODDA* during this period, 314 (68%) were aged 65 or older; 146 (31.7%) were aged between 18–64. The median age was 71.

[638] Another problem they see with the study is methodological. Since death rates from other causes are naturally high among people aged 85 or older, it follows that almost any rate of physician-assisted dying in this age bracket is likely to show as proportionately less.

[639] The authors argue that the Battin et al. Study looks at socioeconomic categories which are of questionable relevance to vulnerability in end-of-life decision-making. In this context, communication difficulties, having unrelated symptoms, being socially undervalued, and other similar factors are a better gauge of vulnerability.

[640] Finally, on the crucial issue of depression, they write that more recently published research indicates that some patients in Oregon had depression at the time they were assessed and their request was granted under the *ODDA*. Moreover, OHD data show a decrease in psychiatric and psychological assessments under the *ODDA* to zero or near zero in recent years.

[641] Dr. Pereira endorses Baroness Finlay and Professor George's challenge to the Battin et al. Study.

[642] Professor Battin et al. published a letter in reply to this critique, "Legal physician-assisted dying in Oregon and the Netherlands: The question of

‘vulnerable’ groups. A reply to I.G. Finlay and R. George”, (27 July 2011) J Med Ethics <http://jme.bmj.com>. The researchers argue that nothing in the critique undercuts the proposition that there is no current evidence for the claim that physician-assisted dying has a disproportionate impact on patients in vulnerable groups in permissive jurisdictions.

[643] With respect to the elderly, the Battin et al. researchers maintain that the data included in the initial paper in fact support their claim that there is no evidence of heightened risk with respect to this group.

[644] As for the identification of the vulnerable groups, they explain that the particular groups were chosen not because of assumptions about vulnerability, but because concerns about those groups play such a prominent role in the public debate regarding physician assistance in dying.

[645] While the focus of their study was not on whether people might seek physician assistance in dying for the “wrong” reasons, such as disturbed emotional states or reactions to loss, Battin et al. say that their paper does indirectly address some of these concerns; for instance, through the examination of rates of assisted dying in cases of depression and in other cases which might be associated with distressed emotional states. They say that rates of depression are elevated in people seeking assistance in dying but may not be elevated in those who actually receive such assistance.

D. Analysis of the Evidence about Effectiveness of Safeguards

1. What level of compliance have the permissive jurisdictions achieved with respect to their safeguards?

[646] The defendants suggest that there are problems with important aspects of compliance and that the objectives of the safeguards in the Netherlands, Oregon, and Belgium are not being met.

[647] What conclusions can be reached about the level of compliance with safeguards in the three jurisdictions that have been most studied? Although the

record is extensive, it is not exhaustive. The data do not permit firm conclusions about certain matters, as is apparent in the evidence of one of the plaintiffs' witnesses, Professor Lewis. Further, independent analysis of the data beyond that which the expert witnesses have undertaken is not possible.

[648] Having said that, I am able to reach some conclusions, based on the testimony of the expert witnesses and the data that they considered.

[649] On their own, the data collected by the OHD do not support very strong conclusions about compliance with some of the safeguards in Oregon. The data largely depend upon self-reporting by physicians, and certain information (such as whether multiple "second opinions" were sought) is not available. As well, doubts exist about full compliance with the requirement for referral to a mental health professional of patients suffering from a psychological or psychiatric disorder or depression causing impaired judgment.

[650] Supplementing the publicly collected data from the self reports by physicians, however, are: the studies conducted by Dr. Ganzini, which involved surveys of physicians that received a healthy response rate; the Starks research; and the Battin et al. Study, which involved not only the OHD data but also three independent surveys of Oregon physicians and hospice professionals. As well, persons who work within the Oregon system, such as Ms. Jackson, Mr. Eighmey, Mr. Renaud and Dr. Bentz, have provided opinion evidence.

[651] Dr. Ganzini and Professor Battin are impressive, respected researchers, who have both made a long-term study of the ethics, and risks, of assisted suicide and euthanasia. Each of them was cross-examined before the Court. Professor Battin testified that, although she is a philosopher and ethicist, not an epidemiologist, her collaborators in the Battin et al. Study were highly qualified empirical researchers and that the analysis they conducted was rigorous. As a positive indicator of Dr. Ganzini's objectivity, I note her evidence that she has changed her view about best practices with possibly depressed patients who request assisted death.

[652] I accept that the opinions of Dr. Ganzini and Dr. Battin were based on the evidence and that they had analyzed that evidence very carefully. I also found Dr. Starks's evidence to be carefully and fairly presented, and I accept it.

[653] However, the anecdotes related by Dr. Bentz and Dr. Hendin and the Ganzini Depression Study show that the safeguards cannot be assumed to be 100% effective. My review of the evidence suggests to me that the following summary by Professor Starks is fair with respect to Oregon – the process is working fairly well but could be improved, including with respect to oversight:

> The publically-available annual reports – that I (and possibly Dr. Pereira) rely on for assessments of the laws as citizens and researchers – suggest that overall, the process is working pretty well. As with any system, there is room for quality improvement and I am the first to embrace changes that would strengthen oversight and the capacity to improve the process for patients, providers, families, policy makers, critics and advocates.

[654] In both the Netherlands and Belgium, where there has been extensive documentation and research, the data are much more detailed and complete.

[655] In the Netherlands, the studies over the years show that there is now much greater compliance than there was pre-legalization with the requirement to report cases of euthanasia; 80% of cases were reported in 2005, up from 18% in 1990. Cases of LAWER continue (thus, cases in which there is non-compliance with the requirement for express request in writing, and possibly with other requirements). The trend is that LAWER cases are declining in numbers (from 1,000 in 1990 to 550 in 2005), although it is important to note that the number of LAWER cases prior to law reform is unknown. Professor Lewis suggests that since 99% of cases involving typical euthanasia drugs are reported, mislabelling by physicians may explain most unreported cases: some physicians do not label death following the administration of other drugs (e.g. morphine) as euthanasia. Dr. van Delden gives similar evidence in this regard.

[656] The evidence supports the conclusion that the compliance with the safeguards in the Netherlands is continually improving, but that it is not yet at an ideal level.

[657] In Belgium there are still low rates of reporting (only approximately 53% of presumed cases of euthanasia were reported in 2007) and high rates of LAWER. However, Professor Lewis's evidence is that the number of LAWER cases has declined since legalization of assisted death.

[658] The defendants argue that what the data show is that increased enforcement of the laws in Belgium, during a time when legal change was being debated, caused the rates of LAWER to decline; the rate dropped from 3.2% in 1998 (prior to the political and social debate surrounding legalization of euthanasia) to 1.5% (mid-debate) in 2001 and then rose again (post-legalization) to 1.8% in 2007. Professor Deliens, on the other hand, emphasizes the comparison between pre-legislation and the present day, and says that an increase from 1.5% to 1.8% lacks statistical significance in the context of these data.

[659] The low rate of reporting in Belgium may have a similar explanation to that suggested above with respect to the Netherlands. I also note that the Smets et al. Reporting Study indicates that physicians who perceive their case to constitute euthanasia report 93.1% of the time. Dr. Bernheim's evidence, giving the opinion that the legislative change in Belgium has improved the carefulness of end-of-life practice, and Professor Deliens's evidence to similar effect, is persuasive.

[660] The evidence suggests that in some measure the impetus toward permissive legislation in the Netherlands and Belgium came from the desire to achieve better understanding, and regulation, of practices of assisted death that were already prevalent and embedded in the medical culture. Looked at in that light, the law reforms in both jurisdictions have made considerable progress in achieving their goals.

2. Do the safeguards effectively prevent abuse of vulnerable individuals?

[661] Professor Battin's opinion with respect to the efficacy of safeguards is captured in this statement:

> In the past, debates about the risks and benefits of legalization have been based on theory and conjecture. However, we now have years of empirical knowledge about the effects of legalization in Oregon and the Netherlands in practice. The empirical data collected from these jurisdictions demonstrates that a legal process can be contained. The empirical data demonstrates that no or little substantive abuse has occurred. None is reported in Oregon, and much, much less than has been claimed occurred in the Netherlands. In my opinion, the opposition to legalization of physician-assisted dying based on "slippery slope" arguments that predict wholesale abuse of assisted dying legislation is utterly unfounded; the objective data available from jurisdictions where legalization has taken place simply do not support these predictions. Further, in my opinion, opponents' presentation of data from Oregon and Netherlands is generally incomplete, frequently filled with factual inaccuracies and distortions, and often meant to construct a false empirical foundation for what is essentially a moral opposition to the practice of physician-assisted death.

[662] With respect to the Netherlands and Oregon, the Battin et al. Study provides evidence (with varying degrees of strength) that the availability of assisted death in those jurisdictions has not inordinately impacted persons who might be seen as "socially vulnerable": elderly, female, uninsured, of low educational status, poor, members of racial or ethnic minorities, physically disabled or chronically but non-terminally ill, minors or mature minors, or psychiatrically ill (including depression). Their data show that people with AIDS exhibit a heightened risk, but the data pre-date the development of highly active antiretroviral therapies.

[663] The study, however, does not address the question of persons who are "situationally vulnerable" due to the factors identified by Baroness Finlay, such as: personality, emotional distress, untreated symptoms, coercion or the desire not to be a burden.

[664] The Battin et al. Study was also criticized by some of the defendants' witnesses. Dr. Pereira spoke from his deep and sincere conviction that assisted death is wrong and unnecessary in the light of the availability of modern palliative

care. He was straightforward but he did not have the benefit of having conducted empirical research of his own; he basically relied on the work of others, including that of Baroness Finlay. She is a very well-respected palliative care physician who has taken a leading role in the debate about assisted suicide and euthanasia in the United Kingdom. So far as I am aware, she and her collaborators in the critique have not themselves conducted an empirical study. Dr. Hendin is a psychiatrist and a leader in suicide prevention, but has not done the same kind of empirical work. Further, his testimony on cross-examination, and his passion on the topic, left me in some doubt as to his impartiality.

[665] I have carefully reviewed the critique made by Baroness Finlay and others of the Battin et al. Study, and I find that the study withstands that critique.

[666] I have considered the study, the critique and the cross-examinations, as well as other evidence (such as that of Ms. Jackson, Dr. Bentz and others) bearing on whether the experience in Oregon and the Netherlands supports the fears of those who argue that the availability of consensual assisted death will lead to the imposition of assisted death on vulnerable persons.

[667] I accept that the conclusions stated in the Battin et al. Study are soundly based on the data. I find that the empirical evidence gathered in the two jurisdictions does not support the hypothesis that physician-assisted death has imposed a particular risk to socially vulnerable populations. The evidence does support Dr. van Delden's position that it is possible for a state to design a system that both permits some individuals to access physician-assisted death and socially protects vulnerable individuals and groups.

[668] No conclusion can be drawn from that study with respect to situational vulnerability. However, there is some evidence bearing on that question.

[669] First, depression is a factor that may enter into decision-making about assisted death. Although many patients are screened out because of depression, Dr. Ganzini acknowledges that it is virtually impossible to guarantee that a person

whose decisional capacity is affected by depression will not slip through the safeguards designed to reduce that risk.

[670] It seems unlikely that persons suffering from Major Depressive Disorder or depression causing impaired judgment would both have the persistence and will-power to work their way through the approval process for assisted death, and escape detection by the reviewing physicians. However, the evidence (from the Ganzini Depression Study) suggests that up to three persons in Oregon may have done so.

[671] Second, patients may have received assistance in death after experiencing subtle or overt pressure, facing unconscious suggestions by caregivers that their circumstances are hopeless, or sensing that they are a burden on their families. It is impossible to know from statistical evidence whether this has occurred, or how often. However, the evidence from both Oregon and the Netherlands about actual decision-making practices does not support the conclusion that pressure or coercion is at all wide-spread or readily escapes detection. Dr. Ganzini, for example, who studied the decision-making process, said that the involvement of family members was usually to try to dissuade rather than persuade patients from seeking assisted death. That most patients in Oregon are in hospice care and that the decision-making process in the Netherlands involves extensive deliberation with a long-term family physician suggest that it is unlikely that many patients successfully obtain a physician-assisted death because of outside pressure to do so. The incidents referred to by Dr. Hendin and others cannot be disregarded, but, on my reading of the evidence, are highly isolated.

[672] With respect to Belgium, it is difficult to reach any firm conclusion. In cross-examination, Professor Deliens acknowledged that patients who do not have a psychiatric disorder but who have some level of depression might be vulnerable to being euthanized. He also acknowledged that patients with cognitive impairments such as dementia might be vulnerable. However, I note Professor Deliens's evidence that the Chambaere et al. Population Study does not show elderly patients

or patients dying of diseases of the nervous system (including dementia) to be proportionately at greater risk of LAWER than other patient groups.

3. What inferences can be drawn with respect to the likely effectiveness of comparable safeguards in Canada, given different cultural contexts?

[673] I will discuss in the next section of these Reasons the feasibility, in general terms, of safeguards based upon the application of criteria such as a patient's competence and the voluntariness of a request for physician-assisted death. At this point, however, having spent some time reviewing the evidence about the experience in permissive jurisdictions, I will note some of the reasons why it is necessary to be cautious about drawing inferences for Canada.

[674] The utility of considering the experience in other jurisdictions depends upon whether there are sufficient similarities between those jurisdictions and Canada to permit inferences to be drawn.

[675] Oregon, Washington, the Netherlands and Belgium are all relatively prosperous Western democracies.

[676] However, though Oregon and British Columbia are geographically proximate, their cultural contexts and methods of health care delivery differ in some ways.

[677] The evidence suggests that palliative care practices in Oregon differ from those in Canada. According to Dr. Ganzini, hospice care is delivered in patients' homes in Oregon. The evidence of Dr. McGregor and Carolyn Tayler (the Director, Clinical Programs End of Life Care for Fraser Health Authority) is that such care, in British Columbia at least, is provided in a broader range of settings, whether in the home, in hospitals, in hospice or in residential care. However, I do not view the differences between Oregon and British Columbia, including the differing ways of delivering palliative care, as very significant in this specific context. Indeed, it may be easier to achieve compliance when most palliative care patients are in an institutional setting (permitting greater monitoring) rather than in their homes.

[678] The overall practice of medicine is different in the Netherlands and in Belgium than in Canada, with a much greater likelihood in those countries that a patient will have a long-term relationship with a family physician. I do view that as a significant difference, and will return to it in the next section of these Reasons when discussing assessment of competence and voluntariness.

[679] One of the striking aspects of the evidence is that the practice of what could be called non-voluntary euthanasia (LAWER) continues in both the Netherlands and Belgium. Dr. Hendin, in his cross-examination, suggested that a possible explanation is that there is little or no enforcement of the law against it, and physicians have a strong position in those cultures, such that they feel able to disregard the law. He opined that it is different in the United States, including in Oregon. As well, in the Netherlands, the judicially-developed defence of necessity continues to apply to some cases of euthanasia.

[680] The evidence suggests (I refer to Dr. Kimsma, Professor Deliens and Dr. Bernheim) that the practice of physician-assisted death existed for some years prior to the euthanasia debate in the Netherlands and in Belgium. There is no evidence suggesting a comparable history in Canada. Indeed, it appears that, with very few exceptions, Canadian medical practitioners are compliant with the current absolute legal prohibition of assisted death, suggesting that physicians would also be compliant with any regulatory regime concerning the practice. Thus, it seems particularly problematic to draw inferences about the likely level of compliance with legislated safeguards in Canada from evidence about Belgium and the Netherlands. In other words, the evidence about non-compliance and LAWER in Belgium and the Netherlands may not tell us much about what would happen in Canada if physician-assisted death were made legal. This is because, in Canada, it would not be a question of attempting to regulate a pre-existing and fairly prevalent practice.

[681] It must also be recognized that the way that regulations are drawn will affect their effectiveness and enforceability. For example, in Oregon, the regulation prohibits issuing a prescription if the patient may be suffering from a psychiatric or

psychological disorder or depression <u>causing impaired judgment</u>. Dr. Ganzini's evidence suggests that a more cautious approach would have been to prohibit lethal prescriptions for anyone who is depressed, without qualification.

[682] Overall, the evidence permits the following conclusions.

[683] First, cultural and historical differences between the Netherlands and Belgium, on the one hand, and Canada on the other, mean that possible concerns about the level of compliance with legislation in those countries do not necessarily transpose into concerns about Canada. The experience of compliance in Oregon is more likely to be predictive of what would happen in Canada if a permissive regime were put in place, although even there only a weak inference can be drawn.

[684] Second, the expert opinion evidence from persons who have done research into the question is that, with respect to all three jurisdictions, the predicted abuse and disproportionate impact on vulnerable populations has not materialized. Again, inferences for Canada can only be drawn with caution.

[685] Third, although none of the systems has achieved perfection, empirical researchers and practitioners who have experience in those systems are of the view that they work well in protecting patients from abuse while allowing competent patients to choose the timing of their deaths.

E. Impact on Palliative Care

[686] A number of the defendants' experts express their concern that legalization of physician-assisted dying will impede the further development of palliative care. Dr. Pereira, for instance, deposes that legalization would jeopardize attempts to train more professionals in palliative care and to increase palliative care resources. Dr. Sheldon and Dr. Bereza both advert to the pressures on resources in the health system. Dr. Bereza questions whether those pressures might lead to an irresistible temptation to view physician-assisted death as a more cost-effective and efficient way of dealing with frail, vulnerable or disenfranchised people, a concern that is also reflected in Dr. Sheldon's evidence. Dr. Chochinov refers to the fact that only a

minority of Canadians have access to comprehensive quality end-of-life care, and opines that "[d]esigning a system that will accommodate a request for hastened death but does not assure attentiveness to the various sources of suffering that can undermine patients' will to live makes little sense". Baroness Finlay expresses her concern that patients may choose a physician-assisted death without ever becoming aware of the complex, holistic aspects of palliative care and the improved experience, reality and support that palliative care may provide.

[687] The evidence, the defendants say, supports concerns that if physician-assisted death is legal, physicians' attention will be diverted from providing therapeutic counselling, comfort and care to their patients, confusion about palliative care (that it includes killing patients) will be generated, and our society's will to invest money and resources in palliative care will be weakened.

[688] In response, the plaintiffs say that the evidence does not bear out these concerns. In particular, they say that the evidence shows that physicians' care for terminally ill patients in permissive jurisdictions improved following legalization. They also say that there is no evidence that permitting physician-assisted dying would exacerbate misconceptions about palliative care, and may in fact provide a needed opportunity for education. They submit that physician-assisted dying and palliative care are complementary.

[689] The Province placed extensive evidence before the Court regarding the palliative care system in British Columbia.

[690] According to Heather Davidson, British Columbia's Assistant Deputy Minister of Health, this province's framework for end-of-life care is based on an integrated approach of providing care to individuals that takes into account their fluctuating and changing needs as they approach the end of life. This integrated approach is designed to provide a range of options to individuals, in terms of settings and caregivers, that will support their quality of living and assist in facilitating a meaningful, comfortable death in the most appropriate setting.

[691] Dr. McGregor, a palliative care specialist and Regional Medical Director, Palliative Care for Vancouver Coastal Health, estimates that 15% of British Columbians die at home, 24% in residential care facilities, 12% in hospices and 47% in hospital. There is no charge for most hospice palliative care services, although there is a daily fee for in-hospice care. The BC Palliative Care Benefits Program will also cover most pharmaceutical prescriptions at home or in a hospice setting if a patient is deemed by his attending physician to have a life expectancy of six months or less.

[692] While the province exercises a superintending and policy role, actual health services are provided by five regional health care authorities. Dr. McGregor explains that each of the five health authorities in the province has developed, and is further developing, primary care and specialized services to meet the needs of the end-of-life population.

[693] According to Dr. McGregor, the Vancouver Coastal Health Authority delivers hospice palliative care services to patients in their homes, hospital, hospice and residential care facilities.

[694] Dr. McGregor explains that most ill patients who are expected to die within six to 12 months receive the majority of their care through primary care and community services. Home and community care teams (which are provided and structured by the Health Authority) are able to provide a range of health care and support services in patients' homes. In addition to care from their family physicians, patients eligible for home and community care may receive home visits from nurses, occupational therapists and physiotherapists, nutritional consultants, and community health workers.

[695] Included in primary care and community services are residential care facilities and hospices. There are approximately 6,000 residential care facility beds in the Vancouver Coastal Health region, and approximately 50 hospice beds in the province. Dr. McGregor testified that the waiting list for a residential care bed is

usually three or four days. In Vancouver, 99% of patients are admitted to their first choice of hospice.

[696] Specialized palliative care services are provided in four dedicated acute hospital palliative care units, as well as through outreach consulting to any other unit in the hospital where patients require such care. There is an emphasis on interdisciplinary teamwork.

[697] Dr. McGregor explains that at any given time, the needs of approximately 65% of individuals requiring end-of-life care and support can be met in primary care services in the community; 20% can have their needs met in the community but require some input from specialist palliative care services; and 15% need specialist, often in-patient, services beyond the scope of practitioners with standard training.

[698] Carolyn Tayler, the Director, Clinical Programs End of Life Care at the Fraser Health Authority, describes the Fraser Health Authority's End of Life Program. In brief, that program builds on community-based models, and has shifted the focus of service delivery away from stand-alone acute palliative care units to an integrated continuum of care that includes the home, residential care, hospice and acute/tertiary care.

[699] Vancouver Island Health Authority's Victoria Hospice is an internationally recognized centre for expertise in palliative pain and symptom management, education and research in palliative care. Dr. Downing, a palliative care physician and Research Director at Victoria Hospice, describes the facilities and services that facility offers and delivers by interdisciplinary teams of palliative care physicians, nurses, social workers/psychologists, spiritual advisors, pharmacists, personal support workers and volunteers. The Hospice provides palliative care services within its 17-bed unit in the Royal Jubilee Hospital, in patients' homes and as specific medical consultation to patients in other health care facilities.

[700] Dr. Downing describes what palliative care services may entail, and the Australian Palliative Approach model, which has three levels: primary, intermediate

and complex care. He deposes that serious deficiencies can occur at any of the three levels due to limited funding, training or expertise. He further states that:

> Thus, while the field of palliative medicine as a specialty is growing, and there are an increasing number of clinicians interested in this as an area of practice, there are still, in Canada and British Columbia, an insufficient number of professionals in all disciplines to provide optimal palliative care to all individuals who need it. Also, the range of palliative care services in Canada remains highly variable, both in terms of the availability of services and access to the comprehensive expertise of palliative care providers. Cost pressures for palliative care services do exist and will only increase with the aging population and increasing numbers of people who require end of life services. Good palliative care is complex, holistic and time-consuming. However, public funding of palliative care services is increasing and models of palliative care are being researched and developed in order to ascertain better ways for high quality palliative care to be integrated into the health system, efficiently and economically.

[701] Various Senate and Parliamentary committees have examined the challenges facing the delivery of palliative care in Canada. The Senate Subcommittee established to examine progress in implementing the recommendations made in the Special Senate Committee Report, tabled its report in June 2000: Standing Senate Committee on Social Affairs, Science and Technology, *Quality End-of-Life Care: the right of every Canadian* (Chair: Sharon Carstairs) [the Senate Subcommittee Report]. As its title makes clear, the Subcommittee concluded that quality end-of-life care, including adequate pain and symptom control, appropriate use of life-sustaining treatments, and support for patients and their families, is an entitlement of all Canadians:

> Quality end-of-life care must become an entrenched core value of Canada's health care system. Each person is entitled to die in relative comfort, as free as possible from physical, emotional, psychological, and spiritual distress. Each Canadian is entitled to access skilled, compassionate, and respectful care at the end of life. This Subcommittee sees care for the dying as an entitlement for all.

[702] While concluding there had been some movement on the issue, the Subcommittee found that overall there had not been sufficient progress in implementing the palliative care recommendations from the Special Senate Committee Report, and recommended that the federal government, in collaboration

with the provinces, develop a national strategy for end-of-life care and a five-year plan for its implementation.

[703] Senator Carstairs tabled two further reports on palliative care in Canada, in June 2005 and June 2010 respectively. *Still Not There: Quality End-of-Life Care: A Progress Report* (Ottawa: Senate Canada, 2005) (Tabled in Senate, *Journals of the Senate*, 38th Parl., 1st Sess., No. 66 (2 June 2005)) highlighted the progress that had been made since the Senate Subcommittee Report, but also called attention to the significant disparities in access to quality of end-of-life care across the country resulting from the relative newness of palliative care, and the number of health care jurisdictions. The report urged the federal government to renew its commitment to a national strategy on palliative and end-of-life care.

[704] *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada* (Ottawa: Senate Canada, 2010) (Tabled in Senate, *Journals of Senate*, 40th Parl., 3rd Sess., No. 35 (8 June 2010)) recognizes that there have been significant improvements in public policy regarding end-of-life care and the delivery of palliative care services in Canada over the years, but urges that it remains necessary to “raise the bar”.

[705] *Raising the Bar* states that only 10% of people die suddenly; the remaining 90% potentially benefit from palliative care. In 1995, only 5% of Canadians had access to quality palliative care. In 2008, a best estimate suggested that between 16-30% of Canadians had some level of access, depending on their location. According to the report, it follows that upwards of 70% of Canadians lack access to even minimal forms of palliative care. The report cautions that the health care system will be further stretched and access to palliative care will be at risk of erosion given the increase in the number of deaths expected over the next generation, together with the prevalence of chronic disease (a result of our ability to manage these conditions longer and more effectively than ever before).

[706] Palliative care was also the subject of recent all-party study in the House of Commons, resulting in the Canadian Parliament Committee Report. The report

focused on three areas relating to compassionate care: palliative care, suicide prevention, and elder abuse.

[707] The Committee observed that the current health care system is geared toward short-term acute care and is less effective at dealing with individuals with chronic conditions, serious pain or mental health concerns, or with the psycho-social and spiritual needs of patients and their families throughout the dying process.

[708] The various Senate and Parliamentary reports consistently note that even where palliative care is available, its quality and accessibility vary according to place of residence – a consequence, in significant measure, of provincial jurisdiction over the delivery of health care. This “patchwork” of services is more pronounced in less populated regions. Many parts of Canada have no palliative care services at all.

[709] Returning to the question of impact of legalized physician-assisted death on the development of palliative care, I turn to the situation in Oregon and Washington.

[710] Dr. Ganzini co-authored E.R. Goy et al., “Oregon hospice nurses and social workers’ assessment of physician progress in palliative care over the past 5 years” (2003) 1 Palliat Support Care 215. Dr. Ganzini provides the following summary of the study and its findings in her affidavit:

> I co-authored a study to obtain hospice nurse and social workers’ assessments of efforts made by Oregon physicians to improve their palliative care skills over the previous 5 years since the enactment of the ODDA. A survey was sent to nurses and social workers from all 50 Oregon outpatient hospice agencies. Oregon hospice nurse (185) and social worker (52) respondents, who had worked in hospice for at least 5 years, rated changes they observed over the past 5 years in physicians’ approach to caring for their hospice clients. Seventy-seven percent of hospice workers rated physicians as more willing to refer patients to hospice whereas only 3% rated them as less willing, 83% rated them as more willing to prescribe sufficient pain medications whereas 3% rated them as less willing, 76% rated physicians as more knowledgeable about using pain medications in hospice patients whereas 6% rated them as less knowledgeable, 67% rated physicians as more interested in caring for hospice patients whereas 5% rated them as less interested, 66% rated them as more competent in caring for hospice patients whereas 4% rated them as less competent, and 26% rated Oregon physicians as more fearful of prescribing sufficient opiate medications whereas 47% rated them as less fearful. We concluded that most

> respondents rated Oregon physicians as showing improvements in knowledge and willingness to refer and care for hospice patients. The major limitation of the study is that physician knowledge and competence in end-of-life care was not actually measured.

[711] Dr. Ganzini was involved in an earlier study which looked at the views of physicians themselves: Ganzini et al., “Oregon Physicians’ Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death With Dignity Act” (May 9, 2001) 285:18 JAMA – J Am Med Assoc 2363. That study indicated that most Oregon physicians who care for terminally ill patients reported that since 1994 (the year the ballot initiative establishing the *ODDA* was passed), they had made efforts to improve their ability to care for these patients. As Dr. Ganzini summarizes in her affidavit, 30% of the 2,461 physicians who responded to the self-administered questionnaire reported that they had increased referrals to hospice, whereas 3% reported they had decreased their hospice referrals since passage of the ballot initiative five years earlier. Of the 2,094 respondents who cared for terminally ill patients, 76% reported that they had made efforts to improve their knowledge of the use of pain medications in the terminally ill.

[712] Dr. Ganzini cautions, with respect to both of these studies, that the improvements cannot necessarily be attributed to the *ODDA*; they do, however, counter concerns that legalization of physician-assisted dying will undermine attempts to improve access to palliative care.

[713] Dr. Ganzini deposes that contrary to the concerns expressed by some, such as Dr. Pereira, the legalization of physician-assisted dying in Oregon has not jeopardized palliative care training. The Oregon Health & Science University, where she holds a number of positions, has a highly sought after palliative medicine fellowship. Further, she says, hospice resources and palliative care consultation groups have grown since passage of the *ODDA*.

[714] Mr. Eighmey deposes that, based on his experience in counselling terminally ill individuals and their physicians with Compassion & Choices Oregon, he believes that patients’ ability to obtain the services of a physician who was able to provide

adequate end-of-life care increased following enactment of the *ODDA*. Accordingly to Mr. Eighmey, there has been a significant increase in physicians' knowledge of palliative care, as well as an increase in physicians' willingness to refer patients to hospice and to care for hospice patients. More than 82% of the patients of Compassion & Choices who obtained lethal prescriptions under the *ODDA* were enrolled in hospice care.

[715] Mr. Miller gives similar evidence based on his personal experience with Compassion & Choices Washington. He deposes that since the enactment of the Washington Act, there has been an increase in physicians' knowledge of palliative care, and an increase in the number of individuals he has dealt with who have been referred as patients to palliative care specialists and to hospice care. More than 85% of the patients who work with Compassion & Choices Washington and who obtain medications for aid-in-dying are enrolled in hospice care.

[716] In response to the evidence concerning the experience in Oregon, Canada says that Dr. Ganzini's evidence does not establish that any improvements in palliative care can be definitively attributed to the legalization of physician assisted death. It says that palliative care improved everywhere, not just in Oregon.

[717] Dr. van Delden and Dr. Kimsma give evidence about the situation in the Netherlands.

[718] Dr. van Delden deposes that a wide range of palliative care services is available in the Netherlands. Palliative care can be received at home or in nursing homes, care homes, hospitals, and both professional and volunteer hospices. He says that it is striking that special facilities for terminally ill patients, such as hospices, only began to appear in the Netherlands in the early 1990s; these sorts of facilities existed earlier in neighbouring countries. The probable explanation, he writes, is that medical practitioners in the Netherlands have always given high priority to care for the dying. (He cites The Netherlands, Ministry of VWS [Health], "Palliative care for terminally ill patients in the Netherlands", by A.L. Francke (The

Hague: NIVEL Netherlands Institute for Health Services Research, 2003), for this evidence).

[719] Citing the same article, Dr. van Delden further deposes as follows:

> It is also worthwhile to comment on the relation between society's commitment to (palliative) care and euthanasia. It is sometimes argued that euthanasia cannot be made available to people in vulnerable groups because that would lessen pressures for improvement of their background circumstances. What is particularly disturbing about this argument is the usually tacit assumption that the suffering of those who are in vulnerable circumstances where euthanasia cannot be allowed, will serve as leverage for improving the provision of such things as adequate terminal care, adequate pain control, and the like. The evidence appears to be the other way around. Pain management was improving in the Netherlands before euthanasia was fully legalized, but has continued to do so at an increasingly rapid rate since legalization. It is legalization, or the prospect of immediate legalization, which appears to contribute to the improvement of terminal care and pain control.

[720] Dr. Kimsma also refers to the "steep rise" in programs aimed at improving palliative care access and expertise in the Netherlands, again beginning in the early 1990s. Dr. Kimsma states that by all comparisons, including the latest European Community-initiated overviews, the Dutch level and practice of palliative care stand well in comparison to other European states.

[721] The plaintiffs' experts also provided evidence on the experience with palliative care in Belgium. Both Dr. Bernheim and Professor Deliens opine that the legalization of physician-assisted dying in Belgium has not impeded the development of palliative care in that country. Professor Deliens states that, to the contrary, legalization has enhanced and is an integral component of palliative care. Dr. Bernheim describes the situation as one of "reciprocity and synergistic evolution".

[722] Dr. Bernheim was lead author of "Development of palliative care and legalisation of euthanasia: antagonism or synergy?" (April 19, 2008) 336 Brit Med J 864. Of note, two of his co-authors, Arsene Mullie and Wilm Distelmans, are the current and past presidents of the Federation Palliative Care Flanders, a

professional organization for palliative care practitioners with more than 1,000 members. The article looks at "the effect of the process of legalisation of euthanasia on palliative care and vice versa by reviewing the published historical, regulatory, and epidemiological evidence in Belgium" (at 864). The authors conclude from this evidence that the movements to develop palliative care and regulate euthanasia in Belgium have been mutually reinforcing.

[723] As Bernheim et al. describe in some detail, the development of palliative care in Belgium began in the early 1980s, at the same time as the drive for the legalisation of euthanasia. These movements were simultaneous and pioneered to a significant degree by the same caregivers. For example, two of the founders of Belgium's first palliative care organization – Continuing Care Community – were advocates of the legalization of euthanasia. (One of these two individuals was Dr. Bernheim.) Several early palliative care workers were also active in Belgian right to die societies.

[724] With respect to palliative care, in an update to this article in the Belgian Medical Journal (Bernheim et al., "The Belgian model of integral end-of-life care: palliative care and legal euthanasia as complementary developments" Tijdschr Geneeskd (forthcoming)), Dr. Bernheim and his co-authors conclude (at 23):

> The concern of some that euthanasia would be performed for lack of access to PC [palliative care] was not verified. All epidemiological data suggest that the more PC, the more life-abbreviating medical decisions at the end of life. We found no data supporting the second concern of the EAPC [European Association for Palliative Care] that the movement for legalisation of euthanasia would hinder development of PC. On the contrary, there were numerous indications of reciprocity and mutually stimulating enhancement.

[725] I referred to a number of studies co-authored by Professor Deliens earlier during my review of some of the empirical evidence regarding the effectiveness of safeguards in Belgium. Some of those studies include data relevant to palliative care.

[726] The Smets et al. Characteristics Study looked at various trends in the characteristics of reported cases between 2002 and 2007. I refer to two trends that relate to palliative care.

[727] First, a physician who receives a euthanasia request is required to consult with an independent physician. In 2002/2003, the speciality of that second physician was palliative care 19.3% of the time. That number decreased to 14.7 in 2004, 10.9% in 2005, 10.0% in 2006 and 8.7% in 2007.

[728] Second, although the Belgian Act does not mandate that a palliative team be consulted, such consultations occurred in 33.9% of cases in 2002/2003; 33.7% in 2004; 31.4% in 2005; 32.5% in 2006 and 39.4% in 2007.

[729] The Chambaere et al. Trends Study found that the rate of euthanasia and assisted suicide rose in all patient groups between 1998 and 2007. Of relevance for present purposes, intensified alleviation of pain and symptoms occurred more often in 2007 than in 1998 and 2001 in all patient groups, except in patients with higher education and in cancer patients. The authors also acknowledge that other factors may have affected this increase in pain and symptom alleviation, such as improved knowledge of opioids abating physicians' fears of providing adequate pain relief at the cost of possible life shortening.

[730] Canada takes issue with the idea that palliative care in Belgium has improved since the legalization of euthanasia, pointing to Dr. Bernheim's evidence on cross-examination that only half of Belgian physician-assisted deaths took place at the end of a palliative care pathway, even though he agreed that adequate palliative care can reduce requests for euthanasia, and to Professor Bernheim's agreement that Belgium has seen a decrease in its ranking in various measures of the quality of palliative care. I take into account, however, Dr. Bernheim's explanation that since Belgium ranked at the top of palliative care providers, there was little room for Belgium to improve and inevitably a change in Belgium's ranking would be in a negative direction as other countries improved. He maintains that palliative care in Belgium continues to rank extremely high.

[731] My review of the evidence regarding Oregon, the Netherlands and Belgium suggests that in those jurisdictions, legalization of assisted death has not undermined palliative care; on the contrary, palliative care provision has improved since legalization by some measures.

[732] Few conclusions, however, can be reached about the possible impact on palliative care from a change in Canadian law regarding physician-assisted death.

[733] First, as Canada points out, palliative care is a developing field; it may be assumed that it is improving not only in permissive jurisdictions but also in jurisdictions that continue to prohibit physician-assisted death.

[734] Second, there are differences in the history, culture and modes of medical practice among the jurisdictions.

[735] Third, further improvements in palliative care in Canada would require commitment of public resources, since health care in Canada is largely delivered through a public system. Some of the debate in the United States has raised the question whether health insurers would refuse to fund palliative care when assisted death was available; no evidence was provided to show that that fear has become reality in Oregon or Washington. It is difficult to imagine that Canadian politicians, public officials or health care providers, if physician-assisted death were legal, would reduce resources for palliative care services for that reason.

[736] In summary, having reviewed the evidence and the submissions on this point, I conclude that while a change in the law to permit physician-assisted death could affect the palliative care system, predictions as to how would be speculative. I find that the evidence establishes that the effects would not necessarily be negative.

F. Impact on Physician-Patient Relationship

[737] The defendants also argue that legalizing physician-assisted death would negatively impact the physician-patient relationship. I will review the main

arguments in that respect and the evidence from other jurisdictions before setting out my conclusions.

[738] Dr. Pereira refers to the power imbalance that would arise, and to worsening misconceptions about palliative care. He expresses concern that some misperceptions, including the idea that opioids invariably shorten life, may leave patients wondering whether a physician administering pain medication is in fact administering a lethal injection.

[739] Dr. Gallagher holds a similar opinion. She says that since the time of the Hippocratic Oath, the goals of medicine have been to prolong life, relieve suffering and improve or maintain functions. Administering a drug with the intent to end the life of a patient, she says, is inconsistent with the goals and core activities of medicine. In her opinion, changing the law to allow physicians to administer a deadly drug would radically change the concept of what a physician is and seriously undermine patients' trust in their physicians.

[740] Baroness Finlay raises concerns about the asymmetries inherent in the physician-patient relationship. She further deposes:

> At the moment there is a bright line. Doctors know what they can do and what they do not do. And patients know – and they know that they can discuss their fears about dying and about wanting to 'end it all' safe in the knowledge that they will not be taken at their word.

[741] Not all of the experts share this view. Dr. Cohen says that, in her opinion, the existing prohibition against physician-assisted death interferes with the physician-patient relationship because it precludes an important treatment option and creates a climate of secrecy and fear. She deposes:

> The blanket prohibition against physician-assisted dying discourages patients who are contemplating a hastened death from talking to their physicians, further isolating these patients. After all, if patients cannot speak openly and honestly to their doctors about end of life issues, then who will they speak to? The burden of secrecy is yet another burden that the already suffering patient is forced to bear.

[742] Dr. van Delden provides a fairly nuanced response to the question of the effect of legalized physician-assisted dying on the physician-patient relationship and trust in physicians. He says that the fear that accepting euthanasia may make people lose trust in their physicians expresses several concerns. If it means that physicians will no longer be committed to prolonging life in all circumstances, then he says the fear is correct, but that the move away from vitalism would better promote the well-being of the patient, which would improve trust. If the fear is that accepting euthanasia would give a right to unbridled autonomy in the form of a right to die, then the fear that trust may be eroded does not concern only physicians but rather the trust that people have in one another. He says, however, that such an individualistic account of autonomy need not be the basis for accepting euthanasia, and that it is not the basis of assisted death in the Netherlands. Finally, he says that losing trust in physicians may express a concern that allowing physician-assisted death may lead to non-voluntary or involuntary euthanasia. He responds to this by rejecting the assumption that physicians will take the opportunity to kill their patients if they are given the opportunity to do so; to the contrary, he says that physicians around the world share the common trait of attempting to cure and relieve suffering.

[743] The plaintiffs point to the evidence of physicians who have actually participated in physician-assisted dying, and say that it should be accorded particular weight. That evidence, they say, is to the effect that addressing such requests with their patients has improved their relationship with those individuals.

[744] Dr. Kimsma, on the basis of his experience as a medical practitioner and SCEN consultant in the Netherlands, deposes as follows:

> The tensions placed on the physician in this respect arise, in part, from the public recognition of the emergence of patient choices and truth at the bedside, leading to respect for patient autonomy and thus to conflicts between physician and patient positions, especially in situations at the end-of-life. Patients and public often have the incorrect opinion that PAD [physician-assisted dying] is a patient’s right as recognized by the Law. The potential for conflict arises also because a physician’s instinct is to preserve life and the “modern” patient may feel that exercise of his autonomy to choose the opposite (death) should not be limited by the fact that the physician is also a moral agent with duties and obligations, such as the

> preservation of life. The effects of requests to help a patient die are therefore very emotional, often deeply moving, because they seem to go so much against the very grain of being a physician. They lead to emotional and ethical conflicts within the physician. ...
>
> PAD is only possible within a meaningful doctor-patient relationship, and a request has precisely the effect of creating such a relationship when both participants realize the gravity of such a request. A request changes the doctor-patient relationship, mostly for the better. A doctor needs to know a patient better and in a different way than in the day-to-day medical relationship, because the physician needs to overcome all the primary inhibitions towards the fundamental rule “Thou shalt not kill” and become convinced in a rational way that the option to end life is really the lesser evil. But also, the physician needs to find out why this suffering is unbearable for this particular patient and why unbearableness for this particular person is understandable. So, that type of assessment is only possible and when and if there is an adequate level of personal interest and a certain bonding.
>
> There is also mutual respect. All patients I have been involved in professionally as a primary caretaker and others where I functioned as a SCEN consultant realized fully the gravity of their request and showed respect for the person who eventually would grant their wish. In fact, some patients in my consultation practice were so much aware of the need for inner development of their physician, that they confided that they saw how difficult the deed was and waited for their physician to work his/her way through their own emotional process, out of respect.

[745] Dr. Crumpacker gives evidence of her experience prescribing lethal prescriptions under the *ODDA* for several of her patients. She concludes:

> I strongly believe that my role as a physician did not end when my patients no longer sought curative treatment; I would not abandon them at the most crucial time of their current lives. This option gave my patients a choice to control the timing and manner of their death, and me the opportunity to complete the job to which I dedicated myself. I remember how frustrated I felt before November 1997 when we did not have a legal aid-in-dying procedure. This law opened doors for patients and their physicians.

[746] My review of the evidence leads me to conclude, with respect to impact on the doctor-patient relationship, that patients’ trust in their physicians, and physicians’ commitment to their patients’ well-being, would not necessarily change for the worse if the law permitted physician-assisted death in highly constrained circumstances. The risk of misconceptions and distrust may be counterbalanced by the possibility of enhanced trust arising from more open communications. In brief, it is likely that the

relationship would change, but the net effect could prove to be neutral or for the good.

[747] Having reviewed the evidence concerning the effectiveness of safeguards in the few jurisdictions that allow physician-assisted dying, I now turn to the feasibility of implementing such safeguards in Canada.

IX. SAFEGUARDS: FEASIBILITY

A. Introduction

[748] It is Canada's position that without an absolute prohibition on physician-assisted suicide, there is a risk of "wrongful deaths". Canada identifies the following key areas of risk.

[749] First, Canada adverts to the deaths of incompetent persons. It can be difficult to determine whether a person is competent to request an assisted death, particularly in the context of a short-term physician-patient relationship. It can be difficult to perform objective assessments uninfluenced by assumptions about the quality of the patient's life and the reasonableness of her desire for death. It can be just as difficult to assess whether and to what extent impaired cognitive function may have affected a person's decision-making capacity.

[750] Second, Canada identifies the risk of involuntary deaths. It points to the need to be certain that a patient's request for an assisted death is voluntary, that is, free from coercion, pressure, undue inducement, and psychological or emotional manipulation. Some of the external forces that can influence a patient's decision include illness (such as depression – even where it is not sufficient to impair capacity, depression can still influence an individual's decision by impacting his or her outlook and perceptions of his or her circumstances); lack of information about options; concerns about burdening, or pressure from, family members; the physician's influence, particularly in light of the power differential that exists between physician and patient; and society's approval of physician-assisted dying. Such forces can elude detection.

[751] Third, Canada says there is a risk of deaths of individuals with treatable conditions. The desire for a hastened death is often associated with underlying conditions that may be amenable to therapeutic intervention, including depression, hopelessness, physical distress and the perceived difficulty of accessing health care resources to relieve pain or other physical suffering.

[752] Fourth, Canada refers to the possible deaths of ambivalent individuals. The desire for death is often transitory, Canada says. Individuals frequently change their minds about suicide, and even life-sustaining treatment options, when they have the opportunity.

[753] Fifth, Canada says there is a risk of deaths of misinformed individuals. It asserts a very real danger that individuals, during difficult periods of illness or disability, may choose assisted suicide based on an inaccurate prognosis, and thereby be deprived of a life they did not realize at the time they could have had.

[754] Finally, Canada identifies the risk of deaths of vulnerable individuals, in particular, the elderly and people with disabilities.

[755] I will briefly digress in order to comment on the term “wrongful death” that Canada employs throughout its submissions.

[756] Canada’s use of the term “wrongful death” is somewhat troubling. The moral force of the term seems inappropriate in at least some of the circumstances included in Canada’s “wrongful deaths” concept: as one example, a physician-assisted death where there has been no intention by medical personnel to misinform a patient, but that patient, who is grievously ill, decisionally capable and not subject to coercion or undue influence, has not been fully informed of his prognosis.

[757] Canada rolls into the “wrongful death” concept the notion that any death which is chosen is wrongful because the individual who made that choice may regret it later (if regret is possible after death). In my view that goes much too far. People choose to forego life-sustaining treatment, and choose to end treatment in circumstances where the cessation of treatment will hasten their deaths. People

choose to embark on risky activities. Many decisions in life have foreseeable, adverse consequences, including the consequence of death. The argument employs reasoning based on hypotheticals such as "if they were able, they might regret that decision" to characterize the results of those decisions as "wrongful". I find that line of reasoning unusual and unpersuasive.

[758] However, having noted my concerns, I will use Canada's term for the sake of convenience in referring to the parties' submissions.

[759] The plaintiffs respond to Canada's concerns about wrongful deaths by proposing a series of safeguards they say would address all reasonable concerns and would protect vulnerable people, in a real and substantial manner, from being induced to commit suicide in the absence of a genuine desire.

[760] Before describing what the plaintiffs submit would constitute effective safeguards, I will review the evidence tendered by the parties regarding the various areas of risk identified by Canada in its submissions.

B. Areas of Risk

[761] I will organize the review of the evidence about risks under five headings: competence, voluntariness, informed consent, ambivalence and socially vulnerable individuals.

1. Competence

a) General

[762] Dr. Martha Donnelly, a specialist and Associate Professor of geriatric psychiatry, has extensive practical experience doing competency assessments, and teaches in that area. Dr. Donnelly deposes that she has assessed, on many occasions, the competence of persons to consent to or refuse medical treatments that may hasten or result in death. She summarizes the criteria for evaluating consent in relation to medical decision-making:

> In all circumstances, the evaluation of the consent given will be based on the patient's ability to comprehend and retain treatment information, to weigh the information, including alternative approaches, to reach a decision, and to communicate that decision. In all cases, the presence of cognitive impairment (e.g., dementia) that could impair decision-making is relevant; clinical depression at a degree of severity that could impair the ability to make decisions is always relevant. Similarly, the question of whether the patient is making a voluntary decision or acting under undue influence or coercion is always relevant in assessing consent.

[763] Dr. Donnelly states that the consequences of a particular medical decision determine the degree of caution or scrutiny that should be exercised in assessing competence. The more significant the decision, the higher the burden of inquiry and investigation on the part of the physician. She says that medical decisions that may result in death attract heightened scrutiny in relation to capacity for informed consent. Extra caution would thus be required with respect to physician-assisted death, for example obtaining a second opinion, or gathering collateral information from people who know the patient, including family members, friends or treating physicians.

[764] Physicians must be alert to conditions that can interfere with or affect competence. Dr. Donnelly identifies a number of such factors, including significant cognitive impairment, severe depression, severe anxiety, external influences which interfere with voluntariness (such as undue influence), coercion and extreme pain. In her view, treatable conditions impairing decision-making ability should be treated before a final assessment of consent is made.

[765] Dr. Gallagher, a specialist and Clinical Professor of palliative care, provides a useful summary of the obligations of physicians in assessing competence:

> It is the obligation of physicians to ensure that a patient has the capability to give informed consent for treatment. An individual is always presumed to be capable until proven otherwise. The capacity required depends upon the decision to be made. Decisions relating to end-of-life care can often involve the decision to forgo further therapy or to withdraw from an ongoing therapy. Often the consequences are that a patient is choosing an intervention that puts quality over quantity of life. The capacity to make these decisions requires the patient to have an adequate understanding of their illness and its prognosis, the nature of the recommended treatment, alternative methods of treatment, and the risks and consequences of each option. The patient must

> use logical reasoning to reach their decision and be free of coercion. Ideally the physician knows the patient well enough to appreciate the patients' values and preferences and should also ensure that the decision the patient makes is in keeping with those values. In general, a person needs intact cognition to make decisions that will affect their quality and length of life. This is particularly so if they are refusing or stopping what seems to be reasonable treatment that will significantly extend their life or improve the quality of their life.

[766] There is some evidence that physicians have difficulty in assessing capacity, generally. For example, Professor Mishara, a Professor of psychology and suicide prevention consultant, opines that inaccurate assumptions can affect assessments. If the assessor believes that it is normal or reasonable to feel depressed or be suicidal when one is very old or seriously disabled or terminally ill, the assessor may not do a thorough job of evaluating decision-making capacity.

[767] Professor Mishara says that there is no simple answer to the question whether it is possible to assess accurately the decision-making capability of individuals who seek assisted suicide. Human decision making is always influenced by the context in which the decision is made, and there are reasons to believe that end-of-life decisions are more irrational and emotional because of the nature of the circumstances. These include the presence of physical pain, and the fact that depression is a predictable corollary when a person suffers from a terminal illness or a progressive debilitating disease.

[768] Professor Marnin Heisel, a clinical psychologist and Associate Professor, has done research into the correlation of suicidal ideation with terminal illness and with desire for hastened death. He comments that his review of the literature suggests that:

> ... health care providers, and even some mental health care providers, currently have difficulty identifying mental health problems and suicidality among terminally ill individuals, lack training and/or expertise in assessing suicide risk and/or the desire to hasten death, and are further unfamiliar with effective and/or efficacious interventions for these conditions.

[769] Professor Heisel agreed on cross-examination that he has never, as a psychologist, been involved in assessing someone's capacity to make medical

decisions and that he is unfamiliar with the test for medical decision-making capacity.

b) Cognitive Impairment

[770] Several of Canada's witnesses provided evidence that it can be particularly difficult to assess the capacity to make end-of-life decisions because of the high incidence of impaired cognitive functioning in patients making those decisions.

[771] Dr. Gallagher gives evidence about some of the challenges in detecting cognitive impairment, as well as the incidence of such impairment in elderly populations. Her evidence sets out reasons for concern about the feasibility of accurately assessing the decision-making capability and voluntariness of patients who seek assistance in dying. Dr. Gallagher does not express confidence that accurate assessments are feasible. She gives, as one example, a patient who seemed to be cognitively intact but proved later to have been seriously delusional.

[772] Dr. Gallagher deposes that cognitive impairment increases dramatically with aging, though anyone who has a serious illness can have temporary cognitive impairment due to severe infection or temporary organ failure. Medications will also often have significant, though temporary, effects on cognition. Dr. Gallagher says that studies indicate that a significant number of hospice patients have undetected, clinically significant cognitive impairment, often from delirium or dementia. Moreover, cognitive impairment is also associated with many degenerative neurological disorders, such as ALS; studies show that 40-50% of patients with this condition will have cognitive impairment affecting decision-making even though only about 10% will develop obvious dementia.

[773] Dr. Meckling, a neurologist, agreed on cross-examination that ALS can affect the prefrontal region of the brain which is responsible for decision making, and that cognitive impairment and psychiatric symptoms are common in people with Huntington's Disease. He testified that cognitive and behavioural changes are almost universal in patients with Parkinson's Disease and that about one-third of patients with the disease will develop dementia.

[774] Baroness Finlay, a palliative care physician, shares the view that cognitive impairment is difficult to detect, though she says that psychiatrists, particularly those who specialize in people with life-threatening illnesses, have a better chance of detecting impairment of this nature. Cognitive impairment is a serious concern since, in her opinion, the decision to end one's life is a cognitively demanding one.

[775] Dr. Ganzini, a geriatric psychiatrist and Professor of psychiatry and medicine, disputes the assertion that the decision to end one's life is necessarily cognitively demanding. Dr. Ganzini cites the decision whether to undergo a neurosurgical procedure as an example of a cognitively demanding one, since the risks, benefits, and various trade-offs between short-term and long-term gains can be very complex and challenging to understand. In contrast, she says, the risks and benefits of a lethal prescription are straightforward and not cognitively complex. The risk is that the prescription might not work; the benefit is that the patient's life will end at a time of her choosing.

[776] Dr. Sheldon, a specialist and Assistant Clinical Professor of geriatric psychiatry, emphasized the complexity of assessing cognitive impairment and competency when an individual has concurrent physical and psychiatric conditions or multiple psychiatric conditions. He is of the opinion that it can be even more difficult when a psychiatric condition, such as existential distress, does not meet the criteria for a mental disorder. Dr. Sheldon proposes "salience" as a useful concept in assessing decision-making.

[777] Dr. Ganzini opines that the ideas expressed in Dr. Sheldon's report "are not consistent with mainstream, evidence based thinking".

[778] Dr. Smith, a psychiatrist and Clinical Professor, has had a great deal of experience in assessing cognitive functioning. He says that assessment of salience is not part of his practice and he does not believe it is important in this context. He further disagrees that it is necessary to determine the nature and impact of concurrent mental states in assessing mental capacity to consent to treatment,

stating that it is the impact of impairments that matters in assessment, not the diagnosis of the cause of the impairment.

[779] Cognitive functioning, Dr. Smith explains, relates to the ability to think and to make decisions, the speed of thinking and memory. Competence, he says, is a distinct question that includes a patient's ability to understand the information being given about his health conditions; the nature of the proposed course of treatment, including the risks, benefits, and alternatives; and that the information applies to his situation. The gold standard for assessing competence, he says, is the clinical interview.

[780] Dr. Smith states that a good understanding of a patient's cognitive functioning is necessary to assess competence, and that achieving that understanding requires time and skill; however, he says, there is no reason to assume that physicians will fail to use appropriate tests in assessing cognitive functioning.

[781] Similarly, although Dr. Donnelly acknowledges that some cognitive impairments can be difficult to diagnose, in her view capacity depends upon functioning rather than diagnosis. Thus, the presence of some degree of cognitive impairment does not dictate a finding of incompetence. Conversely, the absence of cognitive impairment does not dictate a finding of competence. According to Dr. Donnelly, what is relevant is whether there is cognitive impairment (or another factor) that materially impacts the patient's functioning for decision-making purposes; that determination is made by assessing decision-making function itself.

[782] Dr. Donnelly deposes that treatment context critically impacts the type of capacity assessments that are performed. Accordingly, she says, while some cognitive impairments (including delirium) may go undetected across patient groups studied in more general medical contexts, that would not be the case where a physician was assessing competence on the heightened scrutiny basis appropriate for a request for physician-assisted dying – specifically, looking for conditions that could affect capacity.

[783] In Dr. Donnelly's opinion, it would be possible for physicians to ascertain decision-making capability (including voluntariness) as it relates to patients seeking physician-assisted suicide. She says that the task could be performed competently by a physician who has an established relationship of trust with a patient.

[784] If an established relationship of trust is necessary, as Dr. Donnelly's evidence suggests, then the length of time the physician has known the patient may affect the ability of a physician to assess accurately whether a patient is suffering from a cognitive impairment impacting his decision-making capacity. In the Netherlands and Belgium, it is common for patients to have had a long-term relationship with their physician (according to Professor Bernheim and Dr. Kimsma). However, that is not the case for the majority of Canadians, according to Dr. Donnelly. Therefore, in her opinion, in the absence of an established relationship of trust with the patient, the physician should conduct multiple interviews and gather collateral information about the patient, which she suggests a prudent physician would be likely do in any event.

c) Depression

[785] There is a particular concern that while depression may influence decision-making about assisted death, the existence of depression may be overlooked, or depression may be undertreated. The Ganzini Depression Study supports the reality of this risk.

[786] Several of the experts stress the importance of precision when discussing the role of depression. Dr. Smith, for example, cautions that "depression" is a symptom, not a diagnosis. Diagnoses of depressive disorders include Major Depressive Disorder ("MDD"), Dysthymic Disorder and Depressive Disorder NOS. Most mental health professionals in North America, he says, use the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association to diagnose depressive disorders.

[787] Dr. Smith opines that most individuals with depression will not be cognitively impaired to the point that they are incompetent. It is only where depression is severe that concerns will arise in connection with a patient's competence. The best

approach for making this assessment, he states, is the clinical interview. Dr. Smith deposes that incompetence due to depression would be the same whether an individual is making a decision to refuse or direct the withdrawal of life-saving treatment, to consent to terminal sedation or to request physician-assisted dying.

[788] Dr. Ganzini similarly distinguishes between "depression" in the colloquial sense and the clinical condition of MDD. MDD, she says, differs from periods of normal grieving, sadness and dysphoria experienced by many individuals who have a terminal illness. MDD can be reliably diagnosed in 10-20% of terminally ill patients; the corollary is that 80-90% can be reliably diagnosed as not having MDD.

[789] Dr. Ganzini states that it is important to recognize the presence of MDD since it has the potential to impair a person's ability to make authentic decisions. Because MDD renders sufferers unable to enjoy life and have hope about improvement, they can make choices that are inconsistent with their values, lifelong goals and personality. In this way, she says, MDD can impact the choice to hasten death even when a patient has decision-making capacity. Further, says Dr. Ganzini, studies have shown that treatment will improve mood, outlook and function, and ameliorate the desire for death. She acknowledges that diagnosing MDD in the context of a terminal illness can be challenging, as many somatic symptoms of MDD are also common sequelae of severe physical or terminal illness. In Dr. Ganzini's opinion, it is best for patients with MDD to be given a trial of depression treatment instead of a lethal prescription, even if they have adequate decision-making capacity.

[790] Dr. Donnelly opines that forms of major depression can be readily detected in the context of a capacity assessment where that assessment is being carried out at a level of heightened scrutiny, even where the patient is seriously or terminally ill.

[791] Professor Mishara states that depression reduces decision-making capacity, and the decisions a patient makes can be influenced by the hopelessness and despair that are symptoms of clinical depression. Accordingly, diagnosis and treatment of depression is a prerequisite to determining voluntariness of individuals who seek to hasten their deaths. He says that while skilled clinicians are able to

assess the decision-making capacity and voluntariness of individuals who seek assisted death, they often do not make complete assessments because of inaccurate assumptions about the causes of suicidal desires and depressive symptoms. Professor Mishara refers to studies from the Netherlands showing that physicians reported difficulty in determining whether requests for assorted death were voluntary or well considered.

[792] Professor Heisel states that it can be particularly difficult to detect clinical depression in the elderly. He agreed on cross-examination that studies suggest that depressive disorders can be differentiated from non-pathological reactions to illness.

[793] Some of Dr. Ganzini's research (prior to the *ODDA* coming into effect) showed that the personal views of a psychiatrist or psychologist could affect her assessment of whether a patient's judgment was impaired for the purposes of the Oregon legislation. She does not believe, however, that such personal views could result in a failure to identify depression.

[794] Dr. Hendin, a psychiatrist and researcher of end-of-life decisions, is skeptical about the ability of clinicians to diagnose depression. He states that most suicides and most individuals who respond to terminal illness with a desire to hasten death are depressed. He further deposes that a number of studies have shown that general practitioners are not reliably able to diagnose depression, let alone determine whether depression is impairing judgment.

[795] In assessing the evidence bearing on the feasibility of physicians assessing competence in the context of physician-assisted death, I note the expertise and experience of the psychiatrists whose evidence was tendered by the plaintiffs: Dr. Donnelly, Dr. Smith, and Dr. Ganzini. Their evidence supports the conclusion that, even taking into account the possibility of cognitive impairment or depression in patients, and the possibility that physicians may be influenced by inaccurate assumptions about their patients, it is feasible for physicians to assess competence with high reliability. This is on the assumption that physicians who do so apply a rigorous standard of scrutiny given the gravity of the decision, and proceed with due

care (for example, by acquiring collateral information where they do not have a pre-existing long-term relationship with the patient). I accept the evidence of Dr. Smith that cognitive impairment and capacity are distinct; the presence of some cognitive impairment does not necessarily obviate the capacity to give informed consent, although it would underline the need for very careful scrutiny.

[796] I do not give the same weight to the evidence of the psychiatrists whose evidence was tendered by the defendants. Dr. Hendin’s expertise is in suicide prevention, not in assessment of competence. Dr. Sheldon’s opinion does not appear to be based upon mainstream, evidence-based thinking. I also note that the two psychologists whose evidence was tendered by the defendants, Professor Heisel and Professor Mishara, have a different expertise, in suicide prevention, although I accept their expertise and their evidence, which highlights the complexity of competence assessment.

[797] Dr. Gallagher’s experience in palliative care and the treatment of chronic pain is extensive and her opinion about the difficulty in detecting cognitive impairment warrants great respect. However, she does not have the same expertise as do the psychiatrists, particularly on competence assessment. I would make the same observation with respect to the evidence of Baroness Finlay.

[798] Weighing the evidence as a whole, I conclude that it is feasible for properly-qualified and experienced physicians reliably to assess patient competence, including in the context of life-and-death decisions, so long as they apply the very high level of scrutiny appropriate to the decision and proceed with great care.

2. Voluntariness

[799] A person’s desire for hastened death may be subject to many influences, but outside forces influencing a patient’s decision can be difficult for a physician to detect. Professor Mishara refers to a study published by Buiting et al.: “Dutch criteria of due care for physician-assisted dying in medical practice: a physician perspective” (2008) 34:9 J Med Ethics e12. It indicated that 25% of physicians in the Netherlands who have received requests for assisted death reported that they had

experienced problems with respect to at least one of the requirements for access. Of those problems, 58% related to determining whether or not the patient's request was voluntary or well considered.

[800] Professor Mishara agrees, however, that voluntariness can be accurately assessed; his concern is with the skills of the clinician and the completeness of the assessments.

[801] Influence or coercion may come from family members or caregivers or as a result of a long-term abusive relationship. Further, patients are frequently influenced by a concern to avoid becoming a burden to their families, according to Dr. Chochinov and Dr. Gallagher. Dr. Gallagher says that those without family or friends to give care to them may feel that death is a reasonable option in the absence of available community resources.

[802] In one of Dr. Ganzini's studies, she found that in many cases a patient's decision to obtain a lethal prescription was influenced by family. She stated under cross-examination, however, that these were predominantly cases of the family influencing the patient not to die. She also testified that in her experience the patients seeking hastened death are highly independent people who are expressing their life-long values, while their families are expressing a wish to have the chance, for once, to take care of them.

[803] Both Dr. Ganzini and Dr. Donnelly believe that undue influence on a patient can be detected in the course of a capacity assessment.

[804] In Dr. Donnelly's view, the physician should be alert to those possibilities, and ask probing questions as well as consider whether the decision is consistent with the patient's own value system.

[805] Dr. Ganzini suggested that there should be particular scrutiny of the decisions of patients who do not share the strong personality that she says is characteristic of persons seeking assisted dying.

[806] Both of these psychiatrists opined that the possible impact of influences too subtle to be detected should not disqualify a patient from assisted death.

[807] Influence on a patient may be coloured by the fact that family members overestimate or under-appreciate a patient's suffering, according to Dr. Bereza. Dr. Bernheim agreed in cross-examination that health care providers do not always rate the quality of life of chronic illness or disability patients as highly as do the patients themselves.

[808] Further, Baroness Finlay opines that the influence can come at an unconscious level as a result of the dependency of patients on their doctor's knowledge and reliance on the doctor for clinical care. Dr. Gallagher says that institutional culture and external factors can influence the options that are presented, and the way options are presented can influence the decision that is made.

[809] Dr. Ganzini agreed that physicians can be influential, and is of the view that physicians should not themselves propose writing lethal prescriptions. As well, Professor Mishara testified that the presence and involvement of a third party in a suicide, specifically a physician, risks compromising the person's freedom to change their mind without social disapprobation.

[810] Dr. Rasmussen, a retired Oregon palliative care physician, who was asked by the plaintiffs to provide an opinion about some of the evidence tendered by the defendants, describes the coercion issue arising from the physician-patient relationship this way:

> It is true that some patients are susceptible to coercion, and the physician should work to protect the patient from coercion from any source, even the physician. Physicians must understand that patients will sometimes decide not to follow the advice of their doctor. It is dangerous to have the state force a particular medical decision on a patient. And it is dangerous to have a physician force a medical decision on a patient. The patient stands to gain or to lose the most by any decision he or she makes, and the patient is the best judge of his or her own values. By discounting the ability of a patient to know his or her own values, paternalism results in coercion by the physician.
>
> There are two fundamentally different ways to help a patient make an important medical decision. The way of paternalism believes the patient

> cannot be trusted to know his or her own mind, so the physician should do everything, even bully the patient, to get him or her to make the decision the physician believes is right.
>
> The way of autonomy is for the physician to present all options, and to engage the patient in a vigorous debate in which all options are explored and validated. With important decisions it is often helpful to seek the input of many competing sources. This way the patient is empowered to make the decision that is right for him or her.
>
> Dr. Finlay emphasizes that the physician must listen carefully to the patient to learn his or her fears and concerns, and in this she is surely correct. She listens in order to find something she can fix. We all have anecdotes where we fix a problem or help a patient see things from a different perspective, and these are very rewarding times for the physician. But it is hubris to think that the doctor can fix any situation. And it is cruel to force a patient to suffer while the doctor searches endlessly for something else to fix.

[811] Other evidence relevant to the question of physician influence was provided by Professor Frazee, a Professor Emerita of disability studies. She deposes that health care providers regularly assume that a person with disabilities “leans towards death at a sharper angle than the acutely ill – but otherwise non-disabled – patient.” Her evidence is that individuals with disabilities are often steered toward “do not resuscitate” orders or premature surrender to “comfort care”.

[812] Professor Heisel suggests that societal approval of assisted suicide or euthanasia could affect individual decision making or even suggest a social obligation to end life for those no longer “useful” to society. I note, however, that Professor Heisel’s research has not focused on end-of-life decision making; rather, he has researched traditionally-defined suicide among older adults.

[813] Professor James Werth, a Professor and licensed psychologist specializing in end-of-life counselling, deposes that, although decisions to seek hastened death may be made in difficult, emotionally-laden circumstances, nevertheless the decision-making process can be sound, rational and well reasoned. His evidence is that suicide related to mental illness, substance use, impulsivity and other psychosocial factors is different from end-of-life decision making by grievously and irremediably ill individuals. He says that the distinction is now well established in the mainstream of psychotherapy and that “the reasoning on which a terminally ill

person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide."

[814] I accept Professor Werth's evidence that it is problematic to conflate decision-making by grievously and irremediably ill persons about the timing of their deaths, with decision-making about suicide by persons who are mentally ill, or whose thinking processes are affected by substance abuse, trauma or other such factors.

[815] Although I accept the evidence of Dr. Gallagher, Dr. Chochinov, Professor Heisel and Professor Frazee that influence can be subtle and exercised at an unconscious level, I accept the evidence of Dr. Ganzini and Dr. Donnelly that coercion and undue influence can be detected as part of a capacity assessment. To be accurate and reliable, clinicians who perform such assessments would have to be aware of the risks of coercion and undue influence, of the possibility of subtle influence, and of the risks of unconscious biases regarding the quality of the lives of persons with disabilities or persons of advanced age.

3. Informed Consent

[816] I will deal under this heading with two of the concerns that Canada raises: the deaths of individuals who are misinformed, and the deaths of individuals with treatable conditions.

[817] There is little dispute that, at least when it comes to persons with grievous and irremediable illness, the risk of diagnostic error is very low.

[818] Similarly, there is little dispute that prognosis (especially in terms of estimating the amount of time a person has left to live) is an inexact science. A significant risk of error can arise if decisions are dependent on such a factor. Professor Deliens's research shows that, for example, when the death of terminally ill, mainly non-cancer patients was estimated by physicians to be within 22-42 days, the estimates were only accurate 13% of the time (Brandt et al., "Predicted Survival

vs. Actual Survival in Terminally Ill Noncancer Patients in Dutch Nursing Homes" (2006) 32:6 J Pain Symptom Manage 560).

[819] Memorable examples of highly inaccurate prognostication are cited by Canada. David Martin, who has Spinal Muscular Atrophy Type 1, has lived decades longer than was predicted, despite seriously disabling conditions. The account that Professor Frazee relates of the experience of the late Justice Sam Filer of Ontario provides another example. Justice Filer was first diagnosed with ALS in 1987, and went into respiratory failure while in hospital in January 1989. Despite the advice of attending physicians that it would be more humane not to proceed with ventilation, his wife requested the treatment for him, and he lived until 2007, working as a judge until 2004.

[820] Gloria Taylor has already proved inaccurate a January 26, 2010 prognosis that she would likely be paralyzed within six months and die within a year.

[821] A second important element of information needed for decision-making about assisted death is the availability of treatment. A number of witnesses testified that patients seeking a hastened death may be unaware of or have gone without treatment options for their symptoms (Dr. Gallagher, Professor Bernheim) and may require some time to understand the full spectrum of available options (Dr. Bereza). Dr. Pereira gave evidence that there have been significant improvements in pain treatment over the last decade.

[822] Dr. Gallagher has seen a number of patients with significant physical symptoms that were not being adequately controlled who have requested hastened death. Once those symptoms were controlled, she deposes, it became apparent that the patients had thought their only option was to carry on with the inadequately controlled symptoms or die.

[823] As described in the section on Medical Ethics, Dr. Gallagher deposes that opioids used in appropriate doses to control pain and shortness of breath do not cause respiratory depression and do not hasten death; thus, further education of the

medical community should further improve its ability to relieve suffering. Nevertheless, there is consensus among the palliative care witnesses who gave evidence that some suffering still cannot be addressed by palliative care (short of palliative sedation).

[824] Dr. Ganzini's research shows that the vast majority of persons seeking assisted death in Oregon are already enrolled in hospice, where it is more likely that treatment options are fully explored.

[825] As well, therapeutic interventions are possible for distressing symptoms other than pain, such as breathing problems, inability to swallow, or difficulties in communicating, a number of which were described by Dr. Meckling with particular reference to patients with ALS.

[826] Dr. Rasmussen deposes, however, that palliative interventions can bear their own risks and discomfort, and can take time to accomplish their objectives.

[827] Witnesses including Dr. Rodin and Professor Heisel depose that mental health interventions can be effective in reducing or resolving late-life suicide ideation and the desire to hasten death. Professor Heisel suggests that because of health care providers' limited training in or exposure to mental health interventions, patients who might benefit from such interventions will not receive them. However, the limitations of the research studies must be taken into account: they did not involve people actually seeking physician-assisted dying, and Professor Heisel's work relates to traditionally-defined suicide among older adults. Dr. Chochinov agreed on cross-examination that what interview subjects say when presented with a hypothetical scenario may differ from what they would do if actually presented with the option.

[828] Dr. Ganzini and Professor Starks both state the opinion that there is a significant difference between a study of a group of individuals who express a generalized desire for death in a survey of the terminally ill (such as in some studies

done by Dr. Chochinov and Dr. Gary Rodin) and a group of individuals who have actually chosen to pursue assisted dying.

[829] Dr. Ganzini says that it is fallacious to assume that the risk factors for expressing a desire for hastened death are the same as the risk factors for actually pursuing hastened death, calling this the "Epidemiological Fallacy". She deposes:

> Endorsing interest in PAS on a survey appears to be a marker of psychological and symptom distress, however, it appears to be neither sensitive nor specific to patients who actually request PAS under legalized conditions. This concept is important in interpreting and understanding studies that purport to inform the PAS debate, but in whom the data is not based on patients actually requesting PAS, but indicating interest in a survey.

[830] Even the loss of personal dignity can be treated, according to Dr. Chochinov. His opinion is that the most important factor in predicting a sense of dignity is appearance or the perception of how one is seen or appreciated. Thus, he says, health care providers can affirm or disaffirm a person's worth through the attitude they take toward that person. He suggests that if individuals with terminal illness were treated in accordance with the dignity model he has developed, their incentive to end life prematurely would be greatly reduced. Dr. Chochinov does not, however, assert that the availability of dignity therapy would deal with all circumstances that might lead to a wish for assisted death.

[831] The evidence as to informed consent permits me to conclude that, just as physicians routinely assess the requirements for informed consent in patients seeking or refusing medical treatment, it would be feasible to require informed consent for physician-assisted death. In that context, particular care would be required to ensure a patient is properly informed of her diagnosis and prognosis, given the seriousness of the decision. As well, the range of treatment options described would have to encompass all reasonable palliative care interventions, including those aimed at loss of personal dignity.

4. Ambivalence

[832] In Professor Mishara's view, one of the prime characteristics of suicide is that ambivalence is omnipresent. A very large number of people change their minds after considering suicide. Even among those who attempt suicide, the vast majority change their minds after initiating the attempt, he says. The experience in other jurisdictions, and some experience with patients who initially determined to refrain from life sustaining treatment options, shows how often people change their minds.

[833] Expert witnesses called by the plaintiffs, however, emphasize that in their opinion the decision-making process for assisted dying cannot be equated with that involved in suicide outside that context. According to those witnesses, such as Professor Werth and Professor Battin, while it is possible for a person who is grievously and irremediably ill to be "suicidal" in the traditional sense, this is not necessarily the case for those seeking physician-assisted death and it cannot be assumed to be so. Instead, the decisions often reflect long-held, deep-seated values and are rational, consultative, informed and considered.

[834] Professor Mishara opines that the fact that persons have obtained lethal prescriptions in Oregon but then refrained from using them indicates that considerable ambivalence is present. He suggests such ambivalence is evident from the number of people who request euthanasia but, when refused by their physician, do not return.

[835] Other witnesses, such as Dr. Ganzini, Professor Starks and Professor Battin, consider that the fact that many of the patients who obtain a lethal prescription in Oregon do not proceed to take the lethal medication is not necessarily evidence of ambivalence. Instead, it may reflect the fact that the patient's suffering did not reach the point that it was unbearable prior to the patient's death from the illness, or that the patient became unable to take the medication.

[836] Mr. Eighmey, of Compassion and Choices in Oregon, deposes that while many of the individuals he advised obtained prescriptions for lethal doses of medication, many hundreds more did not. He further says that, each year since the

ODDA came into effect, approximately one-third of the patients who obtained medication did not take it. In his experience, many of these individuals died of their underlying illnesses but were comforted in the knowledge that they had the medication available if they decided to use it. Mr. Renaud gives similar evidence.

[837] I agree with the evidence of the plaintiffs' experts that it would be incorrect to draw the inference from the Oregon data that there is widespread ambivalence.

[838] Professor Mishara states that the highest risk of suicide is during the period immediately after diagnosis and following discharge from the hospital, indicating that people kill themselves at a time when they are fearful of what may happen, rather than after they have actually encountered it.

[839] Dr. Downing testified that patients change their minds and often adapt as their circumstances change while under palliative care.

[840] Dr. Gallagher deposes that as people become more disabled, their preference for life-sustaining therapy tends to increase probably because they have learned to adapt, and find that life is still worthwhile.

[841] Canada adduced personal evidence from several individuals, including Baroness Finlay with respect to her own mother and Alison Davis with respect to her own experiences, as to a change of mind about a wish for assisted death. Baroness Finlay deposes that her mother, a strong-willed woman who had been diagnosed with breast cancer, was "absolutely crystal clear" for many weeks that she wanted a physician-assisted death. She felt that she was a burden and that she had no purpose in life. However, upon becoming engaged in a philosophical discussion with a chaplain at her hospice, her feelings about being a burden changed. When her pain was controlled, she went home and lived for another four years, telling Baroness Finlay that "she never believed that her life could be so enriching".

[842] Professor Battin, on the other hand, comments as follows:

> In response to paragraph 25, with regard to the comments regarding spinal injury, there is no obvious guarantee that such persons will in "five to seven

> years" come to see an increase in the value of their lives. This amounts to an assertion that the patient is not entitled to make decisions if negative future circumstances are never fully certain. All decision-making involves a consideration of possibilities and probabilities. Suicide to avoid likely future evils is not irrational as a calculation of future interests; if the likely loss is great enough, to bet against such evils may be folly, to act to avoid them is the rational move. A competent patient is entitled to make an assessment regarding his or her own probable future and to weigh that as a factor in their decision making. Further, not only is the assertion that decisions made to avoid future evils are irrational a false one, it is a position that condemns many to die in the miserable conditions they sought to avoid when faint hope ultimately does not materialize.

[843] The evidence on the question of ambivalence leads me to the conclusion that it is feasible to screen out from physician-assisted death patients who are ambivalent, by assessing capacity and requiring some time to pass between the decision and its implementation. As to the argument that it is impossible to screen out people who may, in the future, come to change their minds, I agree with Professor Battin's observations about the need to respect the decisions that people make, even when future circumstances are not fully certain.

5. Vulnerable Individuals

a) Elderly people

[844] The existence of elder abuse in Canada has been noted by the Parliamentary Committee on Palliative and Compassionate Care, which called it "Canada's hidden crime". Dr. Donnelly testified that between 4% and 10% of Canadian seniors experience some form of abuse or neglect from someone they trust or rely on. Abuse can be physical, psychological or financial, and can impact a person's emotional and social well-being. She agreed on cross-examination that an abusive living situation could influence a patient's medical decision making, and that it could do so in a manner that escapes detection by a physician.

[845] As well, as has been described, assessing cognitive impairment and accurately diagnosing depression in elderly people is challenging. In Professor Heisel's opinion, family physicians have difficulty identifying late-life depression and typically do not assess suicide risk in older adults. He says that many clinicians fail

to recognize that expressing a desire to hasten death can reflect underlying emotional distress or suicidality that can be palliated by mental healthcare. On cross-examination, Professor Heisel agreed, however, that MDD could be diagnosed in the context of a physician-assisted dying decision so long as a relationship was established and a thorough assessment conducted.

[846] Professor Bernheim says that in Belgium the majority of those whose lives are terminated without consent are over 80 years of age. Professor Deliens and his co-authors wrote in the Chambraere et al. Trends Study:

> Third, however, our findings show that some patient groups are particularly at risk of substandard decision-making. Especially for older patients, hospital patients, and non-cancer patients with unpredictable disease prognoses, advance care planning is recommended, either with the patient before she or he becomes incapacitated or with relatives in case of patient incompetence.

The authors suggest that protocols or professional practice standards for advance care planning are likely to improve end of life decision making.

[847] I accept that elderly persons are vulnerable to abuse and that the assessment of voluntariness of elderly people must incorporate an understanding of that reality. As discussed earlier, however, there is no evidence that the elderly access physician-assisted dying in disproportionate numbers in permissive jurisdictions (Professor Battin, Dr. Ganzini, Dr. van Delden, Professor Deliens), and Professor Deliens observed that the number of patients over the age of 80 whose deaths resulted from LAWER in Belgium was not disproportionate.

b) People with disabilities

[848] Professor Frazee, David Martin and Rhonda Wiebe provide evidence, based upon research and upon their personal experience, supporting the concern that persons with disabilities would face particular risks if physician-assisted death were to be permitted. For example, Ms. Wiebe deposes:

> It is not uncommon for me to hear people without disabilities, and people who have recently acquired a disability, express the belief that they would rather be dead than live with a disability.

> In my experience, the idea that it is better to be dead than disabled is an able-ist perception that is deeply embedded in our social conscience. ...
>
> People with disabilities are often, in my experience, pitied and considered to be powerless and helpless. Furthermore, such able-ist social conditioning equates disability with pain, sickness, frailty, incapacity, de-humanization, and poor quality of life.

[849] Professor Frazee's extensive work in human rights and disability rights has included research in the particular area of the risks that physician-assisted dying poses for people with disabilities. She notes that the disability community has struggled with the question whether the availability of physician-assisted death would be of benefit to disabled persons. She states her opinion that the availability of that option would put many disabled people at risk.

[850] Professor Frazee also believes that the discourse of physician-assisted dying reinforces public prejudice and stereotypes about disability. She says that support for physician-assisted dying is linked to a fear of disability and the devaluation of the lives of disabled people. Yet, she says, the discourse does not necessarily reflect the subjective reality of a disabled person's experience:

> Disability prejudice and stereotype are embedded in the discourse around physician assisted suicide. Loss of control of bodily fluids is repeatedly and emphatically represented as a catastrophic assault of *suffering and indignity*, such as to render life no longer worth living. Loss of mobility and diminished capacity for independent self-care are consistently described as a *stripping away of dignity*. Despair and surrender are uncritically accepted as the only possible response to a hopeless predicament – a predicament invariably associated with social shame. Yet the link between dignity and instrumental physical autonomy is not absolute. It is subjective and highly variable.
>
> [Emphasis in original.]

[851] She states the opinion that disabled persons face significant challenges within the medical system, including those posed by physicians who lack exposure to a disability perspective on fundamental questions of ethics and practice. Thus, physicians in particular, and medical professionals in general, consistently and dramatically underestimate disabled patients' quality of life. She says that the ambivalent relationship between the medical professions and people with disabilities would not become less difficult, ambivalent or troubled if medical professionals could

legally terminate disabled persons' lives. She expresses concern that disabled persons may not be supported to resist suicidal tendencies:

> Most people who express suicidal wishes are strongly supported to resist self-destructive impulses. I have little confidence that would be the case for persons whose quality of life has been judged by others to be unacceptable. Moreover, I have concerns that the cultural scripts that narrate disabled lives as heroic will be transformed to hold out an elusive promise of esteem, for persons willing to sacrifice their own lives so that others will be spared the burden of caring for them.

[852] However, there is no evidence that persons with disabilities are at heightened risk of accessing physician-assisted dying in jurisdictions where it is permitted. The Battin et al. Study found that there was no evidence of heightened risk of physician-assisted death in Oregon or the Netherlands for individuals who were physically disabled or chronically ill (except for, possibly, persons with stigmatized diseases, specifically AIDS). Professor Deliens testified that although the survey of physicians in Belgium did not specifically ask about disabled patients, the information was available from the coding on the death certificates and the researchers saw no cases of euthanasia of disabled persons.

[853] I accept that persons with disabilities face prejudice and stereotyping and that there is a risk of unconscious bias about the quality of life of a person with a disability. However, while I accept Professor Frazee's evidence and take into account the submissions of the defendants and the Euthanasia Prevention Coalition, I am not persuaded that the risks to persons with disabilities are such that they cannot be avoided through practices of careful and well-informed capacity assessments by qualified physicians who are alert to those risks.

C. Addressing the Risks

[854] This review of the evidence permits no conclusion other than that there are risks inherent in permitting physician-assisted death, and that the utmost care would be needed in designing and managing a system which would allow it, in order to avoid those risks.

[855] Some of the witnesses in the present proceeding gave opinions regarding appropriate safeguards if physician-assisted dying were legalized in Canada. Dr. Donnelly says, for example, that the vetting process should require a second opinion regarding consent in all cases. This second opinion might involve a referral to a psychiatrist but might also be provided by a general practitioner or by a specialist in another field, as appropriate. She deposes that she would expect that, if physician-assisted dying were to be legalized, the affected medical associations would develop standards of practice and physicians would take their responsibilities especially seriously and undertake capacity assessments especially conscientiously.

[856] Dr. Librach explains his views with respect to the nature of the safeguards that would be required, as follows:

> For the small number of individuals who will access this therapy – and in my view it is a therapy – we need to have a defined, legal process that has safeguards in place to prevent coercion, to protect those who are vulnerable and to make sure we are doing it for physical terminal illnesses and the attendant intractable physical, psychological and spiritual suffering. I believe that existential distress and suffering and that those with chronic mental illnesses should be excluded from access to physician-assisted dying. We also need to ensure that access to quality palliative care and effective assessment is available to all persons. I feel very strongly that palliative care physicians should be involved in assessing people who request physician-assisted dying. There are jurisdictions around the world that have developed systems that seem to be able to protect and regulate physician-assisted dying.
>
> ...
>
> I believe that palliative care physicians and other palliative care professionals should be involved in assessing patients who may request access to this therapy to ensure that the patient requesting such assistance is aware of the dignity and comfort palliative care can offer at the end of life and can experience quality end-of-life care. Patients and families can therefore gain an understanding of the goals of care, the options of care and the possibilities for a good death and more fully understand options at the end of life. This would require governments to ensure further development of and ready access to palliative care programs and professionals for all Canadians.

[857] Dr. Librach adds that most palliative care physicians do not wish to participate in physician-assisted dying, and they should not be forced to comply with a patient's

wishes in this regard. In his view, a system where the patient or a volunteer administers the medication would be preferable.

[858] I have already described the approaches taken in other jurisdictions to the design and monitoring of effective safeguards. It is worthwhile to look, as well, at what the judges who considered the *Rodriguez* case would have found to be appropriate.

[859] At the Court of Appeal (76 B.C.L.R. (2d) 145) [*Rodriguez BCCA*], Chief Justice McEachern, dissenting, would have declared s. 241 of the *Criminal Code* inoperative to the extent it affected Ms. Rodriguez and any physician assisting her. He would have allowed her to arrange for a physician-assisted suicide on conditions, as follows (at paras. 100-108):

> First, the Appellant must be mentally competent to make a decision to end her own life, such competence to be certified in writing by a treating physician and by an independent psychiatrist who has examined her not more than 24 hours before arrangements are put in place which will permit the Appellant to actually terminate her life and such arrangements must only be operative while one of such physicians is actually present with the Appellant.
>
> Such certificate must include the professional opinion of the physicians not just that she is competent, but also that, in the opinion of such physicians, she truly desires to end her life and that, in their opinion, she has reached such decision of her own free will without pressure or influence from any source other than her circumstances.
>
> The fact that the Appellant has made her intentions known by bringing these proceedings, and in many other ways, may be taken into consideration by the physicians in reaching their opinions, but they will of course be careful to ensure that the Appellant has not changed her mind since making her earlier declarations.
>
> Secondly, in addition to being mentally competent, the physicians must certify that, in their opinion, (1) the Appellant is terminally ill and near death, and that there is no hope of her recovering; (2) that she is, or but for medication would be, suffering unbearable physical pain or severe psychological distress; (3) that they have informed her, and that she understands, that she has a continuing right to change her mind about terminating her life; and, (4) when, in their opinion, the Appellant would likely die (a) if palliative care is being or would be administered to her, and (b) if palliative care should not be administered to her.
>
> Thirdly, not less than three clear days before any psychiatrist examines the Appellant for the purposes of preparing a certificate for the purposes aforesaid, notice must be given to the Regional Coroner for the area or

> district where the Appellant is to be examined, and the Regional Coroner or his nominee, who must be a physician, may be present at the examination of the Appellant by a psychiatrist in order to be satisfied that the Appellant does indeed have mental competence to decide, and does in fact decide, to terminate her life.
>
> Fourthly, one of the physicians giving any certificate as aforesaid must re-examine the Appellant each day after the above-mentioned arrangements are put in place to ensure she does not evidence any change in her intention to end her life. If she commits suicide, such physician must furnish a further certificate to the Coroner confirming that, in his or her opinion, the Appellant did not change her mind.
>
> Fifthly, no one may assist the Appellant to attempt to commit suicide or to commit suicide after the expiration of thirty-one days from the date of the first mentioned certificate, and, upon the expiration of that period, any arrangements made to assist the Appellant to end her life must immediately be made inoperative and discontinued. I include this condition to ensure, to the extent it can be ensured, that the Appellant has not changed her mind since the time she was examined by a psychiatrist.
>
> This limitation troubles me greatly as I would prefer that the Appellant be permitted a free choice about the time when she wishes to end her life. I am, however, unwilling to leave it open for a longer period because of the concern I have that the Appellant might change her mind. She is able to proceed at her preferred pace by delaying the time for her psychiatric examination until the time she thinks she is close to the time when she wishes to end her ordeal. If she delays causing her death for more than thirty-one days after such examination then there is a risk either that she had not finally made up her mind, or that, as is everyone's right, she has changed it, or possibly that she is no longer competent to make such a decision.
>
> Lastly, the act actually causing the death of the Appellant must be the unassisted act of the Appellant herself, and not of anyone else.

[860] At the Supreme Court of Canada, the majority considered that no system of safeguards would suffice. Chief Justice Lamer in dissent (Cory J. agreed with this disposition), would have granted Ms. Rodriguez a constitutional exemption on a slightly modified version of Chief Justice McEachern's conditions (at 579):

> (1) the constitutional exemption may only be sought by way of application to a superior court;
>
> (2) the applicant must be certified by a treating physician and independent psychiatrist, in the manner and at the time suggested by McEachern C.J., to be competent to make the decision to end her own life, and the physicians must certify that the applicant's decision has been made freely and voluntarily, and at least one of the physicians must be present with the applicant at the time the applicant commits assisted suicide;
>
> (3) the physicians must also certify:

> > (i) that the applicant is or will become physically incapable of committing suicide unassisted, and
> >
> > (ii) that they have informed him or her, and that he or she understands, that he or she has a continuing right to change his or her mind about terminating his or her life;
>
> (4) notice and access must be given to the Regional Coroner at the time and in the manner described by McEachern C.J.;
>
> (5) the applicant must be examined daily by one of the certifying physicians at the time and in the manner outlined by McEachern C.J.;
>
> (6) the constitutional exemption will expire according to the time limits set by McEachern C.J.; and
>
> (7) the act causing the death of the applicant must be that of the applicant him- or herself, and not of anyone else.

[861] Justices McLachlin and L'Heureux-Dubé, dissenting, thought that some of those conditions may have been inessential. Justice McLachlin (as she then was) stated at 629:

> I concur generally in the remedy proposed by the Chief Justice in his reasons, although I am not convinced that some of the conditions laid down by his guidelines are essential. In the case at bar, where the plaintiff's own act will trigger death, it may not be necessary to ascertain the consent on a daily basis, nor to place a limit of 31 days on the certificate. What is required will vary from case to case. The essential in all cases is that the judge be satisfied that if and when the assisted suicide takes place, it will be with the full and free consent of the applicant. I would leave the final order to be made by the chambers judge, having regard to the guidelines suggested by McEachern C.J. below and the exigencies of the particular case.

[862] Another model for a physician-assisted dying regime in Canada was offered in the minority opinion in *Of Life and Death*, the 1995 Special Senate Committee Report. The majority recommended no change, believing that the risks of a permissive regime would outweigh its benefits.

[863] The minority recommended that an exemption be added to s. 241*(b)* of the *Criminal Code* to permit persons to assist in a suicide under clearly defined conditions. At a minimum, those conditions would include the following elements:

(a) The individual must be competent and must be suffering from an irreversible illness that has reached an intolerable stage, as certified by a medical practitioner.

(b) The individual must make a free and informed request for assistance, without coercive pressures.

(c) The individual must have been informed of and fully understand his or her condition, prognosis and alternative comfort care arrangements, such as palliative care, which are available.

(d) The individual must have been informed of and must fully understand that he or she has a continuing right to change his or her mind about committing assisted suicide.

(e) A health care professional must assess and certify that all of the foregoing conditions have been met.

[864] In addition, the minority said, regulations would be required to deal with monitoring and enforcement of these safeguards, and records of all applications for and instances of assisted suicide would have to be maintained. To avoid abuse, procedural safeguards would require review both prior to and after the act of assisted suicide. Further, no person should be obliged to provide assistance in suicide.

[865] More recently, in the RSC Report, the Expert Panel of the Royal Society of Canada offered recommendations for reform with respect to assisted suicide and voluntary euthanasia.

[866] The Panel identified a number of core elements of a permissive regime, as follows:

(a) Features of the person – The person making the request must be competent or, while competent, must have expressed a wish for voluntary euthanasia through a valid advance directive. If a physician is uncertain about the competence of the person making the request, he or she must take all necessary steps to resolve the uncertainty, for example, by consulting with a colleague with greater experience or expertise. Any age restrictions for access should flow from the mature minor law in the particular jurisdiction.

(b) Features of the decision – The decision must be voluntary and informed.

(c) Features of the person's condition – "Terminal illness" should not be a prerequisite for requesting assistance because it is too vague, under-inclusive, and there is no precise science to providing a prognosis of terminal illness in terms of a specific length of time.

(d) Features of the request for assistance – Written or otherwise recorded requests are preferable but a verbal request is sufficient if properly documented. The time required to elapse between the initial request and the granting of assistance will depend on the time required to ensure that the person's request is voluntary and informed, and that the individual is competent. Once all of the other conditions have been met, there must be a short (for example 24-hour) pause before the assistance is provided to allow confidence that all of the conditions and procedural requirements have been satisfied. Beyond that, the Panel did not recommend any delay requirements.

(e) Features of the provider – Health care professionals should be permitted to provide assistance with suicide or voluntary euthanasia. They must not be obligated to provide such assistance but, if unwilling, should refer the individual making the request to another professional who is willing to consider it. It is an open question whether only health care professionals should be permitted to provide assistance. The Panel recommended that permission to provide assistance be granted only to those who have the knowledge and skills necessary to ensure that the conditions for access (competence, voluntariness, conveyance of information) have been met, and with whom the oversight system can meaningfully function. Furthermore, the more restrictive the list of those permitted to provide assistance, the less that group should be permitted to refuse to provide assistance.

(f) Oversight and control – A national oversight commission should be established to monitor and report annually and publically on assisted suicide and voluntary euthanasia in Canada. To maintain public trust in the system, the commission would collect data and report the data in aggregated form. To prevent mistaken or intentional violations of the new law, the commission would also expertly assess specific cases with appropriate follow-up, which could consist of engagement with specific individual providers or more general education programs.

[867] In 2012, the Québec National Assembly Select Committee on Dying with Dignity recommended the following eligibility requirements for medical aid in dying in the Québec Select Committee Report:

(a) The person is a Québec resident according to the *Health Insurance Act*.

(b) The person is an adult capable of consenting to treatment under the law.

(c) The person himself or herself requests medical aid in dying after making a free and informed decision.

(d) The person is suffering from a serious, incurable disease.

(e) The person is in an advanced state of weakening capacities, with no chance of improvement.

(f) The person has constant and unbearable physical or psychological suffering that cannot be eased under conditions he or she deems tolerable.

[868] The Committee further recommended guidelines. These included that all requests for medical aid in dying must be made in writing by way of a signed form and the request must be repeated within a reasonable period of time, depending on the type of disease. The attending physician must consult with another physician on whether the request meets the eligibility criteria. That physician must be independent of the patient and the attending physician, and be competent with respect to the disease in question. Finally, the attending physician must complete a formal declaration of medical aid in dying.

[869] In order to control and evaluate medical aid in dying, the Committee recommended the creation of a body with the responsibility for verifying whether acts of medical aid in dying were carried out according to the legal conditions, publishing an annual report that includes statistics on medical aid in dying, and publishing a report on the implementation of medical aid in dying provisions every five years. The committee further recommended that the appropriate committee of the National Assembly examine the oversight body’s five-year report.

[870] The Québec Select Committee Report also made a number of recommendations to protect physicians who may or may not choose to participate in the provision of assisted death. These included that: the Attorney General of Québec issue directives to the Director of Criminal and Penal Prosecutions to ensure that a physician who provides medical aid in dying in accordance with the legal criteria cannot be prosecuted; the Collège des Médecins du Québec amend its Code of Ethics so that physicians may provide medical aid in dying in accordance with the criteria provided by law while confirming their right to conscientious objection and their obligation to refer their patient to another physician; and the Ordre des Infirmières et Infirmiers de Québec amend its Code of Ethics to allow members to help provide medical aid in dying in accordance with the criteria provided by law, while confirming their right to conscientious objection.

[871] The Committee also recommended that an adult with the capacity to consent be able to give an advance directive for medical aid in dying upon certain conditions.

[872] Ms. Tucker for the plaintiffs, in reply submissions, provided detail about what they say would constitute effective safeguards.

[873] Beginning with competency, the plaintiffs say that all reasonable concerns can be addressed by:

(a) a mandatory psychiatric evaluation for informed consent carried out at the highest degree of scrutiny, with due regard to collateral information, and involving more than one interview with the patient if, in the assessing psychiatrist's opinion, more than one interview is appropriate;

(b) the disqualification of individuals actively suffering from Major Depressive Disorder; and

(c) the requirement that any death by physician-assisted suicide take place within a minimum period of time following psychiatric approval of the patient's decision-making capacity.

[874] The plaintiffs say that all reasonable concerns regarding voluntariness can be addressed by:

(a) a psychiatric evaluation, as above;

(b) a requirement for a formal written request;

(c) a requirement for repeated requests;

(d) a minimum waiting period (which might vary by category of medical condition and might, for example, provide for a longer waiting period when a patient has recently acquired a disabling condition) to ensure the enduring and persistent nature of the request;

(e) the provision for meaningful rights of withdrawal and refusal throughout (for example, by requiring the patient to positively confirm his or her wishes to a person with no possible investment in the outcome of the process, such as a confidential patient advocate, at all key stages of the process in order to move forward); and

(f) a requirement that a representative of a government agency attend as a witness prior to any death in order to confirm the continuing voluntariness at the time of death.

[875] Further, the plaintiffs say an additional safeguard would be provided if euthanasia were only permitted in circumstances where the patient was physically incapable of committing suicide with assistance.

[876] The plaintiffs' position is that all reasonable concerns that the patient be adequately informed for the purposes of decision-making can be addressed by the following requirements:

(a) the patient must be fully informed by the treating physician as to his or her diagnosis, prognosis, and treatment alternatives, including, but not limited, to palliative care options;

(b) the patient's diagnosis, prognosis, and treatment alternatives must be confirmed by an independent physician who is qualified by expertise or experience regarding the patient's illness, and who has examined the patient and reviewed the patient's relevant medical records;

(c) the patient must have a palliative care consultation with a physician who has expertise in palliative care; and

(d) the patient must be advised of the risks associated with physician-assisted dying, including any risk factors related to the medication to be used.

[877] As for eligibility determination, the plaintiffs submit that access to physician-assisted dying should be limited to those patients who are grievously and irremediably ill, and suffering intolerably as a result of a medical condition. To that

end, eligibility would require that both the physician and the consulting physician be satisfied that the patient has a serious illness, disease or disability that:

(a) is without remedy as determined by treatment options acceptable to the patient; and

(b) causes the patient enduring physical, psychological or psychosocial suffering that:

  (i) is intolerable to that person; and

  (ii) cannot be alleviated by treatment options acceptable to that person.

[878] The plaintiffs submit that requiring a patient to undertake medical treatment that he or she would otherwise decline in order to qualify for physician-assisted dying would be inconsistent with both the patient's rights to liberty and security of the person, and the common law. They submit that it would be similarly inconsistent to require the patient to accept palliative care in order to qualify for assisted-dying. However, were the Court to conclude otherwise, they say that the regime could include a requirement that the patient exhaust reasonable treatment alternatives of a non- or minimally invasive nature with regard to the patient's medical condition or suffering.

[879] Finally, the plaintiffs submit that the following requirements would address all reasonable procedural reporting concerns:

(a) the physician and second physician must each be required to provide a report to an expert review panel that must consist of an ethicist, a lawyer and a doctor;

(b) the members of the expert review panel must, within 48 hours of receiving the reports, review them for accuracy and adequacy of information, and indicate whether they approve of the reports as provided; and

(c) the decision of the expert review panel will be subject to appeal by the patient, on a *de novo* basis, directly to the provincial Superior Court.

[880] Following a physician-assisted death, the physician would be required to file with an appropriate government agency a copy of the reports provided to the expert review panel, proof of the panel’s approval, and the decedent’s death certificate. The agency would then review the case file. The regime could also provide for criminal sanctions and civil liabilities in relation to the physician’s compliance with the requirements and a medical standard of care.

[881] Physicians would not be required to participate in the regime proposed by the plaintiffs.

[882] The plaintiffs do not ask the Court to impose these requirements. Rather, they put them forth to illustrate that less drastic means than a blanket prohibition are available to achieve Parliament’s objective in a real and substantial manner.

D. Conclusion

[883] My review of the evidence in this section, and in the preceding section on the experience in permissive jurisdictions, leads me to conclude that the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced.

[884] I proceed now to address the legal issues.

X. IMPACT OF RODRIGUEZ V. BRITISH COLUMBIA

[885] Before embarking on any analysis of the merits of the plaintiffs’ claim, I must first consider the effect of the Supreme Court of Canada decision in *Rodriguez*. To what extent does that 1993 decision determine the outcome of the challenge now brought by the plaintiffs?

[886] The plaintiffs attack a number of *Criminal Code* provisions in addition to s. 241*(b)*, the sole provision that was challenged in *Rodriguez*, and they seek

remedies that are different, in some respects, from those sought in *Rodriguez*. As Canada points out, the plaintiffs' claim is framed more broadly than was the claim in *Rodriguez*. However, the crux of the plaintiffs' case is the challenge to the prohibition against assisted suicide in s. 241*(b)*; their attack on the other provisions is collateral to that challenge, and would make no sense without it.

[887] Sue Rodriguez, like Gloria Taylor, was diagnosed with amyotrophic lateral sclerosis (ALS). Chief Justice Lamer (in dissenting reasons) described Ms. Rodriguez's situation succinctly (at 531):

> Very soon she will lose the ability to swallow, speak, walk and move her body without assistance. Thereafter she will lose the capacity to breathe without a respirator, to eat without a gastrotomy and will eventually become confined to a bed.
>
> Ms. Rodriguez knows of her condition, the trajectory of her illness and the inevitability of how her life will end; her wish is to control the circumstances, timing and manner of her death. She does not wish to die so long as she still has the capacity to enjoy life. However, by the time she no longer is able to enjoy life, she will be physically unable to terminate her life without assistance. Ms. Rodriguez seeks an order which will allow a qualified medical practitioner to set up technological means by which she might, by her own hand, at the time of her choosing, end her life.

[888] Ms. Rodriguez sought a declaration that s. 241*(b)* of the *Criminal Code* is invalid on the basis of alleged infringement of her rights under s. 7, 12 and 15(1) of the *Charter*. She was unsuccessful in this Court before Mr. Justice Melvin ([1992] B.C.J. No. 2738 [*Rodriguez BCSC*]). The British Columbia Court of Appeal dismissed her appeal (McEachern C.J.B.C. dissenting), and the Supreme Court of Canada dismissed her appeal from that decision (four members of the Court dissenting).

[889] The majority, in reasons written by Justice Sopinka, concluded that s. 241*(b)* did not infringe Ms. Rodriguez's rights under ss. 7 or 12 of the *Charter*, although her right to security of the person was engaged. It further held that the legislation imposed a reasonable limit within the meaning of s. 1 of the *Charter* even assuming an infringement of Ms. Rodriguez's rights under s. 15(1) (a question that the majority did not decide).

[890] In dissent, Chief Justice Lamer found an infringement of s. 15(1) that was not saved by s. 1. Justice McLachlin, with Justice L'Heureux-Dubé, found an infringement of s. 7 that was not justified under s. 1. Justice Cory, in separate dissenting reasons, expressed agreement with both of the other dissents.

[891] Both Canada and British Columbia submit that *Rodriguez* is binding on this Court because the facts pertaining to Gloria Taylor are virtually identical to those in *Rodriguez*, and the *Charter* provisions upon which the plaintiffs rely in this case are the same as those raised in *Rodriguez*. They say that it is not open to this Court to do anything other than dismiss the plaintiffs' claim.

[892] Canada cites cases such as *R. v. Arcand*, 2010 ABCA 363, at para. 184, *R. v. Bernard*, [1988] 2 S.C.R. 833, at para. 28, and *R. v. Chaulk*, [1990] 3 S.C.R. 1303, at 1352-53, for the proposition that a higher court's decision is binding, even if the lower court is of the view that the precedent is clearly wrong or was based on some reasoning or precedent that has become questionable in the interim, and even if the lower court thinks that the general trend of a higher court's views is now contrary.

[893] British Columbia emphasizes that the Supreme Court of Canada has set a high threshold even for itself to depart from its own previous decisions (referring to *Ontario (Attorney General) v. Fraser*, 2011 SCC 20). Mr. Copley also refers to *R. v. Henry*, 2005 SCC 76, where Justice Binnie observed at para. 44 that "[t]he Court should be particularly careful before reversing a precedent where the effect is to diminish *Charter* protection." (As I will describe later, Mr. Copley says the *Charter* protection in question is for vulnerable persons who may become subject to pressure to consider suicide.)

[894] Further, the defendants point to the fact that ten years ago, the Supreme Court of Canada declined to reconsider *Rodriguez* by denying leave to appeal in *Wakeford v. Canada* (2001), 81 C.R.R. (2d) 342 (Ont. Sup. Ct.), upheld (2002), 58 O.R. (3d) 65 (C.A.), leave to appeal to SCC refused, [2002] S.C.C.A. No. 72 [*Wakeford*]. In *Wakeford*, the plaintiff sought a declaration that the assisted suicide prohibition in the *Criminal Code* unjustifiably discriminated against him contrary to

s. 15 of the *Charter*. The Ontario Court of Appeal endorsed the decision of the application judge, which was that the claim failed to disclose a reasonable cause of action because the matter had been fully settled in *Rodriguez*, and there was no indication from the Supreme Court that the matter was open for reconsideration. The application judge, Justice Swinton, further concluded that the 1995 Senate Report did not suffice to show that the legislation was now unsupportable, under s. 1. She observed at para. 14:

> It is true that the Supreme Court of Canada has the power to overrule its past decisions. However, a lower Court should not be quick to assume that it will do so, given the importance of the principle of *stare decisis* in our legal system . In my view, on a motion such as this, where there is a decision of the Supreme Court squarely on point, there must be some indication – either in the facts pleaded or in the decisions of the Supreme Court – that the prior decision may be open for reconsideration For example, prior to *Brooks*, the Supreme Court had faced a barrage of public criticism with respect to the *Bliss* decision, and Dickson C.J.C. notes in *Brooks* that the Court's jurisprudence with respect to human rights and equality had changed significantly following the earlier decision, as had the level of women's labour force participation (at p. 134 C.R.R., p. 1234 S.C.R.). Moreover, there had been foreshadowing that *Bliss* would be overruled in *Brossard (Town) v. Québec (Commission des droits de la personne)*, [1988] 2 S.C.R. 279, 53 D.L.R. (4th) 609, as Dickson C.J.C. observes in *Brooks* (at pp. 134-35 C.R.R., p. 1244 S.C.R.).

[895] The defendants also refer to the numerous occasions, some very recent, on which the Supreme Court of Canada has referred to *Rodriguez* with approval: *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44 [*PHS*], *A.C.*; *Chaoulli*, *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)* 2004 SCC 4, *R. v. Malmo-Levine; R. v. Caine*, 2003 SCC 74 [*Malmo-Levine*].

[896] In response, the plaintiffs argue that this case is distinguishable from *Rodriguez* on a number of bases. First, they say that the majority in *Rodriguez* employed an approach to the principles of fundamental justice, incorporating the weighing of "societal interests", that is no longer viewed as correct. Second, they submit that two principles of fundamental justice (relating to overbreadth and gross disproportionality) had not yet been recognized as such in the s. 7 jurisprudence

when *Rodriguez* was decided. Third, they say that the approach to s. 1 has been clarified and its rigour heightened as a result of *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37 [*Hutterian Brethren*]. Fourth, they submit that the evidentiary record in this case is more complete than it was in *Rodriguez*, and reflects a significant material change from the evidence available when *Rodriguez* was decided. Fifth, the plaintiffs rely on the fact that *Rodriguez* did not decide whether the legislation infringes s. 15 of the *Charter*. Finally, in the context of their submissions regarding s. 7, the plaintiffs submit that since *Rodriguez*, the jurisprudence has evolved, including with respect to the test for arbitrariness.

[897] With respect to *Wakeford*, the plaintiffs submit that refusal of leave to appeal by the Supreme Court of Canada does not necessarily connote approval of the decision below. They also note that the claimant in *Wakeford* did not argue a change in the law, and that the body of evidence available in this case was not available at the time of *Wakeford*. They point to what the application judge said in *Wakeford* at para. 17:

> A concern [of Sopinka J.'s] throughout his s. 1 discussion is the difficulty of building in safeguards to protect the vulnerable, and there is nothing in the material before me to suggest that there is something new in the public policy debate that will answer those concerns.

A. General Principles Regarding *Stare Decisis*

[898] There is no doubt that, pursuant to the long-established principles of *stare decisis*, a decision of the Supreme Court of Canada is binding upon this Court, as are decisions of the Court of Appeal for British Columbia. Both of those courts upheld the constitutionality of s. 241*(b)* of the *Criminal Code* in *Rodriguez*.

[899] The common law doctrine of *stare decisis* requires that cases involving materially the same facts and invoking the same legal principles be decided the same way. Justice Granger explained the doctrine in *Holmes v. Jarrett* (1993), 68 O.R. (3d) 667 (Ont. Ct. J. (Gen. Div.)), in these terms (at 673):

> The phrase *stare decisis* is an abbreviation of the Latin phrase *stare decisis et non quieta movere* [which] may be translated as "to [stand] by decisions

> and not to disturb settled matters". The "rule" as it is often described, has been commonly understood in modern terms to mean that every court is bound to follow any case decided by a court above it in the hierarchy. However, as the entire phrase itself suggests, the "doctrine of *stare decisis* also requires that cases be decided the same way when their material facts are the same": see Glanville Williams, *Learning the Law* (9th ed) (London: Stevens, 1973).

[900] The rationales for the *stare decisis* rule are clear: the need for consistency, predictability and certainty in the law, promoting respect for the law. At the same time, respect for the law will diminish if it fails to adapt and change in response to changed circumstances. The Supreme Court of Canada has accordingly overruled its own previous decisions on some occasions.

[901] To apply the doctrine of *stare decisis*, it is centrally important to identify what a case actually decides on its facts. It is also important, particularly with decisions of the Supreme Court of Canada, to identify legal principles intended to provide future guidance to lower courts. In *Henry*, where the Supreme Court of Canada overruled some of its own previous decisions, Justice Binnie referred to the evolution of the doctrine of *stare decisis* and, with reference to *Charter* cases, noted at paras. 53 and 57:

> Secondly, and more importantly, much of the Court's work (particularly under the *Charter*) required the development of a general analytical framework which necessarily went beyond what was essential for the disposition of the particular case. In those circumstances, the Court nevertheless intended that effect be given to the broader analysis. In [*Oakes*], for example, Dickson C.J. laid out a broad purposive analysis of s. 1 of the *Charte*r, but the dispositive point was his conclusion that there was no rational connection between the basic fact of possession of narcotics and the legislated presumption that the possession was for the purpose of trafficking. Yet the entire approach to s. 1 was intended to be, and has been regarded as, binding on other Canadian courts. It would be a foolhardy advocate who dismissed Dickson C.J.'s classic formulation of proportionality in *Oakes* as mere *obiter*. Thus if we were to ask "what *Oakes* actually decides", we would likely offer a more expansive definition in the post-*Charter* period than the Earl of Halsbury L.C. would have recognized a century ago.
>
> ...
>
> The issue in each case, to return to the Halsbury question, is what did the case decide? Beyond the *ratio decidendi* which, as the Earl of Halsbury L.C. pointed out, is generally rooted in the facts, the legal point decided by this Court may be as narrow as the jury instruction at issue in *Sellars* or as broad

> as the *Oakes* test. All *obiter* do not have, and are not intended to have, the same weight. The weight decreases as one moves from the dispositive *ratio decidendi* to a wider circle of analysis which is obviously intended for guidance and which should be accepted as authoritative. Beyond that, there will be commentary, examples or exposition that are intended to be helpful and may be found to be persuasive, but are certainly not "binding" in the sense the *Sellars* principle in its most exaggerated form would have it. The objective of the exercise is to promote certainty in the law, not to stifle its growth and creativity. The notion that each phrase in a judgment of this Court should be treated as if enacted in a statute is not supported by the cases and is inconsistent with the basic fundamental principle that the common law develops by experience.

[902] The plaintiffs say that, in constitutional cases such as this one, lower courts should address *Charter* claims, even if they concern issues previously decided by higher courts. They rely on a decision of the Ontario Superior Court of Justice: *Bedford SC*.

[903] The issue in *Bedford SC* was the constitutional validity of certain *Criminal Code* sections making it illegal to live off the avails of prostitution, to keep a common bawdy house, and to communicate for the purpose of prostitution. In *Reference Re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.)*, [1990] 1 S.C.R. 1123 [the *Prostitution Reference*], the Supreme Court of Canada had previously upheld the constitutionality of two of those provisions.

[904] At trial, Madam Justice Himel in *Bedford SC* concluded that she was not foreclosed from hearing the s. 7 challenge since the issues were different from those argued in the *Prostitution Reference* and, in her view, the jurisprudence on s. 7 of the *Charter* had evolved considerably in the preceding two decades. The principles of fundamental justice referred to in s. 7 had not been as clearly articulated in 1990 when the *Prostitution Reference* was decided. She also concluded that she could reconsider whether s. 213(1)(c), the communication provision, was in violation of s. 2(b) of the *Charter*.

[905] Justice Himel referred to the breadth of evidence that had been gathered over the course of the intervening 20 years and its relevance to the s. 1 analysis. She questioned whether the social, political and economic assumptions underlying the

Prostitution Reference remained valid and noted a distinction between the type of expression that was at issue (the *Prostitution Reference* focusing on the right to commercial expression for an economic purpose, while *Bedford* related to the expression rights of sex trade workers who would wish to screen potential clients for a propensity for violence).

[906] On the appeal from *Bedford SC*, the Court of Appeal (*per* Doherty, Rosenberg and Feldman JJ.A.) concluded that Himel J. had been correct in conducting a s. 7 analysis, but that she had erred in conducting an analysis of the alleged infringement of s. 2(b) and of possible justification for that infringement under s. 1.

[907] With regard to s. 7, the Court noted that the plaintiffs argued that their security of the person interest was engaged, a point left undecided after the *Prostitution Reference*. The Court further noted that arbitrariness, overbreadth and gross disproportionality were only fully articulated as principles of fundamental justice subsequent to the *Prostitution Reference*. The Court of Appeal concluded that the substantive s. 7 issues in *Bedford* had not been decided in the *Prostitution Reference*, and it had been open to Justice Himel to decide them.

[908] With respect to the challenge under s. 2(b), the Court held that the pivotal issue to be decided in both the *Prostitution Reference* and *Bedford* was whether the infringement of freedom of expression (which was conceded) could be justified as a reasonable limit under s. 1 of the *Charter*. It held that it was an error to depart from the s. 1 analysis found in the *Prostitution Reference*. The Court stated (at para. 76):

> This is not to say that a court of first instance has no role to play in a case where one party seeks to argue that a prior decision of the Supreme Court should be reconsidered and overruled based on significant changes in the evidentiary landscape. The court of first instance does have a role in such a case, albeit a limited one. It may allow the parties to gather and present the appropriate evidence and, where necessary, make credibility findings and findings of fact. In doing so, the court of first instance creates the necessary record should the Supreme Court decide that it will reconsider its prior decision.

[909] In the Court of Appeal's view in *Bedford*, a robust application of *stare decisis* is particularly important in *Charter* litigation. The Court acknowledged that in such cases, the evidence, legislative facts, values, attitudes and perspectives will all continue to evolve. However, it said, if those developments are sufficient to trigger a reconsideration in the lower courts, those courts will be forced to reconsider cases despite authoritative rulings, which would undermine the legitimacy of *Charter* decisions and the rule of law. Such an approach, the Court opined, would yield "not a vibrant living tree but a garden of annuals to be regularly uprooted and replaced" (at para. 84).

[910] The plaintiffs say that this Court should follow the approach taken by the application judge in *Bedford SC*. The plaintiffs agree with the Court of Appeal's approach to s. 7, but disagree with what it said about revisiting a conclusion under s. 1. The two defendant governments, on the other hand, generally agree with the Court of Appeal's decision, but seek to distinguish this case on the basis that in *Rodriguez* all of the substantive s. 7 and s. 1 issues were decided even though the substantive legal frameworks had not been fully articulated.

B. What did Rodriguez Decide?

[911] The majority in *Rodriguez* concluded that s. 241*(b)* is consistent with the *Charter*. Although a narrow view of *stare decisis* would suggest that there is no further room for discussion, I agree with the appeal decision in *Bedford*. The majority in *Bedford* observed that it is tempting to view the constitutional questions and single-word answers from the *Prostitution Reference* as the *ratio decidendi* of the case, but declined to take that approach because it does not comport with the more nuanced understanding of *stare decisis* enunciated in cases such as *Henry* and *R. v. Prokofiew*, 2010 ONCA 423. The majority in *Bedford* wrote, at paras. 69-70:

> *Henry* and *Prokofiew* stand for the proposition that the actual words of the Supreme Court do not bind lower courts when those words are sufficiently tangential to the disposition of the case. Surely, then, the *silence* of the Supreme Court on "independent interests ... which must be given

> independent significance" (*Morgentaler*, at p. 52) cannot preclude future consideration of those interests by a court of first instance.
>
> It cannot be said that the *Prostitution Reference* decided the substantive s. 7 issues before the application judge in this case. Therefore, *stare decisis* did not apply, and the application judge did not err by conducting her own analysis and coming to her own conclusions.
>
> [Emphasis in original.]

[912] Accordingly, it is necessary to analyze the substantive reasoning that led to the conclusion in *Rodriguez*. I will begin at the core. The only provision challenged in *Rodriguez* was s. 241*(b)*, and Ms. Rodriguez, whose circumstances were similar to those of Ms. Taylor, was the only plaintiff. She claimed that the prohibition unjustifiably infringed her rights under ss. 7, 12 and 15 of the *Charter*. Ms. Rodriguez's claim under s. 7 of the *Charter* is described at 583:

> The appellant argues that, by prohibiting anyone from assisting her to end her life when her illness has rendered her incapable of terminating her life without such assistance, by threat of criminal sanction, s. 241*(b)* deprives her of both her liberty and her security of the person. The appellant asserts that her application is based upon (a) the right to live her remaining life with the inherent dignity of a human person, (b) the right to control what happens to her body while she is living, and (c) the right to be free from governmental interference in making fundamental personal decisions concerning the terminal stages of her life. The first two of these asserted rights can be seen to invoke both liberty and security of the person; the latter is more closely associated with only the liberty interest.

[913] *Rodriguez* clearly decided that the s. 7 *Charter* right of the plaintiff to security of the person was engaged, but that she was not deprived of that right arbitrarily. *Rodriguez* did not decide whether the plaintiff's right to equality under s. 15 was infringed, but the majority held that, if there was such an infringement, it was justified under s. 1.

[914] Counsel in the case before me disagreed as to whether the majority in *Rodriguez* went any further with respect to s. 7, and reached conclusions as to engagement of the right to life and liberty. The summary paragraph in Justice Sopinka's judgment states (at 583):

> The most substantial issue in this appeal is whether s. 241*(b)* infringes s. 7 in that it inhibits the appellant in controlling the timing and manner of her death.

> I conclude that while the section impinges on the security interest of the appellant, any resulting deprivation is not contrary to the principles of fundamental justice. I would come to the same conclusion with respect to any liberty interest which may be involved.

[915] The plaintiffs' position is that, although the majority considered life and autonomy to be animating values in s. 7, it did not address the question whether s. 241*(b)* infringed the right to life or liberty.

[916] The defendants point to the fact that the *Rodriguez* case was argued on the basis of a deprivation of Ms. Rodriguez's interest in liberty as well as security of the person. Further, they say, although the Court majority found Ms. Rodriguez's claim to be supported on the ground that her liberty and security of the person interests were engaged, it also said that the consideration of those interests could not be divorced from the sanctity of life, which was one of the three *Charter* values protected by s. 7.

[917] The majority in *Rodriguez* stated at 585 that the existence of the "criminal prohibition in s. 241*(b)* which has the effect of depriving the appellant of the ability to end her life when she is no longer able to do so without assistance is a sufficient interaction with the justice system to engage the provisions of s. 7 assuming a security interest is otherwise involved."

[918] With specific reference to security of the person, Justice Sopinka referred to *R. v. Morgentaler*, [1988] 1 S.C.R. 30, and concluded that the opinions of the Supreme Court in *Morgentaler* "encompass a notion of personal autonomy involving, at the very least, control over one's bodily integrity free from state interference and free from state-imposed psychological and emotional stress" (at 587-88). He concluded (at 588):

> There is no question, then, that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these.

[919] After referring to the circumstances of Ms. Rodriguez, the majority stated (at 588-89):

> That there is a right to choose how one's body will be dealt with, even in the context of beneficial medical treatment, has long been recognized by the common law. To impose medical treatment on one who refuses it constitutes battery, and our common law has recognized the right to demand that medical treatment which would extend life be withheld or withdrawn. In my view, these considerations lead to the conclusion that the prohibition in s. 241*(b)* deprives the appellant of autonomy over her person and causes her physical pain and psychological stress in a manner which impinges on the security of her person. The appellant's security interest (considered in the context of the life and liberty interest) is therefore engaged, and it is necessary to determine whether there has been any deprivation thereof that is not in accordance with the principles of fundamental justice.

[920] I agree that a fair reading of *Rodriguez* is as asserted by counsel for Canada, as follows:

> The majority held that liberty interests were engaged because of the existence of a criminal offence and the potential for incarceration but grounded its discussion of the substantive issue of assisted suicide in security of the person and in autonomy rights in the particular context of bodily integrity.

[921] With respect to the s. 7 right to life, the *Rodriguez* majority did not consider whether it was engaged by s. 241*(b)* of the *Criminal Code*. The discussion of "life" in the majority decision overall, including in the segment focussed on engagement of s. 7 rights, refers to "life" as a *Charter* value, often in the context of "sanctity of life". For instance, Sopinka J. wrote, at 586: "I do not draw from this that in such circumstances life as a value must prevail over security of person or liberty as these have been understood under the *Charter*, but that it is one of the values engaged in the present case."

[922] Canada contends that although Ms. Rodriguez framed her challenge in terms of liberty and security of the person, the Court majority found that her claim could not be divorced from a consideration of the life interest, which it considered to operate in tension with the liberty and security of the person's interests. Canada says that the Supreme Court of Canada in *Rodriguez* was not silent on any of the independent

interests protected under s. 7 so as to displace the operation of *stare decisis*. Canada also notes that the essence of the plaintiff's claim is the same as that of Ms. Rodriguez, referring to the description of Ms. Rodriguez's s. 7 claim at 583.

[923] The plaintiffs, on the other hand, submit that touching on a matter tangentially is not the same as deciding it, and that an absence of reference, or silence, as to a concept is not equivalent to a ruling.

[924] I think the plaintiffs are correct. *Rodriguez* did not decide whether the right to life under s. 7 was engaged by s. 241*(b)* of the *Criminal Code*.

[925] I turn to other aspects of the *Rodriguez* decision.

[926] For the purposes of both its s. 7 and s. 1 analyses, the majority held that the objective of s. 241*(b)* is the protection of the vulnerable who might be induced in moments of weakness to commit suicide. It held that objective to be grounded in the state interest in protecting life, and in the state policy that human life should not be depreciated by allowing life to be taken. As to the objective underlying Parliament's repeal of the attempted suicide offence in 1972, the majority held that the objective was not to recognize a consensus that the autonomy interest of those who might wish to kill themselves is paramount to the state interest in protecting the lives of citizens; rather, it was to recognize that attempted suicide did not mandate a legal remedy.

[927] In *Rodriguez*, arbitrariness was the principle of fundamental justice that the Court explicitly considered. As I will discuss later, counsel disagree as to whether it also implicitly considered overbreadth and gross disproportionality, principles of fundamental justice not yet identified as such in 1993.

[928] With respect to arbitrariness, *Rodriguez* laid down legal principles that the Supreme Court has continued to apply, although the plaintiffs argue that the "test" for arbitrariness articulated in *Rodriguez* has been displaced by that in *Chaoulli* (as I will discuss later). The majority held that respect for human dignity is not in itself a principle of fundamental justice, and explained principles of fundamental justice and

the relevance of societal interests in that context. (I will refer later to the plaintiffs' arguments that what the majority said in *Rodriguez* has since been disavowed.) Noting that principles of fundamental justice are meant to embody a consensus among reasonable people, the majority observed that to the extent that there is a consensus, it is that human life must be respected and courts must be careful not to undermine the institutions that protect it.

[929] *Rodriguez* also summarized and clarified the law regarding the common law right of patients to refuse consent to life-sustaining medical treatment, and to demand that such treatment be withdrawn or discontinued. As I have earlier described, the majority accepted that there is a valid distinction between the role of physicians in those situations and the role of physicians in assisted suicide or euthanasia, based on the intention of the physician.

[930] In his conclusion on the s. 7 issue, Sopinka J. referred to the official positions of various medical associations against decriminalizing assisted suicide, and then stated (at 608):

> Given the concerns about abuse that have been expressed and the great difficulty in creating appropriate safeguards to prevent these, it can not be said that the blanket prohibition on assisted suicide is arbitrary or unfair, or that it is not reflective of fundamental values at play in our society. I am thus unable to find that any principle of fundamental justice is violated by s. 241*(b)*.

[931] Chief Justice Lamer (in dissent) held that s. 241*(b)* infringes s. 15 of the *Charter*. Having assumed (without deciding) that s. 241*(b)* infringes s. 15, the majority held that the infringement was justifiable. The discussion of s. 1 overall is brief. Justice Sopinka found that the prohibition on giving assistance to commit suicide is rationally connected to the purpose of s. 241*(b)*, and that there is no halfway measure that could be relied upon with assurance to fully achieve the purpose of the legislation. He also emphasized that Parliament must be accorded some flexibility in dealing with this contentious and morally laden issue.

[932] Justice Sopinka referred to the fact that introducing an exception to the blanket protection for certain groups would create an inequality, and that s. 241*(b)* protects all individuals against the control of others over their lives. He referred to the substantial consensus among western countries, medical organizations and the Canadian Law Reform Commission that a prohibition without exceptions is the best approach. He further stated, at 613:

> Attempts to fine tune this approach by creating exceptions have been unsatisfactory and have tended to support the theory of the "slippery slope". The formulation of safeguards to prevent excesses has been unsatisfactory and has failed to allay fears that a relaxation of the clear standard set by the law will undermine the protection of life and will lead to abuses of the exception.

[933] The majority referred to the Law Reform Commission of Canada, *Working Paper 28: Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1982), which emphasized the difficulty in determining the true motivation of persons committing acts of "compassionate murder", and held, at 614:

> The foregoing is also the answer to the submission that the impugned legislation is overbroad. There is no halfway measure that could be relied upon with assurance to fully achieve the legislation's purpose; first, because the purpose extends to the protection of the life of the terminally ill. Part of this purpose, as I have explained above, is to discourage the terminally ill from choosing death over life. Secondly, even if the latter consideration can be stripped from the legislative purpose, we have no assurance that the exception can be made to limit the taking of life to those who are terminally ill and genuinely desire death.

[934] Stating that the test at the end of the day is whether the government can "show that it has a reasonable basis for concluding that it has complied with the requirement of minimal impairment" (from *Tétreault-Gadoury v. Canada (Employment and Immigration Commission)*, [1991] 2 S.C.R. 22, at 44), Justice Sopinka concluded, at 614-15:

> In light of the significant support for the type of legislation under attack in this case and the contentious and complex nature of the issues, I find that the government had a reasonable basis for concluding that it had complied with the requirement of minimum impairment. This satisfies this branch of the

> proportionality test and it is not the proper function of this Court to speculate as to whether other alternatives available to Parliament might have been preferable.
>
> It follows from the above that I am satisfied that the final aspect of the proportionality test, balance between the restriction and the government objective, is also met. I conclude, therefore, that any infringement of s. 15 is clearly justified under s. 1 of the *Charter*.

[935] I will discuss later the plaintiffs' argument that the s. 1 analysis in *Rodriguez* does not reflect what the Supreme Court, in *Hutterian Brethren*, has since clarified.

[936] The majority in *Rodriguez* did not address whether the legislation engaged the right to life of the plaintiff. It did not address whether the deprivation of security of the person or liberty was contrary to the principles of fundamental justice regarding overbreadth and gross disproportionality. It did not address whether or, if so, how, s. 241*(b)* infringes s. 15 of the *Charter*. Finally, it addressed only very summarily the final step in the s. 1 analysis, balancing salutary and deleterious effects of the legislation.

C. What Remains Open for Decision in This Case?

[937] The first question is whether this case involves facts that are materially the same as those in *Rodriguez*.

[938] The law has developed a distinction between different kinds of evidence: *R. v. Spence*, 2005 SCC 71. Evidence as to "adjudicative facts" relates to the parties, and to the "who, what, when and where" of the events that allow the parties to bring or defend the claims. In this case, the only evidence regarding adjudicative facts is that describing the experiences of the individual plaintiffs: Gloria Taylor, Lee Carter, Hollis Johnson and Dr. William Shoichet.

[939] The adjudicative facts with respect to Gloria Taylor are very similar to those established in *Rodriguez*. Both women, diagnosed with ALS, wish the choice to end their own lives at the time of their choosing, with the assistance of a physician.

[940] As for the other individual plaintiffs in this case (Lee Carter, Hollis Johnson and Dr. William Shoichet), there was no equivalent in *Rodriguez*. Those plaintiffs

challenge the same legislation as does Ms. Taylor. One factor that distinguishes Ms. Carter's and Mr. Johnson's claim is that their interest in liberty may be engaged due to the potential of criminal prosecution against them, as a result of their having provided assistance to Ms. Carter's mother in going to Switzerland where she was assisted in suicide by a Swiss organization.

[941] The adjudicative facts in this case, however, do not distinguish it in any meaningful way from *Rodriguez*.

[942] The evidence as to legislative and social facts in this case, however, is different from that in *Rodriguez*. By evidence as to "legislative and social facts", I refer to all of the evidence tendered in this case on matters other than the adjudicative facts – regarding topics such as the legislation and experience in jurisdictions with legalized physician-assisted death or assisted death, palliative care practice including palliative sedation, end-of-life decision making, Canadian public opinion regarding euthanasia or physician-assisted death, Parliamentary and other reports since *Rodriguez*, and medical ethics.

[943] A comparison between the legislative and social fact evidence in this case and that in *Rodriguez* is possible because the Attorney General of British Columbia placed before this Court the entire record that was before the Supreme Court of Canada in *Rodriguez*. I have reviewed that record, which Mr. Copley (who was also counsel for British Columbia on *Rodriguez*) advised was assembled quite quickly. It includes: law review, medical journal and other articles and book chapters regarding the legal and ethical position with respect to assisted suicide; descriptions and evaluations of the experience in the Netherlands prior to legislation; statistical information regarding suicide in Canada; historical information bearing on the moral and legal prohibitions against suicide; information about palliative care, including specific palliative care options for patients with ALS; reports of the British Columbia Royal Commission on Heath Care, the Law Reform Commission of Canada and the British Medical Association on Euthanasia; an expert report from a medical ethicist; Gallup Survey evidence regarding Canadian public opinion with respect to

euthanasia; surveys of laws in other jurisdictions; and information about the positions taken by medical associations.

[944] The most notable difference between the records in this case and in *Rodriguez* is that the record in this case includes: evidence pertaining to the experience with legal physician-assisted death in Oregon, Washington, Belgium, Luxembourg and the Netherlands and with assisted death in Switzerland; opinion evidence of medical ethicists and practitioners informed by the experience in jurisdictions with legalized assisted death; specific evidence pertaining to current palliative care and palliative or terminal sedation practices; and evidence regarding prosecution policies in British Columbia and the United Kingdom formulated since *Rodriguez*.

[945] The evidence regarding the experience in jurisdictions permitting physician-assisted death was available neither at the time *Rodriguez* was decided, nor when *Wakeford* was considered.

[946] In *Bedford*, the Court of Appeal held that changes in legislative and social facts are not grounds for declining to follow binding precedent, a point with which the defendants agree. According to *Bedford*, the trial court's proper role is to make the relevant credibility findings and findings of fact, if necessary, so that the appellate court may reconsider its prior decision if it so chooses. On the other hand, the plaintiffs say that because of the importance of a factual matrix in constitutional adjudication, particularly with respect to the s. 1 analysis, a trial judge in a position to do so should make a finding that the relevant factual matrix is significantly and materially different, and proceed to decide the issue based on new facts.

[947] In *Bedford*, the plaintiffs unsuccessfully argued that the existence of changed legislative and social facts alone sufficed to justify a trial court considering afresh the s. 1 justification for legislation. The plaintiffs in this case argue, in addition, that the s. 1 "test" has changed as a result of *Hutterian Brethren*. If they are correct, it is unnecessary to decide whether the different factual record in this case would, alone,

permit this Court to analyze the s. 1 arguments. I will return to this question, therefore, when I discuss the impact of *Hutterian Brethren*.

[948] I will now address the plaintiffs' arguments for distinguishing *Rodriguez*.

1. Section 7

a) Role for Consideration of Societal Interests in S. 7 Analysis; Relationship between S. 7 And S. 1

[949] The plaintiffs submit that a strong distinguishing feature of the majority's reasons in *Rodriguez*, in comparison with the dissents, is the extent to which the majority, *per* Sopinka J., incorporated consideration of societal interests in its assessment of whether Ms. Rodriguez's s. 7 right had been infringed, as opposed to leaving such consideration to the justification stage under s. 1.

[950] The difference in approaches is highlighted in passages from the majority decision at 592-95, and from the dissenting opinion of McLachlin J. at 620-22.

[951] The plaintiffs contend that the law has moved in the direction articulated by the dissent in *Rodriguez*, that is, against incorporating societal interests into the exercise of determining whether there has been a s. 7 infringement. Ms. Tucker refers particularly to *Malmo-Levine*.

[952] *Malmo-Levine* arose out of challenges to the criminalization of possession of marijuana. The Court's majority (*per* Gonthier and Binnie JJ.) discussed the question of reference to societal interests in the s. 7 analysis in general, affirming three broad propositions. First, contrary to what might have been suggested in *Cunningham v. Canada*, [1993] 2 S.C.R. 143, it is not a principle of fundamental justice that the legislature must strike the right balance between the rights of the individual and the interests of the State. Second, in delineating the principles of fundamental justice, societal values inevitably play some role. Finally, the analysis of attempted justification of the provisions based on broad societal interests takes place under s. 1, where the burden is on the government (at paras. 94-99).

[953] Further, in the context of its discussion of gross disproportionality, the majority stated at paras. 179-182:

> Finally, the appellants say that the prohibition is disproportionate to the state's interest because its negative consequences are grossly disproportionate to its positive features, if any.
>
> In this connection, Braidwood J.A. reproduced a summary of the evidence of harm to society resulting from the prohibition itself including disrespect for the law among those who disagree with it; distrust of health and educational authorities who have "promoted false and exaggerated allegations about marihuana"; lack of communication between youth and their elders about the use of marihuana; risks from involvement with criminals and hard-drug users; lack of governmental control over drug quality; "the creation of a lawless sub-culture"; financial costs associated with enforcing the law; and "the inability to engage in meaningful research into the properties, effects and dangers of the drug, because possession of the drug is unlawful" (para. 28).
>
> <u>In effect, the exercise undertaken by Braidwood J.A. was to balance the law's salutary and deleterious effects. In our view, with respect, that is a function that is more properly reserved for s. 1. These are the types of social and economic harms that generally have no place in s. 7.</u>
>
> The appellants were correct to criticize the government's attempted wholesale importation of "societal interests" from s. 1 to s. 7 to try to support the constitutional validity of the prohibition. In our view, the appellants should equally be stopped from importing the "salutary/deleterious" effects balance from s. 1 in order to try to justify the opposite conclusion.
>
> [Emphasis added.]

[954] The plaintiffs say that the Supreme Court of Canada made clear in *Malmo-Levine* that the views expressed by Justice McLachlin in her dissenting reasons in *Rodriguez* had been adopted, and that whether the right balance is struck between individual and societal interests is a matter for determination under s. 1 where the burden is on the government.

[955] However, the cases since *Malmo-Levine* (for example, *R. v. Demers*, 2004 SCC 46; *Charkaoui v. Canada (Citizenship and Immigration,* 2007 SCC 9; *Chaoulli*; *A.C.*; and *PHS*) suggest that a more nuanced view is necessary.

[956] Possibly the jurisprudence reflects the fact that a different approach is appropriate under s. 7 when the principle of fundamental justice at stake is something like the fairness of a hearing (*Charkaoui*) as opposed to the alleged

arbitrariness, gross disproportionality or overbreadth of legislation (*A.C.* and *PHS*). In assessing whether legislation or government action is "arbitrary", it is essential to have an eye to the objective of the legislation or action. Societal interests inevitably enter into that analysis. Similarly, in analyzing whether legislation or government action is grossly disproportionate in its effects on the claimant in comparison with its benefits, or is overbroad, a court must have a firm grasp on the governmental objectives and the importance of those objectives in order to conduct the assessment.

[957] Where there is a concern about procedural fairness, it may be possible to separate out the question whether the legislation or government action is fundamentally fair, from the question whether the importance of the government's objectives might outweigh any unfairness to the individuals affected.

[958] However, there is no need to try to resolve that interesting question in order to determine the issues raised in the case before me. In my opinion, *A.C.* makes clear that the majority decision in *Rodriguez* continues to state the analytical approach to be followed under s. 7.

[959] I accept the submissions of counsel for British Columbia that, whatever was said in the past as to the general principles governing reference to societal interests under s. 7, it is now clear as a result of *A.C.* that such interests must be considered in order to determine whether the impugned *Criminal Code* provisions in this case are consistent with the principles of fundamental justice.

[960] The issue in *A.C.* was the constitutionality of provisions of the Manitoba *Child and Family Services Act*, C.C.S.M., c. C80, which permitted a court to authorize medical treatment found to be in a child's best interests. The legislation presumed that the best interests of a child over the age of 16 will be most effectively promoted by allowing the child's views to be determinative. A.C. was two months short of 15 years of age when she was admitted to hospital suffering from lower gastrointestinal bleeding. She refused to consent to the transfusion of blood because of her

religious beliefs, but the Court made an order authorizing the treatment. She challenged the legislation on the basis of ss. 2(a), 7 and 15 of the *Charter*.

[961] The majority of the Court (*per* Abella J.) upheld the legislation, after finding that it should be read so as to require consideration of a young person's views before ordering treatment, even when the young person is under the age of 16 .

[962] On her path to that conclusion, Justice Abella first framed the issue in a way that echoes the issues in the case before me (at para. 30):

> The question is whether the statutory scheme 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. This requires examining the legislative scheme, the common law of medical decision making both for adults and minors, a comparative review of international jurisprudence, and relevant social scientific and legal literature. The observations that emerge from this review will inform the constitutional analysis.

[963] Justice Abella then reviewed the legislative scheme, the "best interests of the child" standard that it incorporates, and the common law rules regarding consent to medical treatment by adults and minors, in Canada and other jurisdictions.

[964] The majority concluded that when there are contested treatment decisions involving young persons, the court must decide whether the young person's exercise of autonomy in a given situation actually accords with his or her best interests (para. 86), and that (at para. 87):

> 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 s. 25(8). In some cases, courts will inevitably be so convinced of a child's maturity that the principles of welfare and autonomy will collapse altogether and the child's wishes will become the controlling factor. If, after a careful and sophisticated analysis of the young person's ability to exercise mature, independent judgment, 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. Such an approach clarifies that in the context of medical treatment, young people under 16 should be permitted to attempt to demonstrate that their views about a particular medical treatment decision reflect a sufficient degree of independence of thought and maturity.

[965] Justice Abella wrote in conclusion at para. 114:

> In conclusion, I agree with A.C. that it is inherently arbitrary to deprive an adolescent under the age of 16 of the opportunity to demonstrate sufficient maturity when he or she is under the care of the state. It is my view, however, that the "best interests" test referred to in s. 25(8) of the Act, properly interpreted, provides that a young person is entitled to a degree of decisional autonomy commensurate with his or her maturity.

[966] Both the majority and the concurring minority in *A.C.* incorporated societal interests into the s. 7 analysis. In the majority's reasons, the concluding summary regarding arbitrariness (para. 108) states:

> Interpreting the best interests standard so that a young person is afforded a degree of bodily autonomy and integrity commensurate with his or her maturity navigates the tension between an adolescent's increasing entitlement to autonomy as he or she matures and society's interest in ensuring that young people who are vulnerable are protected from harm. This brings the "best interests" standard in s. 25(8) in line with the evolution of the common law and with international principles, and therefore strikes what seems to me to be an appropriate balance between achieving the legislative protective goal while at the same time respecting the right of mature adolescents to participate meaningfully in decisions relating to their medical treatment. The balance is thus achieved between autonomy and protection, and the provisions are, accordingly, not arbitrary.
>
> [Emphasis added.]

[967] Chief Justice McLachlin for the concurring minority stated at para. 141:

> In order to determine whether a statutory provision is arbitrary and therefore contrary to fundamental justice, "the relationship between the provision and the state interest must be considered": Sopinka J. in *Rodriguez*, at p. 594. In the present case, the relevant statutory provisions address the circumstance where a parent or legal guardian refuses to obtain or allow necessary medical care to be provided to a child in his or her care. Where the affected adolescent also refuses care, a medical professional cannot legally administer treatment. To resolve the dilemma between adolescent autonomy and the state's interest in ensuring child welfare, the *CFSA* allows courts to authorize necessary treatment under certain conditions. The objective of the statutory scheme is to balance society's interest in ensuring that children receive necessary medical care on the one hand, with the protection of minors' autonomy interest to the extent this can be done, on the other. Sections 25(8) and 25(9), informed by s. 2(1), set up a mechanism to achieve this goal.
>
> [Emphasis added.]

[968] In *PHS*, its most recent decision involving s. 7, the Supreme Court of Canada took a similar approach to that in *A.C.* The claimants in *PHS* said, alternatively, that their rights under s. 7 of the *Charter* were infringed by prohibitions against possession of drugs in the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19, or by the Minister's decision not to renew an exemption from that legislation for a safe injection site. The gravamen of their claim that the legislation was unconstitutional was described by the Court (*per* McLachlin C.J.) at para. 108:

> The claimants argue that the prohibition on possession of illegal drugs in s. 4(1) of the *CDSA* is not in accordance with the principles of fundamental justice because it is arbitrary, disproportionate in its effects, and overbroad. They say it is arbitrary because, when applied to Insite, it is not only inconsistent with the goals of the *CDSA*, but undermines them. They submit that it is disproportionate in its effects, as it causes significant harm to the clients of Insite and those like them, while providing no commensurate benefit. And they assert that it is overbroad because its application to Insite is unnecessary to meet the state's objectives.

[969] The claim regarding the legislation failed, but the Court held that the Minister's decision not to renew the exemption infringed the principles of arbitrariness and gross disproportionality.

[970] The Court concluded (at para. 137) that if a s. 1 analysis was required (a point not argued), no s. 1 justification could succeed. In my view, that conclusion confirms that societal considerations inevitably entered into the s. 7 analysis.

[971] In short, as I read the authorities, while the Supreme Court has continued to spell out the implications of s. 7 it has shown, in its most recent cases, ongoing support for the approach taken by the majority in *Rodriguez* with respect to incorporating societal interests into the s. 7 analysis.

[972] Accordingly, I am not persuaded by the plaintiffs' first ground for distinguishing *Rodriguez* from this case.

[973] However, the jurisprudence does show that the law continues to evolve. In particular, the emergence of the principles of fundamental justice relating to gross

disproportionality and overbreadth marks a change from the state of the law at the time of *Rodriguez*, as I will discuss in the next section.

b) Later-Recognized Principles of Fundamental Justice

[974] The second basis for the plaintiffs' contention that there are different issues at stake under s. 7 is that *Rodriguez* was decided in 1993 through application of the principle of fundamental justice precluding arbitrary legislation or government action. They say that the jurisprudence regarding the principles of fundamental justice has further evolved since that time; specifically, two further principles of fundamental justice have been recognized and applied by the Supreme Court of Canada. These relate to overbreadth and gross disproportionality.

i. Overbreadth

[975] The Supreme Court of Canada first identified overbreadth in the context of the principles of fundamental justice in *R. v. Heywood*, [1994] 3 S.C.R. 761. In that case, the majority found that s. 179(1)(b) of the *Criminal Code*, which prohibited persons with prior convictions of sexual assault involving children from loitering near playgrounds, school yards or public parks, infringed s. 7 and was not justified under s. 1 of the *Charter*. The legislation was inconsistent with the principles of fundamental justice because it restricted liberty far more than necessary to accomplish its goal. Justice Cory for the majority wrote at 792 that overbreadth and vagueness are related but distinct concepts. They are both the result of insufficient precision by the legislature in the means used to accomplish an objective. Where the means are too sweeping in relation to the objective, the legislation suffers from overbreadth.

ii. Gross Disproportionality

[976] In *Malmo-Levine*, in 2003, the Supreme Court of Canada stated that disproportionality may be an element in the s. 7 analysis of legislation's consistency with the principles of fundamental justice. In that case, the issue was the criminalization of possession of marijuana through an offence carrying the possibility of imprisonment. The majority, having found that the legislation was rationally

connected to a reasonable apprehension of harm and not arbitrary, proceeded to ask whether criminalization of marijuana possession was nevertheless disproportionate to any threat posed by marijuana use. Justices Gonthier and Binnie wrote at paras. 143-44:

> In short, after it is determined that Parliament acted pursuant to a legitimate state interest, the question can still be posed under s. 7 whether the government's legislative measures in response to the use of marihuana were, in the language of *Suresh*, <u>"so extreme that they are *per se disproportionate* to any legitimate government interest"</u> (para. 47 (emphasis added)). As we explain below, <u>the applicable standard is one of *gross* disproportionality, the proof of which rests on the claimant</u>.
>
> The aspect of proportionality of interest to the appellants is the alleged lack of proportionality between the contribution of the marihuana prohibition to public health and safety (the appellants say the prohibition is so ineffective that it contributes little) and the adverse effects on persons subject to the prohibition, including those who are charged and convicted of the offence (the appellants say the adverse effects are severe and lasting). The relevant effects include those that relate to the life, liberty or security of an individual, and that are the product of the state action complained of.
>
> [Italic emphasis in original; underline emphasis added.]

iii. Analysis

[977] Canada and British Columbia argue, however, that the elaboration of the law with respect to the principles of fundamental justice does not amount to a material change that would warrant reconsideration of *Rodriguez*. Canada argues that consideration of over-inclusiveness was inherent in the Supreme Court of Canada's analysis in *Rodriguez*. British Columbia says that the *Rodriguez* case was "all about overbreadth and proportionality", even if they were not identified as separate doctrines *per se*.

[978] The majority in *Rodriguez* defined the issue concerning the principles of fundamental justice as follows, at 590-91, using some language that foreshadowed the overbreadth analysis to come a year later in *Heywood*:

> In this case, it is not disputed that in general s. 241*(b)* is valid and desirable legislation which fulfils the government's objectives of preserving life and protecting the vulnerable. <u>The complaint is that the legislation is over-inclusive because it does not exclude from the reach of the prohibition those in the situation of the appellant who are terminally ill, mentally competent, but</u>

> cannot commit suicide on their own. It is also argued that the extension of the prohibition to the appellant is arbitrary and unfair as suicide itself is not unlawful, and the common law allows a physician to withhold or withdraw life-saving or life-maintaining treatment on the patient's instructions and to administer palliative care which has the effect of hastening death. The issue is whether, given this legal context, the existence of a criminal prohibition on assisting suicide for one in the appellant's situation is contrary to principles of fundamental justice.
>
> [Emphasis added.]

[979] The most recent decisions from the Supreme Court of Canada addressing the definition and scope of the principles of fundamental justice in s. 7 of the *Charter* are *Chaoulli* in 2005, *A.C.* in 2009 and *PHS* in 2011. In both *Chaoulli* and *A.C.*, the s. 7 analyses related solely to arbitrariness.

[980] In *PHS*, the federal government's action in declining to extend an exemption from the operation of criminal laws for the safe drug-injection site in Vancouver was found to be both arbitrary and grossly disproportionate in its effects. With respect to gross disproportionality and overbreadth, the unanimous Court (*per* McLachlin C.J.) stated at paras. 133-34:

> *(b) Gross Disproportionality*
>
> The application of the possession prohibition to Insite is also grossly disproportionate in its effects. Gross disproportionality describes state actions or legislative responses to a problem that are so extreme as to be disproportionate to any legitimate government interest: *Malmo-Levine*, at para. 143. Insite saves lives. Its benefits have been proven. There has been no discernible negative impact on the public safety and health objectives of Canada during its eight years of operation. The effect of denying the services of Insite to the population it serves is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics.
>
> *(c) Overbreadth*
>
> Having found the Minister's decision arbitrary and its effects grossly disproportionate, I need not consider this aspect of the argument.

[981] In the concluding paragraph of the s. 7 analysis in *PHS*, McLachlin C.J. wrote (at para. 136):

> The Minister's decision thus engages the claimants' s. 7 interests and constitutes a limit on their s. 7 rights. Based on the information available to

> the Minister, this limit is not in accordance with the principles of fundamental justice. It is arbitrary, undermining the very purposes of the *CDSA*, which include public health and safety. It is also grossly disproportionate: the potential denial of health services and the correlative increase in the risk of death and disease to injection drug users outweigh any benefit that might be derived from maintaining an absolute prohibition on possession of illegal drugs on Insite's premises.

[982] The *PHS* decision, in applying the gross disproportionality principle enunciated in *Malmo-Levine*, supports the plaintiffs' contention that the jurisprudence under s. 7 has evolved since *Rodriguez* was decided.

[983] I think that additional principles of fundamental justice have been recognized and defined since *Rodriguez* was decided. Although the majority in *Rodriguez* referred to over-inclusiveness (at 590), this was subsumed in its discussion of arbitrariness. It was not until 1994, in *Heywood*, that overbreadth was recognized as a principle of fundamental justice, distinct from arbitrariness. Similarly, although arguably consideration of gross disproportionality was inherent in some sense in the majority's reasoning in *Rodriguez*, it was not until 2003, in *Malmo-Levine*, that gross disproportionality was recognized as a principle of fundamental justice, distinct from arbitrariness.

[984] The reasons in *PHS* show a unanimous Supreme Court of Canada discussing, in turn, whether the Ministerial decision was arbitrary, grossly disproportionate or overbroad.

[985] The Ontario Court of Appeal in *Bedford* concluded that it was appropriate to revisit the constitutionality of provisions that had been upheld before certain principles of fundamental justice (in that case, arbitrariness, overbreadth and gross disproportionality) had been identified and articulated. I agree, and have concluded that in this case it is appropriate to revisit under s. 7 of the *Charter* the constitutionality of s. 241*(b)* of the *Criminal Code*, which was upheld in *Rodriguez* before the principles of overbreadth and gross disproportionality had joined the pantheon of principles of fundamental justice.

2. Section 15

[986] The plaintiffs say that nothing in *Rodriguez* would prevent this Court from finding that the plaintiffs' rights under s. 15 have been infringed.

[987] The defendants argue that although the Supreme Court majority assumed an infringement of s. 15, that was because the case raised difficult and important issues regarding the scope of the equality provision, which it was preferable not to discuss because any infringement was clearly saved under s. 1 of the *Charter*. Canada suggests that if the Supreme Court had any doubt about the s. 15 issue, or wanted to reconsider *Rodriguez* for any reason, it would not have denied leave to appeal in *Wakeford*.

[988] Because the refusal of leave to appeal does not signify approval of the decision below (*Canadian Western Bank v. Alberta*, 2007 SCC 22 at para. 88), I decline to draw the inference that the defendants urge. Further, I note that two members of the Supreme Court in *Rodriguez* (Lamer C.J. and Cory J.) found that s. 15 was infringed. In my opinion, it is open to this Court to assess the plaintiffs' s. 15 claim.

3. Section 1

[989] The plaintiffs submit that as a result of the decision of the Supreme Court of Canada in *Hutterian Brethren*, a more rigorous analysis of proposed justification for *Charter*-infringing legislation is now required than was performed by the majority in *Rodriguez*. They say that in *Hutterian Brethren*, the Court recognized the distinct importance of the final branch of the test for justification under s. 1 set out in *R. v. Oakes*, [1986] 1 S.C.R. 103, where deleterious and salutary effects of the legislation must be balanced against one another.

[990] The plaintiffs say that in *Rodriguez* both Chief Justice Lamer and Justice McLachlin, having determined that s. 241*(b)* failed at the minimal impairment stage of the *Oakes* test, did not proceed to consider the final step in the *Oakes* test. Justice Sopinka, for the majority, discussed the final step only very briefly (at 615),

indicating that the conclusion about the ultimate balance flowed inevitably from the conclusion about rational connection and minimal impairment.

[991] The plaintiffs submit that since *Hutterian Brethren*, it no longer follows that the law passes the final step in the *Oakes* test simply because it passes all of the preceding steps. They emphasize the "severity of the deleterious effects of a measure on individuals or groups", which are to be taken fully into account at this final stage, where the focus shifts to the overall balancing and away from the objectives of the legislation.

[992] Canada, on the other hand, argues that *Hutterian Brethren* did not mark a major shift in the law. It says that any nuance or change in the law as a result of *Hutterian Brethren* does not suffice to call into question the conclusion of the Supreme Court in *Rodriguez* that any s. 15 infringement is justified under s. 1.

[993] In *Hutterian Brethren,* the Supreme Court majority referred to what Chief Justice Dickson had said in *Oakes* about the function of the third step in the proportionality analysis and then stated at paras. 75-78:

> Despite the importance Dickson C.J. accorded to this stage of the justification analysis, it has not often been used. Indeed, Peter W. Hogg argues that the fourth branch of *Oakes* is actually redundant: *Constitutional Law of Canada* (5th ed. Supp.), vol. 2, at section 38.12. He finds confirmation of this view in the fact that he is unable to locate any case in which this stage of the analysis has been decisive to the outcome. In his opinion, this is because it essentially duplicates the analysis undertaken at the first stage, pressing and substantial objective. If a law has an objective deemed sufficiently important to override a *Charter* right and has been found to do so in a way which is rationally connected to the objective and minimally impairing of the right, Hogg asks rhetorically, how can the law's effects nonetheless be disproportionate to its objective? In his view, a finding that a law's objective is "pressing and substantial" at the first stage of *Oakes* will *always* produce a conclusion that its effects are proportionate. The real balancing must be done under the heading of minimal impairment and, to a much more limited extent, rational connection.
>
> It may be questioned how a law which has passed the rigours of the first three stages of the proportionality analysis – pressing goal, rational connection, and minimum impairment – could fail at the final inquiry of proportionality of effects. The answer lies in the fact that the first three stages of *Oakes* are anchored in an assessment of the law's purpose. Only the

fourth branch takes full account of the "severity of the deleterious effects of a measure on individuals or groups". As President Barak explains:

> Whereas the rational connection test and the least harmful measure test are essentially determined against the background of the proper objective, and are derived from the need to realize it, the test of proportionality (*stricto sensu*) examines whether the realization of this proper objective is commensurate with the deleterious effect upon the human right... . It requires placing colliding values and interests side by side and balancing them according to their weight. [p. 374]

In my view, the distinction drawn by Barak is a salutary one, though it has not always been strictly followed by Canadian courts. Because the minimal impairment and proportionality of effects analyses involve different kinds of balancing, analytical clarity and transparency are well served by distinguishing between them. Where no alternative means are reasonably capable of satisfying the government's objective, the real issue is whether the impact of the rights infringement is disproportionate to the likely benefits of the impugned law. Rather than reading down the government's objective within the minimal impairment analysis, the court should acknowledge that no less drastic means are available and proceed to the final stage of *Oakes*.

The final stage of *Oakes* allows for a broader assessment of whether the benefits of the impugned law are worth the cost of the rights limitation. In *Thomson Newspapers Co. v. Canada (Attorney General)*, [1998] 1 S.C.R. 877, Bastarache J. explained:

> The third stage of the proportionality analysis performs a fundamentally distinct role... . The focus of the first and second steps of the proportionality analysis is not the relationship between the measures and the *Charter* right in question, but rather the relationship between the ends of the legislation and the means employed. Although the minimal impairment stage of the proportionality test necessarily takes into account the extent to which a *Charter* value is infringed, the ultimate standard is whether the *Charter* right is impaired as little as possible *given the validity of the legislative purpose*. The third stage of the proportionality analysis provides an opportunity to assess, in light of the practical and contextual details which are elucidated in the first and second stages, whether the benefits which accrue from the limitation are proportional to its deleterious effects as measured by the values underlying the *Charter*. [Emphasis in original; para. 125.]

In my view, this is a case where the decisive analysis falls to be done at the final stage of *Oakes*. The first two elements of the proportionality test – rational connection and minimum impairment – are satisfied, and the matter stands to be resolved on whether the "deleterious effects of a measure on individuals or groups" outweigh the public benefit that may be gained from the measure. In cases such as this, where the demand is that the right be fully respected without compromise, the justification of the law imposing the limit will often turn on whether the deleterious effects are out of proportion to the public good achieved by the infringing measure.

[Italic emphasis in original; underline emphasis added.]

[994] It is true, as the defendants submit, that the Supreme Court did not enunciate a new test. However, in my view *Hutterian Brethren* marks a substantive change, rather than the addition of a nuance. The Court made clear that the final step in the proportionality analysis is neither redundant nor a mere summary of the first two steps, although, as Professor Hogg observed, it had come to be viewed that way. Courts are to widen their perspective at the final stage to take full account of the deleterious effects of the infringement on individuals or groups, and determine whether the benefits of the legislation are worth that cost. That is a different question than whether the legislation is rationally connected to the government's objective or impairs the rights as little as possible.

[995] I agree with the plaintiffs that the Supreme Court of Canada, in *Hutterian Brethren*, put life into the final balancing step in the analysis of proffered justifications for infringements of *Charter* rights.

[996] In *Bedford*, it was not argued that the law with respect to s. 1 analysis had evolved; only that the legislative and social facts had changed.

[997] I note as well that, while in principle a trial judge could find facts without conducting a legal analysis in order to create a record for appellate courts to decide section 1 issues, it would be an unusual exercise. Facts are not normally found in a legal vacuum – they are found in a context, for a reason and with a purpose. Indeed, without a legal framework, how is the primordial task of determining the relevance of evidence possible? *Charter* analysis is always to be contextual. Assessing justification under s. 1 is a particularly fact-intensive process. Similarly, it might be said that finding facts for a s. 1 inquiry is law-intensive, making reference to the governing legal principles essential.

[998] The existence of a different set of legislative and social facts on its own may not warrant a fresh s. 1 inquiry. However, it is unnecessary for me to say more about that point because I think that significantly and materially different legislative facts, along with a change in the legal principles to be applied, can. Because those conditions exist in this case, I will address the s. 1 arguments of the parties,

particularly at the final two stages where minimal impairment and proportionality of effects are assessed.

D. Conclusion

[999] Neither of the defendants sought to have the case struck before the hearing for want of a triable issue (as did the defendants in *Wakeford*).

[1000] However, Canada argues that different legislative facts, or new developments in the law, are not reasons to disregard prior binding authorities. Further, it says that even if the analysis of cases under s. 7 or s. 1 is different now (which it disputes), only the Supreme Court of Canada can give effect to that change when a new case is indistinguishable on its facts. British Columbia emphasizes that the application of the doctrine of *stare decisis* is clear in this case, and that there is nothing in the circumstances that would provide a compelling argument even for the Supreme Court of Canada to consider overruling its own precedent.

[1001] All parties put great effort into assembling a comprehensive evidentiary record. The record in this case differs from the record in *Rodriguez* both in its scope and its contents. Most notably, it contains an enormous amount of evidence about the experience with legal physician-assisted death in other jurisdictions. The record permits assessment of the current approach to and understanding of end-of-life decision-making, and the current understanding of the efficacy of possible safeguards that might permit persons in the position of Ms. Taylor to have the option that she seeks, while protecting those who are vulnerable. The evidence about the efficacy of such safeguards did not exist when *Rodriguez* was decided.

[1002] The legal issues are not identical. The plaintiffs Lee Carter, Hollis Johnson and William Shoichet are in a different situation than that of Ms. Taylor and Ms. Rodriguez, and their liberty interests may be affected in a different way. More importantly, a person whose interest in life, liberty or security of the person has been engaged may now argue deprivation of her s. 7 rights because of inconsistency with the principles of fundamental justice prohibiting legislation or action that is overbroad or grossly disproportionate. Those principles had not been identified as such at the time *Rodriguez* was decided.

[1003] The clarification in *Hutterian Brethren* regarding the final step in the *Oakes* test has significant consequences in this case. Further, I note that the evidentiary record, bearing both on the assessment of consistency with the principles of fundamental justice under s. 7, and on justification under s. 1, is very different than the record that was before the courts in *Rodriguez*.

[1004] Respecting that under the principles of *stare decisis* the Supreme Court's decision in *Rodriguez* is binding, I will now summarize the issues which *Rodriguez* has determined and those which, in my opinion, remain to be addressed in this case.

[1005] For the purposes of this summary, *Rodriguez* decides that the impugned legislation engages Gloria Taylor's rights to security of the person and liberty, and further decides that s. 241*(b)* of the *Criminal Code* is not arbitrary. I will say more later, in the discussion of the s. 1 and s. 7 issues, about what *Rodriguez* decides and does not decide.

[1006] It remains to be determined whether the legislation infringes Ms. Taylor's equality rights under s. 15 of the *Charter* and whether any infringement is justified, viewed through the lens of current s. 1 jurisprudence.

[1007] Still to be decided as well is whether the legislation infringes Ms. Taylor's right to life, and whether any of the plaintiffs has been deprived of s. 7 rights not in accordance with the principles of fundamental justice regarding overbreadth and gross disproportionality.

[1008] I will begin with the equality claim, and whether any infringement is justified. I will then review the s. 7 claim. As will become evident, there is some overlap between the submissions regarding justification under s. 1, and regarding the principles of fundamental justice under s. 7. Accordingly, the s. 7 discussion will draw somewhat on the s. 1 analysis.

XI. EQUALITY

[1009] The plaintiffs rely on s. 15 of the *Charter*, claiming that the *Criminal Code* provisions impose a disproportionate and discriminatory burden on persons who are materially physically disabled.

[1010] Section 15 provides:

> (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
>
> (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[1011] Since 1972, there has been no criminal sanction against suicide or attempted suicide. Persons who are physically able to commit the act of suicide are free to do so or attempt to do so. However, the *Criminal Code* amendments in 1972 left the prohibition against assisted suicide in place. As a result, persons who are physically unable to swallow pills or do other acts designed to end their lives are effectively precluded from suicide because providing assistance in suicide is a criminal act. Ms. Taylor's position is that the legislation thus discriminates against her based on physical disability.

[1012] Before discussing the analytical framework that now governs s. 15, it is useful to review what was said in *Rodriguez* about the application of the *Charter* equality rights to assisted suicide.

[1013] Chief Justice Lamer was the only member of the Court in *Rodriguez* to consider the s. 15 claim; the majority assumed a s. 15 infringement but determined that it was justifiable under s. 1.

[1014] In Chief Justice Lamer's view, s. 241*(b)* of the *Criminal Code* creates an inequality by preventing persons physically unable to end their lives from having the option to choose suicide, while other members of the public have that option. He found that the inequality is imposed because of a physical disability, a personal characteristic among the grounds of discrimination listed in s. 15(1). He concluded, at 549-50, that the inequality constitutes a burden or disadvantage since it limits the ability of persons who are subject to the inequality to take and act upon fundamental decisions regarding their lives and persons; for them, "the principle of self-determination has been limited". Differing from the majority, he found that the infringement of s. 15 was not justified under s. 1.

[1015] Justices McLachlin and L'Heureux-Dubé (*per* McLachlin J.) came to the same conclusion as to the outcome, but took a different route, stating at 616 that "this is not at base a case about discrimination under s. 15 of the *Canadian Charter of Rights and Freedoms*, and that to treat it as such may deflect the equality jurisprudence from the true focus of s. 15 – 'to remedy or prevent discrimination against groups subject to stereotyping, historical disadvantage and political and social prejudice in Canadian society'". They held that the reasoning of the majority in *Morgentaler* was dispositive in favour of the s. 7 claim, since the legislative scheme has the effect of denying to some people the choice of ending their lives simply because they are physically unable to do so (at 617). They concluded that the infringement of s. 7 was not saved by s. 1.

[1016] Although Justice McLachlin chose to address the comparison between Ms. Rodriguez and other persons in the context of her discussion of arbitrariness under s. 7, her comments echo those of Chief Justice Lamer in his discussion of s. 15. She wrote at 620:

> This brings us to the critical issue in the case. Does the fact that the legal regime which regulates suicide denies to Sue Rodriguez the right to commit suicide because of her physical incapacity, render the scheme arbitrary and hence in violation of s. 7? Under the scheme Parliament has set up, the physically able person is legally allowed to end his or her life; he or she cannot be criminally penalized for attempting or committing suicide. But the person who is physically unable to accomplish the act is not similarly allowed to end her life. This is the effect of s. 241*(b)* of the *Criminal Code*, which criminalizes the act of assisting a person to commit suicide and which may render the person who desires to commit suicide a conspirator to that crime. Assuming without deciding that Parliament *could* criminalize all suicides,

> whether assisted or not, does the fact that suicide is not criminal make the criminalization of all assistance in suicide arbitrary?
>
> My colleague Sopinka J. has noted that the decriminalization of suicide reflects Parliament's decision that the matter is best left to sciences outside the law. He suggests that it does not reveal any consensus that the autonomy interest of those who wish to end their lives is paramount to a state interest in protecting life. I agree. But this conclusion begs the question. What is the difference between suicide and assisted suicide that justifies making the one lawful and the other a crime, that justifies allowing some this choice, while denying it to others?
>
> [Italic emphasis in original; underline emphasis added.]

[1017] Similarly, Justice Cory, at 630-31, emphasized the unequal position of persons with disabilities under the assisted suicide provisions.

[1018] The jurisprudence under s. 15 has taken some twists and turns since April 17, 1985 when the equality rights first became effective. However, recent decisions from the Supreme Court of Canada have emphasized the importance of what was said in the first s. 15 case to reach that Court: *Andrews v. Law Society*, [1989] 1 S.C.R. 143 (see *R. v. Kapp*, 2008 SCC 41, at paras. 14-20 and 24 and *Withler v. Canada*, 2011 SCC 12, at paras. 2 and 29-32).

[1019] In *Andrews*, Justice McIntyre addressed the origin and scope of s. 15 at 164-165. He referred to the elusive nature of the concept of equality. Having noted that equality is a comparative concept, he said that nevertheless not every difference in treatment between individuals under the law will necessarily result in inequality. He wrote at 165:

> In simple terms, then, it may be said that a law which treats all identically and which provides equality of treatment between "A" and "B" might well cause inequality for "C", depending on differences in personal characteristics and situations. To approach the ideal of full equality before and under the law – and in human affairs an approach is all that can be expected – the main consideration must be the impact of the law on the individual or the group concerned. Recognizing that there will always be an infinite variety of personal characteristics, capacities, entitlements and merits among those subject to a law, there must be accorded, as nearly as may be possible, an equality of benefit and protection and no more of the restrictions, penalties or burdens imposed upon one than another. In other words, the admittedly unattainable ideal should be that a law expressed to bind all should not

> because of irrelevant personal differences have a more burdensome or less beneficial impact on one than another.
>
> [Emphasis added.]

[1020] Justice McIntyre addressed the purpose of s. 15, stating that its purpose is to "ensure equality in the formulation and application of the law" – but not to eliminate all distinctions, since "identical treatment may frequently produce serious inequality" (at 171).

[1021] The *Andrews* approach to s. 15 has been dubbed "substantive equality".

[1022] In its most recent s. 15 decision, *Withler*, the Court (*per* McLachlin C.J. and Abella J.) reaffirmed that the "animating norm" of s. 15 jurisprudence is substantive equality, at paras. 1-3:

> The plaintiffs are widows whose federal supplementary death benefits were reduced because of the age of their husbands at the time of death. They argue that the legislation reducing their benefits discriminates on the basis of age, violating the equality guarantee in s. 15(1) of the *Canadian Charter of Rights and Freedoms*. We agree with the trial judge and the majority of the Court of Appeal that it does not.
>
> To resolve this appeal, we must consider comparison and the role of "mirror" comparator groups under s. 15(1), an issue that divided the courts below. In our view, the central issue in this and other s. 15(1) cases is whether the impugned law violates the animating norm of s. 15(1), substantive equality: [*Andrews*]. To determine whether the law violates this norm, the matter must be considered in the full context of the case, including the law's real impact on the claimants and members of the group to which they belong. The central s. 15(1) concern is substantive, not formal, equality. A formal equality analysis based on mirror comparator groups can be detrimental to the analysis. Care must be taken to avoid converting the inquiry into substantive equality into a formalistic and arbitrary search for the "proper" comparator group. At the end of the day there is only one question: Does the challenged law violate the norm of substantive equality in s. 15(1) of the *Charter*?
>
> Where, as here, the impugned distinction is the denial of a benefit that is part of a statutory benefit scheme that applies to a large number of people, the discrimination assessment must focus on the object of the measure alleged to be discriminatory in the context of the broader legislative scheme, taking into account the universe of potential beneficiaries. The question is whether, having regard to all relevant factors, the impugned measure perpetuates disadvantage or stereotypes the claimant group, contrary to s. 15(1) of the *Charter*.
>
> [Emphasis added.]

[1023] Equality is a comparative concept; comparisons are inherent in the equality analysis. However, the Supreme Court in *Withler* rejected the “mirror comparator group” approach requiring a comparison between groups closely matched to one another but for the allegedly discriminatory factor, as defined in *Hodge v. Canada (Minister of Human Resources and Development)*, 2004 SCC 65, at para. 23; *Withler* at para. 60.

[1024] Hart Schwartz, in “Making Sense of Section 15 of the Charter”, 29 Nat’l J Const L 201, suggests that this move away from an emphasis on comparator groups re-focuses the s. 15 inquiry on the same search for substantive equality that underlies the recognition of effect-based discrimination claims. He sees *Withler* as a recognition “that strict adherence to mirror comparisons may substitute a formal “treat likes alike” analysis for a proper substantive equality inquiry” and notes that “[m]irror comparisons become a search for sameness rather than a search for disadvantage” (at 226). I agree with his observation.

[1025] The Court in *Withler* referred to the definition of “discrimination” in *Andrews*, then summarized the two-step analytical framework to be applied to s. 15 cases, at paras. 29-31:

> Discrimination was defined by McIntyre J. in *Andrews*, as follows:
>
> > ... discrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual’s merits and capacities will rarely be so classed. [pp. 174-75]
>
> (See also [*Kapp*], at para. 17; *Ermineskin Indian Band and Nation v. Canada*, 2009 SCC 9, [2009] 1 S.C.R. 222, at para. 188; [*A.C.*], at para. 109; [*Hutterian Brethren*], at para. 106.)
>
> The jurisprudence establishes a two-part test for assessing a s. 15(1) claim: (1) Does the law create a distinction based on an enumerated or analogous

> ground? (2) Does the distinction create a disadvantage by perpetuating prejudice or stereotyping? (See *Kapp*, at para. 17.)
>
> The two steps reflect the fact that not all distinctions are, in and of themselves, contrary to s. 15(1) of the *Charter* (*Andrews*; *Law*; *Ermineskin Indian Band*, at para. 188). Equality is not about sameness and s. 15(1) does not protect a right to identical treatment. Rather, it protects every person's equal right to be free from discrimination. Accordingly, in order to establish a violation of s. 15(1), a person "must show not only that he or she is not receiving equal treatment before and under the law or that the law has a differential impact on him or her in the protection or benefit accorded by law but, in addition, must show that the legislative impact of the law is discriminatory" (*Andrews*, at p. 182; *Ermineskin Indian Band*, at para. 188; *Kapp*, at para. 28).

[1026] I will address the s. 15 claim pursuant to the two-step process described in *Withler*:

1. Does the law create a distinction based on an enumerated or an analogous ground?
2. Does the distinction create a disadvantage by perpetuating prejudice or stereotyping?

A. Does the Law Create a Distinction Based on an Enumerated or Analogous Ground?

1. Enumerated or Analogous Ground

[1027] Only distinctions based on grounds enumerated in s. 15 or grounds analogous to those are the subject of scrutiny under s. 15. There is no doubt that physical disability is an enumerated ground, and that Ms. Taylor can invoke that ground in her challenge to the legislation.

[1028] Counsel for the plaintiffs also invoke a second ground, family status, arguing that the *Charter* rights of family members of individuals affected by the legislation are also infringed and that family status is an analogous ground.

[1029] Because of the conclusion I have reached regarding Ms. Taylor's claim, it is unnecessary for me to address the argument that the legislation infringes the equality rights of other persons, such as Lee Carter or Hollis Johnson, based on their family status.

[1030] Since it is clear that this claim invokes an enumerated ground, the central issue becomes whether the law creates a distinction based on that ground. I will address that issue under several headings, related to the main submissions of the parties.

2. Effects-Based Discrimination

[1031] The plaintiffs argue that the absolute prohibition against assisted suicide imposes a disproportionate burden on persons who are physically disabled by depriving them of the choice to commit suicide, resulting in a distinction that is discriminatory.

[1032] The *Criminal Code* does not express a distinction based on physical disability; s. 241*(b)* simply prohibits anyone from assisting anyone else to commit suicide.

[1033] However, it has been clear since *Andrews* that the equality guarantee in s. 15(1) is not fulfilled simply because a law applies equally to all persons. Even distinctions created unintentionally and implicitly, through the disparate impact of the law on a particular group of persons, may infringe s. 15 and should be interrogated in the same way as are intentional or explicit distinctions. This is because the commitment to substantive equality entails consideration of the actual impact of the law on the persons it affects (see *Symes v. R.*, [1993] 4 S.C.R. 695 at 755, *per* Iacobucci J.).

[1034] Chief Justice Lamer took this approach in *Rodriguez*. Adopting the definition of “discrimination” from *Andrews*, he discussed the concepts of involuntary and adverse effects discrimination. Based on *Andrews* and on *Ontario Human Rights Commission v. Simpsons-Sears Ltd.*, [1985] 2 S.C.R. 536, he stated at 549:

> Not only does s. 15(1) require the government to exercise greater caution in making express or direct distinctions based on personal characteristics, but legislation equally applicable to everyone is also capable of infringing the right to equality enshrined in that provision, and so of having to be justified in

> terms of s. 1. Even in imposing generally applicable provisions, the government must take into account differences which in fact exist between individuals and so far as possible ensure that the provisions adopted will not have a greater impact on certain classes of persons due to irrelevant personal characteristics than on the public as a whole. In other words, to promote the objective of the more equal society, s. 15(1) acts as a bar to the executive enacting provisions without taking into account their possible impact on already disadvantaged classes of persons.
>
> [Emphasis added.]

[1035] In *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, on the basis of adverse effects analysis, the Supreme Court held that the provincial government's failure to provide funding for sign language interpreters for deaf persons when they receive medical services infringed s. 15(1) of the *Charter* and did not constitute a reasonable limit under s. 1. Justice LaForest, for the Court, stated at paras. 60-62, 64 and 77:

> The only question in this case, then, is whether the appellants have been afforded "equal benefit of the law without discrimination" within the meaning of s. 15(1) of the *Charter*. On its face, the medicare system in British Columbia applies equally to the deaf and hearing populations. It does not make an explicit "distinction" based on disability by singling out deaf persons for different treatment. Both deaf and hearing persons are entitled to receive certain medical services free of charge. The appellants nevertheless contend that the lack of funding for sign language interpreters renders them unable to benefit from this legislation to the same extent as hearing persons. Their claim, in other words, is one of "adverse effects" discrimination.
>
> This Court has consistently held that s. 15(1) of the *Charter* protects against this type of discrimination. In *Andrews*, *supra*, McIntyre J. found that facially neutral laws may be discriminatory. "It must be recognized at once", he commented, at p. 164, ". . . that every difference in treatment between individuals under the law will not necessarily result in inequality and, as well, that identical treatment may frequently produce serious inequality"; see also *Big M Drug Mart Ltd.*, *supra*, at p. 347. Section 15(1), the Court held, was intended to ensure a measure of substantive, and not merely formal equality.
>
> As a corollary to this principle, this Court has also concluded that a discriminatory purpose or intention is not a necessary condition of a s. 15(1) violation; see *Andrews*, at pp. 173-74, and [*Rodriguez*], at pp. 544-49 (*per* Lamer C.J.); see also [*Simpsons-Sears*]. A legal distinction need not be motivated by a desire to disadvantage an individual or group in order to violate s. 15(1). It is sufficient if the *effect* of the legislation is to deny someone the equal protection or benefit of the law. As McIntyre J. stated in *Andrews*, at p. 165, "[t]o approach the ideal of full equality before and under the law ... the main consideration must be the impact of the law on the individual or the group concerned". In this the Court has staked out a

different path than the United States Supreme Court, which requires a discriminatory intent in order to ground an equal protection claim under the Fourteenth Amendment of the Constitution; see *Washington, D.C. v. Davis*, 426 U.S. 229 (1976), *Village of Arlington Heights v. Metropolitan Housing Development Corp.*, 429 U.S. 252 (1977), and *Personnel Administrator of Massachusetts v. Feeney*, 442 U.S. 256 (1979).

...

Adverse effects discrimination is especially relevant in the case of disability. The government will rarely single out disabled persons for discriminatory treatment. More common are laws of general application that have a disparate impact on the disabled. This was recognized by the Chief Justice in his dissenting opinion in *Rodriguez*, *supra*, where he held that the law criminalizing assisted suicide violated s. 15(1) of the *Charter* by discriminating on the basis of physical disability. There, a majority of the Court determined, *inter alia*, that the law was saved by s. 1 of the *Charter*, assuming without deciding that it infringed s. 15(1). While I refrain from commenting on the correctness of the Chief Justice's conclusion on the application of s. 15(1) in that case, I endorse his general approach to the scope of that provision, which he set out as follows, at p. 549:

> Not only does s. 15(1) require the government to exercise greater caution in making express or direct distinctions based on personal characteristics, but legislation equally applicable to everyone is also capable of infringing the right to equality enshrined in that provision, and so of having to be justified in terms of s. 1. Even in imposing generally applicable provisions, the government must take into account differences which in fact exist between individuals and so far as possible ensure that the provisions adopted will not have a greater impact on certain classes of persons due to irrelevant personal characteristics than on the public as a whole. In other words, to promote the objective of the more equal society, s. 15(1) acts as a bar to the executive enacting provisions without taking into account their possible impact on already disadvantaged classes of persons.

....

This Court has consistently held, then, that discrimination can arise both from the adverse effects of rules of general application as well as from express distinctions flowing from the distribution of benefits. Given this state of affairs, I can think of no principled reason why it should not be possible to establish a claim of discrimination based on the adverse effects of a facially neutral benefit scheme. Section 15(1) expressly states, after all, that "[e]very individual is equal before and under the law and has the right to the equal protection *and* equal benefit of the law without discrimination ..." (emphasis added). The provision makes no distinction between laws that impose unequal burdens and those that deny equal benefits. If we accept the concept of adverse effect discrimination, it seems inevitable, at least at the s. 15(1) stage of analysis, that the government will be required to take special measures to ensure that disadvantaged groups are able to benefit equally

> from government services. As I will develop below, if there are policy reasons in favour of limiting the government's responsibility to ameliorate disadvantage in the provision of benefits and services, those policies are more appropriately considered in determining whether any violation of s. 15(1) is saved by s. 1 of the *Charter*.
>
> [Italic emphasis in original; underline emphasis added.]

[1036] *Eldridge* shows that substantive equality may require governments to take into account and accommodate the differing circumstances of all persons affected by laws, as well as to refrain from making explicitly discriminatory distinctions.

[1037] Although the analytical approach under s. 15 has evolved since *Andrews*, the commitment to substantive equality has continued. I will discuss later whether the principle so clearly stated in *Eldridge* is limited, as the defendants suggest, to the context of government services or benefit programs.

[1038] In *Withler* the Court confirmed the viability of effect-based discrimination claims, while suggesting that such claims are less straightforward than those based on facial distinctions (at para. 64):

> In some cases, identifying the distinction will be relatively straightforward, because a law will, on its face, make a distinction on the basis of an enumerated or analogous ground (direct discrimination). This will often occur in cases involving government benefits, as in *Law*, *Lovelace* and *Hodge*. In other cases, establishing the distinction will be more difficult, because what is alleged is indirect discrimination: that although the law purports to treat everyone the same, it has a disproportionately negative impact on a group or individual that can be identified by factors relating to enumerated or analogous grounds. Thus in *Granovsky*, the Court noted that "[t]he CPP contribution requirements, which on their face applied the same set of rules to all contributors, operated unequally in their effect on persons who want to work but whose disabilities prevent them from working" (para. 43). In that kind of case, the claimant will have more work to do at the first step. Historical or sociological disadvantage may assist in demonstrating that the law imposes a burden or denies a benefit to the claimant that is not imposed on or denied to others. The focus will be on the effect of the law and the situation of the claimant group.
>
> [Emphasis added.]

3. Comparisons

[1039] The Court explained in *Withler* the proper role of comparisons in establishing a distinction based on an enumerated or analogous ground, at paras. 62-63:

> The role of comparison at the first step is to establish a "distinction". Inherent in the word "distinction" is the idea that the claimant is treated differently than others. Comparison is thus engaged, in that the claimant asserts that he or she is denied a benefit that others are granted or carries a burden that others do not, by reason of a personal characteristic that falls within the enumerated or analogous grounds of s. 15(1).
>
> It is unnecessary to pinpoint a particular group that precisely corresponds to the claimant group except for the personal characteristic or characteristics alleged to ground the discrimination. Provided that the claimant establishes a distinction based on one or more enumerated or analogous grounds, the claim should proceed to the second step of the analysis. This provides the flexibility required to accommodate claims based on intersecting grounds of discrimination. It also avoids the problem of eliminating claims at the outset because no precisely corresponding group can be posited.

[1040] Mr. Arvay for the plaintiffs submits that the *Criminal Code* provisions create a distinction by having "a disproportionate impact on persons who, because of physical disability, are unable to act on the decision to end their lives as compared to those, who not being so disabled, are able to undertake that act of self-determination whenever they so choose".

[1041] The plaintiffs provide evidence that some individuals who wish to end their lives are unable to do so without assistance because of grievous and irremediable illness, and that some individuals, including Ms. Taylor, face the prospect of becoming unable, because of grievous and irremediable illness, to end their lives at the time of their choosing. The illnesses they point to include ALS, Huntington's disease, locked-in syndrome and severe inoperable spinal stenosis.

[1042] The evidence shows that for some individuals, the knowledge that they will be able to receive assistance in dying when they feel that they need such assistance allows them to continue living longer, and to continue to enjoy their lives while they can. Further, people with physical disabilities who are unable to end their lives themselves are forced into the dilemma of either continuing to suffer or exposing other persons to criminal sanctions. Some resolve this dilemma by taking their lives before their illnesses progress to a point where they are no longer able to do so.

[1043] I refer to some of this evidence.

[1044] Gloria Taylor deposes that her present quality of life is impaired by the fact that she is unable to ask for physician-assisted dying when she has reached a point that her life has ceased to be worthwhile for her. She says that she lives in apprehension that her death will be slow, difficult, unpleasant, painful, undignified and inconsistent with the values and principles she has tried to live by. She further deposes:

> I simply cannot understand why the law holds that the able-bodied who are terminally ill are allowed to shoot themselves when they have had enough because they are able to hold a gun steady, but because my illness affects my ability to move and control my body, I cannot be allowed compassionate help to allow me to commit an equivalent act using lethal medication. The law obliges me to act now and kill myself – while I am able but while my life is still enjoyable – or to forego altogether the right and ability to legally exercise control over the manner and timing of my death. That is a cruel choice to impose on someone.

[1045] In Australia, Robert Cordover suffered Motor Neuron Disease, a terminal neurological disease that causes progressive, irreversible paralysis but leaves the mind intact. Nica Cordover, his wife, deposes that he had watched his mother die of the same illness and knew soon after his diagnosis that he did not want to suffer through the entire cycle of the disease. Ms. Cordover describes her husband’s frustration because he wished to discuss with his physicians how he could take his own life when he had had enough but could not have the discussion because of the doctors’ fear of prosecution for assisting suicide. Mr. Cordover put much effort into researching means of an early death, and discussed with his wife such options as slitting his wrists, being abandoned to dehydration in the outback, and being put on a boat so that he could be “lost at sea”. However, he was loath to expose his family to the risk of investigation and prosecution at a time when they would be mourning his passing and already in distress.

[1046] In the end, Mr. Cordover obtained medication from a physician, Dr. Rodney Syme, and ended his life at a time that he chose.

[1047] Ian Petrie suffers from ALS. He describes the dilemma that he and his wife face because of the criminalization of physician-assisted dying:

> A physician-assisted death would be compassionate, legal, painless and dignified. The alternatives seem barbaric and cruel. There is also the fear and anxiety associated with taking my own life by other means. I am concerned about having a protracted and painful death should I do nothing, while on the other hand I dread the thought of suicide with the complexities and legal dilemma that will be involved if I have my wife assist me. We both face this reality, that we have only two terrible and imperfect options with a sense of horror and loathing.

[1048] Rosana Pellizzari's close friend Jacqui Emily Spoth had Friedreich's Ataxia, a rare genetic disorder that attacks the neuromuscular junction and leads to progressive muscle failure. Ms. Spoth used a wheelchair and remained independent with the support of attendants. Ms. Pellizzari described her friend as courageous and tenacious, as someone who loved life and lived it fully. However, the progress of the disease was unrelenting and her life became a struggle. As Ms. Pellizzari recounts:

> She said that she wanted to be able to choose the time when the pain and suffering outweighed any joy of living and she told me that she wished to commit suicide at that point. She researched and found out about methods of committing suicide. She discussed the methods and I knew what means she was going to use. Jacqui was very angry that as a disabled person, she did not have the same rights as able bodied persons: she said and I verily believed that she felt that she was going to have to choose suicide earlier than she may have liked as she was losing the ability to use her hands. She said that it would have been her choice to have a physician assist her with suicide. Had that been available to her, she said and I verily believed that she would have agreed to live longer. She told me that it was the fear of being trapped as an invalid with no one to assist her that drove her to choose an earlier end.

Ms. Pellizzari deposes that her friend took her own life, and died alone.

[1049] Canada acknowledges that physically disabled individuals are in a different situation than those without a physical disability with respect to their ability to end their lives without contravening the criminal law. However, it notes that people with complete disability can still commit suicide by refusing treatment, hydration or nutrition. Further, Canada points out that suicide is not an easy or comfortable experience for anyone.

[1050] While, on the basis of the comparison urged by the plaintiffs, there is clearly a distinction between physically disabled persons and others, both defendants argue that the plaintiffs need to show as well that the distinction relates to a "benefit of the law", a separate requirement that they say was established in *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, 2004 SCC 78 [*Auton*]*.* They say that both *Auton* and this case are distinguishable from *Eldridge* on that basis. I will address that question next.

4. Benefit Provided by Law

[1051] In *Auton*, the issue was the British Columbia government's failure to fund applied behavioral therapy for autism. The government funded a number of programs for autistic children but did not fund applied behavioural therapy for all autistic children between the ages of three and six. Among other reasons, the government cited financial constraints and the emergent and controversial nature of that therapy. Although the petitioners succeeded at trial and in the Court of Appeal, the Supreme Court of Canada dismissed their claim. One of the reasons was that the benefit claimed – funding for all medically required treatment – was not provided by law. The Court in *Auton* distinguished *Eldridge* at para. 38, stating:

> The petitioners rely on *Eldridge* in arguing for equal provision of medical benefits. In *Eldridge*, this Court held that the Province was obliged to provide translators to the deaf so that they could have equal access to core benefits accorded to everyone under the British Columbia medicare scheme. The decision proceeded on the basis that the law provided the benefits at issue – physician-delivered consultation and maternity care. However, by failing to provide translation services for the deaf, the Province effectively denied to one group of disabled people the benefit it had granted by law. *Eldridge* was concerned with unequal access to a benefit that the law conferred and with *applying* a benefit-granting law in a non-discriminatory fashion. <u>By contrast, this case is concerned with access to a benefit that the law has not conferred. For this reason, *Eldridge* does not assist the petitioners.</u>
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> [Italic emphasis in original; underline emphasis added.]

[1052] British Columbia argues that assistance by physicians in committing suicide is not a benefit provided by either the provincial or federal government. Thus, it says, the plaintiffs have failed to show a distinction based on an enumerated or analogous ground.

[1053] British Columbia urges that *Eldridge* is distinguishable because, in *Eldridge*, the provincial government provided a benefit, quality health care services. Although in principle the province provided that benefit equally to all, in fact persons whose deafness required a sign language interpreter could not access the benefit.

[1054] Canada's position is similar. It concedes that the prohibition on assisted suicide may result in a distinction between persons who, because of disability, are unable to end their lives without assistance, and those persons who are able to do so. However, the distinction does not relate to a benefit of the law under s. 15. Canada says that neither choice in the time and manner of one's death, nor access to a physician-assisted death, is a benefit of the law that is provided to anyone.

[1055] The plaintiffs reply that British Columbia's reliance on *Auton* is misplaced. They say that *Auton* was about the denial of benefits under a provincial health plan, but the plaintiffs are not seeking access to a benefit program such as health care or a pension plan. Rather, the benefit they claim is the benefit of being left alone to exercise their free choice on a fundamentally important matter. Counsel for the plaintiffs submits that Ms. Taylor's claim could equally be characterized as seeking freedom from a burden imposed by the law. Mr. Arvay refers to this statement in para. 27 in *Auton*:

> In order to succeed, the claimants must show unequal treatment under the law – more specifically that they failed to receive a benefit that the law provided, or was saddled with a burden the law did not impose on someone else. The primary and oft-stated goal of s. 15(1) is to combat discrimination and ameliorate the position of disadvantaged groups within society. Its specific promise, however, is confined to benefits and burdens "of the law". Combatting discrimination and ameliorating the position of members of disadvantaged groups is a formidable task and demands a multi-pronged response. Section 15(1) is part of that response. Section 15(2)'s exemption for affirmative action programs is another prong of the response. Beyond these lie a host of initiatives that governments, organizations and individuals

> can undertake to ameliorate the position of members of disadvantaged groups.
>
> [Emphasis added.]

[1056] The plaintiffs say that "the fact that the law does not provide a *positive* right to suicide is of no importance because the choice of suicide might be better characterized as the exercise of a *freedom*" (emphasis in original). Even if there is neither a positive right nor freedom to commit suicide, it is enough that the law denies the choice of suicide to one group while leaving it available to others. This, they say, denies a very important benefit or imposes a significant burden of the law, especially taking into account the nature of the interest at stake.

[1057] The plaintiffs rely on *Lavoie v. Canada*, 2002 SCC 23 at para. 45 as showing that the nature of the interest at stake must be taken into account in this analysis.

[1058] The plaintiffs say that the impugned *Criminal Code* provisions impose burdens on materially physically disabled individuals by disproportionately standing between these individuals and a timely end to their suffering – either because they must suffer longer than they wish to or because they must, in order to be autonomous, take steps to die at a time earlier than they would otherwise wish. In addition, they say that the affected individuals are robbed of the quality of their remaining life, subjected to psychological suffering related to decisions about imperilling their families, and required to burden their families with psychological suffering caused by witnessing them suffer.

[1059] The plaintiffs rely on the Reasons of Chief Justice Lamer in *Rodriguez*. The plaintiff in that case, as in this case, did not argue that suicide is a benefit of which she had been deprived. Instead, Ms. Rodriguez argued that she would be deprived of the right to choose suicide, and so to decide the conduct of her life for herself (at 552). Chief Justice Lamer referred to *R. v. Turpin*, [1989] 1 S.C.R. 1296 for the proposition that being deprived of the right to choose could be a disadvantage or burden for the purposes of an analysis under s. 15(1) of the *Charter* (at 553).

[1060] In *Turpin*, the issue was whether the plaintiffs had been deprived of their right to choose to be tried by judge alone (as opposed to a judge with a jury) in contravention of their right to equality under s. 15(1) of the *Charter.* Writing for the Court, Wilson J. concluded that being deprived of that choice constituted a disadvantage or burden imposed by law (at 1329-1330):

> The guarantee of equality before the law is designed to advance the value that all persons be subject to the equal demands and burdens of the law and not suffer any greater disability in the substance and application of the law than others. This value has historically been associated with the requirements of the rule of law that all persons be subject to the law impartially applied and administered. It was held by a majority of this Court in *R. v. Drybones*, [1970] S.C.R. 282, to require a law which made it an offence for an Indian to be intoxicated off a reserve to be struck down. As Ritchie J. stated at p. 297:
>
>> I think that the word “law” as used in s. 1(b) of the Bill of Rights is to be construed as meaning “the law of Canada” as defined in s. 5(2) (i.e. Acts of the Parliament of Canada and any orders, rules or regulations thereunder) and without attempting any exhaustive definition of “equality before the law” I think that s. 1(b) means at least that no individual or group of individuals is to be treated more harshly than another under that law, and I am therefore of opinion that an individual is denied equality before the law if it is made an offence punishable at law, on account of his race, for him to do something which his fellow Canadians are free to do without having committed an offence or having been made subject to any penalty.
>
> ...
>
> In short, the impugned provisions of the *Criminal Code* treat the appellants and those charged with the offences listed in s. 427 more harshly than those charged with the same offences in the province of Alberta who, because of s. 430, have an opportunity to be tried by judge alone if they deem this to be to their advantage. I would conclude, therefore, that the appellants’ right to equality before the law has been violated.

[1061] In response to the plaintiffs’ arguments about disproportionate burden, Canada emphasizes the context of the legislation, within a legal system embodying a general and centrally-important prohibition against the ending of human life. In this context, Canada says, there is no disproportionate burden on the plaintiffs.

[1062] In considering these arguments about whether the plaintiffs must establish that they are deprived of a benefit provided by law, I note that the Supreme Court not only has directed an ongoing focus on substantive equality, but also has rejected approaches which have proven susceptible to a slide into formalism or confusion: the "mirror comparator group" requirement (*Withler*); the "human dignity" test (*Kapp*); and the *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 [*Law*] conceptual factors as rigid requirements (*Kapp*).

[1063] In *Kapp*, McLachlin C.J. and Abella J., for the majority, discussed the idea of substantive equality at paras. 14-15, referring to *Andrews* and making clear that the equality guarantee relates to both benefits and burdens:

> Nearly 20 years have passed since the Court handed down its first s. 15 decision in the case of [*Andrews*]. *Andrews* set the template for this Court's commitment to substantive equality – a template which subsequent decisions have enriched but never abandoned.
>
> Substantive equality, as contrasted with formal equality, is grounded in the idea that: "The promotion of equality entails the promotion of a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration": *Andrews*, at p. 171, *per* McIntyre J., for the majority on the s. 15 issue. Pointing out that the concept of equality does not necessarily mean identical treatment and that the formal "like treatment" model of discrimination may in fact produce inequality, McIntyre J. stated (at p. 165):
>
>> To approach the ideal of full equality before and under the law – and in human affairs an approach is all that can be expected – the main consideration must be the impact of the law on the individual or the group concerned. <u>Recognizing that there will always be an infinite variety of personal characteristics, capacities, entitlements and merits among those subject to a law, there must be accorded, as nearly as may be possible, an equality of benefit and protection and no more of the restrictions, penalties or burdens imposed upon one than another. In other words, the admittedly unattainable ideal should be that a law expressed to bind all should not because of irrelevant personal differences have a more burdensome or less beneficial impact on one than another.</u>
>
> While acknowledging that equality is an inherently comparative concept (p. 164), McIntyre J. warned against a sterile similarly situated test focussed on treating "likes" alike. An insistence on substantive equality has remained central to the Court's approach to equality claims.
>
> [Emphasis added.]

[1064] In my view, the need to focus on substantive equality, emphatically reaffirmed in *Kapp* and *Withler*, is not limited to cases where a "benefit provided by the law", in the sense of access to a government benefit program, has been denied. The

Supreme Court of Canada dismissed the claim in *Auton*, among other reasons, because the plaintiff in effect was seeking to compel the government to expand a benefit program. The Court in *Auton* did not state that s. 15 only encompasses claims for benefits conferred by the law. Section 15, and the substantive equality approach, also encompass claims for the removal of burdens imposed by the law where those burdens are based on characteristics (such as disability) specified in s. 15 or analogous to them.

5. What counts as a "distinction"?

[1065] The law prohibits assisted suicide for able-bodied and disabled persons alike; the law permits death-hastening acts through refusal or withdrawal of treatment and palliative/terminal sedation for able-bodied and disabled persons alike.

[1066] British Columbia's position is that even if they are not defeated by the "benefit of the law" requirement, the plaintiffs have failed to establish a "distinction". It says that, upon analysis, the plaintiffs are not denied either equal protection or equal benefit of the law.

[1067] Mr. Copley argues that the legislation does not create a distinction since both disabled and able-bodied persons receive exactly the same protection from the state; all persons are denied access to physician-assisted suicide or euthanasia. He submits that "the able bodied and the disabled can equally commit suicide by refusing to eat or drink or by refusing provision of artificial nutrition or hydration". Decriminalization of suicide does not in purpose or effect draw a distinction between the able-bodied and the disabled, and s. 241*(b)* of the *Criminal Code* merely removes one means of committing suicide. Although an able-bodied person may have more possible choices as to means of committing suicide, the means of committing suicide is not a benefit conferred by government in the first place.

[1068] British Columbia suggests that the plaintiffs' claim rests on an inaccurate premise: that there are people whose physical incapacity prevents them from ending their own lives. The premise is inaccurate, it says, because anyone, disabled or able-bodied, can choose to die by starvation or dehydration.

[1069] Canada, too, submits that those with a complete physical disability may still commit suicide by refusing sustenance. Canada's argument asserts that persons with disabilities are treated with equal dignity and respect since they, along with the able-bodied, are equally denied access to assisted death.

[1070] With respect to the argument that physically disabled persons are not actually disproportionately burdened because they can choose to die through starvation, dehydration or both, the plaintiffs say that leaving the physically disabled to that choice is cruel, given the evidence that such a death can be slow and excruciating.

[1071] Dr. Syme deposes that the palliative sedation of a person who is suffering intolerably, but has a strong cardio-respiratory system and is well-hydrated may take up to 7-10 days. He states that "[s]uch a death is frankly a gruesome and macabre process for all involved if it takes more than 3 days. For patients with some chronic neurological disease and for some cancers with bone and neuropathic pain, it may well take that or even longer."

[1072] With respect to the legal assumption embedded in the defendants' argument, the plaintiffs point to the reasons of Chief Justice McLachlin in *Lavoie*, dissenting but not on this point (at para. 5):

> Finally, much has been made of the fact that some of the appellants in this case could have become citizens, but chose not to. In our view, this consideration does not militate against a finding of discrimination. First, such a choice can be attributed to only two of the appellants. Second, in any event the benefit is denied during the period that is required before a permanent resident can obtain citizenship. <u>Third, the fact that a person could avoid discrimination by modifying his or her behaviour does not negate the discriminatory effect. If it were otherwise, an employer who denied women employment in his factory on the ground that he did not wish to establish female changing facilities could contend that the real cause of the discriminatory effect is the woman's "choice" not to use men's changing facilities. The very act of forcing some people to make such a choice violates human dignity, and is therefore inherently discriminatory. The law of discrimination thus far has not required applicants to demonstrate that they could not have avoided the discriminatory effect in order to establish a denial of equality under s. 15(1).</u> The Court in Andrews was not deterred by such considerations. On the contrary, La Forest J. specifically noted that acquiring Canadian citizenship could in some cases entail the "serious hardship" of losing an existing citizenship. He left no doubt that this hardship was a cost

> to be considered in favour of the individual affected by the discrimination: Andrews, supra, at p. 201.
>
> [Emphasis added.]

[1073] The Supreme Court of Canada's direction for courts is to retain focus on the central purpose of s. 15 and its animating norm: substantive equality. I have already set out why the norm of substantive equality requires attention to both express distinctions in the law and distinctions arising from the ways in which some formally neutral laws may affect people differently. The defendants' argument that everyone is precluded from assistance in suicide, not only persons who are physically disabled, ignores the adverse impact/unintended effects discrimination analysis central to the substantive equality approach.

[1074] British Columbia also suggests that the plaintiffs' claim is problematic because it does not encompass all persons who might wish to be able to receive assistance in suicide, "leaving out" those whose problem is not physical disability but lack of will to attempt suicide themselves. Insofar as that argument suggests that the plaintiffs' claim is flawed because it fails to include all persons who might have claims under s. 15 based on enumerated or analogous grounds, I think it fails. It is not necessary for every member of a disadvantaged group to be affected the same way in order to establish that the law creates a distinction based upon an enumerated or analogous ground. In *Nova Scotia (Workers' Compensation Board) v. Martin*, [2003] 2 S.C.R. 504, Gonthier J. for the Court stated at paras. 75-77:

> The relevant potential ground of discrimination in this case is "physical disability", a ground expressly included in s. 15(1). The question here is whether the differential treatment of chronic pain sufferers is truly based on this enumerated ground. While the Attorney General of Nova Scotia concedes that it is, the Board argues that since both the claimants and the comparator group suffer from physical disabilities, differential treatment of chronic pain within the workers' compensation scheme is not based on physical disability. Rather, argues the Board, the differential treatment must derive from some other basis.
>
> In my view, this argument is without merit. <u>This Court has long recognized that differential treatment can occur on the basis of an enumerated ground despite the fact that not all persons belonging to the relevant group are equally mistreated.</u>
>
> ...

> Likewise, in *Brooks v. Canada Safeway Ltd*., [1989] 1 S.C.R. 1219, the employer argued that the exclusion of pregnancy from a group health insurance policy did not amount to sex discrimination, because it did not affect all women but only those who were pregnant. Dickson C.J. rejected this argument too, holding that, since only women could become pregnant, distinctions based on pregnancy could be nothing other than distinctions based on or related to sex. Thus, he concluded, the exclusion of pregnancy from the list of compensable conditions constituted sex discrimination.
>
> [Emphasis added.]

[1075] In summary, the defendants submit that there is really no distinction because, first, the law prohibits assisted suicide for able-bodied and disabled persons alike and, second, the law permits death-hastening acts through refusal or withdrawal of treatment, or declining nutrition and hydration while under palliative sedation, for able-bodied and disabled alike.

[1076] My conclusion is that the first argument is no answer to the claim since the plaintiffs have shown that the impact of the law on themselves and others is distinct, based on the enumerated ground of disability. The second argument fails because there are means of suicide available to non-disabled persons that are much less onerous than self-imposed starvation and dehydration, and it is only physically disabled persons who are restricted to that single, difficult course of action.

6. Conclusion

[1077] I find the conclusion inescapable that the *Criminal Code* provisions regarding assisted suicide have a more burdensome effect on persons with physical disabilities than on others. I am satisfied that the absolute prohibition against assisted suicide creates a distinction based on the enumerated ground of physical disability.

[1078] I turn to the next question: whether the plaintiffs have shown that the distinction is discriminatory.

B. Is the Distinction Discriminatory in that it Creates a Disadvantage by Perpetuating Prejudice or Stereotyping?

[1079] The second step of the test as summarized in *Withler* at para. 30 is: "Does the distinction create a disadvantage by perpetuating prejudice or stereotyping?"

[1080] I begin by noting that the concise wording of this second step of the test (formulated in *Kapp*, then reiterated in *Withler*) does not require literal reading, as if it were a statutory provision. The Supreme Court made clear in *Withler* that it is not only when a distinction "perpetuates prejudice or stereotyping" that it may be discriminatory. The real question is whether the distinction perpetuates disadvantage or prejudice, or stereotypes people in a way that does not correspond to their actual characteristics or circumstances. That there are at least two alternative ways in which discrimination may be found (through perpetuation of disadvantage or prejudice, or through stereotyping) is evident in these comments of McLachlin C.J. and Abella J. in *Withler* at paras. 35-36:

> The first way that substantive inequality, or discrimination, may be established is by showing that the impugned law, in purpose or effect, perpetuates prejudice and disadvantage to members of a group on the basis of personal characteristics within s. 15(1). Perpetuation of disadvantage typically occurs when the law treats a historically disadvantaged group in a way that exacerbates the situation of the group. Thus judges have noted that historic disadvantage is often linked to s. 15 discrimination. In [*Turpin*], for example, Wilson J. identified the purposes of s. 15 as "remedying or preventing discrimination against groups suffering social, political and legal disadvantage in our society" (p. 1333). See also *Haig v. Canada (Chief Electoral Officer)*, [1993] 2 S.C.R. 995, at pp. 1043-44; *Andrews*, at pp. 151-53, *per* Wilson J.; *Law*, at paras. 40-51.
>
> The second way that substantive inequality may be established is by showing that the disadvantage imposed by the law is based on a stereotype that does not correspond to the actual circumstances and characteristics of the claimant or claimant group. Typically, such stereotyping results in perpetuation of prejudice and disadvantage. However, it is conceivable that a group that has not historically experienced disadvantage may find itself the subject of conduct that, if permitted to continue, would create a discriminatory impact on members of the group. If it is shown that the impugned law imposes a disadvantage by stereotyping members of the group, s. 15 may be found to be violated even in the absence of proof of historic disadvantage.
>
> [Emphasis added.]

[1081] The analysis requires consideration of the actual impact of the law, as stated in *Withler* at paras. 37 and 39-40:

> Whether the s. 15 analysis focuses on perpetuating disadvantage or stereotyping, the analysis involves looking at the circumstances of members of the group and the negative impact of the law on them. The analysis is contextual, not formalistic, grounded in the actual situation of the group and the potential of the impugned law to worsen their situation.
>
> ...
>
> Both the inquiries into perpetuation of disadvantage and stereotyping are directed to ascertaining whether the law violates the requirement of substantive equality. Substantive equality, unlike formal equality, rejects the mere presence or absence of difference as an answer to differential treatment. It insists on going behind the facade of similarities and differences. It asks not only what characteristics the different treatment is predicated upon, but also whether those characteristics are relevant considerations under the circumstances. <u>The focus of the inquiry is on the actual impact of the impugned law, taking full account of social, political, economic and historical factors concerning the group. The result may be to reveal differential treatment as discriminatory because of prejudicial impact or negative stereotyping. Or it may reveal that differential treatment is required in order to ameliorate the actual situation of the claimant group.</u>
>
> It follows that a formal analysis based on comparison between the claimant group and a “similarly situated” group, does not assure a result that captures the wrong to which s. 15(1) is directed – the elimination from the law of measures that impose or perpetuate substantial inequality. What is required is not formal comparison with a selected mirror comparator group, but an approach that looks at the full context, including the situation of the claimant group and whether the impact of the impugned law is to perpetuate disadvantage or negative stereotypes about that group.
>
> [Emphasis added.]

[1082] The above passage from *Withler*, at paras. 37 and 39, shows that an effects-based analysis is just as necessary in assessing discrimination, in this second part of the test, as it is in identifying a distinction, in the first part of the test.

[1083] That the concise summary of the test (essentially, from *Kapp*) is not to be applied literally is further underscored by this statement by McLachlin C.J. and Abella J. at the outset of their application of the test to the facts in *Withler*, at para. 70:

> The issue is whether the Reduction Provisions that reduce the supplementary death benefit for the beneficiaries of older deceased members violate

> s. 15(1)'s protection of substantive equality. <u>The question is whether, having regard to the relevant context, the impugned law perpetuates disadvantage or prejudice, or stereotypes the claimant group.</u>
>
> [Emphasis added.]

[1084] In *Withler*, in the context of its discussion of the proper approach to comparison in s. 15 analysis, the Court elaborated on the analytical framework to be employed in the second step and addressed the role of comparisons (at para. 65):

> The analysis at the second step is an inquiry into whether the law works substantive inequality, by perpetuating disadvantage or prejudice, or by stereotyping in a way that does not correspond to actual characteristics or circumstances. At this step, comparison may bolster the contextual understanding of a claimant's place within a legislative scheme and society at large, and thus help to determine whether the impugned law or decision perpetuates disadvantage or stereotyping. The probative value of comparative evidence, viewed in this contextual sense, will depend on the circumstances.

[1085] In determining whether a distinction is discriminatory, the contextual factors specified in *Law* (pre-existing disadvantage, correspondence with actual characteristics, ameliorative purposes or effects and the nature of the interest affected) may be considered, among other factors, as the Court stated in *Withler* at paras. 38 and 66:

> Without attempting to limit the factors that may be useful in assessing a claim of discrimination, it can be said that where the discriminatory effect is said to be the perpetuation of disadvantage or prejudice, evidence that goes to establishing a claimant's historical position of disadvantage or to demonstrating existing prejudice against the claimant group, as well as the nature of the interest that is affected, will be considered. Where the claim is that a law is based on stereotyped views of the claimant group, the issue will be whether there is correspondence with the claimants' actual characteristics or circumstances. Where the impugned law is part of a larger benefits scheme, as it is here, the ameliorative effect of the law on others and the multiplicity of interests it attempts to balance will also colour the discrimination analysis.
>
> ...
>
> The particular contextual factors relevant to the substantive equality inquiry at the second step will vary with the nature of the case. A rigid template risks consideration of irrelevant matters on the one hand, or overlooking relevant considerations on the other: *Kapp*. <u>Factors such as those developed in *Law*- pre-existing disadvantage, correspondence with actual characteristics, impact</u>

> on other groups and the nature of the interest affected – may be helpful. However, they need not be expressly canvassed in every case in order to fully and properly determine whether a particular distinction is discriminatory (see *Ermineskin Indian Band*; *A.C. v. Manitoba*; *Hutterian Brethren*). Just as there will be cases where each and every factor need not be canvassed, so too will there be cases where factors not contemplated in *Law* will be pertinent to the analysis. At the end of the day, all factors that are relevant to the analysis should be considered. As Wilson J. said in *Turpin*,
>
>> In determining whether there is discrimination on grounds relating to the personal characteristics of the individual or group, it is important to look not only at the impugned legislation which has created a distinction that violates the right to equality but also to the larger social, political and legal context.
>
> [Emphasis added.]

[1086] Under the *Law* approach, the contextual factors were construed in the light of their impact on human dignity. In *Kapp*, however, the Supreme Court of Canada observed that while respect for human dignity is an essential value underlying the *Charter* guarantee, it is an abstract and subjective notion, and its use as part of a legal test has led to difficulty (at para. 22):

> But as critics have pointed out, human dignity is an abstract and subjective notion that, even with the guidance of the four contextual factors, cannot only become confusing and difficult to apply; it has also proven to be an *additional* burden on equality claimants, rather than the philosophical enhancement it was intended to be. Criticism has also accrued for the way *Law* has allowed the formalism of some of the Court's post-*Andrews* jurisprudence to resurface in the form of an artificial comparator analysis focussed on treating likes alike.
>
> [Emphasis in original.]

Therefore, the Court said, it is more useful to focus on the contextual factors themselves rather than on the "dignity" analysis.

[1087] With respect to discrimination through perpetuation of disadvantage, the plaintiffs say that people with grievous illnesses suffering from physical disabilities are disadvantaged and that the law disadvantages them further.

[1088] With respect to discrimination through stereotyping, the plaintiffs argue that a law that says that physically disabled persons may not kill themselves, while others can, is predicated on a belief that physically disabled persons lack sufficient autonomy or agency to make such momentous decisions. Mr. Arvay characterizes the premise that disabled people are more susceptible to coercion or influence as patronizing, and says that such an assumption infantilizes disabled people and feeds prejudice and discrimination against them.

[1089] Canada, on the other hand, says that the plaintiffs' claim amounts to this: Parliament must create an exemption, sanctioning the giving of assistance to extremely disabled people who wish to end their lives. It points, however, to the overarching principle to be found in our laws, the prohibition against the taking of life. Canada thus argues that if the prohibition does create a distinction on the basis of disability, it does not arise from discrimination but from a "neutral and rationally defensible policy choice", in the words of the majority in *Hutterian Brethren* at para. 108.

[1090] The defendants rely on two cases (*A.C.*; *Hutterian Brethren*), both decided since *Kapp* but prior to *Withler*, for the proposition that where a government policy is neutral and rational, it is not discriminatory, even if it has a particular impact on persons who, for example, are disabled.

[1091] *Hutterian Brethren* involved a challenge to provincial legislation that required the taking of photographs for drivers' licences. The plaintiffs objected on religious grounds. The majority of the Court, *per* McLachlin C.J., addressed in some detail the plaintiffs' claim that the requirement infringed their freedom of religion, and dismissed that claim on the ground that the legislation constituted a justifiable limit under s. 1. With respect to the s. 15 claim, the majority stated at paras. 105-108:

> <u>The s. 15 claim was not considered at any length by the courts below and addressed only summarily by the parties in this Court</u>. In my view, it is weaker than the s. 2(*a*) claim and can easily be dispensed with. To the extent that the s. 15(1) argument has any merit, many of my reasons for dismissing the s. 2(*a*) claim apply to it as well.
>
> Briefly, s. 15(1) is "aimed at preventing discriminatory distinctions that impact adversely on members of groups identified by the grounds enumerated in s. 15 and analogous grounds": [*Kapp*], at para. 16. Religion is a ground enumerated in s. 15. As recently restated by this Court in *Kapp*, at para. 17, the test for discrimination under s. 15(1) is as follows:

> > (1) Does the law create a distinction based on an enumerated or analogous ground?
> >
> > (2) Does the distinction create a disadvantage by perpetuating prejudice or stereotyping?
>
> The respondents claim that “[r]efusing to issue licences to the Wilson Members who otherwise qualify for such licences simply because they refuse to abandon their religious belief in the Second Commandment, but issuing licences to the comparator group simply because they do not share such religious belief, clearly demeans and infringes upon the human dignity of the Wilson Members” (Factum, at para. 39). However, photo licences are not issued to other drivers “simply because they do not share such religious belief”, but rather because they meet the statutory requirements for issuance of a licence – which include having a photo taken.
>
> Assuming the respondents could show that the regulation creates a distinction on the enumerated ground of religion, it arises not from any demeaning stereotype but from a neutral and rationally defensible policy choice. There is no discrimination within the meaning of [*Andrews*], as explained in *Kapp*. The Colony members’ claim is to the unfettered practice of their religion, not to be free from religious discrimination. The substance of the respondents’ s. 15(1) claim has already been dealt with under s. 2(*a*). There is no breach of s. 15(1).
>
> [Emphasis added.]

[1092] In *Withler*, the Court reaffirmed that proof of intention to discriminate is not a requirement at any stage of the s. 15 analysis. Although the defendants argue that the failure of the s. 15 claim in *Hutterian Brethren* indicates otherwise, I do not think that can be the case.

[1093] The defendant government in *Hutterian Brethren* conceded an infringement of freedom of religion, and the focus of the case was on justification under s. 1 (the majority finding that the infringement was justified, the three dissenting members of the Court, *per* Abella J., concluding that it was not). The majority’s s. 15 analysis in *Hutterian Brethren* was very brief, and stemmed from less than full argument by counsel. It included no discussion of adverse impact discrimination, nor any reference to *Eldridge* or to the statements of principle in *Andrews* and *Law*, reaffirmed in *Kapp*. It would be mistaken, in my view, to read the *Hutterian Brethren* decision as a repudiation of the adverse impact analysis approved in the long line of cases I have referred to, especially in the light of what the Court later said in *Withler*.

[1094] The second case upon which the defendants rely is *A.C.*, decided shortly before *Hutterian Brethren*. The majority's reasoning in the s. 15 analysis in *A.C.* turned on its conclusion that the legislation appropriately permitted room for consideration of a mature minor's views regarding medical treatment. The majority indicated that otherwise, if the legislation did not allow for consideration of the individual minor's views, it would likely have been found to infringe s. 15. I do not think that *A.C.* adds weight to the defendants' contention that the existence of a "neutral and rationally defensible policy choice" provides a final answer to a s. 15 claim.

[1095] Read in context, the expression "neutral and rationally defensible policy choice" in *Hutterian Brethren* simply states the majority's conclusion about the s. 15 claim in that case, upon consideration of the relevant factors there. I do not believe that the majority's s. 15 discussion is meant to state a new test for s. 15 infringement. The fact that "neutral and rationally defensible policy choice" was not a term used subsequently in *Withler*, where the Court was setting out the proper analytical framework for s. 15, supports that conclusion.

[1096] I will proceed, then, to assess whether there is discrimination according to the test set down in *Withler*, with reference to the contextual factors first recognized in *Law*.

1. First Contextual Factor: Pre-Existing Disadvantage

[1097] The first contextual factor goes to the heart of s. 15 by directing attention to whether a group has been historically disadvantaged.

[1098] In *Law*, Justice Iacobucci for the Court stated, at para. 63, that pre-existing disadvantage may be the most compelling factor bearing on whether a distinction is truly discriminatory:

> As has been consistently recognized throughout this Court's jurisprudence, probably the most compelling factor favouring a conclusion that differential treatment imposed by legislation is truly discriminatory will be, where it exists, pre-existing disadvantage, vulnerability, stereotyping, or prejudice experienced by the individual or group: [citations omitted]. These factors are

> relevant because, to the extent that the claimant is already subject to unfair circumstances or treatment in society by virtue of personal characteristics or circumstances, persons like him or her have often not been given equal concern, respect, and consideration. It is logical to conclude that, in most cases, further differential treatment will contribute to the perpetuation or promotion of their unfair social characterization, and will have a more severe impact upon them, since they are already vulnerable.
>
> [Emphasis added.]

[1099] The plaintiffs point to the evidence that they have provided, and to evidence provided by Canada, that disabled people face pre-existing disadvantage, vulnerability, stereotyping and prejudice in Canadian society. For example, Professor Frazee, a Professor Emerita of disability studies, states in her affidavit:

> Disabled people have a distinct experience. We are perceived as less fortunate than nondisabled people and assigned a diminished status in everyday life – these perceptions and status shape our experience, both when we are lively and autonomous and when we are fragile and vulnerable.
>
> Disability rights advocates have for decades fought against negative stereotypes, discriminatory barriers and persistent cultural devaluation in the effort to achieve equality. Discrimination on the basis of disability – both direct and systemic – is pervasive and persistent. As acknowledged by the Supreme Court of Canada in the Eldridge decision:
>
> > It is an unfortunate truth that the history of disabled persons in Canada is largely one of exclusion and marginalization. Persons with disabilities have too often been excluded from the labour force, denied access to opportunities for social interaction and advancement, subjected to invidious stereotyping and relegated to institutions ...

[1100] The defendants do not dispute the existence of pre-existing disadvantage affecting people with disabilities, although Canada says that this first contextual factor is not particularly important in this case.

[1101] In my view, it is important to recognize that there are many reasons why a person might be seriously physically disabled: disabilities may be congenital, acquired through trauma, or arise from disease. In that and in their nature, physical disabilities vary widely, as do the people who live with them.

[1102] Persons (such as Ms. Rodriguez and Ms. Taylor) who have acquired physically disabling conditions as a result of serious illness but who have not lived with such disabilities throughout their lives may be seen for that reason to fall outside the category of persons with pre-existing disadvantage. I refer here to the dissenting Reasons of Justices McLachlin and L'Heureux-Dubé in *Rodriguez* at 616, when they refer to the "true focus" of s. 15 on remedying or preventing discrimination against groups subject to stereotyping, historical disadvantage and political and social prejudice. Their reasoning may have reflected that view. However, in my respectful opinion, s. 15 is aimed not only at groups but also at individuals. Further, persons with recently-acquired disabilities who are grievously ill and suffering are just as precluded from the option of suicide as are those with lifelong experience of living with disability, their disabilities are just as real, and they, too, are subject to disadvantage.

2. Second Contextual Factor: Correspondence Between the Law and the Claimant's Circumstances

[1103] This second contextual factor from the *Law* analysis was described by Iacobucci J. for the Court this way at para. 70:

> It is thus necessary to analyze in a purposive manner the ground upon which the s. 15(1) claim is based when determining whether discrimination has been established. As a general matter, as stated by McIntyre J. in *Andrews*, *supra*, and by Sopinka J. in *Eaton*, *supra*, and referred to above, legislation which takes into account the actual needs, capacity, or circumstances of the claimant and others with similar traits in a manner that respects their value as human beings and members of Canadian society will be less likely to have a negative effect on human dignity. This is not to say that the mere fact of impugned legislation's having to some degree taken into account the actual situation of persons like the claimant will be sufficient to defeat a s. 15(1) claim. The focus must always remain upon the central question of whether, viewed from the perspective of the claimant, the differential treatment imposed by the legislation has the effect of violating human dignity. The fact that the impugned legislation may achieve a valid social purpose for one group of individuals cannot function to deny an equality claim where the effects of the legislation upon another person or group conflict with the purpose of the s. 15(1) guarantee. In line with the reasons of McIntyre J. and Sopinka J., I mean simply to state that it will be easier to establish discrimination to the extent that impugned legislation fails to take into account a claimant's actual situation, and more difficult to establish discrimination to the extent that legislation properly accommodates the claimant's needs, capacities, and circumstances.
>
> [Emphasis added.]

[1104] Thus, the Supreme Court of Canada in *Law* emphasized that, to the extent that the law takes into account the claimant's actual situation in a manner that respects the claimant's needs, capacities and circumstances, it is less likely to be discriminatory.

[1105] It is useful to note the two examples that the Court chose in *Law* to illustrate this contextual factor (at para. 71): *Eldridge*, and *Weatherall v. Canada (Attorney General)*, [1993] 2 S.C.R. 872. I have already described *Eldridge*. *Weatherall* concerned a challenge by a male prisoner to frisk searching and patrolling of cell ranges conducted by female guards. The Court held at 877-78:

> It is also doubtful that s. 15(1) is violated. In arguing that the impugned practices result in discriminatory treatment of male inmates, the appellant points to the fact that female penitentiary inmates are not similarly subject to cross-gender frisk searches and surveillance. The jurisprudence of this Court is clear: equality does not necessarily connote identical treatment and, in fact, different treatment may be called for in certain cases to promote equality. Given the historical, biological and sociological differences between men and women, equality does not demand that practices which are forbidden where male officers guard female inmates must also be banned where female officers guard male inmates. The reality of the relationship between the sexes is such that the historical trend of violence perpetrated by men against women is not matched by a comparable trend pursuant to which men are the victims and women the aggressors. Biologically, a frisk search or surveillance of a man's chest area conducted by a female guard does not implicate the same concerns as the same practice by a male guard in relation to a female inmate. Moreover, women generally occupy a disadvantaged position in society in relation to men. Viewed in this light, it becomes clear that the effect of cross-gender searching is different and more threatening for women than for men. The different treatment to which the appellant objects thus may not be discrimination at all.
>
> [Emphasis added.]

[1106] Neither case involved the defence of legislative provisions on the basis that they protected persons who disagreed that they needed such protection (which is how the plaintiffs would characterize a defence of s. 241*(b)* on the ground that it protects persons with disabilities). The examples show that the Court was alert to the risk that this second contextual factor, if used simply to assess the closeness of the "fit" of the legislation, could boil down to the formalistic "similarly situated" test rejected in *Andrews*.

[1107] Thus, this factor takes account of the fact that the Canadian conception of equality requires the government to accommodate difference, which was the conclusion in both *Eldridge* and *Weatherall*. Identical treatment in the sense of uniform application of the rules would have created inequality in both of those cases.

[1108] With reference to the second contextual factor, the majority in *Kapp* wrote that it is essentially aimed at stereotyping (at para. 23):

> The analysis in a particular case, as *Law* itself recognizes, more usefully focuses on the factors that identify impact amounting to discrimination. The four factors cited in *Law* are based on and relate to the identification in *Andrews* of perpetuation of disadvantage and stereotyping as the primary indicators of discrimination. Pre-existing disadvantage and the nature of the interest affected (factors one and four in *Law*) go to perpetuation of disadvantage and prejudice, <u>while the second factor deals with stereotyping.</u> The ameliorative purpose or effect of a law or program (the third factor in *Law*) goes to whether the purpose is remedial within the meaning of s. 15(2). (We would suggest, without deciding here, that the third *Law* factor might also be relevant to the question under s. 15(1) as to whether the effect of the law or program is to perpetuate disadvantage.)
>
> [Emphasis added.]

[1109] In *Withler*, the Supreme Court of Canada approved the decision of the trial judge, who had considered the entire context and purpose of a broad-based benefit scheme meant to cover the competing interests of various age groups and then concluded that the legislative scheme as a whole accounted for the claimants' needs. The Court noted (at para. 77) that the degree of correspondence between the differential treatment and the claimant group's reality confirmed the absence of negative stereotyping on the basis of age.

[1110] The plaintiffs argue that the impugned provisions do not correspond at all with the needs and circumstances of persons with physical disabilities. This is because, they say, if the provisions seek to prevent vulnerable populations, such as people with disabilities, from being coerced or unduly influenced into hastening their death against their true wishes, or from hastening their death in a time of depression, they rest upon a false premise – that people with disabilities are more susceptible than others, less autonomous, less capable of agency, or more likely to be suicidal.

[1111] The plaintiffs refer to opinion evidence from Professors Sheila McLean and Laura Williamson, both law and medicine researchers in Scotland, who opine that whatever special considerations may pertain when decisions are being made on behalf of people with disabilities, “there is little logic in suggesting that people with disabilities are less able than non-disabled people to make decisions *for themselves* that reflect their own considered and competent opinions” (emphasis in original). Professors McLean and Williamson state:

> Silvers, for example, opines and we agree that making any such assumption feeds rather than starves discriminatory attitudes, saying that ‘[c]haracterizing people with disabilities as incompetent, easily coerced, and inclined to end their lives places them in the roles to which they have been confined by disability discrimination. She further contends that:
>
>> There was no reason to accept the claim that the judgment of individuals with disabilities is so incapacitated by the exclusion and isolation they face as to make them incompetent and incapable of self-determination. Moreover, despite acknowledging the systematic marginalization that people with disabilities endure, it seems wrong to think that having any kind of disability means being cognitively or psychologically disabled by society. To do so is to equate being disabled in any way with being globally debilitated.
>
> We adopt that opinion.
>
> Nor is there reason to believe that people with disability are more likely to be suicidal or to seek an assisted death. As Silvers notes, ‘[n]oticeably absent from the current discussion about assisted suicide are data showing that people with disabilities are more apt to end their lives than other classes of people.’ Indeed, in the US state of Oregon, where physician assisted suicide is legalised in certain circumstances, the consistent majority of those obtaining a lethal prescription are suffering from cancer, and while cancer is accepted as a ‘disability’ in some countries, such as the United Kingdom, it is clear that it is not to this group of people with disability that the rhetoric of the disability organisations is primarily addressed.
>
> In addition, we must be careful to distinguish between situations where autonomy is ignored or overridden and those where people wish to make their own decisions. As Shakespeare says and we agree:
>
>> ... it is important to distinguish situations where the autonomy of disabled people is undermined (abuse of ‘do not resuscitate’ notices, non-voluntary euthanasia) from situations where disabled or terminally ill people themselves are exercising their autonomy by requesting assistance with death, or withdrawal of treatment (advance directives, assisted suicide). A failure to draw relevant distinctions and a

> failure to engage with the clinical realities undermines many disability rights critiques.
>
> [Footnotes omitted.]

[1112] The plaintiffs say that the evidence before this Court supports the validity of what Professors McLean and Williamson assert. They point to persons who are suffering disabling conditions who are neither apparently depressed nor vulnerable. Ms. Taylor is one such individual.

[1113] The plaintiffs contend that the evidence from other jurisdictions supports the opinion of Professors McLean and Williamson. That evidence, they say, shows that the liberalization of the laws on assisted dying has not disproportionately impacted vulnerable populations, such as the disabled, and that most of those who seek assisted death have cancer but do not suffer from an otherwise disabling condition.

[1114] I have referred to much of this evidence in my discussion of the effectiveness of safeguards and will not repeat it here. I concluded that the evidence does generally support the plaintiffs' argument.

[1115] On the other hand, Canada argues that the impugned legislation takes into account the actual needs, capacities or circumstances of the plaintiffs in a manner that respects their value as human beings and members of Canadian society, and is therefore not discriminatory. British Columbia adopts Canada's submission.

[1116] Taking the purpose of the legislation as the protection of individuals who might be induced in moments of weakness to commit suicide (as found by the Supreme Court of Canada in *Rodriguez* at 595), Canada says that the legislation does not rest on an assumption that an individual with disability is less able to make autonomous decisions than an individual without disability. Instead, it is based on the understanding that all persons who are considering suicide are vulnerable and in need of protection from the interventions of others.

[1117] Canada refers to the evidence regarding Parliament's objectives when it repealed the criminal offence of attempted suicide in 1972, and submits as follows:

> The absence of a criminal prohibition on suicide and attempted suicide is not a reflection of a greater degree of respect for the autonomous decision-making capacity of able-bodied persons. It simply reflects the limits of the criminal law in relation to the motivation that drives the person who wishes to end his or her life. Parliament has deemed that people contemplating suicide are not objects of the criminal law, but rather people who need help. <u>Although it may seem paternalistic to seek to dissuade those who no longer wish to live from committing suicide, it is no more paternalistic than other laws designed to "save people from themselves." [referring to *Malmo-Levine* at para. 124] The law in this respect is equally paternalistic to the able-bodied and the disabled.</u>
>
> [Emphasis added.]

[1118] Canada further suggests that the heightened risk for individuals with disabilities does not flow from their capacity to make autonomous decisions, but from the way in which a disabled person's request for physician-assisted dying is perceived in an "ableist" society. Ms. Nygard argues that, for example, "[t]wo individuals who are diagnosed with a treatable form of cancer, one with disabilities and one without, have the same ability to make autonomous decisions", but the concern is that "the request from a disabled person will more readily be presumed to be rational … because of stereotypical assumptions about the disabled individual's quality of life". She submits that disabled people may be more vulnerable for that reason, and they should therefore not be excluded from the prohibition against assisted death. Such a concern was recognized in the United States Supreme Court in *Washington v. Glucksberg*, 521 US 702 (1997) at 732:

> The State's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference" 49 F. 3d, at 492. The State's assisted suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's.

[1119] Context is vital in the analysis, Canada submits, referring to *Gosselin v. Québec (Attorney General)*, 2002 SCC 84, at paras. 24-25, where Chief Justice McLachlin, for the majority, wrote:

> To determine whether a distinction made on an enumerated or analogous ground is discriminatory, we must examine its context. As Binnie J. stated in *Granovsky, supra*, at para. 59, citing U.S. Supreme Court Marshall J.'s partial dissent in *Cleburne v. Cleburne Living Centre, Inc.*, 473 U.S. 432 (1985): "[a] sign that says 'men only' looks very different on a bathroom door than a courthouse door". In each case, we must ask whether the distinction, viewed in context, treats the subject as less worthy, less imbued with human dignity, on the basis of an enumerated or analogous ground.
>
> The need for a contextual inquiry to establish whether a distinction conflicts with s. 15(1)'s purpose is the central lesson of *Law*. The issue, as my colleagues and I all agree, is whether "a reasonable person in circumstances similar to those of the claimant would find that the legislation which imposes differential treatment has the effect of demeaning his or her dignity" having regard to the individual's or group's traits, history, and circumstances: *Law*, at para. 60, followed in *Lovelace, supra*, at para. 55.
>
> [Emphasis added.]

[1120] Canada's position is that although the prohibition against assisted death may impact the disabled differently, it is not rooted in stereotypical assumptions about the disabled and does not treat them as being less worthy of respect than able-bodied persons. Rather, Canada says, the legislation corresponds to the real needs and circumstances of the disabled. The intervenor Euthanasia Prevention Coalition makes a similar argument.

[1121] I also note the submissions of the Christian Legal Fellowship. That intervenor argues that the absolute prohibition effectively promotes the equality of all persons by drawing a bright line at the inviolability principle, which prevents the intentional taking of innocent human life. Allowing a choice to end life, the CLF says, promotes the view that some lives are more valuable than others, and threatens the principle of equality.

[1122] In reply, the plaintiffs point to Canada's concessions that not every person who wishes to commit suicide is vulnerable and that not every physically disabled person is vulnerable. They say that those concessions reinforce the point that the law is based on a stereotypical assumption that the disabled are more vulnerable, and less autonomous, than the able-bodied.

[1123] The plaintiffs also say that there is no evidence that doctors will be more predisposed to agree to assisted death with disabled patients than with cancer patients, and that the existence of any such predisposition is implausible.

[1124] At a fundamental level, the plaintiffs say, they disagree with the approach to disability rights infusing the governments' position and the position of the EPC. They say that it is arrogant for governments or disabled rights activists to assume that a person whose illness has led to disability and dependency on others for feeding, toileting and all other bodily needs, must be acting irrationally in wishing to have the choice to end their existence.

[1125] Counsel for the intervenor Ad Hoc Coalition of People with Disabilities who are Supportive of Physician-Assisted Dying similarly says that the legislative purpose enunciated by the Crown – protecting the vulnerable from being coerced to end their own lives – incorporates the untenable assumption that all those persons who cannot end their own lives without assistance due to disability are by definition vulnerable, or more vulnerable, to coercion than others. In that respect, it argues that the absolute prohibition fails to correspond to the actual circumstances of persons with disabilities, as it encompasses an assumption that the fact of physical disability renders otherwise autonomous decisions less than fully autonomous.

[1126] Canada does not argue that someone who is seriously physically disabled is therefore less able to make autonomous decisions. It does argue, however, that people who are seriously physically disabled as a result of serious illness may be vulnerable and require protection from inducement, in moments of weakness, to commit suicide, just as anyone contemplating suicide is vulnerable and in need of protection.

[1127] Canada's argument also draws on the particular vulnerability that persons with disabling conditions (however acquired) may experience due to the social construction of disability and its impact on health care providers, family members and patients themselves.

[1128] In summary, Canada's arguments about the second contextual factor rest upon two contentions. First, it argues that the absolute prohibition against assisted death is necessary and "fits" (corresponds with) the actual needs, capacities and circumstances of persons with physical disabilities, including persons such as Gloria Taylor. Second, it asserts that persons with disabilities are treated with equal dignity and respect since they, along with the able-bodied, are equally denied access to assisted death.

[1129] Canada's submissions attempt to situate the risk not in some lack of capacity or strength of will of the disabled people who might request assisted death, but rather in unconscious bias on the part of those who might respond to such requests. However, there is little evidence before the Court that physicians and other care-givers would, even unconsciously, respond differently to requests for assisted death from physically disabled persons as opposed to others. Even if that were the case, the argument still rests upon the assumption that even the most independent-minded, clearest-thinking person with physical disabilities needs protection from the bias of doctors and caregivers.

[1130] With regard to the second aspect of Canada's argument, I think that it ignores the adverse impact/unintended effects discrimination analysis central to the substantive equality approach. At bottom, this contention amounts to the same form of argument as the rejected similarly situated approach. That approach was rejected because it is no answer to an equality claim to show that the impugned legislation closely or perfectly fits its designated objective such that "similarly situated people" are treated "similarly". In this case, by Canada's admission, the legislation operates to deprive non-vulnerable people such as Ms. Taylor of the agency that they would have if they were not physically disabled. Thus, although (as Canada submits) the law is "equally paternalistic to the able-bodied and the disabled", the paternalism does not affect them all in the same way, with very significant consequences.

3. Third Contextual Factor: Ameliorative Purpose

[1131] In *Law*, the Supreme Court described the third contextual factor in these terms at para. 72:

> Another possibly important factor will be the ameliorative purpose or effects of impugned legislation or other state action upon a more disadvantaged person or group in society. As stated by Sopinka J. in *Eaton*, *supra*, at para. 66: “the purpose of s. 15(1) of the *Charter* is not only to prevent discrimination by the attribution of stereotypical characteristics to individuals, but also to ameliorate the position of groups within Canadian society who have suffered disadvantage by exclusion from mainstream society”. <u>An ameliorative purpose or effect which accords with the purpose of s. 15(1) of the *Charter* will likely not violate the human dignity of more advantaged individuals where the exclusion of these more advantaged individuals largely corresponds to the greater need or the different circumstances experienced by the disadvantaged group being targeted by the legislation.</u> I emphasize that this factor will likely only be relevant where the person or group that is excluded from the scope of ameliorative legislation or other state action is more advantaged in a relative sense. Underinclusive ameliorative legislation that excludes from its scope the members of a historically disadvantaged group will rarely escape the charge of discrimination: see *Vriend*, *supra*, at paras. 94-104, *per* Cory J.
>
> [Emphasis added.]

[1132] In *Kapp*, this factor was said to go to whether the purpose is remedial within the meaning of s. 15(2) (the affirmative action provision) or, possibly, to whether the effect of the law or program is to perpetuate disadvantage.

[1133] In *Kapp*, the Court found that the government’s aboriginal fisheries program, challenged by non-aboriginal fishers, fell within the meaning of s. 15(2) and, accordingly, did not infringe s. 15(1).

[1134] The plaintiffs argue that the third contextual factor has no application in this case since the issue before the Court does not involve a more advantaged group of individuals making a discrimination claim against a program designed to assist a less advantaged group. They characterize the defendants’ position this way: “the purpose or effect of the Impugned Provisions are to protect the disabled, *all of whom are vulnerable whether they realize it or not* based on the ‘social model’ of disability” (emphasis in original). They reply to that position in these terms:

> It ... takes the social model of disability too far if it can be used to allow Parliament to enact laws that *burden severely disabled individuals and attribute to them functional limitations that they do not have* simply on the theory that disability is often socially constructed. It is one thing to *prevent* Parliament from imposing burdens on the disabled that may be based on socially constructed limitations; it is entirely another matter to allow Parliament to *impose* burdens on the disabled because of a fear that socially constructed ideas or limitations can somehow overwhelm individual choice and decision making.
>
> [Emphasis in original.]

[1135] The plaintiffs refer to *Granovsky v. Canada (Minister of Employment and Immigration)*, 2000 SCC 28 at para. 30, where Binnie J., for the Court, wrote with reference to the social model of disability:

> The bedrock of the appellant's argument is that many of the difficulties confronting persons with disabilities in everyday life do not flow ineluctably from the individual's condition at all but are located in the problematic response of society *to* that condition. <u>A proper analysis necessitates unbundling the impairment from the reaction of society to the impairment, and a recognition that much discrimination is socially constructed</u>. See, e.g., D. Pothier, "Miles to Go: Some Personal Reflections on the Social Construction of Disability" (1992), 14 *Dalhousie L.J.* 526. <u>Exclusion and marginalization are generally not created by the individual with disabilities but are created by the economic and social environment and, unfortunately, by the state itself. Problematic responses include, in the case of government action, legislation which discriminates *in its effect* against persons with disabilities, and thoughtless administrative oversight.</u> The appellant says that his treatment by the CPP shows the inequality that can result when government enacts social programs with inadequate attention, at the design stage, for the true circumstances of people with disabilities.
>
> [Italic emphasis in original; underline emphasis added.]

[1136] Canada does not in fact emphasize this third contextual factor. It simply submits as follows:

> It is recognised that not every person who wishes to commit suicide is vulnerable, and that there may be people with disabilities who have a considered, rational and persistent wish to end their own lives. Ms. Taylor may be such a person. However, as already discussed at length above, there are other individuals who may be vulnerable because of their circumstances. The blanket prohibition reflects the difficulty of reliably identifying and protecting those vulnerable persons who may be at greater risk if some form of assisted suicide or euthanasia was allowed.

[1137] Canada also says that an ameliorative effect of a provision may be considered in the context of a s. 15(1) analysis even where the provision does not have an ameliorative purpose within the meaning of s. 15(2). Canada relies on *Withler* at para. 38, where the Court said that "[w]here the impugned law is part of a larger benefits scheme, as it is here, the ameliorative effect of the law on others and the multiplicity of interests it attempts to balance will also colour the discrimination analysis". Canada further relies on *Kapp* at para. 23.

[1138] The intervenor Euthanasia Prevention Coalition submits that this factor ought to weigh towards a conclusion that the absolute prohibition is not discriminatory because it ameliorates the position of disadvantaged persons by preventing the risk of harm to and further devalued perception of persons with disabilities.

[1139] As already mentioned, in *Withler* and *Kapp* the Supreme Court of Canada made clear that the contextual factors are not to be applied as a rigid formula. Not every factor will be relevant to every case.

[1140] The ameliorative purpose or effects factor suggests that s. 15 is not infringed if the challenged law or activity serves to reduce the disparity between a disadvantaged group or individual and a more advantaged counterpart. In my view, *Law* holds that this factor will likely only be relevant when the person or group excluded from ameliorative laws or activities is more advantaged in a relative sense. In this case, the materially physically disabled persons who are affected by the *Criminal Code* provisions are less advantaged, in a relative sense, than other Canadians who are able to choose to die without attracting the attention of the *Criminal Code*.

[1141] I have also set out why I believe that the *Criminal Code* provisions impose an added burden on claimants, rather than depriving them of a benefit. In my opinion, this is not a case where a program aimed at ameliorating the condition of disadvantaged persons is challenged by others who are excluded from it. It is not a remedial program within the meaning of s. 15(2). Thus, I conclude that the third contextual factor has no application to this case.

4. Fourth Contextual Factor: Nature of the Interest Affected

[1142] The fourth factor was described in *Law* at para. 74 in these terms:

> A further contextual factor which may be relevant in appropriate cases in determining whether the claimant's dignity has been violated will be the nature and scope of the interest affected by the legislation. This point was well explained by L'Heureux-Dubé J. in *Egan*, *supra*, at paras. 63-64. As she noted, at para. 63, "[i]f all other things are equal, the more severe and localized the . . . consequences on the affected group, the more likely that the distinction responsible for these consequences is discriminatory within the meaning of s. 15 of the *Charter*". L'Heureux-Dubé J. explained, at para. 64, that <u>the discriminatory calibre of differential treatment cannot be fully appreciated without evaluating not only the economic but also the constitutional and societal significance attributed to the interest or interests adversely affected by the legislation in question. Moreover, it is relevant to consider whether the distinction restricts access to a fundamental social institution, or affects "a basic aspect of full membership in Canadian society", or "constitute[s] a complete non-recognition of a particular group".</u>
>
> [Emphasis added.]

[1143] The plaintiffs emphasize this factor and say that the interests at stake in this case are fundamental, relating to personal integrity, autonomy and fundamental choices about one's own body and life.

[1144] The plaintiff Gloria Taylor deposes:

> What I want is to be able to die in a manner that is consistent with the way that I lived my life. I want to be able to exercise control and die with dignity and with my sense of self and personal integrity intact. I want to be able to experience my death as part of my life and part of my expression of that life. I do not want the manner of my death to undermine the values that I lived my life in accordance with. I do not need the government to dictate for me how I should spend the last moments of my life or how I should die.

[1145] One of the plaintiffs' witnesses, Elayne Shapray, who has secondary progressive multiple sclerosis, deposes:

> I understand that suicide is no longer a crime in Canada. The irony of the current situation as I experience it is that an able-bodied person can commit suicide in a lawful manner but somebody such as myself, who is unable by reason of their disability to do so, cannot. The means available to me to terminate my life unassisted at this time, if I was so inclined, are extremely limited and would likely involve violent, painful or personally terrifying outcomes. I consider the option of taking my own life by conventional

> "suicide" means, assuming that I was otherwise physically and emotionally able to do so, not only to be dangerous and inhumane, but also likely to be extremely traumatic to my family and my friends.
>
> I live in dread of the day when I will have been robbed of all meaningful quality of life by the progression of my disease. I fear that I will not have the option that others have of ending ones' own life. I wish to have the choice of a dignified, physician-assisted termination of my life at the time of my choosing rather than being terrified daily about how I may end up simply because at a future date there would be no one able to legally help me.
>
> The current state of the law deprives me of the freedom to choose how and when I would end my life. The current law may cause me to initiate a premature termination of my life simply because if I wait until I am ready to do so, I may be unable to do so, in any humane fashion, without asking my loved ones to put themselves at legal risk.

[1146] Counsel for Canada defines the interest at stake differently and much more specifically: "the ability for a person to end his or her life in a manner and at a time of his or her choosing." Referring to the language of the Supreme Court of Canada in *Law*, Canada submits that a person's ability to end his life in the manner and time of his choice is not a basic aspect of full membership in Canadian society, and suicide is not a fundamental social institution. Canada argues that Parliament did not signal recognition of a right to commit suicide when it abolished the criminal prohibition on suicide, nor did it signal that individual autonomy would predominate over the state interest in preserving life. Instead, Canada says, the abolition of the criminal offence of suicide "simply reflects Parliament's considered view that the person who wishes to end his or her own life is properly the subject of health law, rather than the criminal law."

[1147] Canada emphasizes that suicide is not condoned, let alone recognized as a legal right.

[1148] The arguments here intersect with those made in the context of s. 7 regarding deprivation of life, liberty and security of the person. The interests at stake relate to the autonomy of an individual over her or his own body, and to the quality of life of terminally ill persons.

[1149] Autonomy with respect to physical integrity is a value of fundamental importance in the Canadian Constitution. Its place in the constitutional order is paralleled by its place in the common law. The starting point in our law – the default position – is that persons control their own physical integrity. Instances when other persons or the state are permitted to usurp that control are the exception, not the rule.

[1150] In fact, the historical direction of the law has been to limit and circumscribe the occasions when an individual’s physical integrity may be usurped, as part of the increasing recognition of full personhood in previously excluded categories of persons.

[1151] An example with direct relevance to this case is the evolution of the doctrine of informed consent to medical treatment. As outlined in the section on medical ethics, the law has now made clear that competent and informed individuals have the absolute right to refuse or withdraw from medical treatment, including life-sustaining treatment.

[1152] In the RSC Report, the expert panel saw the value of informed choice as a central pillar of contemporary health ethics and of Canadian health law, stating at 43:

> Informed choice is grounded in autonomy; it seeks to apply the abstract value of autonomous decision making to the context of health care. It requires that competent patients must not be subjected to treatment unless they have consented to it. That consent is subject to three conditions: first, it must be uncoerced; second, it must result from the decision making capacity of a cognitively competent individual; and third, it must be informed. A conception of autonomy can thus be read in informed choice as the cornerstone of modern medical ethics and Canadian health law. An autonomous person would, according to this conception, be a substantively cognitively competent and uncoerced individual who arrives at his or her decisions after having been offered relevant information about the decision at hand.
>
> [Footnotes omitted.]

[1153] Autonomy, however, is not the sole constitutional value. Canadian values are not limited to those of autonomy and freedom from state interference. They also include recognition of the value of social connection and community. Indeed, the equality value itself has both an individual and a group dimension.

[1154] The intervenor Euthanasia Prevention Coalition submits that the principles of community interdependence and the sanctity of life justify the Criminal Code provisions. Legalizing assisted suicide, it says, would erode these principles by dehumanizing certain members of the community. The EPC says the Court must weigh these values against the values of autonomy and self-determination emphasized by the plaintiffs.

[1155] Recognizing the strength of that point, for the purposes of this discussion – regarding the nature of the interests affected by the absolute prohibition against assisted death – it suffices to say that while the interests affected, including autonomy with respect to physical integrity, may not trump all other constitutional values, they are among the values that are fundamentally important and central to personhood and have long been affirmed in the common law and in the Canadian Constitution.

[1156] It must not be overlooked that what is at stake for someone in Gloria Taylor's situation is not merely autonomy, nor is it simply autonomy with respect to physical integrity. It is the autonomy to relieve herself of suffering.

[1157] I think that the interests at stake in this case should not be narrowly defined. They are, as the plaintiffs submit, fundamental.

C. Conclusion

[1158] The law, viewed as a whole, embodies the following principles: (1) persons who seek to take their own lives, but fail, are not subject to criminal sanction because there is no longer a criminal offence of suicide or attempted suicide; (2) persons who are rendered unable, by physical disability, to take their own lives are precluded from receiving assistance in order to do so by the *Criminal Code* offence of assistance with suicide. Those principles create a distinction based on physical disability.

[1159] The effect of the distinction is felt particularly acutely by a subset of persons with physical disabilities represented by the plaintiff Gloria Taylor and others such as Mr. Fenker (now deceased), Mr. Morcos and Ms. Shapray – persons who are grievously and irremediably ill and physically disabled or will soon become so, are mentally competent, have full cognitive capacity, and wish to have a measure of control over their circumstances at the end of their lives. They may not wish to experience prolonged pain. They may wish to avoid the anxiety that comes with fear that future pain will become unbearable at a time when they are helpless. They may not wish to undergo palliative sedation without hydration or nutrition for reasons including concern for their families, fear for themselves or reaction against the total loss of independence at the end of their lives.

[1160] The defendants' position is that, nevertheless, the distinction is not discriminatory because its purpose is to protect vulnerable people, including people with disabilities, and it is effective in doing so.

[1161] In my opinion, the law creates a distinction that is discriminatory. It perpetuates and worsens a disadvantage experienced by persons with disabilities. The dignity of choice should be afforded to Canadians equally, but the law as it stands does not do so with respect to this ultimately personal and fundamental choice. I will address in the next section, on s. 1 justification, the arguments raised by the defendants regarding the purpose and benefits of the legislation.

[1162] I find that the plaintiff Gloria Taylor has established an infringement of her right to equality under s. 15 of the *Charter*.

XII. JUSTIFICATION

[1163] Having found that the impugned provisions infringe s. 15 in that they preclude persons with material physical disability who are grievously ill and experiencing intractable suffering from receiving assistance in suicide, I turn to the question whether the prohibition on assisted death nevertheless constitutes a reasonable limit that is justified under s. 1 of the *Charter*.

[1164] Section 1 provides:

> The *Canadian Charter of Rights and Freedoms* guarantees the rights and 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.

A. The Rodriguez Conclusion on S. 1

[1165] The majority of the Supreme Court of Canada in *Rodriguez* held that any violation of s. 15 could not be saved by s. 1 (at 613-615). The defendants say that that decision is binding and correct.

[1166] I have referred to the majority decision in *Rodriguez* on s. 1 justification earlier in subsection X (B), “What did *Rodriguez* Decide?”. In its brief discussion of s. 1, the majority held that s. 241*(b)* of the *Criminal Code* has a pressing and substantial purpose – the protection of the vulnerable who might be induced in moments of weakness to commit suicide – and that the legislation is rationally connected to that purpose. Parliament must be accorded some flexibility in dealing with this contentious and morally laden issue, and the government had shown a reasonable basis for concluding that it had complied with the requirement for minimal impairment. No halfway measure would assuredly achieve the legislation’s purpose. It followed, Sopinka J. wrote, that the final aspect of the proportionality test had also been met.

[1167] Justice Sopinka placed considerable reliance on the consensus among western countries, medical organizations and the Law Reform Commission of Canada, and on the lack of evidence supporting the effectiveness of safeguards.

[1168] I have explained why I think that it is appropriate for this Court, applying the *Hutterian Brethren* framework, to address the s. 1 justification arguments based on the evidence in this case. Because the change in the s. 1 framework marked by *Hutterian Brethren* relates essentially to the final step, my analysis will be briefer with respect to the other steps. I will, however, address each of them in order to provide context for the final aspect of the test, where the salutary and deleterious effects are balanced.

B. The Analytical Framework

[1169] The analytical framework for a s. 1 analysis is well-known, and was most recently set out in *Hutterian Brethren*. Broadly speaking, after addressing whether the limit is prescribed by law, the analysis focuses on proportionality and proceeds through these steps:

(1) Is the purpose for which the limit is imposed pressing and substantial?
(2) Are the means by which the legislative purpose is furthered proportionate?
    (a) Is the limit rationally connected to the purpose?
    (b) Does the limit minimally impair the *Charter* right?
    (c) Is the law proportionate in its effect?

[1170] It is the objective for the infringing measure or omission that is relevant (*RJR-MacDonald v. Canada (Attorney General)*, [1995] 3 S.C.R. 199 at para. 144).

[1171] In this case, I have found that the infringement arises from the preclusion of physically disabled persons who are grievously ill and experiencing intractable suffering from ending their lives. Thus, it is the absolute nature of the prohibition against assisted suicide that requires justification, not the prohibition overall. In other words, the real question is whether the defendants have demonstrated justification for criminalizing the rendering of assistance in suicide to persons such as Gloria Taylor.

C. Burden and Standard of Proof, Deference and Context

[1172] The burden is on the defendants to prove on the balance of probabilities that the limit on the plaintiffs' *Charter* right is justified: *Oakes* at paras. 64-68. Chief Justice Dickson described the standard of justification this way in *Oakes* at paras. 65-66:

> The rights and freedoms guaranteed by the *Charter* are not, however, absolute. It may become necessary to limit rights and freedoms in circumstances where their exercise would be inimical to the realization of collective goals of fundamental importance. For this reason, s. 1 provides

> criteria of justification for limits on the rights and freedoms guaranteed by the *Charter*. These criteria impose a stringent standard of justification, especially when understood in terms of the two contextual considerations discussed above, namely, the violation of a constitutionally guaranteed right or freedom and the fundamental principles of a free and democratic society.
>
> The onus of proving that a limit on a right or freedom guaranteed by the *Charter* is reasonable and demonstrably justified in a free and democratic society rests upon the party seeking to uphold the limitation. It is clear from the text of s. 1 that limits on the rights and freedoms enumerated in the *Charter* are exceptions to their general guarantee. The presumption is that the rights and freedoms are guaranteed unless the party invoking s. 1 can bring itself within the exceptional criteria which justify their being limited. This is further substantiated by the use of the word "demonstrably" which clearly indicates that the onus of justification is on the party seeking to limit: *Hunter v. Southam Inc., supra*.
>
> [Emphasis added.]

[1173] Those comments must, of course, be read in light of what was said in later cases, and most recently in *Hutterian Brethren*.

[1174] In *Hutterian Brethren,* Chief Justice McLachlin made these observations, for the majority at paras. 35, 37:

> This Court has recognized that a measure of leeway must be accorded to governments in determining whether limits on rights in public programs that regulate social and commercial interactions are justified under s. 1 of the *Charter*. Often, a particular problem or area of activity can reasonably be remedied or regulated in a variety of ways. The schemes are typically complex, and reflect a multitude of overlapping and conflicting interests and legislative concerns. They may involve the expenditure of government funds, or complex goals like reducing antisocial behaviour. The primary responsibility for making the difficult choices involved in public governance falls on the elected legislature and those it appoints to carry out its policies. Some of these choices may trench on constitutional rights.
>
> ...
>
> If the choice the legislature has made is challenged as unconstitutional, it falls to the courts to determine whether the choice falls within a range of reasonable alternatives. Section 1 of the *Charter* does not demand that the limit on the right be perfectly calibrated, judged in hindsight, but only that it be "reasonable" and "demonstrably justified". Where a complex regulatory response to a social problem is challenged, courts will generally take a more deferential posture throughout the s. 1 analysis than they will when the impugned measure is a penal statute directly threatening the liberty of the accused. Courts recognize that the issue of identity theft is a social problem that has grown exponentially in terms of cost to the community since photo licences were introduced in Alberta in 1974, as reflected in the government's

> attempt to tighten the scheme when it discontinued the religious exemption in 2003. The bar of constitutionality must not be set so high that responsible, creative solutions to difficult problems would be threatened. A degree of deference is therefore appropriate: *Edwards Books*, at pp. 781-82, *per* Dickson C.J., and [*JTI-Macdonald Corp.*] at para. 43, *per* McLachlin C.J.
>
> [Emphasis added.]

[1175] Justification under s. 1 is a process of demonstration, not intuition or automatic deference (*RJR* at para. 128):

> Second, to meet its burden under s. 1 of the *Charter*, the state must show that the violative law is “demonstrably justified”. The choice of the word “demonstrably” is critical. The process is not one of mere intuition, nor is it one of deference to Parliament’s choice. It is a process of demonstration. This reinforces the notion inherent in the word “reasonable” of rational inference from evidence or established truths.

[1176] Analyzing the objective of an impugned provision and whether that provision is justified requires close attention to the provision’s context. The context is relevant to calibration of the level of deference due to legislative choice. The context, and the appropriate level of deference, in turn affect the standard of proof that the defender of the provision will be required to provide.

[1177] In *Thomson Newspapers Co. v. Canada (Attorney General)*, [1998] 1 S.C.R. 877 at para. 88, Bastarache J. for the majority wrote:

> Characterizing the context of the impugned provision is also important in order to determine the type of proof which a court can demand of the legislator to justify its measures under s. 1. This question is suitably addressed at the outset because it affects the entirety of the s. 1 analysis, and because of the nature of the evidence in this case.

[1178] The standard of proof was addressed in *Sauvé v. Canada (Chief Electoral Officer)*, 2002 SCC 68 at para. 18, where McLachlin C.J., for the majority, adverted to the fact that some matters are not amenable to scientific proof and that what is required is “rational, reasoned defensibility”:

> While deference to the legislature is not appropriate in this case, legislative justification does not require empirical proof in a scientific sense. <u>While some matters can be proved with empirical or mathematical precision, others, involving philosophical, political and social considerations, cannot. In this</u>

> case, it is enough that the justification be convincing, in the sense that it is sufficient to satisfy the reasonable person looking at all the evidence and relevant considerations, that the state is justified in infringing the right at stake to the degree it has: see *RJR-MacDonald*, *supra*, at para. 154, *per* McLachlin J.; *R. v. Butler*, [1992] 1 S.C.R. 452, at pp. 502-3, *per* Sopinka J. What is required is "rational, reasoned defensibility": *RJR-MacDonald*, at para. 127. Common sense and inferential reasoning may supplement the evidence: *R. v. Sharpe*, [2001] 1 S.C.R. 45, 2001 SCC 2, at para. 78, *per* McLachlin C.J. However, one must be wary of stereotypes cloaked as common sense, and of substituting deference for the reasoned demonstration required by s. 1.
>
> [Emphasis added.]

[1179] In the context of this case, several factors favour deference to Parliament. First, the question of physician-assisted death involves a fundamental and complex social policy choice about which there are conflicting views in Canada. Second, making that choice involves weighing the suffering of known individuals against the potential harm to other unknown individuals and to societal values. Third, the potential harms and benefits to society are not amenable to clear scientific proof.

[1180] At the same time, and weighing to some extent against deference, the simple, blanket prohibition embodied in the impugned *Criminal Code* provisions does not fall within the description (from *Hutterian Brethren*) of a "complex regulatory response to a social problem". Further, at issue is a penal statute directly threatening the liberty of those who fail to abide by it.

[1181] The primary responsibility for making the difficult choices, as the majority stated in *Hutterian Brethren*, falls on the elected legislature. I have found that the choice to maintain an absolute prohibition against physician-assisted death trenches on constitutional rights. In considering whether that choice is justifiable, I must afford to Parliament a degree of deference.

[1182] I will return to the question of deference at the minimal impairment stage of my analysis. As the majority in *M. v. H.*, [1999] 2 S.C.R. 3 pointed out at para. 79, the question of deference is intimately tied up with the nature of the particular claim or evidence at issue.

D. Are the Limits on *Charter* Rights Prescribed by Law?

[1183] It is undisputed, and I find, that the limits are prescribed by law.

E. Is the Purpose of the Legislation Pressing and Substantial?

1. What is the purpose of the legislation?

[1184] The decision in *Rodriguez* is binding; therefore, I will begin with a review of what the judges who considered that case determined to be the purpose of s. 241*(b)* of the *Criminal Code*. British Columbia provided a compendium in its submissions, from which I quote:

> At trial in *Rodriguez* Mr. Justice Melvin captured in a few words a vivid picture of the state objective or the legislative purpose of s. 241*(b)* of the *Criminal Code* which was challenged in that case:
>
> > When one considers the nature of s. 241 and its purpose, in my view, it is demonstrably justified in a free and democratic society as it is designed to protect those who may at a moment of weakness, or when they are unable to respond or unable to make competent value judgments, may find themselves at risk at the hand of others who may, with the best or with the worst of motives, aid and abet in the termination of life. Section 241 protects the young, the innocent, the mentally incompetent, the depressed, and all those other individuals in our society who at a particular moment in time decide that termination of their life is a course that they should follow for whatever reason. Section 241 precludes anyone aiding and abetting in that conduct.
> >
> > [*Rodriguez BCSC* at 9]
>
> …
>
> Chief Justice McEachern (in dissent on the result but not on the purpose of the legislation) in the Court of Appeal expressly adopted the passage quoted above saying: “I am content to accept the description of the purpose of s. 241 given by the learned trial judge in this case ... .”
>
> > [*Rodriguez BCCA* at para. 81]
>
> Mr. Justice Hollinrake had a similar view of the protective aspect of s. 241*(b)* as McEachern C.J. and cited the reasons the Law Reform Commission of Canada gave in Working Paper 28 for prohibiting assisted suicides in the case of the terminally ill:
>
> > The probable reason why legislation has not made an exception for the terminally ill lies in the fear of the excesses or abuses to which liberalization of the existing law could lead. As in the case of “compassionate murder”, decriminalization of

> aiding suicide would be based on the humanitarian nature of the motive leading the person to provide such aid, counsel or encouragement. As in the case of compassionate murder, moreover, the law may legitimately fear the difficulties involved in determining the true motivation of the person committing the act.
>
> Aiding or counseling a person to commit suicide, on the one hand, and homicide, on the other, are sometimes extremely closely related. Consider, for example, the doctor who holds the glass of poison and pours the contents into the patient's mouth. Is he aiding him to commit suicide? Or is he committing homicide, since the victim's willingness to die is legally immaterial? There is reason to fear that homicide of the terminally ill for ignoble motives may readily be disguised as aiding suicide.
>
> [*Rodriguez BCCA* at paras. 125, 154-155]

Like Hollinrake J.A., Proudfoot J.A. quoted the concerns of the Law Reform Commission of Canada in Working Paper No. 28 as support for her position that the broad, religious, ethical, moral and social issues implicit in the case before the court are not suited to resolution by a court on affidavit evidence at the instance of a single individual.

> [*Rodriguez BCCA* at paras. 170-172]

In the SCC in *Rodriguez*, Lamer C.J. (in dissent on the result but not on the purpose of the legislation) characterized the legislative objective of s. 241*(b)* as follows:

> The appellant does not appear to dispute that the legislation in question is aimed at the protection of persons who may be vulnerable to the influence of others in deciding whether, when and how to terminate their lives. The trial judge referred to this constituency in the following terms:
>
> > ... those who may at a moment of weakness, or when they are unable to respond or unable to make competent value judgments, may find themselves at risk at the hand of others who may, with the best or with the worst of motives, aid and abet in the termination of life. Section 241 protects the young, the innocent, the mentally incompetent, the depressed, and all those other individuals in our society who at a particular moment in time decide the termination of their life is a course that they should follow for whatever reason.
>
> I accept this characterization.
>
> [*Rodriguez* at 558]

The Chief Justice found this legislative objective as he expressed it to be "pressing and substantial":

> With these limitations in mind, I conclude that the objective of s. 241*(b)* of the Code may properly be characterized as the protection of vulnerable people, whether they are consenting

> or not, from the intervention of others in decisions respecting the planning and commission of the act of suicide. Underlying this legislative purpose is the principle of preservation of life. Section 241*(b)* has, therefore, a clearly pressing and substantial legislative objective
>
> [*Rodriguez* at 561]

Sopinka J. for majority in terse language captured the very essence of the purpose of s. 241*(b)*:

> Section 241*(b)* has as its purpose the protection of the vulnerable who might be induced in moments of weakness to commit suicide. This purpose is grounded in the state interest in protecting life and reflects the policy of the state that human life should not be depreciated by allowing life to be taken.
>
> [*Rodriguez* at 595, 613]

[1185] While British Columbia's position is that the impugned legislation has as its purpose the protection of the vulnerable who might be induced in moments or times of weakness to commit suicide, Canada asserts broader objectives for the legislation. Although it does not argue that the objective is the preservation of life, without qualification, it says that the prohibition against assisted suicide and euthanasia is grounded in the state interest in the preservation of life, and reflects the policy that human life should not be depreciated by allowing one person to take another's life (referring to *Rodriguez* at 595). Canada agrees that one of the harms the prohibition seeks to prevent is inducement of vulnerable individuals to commit suicide in moments of weakness.

[1186] Counsel for Canada submits that Parliament has identified additional harms to individuals and Canadian society since *Rodriguez*. Ms. Nygard refers to debates on Private Member's Bills over the past two decades, including in particular the Parliamentary debate in 2010 on Bill C-384, *An Act to Amend the Criminal Code (right to die with dignity)*.

[1187] In submissions that I take to be alternative to its main submission that *Rodriguez* is binding, Canada argues these objectives for the legislation:
(1) preserving life by not condoning the taking of life; and (2) preventing harm to individuals and society including: (a) protecting vulnerable individuals from being

induced to commit suicide in moments of weakness; (b) preventing damage to the doctor-patient relationship; (c) preventing a negative impact on palliative care; and (d) preventing negative messages about the value of human life, particularly the value of the lives of individuals with disabilities.

[1188] The plaintiffs disagree with Canada's characterization of the objectives and agree with British Columbia that the true objective of the legislation is the protection of vulnerable individuals who might be induced in moments of weakness to commit suicide. The plaintiffs concede that this is a pressing and substantial objective.

[1189] The Supreme Court has stated that the purpose of the legislation should be stated as precisely and specifically as it can be. For example, in *Harper v. Canada (Attorney General)*, 2004 SCC 33 at para. 92, Bastarache J. for the majority wrote:

> For the purpose of the section 1 analysis, however, 'it is desirable to state the purpose of the limiting provision as precisely and specifically as possible so as to provide a clear framework for evaluating its importance, and the precision with which the means have been crafted to fulfill that objective'; see *Thompson Newspapers*, at para. 98.

[1190] I conclude that the objective of the legislation is, by imposing criminal sanctions on persons who assist others with suicide, to protect vulnerable persons from being induced to commit suicide at a time of weakness. The underlying state interest which this purpose serves is the protection of life and maintenance of the *Charter* value that human life should not be taken, as Justice Sopinka stated in *Rodriguez* at 608:

> This consensus finds legal expression in our legal system which prohibits capital punishment. This prohibition is supported, in part, on the basis that allowing the state to kill will cheapen the value of human life and thus the state will serve in a sense as a role model for individuals in society. <u>The prohibition against assisted suicide serves a similar purpose. In upholding the respect for life, it may discourage those who consider that life is unbearable at a particular moment, or who perceive themselves to be a burden upon others, from committing suicide.</u> To permit a physician to lawfully participate in taking life would send a signal that there are circumstances in which the state approves of suicide.
>
> [Emphasis added.]

[1191] I will refer to and take into account the other matters raised by Canada (such as the need to avoid negative messages about the value of life, and harm to both palliative care and the physician-patient relationship) at the final stage of the proportionality assessment, where the salutary and deleterious effects of the legislation are weighed.

[1192] In the context of its submissions on s. 7 and the other elements of the s. 1 test, Canada argues that the plaintiffs must show that absolutely no "wrongful deaths" would occur if the blanket prohibition against physician-assisted death were removed. As described in the introduction to subsection IX, "Safeguards: Feasibility", by "wrongful deaths", counsel for Canada refers to all of the following: deaths of persons who are not competent to consent to death; persons who are not free from coercion, pressure, undue influence or psychological and emotional manipulation; persons who have treatable conditions that have not been treated; persons who are misinformed as to their diagnosis or prognosis; and persons who are ambivalent. In describing the concept of "wrongful deaths" in oral submissions, counsel went even farther. She emphasized the irrevocability of death and submitted that there will never be a way to tell after the fact whether the decision to die is one that the individual would have come to regret.

[1193] Canada refers to *Burns*, where the Supreme Court of Canada recognized the fallibility of the criminal justice system, even with its elaborate safeguards, and refused to permit extradition of the accused persons without assurances that capital punishment would not be imposed on them. Ms. Nygard submits that, just as Canada has abolished the death penalty because it is impossible to know for certain whether the criminal justice process has produced a correct result, so it is necessary to have an absolute prohibition against assisted death.

[1194] Canada's counsel agrees that the standard "absolutely no wrongful deaths" may set up an impossible threshold but argues that it comes back to the issue of whether this is properly a constitutional question or a policy question. She submits that while it would be open to Parliament as a matter of policy to decide that we are willing as a society to take the risk of “wrongful deaths”, it would be a different matter for a court to decide that there is a constitutional obligation for Parliament to enact legislation that takes that risk.

[1195] British Columbia, too, refers to *Burns* and argues that where assisted suicide is sought, the state’s permission for even one vulnerable person to be induced to die or to be killed is “one too many”. It says that the question to be addressed is, “Does the blanket prohibition go beyond what is necessary to achieve the government objective of avoiding one too many?”

[1196] Through these submissions, Canada in effect is arguing that the purpose of the legislation is to eliminate all risk that, if exceptions were created to the blanket prohibition, even one person would ever be inaccurately assessed as competent, free from coercion or undue influence, or non-ambivalent, or that even one person would ever be given an inaccurate prognosis or diagnosis.

[1197] The plaintiffs disagree with that premise.

[1198] First, they say that such an objective is unrealistic. Second, they suggest that prevention of all wrongful deaths cannot be the legislative objective, given the absence of regulation of the currently accepted end-of-life practices of physicians withdrawing or withholding treatment, and administering palliative sedation.

[1199] I agree with the plaintiffs’ submissions on this point. Further, the formulation of legislative purpose that would flow from Canada’s submissions is very different from the *Rodriguez* conclusion that the legislative purpose is to protect vulnerable persons from being induced to commit suicide at a time of weakness.

[1200] Although the analogy with *Burns*, capital punishment and fear of wrongful convictions is initially attractive, it breaks down when one considers context. In *Burns*, the choice was between granting the specific extradition request, or granting extradition only if the requesting state provided assurances that capital punishment would not be imposed. Placing Canadian citizens (Mr. Burns and Mr. Rafay), who disputed their guilt and did not seek to die, at risk of state-imposed death was unacceptable to the Court. Here, the choice is between an absolute prohibition and a less-than-absolute prohibition that would permit grievously ill individuals, who may be already close to death, from receiving medical assistance in dying when they seek to do so.

[1201] Therefore, I decline to accept Canada's submissions in this regard. Not only does this formulation of the objective differ from that stated in *Rodriguez,* but also it seems to conflict with what was said in *Hutterian Brethren* at para. 55: the court should not accept an unrealistically exacting or precise formulation of the government's objective which would effectively immunize the law from scrutiny at the minimal impairment stage.

2. Is that purpose pressing and substantial?

[1202] Justice Sopinka in *Rodriguez* found the legislative purpose to be pressing and substantial, stating at 613:

> I agree with the Chief Justice that s. 241*(b)* has "a clearly pressing and substantial legislative objective" grounded in the respect for and the desire to protect human life, a fundamental *Charter* value. I elaborated on the purpose of s. 241*(b)* earlier in these reasons in my discussion of s. 7.

[1203] British Columbia urges that every judge who participated in the *Rodriguez* decision at all levels of court agreed that the purpose of protecting vulnerable persons from inducement to commit suicide is pressing and substantial.

[1204] No party suggests that anything has changed that would warrant revisiting that conclusion, and the plaintiffs concede that the objective of preventing inducement of vulnerable people to commit suicide is pressing and substantial.

[1205] I am bound by the decision in *Rodriguez* and reach the same conclusion.

[1206] The next question, therefore, is whether the legislation is rationally related to that objective and proportional to it.

F. Proportionality

1. Rational Connection

[1207] The second step in the *Oakes* analysis requires an assessment of whether the infringing measure is rationally connected to the pressing and substantial objective it is said to serve. Chief Justice McLachlin described the rational connection analysis in *Hutterian Brethren* as follows (at para. 48):

> To establish a rational connection, the government "must show a causal connection between the infringement and the benefit sought on the basis of reason or logic": [*RJR- MacDonald*] at para. 153 . The rational connection requirement is aimed at preventing limits being imposed on rights arbitrarily. The government must show that it is reasonable to suppose that the limit may further the goal, not that it will do so.

[1208] In *Rodriguez*, Justice Sopinka (at 613) had no difficulty concluding that the prohibition of assisted death was rationally connected to the purpose of s. 241*(b)*.

[1209] I am bound by that decision, and reach the same conclusion.

[1210] Showing that there are pressing and substantial objectives for the provision and that there is a rational connection between the objectives and the provision is not the end of the analysis; the government must still demonstrate that the provision minimally impairs the *Charter* right that is infringed, and that the law appropriately balances salutary and deleterious effects.

2. Minimal Impairment

a) Introduction

[1211] The question at this stage of the analysis is whether the limit on the *Charter* right is reasonably tailored to the pressing and substantial goal put forward to justify that limit.

[1212] The majority in *Rodriguez* held that the legislation minimally impairs *Charter* rights because no halfway measure could be relied upon with assurance fully to achieve the legislation's purpose, stating at 614:

> The foregoing is also the answer to the submission that the impugned legislation is overbroad. There is no halfway measure that could be relied upon with assurance to fully achieve the legislation's purpose; first, because the purpose extends to the protection of the life of the terminally ill. Part of this purpose, as I have explained above, is to discourage the terminally ill from choosing death over life. Secondly, even if the latter consideration can be stripped from the legislative purpose, we have no assurance that the exception can be made to limit the taking of life to those who are terminally ill and genuinely desire death.

[1213] As already noted, Sopinka J. referred to the need to give Parliament some flexibility on this issue.

b) Principles

[1214] In *RJR-MacDonald*, the minimal impairment analysis was explained as follows (at para. 160):

> As the second step in the proportionality analysis, the government must show that the measures at issue impair the right of free expression as little as reasonably possible in order to achieve the legislative objective. The impairment must be "minimal", that is, the law must be carefully tailored so that rights are impaired no more than necessary. The tailoring process seldom admits of perfection and the courts must accord some leeway to the legislator. <u>If the law falls within a range of reasonable alternatives, the courts will not find it overbroad merely because they can conceive of an alternative which might better tailor objective to infringement ... On the other hand, if the government fails to explain why a significantly less intrusive and equally effective measure was not chosen, the law may fail.</u>
>
> [Emphasis added; citations omitted.]

[1215] In *Hutterian Brethren*, Chief Justice McLachlin described the question to be addressed this way (at para. 53):

> The question at this stage of the s. 1 proportionality analysis is whether the limit on the right is reasonably tailored to the pressing and substantial goal put forward to justify the limit. Another way of putting this question is to ask whether there are less harmful means of achieving the legislative goal. In making this assessment, the courts accord the legislature a measure of deference, particularly on complex social issues where the legislature may be better positioned than the courts to choose among a range of alternatives.

[1216] At para. 55, she added:

> I hasten to add that in considering whether the government's objective could be achieved by other less drastic means, the court need not be satisfied that the alternative would satisfy the objective to *exactly* the same extent or degree as the impugned measure. In other words, the court should not accept an unrealistically exacting or precise formulation of the government's objective which would effectively immunize the law from scrutiny at the minimal impairment stage. The requirement for an "equally effective" alternative measure in the passage from *RJR-MacDonald*, quoted above, should not be taken to an impractical extreme. It includes alternative measures that give sufficient protection, in all the circumstances, to the government's goal: [*Charkaoui*]. While the government is entitled to deference in formulating its objective, that deference is not blind or absolute. The test at the minimum impairment stage is whether there is an alternative, less drastic means of achieving the objective in a real and substantial manner. ...
>
> [Italic emphasis in original; underline emphasis added.]

[1217] Inevitably, the parties' submissions on minimal impairment under s. 1 and overbreadth under s. 7 overlapped. I will to some extent refer to both sets of submissions in both contexts, while recognizing that the analytical frameworks are different and the burden lies on the plaintiffs under s. 7 but on the governments under s. 1.

c) Positions of the Parties

[1218] Canada's position is that the only question is whether Parliament's choice in enacting a blanket prohibition falls within a range of reasonable alternatives, relying on *Canada (Attorney General) v. JTI-MacDonald*, 2007 SCC 30 [*JTI-MacDonald*] at para. 43 and *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713 [*Edwards Books*] at paras. 150-151.

[1219] Canada says that Parliament is entitled to deference at the minimal impairment stage of the test because the question of assisted dying is a difficult policy judgment involving the claims of competing groups, requiring the evaluation of complex and conflicting social science research. Canada takes the position that the case engages complex social issues that are within the institutional competence of legislatures rather than the judiciary.

[1220] Supporting deference, Canada says, are the following: the state's objectives include protecting the vulnerable (able-bodied and disabled alike) from death – the most serious and irreparable of harms; the lack of scientific or academic consensus on the adequacy of safeguards; and the serious questions about the degree to which the risk of harm is capable of reliable measurement.

[1221] Canada points to evidence that it says reveals that no halfway measure could assuredly achieve the governments' purpose. With regard to those jurisdictions where assisted death is allowed, Canada says that the evidence establishes that wrongful deaths can and do occur. Canada also points to evidence that Parliamentary committees in most western democracies have concluded that a blanket prohibition of assisted suicide and euthanasia is necessary.

[1222] British Columbia agrees with Canada's submissions. Mr. Copley submits that this is a case where the concerns are grave and the challenges complex, as demonstrated by the fact that there is no unanimity among the plaintiffs' experts as to what safeguards would be appropriate or required in the context of physician-assisted death, and no unanimity in the approaches taken in the jurisdictions that have legalized physician-assisted death.

[1223] The plaintiffs' position is that the prohibition of assisted death does not minimally impair their rights because it does not affect their rights "as little as possible". They point to the evidence regarding regimes in other jurisdictions, noting that similar evidence was not before the Court in *Rodriguez*.

[1224] The plaintiffs argue that the government must prove that <u>only</u> an absolute prohibition would allow the government to meet its objectives in a real and substantial manner.

[1225] The position of the plaintiffs is that a properly-administered regime with stringent safeguards can achieve the objectives of the impugned provisions in a real and substantial way without infringing the *Charter* rights of the plaintiffs.

d) Analysis

[1226] I do not accept Canada's submission that the only question in this case is whether Parliament's choice in enacting a blanket prohibition falls within a range of reasonable alternatives. The cases upon which Canada relies (*JTI-MacDonald* and *Edwards Books*) both preceded *Hutterian Brethren*. I accept the plaintiffs' submissions that in the *Hutterian Brethren* case the Supreme Court laid down the general approach to be followed in s. 1 proportionality analysis, including in this case. 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).

[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.

[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.

[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).

[1230] The defendants emphasize that, when it comes to the possibility of wrongful death, there can be no room for error. They point to the evidence that, in jurisdictions where physician-assisted death is permitted, there have been errors. They point to the plaintiffs' concession that the possibility of error cannot be excluded in any system. Thus, they say, nothing short of an absolute prohibition will achieve the government's chief objective.

[1231] I have already expressed my view that to state the objective in the way that Canada urges is to do what the majority in *Hutterian Brethren* warned against – adopt an unrealistically exacting or precise formulation of the government's objective that effectively immunizes the law from scrutiny at the minimal impairment stage.

[1232] The question, then, is whether there is an alternative means for the legislature to achieve its objective in a real and substantial way that less seriously infringes the *Charter* rights of Gloria Taylor and others in her situation.

[1233] Clearly, it is theoretically possible for the legislature to do so. Parliament could prohibit assisted death but allow for exceptions. The exceptions could permit physician-assisted death under stringent conditions designed to ensure that it would only be available to grievously ill, competent, non-ambivalent, voluntary adults who were fully informed as to their diagnosis and prognosis and who were suffering symptoms that could not be treated through means reasonably acceptable to those persons.

[1234] *A.C.* provides an illustration, in a related context, of the potentially constitutionally-significant difference between an absolute rule and a rule with exceptions. In *A.C.*, the majority upheld legislation allowing the imposition of medical treatment on minors under the age of 16 because the majority read the legislation as permitting individual minors under 16 to lead evidence as to their maturity and ability to determine medical choices. Thus, if a minor under 16 could satisfy the court that he was able to meet the criteria for competence to give informed consent, an exception would be made. It appears that an absolute rule would have been found unconstitutional. At para. 116, Abella J. wrote:

> If ss. 25(8) and 25(9) did in fact grant courts an unfettered discretion to make decisions on behalf of all children under 16, despite their actual capacities, while at the same time presuming that children 16 and over were competent to veto treatment they did not want, I would likely agree that the legislative scheme was arbitrary and discriminatory. 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. However, this is not the effect of ss. 25(8) and 25(9). As the foregoing analysis demonstrates, a child's maturity and corresponding interest in self-determination will factor significantly into any determination of his or her "best interests" under s. 25(8) of the Act, with the child's views becoming increasingly determinative as his or her maturity increases.

[1235] 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.

[1236] Canada and British Columbia both point to multiple possible sources of error. Prognostic predictions about the length of a person's remaining life can be wrong. Cognitive impairment, depression or other mental illness in a patient can be overlooked, especially when the physician has not had a long-term relationship with the patient. Coercion or influence from persons who do not see value in the patient's life or who might stand to gain from a patient's hastened death can escape detection. People who seem resolute about their wish to die may in fact be ambivalent. Insufficient pain management or symptom control can undermine a patient's will to live. The possibility of such errors gives rise to risks.

[1237] The plaintiffs suggest, however, that the very same risks exist with respect to current end-of-life practices. A patient who chooses to withdraw from life-sustaining treatment may present exactly the same challenges to caregivers, who need to know if the patient is truly giving informed consent, is not suffering from untreated depression, or is acting under some kind of duress or coercion.

[1238] I have reviewed the evidence regarding the inherent challenges in creating and enforcing safeguards that depend upon physicians' assessment of matters such as competence, voluntariness and non-ambivalence. As well, I have reviewed the evidentiary record, particularly regarding Oregon, the Netherlands and Belgium, where much research has been done and data accumulated. This Court has had the benefit of the opinions of respected scientists, medical practitioners and other persons who are familiar with the end-of-life decision-making both in Canada and in other jurisdictions.

[1239] The evidence shows that the effectiveness of safeguards depends upon, among other factors, the nature of the safeguards, the cultural context in which they are situate, the skills and commitment of the physicians who are responsible for working within them, and the extent to which compliance with the safeguards is monitored and enforced.

[1240] In my view, the evidence supports the conclusion that the risks of harm in a regime that permits physician-assisted death can be greatly minimized. Canadian physicians are already experienced in the assessment of patients' competence, voluntariness and non-ambivalence in the context of end-of-life decision-making. It is already part of sound medical practice to apply different levels of scrutiny to patients' decisions about different medical issues, depending upon the gravity of the consequences. The scrutiny regarding physician-assisted death decisions would have to be at the very highest level, but would fit within the existing spectrum. That spectrum already encompasses decisions where the likely consequence of the decision will be the death of the patient.

[1241] Further, the evidence from other jurisdictions shows that the risks inherent in legally permitted assisted death have not materialized in the manner that may have been predicted. For example, in both the Netherlands and Belgium, the legalization of physician-assisted death emerged in a context in which medical practitioners were already performing life-ending acts, even without the explicit request of their patients. After legalization, the number of LAWER deaths has significantly declined in both jurisdictions. This evidence serves to allay fears of a practical slippery slope.

[1242] The evidence does not support the conclusion that, since the legalization of physician-assisted death, there has been a disproportionate impact, in either Oregon or the Netherlands, on socially vulnerable groups such as the elderly or persons with disabilities. While there is some evidence of a heightened risk to persons with

HIV/AIDS, that evidence pre-dates the development of highly effective antiretroviral medications.

[1243] A less drastic means of achieving the objective of preventing vulnerable persons from being induced to commit suicide at times of weakness would be to keep the general prohibition in place but allow for a stringently limited, carefully monitored system of exceptions. Permission for physician-assisted death for grievously ill and irremediably suffering people who are competent, fully informed, non-ambivalent, and free from coercion or duress, with stringent and well-enforced safeguards, could achieve that objective in a real and substantial way.

[1244] I conclude that the defendants have failed to show that the legislation impairs Ms. Taylor's *Charter* rights as little as possible.

3. Proportionality of Effects

[1245] In *Rodriguez*, Sopinka J. held that, in light of his conclusions on the first branches of the *Oakes* test, it followed that the final aspect of the proportionality test was also met.

[1246] At the minimal impairment stage, the focus is on the government's objective, and on whether there are reasonable means of achieving it that are less impairing of *Charter* rights. *Hutterian Brethren* clarifies that at the final step of the proportionality analysis, the focus widens to include the seriousness of the infringement, and asks more broadly whether the "benefits of the impugned law are worth the costs of the rights limitation" (at para. 77). As Chief Justice McLachlin explained (at para. 76), only the final branch takes full account of the severity of the deleterious effects of a measure on individuals or groups.

[1247] Canada says that, at this stage of the test, the government is not required to prove that the law will produce the forecasted benefits, relying on *Hutterian Brethren* at para. 85. Instead, Canada says, the Court must address whether the autonomy interests and suffering of some individuals are outweighed by the public benefits of promoting the value of every life, preserving life, protecting the vulnerable, preventing abuses, maintaining the physician-patient relationship and promoting palliative care.

[1248] Canada urges that weighing the legislation's deleterious effects against its benefits reveals that the government's decision, to prohibit assisted suicide and euthanasia absolutely, is entirely reasonable in light of the gravity of the potential for wrongful death. The potential for such deaths, Canada says, cannot be outweighed.

[1249] Concerning the negative effects of the prohibition, Canada refers to its s. 7 submissions, where it addresses three potential adverse effects: limitations on autonomy, increased individual suffering, and the dangers of unregulated physician-assisted dying. Canada says that both law and medicine already accept limits on individual autonomy. It points, for example, to the fact that consent is not available as a defence to many *Criminal Code* offences and that autonomy is not an absolute principle in medicine such that a patient can demand a specific treatment from a physician contrary to the physician's professional judgment.

[1250] Canada contends that the evidence discloses that the majority of people can have their suffering relieved or reduced through palliative care and other interventions, and the harm to those who cannot does not outweigh the risk of wrongful deaths. It quotes a witness's evidence referred to in the 1995 Special Senate Committee Report, who acknowledged that palliative care may be ineffective for a small minority, but noted:

> That does not mean that the rare case should drive the social and moral fibre of this country in terms of its attitudes towards dying. ... We cannot say that we have to change the ethics of this country for the occasional dreadful, horrible case that cannot be accommodated by the system.

[1251] Canada says that the evidence does not disclose that the prohibition has led to unregulated physician-assisted dying in Canada, and further submits that the fact that people may disregard the law is not grounds for overturning it, relying on *Malmo-Levine*.

[1252] Concerning the individual benefits of the prohibition, Canada argues that a blanket prohibition prevents the serious risk of wrongful deaths of incompetent persons, persons who are coerced or unduly influenced, persons who have treatable conditions, persons who are ambivalent, and persons who are misinformed. It also prevents abuse of vulnerable individuals, negative messaging, a weakening of palliative care and harm to the physician-patient relationship.

[1253] Ms. Nygard, for Canada, further submits that the prohibition serves the public interest by reaffirming the value of human life, and by protecting the elderly and disabled through the prevention of negative messaging.

[1254] The prohibition of assisted deaths in other western democracies supports the view that there are individual and social benefits to such a prohibition, Canada says.

[1255] British Columbia submits that the benefit of the prohibition of assisted death is the preservation of the lives of vulnerable persons. This is balanced against a violation of the constitutional rights of an indeterminate but small number of persons who are suffering unbearably. Mr. Copley says that it cannot logically be disproportionate to preserve the *Charter* guaranteed right of one person if it results in the violation of a *Charter* right of another person.

[1256] The plaintiffs urge that the deleterious effects of the law outweigh any salutary effects. They argue that the prohibition of assisted death deprives individuals of: the ability to end their lives at the time and in the manner of their choosing, a matter of fundamental personal importance; the quality of their remaining life; their remaining life if they decide that they must end their own suffering while they still are physically able to do so; and the ability to put an end to physical pain and psychological stress. They say the absolute prohibition additionally causes psychological stress and deep suffering; damages some physician-patient relationships; deprives some physicians of the ability to fulfil what they consider to be their ethical duties as physicians; erects a barrier to appropriate health care; perpetuates prejudice and disadvantage vis-à-vis persons with disability by imposing these deleterious effects disproportionately upon the physically disabled and feeding discriminatory attitudes; and imposes disproportionate suffering on the loved ones of disabled people.

[1257] Further, the plaintiffs take the position that the provisions deprive Ms. Taylor of a meaningful choice, and leave her with the stark choice of disobeying the law or foregoing her constitutional rights. They invoke terms used in *Hutterian Brethren* at para. 94, where the majority stated:

> The incidental effects of a law passed for the general good on a particular religious practice may be so great that they effectively deprive the adherent of a meaningful choice: see *Edwards Books*. Or the government program to which the limit is attached may be compulsory, with the result that the adherent is left with a stark choice between violating his or her religious belief and disobeying the law: *Multani* [*Multani v. Commission scolaire Marguerite-Bourgeoys*, 2006 SCC 6, [2006] 1 S.C.R. 256]. The absence of a meaningful choice in such cases renders the impact of the limit very serious.

[1258] The plaintiffs say that the government is obliged to adduce some evidence that the law achieves the salutary effects it asserts, relying on *Hutterian Brethren* at paras. 81-83, 85, 101, 150 and 154. They point out that in *PHS,* the Court found it relevant that a law was ineffective in reaching its stated objective.

[1259] With regard to the salutary effects of promoting the value of life, preserving life, protecting the vulnerable and preventing abuse, the plaintiffs say that the evidence adduced by the government has not established that the provisions in fact produce the salutary effect of preventing deaths.

[1260] The plaintiffs further urge that the prohibition of assisted death creates a “maze of back alleys that put vulnerable populations at greater risk than a regulated scheme”. They rely on evidence from Dr. Bereza that physicians have ignored the prohibition of assisted death. They also note that British Columbia conceded that some people break the law, in the context of the Province’s opposition to evidence tendered by the plaintiffs from an anonymous deponent (L.M.) who allegedly described his participation in the assisted deaths of his parents. (The evidence was not admitted because the deponent wished to remain anonymous.) The plaintiffs also refer to evidence regarding unregulated information distributed by not-for-profit societies, and people travelling abroad to seek assisted death. In the plaintiffs' submission, the government's inability to prove that its law prevents wrongful deaths after asserting that any wrongful death is "one too many" is detrimental to its claim that the law achieves the stated salutary effect.

[1261] As to the alleged salutary effect of promoting palliative care, the plaintiffs say that there is no evidence that the prohibition has that effect. They point to evidence that they say establishes that Canada provides inadequate palliative care despite having prohibited assisted death for an enduring period of time. They also rely on evidence that palliative care has improved in those jurisdictions with regulated assisted death regimes.

[1262] In response to Canada's assertion that the provisions send a message that suicide is not an answer, the plaintiffs say that Canada mistakenly presumes that Canadians do not see a difference between assisted death in response to intolerable suffering at the end of life, and suicide arising out of mental illness or transitory sadness. The plaintiffs argue that the evidence does not support the existence of a messaging effect, pointing to evidence that suicide remains a serious problem in Canada. They suggest that a regulated regime may be more effective at bringing suicidal people to the attention of the health care community.

[1263] The plaintiffs also argue that the evidence fails to establish that the provisions achieve the salutary effects of protecting the physician-patient relationship, sending a positive message about the value of the elderly, or sending a positive message about the lives of the disabled. In all of these situations, the plaintiffs say, the evidence reveals that the provisions have the opposite effects.

[1264] Mindful of the deference due to Parliament, I am also mindful of the starting point of this analysis: the legislated infringement of a *Charter* right. The law prevents physically disabled, grievously ill people who are suffering unbearably from receiving assistance in taking the steps that they see fit to end their own lives, unless they happen to be in a position where refusing or requiring the withdrawal of treatment will achieve that goal. It imposes a disproportionate burden on them that it does not impose on able-bodied persons.

[1265] I accept that suicide and attempts at suicide are serious public health problems that governments are trying to address. To that end, the absolute prohibition may have some of the salutary effects the defendants allege, for example, sending an anti-suicide message and a message about the value of every life, including the lives of those who are elderly or disabled.

[1266] Nevertheless, I note that by thwarting the wishes of persons who are physically disabled, grievously ill and suffering intractably, the law sends a negative message that their wishes, and their suffering, are not as important as are other considerations. The law's positive general message about the value of human life must be weighed against its negative message specific to the people whom it most directly affects.

[1267] With respect to the absolute prohibition's alleged salutary effects in preventing wrongful deaths, or in preventing abuse of vulnerable people, my review of the evidence from Canada and elsewhere leaves me unconvinced that an absolute prohibition has that effect in comparison with a prohibition combined with stringently limited exceptions. I have set out my reasons for that conclusion above, in discussing minimal impairment. I accept that the absolute prohibition likely does have that effect in comparison with no prohibition.

[1268] The absolute prohibition against assisted suicide has the advantage of simplicity and clarity. The evidence shows that the prohibition acts as a deterrent to assisted death, including physician-assisted death, and therefore probably results in some patients continuing to live longer than they otherwise would. Of course, it is unknown whether those patients are grateful for that further time. The evidence shows that some would not be. (I refer, for example, to Grace Fenker's description of her husband Peter Fenker's death.)

[1269] The absolute prohibition has an impact on the role of physicians. The evidence suggests that the impact is both positive and negative.

[1270] On the positive side, under the current state of the law, patients in Canada are very unlikely to be confused about the fact that their physicians are there to treat their symptoms and prolong their lives. The law reduces or eliminates the prospects of a confused elderly patient wondering if the physician at her bedside is there with a lethal injection, or of the family members of a very ill and demanding patient wondering if the physician has mixed motives for agreeing to discuss assisted death. The existing state of the law promotes clarity about physicians' role and confidence that they will not administer medications or take other steps in order to kill their patients.

[1271] On the negative side, the fact that assisted death is illegal probably means that patients are less able to be open about their thoughts and wishes, and that physicians are put in the position of either avoiding such discussion or, having entered into it, refusing to assist. In the view of some physicians, the law prevents them from doing what is in their patients' best interests and requires them to abandon their patients. For physicians who see no ethical distinction between assisted death for grievously ill patients and certain current legal end-of-life practices, the law draws an arbitrary line and promotes a kind of hypocrisy. Removing it would permit physicians a more open relationship with their patients and support intellectual honesty in the ethical debate. Indeed, evidence from other jurisdictions suggests that physicians are able to provide better overall end-of-life treatment to patients at the end of their lives once the topic of assisted death is openly put on the table.

[1272] The absolute prohibition, or its potential removal, may have an impact on palliative care. Again, the evidence suggests both negative and positive possible impacts.

[1273] The positive impact of retaining the absolute prohibition may be to keep up public pressure in favour of funding a strong palliative care system. However, it is possible that removal of the absolute prohibition would do even more; the evidence from other jurisdictions where palliative care has improved after legalization of physician-assisted death gives some support to that hypothesis.

[1274] In considering the impact on palliative care, two factors cannot be overlooked. First, funding and support for palliative care in Canada are very largely in the control of the two defendants in these proceedings. Second, the argument that legalization should not be contemplated until palliative care is fully supported rests, as Dr. van Delden observed, on a form of hostage-taking. In other words, this argument suggests, the suffering of grievously-ill individuals who wish to die will serve as leverage for improving the provision of adequate palliative care.

[1275] In the main, the benefits of the absolute prohibition arise from its presumed effects on maintaining high social value on human life. The benefits are experienced by unknown persons who may be protected from being induced into suicide when they are vulnerable, deterred from suicide in general, valued as members of society, able to know that their physicians cannot act on a view that it is in their best interests to die, and able to receive palliative care and other medical care uncomplicated by the existence of legalized physician-assisted death.

[1276] The costs are experienced by persons who are in the position of Sue Rodriguez or Gloria Taylor, and are considerable.

[1277] The plaintiffs have provided evidence that the existence of the prohibition has the effect of denying to persons who are physically disabled, grievously ill and suffering the comfort that an “exit strategy” might provide, and requiring them to take steps to end their own lives earlier than they would otherwise have to. They refer to evidence from witnesses who give first-hand accounts, from their own or from loved ones’ experience, of very ill people dealing with this fear and the dilemma it creates (Rosana Pellizzari, Elayne Shapray, Leslie LaForest, Susan Bracken and Peter Fenker).

[1278] Peter Fenker, who had ALS, died on October 17, 2011, after a long struggle and in great pain according to an affidavit provided by his wife, Grace Fenker. Before he died, he deposed as follows about his situation:

> When I am ready to call it quits, I would like to be able to have a doctor with me to end my life with peace and dignity. For me, it is all about wanting choice – the ability to make decisions about my own life, my own body, and how much suffering I can take. Nobody wants to die – I do not want to die. Right now, I am not ready to end my life. I am still able to move around and I have some independence. I am still somewhat functioning. I have my family that I love. But when I become bedridden, that is where I will draw the line. I will know then that it is time to go.
>
> When I was first diagnosed, I considered committing suicide. I was going to blow my head off. I have a gun and I seriously considered doing it. I decided that I could not do that to my family. It would be horrible to put them through something like that. I would hate to say goodbye to the world in such an ugly manner. I want a better choice than that. I would only want to end my life if I had talked it through with my family first, and made the decision calmly and rationally, not out of depression or shock. Now, even if I wanted to, I could not take my life – I would not be able to hold anything or have the strength to do anything to myself. I could not hold a gun. I could not hang myself. I could not take medication without having my wife mix it into my porridge for me.
>
> I would like my life to end in a dignified way, with the help of a doctor, and in a way that is not painful for my family. I would like to be at home and to have my family gathered around me. When my suffering becomes unbearable, I want to have the right to end my life with dignity. Everything has been taken away from me except for my body. My body belongs to me, and it always will. The government should not be able to tell me what I can do with my body; the government should not be able to control my body.

[1279] I refer again to the discussion, in the s. 15 analysis, of the interests at stake. Ms. Taylor and others in her situation have interests not only in exercising autonomy in decision making about their own bodies and their own lives, but also in avoiding physical suffering and mental anguish. The affidavit of Leslie LaForest, who has Stage IIIC anal cancer, provides a compelling example of suffering and the fear of suffering:

> I have been told that I will likely experience a number of alarming side effects. Radiation and chemotherapy will wipe out my red and white blood cells to dangerous levels, leaving me susceptible to infections, moulds and severe fatigue. The radiation may lead to severely burned skin. My doctors have told me to expect burning of my vulva, anus, bowel, vaginal canal and

> bladder. This cannot be avoided as I am being irradiated right through the pelvis.
>
> If I survive the cancer, I may end up with permanent scarring of my bowel and anus resulting in diarrhea and incontinence. My vulva and vaginal canal will likely shrink and be scarred making intercourse painful in the future. My bladder may be damaged and require, like the vagina, dilators to stretch out badly scarred tissue, and stents to hold open vessels and canals that have collapsed.
>
> I asked my oncologist what would happen if I decided not to have this painful treatment. They told me this was not an option. They described that death by this type of disease is ugly. It is not a way anyone would want to die. It would take time and I would die in agony, regardless of pain medication and therapies that currently exist. They described how my legs would swell to gross proportion as the poisons and toxins built up in my system. And the tumour would continue to grow to explosive proportions blocking off the bowel which will begin to twist and contort under pressure. I would ooze putrescence and mucous, blood and fecal matter out of every orifice. No amount of drugs they assured me would deal with the “break through” pain.
>
> I decided that I would undergo the treatments to try to avoid an awful death, and also because my daughter is just starting university in the fall, and I wanted to make sure that she could take her first steps into adulthood unencumbered by that nightmare. Even if I were to only get another year, I want that time.
>
> Of course, there is the possibility that even despite all my best attempts to beat this disease, I might not be one of the lucky ones. The normal course of incurable anal cancer is that the tumour in the rectal area infects local nodes, which go on to involve the lymphatic system. These nodes enter the bloodstream and are quickly spread to the adrenal glands, then to the liver and lungs, and then if you survive long enough, into the brain. It was easy for me to deduce that if I am not lucky this first time around, I have months, maybe years of medical torture and agony to face before hitting the end of this vicious disease. Now if you were to take my place in this story, can you understand why I might want to skip the last chapter?

[1280] Their interests also include living past the point where they become physically unable to take their own lives. The availability of assisted death, a number of witnesses deposed, can allow patients some peace of mind and strengthen their will to carry on living a while longer.

[1281] The legislation has very severe and specific deleterious effects on persons in Gloria Taylor’s situation. It categorically denies autonomy to persons who are suffering while they face death in any event. It also has deleterious effects on some physician-patient relationships and on the kind of care that some patients receive.

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[1282] Further, the evidence supports the conclusion that, from time to time, assisted death occurs in Canada, contrary to the law. The positive effect of bringing under regulation what has previously been unregulated must be taken into account.

[1283] The salutary effects of the legislation are generalized and, in some instances, ambivalent. As well, for the reasons set out in my discussion of minimal impairment, I believe that the salutary effects of the legislation can be preserved by leaving an almost-absolute prohibition in effect, and permitting only stringently-limited exceptions.

[1284] I note in this regard the low numbers of persons in Oregon who have availed themselves of physician-assisted suicide. I also note that the evidence suggests that it is extremely unlikely that physicians in Canada would be other than rigorously compliant with legislation. It must also be remembered that the criminal law regarding offences to the person would continue to apply.

[1285] I conclude that the benefits of the impugned laws are not worth the costs of the rights limitation they create.

XIII. LIFE, LIBERTY AND SECURITY OF THE PERSON

A. Introduction

[1286] Section 7 provides:

> Everyone 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.

[1287] In *Rodriguez*, the Supreme Court of Canada dismissed the plaintiff’s claim, holding that the deprivation of her right to security of the person and any possible deprivation of her right to liberty was in accordance with the principles of fundamental justice. The only principle of fundamental justice that the Court addressed explicitly was arbitrariness.

[1288] The plaintiffs acknowledge that they bear the burden, on a balance of probabilities, of establishing: (1) a deprivation of their rights to life, liberty and security of the person; and, (2) that the deprivation is not in accordance with the principles of fundamental justice. The principles of fundamental justice that they invoke are arbitrariness, overbreadth and gross disproportionality.

[1289] In the course of the parties' submissions on arbitrariness, counsel made fairly detailed submissions about the burden of proof; specifically, about the burden on claimants once the government has shown a "reasonable apprehension of harm". Because I will not address the question of arbitrariness, which was decided in *Rodriguez*, I will not address the parties' submissions about the "reasoned apprehension of harm" standard in that context, although I will do so briefly in the course of the discussion of overbreadth.

[1290] As well, I will not address the plaintiffs' submissions to the effect that equality is or should be recognized as a principle of fundamental justice, because it is unnecessary for me to do so.

B. Deprivation

1. Liberty and Security of the Person

[1291] Ms. Rodriguez was in a situation comparable to that of Ms. Taylor in this case. The majority in *Rodriguez* referred to the arguments that s. 241*(b)* deprived Ms. Rodriguez of both her liberty and security of the person. It then stated, at 583:

> The appellant asserts that her application is based upon (a) the right to live her remaining life with the inherent dignity of a human person, (b) the right to control what happens to her body while she is living, and (c) the right to be free from governmental interference in making fundamental personal decisions concerning the terminal stages of her life. The first two of these asserted rights can be seen to invoke both liberty and security of the person; the latter is more closely associated with only the liberty interest.

[1292] Justice Sopinka rejected the argument that Ms. Rodriguez's problems were due to physical disabilities caused by her terminal illness, and not by governmental action. He found that the prohibition in s. 241*(b)* would contribute to her distress if she was prevented from managing her death in the circumstances that she feared would occur. Sopinka J. further stated that the fact that the criminal prohibition had the effect of depriving Ms. Rodriguez "of the ability to end her life when she is no longer able to do so without assistance is a sufficient interaction with the justice system to engage the provisions of s. 7 assuming a security interest is otherwise involved" (at 585).

[1293] The Court majority referred to *Morgentaler* and then summarized at 587-589:

> In my view, then, the judgments of this Court in *Morgentaler* can be seen to encompass a notion of personal autonomy involving, at the very least, control over one's bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress. In *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.), supra*, Lamer J. (as he then was) also expressed this view, stating at p. 1177 that "[s]ection 7 is also implicated when the state restricts individuals' security of the person by interfering with, or removing from them, control over their physical or mental integrity". <u>There is no question, then, that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these.</u>
>
> The effect of the prohibition in s. 241*(b)* is to prevent the appellant from having assistance to commit suicide when she is no longer able to do so on her own. She fears that she will be required to live until the deterioration from her disease is such that she will die as a result of choking, suffocation or pneumonia caused by aspiration of food or secretions. She will be totally dependent upon machines to perform her bodily functions and completely dependent upon others. Throughout this time, she will remain mentally competent and able to appreciate all that is happening to her. Although palliative care may be available to ease the pain and other physical discomfort which she will experience, the appellant fears the sedating effects of such drugs and argues, in any event, that they will not prevent the psychological and emotional distress which will result from being in a situation of utter dependence and loss of dignity. That there is a right to choose how one's body will be dealt with, even in the context of beneficial medical treatment, has long been recognized by the common law. To impose medical treatment on one who refuses it constitutes battery, and our common law has recognized the right to demand that medical treatment which would extend life be withheld or withdrawn. <u>In my view, these considerations lead to the conclusion that the prohibition in s. 241*(b)* deprives the appellant of autonomy over her person and causes her physical pain and psychological stress in a manner which impinges on the security of her person. The appellant's security interest (considered in the context of the life and liberty interest) is therefore engaged, and it is necessary to determine whether there</u>

> has been any deprivation thereof that is not in accordance with the principles of fundamental justice.
>
> [Emphasis added.]

[1294] Thus, it is clear from *Rodriguez* that Ms. Taylor's security of the person interest, considered in the context of her life and liberty interest, is engaged by the legislation. Further, with respect to the other individual plaintiffs, both Canada and British Columbia concede that the liberty interest of a person who assists or supports another person to obtain assisted death is engaged by prosecution or the threat of prosecution under the impugned provisions.

[1295] The plaintiffs urge that Ms. Taylor's right to liberty is engaged by state interference with the right of grievously and irremediably ill individuals to a protected sphere of autonomy over decisions of fundamental personal importance.

[1296] The defendants, on the other hand, submit that the jurisprudence on liberty interests does not go that far.

[1297] Canada argues that the liberty interest does not protect an individual's choice of a particular medical treatment, though it may protect the right to refuse treatment, and does not protect a right to physician-assisted dying.

[1298] In *A.C.*, Justice Abella (for the majority) referred to *Rodriguez* in the course of her analysis of why the legislation at issue engaged the security of the person and liberty interests of A.C. The statute limited minors' decision-making autonomy over medical treatment. Justice Abella stated at para. 100 that "[a]n order imposing medical treatment ... implicates a child's liberty and security of the person."

[1299] After citing Justice Wilson in *Morgentaler*, who stated at 166 that "[liberty], properly construed, grants the individual a degree of autonomy in making decisions of fundamental personal importance", Abella J. referred to other authorities on the same point, and continued (at para. 100), citing the Reasons of both Sopinka J. and McLachlin J. in *Rodriguez*:

> And in *Rodriguez*, Sopinka J. for the majority confirmed that the concept of security of the person encompasses “a notion of personal autonomy involving, at the very least, control over one’s bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress” (pp. 587-88). As McLachlin J. (as she then was) explained in dissent:
>
> > Security of the person has an element of personal autonomy, protecting the dignity and privacy of individuals with respect to decisions concerning their own body. It is part of the persona and dignity of the human being that he or she have the autonomy to decide what is best for his or her body. This is in accordance with the fact ... that “s. 7 was enacted for the purpose of ensuring human dignity and individual control, so long as it harms no one else”. [p. 618]
>
> (See also *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.)*, [1990] 1 S.C.R. 1123, at p. 1177: “Section 7 is ... implicated when the state restricts individuals’ security of the person by interfering with, or removing from them, control over their physical or mental integrity.”)

[1300] Justice Abella in *A.C.* also stated at para. 101, referring to *Fleming* and to *Ciarlariello*:

> The notion that ss. 25(8) and 25(9) engage A.C.’s security of the person and liberty interests also finds support in the common law, which, as shown earlier in these reasons, has long recognized “[t]he right to determine what shall, or shall not, be done with one’s own body, and to be free from non-consensual medical treatment”.

[1301] Justice Abella concluded at para. 102:

> The inability of an adolescent to determine her own medical treatment, therefore, constitutes a deprivation of liberty and security of the person, which must, to be constitutional, be in accordance with the principles of fundamental justice (Gerald Dworkin, “Consent, Representation, and Proxy Consent,” in Willard Gaylin and Ruth Macklin, eds., *Who Speaks For The Child: The Problems of Proxy Consent* (1982), 191, at p. 203).

[1302] I think that the majority decision in *A.C.* supports the proposition that the liberty interest encompasses the right to non-interference by the state with fundamentally important and personal medical decision-making. Though *A.C.* arose in the context of a refusal of life-sustaining treatment, I do not view it as limited to those precise circumstances.

[1303] I also believe that *A.C.* serves to confirm that the Court in *Rodriguez* found a deprivation of both liberty and security of the person through legislative interference with personal autonomy involving control over one's bodily integrity.

[1304] Accordingly, I find that Ms. Taylor's interests in security of the person and liberty, and the liberty interests of Mr. Johnson and Ms. Carter (through possible susceptibility to imprisonment) are engaged by the impugned legislation. It is unnecessary for me to decide whether Dr. Shoichet's interest in liberty is engaged.

2. Life

[1305] Is Ms. Taylor's right to life engaged?

[1306] The three rights in s. 7 – to life, liberty and security of the person – should be read together. They influence the meaning of one another, and all must be taken into account in determining the content of the principles of fundamental justice (*Rodriguez* at 584). Further, the rights of the *Charter* as a whole must be read in the light of one another and with an understanding of the underlying values that they represent. One such value is the inherent value of human life, as recognized in *Rodriguez*, where the majority stated that Canadian society is "based upon the intrinsic value of human life and on the inherent dignity of every human being" (at 585).

[1307] The plaintiffs argue that Gloria Taylor's right to life is engaged by the impugned provisions because they deprive her of the right to make and carry out the decision to end her own life.

[1308] They refer to Ms. Taylor's evidence that she does not want the manner of her death to undermine the values according to which she has lived her life. She wishes to be able to die with dignity, maintaining intact her sense of self and personal integrity.

[1309] The plaintiffs submit that the right to life is also engaged because the provisions may cause her to end her own life earlier than she would otherwise want to, out of fear that the progression of her illness will prevent her from doing so later.

[1310] The plaintiffs refer to the dissents of Chief Justice McEachern in *Rodriguez CA* and Justice Cory in the Supreme Court of Canada, in *Rodriguez*.

[1311] Chief Justice McEachern wrote that he had "no doubt that a terminally ill person facing what the Appellant faces qualifies under the value system upon which the *Charter* is based to protection under the rubric of either liberty or security of her person ... to terminate her own life, and, in my view, to assistance under proper circumstances." He went on to state at para. 51:

> It would be wrong, in my view, to judge this case as a contest between life and death. The *Charter* is not concerned only with the fact of life, but also with the quality and dignity of life. In my view, death and the way we die is a part of life itself.

[1312] In his dissent, Cory J. found that the right to life was engaged by the impugned provisions, and stated at 630:

> The life of an individual must include dying. Dying is the final act in the drama of life. If, as I believe, dying is an integral part of living, then as a part of life it is entitled to the constitutional protection provided by s. 7. It follows that the right to die with dignity should be as well protected as is any other aspect of the right to life. State prohibitions that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity.

[1313] The defendant Canada argues, on the other hand, that the s. 7 right to life does not encompass quality of life issues, which it says may implicate security of the person, but not the right to life itself.

[1314] Canada argues that the right to life does not include the right to choose death. It submits that such an interpretation would directly contradict the plain and obvious meaning of a right to life and would mark a significant departure from existing Supreme Court of Canada jurisprudence.

[1315] Canada says that the jurisprudence has consistently recognized that the right to life protects individuals from death or the risk of death, rather than conferring on them a right to die. It points to *Chaoulli* at para. 123, where Chief Justice McLachlin and Justice Major stated:

> Not every difficulty rises to the level of adverse impact on security of the person under s. 7. The impact, whether psychological or physical, must be serious. However, because patients may be denied timely health care for a condition that is clinically significant to their current and future health, s. 7 protection of security of the person is engaged. Access to a waiting list is not access to health care. As we noted above, there is unchallenged evidence that in some serious cases, patients die as a result of waiting lists for public health care. Where lack of timely health care can result in death, s. 7 protection of life itself is engaged. The evidence here demonstrates that the prohibition on health insurance results in physical and psychological suffering that meets this threshold requirement of seriousness.
>
> [Emphasis added.]

[1316] Canada also refers to the majority decision in *Rodriguez*. Although Ms. Rodriguez did not assert that she was deprived of the right to life, Canada suggests that the reasoning of the majority is inconsistent with the view that the right to life includes a right to death.

[1317] Finally, Canada refers to *Pretty v. The United Kingdom*, No. 2346/02, [2002] ECHR 427, where the European Court of Human Rights declined to interpret the right to life as including the right to die, even to prevent suffering and indignity (at paras. 37-40).

[1318] British Columbia initially made no submissions with respect to the interest in life, except that it endorses Canada's submissions. In further submissions requested by the Court with respect to the impact of the decision of the Court of Appeal for Ontario in *Bedford*, counsel for British Columbia submitted that *Rodriguez* in effect deals with the right to life, because Justice Sopinka's Reasons show that he was very aware of the concerns with respect to a diminished quality of life cited by Ms. Rodriguez in support of her claim (referring to 589). Mr. Copley submits that Sopinka J., instead of treating the right to life as implying a right to die, chose to consider the right to life as a value to be considered in analyzing the constitutionality of s. 241*(b)* (at 585-586).

[1319] I agree with the plaintiffs that *Rodriguez* does not decide whether the right to life is engaged by the legislation, and since Ms. Rodriguez did not claim a deprivation of her right to life, I refrain from drawing any inferences in this regard from the reasoning in the majority decision.

[1320] However, I agree with Canada that the Chief Justice's comment in *Chaoulli* at para. 123 suggests that the right to life is engaged only when there is a threat of death, although security of the person may be engaged with respect to impingement on the quality of life.

[1321] In my opinion, the security of the person and liberty interests engaged by the legislation encompass the essence of the plaintiffs' claim.

[1322] Only one aspect of Ms. Taylor's claim seems to implicate the right to life *per se,* in the sense of a right not to die. The plaintiffs urge that the legislation has the effect of shortening the lives of persons who fear that they will become unable to commit suicide later, and therefore take their own lives at an earlier date than would otherwise be necessary. That point is supported by evidence from Ms. Taylor as well as other witnesses. In that respect, I agree with the plaintiffs that the right to life is engaged by the effect of the legislation in forcing an earlier decision and possibly an earlier death on persons in Ms. Taylor's situation.

3. Nature of the Deprivation

[1323] Before moving on to address whether the deprivation of life, liberty or security of the person is in accordance with the principles of fundamental justice, I will summarize the evidence bearing on the extent or severity of those deprivations with respect to Ms. Taylor, Ms. Carter and Mr. Johnson.

[1324] With respect to Ms. Taylor and others in her position, I note the following.

[1325] First, they experience a shortened lifespan if they take steps to end their lives sooner than they would feel it necessary to do if they were able to receive assistance.

[1326] Second, they are denied the opportunity to make a choice that may be very important to their sense of dignity and personal integrity, that is consistent with their lifelong values and that reflects their life's experience. Further, their ability to discuss and receive support in this choice from their physicians is impaired.

[1327] Third, for persons who are physically disabled, they are deprived of a measure of self-worth in that they are denied the same degree of autonomy as that afforded to others.

[1328] Fourth, while palliative care including palliative sedation may relieve the suffering of many, for some persons it may be unavailable (due to the nature of their illness) or unacceptable to them (because they value maintaining consciousness and the ability to communicate, feel that death while under palliative sedation will be difficult for their families to observe, worry that they will in fact maintain consciousness, or for other reasons). Thus, they may be required to continue to undergo physical pain or psychological suffering or both, possibly exacerbated by terrible fear about what is yet to come.

[1329] Fifth, they are required to undergo stress. The non-availability of physician-assisted death means that patients cannot obtain an "insurance policy" that they may never use but that gives them some peace of mind and relieves their fear.

[1330] As to Ms. Carter and Mr. Johnson and others in their position, they are forced to risk prosecution for a serious criminal offence if, even reluctantly and purely out of compassion, they accede to a request to help a relative or loved one who wishes to obtain assisted death.

C. Principles of Fundamental Justice

1. Arbitrariness

[1331] It is a principle of fundamental justice that a law must not be arbitrary. The majority in *Rodriguez* concluded that s. 241*(b)* of the *Criminal Code* is not arbitrary, and that conclusion is binding.

[1332] The test for arbitrariness stated in *Rodriguez* has been frequently cited in subsequent jurisprudence. In *Bedford*, the Ontario Court of Appeal proceeded on the basis that it remains the leading test, despite the emergence of a somewhat different approach adopted by a plurality of the Supreme Court of Canada in *Chaoulli*. The plaintiffs suggest that the law has changed as a result of *Malmo-Levine, A.C.* and *PHS Community Service Society v. Canada (Attorney General)*, 2010 BCCA 15 [*PHS BCCA*], but I agree that it is unclear that the Supreme Court of Canada has decided to depart from the test for arbitrariness stated in *Rodriguez*. I adopt the reasoning of the majority in *Bedford*, which stated at paras. 145-147:

> When the court considers arbitrariness, it asks whether the challenged law bears no relation to, or is inconsistent with, its legislative objective. Put another way, arbitrariness is established where a law deprives a person of his or her s. 7 rights for no valid purpose: *Rodriguez*, at pp. 594-595.
>
> As the Supreme Court noted in [*PHS*] at para. 132, the jurisprudence on arbitrariness is not entirely settled. The ambiguity arises from *Chaoulli*, in which the Court split 3-3 on the question of whether a more deferential standard of inconsistency, or a more exacting standard of necessity, should drive the arbitrariness inquiry. In other words, must a law be inconsistent with, or bear no relation to, its purpose to be arbitrary, or is it sufficient to establish that the law is not necessary to achieve the purpose?
>
> In this case, we adopt the more conservative test for arbitrariness from *Rodriguez* that requires proof of inconsistency, and not merely a lack of necessity. Until a clear majority of the Supreme Court holds otherwise, we consider ourselves bound by the majority in *Rodriguez* on this point.

[1333] I will briefly refer to the *Rodriguez* majority's statement of the arbitrariness test and why s. 241*(b)* passed it, before moving on to the questions of overbreadth and gross disproportionality.

[1334] The majority in *Rodriguez* stated at 594-595:

> Where the deprivation of the right in question does little or nothing to enhance the state's interest (whatever it may be), it seems to me that a breach of fundamental justice will be made out, as the individual's rights will have been deprived for no valid purpose. This is, to my mind, essentially the type of analysis which E. Colvin advocates in his article "Section Seven of the Canadian Charter of Rights and Freedoms" (1989), 68 *Can. Bar Rev.* 560, and which was carried out in *Morgentaler*. That is, both Dickson C.J. and Beetz J. were of the view that at least some of the restrictions placed upon access to abortion had no relevance to the state objective of protecting the foetus while protecting the life and health of the mother. In that regard the restrictions were arbitrary or unfair. It follows that before one can determine that a statutory provision is contrary to fundamental justice, the relationship between the provision and the state interest must be considered. One cannot conclude that a particular limit is arbitrary because (in the words of my colleague, McLachlin J. at pp. 619-20) "it bears no relation to, or is inconsistent with, the objective that lies behind the legislation" without considering the state interest and the societal concerns which it reflects.
>
> The issue here, then, can be characterized as being whether the blanket prohibition on assisted suicide is arbitrary or unfair in that it is unrelated to the state's interest in protecting the vulnerable, and that it lacks a foundation in the legal tradition and societal beliefs which are said to be represented by the prohibition.
>
> [Emphasis added.]

[1335] After referring to the principle of the sanctity of human life, the history of the *Criminal Code* suicide provisions, medical care at the end of life and legislation in other countries, Sopinka J. concluded at para. 175 that "it can not be said that the blanket prohibition on assisted suicide is arbitrary or unfair, or that it is not reflective of fundamental values at play in our society."

[1336] The plaintiffs' submissions on arbitrariness focus on their contention that there is no ethically meaningful distinction between physician-assisted dying and certain other, currently ethically accepted and legal end-of-life practices. Because there is every likelihood that this case will proceed further through the courts, I have reviewed the evidentiary record and made findings in the section on Medical Ethics and End-of-Life Practices. In particular, I found that the preponderant ethical opinion is that there is no bright-line ethical distinction, in an individual case, between physician-assisted dying and end-of-life practices such as withholding or withdrawing life-sustaining treatment or administering palliative sedation where the highly probable consequence is to hasten death.

[1337] However, it is unnecessary for me to review the parties' legal submissions on arbitrariness, since that question was decided in *Rodriguez*.

2. Overbreadth

[1338] When *Rodriguez* was decided, the principle of fundamental justice that legislation should not be overbroad had not yet been specifically identified as part of s. 7 analysis. That principle was first identified one year later in *Heywood*.

[1339] The essence of the overbreadth principle is that restrictions on life, liberty and security of the person must not be more broadly framed than necessary to achieve the legislative purpose. The plaintiffs have the burden to show that the legislation fails to meet that requirement.

[1340] Overbreadth and gross disproportionality are related and somewhat overlapping concepts. For example, in *R. v. Clay*, 2003 SCC 75, a majority of the Supreme Court stated that overbreadth requires that the adverse effect of a legislative measure be grossly disproportionate to the state interest the legislation seeks to protect (at para. 38). However, as the Ontario Court of Appeal observed in *Bedford* (at para. 155), the Supreme Court of Canada treated overbreadth and gross disproportionality as distinct principles in its most recent decision, *PHS*. I will follow that course.

[1341] Cory J., writing for the majority, explained in *Heywood* (at 792-793):

> Overbreadth analysis looks at the means chosen by the state in relation to its purpose. In considering whether a legislative provision is overbroad, a court must ask the question: are those means necessary to achieve the State objective? If the State, in pursuing a legitimate objective, uses means which are broader than is necessary to accomplish that objective, the principles of fundamental justice will be violated because the individual's rights will have been limited for no reason. The effect of overbreadth is that in some applications the law is arbitrary or disproportionate.

[1342] At issue in *Heywood* was whether s. 179(1) of the *Criminal Code* was overbroad. The provision made it illegal for individuals convicted of specific offences to be found loitering near parks and school grounds. Cory J. articulated the question to be determined as follows (at 794):

> The purpose of s. 179(1)(b) is to protect children from becoming victims of sexual offences. This is apparent from the prohibition which applies to places where children are very likely to be found. In determining whether s. 179(1)(b) is overly broad and not in accordance with the principles of fundamental justice, it must be determined whether the means chosen to accomplish this objective are reasonably tailored to effect this purpose. In those situations where legislation limits the liberty of an individual in order to protect the public, that limitation should not go beyond what is necessary to accomplish that goal.
>
> [Emphasis added.]

[1343] Courts must be cautious when analysing a provision for overbreadth, as the legislative means chosen are entitled to a measure of deference (*Heywood* at 793):

> In analyzing a statutory provision to determine if it is overbroad, a measure of deference must be paid to the means selected by the legislature. While the courts have a constitutional duty to ensure that legislation conforms with the *Charter*, legislatures must have the power to make policy choices. A court should not interfere with legislation merely because a judge might have chosen a different means of accomplishing the objective if he or she had been the legislator.

[1344] In *Demers*, the Court found that the regime established by Part XX.1 of the *Criminal Code* dealing with mentally ill accused was overbroad. Under the regime, an accused person found unfit to stand trial remained in the system established under that Part until he or she either became fit to stand trial or the Crown failed to establish a *prima facie* case against him or her. An absolute discharge was not available to an accused found unfit to stand trial. Individuals who were permanently unfit – such as the accused, who had Down Syndrome – could never stand trial and were therefore subject to indefinite appearances before the Review Board.

[1345] The Court characterized the purpose of the regime as protecting the public and treating the mentally ill accused fairly and appropriately. The Court then held (at para. 43):

> Consequently, the continued subjection of an unfit accused to the criminal process, where there is clear evidence that capacity will never be recovered

> and there is no evidence of a significant threat to public safety, makes the law overbroad because the means chosen are not the least restrictive of the unfit person's liberty and are not necessary to achieve the state's objective. Accordingly, these sections of the law restrict the liberty of permanently unfit accused "for no reason", to use Cory J.'s words in *Heywood, supra*, at p. 793.
>
> [Emphasis added.]

[1346] In *Heywood*, Cory J. observed that "[o]verbroad legislation which infringes s. 7 of the *Charter* would appear to be incapable of passing the minimal impairment branch of the s. 1 analysis" (801-802). The majority in *Demers* cited *Heywood* to this effect, and concluded that to the extent the impugned regime was overbroad, it "impairs individuals' interests unnecessarily, and therefore has not employed the least restrictive means of achieving Parliament's objective under the circumstances" (para. 46).

[1347] The majority in *Clay* also commented on the relevance of overbreadth to s. 1, as follows (at paras. 35-36):

> Overbreadth is a concept that is relevant both to consideration of an infringement of a *Charter* right (here s. 7) and, if a *prima facie* infringement is found too, the assessment of the proffered s. 1 justification.
>
> In its application under s. 1 of the *Charter*, overbreadth fits comfortably under the "minimal impairment branch" of the *Oakes* test: see *R. v. Nova Scotia Pharmaceutical Society*, [1992] 2 S.C.R. 606, at p. 629. In s. 1, of course, the Court is examining an encroachment on constitutionally protected conduct. A protected *Charter* right or freedom will already have been found to be infringed, and the s. 1 issue is whether the infringement is a reasonable limit that can be demonstrably justified in a free and democratic society. In the reasons set out in *Malmo-Levine* and *Caine*, we have concluded that using marihuana is not, as such, a constitutionally protected activity. Thus, overbreadth in its s. 1 aspect is not engaged in this case.

[1348] Counsel for the plaintiffs submits that the impugned provisions fail the overbreadth test. Ms. Tucker makes arguments similar to those regarding minimal impairment under s. 1. In this analysis of the s. 7 claim, however, the plaintiffs have the burden, not the defendants. The plaintiffs must show, on a balance of probabilities, that the blanket prohibition is broader than is necessary to achieve the state's goal of preventing vulnerable persons from being induced, in moments of weakness, to commit suicide.

[1349] As in its s. 1 argument concerning minimal impairment, Canada argues that it is insufficient for the plaintiffs to establish that wrongful deaths can *mostly* be adverted, and relies on *Burns* to say that the plaintiffs must show that absolutely *no* such deaths would occur. Accordingly, submits Canada, when death is the harm being guarded against, the plaintiffs must show that the reasonable apprehension that even one vulnerable person may be induced to commit suicide is averted. British Columbia likewise relies on *Burns* in the manner described at the minimal impairment stage of the s. 1 analysis. It frames the question in terms of whether the blanket prohibition goes beyond what is necessary to achieve the objective of avoiding “one too many”. Canada argues that where the risks are so serious and the consequences irreversible, the court must require compelling and conclusive evidence that there is no such risk.

[1350] Canada acknowledges a dearth of jurisprudence on this question, but cites *A.C.* as the closest authority on point. In its discussion of arbitrariness, the majority in *A.C.* at para. 103 cited para. 131 of *Chaoulli*:

> In order not to be arbitrary, the limit on life, liberty and security requires not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts. The onus of showing lack of connection in this sense rests with the claimant. The question in every case is whether the measure is arbitrary in the sense of bearing no real relation to the goal and hence being manifestly unfair. The more serious the impingement on the person’s liberty and security, the more clear must be the connection. Where the individual’s very life may be at stake, the reasonable person would expect a clear connection, in theory and in fact, between the measure that puts life at risk and the legislative goals.
>
> [Emphasis added.]

[1351] With reference to this passage, Canada submits that the majority is stating that where a claimant’s life is at risk, the claimant only need show the lack of a clear connection in fact between the goals and the legislation. The reverse situation, Canada submits, is at play in the present case. Where, by asserting their rights, the plaintiffs may risk the lives of others, the onus is on the plaintiffs to show that it is clear in fact that these other lives will not be at risk.

[1352] The plaintiffs strenuously dispute Canada's assertion that they must prove that something short of a blanket prohibition will avert the risk of even one wrongful death. They say there is simply no authority for that proposition, and that Canada's reliance on *Chaoulli* does not withstand scrutiny. Specifically, the plaintiffs say that the reference in the quoted passage to "impingement on the person's liberty or security of the person" is a reference to an impingement by the impugned provisions, that is, by the state. According to the plaintiffs, Canada wrongly interprets the passage as if the impingement is being caused by the plaintiffs, and then says that if the remedy sought could impinge on another person's life, the remedy is unconstitutional.

[1353] The plaintiffs say that Canada has set a zero tolerance standard so extreme that no claimant could ever succeed in a challenge under the *Charter*. The correct approach, the plaintiffs assert, is that set out in *Hutterian Brethren*, where, in discussing minimal impairment under s. 1, the majority stated that "the court should not accept an unrealistically exacting or precise formulation of the government's objective which would effectively immunize the law from scrutiny at the minimal impairment stage" (para. 55). The majority added, in the same paragraph, that "[t]he test at the minimum impairment stage is whether there is an alternative, less drastic means of achieving the objective in a real and substantial manner." The plaintiffs point out that the analyses of overbreadth under s. 7 and minimal impairment under s. 1 are substantially similar.

[1354] The plaintiffs submit that it is ultimately for the Court to balance Parliament's objective of preventing vulnerable persons from being induced to commit suicide, against the constitutional rights of the plaintiffs.

[1355] I agree with the plaintiffs with respect to this issue.

[1356] To start, as I explained in the s. 1 analysis, I do not see the defendant governments' reliance on *Burns* for the notion that "even one is too many" to be particularly apt. Capital punishment, the taking of an individual's life by the state, bears no resemblance to physician-assisted dying in the context we are concerned with here.

[1357] There is no authority for the proposition put forth by Canada that when death is the harm being guarded against, the plaintiffs bear the onus of demonstrating that the risk of even one wrongful death can be averted. *Chaoulli* does not make this point, nor can it be analogized to do so in the manner Canada has proposed.

[1358] Further, the comments in *Chaoulli* upon which Canada relies, requiring “a clear connection, in theory and in fact, between the [governmental] measure that puts life at risk and the legislative goals” were made in the course of the Court’s analysis of arbitrariness. That context, in which the analytical approach is somewhat analogous to the “rational connection” stage of s. 1 analysis, is different from overbreadth analysis under s. 7 or minimal impairment analysis under s. 1.

[1359] While the seriousness of the risk and its consequences are clearly factors to be taken into account when weighing the various rights and interests at stake, they are not reason to depart from what the jurisprudence mandates regarding assessment of s. 7 claims.

[1360] The Supreme Court’s comments in *Hutterian Brethren* upon which the plaintiffs rely illustrate that the formulation of the state objective is not to be “unrealistically exacting”. While the comments were made in the context of a discussion regarding minimal impairment under s. 1, as is evident in the authorities, concepts infusing s. 1 analysis are also relevant to the s. 7 analysis, and that analysis, too, focuses on the objective of the legislation.

[1361] In summary with respect to the burden on the plaintiffs, they must establish a deprivation of their life, liberty or security of the person in a manner not in accordance with principles of fundamental justice. In the specific context of their claim that the absolute prohibition infringes the principle of fundamental justice regarding overbreadth, they have the burden to show that the absolute prohibition (the means chosen) is not the least restrictive of their interests in life, liberty and security of the person and is not necessary to achieve the state’s objective.

[1362] To reiterate, the purpose of the prohibition against assisted suicide is the protection of vulnerable persons from being induced to commit suicide at times of weakness, a purpose grounded in the respect for and the desire to protect human life.

[1363] Is an absolute prohibition the least restrictive means of preventing the inducement to suicide of vulnerable persons? Is an absolute prohibition necessary in order for the state to achieve its objective?

[1364] A prohibition with carefully designed and well enforced exceptions would less restrict the plaintiffs’ interests in life, liberty and security of the person, but the question is whether a prohibition without exceptions is necessary in order to meet the government’s objectives.

[1365] An absolute prohibition would seem necessary if the evidence showed that physicians are unable reliably to assess competence, voluntariness and non-ambivalence in patients, or that physicians fail to understand or apply the informed consent requirement for medical treatment.

[1366] An absolute prohibition might be called for if the evidence from permissive jurisdictions showed abuse of patients, or carelessness or callousness on the part of physicians, or evidence of the reality of a practical slippery slope.

[1367] However, that is not what the evidence shows. I have found that the evidence supports the conclusion that a system with properly designed and administered safeguards could, with a very high degree of certainty, prevent vulnerable persons from being induced to commit suicide while permitting exceptions for competent, fully-informed persons acting voluntarily to receive physician-assisted death.

[1368] I also note, as the intervenor Canadian Unitarian Counsel argued, that if the doctrine of informed consent is sufficient to address concerns about abuse in cases of refusal or withdrawal of life-sustaining treatment, rigorously applied, it can also address concerns about abuse in physician-assisted dying.

[1369] The necessity of an absolute prohibition might be reinforced if physician-assisted death were clearly inconsistent with medical ethics, simply because in those circumstances any physicians providing assisted death would be those who were prepared to disregard ethical principles. However, as set out in my review of the evidence with respect to safeguards, in the opinion of a number of respected ethicists and practitioners, physician-assisted death in an individual case is not ethically distinguishable from currently legal and ethically accepted end-of-life practices.

[1370] I also take into account the unknown extent to which physician-assisted death and assisted death by non-physicians already occurs in Canada. I have found that the evidence supports the conclusion that such deaths do occur, though likely in a very small number of instances. Moving to a system of physician-assisted death under strict regulation would probably greatly reduce or even eliminate such deaths and enhance the likelihood that only competent, fully-informed, voluntary and non-ambivalent patients would receive such assistance.

[1371] I conclude, therefore, that the impugned provisions are overbroad and that the plaintiffs have established their claim under s. 7.

3. Gross Disproportionality

[1372] Although it is strictly speaking unnecessary for me to do so in the light of my conclusion regarding overbreadth, I will briefly address the arguments regarding gross disproportionality.

[1373] That term describes state actions or legislative responses to a problem that are so extreme as to be disproportionate to any legitimate government interest: *Malmo-Levine* at para. 143, cited in *PHS* at para. 133. Thus, the analysis requires a consideration of the nature and gravity of the alleged *Charter* infringement in relation to the importance of the government interest. The standard is high, as s. 7 is not breached by laws that are merely disproportionate rather than grossly disproportionate.

[1374] In *Malmo-Levine*, the claimants had argued that criminalization of marijuana was disproportionate to the threat posed by its use. The majority set out the contours of the principle as follows (at paras. 142-43):

> In [*Suresh*], at para. 47, the Court accepted that the means taken to achieve an objective can be so disproportionate to the desired end so as to offend the principles of fundamental justice:
>
> > Determining whether deportation to torture violates the principles of fundamental justice requires us to balance [under s. 7] Canada's interest in combatting terrorism and the Convention refugee's interest in not being deported to torture. Canada has a legitimate and compelling interest in combatting terrorism. But it is also committed to fundamental justice. The notion of proportionality is fundamental to our constitutional system. Thus we must ask whether the government's proposed response is reasonable in relation to the threat. In the past, we have held that *some responses are so extreme that they are per se disproportionate to any legitimate government interest*: see *Burns, supra*. We must ask whether deporting a refugee to torture would be such a response. [Emphasis added.]
>
> See also [*Burns*], at para. 78.
>
> In short, after it is determined that Parliament acted pursuant to a legitimate state interest, the question can still be posed under s. 7 whether the government's legislative measures in response to the use of marihuana were, in the language of *Suresh*, "so extreme that they are *per se disproportionate* to any legitimate government interest" (para. 47 (emphasis added)). As we explain below, the applicable standard is one of *gross* disproportionality, the proof of which rests on the claimant.
>
> [Emphasis in original.]

[1375] In *PHS*, the Court's analysis of gross disproportionality with respect to the Minister's refusal to grant an exemption to Insite was brief (at para. 133):

> Insite saves lives. Its benefits have been proven. There has been no discernible negative impact on the public safety and health objectives of Canada during its eight years of operation. The effect of denying the services of Insite to the population it serves is grossly disproportionate to any benefit

> that Canada might derive from presenting a uniform stance on the possession of narcotics.

[1376] The plaintiffs have the burden to show that the impugned provisions (the absolute prohibition) are so extreme that they are *per se* disproportionate to any legitimate government interest.

[1377] In my analysis of the s. 1 justification arguments put forward by the parties, I have reviewed the salutary and deleterious effects of the absolute prohibition, and of a prohibition with exceptions. I have taken into account in that analysis not only the objective of the legislation found in *Rodriguez*, but also the other effects that the governments say flow from it, with respect to enhancing respect for life, preventing “wrongful deaths”, protecting vulnerable people, supporting palliative care, and preserving the physician-patient relationship.

[1378] I conclude, based on that analysis, that the effect of the absolute prohibition on the life, liberty and security of the person interests of the plaintiffs is very severe, and is grossly disproportionate to its effect on preventing inducement of vulnerable people to commit suicide, promoting palliative care, protecting physician-patient relationships, protecting vulnerable people, and upholding the state interest in the preservation of human life.

D. Section 1 Justification

[1379] The plaintiffs say that if they are successful in their challenge to the legislation on the basis of section 7, then it is questionable whether any analysis under s. 1 of the *Charter* is required, relying on *PHS*. In that case, the Court said at para. 137 that if a s. 1 analysis were required, which no party argued, it could not succeed because the Minister’s decision bore no relation to his objectives. The plaintiffs also note that there has not been a single instance in which a deprivation of life, liberty or security of the person in breach of the principles of fundamental justice has been found to be justified under s. 1.

[1380] The Supreme Court of Canada has itself expressed doubt about the likelihood of a breach of s. 7 being justified under s. 1. In *Re: BC Motor Vehicle Act*, [1985] 2 S.C.R. 486, in the context of a s. 7 challenge to an absolute liability offence, Chief Justice Lamer wrote at para. 85:

> Administrative expediency, absolute liability's main supportive argument, will undoubtedly under s. 1 be invoked and occasionally succeed. Indeed, administrative expediency certainly has its place in administrative law. But when administrative law chooses to call in aid imprisonment through penal law, indeed sometimes criminal law and the added stigma attached to a conviction, exceptional, in my view, will be the case where the liberty or even the security of the person guaranteed under s. 7 should be sacrificed to administrative expediency. Section 1 may, for reasons of administrative expediency, successfully come to the rescue of an otherwise violation of s. 7, but only in cases arising out of exceptional conditions, such as natural disasters, the outbreak of war, epidemics, and the like.

[1381] Counsel for British Columbia questions the relevance of this statement to this case, given Chief Justice Lamer's reference to the use of "administrative expedience" as a justification under s. 1, particularly in the case of absolute liability offences.

[1382] Further, British Columbia notes that the Supreme Court of Canada has done a s. 1 analysis in a number of s. 7 cases, although it concedes that none of those s. 7 infringements was found to be justified. In *Charkaoui*, the Court stated that the task of justifying a s. 7 infringement "may not be impossible", particularly in "extraordinary circumstances where concerns are grave and the challenges complex". Counsel for British Columbia urges that this is a case involving grave concerns and complex challenges, emphasizing the lack of unanimity among experts on how to address the issue and protect vulnerable populations.

[1383] I have already addressed s. 1 in the context of the s. 15 infringement. If it were necessary or appropriate for me to do so again in the context of the s. 7 infringement, I would reach the identical conclusion.

XIV. REMEDY

A. Declaratory Relief

[1384] The plaintiffs seek the following declaratory orders:

> (1) a declaration that to the extent that the impugned provisions prohibit physician-assisted dying, they unjustifiably infringe s. 7 of the *Charter*, and are, to that extent, of no force and effect;
>
> (2) a declaration that to the extent that the impugned provisions prohibit physician-assisted dying, they unjustifiably infringe s. 15 of the *Charter* and are, to that extent, of no force and effect.

[1385] The plaintiffs define “physician-assisted dying” to include both “physician-assisted suicide” and “consensual physician-assisted death”, where the assistance is provided to a grievously and irremediably ill patient within the context of a patient-physician relationship, by a medical practitioner or a person acting under the general supervision of a medical practitioner. Their definition of “grievously and irremediably ill persons” refers to persons who have a serious medical condition that has been diagnosed as such by a medical practitioner and which is without remedy, as determined by reference to treatment options acceptable to the person, and which causes the person enduring physical, psychological or psychosocial suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person. Finally, the plaintiffs define “medical condition” as an illness, disease or disability, including a disability arising from traumatic injury.

[1386] It is the proper task of Parliament, not the courts, to determine how to rectify legislation that has been found to be unconstitutional. However, in a case such as this, where the unconstitutionality arises from the legislation’s application in certain specific circumstances, it is incumbent on the Court to specify what those circumstances are.

[1387] In specifying those circumstances, I begin with the plaintiffs’ definition of “physician-assisted dying”, “grievously and irremediably ill persons” and “medical condition”, but make the following important modifications.

[1388] First, my conclusion is that the unconstitutionality of the legislation under s. 7 arises from its application to competent, fully-informed, non-ambivalent adult persons who personally (not through a substituted decision-maker) request physician-assisted death, are free from coercion and undue influence and are not clinically depressed. With respect to s. 15, the unconstitutionality of the legislation arises from its application to persons who fall under the description above and who, in addition, are materially physically disabled or soon to become so.

[1389] Second, I do not accept that the term “physician-assisted” should include the provision of assistance by persons other than physicians.

[1390] Third, I do not accept that the term “grievously and irremediably ill persons” should incorporate reference to “psychosocial suffering”.

[1391] Fourth, the reference to “grievously and irremediably ill persons” should be limited to those who are also in an advanced state of weakening capacities, with no chance of improvement.

[1392] Finally, the legislative infringement of s. 15 stems from its prohibition of physician-assisted suicide, and the declaratory relief with respect to that infringement should be limited accordingly.

[1393] Accordingly, the following declaratory orders will be made:

(a) A declaration that the impugned provisions unjustifiably infringe s. 15 of the *Charter*, and are of no force and effect to the extent that they prohibit physician-assisted suicide by a medical practitioner in the context of a physician-patient relationship, where the assistance is provided to a fully-informed, non-ambivalent competent adult patient who: (a) is free from coercion and undue influence, is not clinically depressed and who personally (not through a substituted decision-maker) requests physician-assisted death; and (b) is materially physically disabled or is soon to become so, has been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury), is in a state of advanced weakening capacities with no chance of improvement, has an illness that is without remedy as determined by reference to treatment options acceptable to the person, and has an illness causing enduring physical or psychological suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person.

(b) A declaration that the impugned provisions unjustifiably infringe s. 7 of the *Charter*, and are of no force and effect to the extent that they prohibit physician-assisted suicide or consensual physician-assisted death by a medical practitioner in the context of a physician-patient relationship, where the assistance is provided to a fully-informed, non-ambivalent competent adult person who: (a) is free from coercion and undue influence, is not clinically depressed and who personally (not through a substituted decision-maker) requests physician-assisted death; and (b) has been diagnosed by a medical practitioner as having a serious illness, disease or disability (including disability arising from traumatic injury), is in a state of advanced weakening capacities with no chance of improvement, has an illness that is without remedy as determined by reference to treatment options acceptable to the person, and has an illness causing enduring physical or psychological suffering that is intolerable to that person and cannot be alleviated by any medical treatment acceptable to that person.

[1394] The plaintiffs ask that the effect of the declarations of constitutional invalidity or inapplicability be suspended for a period of six months.

[1395] Canada's position is that if there is to be a declaration of constitutional invalidity, its effect should be suspended for at least twelve months in order to allow Parliament to have time to draft and consider any legislation. Canada says that a further suspension may be necessary given the realities of the appeal process and the complexity of the issues Parliament would face.

[1396] With some relevance to the question of the appropriate length of the period of suspension, British Columbia made submissions (in response to the plaintiffs' submissions regarding the alleged arbitrariness of the legislation) that if the impugned laws are struck down, there is no certainty that Parliament will enact legislation thereafter. It pointed to Colombia, where no legislation was passed after a decision of the Constitutional Court legalized euthanasia in that country, and to the absence of legal regulatory safeguards in Switzerland and Montana, where courts have similarly recognized assisted suicide. British Columbia also pointed to the fact that Parliament has not enacted any regulatory safeguards in the wake of the Supreme Court's 1988 decision in *Morgentaler*.

[1397] British Columbia also argued that if physician-assisted death is proper medical treatment, as the plaintiffs suggest, there may be considerable debate whether Parliament even has the constitutional jurisdiction to enact safeguards (referring to *Reference re Assisted Human Reproduction Act*, 2010 SCC 61 at paras. 263-67 and to *PHS*).

[1398] The plaintiffs in reply characterized British Columbia's argument as *in terrorem*. They submitted that it would be remarkable if the governments were to elect not to enact any safeguards to protect individuals from the concerns they have voiced in these proceedings. However, they argued, there has been no evidence in these proceedings of catastrophic outcomes in those jurisdictions with unregulated assisted dying regimes (Switzerland, Montana and Colombia).

[1399] I have considered the submissions of the parties and am persuaded that suspension of the declaratory relief for six months would be clearly insufficient. The effect of the declarations is suspended for one year.

B. Constitutional Exemption

[1400] For Gloria Taylor, the plaintiffs seek a remedy under s. 24(1) of the *Charter*: an immediate constitutional exemption that would allow her to avail herself of a physician-assisted death at such time and subject to such terms and conditions that the Court allows or requires.

[1401] The plaintiffs rely on *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, [1999] 2 S.C.R. 203, where the Supreme Court recognized that a constitutional exemption may be granted as an interim remedial measure accompanying a declaration of invalidity under s. 52(1), the operation of which is suspended.

[1402] In *R. v. Ferguson*, [2008] 1 S.C.R. 96, the claimant applied for constitutional exemption from legislation creating a mandatory minimum sentence. Although the Supreme Court held that a constitutional exemption is not appropriate as a stand-alone remedy for a claimant who establishes that certain applications of a law are unconstitutional, it indicated that constitutional exemptions may still be available in other cases, for example, when they accompany a suspended declaration of invalidity. The Court stated at para. 63:

> The jurisprudence of this Court allows a s. 24(1) remedy in connection with a s. 52(1) declaration of invalidity in unusual cases where additional s. 24(1) relief is necessary to provide the claimant with an effective remedy: [*Demers*]. However, the argument that s. 24(1) can provide a stand-alone remedy for laws with unconstitutional effects depends on reading s. 24(1) in isolation, rather than in conjunction with the scheme of the *Charter* as a whole, as required by principles of statutory and constitutional interpretation. When s. 24(1) is read in context, it becomes apparent that the intent of the framers of the Constitution was that it function primarily as a remedy for unconstitutional government acts.

[1403] The plaintiffs also refer to *PHS*, at the trial and appellate level. In the Supreme Court (2008 BCSC 1453), Mr. Justice Pitfield granted a constitutional exemption for the staff and users of Insite for the same period of time as the suspension of the declaration of invalidity. In her decision in *PHS BCCA*, Madam

Justice Rowles approved the form of order and confirmed the availability of a constitutional exemption. She wrote, at paras. 18-20:

> In light of the 2008 decision of the Supreme Court of Canada in [*Ferguson*] at paras. 33-34, 37-38, 40, 46, 59-61, 65, 71-74, the appropriate remedy in cases where a law has an unconstitutional application is to declare the law of no force or effect and leave it to Parliament to decide whether to enact a new law that accords with the Constitution.
>
> By suspending his declaration of invalidity in this case, the trial judge ensured that ss. 4(1) and 5(1) continue to operate as they did in the past and in circumstances where there could be no constitutional objection. But, at the same time, it was necessary to exempt the users and staff at Insite (acting in conformity with the operating protocol then in effect from the application of ss. 4(1) and 5(1) of the *CDSA* in order to give effect) to their constitutional rights.
>
> I note that the approach the judge took is consistent with that of the Ontario Court of Appeal in *R. v. Parker* (2000), 146 C.C.C. (3d) 193 (Ont. C.A.) [*Parker*], where the law prohibiting possession of marihuana was held to be contrary to s. 7 in its application to Mr. Parker. While *Parker* predated *Ferguson*, the approach taken was prescient of what the Supreme Court of Canada required in *Ferguson.*
>
> [Emphasis added.]

[1404] The Supreme Court of Canada in *PHS* denied the application for a permanent constitutional exemption. It stated (at paras. 148-149) that a constitutional exemption is not an appropriate remedy for infringement through a state action rather than a law, and that the Minister should be able to retain some flexibility. It also referred to *Ferguson* and reiterated that constitutional exemptions are to be avoided

[1405] The plaintiffs cite, in addition, *R. v. Mernagh*, 2011 ONSC 2121 (which, counsel advised, is on appeal).

[1406] Canada contends that it would be inappropriate to grant a constitutional exemption in this case. It agrees that, as stated in *Corbiere*, an exemption is available where the Court finds that a law is invalid but suspends the declaration of invalidity. However, it refers to *Schachter v. Canada*, [1992] 2 S.C.R. 679 at 721 and to *Demers* at paras. 61-62 for the proposition that a constitutional exemption is the exception and not the rule, a point reinforced in *Ferguson*.

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[1407] Canada submits that, in fashioning a *Charter* remedy, a court must "apply the measures that will best vindicate the values expressed in the *Charter*" and "refrain from intruding into the legislative sphere beyond what is necessary" (citing *Osborne v. Canada (Treasury Board)*, [1991] 2 S.C.R. 69 (at 104)). It points to the Supreme Court's statement in *Ferguson* that the constitutional exemption sought there raised concerns relative to the values underpinning the rule of law: "certainty, accessibility, intelligibility, clarity and predictability".

[1408] It is Canada's position that, in creating a constitutional exemption with a set of "safeguards", the Court would be usurping the function of Parliament and risking permitting a physician-assisted death that would not fall under a scheme that Parliament eventually creates. It would also be opening the door to applications for similar exemptions from other individuals.

[1409] *Ferguson* makes clear that the remedy of a constitutional exemption, though available, is truly exceptional. However, it is also clear from *Corbiere* that this exceptional remedy may be appropriate when it is necessary to protect the interests of a successful party because a constitutional declaration of invalidity has been suspended (at para. 22):

> The remedy of constitutional exemption has been recognized in a very limited way in this Court, to protect the interests of a party who has succeeded in having a legislative provision declared unconstitutional, where the declaration of invalidity has been suspended; see [*Schachter*]; [*Rodriguez*].

[1410] Notably, *Rodriguez* was one of the cases upon which the Court relied in *Corbiere* with respect to the availability of constitutional exemptions.

[1411] Recognizing that it is up to Parliament to decide whether and how to respond to the declarations of constitutional invalidity, I conclude that in the interim, while the declarations are suspended, the plaintiff Gloria Taylor should be granted the exceptional remedy of a constitutional exemption. The circumstances of this case fit within the narrow range of cases in which a constitutional exemption is appropriate under *Ferguson*.

[1412] I have set out previously in these Reasons in subsection IX (C), “Addressing the Risks”, the conditions applicable to the constitutional exemption that Chief Justice McEachern and Chief Justice Lamer would have granted during the period of suspension of the declaration of invalidity.

[1413] The plaintiffs in this case seek an exemption for both Ms. Taylor and her physician, submitting that the following conditions would be appropriate:

> 1. In accordance with paragraph 4 of Part 2 of the Amended Notice of Civil Claim, that a constitutional exemption be granted allowing Ms. Taylor to obtain physician-assisted dying on the following proposed terms and conditions:
>
>   a. Ms. Taylor provides a written request for a physician-assisted death;
>
>   b. her attending physician attests that Ms. Taylor has been:
>
>   i. informed of her medical diagnosis and prognosis;
>
>   ii. informed of the feasible alternative treatments, including palliative care options;
>
>   iii. informed of the risks associated with physician-assisted dying and the probable result of the medication proposed for use in her physician-assisted death;
>
>   iv. referred to a physician with palliative care expertise for a palliative care consultation;
>
>   c. her attending physician and a consulting psychiatrist each attest that Ms. Taylor is competent and that her request for physician-assisted death is voluntary; and
>
>   d. her attending physician attests to the kind and amount of medication proposed for use in any physician-assisted death that may occur.
>
> 2. Ms. Taylor may then make an application to the British Columbia Supreme Court, without notice to any other party, and upon proof of the above to the Court’s satisfaction, the Court shall order that:
>
>   a. a physician may legally provide Ms. Taylor with a physician-assisted death at the time of her choosing provided that Ms. Taylor is, at the material time:
>
>   i. suffering from enduring physical, psychological or psychosocial suffering that is intolerable to her and which cannot be alleviated by any medical treatment acceptable to her;

> ii. in the opinion of the assisting physician, or if necessary in the opinion of the assisting physician a consulting psychiatrist, competent, and voluntarily seeking a physician-assisted death;
>
> b. notwithstanding any other provision of law, should Ms. Taylor seek and obtain a physician-assisted death, that the assisting physician be authorized to complete her death certificate indicating death from her underlying illness as cause of death.

[1414] I have concluded that, in order to ensure that Ms. Taylor, a successful litigant, has an effective remedy, during the period of suspension of the declaration of constitutional invalidity there will be a constitutional exemption permitting Ms. Taylor to obtain physician-assisted death, under the following conditions:

(a) Ms. Taylor provides a written request.

(b) Her attending physician attests that Ms. Taylor is terminally ill and near death, and there is no hope of her recovering.

(c) Her attending physician attests that Ms. Taylor has been:

  (i) informed of her medical diagnosis and prognosis;

  (ii) informed of the feasible alternative treatments, including palliative care options;

  (iii) informed of the risks associated with physician-assisted dying and the probable result of the medication proposed for use in her physician-assisted death;

  (iv) referred to a physician with palliative care expertise for a palliative care consultation;

  (v) advised that she has a continuing right to change her mind about terminating her life.

(d) Her attending physician and a consulting psychiatrist each attest that Ms. Taylor is competent and that her request for physician-assisted death is voluntary and non-ambivalent. If a physician or consulting psychiatrist has declined to make that attestation, that fact will be made known to subsequent physicians or consulting psychiatrists and to the court.

(e) Her attending physician attests to the kind and amount of medication proposed for use in any physician-assisted death that may occur.

(f) Unless Ms. Taylor has become physically incapable, the mechanism for the physician-assisted death shall be one that involves her own unassisted act and not that of any other person.

[1415] Once these conditions are met, Ms. Taylor may then make an application to the British Columbia Supreme Court, without notice to any other party, and upon proof of the above to the Court's satisfaction, the Court shall order that:

(a) a physician may legally provide Ms. Taylor with a physician-assisted death at the time of her choosing provided that Ms. Taylor is, at the material time:

  (i) suffering from enduring and serious physical or psychological distress that is intolerable to her and that cannot be alleviated by any medical or other treatment acceptable to her;

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

(b) notwithstanding any other provision of law, should Ms. Taylor seek and obtain a physician-assisted death, that the assisting physician be authorized to complete her death certificate indicating death from her underlying illness as cause of death.

[1416] If it is necessary, the parties may speak to the form of the Order and may make submissions as to costs.

"Lynn Smith J."

[1417]

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