Translated from the original French
Truchon c. Procureur général du Canada **2019 QCCS 3792**

SUPERIOR COURT

CANADA
PROVINCE OF QUEBEC
DISTRICT OF MONTREAL

NO.: 500-17-099119-177

DATE: September 11, 2019

PRESIDING: THE HONOURABLE CHRISTINE BAUDOUIN, J.S.C.

JEAN TRUCHON
-AND-
NICOLE GLADU
Applicants

v.

ATTORNEY GENERAL OF CANADA
-AND-
ATTORNEY GENERAL OF QUEBEC
Defendants

-AND-
ASSOCIATION QUÉBÉCOISE POUR LE DROIT DE MOURIR DANS LA DIGNITÉ
-AND-
DYING WITH DIGNITY CANADA
-AND-
LE COLLECTIF DES MÉDECINS CONTRE L'EUTHANASIE
-AND-
LIVING WITH DIGNITY
-AND-
CANADIAN ASSOCIATION FOR COMMUNITY LIVING
-AND-
COUNCIL OF CANADIANS WITH DISABILITIES
-AND-

CHRISTIAN LEGAL FELLOWSHIP
-AND-
ALLIANCE DES CHRÉTIENS EN DROIT
Interveners

JUDGMENT

TABLE OF CONTENTS

OVERVIEW

[1] Is it permissible, in the absence of coercion or constraint, for a capable, adult person who is seriously ill with no chance of improvement, in an advanced state of irreversible decline in capability and enduring constant and intolerable suffering to receive medical assistance in dying even though he or she is not approaching death?

[2] Medical assistance in dying, legalized in the wake of the 2015 Supreme Court judgment in *Carter*,[1] is strictly circumscribed in this country.[2] To receive such assistance, a person must be of full age and eligible for publicly-funded healthcare. He or she must also be capable of making decisions with respect to his or her health, of making a voluntarily request, and of providing free and informed consent. There are also requirements relating to the person's medical condition.

[3] In Canada, the *Criminal Code*[3] provides that a person must have a grievous and irremediable medical condition fulfilling the following criteria, all of which must be met: (a) they have a serious and incurable illness, disease or disability; (b) their medical condition is characterized by an advanced state of irreversible decline in capability; (c) they are subject to enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions they consider acceptable; and (d) their natural death has become reasonably foreseeable.

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[1] *Carter v. Canada (Attorney General)*, [2015] 1 S.C.R. 331, 2015 SCC 5. 331 ("*Carter*").

[2] *Criminal Code*, R.S.C. (1985), c. C-46, ss. 241.1-241.4; *Act respecting end-of-life care*, CQLR, c. S-32.0001, s. 26-32. The provisions concerning medical assistance/aid in dying are reproduced in their entirety in a schedule to this judgment.

[3] R.S.C. 1985, c. C-46 ("*Cr. C.*" or "federal statute" or "Bill C-14").

[4] In Quebec, the *Act respecting end-of-life care*[4] requires that the person be at the end of life, be suffering from a serious and incurable illness, be in an advanced state of irreversible decline in capability, and experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.

[5] The applicants, Mr. Jean Truchon and Ms. Nicole Gladu, who have been declared ineligible for medical assistance in dying, challenge the constitutional validity of the requirements in s. 241.2(2)(d) of the *Criminal Code* and subsection 3 of the first paragraph of s. 26 of the *Act respecting end-of-life care*, which respectively require that their natural death be reasonably foreseeable or that they be at the end of life in order to obtain such assistance.

[6] They argue that these requirements infringe upon their right to life, liberty and security of the person and their right to equality, which are guaranteed by ss. 7 and 15 of the *Canadian Charter of Rights and Freedoms*.[5]

[7] In their view, these requirements also violate the principles set out in *Carter*, with the consequence of removing from them their right to obtain medical assistance in dying, which this decision had, in fact, granted them.

[8] Should the Court rule in favour of their applications, they ask that no suspension of the declaration of constitutional invalidity be granted the Attorneys General or, in the alternative, that they be granted a constitutional exemption to allow them to obtain medical assistance in dying.

[9] The Attorney General of Canada argues that Parliament’s response to *Carter*, which requires a reasonably foreseeable natural death, makes it possible to achieve the legislative objectives at issue. More specifically, he argues that permitting medical assistance in dying only for people whose deaths are reasonably foreseeable strikes a reasonable and appropriate balance between, on the one hand, the autonomy of persons who seek medical assistance in dying and, on the other, the interests of society and of vulnerable persons. Thus, this requirement appears to be consistent not only with the *Charter* but also with the spirit of the judgment in *Carter*.

[10] He argues that the reasonably foreseeable natural death requirement does not infringe ss. 7 and 15 of the *Charter* but maintains that, were such an infringement to exist, it would be justified under s. 1 of the *Charter* because it is a reasonable requirement that can be justified in a free and democratic society.

[11] The Attorney General of Quebec fully agrees with the arguments of the Attorney General of Canada. She defends the constitutional validity of the provincial statute because it was enacted within the province’s jurisdiction over health and because the objective sought by the Quebec legislature in enacting it was to allow medical aid in dying solely to persons who are at the end of life.

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[4] CQLR, c. S-32.0001 (”provincial statute” or “Quebec statute” or “Bill 52”).

[5] *Canadian Charter of Rights and Freedoms,* Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, s. 15 (”*Charter*”).

[12] After analyzing all the evidence, the Court finds that the reasonably foreseeable natural death requirement in the *Criminal Code* infringes upon the applicants' fundamental rights set out in ss. 7 and 15 of the *Charter*, that the end-of-life requirement in the *Act respecting end-of-life care* also violates s. 15 of the *Charter*, and that these infringements cannot be justified under s. 1. Therefore, the Court declares the impugned provisions to be constitutionally invalid.

[13] Given the specific circumstances of these proceedings, the Court will grant both legislatures a six-month suspension of the declaration of constitutional invalidity.

[14] However, the Court will also grant a constitutional exemption to the applicants, who may obtain medical assistance in dying during this period if they meet the eligibility conditions set out in the federal and provincial statutes.

[15] This case raises many legal, ethical and moral issues that touch on the very foundations of our society, on death and on our relationship with it. First, the Court will consider the situations of the applicants themselves. It will then examine the legislative and social context surrounding the enactment of the federal and Quebec statutes and the process of medical assistance in dying, as currently practiced in Canada. While everyone agrees that this judicial application is important to society as a whole, it is first and foremost a debate anchored in the day-to-day realities of Mr. Jean Truchon and Ms. Nicole Gladu, two citizens who have shown courage and determination in bearing the weight of this case on their shoulders.

[16] Although the debate over the decriminalization of medical assistance in dying in Canada has already taken place, it is evident that this final act still prompts concern in many and continues to raise questions that remain unanswered, such as, should minors or persons who are incapable be allowed access to medical assistance in dying and should such assistance be permitted on the basis of medical instructions given ahead of time? These matters, which are undoubtedly extremely important, are not at issue in this case. The Court must solely determine the constitutional validity of the legislative requirements of reasonably foreseeable natural death and of being at the end of life, as set out in the *Criminal Code* and the *Act respecting end-of-life care*, respectively. This is therefore the only question that it will answer.

BACKGROUND

1. The Plaintiffs

1.1 Mr. Jean Truchon

[17] Mr. Truchon is 51 years old and has suffered from spastic cerebral palsy with triparesis since birth. As a result of this condition, he was completely paralyzed with the exception of his left arm, which was functional and which, until 2012, allowed him to perform certain everyday tasks and to move around in a wheelchair.

[18] His cognitive and mental functions are fully intact, even above normal.[6]

[19] Mr. Truchon's physical condition did not prevent him from leading a full and independent life [TRANSLATION] "that brought him all the satisfaction he could expect from life".[7] He graduated from university in 1992, obtaining an undergraduate degree in literature from Université Laval.[8] During his studies, he lived alone in residence.

[20] After he graduated, he moved to Montreal and lived in a supervised apartment, where he received care at home that he could not provide for himself, including help getting up, going to bed, and preparing meals.

[21] Until 2012, Mr. Truchon was active, despite his disability. He would go to the pool, play wheelchair ball hockey, and play chess regularly. His active social life revolved around his family and friends, with whom he would go out to take part in varied activities. An only child, he is close to his parents, who live in the Saguenay region. He would visit them occasionally, taking the bus on his own.

[22] Although he always saw his life as a battle for autonomy, he was nevertheless relatively satisfied with his daily life and states that he led a more-or-less normal life.

[23] In 2011, he experienced weakness and a gradual loss of sensitivity in his left arm. In March 2012, he was diagnosed with severe spinal stenosis (narrowing of the spinal canal) as well as myelomalacia (spinal cord necrosis).[9]

[24] This is a degenerative condition for which no surgical or pharmacological treatment exists that caused the gradual paralysis of his only working limb. As a result, in 2012, Mr. Truchon permanently lost the use of his left arm and became fully paralyzed, with no hope of improvement.

[25] This new condition was accompanied by significant physical pain in the arms and neck, with intense burning sensations and painful spasms. Treatments were attempted to relieve his suffering, but to no avail. The pain became enduring and constant. From that moment on, Mr. Truchon has also experienced equally intense psychological suffering because he is now completely dependent when it comes to the daily activities that he had managed to master on his own. He can no longer live in an apartment alone. He says that, in 2012, he died.

[26] He had to move into a health and social services centre adapted to his needs. Although the transition has not always been easy, Mr. Truchon has tried to cope with his new reality and life in an institution. He went through a depressive episode, but he eventually came out of it.

[27] He met regularly with Ms. Malo, a psychologist at the Centre, who helped him to try to move forward and find ways to adapt. In 2014, he realized that he

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[6] Exhibit P-5: Expert report of Dr. Jean-François Giguère, neurosurgeon, January 6, 2017.

[7] Originating application for declaratory judgment at para. 10.

[8] Exhibit P-1: Diploma of Mr. Jean Truchon, Université Laval, June 30, 1992.

[9] Originating application for declaratory judgment at paras. 17-19 and Exhibit P-5: Expert report of Dr. Giguère at 2.

was unable to do it. He summarizes his typical day at the Centre as follows: [TRANSLATION] "They come to give me my pills at 8:00 a.m. I eat breakfast around 9:00 a.m. I am given 15 minutes to digest. After that, I try to catch someone as they are going down the hall to lower the head of my bed and my feet too. After that, they roll me onto my side because it's more comfortable for me and there's less pain. Now it's 11:00 a.m. They get me up, get me dressed, and put me in my armchair. At noon, they feed me. Around 1:00 p.m. or 1:15 p.m., they put me in place to have a bowel movement, every day. I attend the activities in the afternoons or I play chess with friends who come by, three or four times a week. I go to the Centre's activities. I eat supper around 5:00 p.m. Once again, they feed me because of my arm. Afterwards, around 8:30 p.m., they lay me down and I watch television until 11:00 or 11:30 p.m. That's basically my life, my poor life."[10]

[28] He can no longer go to the pool or play ball hockey, and he rarely goes out, because moving around in a wheelchair, which he now must control by using his chin, is difficult and causes him a lot of pain.

[29] He therefore began to think about dying in the manner and at the time of his own choosing. Over time, this idea began to take up more and more space in his thoughts. He devised several scenarios to bring his days to an end, taking into consideration the restrictions imposed by his disability.

[30] First, he considered fasting, but gave up on that idea at the time because of the stages of suffering it causes. He said that he did not want to put his parents through that ordeal. He thought about throwing his wheelchair in front of the metro, a truck or a bus. He also abandoned that idea, saying that he does not want to traumatize the drivers and risk destroying lives other than his own. He also says that he fears failing and finding himself in an even worse condition than now. He thought about drowning himself by driving his wheelchair into the river. But again, he gave up on the idea when he realized that someone might try to save him, putting his or her own life in danger. Finally, he devised a plan to buy a drug on the street and to take a lethal dose, but he was afraid of having his money stolen by dealers and not getting what he wanted.

[31] Meanwhile, he asked his treatment team to lower his care level from level 2 to level 3[11], so that he would not be transferred to a hospital or resuscitated if his medical condition so required.

[32] In 2015, he told the team that he had finally decided to stop eating to end his life, starting in September 2016, after his parents' 50th wedding anniversary.

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[10] Testimony of Mr. Truchon, January 8, 2019, at 32-33.

[11] Exhibit P-4: Mr. Truchon's medical record at 4. There are four levels of intervention and cardiopulmonary resuscitation for the medical team: level 1 (maintain all bodily functions by any means possible including investigation, IV solution, transfer to acute care, surgery, intensive care and cardiopulmonary resuscitation); level 2 (receive all care that the patient's condition requires, including transfer to hospital but excluding cardiopulmonary resuscitation); level 3 (receive necessary care that is available at residential care facility); and level 4 (receive comfort care, i.e., relief of pain and other discomforts, but without curative treatment, transfer to hospital, or cardiopulmonary resuscitation).

This decision was restated in a letter[12] he wrote to the treatment team in January 2016, in which he asked that his doctor be authorized to administer medication to relieve his pain during the process.[13]

[33] In a few sentences, Mr. Truchon expressed all the suffering, despair and helplessness that his condition caused him, as well as his [TRANSLATION] "carefully considered"[14] decision to end his life by refusing all food and liquid. Despite the good care he was receiving and the efforts he had made to adapt, he said that he was unable to prolong his life in the circumstances. He told the team about his decision and asked them to understand and respect it: [TRANSLATION] "I am aware that going before my parents do is not the best way, because it defies logic, but I can't take it anymore. ... My family and my friends know this and they respect my decision, even if they do not accept losing me."[15]

[34] He provided the Court with a lucid description, in simple and direct language, of what he would experience, because he has learned about every stage of fasting from the professionals at the Centre. He knows that it is a long process, that it causes terrible suffering, and that he will fall into a state of confusion, followed by death.

[35] At the time, Mr. Truchon was aware that his condition would probably make him ineligible for medical aid in dying because he is not at the end of life. Indeed, his life prognosis is several years, despite his condition. Nevertheless, faced with this prospect, in February 2016, with the help of his father, Mr. Truchon filled out an official request for medical aid in dying.[16] Because he was not at the end of life, his request was refused by the doctor who received it.[17]

[36] In 2017, he decided to challenge the legislative provisions at issue, more specifically, the requirements to be at the end of life and that his natural death be reasonably foreseeable in order to be eligible for medical assistance in dying. He states that he has not given up his intention to stop eating and drinking should the Court not rule in favour of his request.

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[12] Exhibit P-2: Letter from Mr. Truchon to his treatment team, January 20, 2016. This letter was read before the House of Commons during the second reading of Bill C-14. Exhibit PGC-9: Canada, House of Commons Debates, 1st Sess., 42nd Parl., 2 May 2016, "Ministerial Initiatives. *Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*" at 2698 (Mr. Lemieux).

[13] His application was studied by the Centre's clinical ethics support committee, which had to explain the difference between refusal to eat/hydrate with the aim of dying and medical aid in dying to the interdisciplinary team treating Mr. Truchon. This gave the team the opportunity to consider how to support Mr. Truchon as he experienced pain. Mr. Truchon was thus reassured that he had the support and commitment of the team. Exhibit P-4C: Consultation report of the clinical ethics support committee of the CSSS Jeanne-Mance.

[14] Exhibit P-2: Letter from Mr. Truchon to his treatment team, January 20, 2016.

[15] *Ibid*.

[16] Exhibit P-3: Mr. Truchon's request for medical aid in dying, February 29, 2016.

[17] Exhibit P-4: Mr. Truchon's medical record with the Centre intégré de santé et des services sociaux du Centre-Sud-de-l'Est-de-l'île-de-Montréal at 17.1, note of April 4, 2016, signed by Dr. Camus.

[37] Mr. Truchon's condition, which has been evaluated by several specialists, is the subject of several reports that have not been disputed.

[38] First, the report of Jean-François Giguère, neurosurgeon, describes the following:[18]

1. Mr. Truchon suffers from spinal stenosis with myelomalacia and C1-C2 subluxation, secondary to his cerebral palsy. This is a serious degenerative disease, as it has led to the loss of his upper left limb;
2. The illness is incurable and the myelomalacia will continue to progress. There is no treatment available to rehabilitate his arm;
3. There is no indication that his current condition will have an impact on his life expectancy or lead to his death in the foreseeable future;
4. Because he has lost use of his only functioning limb, Mr. Truchon's motor condition cannot deteriorate any further, which corresponds to an advanced state of irreversible decline in capability;
5. He understands the nature of his illness very well, and it has no effect on his higher mental functions.
6. Mr. Truchon certainly experiences physical and psychological pain, but it is difficult to assess whether or not it is tolerable. According to Mr. Truchon's statements, the pain is unbearable.

[39] Dr. Jean-Robert Turcotte, psychiatrist, testified at the hearing.[19] He has been a doctor since 1975, first practicing for ten years as a family physician before obtaining a Master's in Public Health from Harvard University. He subsequently completed a specialization in psychiatry at McGill University and has been practicing in that field since 1991. He holds an academic position at the Université de Montréal and his practice regularly involves evaluating the capacity of the patients under his care. In addition to meeting with Mr. Truchon on two occasions, Dr. Turcotte studied his full medical file, including the clinical notes of psychologist Ms. Malo. He presented the following portrait:

1. Mr. Truchon is able to consent to his treatments, including his request for medical assistance in dying, in a free and informed manner. He has no cognitive issues and is entirely capable of deciding for himself with regard to both his treatments and the administration of his property;
2. He is not affected by any psychiatric condition. He does not meet the criteria for major depression, adaptive disorder, anxiety disorder, or any psychotic or cognitive problems;
3. He went through a period of depression in 2014, which improved. He continues to have symptoms of sadness and anxiety in anticipation of his future life, but these symptoms are entirely consistent with his

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[18] Exhibit P-5: Expert report of Dr. Giguère. The report is admitted. He did not testify at the hearing.

[19] Exhibit P-6: Expert report of Dr. Jean-Robert Turcotte, psychiatrist, June 13, 2017.

current medical condition and are not pathological. He also experiences intolerable psychological suffering.

4. Antidepressant medication or treatment is therefore not indicated in Mr. Truchon's case; on the contrary, it could cause side effects and a deterioration in his current condition.
5. Mr. Truchon is not suicidal, despite his wish to die. He still takes pleasure in certain things and is capable of humour, but he is determined not to continue living in this state or to die in conditions that are in his view degrading.

[40] Dr. Alain Naud, a family doctor and palliative care physician for the last 31 years, testified at the hearing.[20] He is a tenured clinical professor at Université Laval, a clinician and instructor in family medicine, and a Fellow of the College of Family Physicians of Canada. He has evaluated numerous suicidal patients throughout his career. Since the Quebec law came into force in December 2015, he has provided medical aid in dying to 65 individuals and given several lectures on the subject.

[41] Dr. Naud's mandate was to determine whether Mr. Truchon was eligible for medical assistance in dying under the criteria of both the federal and the provincial statutes. To do so, he considered all of Mr. Truchon's medical files and the notes of the psychologist, Ms. Malo, among other things. He also met with Mr. Truchon.[21]

[42] Dr. Naud's observations are clear:

1. Mr. Truchon's neurological condition is without a doubt an undeniably serious and incurable degenerative illness;
2. This medical condition is characterized by an advanced state of irreversible decline in capability. No curative treatments would allow him to recover or even improve his capability.
3. Mr. Truchon shows many signs of physical suffering: constant physical pain affecting his entire body, contraction of the upper limbs, painful muscle spasms in the lower limbs, cervical dystonia, complete paralysis of the four limbs, total confinement to bed, dysarthria, neurogenic bladder, and total loss of autonomy. In this respect, he states that physical suffering is not just a synonym for physical pain. Confinement to bed and the numerous consequences of this state, not to mention permanent paralysis and severe loss of autonomy, also factor into the physical suffering of end-of-life patients and of patients who, like Mr. Truchon, suffer from a severe but non-terminal condition;
4. Mr. Truchon also experiences considerable psychological pain. He is

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[20] Exhibit P-23B: Expert report of Dr. Alain Naud, family physician and palliative care physician, dated September 8, 2017, and up-to-date curriculum vitae.

[21] Dr. Naud also reviewed the reports of Dr. Giguère (Exhibit P-5) and of Dr. Turcotte (Exhibit P-6).

unable to find meaning in his life, and he no longer recognizes himself. The few moments of pleasure he still sometimes feels – when he plays chess, for example – hardly compensate for his suffering. Like Dr. Turcotte, Dr. Naud finds no element of depression or a cognitive disorder in Mr. Truchon. His sadness is entirely consistent with his situation;

5. Mr. Truchon's life prognosis is impossible to establish because the condition afflicting him is not in itself fatal. If he continues to eat, drink and receive care, he could still live many years.
6. Mr. Truchon is perfectly able to consent to receiving medical assistance in dying. He understands his medical condition and the fact that it is irreversible and incurable. He is also very well informed about medical assistance in dying, and about the procedure, the risks and the possibility of changing his mind at any time, as well as the requirement that he be capable until it is administered. His decision to request medical assistance in dying is not the result of an impulsive act but of a long reflection that he has shared with his psychologist, the professionals at the Centre, his friends and his parents.
7. Mr. Truchon is not suicidal. He does not suffer from any psychiatric condition likely to affect his capacity to consent, and he has not been subjected to any external pressure regarding his request for medical assistance in dying.
8. Mr. Truchon thus meets all of the requirements of the federal legislation, except for the requirement that his natural death be reasonably foreseeable, as well as all of the criteria of the provincial legislation, except for the requirement that he be at the end of life.

[43] Finally, Dr. Claude Rivard, a family physician since 1995, has devoted most of his practice to emergency medicine and intensive care. Since January 2017, he has turned his practice toward palliative care. He filed his report on the medical condition of the plaintiffs, including Mr. Truchon.[22]

[44] Since December 2015, he has evaluated approximately 150 patients for requests for medical aid in dying and administered the procedure more than 130 times. He has trained approximately 20 physicians in this area of practice. Dr. Rivard testified at the request of the Attorney General of Canada.

[45] To assess Mr. Truchon's eligibility for medical assistance in dying, Dr. Rivard consulted all his medical files and Dr. Naud's report. He also met with Mr. Truchon. His observations are the following:

1. Mr. Truchon is entirely capable of consenting to medical assistance in dying. He perfectly understands the purpose and finality of the procedure. He understands the risks and the benefits, and he is also

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[22] Exhibit PGC-66: Expert report of Dr. Claude Rivard, family physician, December 22, 2107, and up-to-date curriculum vitae.

aware of the alternatives such as palliative care;

2. He has excellent insight and is able to choose from the different treatment options available to him and to understand the consequences of that choice. Mr. Truchon has not been subjected to any external pressure regarding his request for medical assistance in dying;
3. He suffers from a serious and incurable disease that is characterized by an advanced state of irreversible decline in capability. He is a prisoner of his body, yet his intellect is intact. He suffers from spastic rigidity of his limbs and his inability to control his muscles means that they frequently contract for no apparent reason, which can be very painful. He also suffers psychologically because of his high degree of dependence, among other things;
4. Despite the support and the medication he takes to try to control his multiple disabilities and his suffering, Mr. Truchon deems that his current life is intolerable and that his pain, both physical and psychological, is unacceptable;
5. Using the PPS scale,[23] which is aimed primarily at establishing a survival prognosis for cancer patients, he evaluated Mr. Truchon's at 30% for the past five years. Therefore, Mr. Truchon could still live several years if he continues to eat and to receive the care that is currently being provided. There is a possibility that he will suffer a complication that would render him eligible for medical assistance in dying, such as pneumonia or another infection;
6. Mr. Truchon therefore meets all the requirements under both the federal legislation and the provincial legislation, except for the requirements of natural death being reasonably foreseeable and of being at the end of life.

[46] The Court has also heard the testimony of Ms. Malo, Mr. Truchon's psychologist since 2014, whose up-to-date clinical notes outline Mr. Truchon's thought processes in recent years. In her testimony, she revealed her profound attachment to and respect for Mr. Truchon.

[47] She related that Mr. Truchon's life no longer has meaning for him, despite the many efforts he has made to try to adapt to his condition. After changing his level of care and considering starving himself, he began this legal battle to obtain medical assistance in dying because, even though he has not given up the idea

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[23] Palliative Performance Scale. Dr. Rivard is of the view that the PPS is a valuable tool in determining whether natural death is reasonably foreseeable. Depending on the patient's clinical condition, he tries to construct an end-of-life scenario, referring to the types of end-of-life trajectories described in the *Guide d'exercice et lignes directrices pharmacologiques du Collège des médecins du Québec*. Exhibit PGC-66: Expert report of Dr. Rivard at paras. 36 and 68.

of fasting, it is a long and painful process and he is hesitant about putting his parents through this ordeal.[24]

[48] Ms. Malo confirmed that Mr. Truchon is not suicidal. His desire to end his life appears considered and is an act of dignity in a situation of intolerable suffering. The symptoms of depression and sadness that he sometimes displays are explained by his condition. He wants to be able to end his life when he himself wishes, and he is in no way ambivalent about this plan.

[49] From these reports and testimonies, the Court essentially finds that Mr. Truchon's current medical condition does not render him eligible for medical assistance in dying. Despite the fact that he meets all the other legislative requirements, his degenerative illness will not cause or hasten his death. Since he could continue to live this way for many years, his natural death is not reasonably foreseeable and he is not at the end of life.

[50] The Court was very moved by Mr. Truchon's testimony, which was dignified and modest, while expressing undeniable and palpable suffering. He is an intelligent, perceptive, courageous, empathetic and determined man. Mr. Truchon's moving testimony was sometimes humorous, and it affected all those present at the hearing.

1.2 Ms. Nicole Gladu

[51] Ms. Gladu is 73 years old. She was born before the time of widespread vaccinations against poliomyelitis. She survived an acute paralyzing form of this disease, which she developed at the age of 4 and which sent her into a coma, from which she emerged with significant sequelae, including residual paralysis of the left side and severe scoliosis caused by the gradual deformation of her spinal column.

[52] Although it was predicted that she would never walk again, she beat the odds. Ms. Gladu spent years in physiotherapy and, at the age of 10, underwent three spinal grafts. Although her scoliosis was only partially corrected, she nevertheless describes a happy childhood thanks to her parents, who raised her in an intellectually stimulating environment.

[53] She had a classical education and went to university. Her professional career is impressive. She became a journalist for Radio-Canada, a Parliamentary correspondent at Montréal-Matin, a press attaché for the United Nations in New York, and director of communications at the Québec Government Office in New York. She also completed a master's degree at ÉNAP in 1994. She appears very proud of all of her professional accomplishments despite her physical limitations.

[54] A very active, energetic and cultured woman, Ms. Gladu has travelled extensively.

[55] In 1992, at the age of 47, the [TRANSLATION] "ghost of her childhood"[25] re-emerged when she was diagnosed with degenerative muscular post-polio

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[24] Mr. Truchon's father died in 2018.

syndrome, a degenerative neurological disease characterized by general fatigue, gradual or sudden muscular weakness, and mobility-reducing muscle pain. This incurable condition is the result of the body's overcompensation in polio survivors. [TRANSLATION] "The degeneration is unpredictable. The disease is like a staircase that one does not descend step by step, but falls down from landing to landing. I have reached the basement."[26]

[56] In 1997, she developed thrombophlebitis and a hiatal hernia. Reality was difficult for Ms. Gladu. She suffered from two depressions after the death of her mother and because of her own condition, which was deteriorating. Then one day she said to herself, [TRANSLATION] "Once I've had enough, I'll just cut the cord." [27] At that point, she got back on her feet and decided to live fully with her remaining capability, taking advantage of each moment that life brought her.

[57] Little by little, however, her fatigue, muscle weakness and balance issues have gotten worse. She suffers a serious case of osteoporosis. Her body can no longer hold her up. In addition, her spinal deformity has worsened and the thoracolumbar scoliosis has caused a severe restrictive lung disease with nocturnal desaturation. Her lung capacity is reduced to the equivalent of half a lung. Every breath is a battle. The compression of her rib cage, combined with a hiatal hernia, also makes eating difficult.

[58] Having always enjoyed an active and proudly independent life, she rejects the prospect of having to depend on others and, above all, of finishing her days in an institution. She became involved in the debate in Quebec through the National Assembly's Select Committee on Dying with Dignity.[28] She was shocked and angered by the enactment of the federal statute, which requires that natural death be reasonably foreseeable to obtain medical assistance in dying.

[59] Today, she is very weak. She needs a walker to move around, even inside her own apartment, because she has hardly any limb strength left and a great deal of trouble maintaining her centre of gravity. Simple daily tasks require a lot of effort. She is at a high risk of falling. She broke her femur in 2011.

[60] Ms. Gladu is in constant pain. Her sciatic nerve, knee, back and hips cause her suffering. She is in a perpetual state of great discomfort and malaise. She never feels well, and she cannot stay in the same position for long. The medication provides no relief.

[61] Ms. Gladu thought about suicide, but she more seriously considered going to an assisted suicide clinic in Switzerland. She finds it unjust that this possibility is available only to people with financial means and is sad at the prospect of

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[25] Testimony of Ms. Gladu, January 7, 2019, at 125.

[26] *Ibid*. at 132.

[27] *Ibid.* at 134.

[28] Exhibit P-9: Brief drafted by Ms. Gladu for the National Assembly's Select Committee on Dying with Dignity.

having to [TRANSLATION] "die alone in a small beige room".[29] At the moment, however, she has not ruled out this possibility.

[62] After this full life of which she took full advantage, she says that she is worn out and at the end of her rope, a prisoner of her body and her disease. In her eyes, life is active, it has momentum and energy. She has displayed a formidable appetite for life during her entire existence, and she cannot resign herself to simply existing...like [TRANSLATION] "a plant".[30]

[63] She is therefore faced with a terrible choice, which she explains clearly: she can continue to suffer and deteriorate; she can voluntarily submit herself to additional suffering or a deterioration of her condition in the hopes of qualifying for medical assistance in dying; or she can commit suicide.

[64] She questions the logic of the principle that she can decide to subject herself to additional suffering by ceasing to eat or drink, for example, in order to achieve a state where she is eligible for medical assistance in dying. In her case, she cannot choose to interrupt or stop treatment because she is not following any.

[65] Although she did not know Mr. Truchon, she decided to join forces with him to bring this legal action. For this purpose, Ms. Gladu underwent a series of medical exams to determine whether she is eligible for medical assistance in dying under the legislative criteria currently in force.

[66] In the spring of 2017, Ms. Gladu met with neurologist Dr. Michel Aubé to determine the extent of her illness and its impact on her life.[31] His written report provides the following information:

1. Ms. Gladu has post-polio syndrome, an incurable degenerative disease which does not stop progressing, although over time its development may appear to slow down;
2. There is no known specific treatment for this syndrome, only non-specific support treatments;
3. Ms. Gladu has lost a significant portion of her motor function and strength in many of her limbs. As a result, only her right upper limb has any real function remaining;
4. Post-polio syndrome is not a fatal illness in itself, unless it involves the respiratory system. Ms. Gladu suffers from severe lung disease secondary to the progressive development of her thoracoscoliosis. In her case, mortality related to her illness remains a very real possibility;
5. There is no treatment for thoracoscoliosis or for the associated progressive respiratory insufficiency, aside from nocturnal improvement with a BiPAP machine;

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[29] Testimony of Ms. Gladu, January 7, 2019, at 156.

[30] *Ibid*. at 166.

[31] Exhibit P-11: Expert report of Dr. Michel Aubé, neurologist, May 8, 2017. This report is admitted. Dr. Aubé did not testify at the hearing.

6. Ms. Gladu experiences physical suffering as a consequence of her moderate intensity musculoskeletal condition. Her psychological suffering is real because of her loss of autonomy;
7. She is very familiar with her condition and her death prognosis, which can be anticipated within the next two to three years because of her lung condition. She does not appear to have symptoms of depression and is entirely lucid with regard to consent to medical assistance in dying.

[67] Psychiatrist Dr. Jean-Robert Turcotte assessed Ms. Gladu's capacity. He outlined his findings in light of her earlier medical records and his meetings with her:[32]

1. No psychiatric illness – depression, anxiety disorder, cognitive or psychotic disorder – impairs her judgment or her cognitive functions, which appear entirely normal. She exhibits no signs of sadness, anxiety, delusion or cognitive disorder connected with any psychiatric diagnosis or pathology.
2. Although she has suffered from two depressions in the past, one of them situational in the late 80s and a second in 2001, they have had no effect on her current capacity to consent to medical assistance in dying. She continues to take antidepressants preventively to reduce the risk of a third episode;
3. The sadness and anxiety she feels are a direct result of her current situation. She experiences significant psychological suffering that she deems intolerable because she is worried about her illness and about the realization that her condition is deteriorating progressively and rapidly. The idea of becoming completely dependent, powerless and bedridden terrifies her;
4. Although her physical pain can be relative, she is constantly uncomfortable and unable to find an acceptable position or to live a normal life;
5. She knows her illness very well. She knows that it is incurable and is aware of the dire prognosis awaiting her. She knows that her illness will never affect her cognitive functions and that she will remain aware until the end;
6. Ms. Gladu does not intend to commit suicide. Her steps to obtain medical assistance in dying seem considered and not impulsive. She has discussed it with her loved ones and is under no external pressure in this respect.

[68] As was the case for Mr. Truchon, Dr. Alain Naud assessed Ms. Gladu's condition to determine whether she is eligible to receive medical assistance in

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[32] Exhibit P-10: Expert report of Dr. Jean-Robert Turcotte, psychiatrist, and his testimony at the hearing on January 10, 2019.

dying under the legislative provisions in force, both federally and provincially. He drew the following conclusions:[33]

1. Ms. Gladu suffers from post-poliomyelitis syndrome, from extreme deformities of the spinal column and thoracic spine assessed at 75 degrees, which has left her completely deformed and which affects her lung capacity.
2. She now also suffers from severe, chronic respiratory insufficiency, certainly below the 34% measured in 1999. A hiatal hernia contributes to her lung compression. She suffers from fracturary osteoporosis and arthrosis that will only worsen. Ms. Gladu’s condition, which is related to post-polio syndrome, is without a doubt a grievous and incurable illness, and no treatment exists to cure it.
3. It remains impossible to establish a life prognosis in this case. Post-polio syndrome does not lead to death, nor do any of Ms. Gladu’s other conditions. That said, her life expectancy may be lower than that of another person of the same age because of her fragile state;
4. Ms. Gladu’s overall medical condition is characterized by an advanced and progressive state of decline in her capability, for example: muscle weakness, functional limitation of three of her four limbs, significant loss of autonomy, chronic pain, severe respiratory insufficiency, difficulty swallowing, generalized and constant discomfort, balance issues, reduced muscle mass and weight loss, major physical deconditioning and increased drowsiness during the day;
5. She feels physical pain that is intolerable to her, in particular permanent back, hip and knee pain, generalized and constant discomfort, constant respiratory insufficiency with difficulty breathing, significant deformities of the rib case, generalized muscle weakness, limitation in her limbs, and severe balance problems;
6. She does not suffer from depression at this time. Since her depression 15 years ago, she has been taking antidepressants prophylactically, which is an excellent practice. It is nevertheless clear that she experiences undeniable psychological suffering as a result of her condition. She has had an active and independent life, and now she feels dependent. She also detests her body image. The things that keep her attached to life – for example, her cat, visits from friends, and the view from her apartment – do not compensate for her suffering. She says she is worn out and has reached the end of the road;
7. Ms. Gladu is fully capable of consenting to receiving medical assistance in dying. She has no symptoms of depression or any mental conditions that might affect her capacity to consent. She is perfectly aware of the nature of her condition and her life prognosis. Her consent seems free

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[33] Exhibit P-23A: Expert report of Dr. Alain Naud, and testimony at the hearing on January 9, 2019.

and informed, and far from impulsive; on the contrary, it is the fruit of a long process of reflection with no external pressure whatsoever;

8. She therefore meets all of the requirements of the federal statute and the provincial statute, except for the requirements of natural death being reasonably foreseeable and of being at the end of life.

[69] Finally, Dr. Claude Rivard, the expert hired by the Attorney General of Canada, met with Ms. Gladu and reviewed her prior medical assessments to verify her eligibility for medical assistance in dying:[34]

1. He made the same observations as the other experts regarding Ms. Gladu's diagnosis and its consequences on her condition. He claims that her strength of character is inversely proportional to her physical problems. She suffers from pathologies with disabilities that are serious and incurable. There is in fact no known treatment for her medical condition;
2. He also confirms that she is perfectly aware that her illness is incurable and that there is no chance of improvement. She is highly adaptable despite her advanced state of irreversible decline in capability;
3. She is capable of consenting to medical assistance in dying and of understanding the objective and purpose of the procedure and the risks and benefits of medical assistance in dying, and she is also aware of the other potential options such as palliative care. She was under no external pressure when making her request;
4. Without a doubt, she suffers from constant physical and psychological pain, which is exacerbated by the gradual loss of her functional autonomy. She deems her current life intolerable and her physical and psychological pain unacceptable;
5. On the PPS scale, she has a score of 40%, which means that she could still live a few years if she continues to eat and receive the support she needs. She does not meet the requirement of being at the end of life or of a reasonably foreseeable death, however. If her condition deteriorates, she may have access to it at that time.

[70] The Court finds that Ms. Gladu also meets all of the federal and provincial legislative requirements except the requirement of being at the end of life or of her natural death being reasonably foreseeable.

[71] The Court would like to stress Ms. Gladu's determination and courage when she testified in Court. She is as everyone describes her: an intelligent woman, a fighter with determination that inspires admiration, esteem and respect. At times a little mischievous, she has displayed lucidity and courage throughout her life.

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[34] Exhibit PGC-66: Expert report of Dr. Rivard and testimony at the hearing on January 14, 2019.

[72] Both Ms. Gladu and Mr. Truchon felt betrayed and bitterly disappointed when the federal government decided to include the requirement of natural death to be reasonably foreseeable to qualify for medical assistance in dying into the legislative regime it put in place after the judgment in *Carter*. They consider themselves capable and able to make this decision without the state preventing them from doing so under pretense of protecting them.

[73] In the next section, the Court will outline the major stages of the legislative history of Bill C-14 and Bill 52 to ensure proper comprehension of the reality and issues that were debated in Canadian and Quebec society and that led to the legislative regimes currently in place.

2. <u>Legislative History</u>

2.1 Canada: Legislative History of Bill C-14

[74] The judgment in *Carter*, rendered on February 6, 2015, shook up the country's established framework by decriminalizing assisted suicide under certain conditions. By declaring ss. 241(*b*) and 14 of the *Criminal Code* unconstitutional, the Supreme Court gave Parliament the option of establishing a legislative regime that complied with the principles in its judgment and ordered the suspension of the declaration of constitutional invalidity for one year.[35]

[75] The government was granted an additional suspension period to complete its task.[36] On June 17, 2016, the *Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*[37] received royal assent, and ss. 241.1 to 241.2 Cr. C. respecting medical assistance in dying came into force.

[76] To better understand the process leading up to the passage of Bill C-14, it is useful to divide the period from the rendering of the judgment in *Carter* to the royal assent of the bill into several stages, the first ones characterized by the work of three committees[38] that were formed with a view to drafting the bill.[39]

- **External Panel (July - December 2015)**

[77] The External Panel created to "hold discussions with the interveners in *Carter* and with 'relevant medical authorities,' and to conduct an online

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[35] *Carter* at paras. 127 and 128.

[36] *Carter v. Canada* (Attorney General), [2016] 1 S.C.R. 13.

[37] S.C. 2016, c. 3.

[38] The External Panel on Options for a Legislative Response to *Carter v. Canada* ("External Panel"), the Provincial-Territorial Expert Advisory Group ("Advisory Group"), and the Special Joint Committee of the Senate and the House of Commons ("Joint Committee").

[39] The three committees were all constituted before the motion seeking an order extending the suspension of the declaration of constitutional invalidity and the Parliamentary proceedings surrounding the enactment of the federal statute.

consultation open to all Canadians and other stakeholders"[40] also led fact-finding missions to four countries[41] that have legalized medical assistance in dying.

[78] The election of a new government in October 2015 resulted in a deferral and modification of its mandate. The External Panel was no longer to present legislative options in response to *Carter*, but merely to summarize its consultation activities and main findings. The External Panel's report was presented to the Minister of Justice and the Minister of Health on December 15, 2015.[42]

[79] Without making any recommendations, the External Panel found that "respect for autonomy intersects with the protection of vulnerable persons": on the one hand, "[v]ulnerability, in and of itself, must not preclude the expression and recognition of an autonomous choice to pursue physician-assisted death"; on the other, "vulnerability...may impede or distort the expression of autonomy, when choices are coerced or induced".[43]

[80] According to the External Panel, the Supreme Court's declaration of invalidity in *Carter* "did not limit access to persons with terminal conditions, or physical conditions".[44] It also found that, "the Court did not indicate that the person must be at the end of life, have a terminal diagnosis or be at an advanced stage of decline."[45] In other words, "*Carter* extends beyond those diagnostic and prognostic parameters".[46]

- **Advisory Group (August-November 2015)**

[81] At the same time, a Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying established by 11 provinces and territories[47] carried out consultation activities on issues relating to medical assistance in dying. Its mandate was to develop recommendations "to assist provinces and territories in

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[40] Exhibit PGC-1: External Panel on Options for a Legislative Response to *Carter v. Canada, Consultations on Physician-Assisted Dying - Summary of Results and Key Findings. Final report*, December 15, 2015, at iv.

[41] Oregon (United States), the Netherlands, Belgium and Switzerland.

[42] The External Panel received more than 300 briefs and met with 73 experts and 92 representatives of 46 organizations and groups of interveners in *Carter*, holding discussions mainly on "eligibility criteria, defining key terms, the risks of physician-assisted dying to individuals in society, what safeguards can be used to address the risks and finally procedures for assessing requests for assistance in dying". The "loss of respect for the elderly, those with disabilities and other vulnerable persons" is one of the risks cited in the briefs summarized by the External Panel. The Panel noted the "idea often expressed ... that when death is considered a way to avert potential future suffering and its consequences -- for both the individuals and their friends and loved ones -- vulnerable groups are at increased risk of harm." Exhibit PGC-1: *Final report of the External Panel on Options for a Legislative Response to* Carter v. Canada*, Consultations on Physician-Assisted Dying – Summary of Results and Key Findings* (December 15, 2015) Annex E and F.

[43] *Ibid*. at 2.

[44] *Ibid.* at 42.

[45] *Ibid.* at 57.

[46] *Ibid.* at 82.

[47] Quebec did not participate, and British Columbia took part as an observer.

deciding what policies and procedures should be implemented within their jurisdictions in response to the Supreme Court's judgment in *Carter*."[48]

[82] The Advisory Group acknowledged the authority of each provincial government to respond to *Carter* "as it deems appropriate" within its area of jurisdiction. It nevertheless urged the provinces and territories to "work closely with the federal government, with each other and with health professional regulatory authorities to ensure an efficient approach to planning, communication and implementation"[49] with regard to medical assistance in dying throughout Canada.

[83] The Advisory Group found that medical assistance in dying "fits within a continuum of end-of-life services"[50] and that it "should be treated as one appropriate medical practice within a continuum of services available at the end-of-life."[51]

[84] The Advisory Group formulated its recommendations specifically in response to *Carter*. Its final report, published on November 30, 2015, contains 43 recommendations to be implemented in provincial and territorial legislation. The Court considers the following recommendations to be of relevance to this case :

> RECOMMENDATION 12: Provinces and territories should request that the federal government make it clear in its changes to the Criminal Code that at any time following the diagnosis of a grievous and irremediable condition, a request for physician-assisted dying made through a valid patient declaration form may be fulfilled when suffering becomes intolerable.[52]
>
> RECOMMENDATION 18: "Grievous and irremediable medical condition" should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as "grievous and irremediable" should not be delineated in legislation or regulation.[53]
>
> RECOMMENDATION 20: Physicians should use existing processes in the health care system to assess competency and consent.[54]

[85] According to the Advisory Group, the eligibility criteria for medical assistance in dying should be the ones established by the Supreme Court in *Carter*.[55] It underlines that "the Supreme Court did not limit the ruling to those

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[48] Exhibit PGC-2: *Final Report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying of November 30, 2015*, at 12.

[49] *Ibid.* at 14.

[50] *Ibid.* at 51.

[51] *Ibid.* at 19.

[52] *Ibid.* at 30.

[53] *Ibid.* at 34.

[54] *Ibid.* at 35.

[55] *Ibid.* at 34.

unable to take their own lives, to cases of terminal illness, or to people near death".[56]

[86] It proposes a pathway for the assessment of eligibility for medical assistance in dying based on the following criteria: eligibility for publicly funded health services, competency, grievous and irremediable medical condition, and intolerable suffering. When the patient's eligibility appears unclear, the doctor should seek an additional assessment from relevant experts.

[87] Despite the concerns expressed by some of the interveners about vulnerable populations and the need to protect them by enacting measures such as a mandatory mental health assessment, the Advisory Group believes that "existing mechanisms are sufficient to ensure that patients are making an informed choice and that physicians can effectively assess patient competence".[57]

- **Joint Committee (December 2015 -- February 2016)**

[88] In December 2015, Parliament resumed its work after the federal elections and implemented a Special Joint Committee of the Senate and the House of Commons[58] to "make recommendations on the framework of a federal response on physician-assisted dying"[59] that complies with the *Charter*.

[89] In its report, filed on February 25, 2016, the Joint Committee formulated 21 recommendations relating to "eligibility for MAID (which are substantive safeguards), procedural safeguards, and oversight",[60] of which the following are relevant in this case:

> RECOMMENDATION 2
>
> That medical assistance in dying be available to individuals with terminal and non-terminal grievous and irremediable medical conditions that cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

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[56] *Ibid.* at 15 and 35. In addition, according to the interveners consulted by the Advisory Group, "[n]o list of specific conditions could capture the range of illnesses, diseases and disabilities that might meet the parameters established by the Supreme Court", as the degree of grievousness must be determined on a case-by-case basis.

[57] *Ibid.* at 35-36. These interveners were primarily concerned with persons afflicted with psychiatric disorders who "may not be capable of appreciating the consequences of the decision because of their mental condition" as well as persons with severe disabilities who "may be particularly vulnerable to coercion or make the choice because of a lack of social supports and few other options".

[58] Composed of 5 senators and 17 Members of Parliament, the Joint Committee held 16 meetings, heard 61 witnesses and received more than a hundred briefs. Exhibit PGC-3: Parliament Canada, *Report of the Special Joint Committee on Physician-Assisted Dying, Medical Assistance in Dying: a Patient-Centred Approach* (February 25, 2016) at 2.

[59] *Ibid*. citing the motions passed on December 11, 2015, to form the Special Joint Committee.

[60] *Ibid*. at 3.

> RECOMMENDATION 4
>
> That physical or psychological suffering that is enduring and intolerable to the person in the circumstances of his or her condition should be recognized as a criterion to access medical assistance in dying.
>
> RECOMMENDATION 5
>
> That the capacity of a person requesting medical assistance in dying to provide informed consent should be assessed using existing medical practices, emphasizing the need to pay particular attention to vulnerabilities in end-of-life circumstances.[61]

[90] The Joint Committee noted the differences in the interpretation of *Carter* regarding terminal illness as a condition of eligibility for medical assistance in dying:

> Witnesses diverged in their interpretation of the *Carter* decision and its implications for future legislation. Some witnesses said that only individuals with a terminal diagnosis should be able to access MAID while others said that *Carter* clearly did not include such a requirement.[62]

[91] The Joint Committee declared however, that it "agrees with the External Panel and does not interpret *Carter* as limiting MAID to terminally ill individuals". It justified its recommendation proposing access to medical assistance in dying for individuals with terminal and non-terminal illness by enduring suffering that is intolerable:

> ... limiting MAID in this way would result in Canadians with grievous and irremediable conditions faced with enduring and intolerable suffering having to continue suffering against their will.[63]

[92] As for the balance between the protection of vulnerable people and the right to autonomy, the Joint Committee recommends that each case be assessed individually, taking into account "any factors affecting consent, such as pressure from others, feelings of being a burden or lack of supports".[64]

[93] The Vice-Chair of the Joint Committee and three other members filed a dissenting report. According to them, the regime recommended by the Committee does not comply with *Carter* because it is too permissive and does not sufficiently protect vulnerable individuals.[65]

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[61] *Ibid.* at 35.

[62] *Ibid.* at 12.

[63] *Ibid.* at 12 and 15: Like the External Panel, the Joint Committee noted that *Carter* was silent on the issue of physician-assisted dying in situations of psychiatric disorders. Despite the possible difficulties with the practical application of the medical assistance in dying criteria in cases where mental illness is the condition underlying the request, it found that "[t]he difficulty surrounding these situations is not a justification to discriminate against affected individuals by denying them access to MAID."

[64] *Ibid.* at 17.

[65] *Ibid.* at 51-54.

2.2 Motion Seeking an Order Extending the Suspension of the Declaration of Constitutional Invalidity (January 2016)

[94] Under *Carter*, the declaration of constitutional invalidity of ss. 241(*b*) and 14 of the *Criminal Code* was to take effect 12 months later, that is, on February 6, 2016.[66]

[95] In this context, in January 2016, the Attorney General of Canada asked the Supreme Court to extend for six months the suspension of the declaration of invalidity. The motion was opposed by the claimants in *Carter*, who in turn, along with certain interveners, sought an individual constitutional exemption for persons who wished to obtain medical assistance in dying during this period. The Attorney General of Quebec also asked that Quebec be exempted from the suspension if the extension was granted "to avoid uncertainty as to whether the Quebec regime conflicts with the federal prohibition preserved by any extension of the suspension."[67]

[96] Given the interruption of parliamentary business for the federal elections, the Supreme Court granted the extension, but only for four months, giving Parliament until June 6, 2016 to formulate a legislative response to *Carter*.

[97] The Supreme Court recognized the tight deadline imposed on Parliament but found that this did not justify "unfairly prolong[ing] the suffering of those who meet the clear criteria […] set out in *Carter*."[68] Individuals eligible for medical assistance in dying under paragraph 127 of *Carter* were therefore granted individual exemptions, which allowed them during that additional period of suspension to apply to the superior court of their jurisdiction for an order authorizing the administration of medical assistance in dying.[69]

[98] Quebec was also granted an exemption from the four-month extension. In authorizing the exemption, the Supreme Court took into consideration the lack of opposition from the Attorney General of Canada and from the provincial Attorneys General. The Court also noted that granting the exemption "should not be taken as expressing any view as to the validity"[70] of the Quebec statute.

[99] Four judges, dissenting in part, were of the view that individual exceptions should not be granted[71] and that Quebec[72] should not be exempted during the four-month extension.

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[66] *Carter* at para. 128.

[67] *Carter v. Canada (Attorney General)*, [2016] 1 S.C.R. 13 at para. 1.

[68] *Ibid.* at para. 6 (emphasis added).

[69] *Ibid.* at para. 4.

[70] *Ibid.*

[71] The considerations that were taken into account in *Carter*, whereby a procedure should not be created during the initial period of suspension of the declaration of invalidity, remained convincing for the dissenting judges McLachlan C.J. and Cromwell, Moldaver and Brown JJ.

[72] They found that the exemption sought by the Attorney General of Quebec was pointless because the Quebec statute had come into force during the initial suspension of the declaration of invalidity without an exemption being sought at that time. Therefore, granting an exemption at the same time as the extension would neither add nor take away from

2.3 Canada: Parliamentary Proceedings on Bill C-14 (April – June 2016)

- **House of Commons**

[100] In April 2016, the government introduced Bill C-14 in the House of Commons[73]. This came after several months of focused work that involved analyses of *Carter*, of the reports of the committees referred to above, of the consultations led by provincial physicians' associations and other medical associations, as well as of the substance of other legislative regimes to regulate medical assistance in dying, including the approach favoured by the Quebec legislator that would serve as a source of inspiration for Parliament.[74]

[101] During the second reading of the Bill, the Minister of Justice described the government's process:

> From the start, we have known from the Supreme Court of Canada's unanimous *Carter* decision, that it is not about whether or not to have medical assistance in dying; it is about how we will do it....
>
> With all of this in mind, and in appreciating the limited time frame we have had to respond to the *Carter* decision, our government has chosen an approach that respects both the charter and the needs and values of Canadians.
>
> First, it would permit physicians and nurse practitioners to provide medical assistance in dying, so that patients who are suffering intolerably from a serious medical condition, and whose death is reasonably foreseeable given all of their medical circumstances, can have a peaceful death and not be forced to endure slow and painful suffering.
>
> Second, it would commit to study the other situations in which a request for medical assistance in dying might be made; situations that were not in evidence before the court in the *Carter* litigation and were beyond the scope of its ruling.
>
> This evidenced-based approach will allow us to respect the autonomy and the charter rights of Canadians while ensuring robust protections for vulnerable persons. It is the right approach for our country.[75]

[102] Referring to paragraph 127 *in fine* of *Carter*, the Minister of Justice stated that she was persuaded that Gloria Tayler and Kay Carter, the claimants in that case, would be eligible for medical assistance in dying under the proposed bill

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whatever clarity existed in Quebec when the Quebec statute came into force: *Carter v. Canada (Attorney General)*, [2016] 1 S.C.R. 13 at para. 10.

[73] Exhibit PGC-8: "Routine Proceedings. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)", *House of Commons Debates*, 42-1(14 April 2016) at 2205 (Justice Minister Wilson-Raybould).

[74] Exhibit PGC-14: "Oral Questions. Medical Assistance in Dying" *House of Commons Debates* (31 May 2016) at 3831 (Prime Minister Justin Trudeau).

[75] Exhibit PGC-9: "Government Orders. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)", *House of Commons Debates*, 42-1 (22 April 2016) at 2579 (Minister of Justice Jody Wilson-Raybould).

and said that “this approach to eligibility” is consistent with the parameters set out by the Supreme Court:

> The eligibility criteria in the bill are consistent not only with the legal principles of *Carter* but with the circumstances of the plaintiffs in the *Carter* case, including Gloria Taylor, who was suffering from fatal ALS, and Kay *Carter*, who was also in a state of irreversible decline and nearing the end of her life.[76]

[103] The bill’s consistency with *Carter* is also discussed through the prism of Parliament’s role in legislating in the interest of the population without merely copying the words of the Supreme Court in its new bill.[77]

[104] The Minister of Justice drew a line between the risks related to medical assistance in dying, particularly for vulnerable individuals, and the control of these risks in the case of dying patients:

> We have listened to those who say that permitting medical assistance in dying as a response to suffering in life, as opposed to suffering in the dying process, will put already vulnerable individuals at greater risk. We recognize that medical assistance in dying will in many respects fundamentally change our medical culture and our society. It is appropriate in this context to focus our attention on facilitating personal autonomy in the dying process where the risks to the vulnerable are manageable.[78]

[105] Thus, the government found that it “makes sense” to limit medical assistance in dying to persons whose death is reasonably foreseeable in reaction to the fear that medical assistance in dying would be considered “an appropriate response to a life with disability” or that its availability might inadvertently tempt vulnerable persons to choose a premature death.[79]

[106] Essentially, the Minister of Justice stated that Bill C-14 “respects personal autonomy, protects the vulnerable, and affirms the inherent value in every human life.”[80] In the same vein, the Minister of Health found that this bill demonstrated “the government’s commitment to supporting the autonomy of patients who are approaching the end of their lives, while protecting the most vulnerable in our society.”[81]

[107] The speeches in response to the one of the Minister of Justice reveal the MPs’ contrasting readings of the bill. Some felt that it is inconsistent with *Carter* because it represents a “slippery slope”[82] and is not in harmony with efforts to

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[76] *Ibid.* at 2581.

[77] *Ibid.*

[78] *Ibid.* at 2580.

[79] *Ibid.* at 2581.

[80] *Ibid.*

[81] *Ibid.* at 2602 (Minister of Health Philpott).

[82] *Ibid.* (2 May 2016) at 2681-2682 (Mr. O’Toole); See also *Ibid*. (3 May 2016) at 2741–2742 (Ms. Wagantall) and 2815 (Mr. McColeman).

eliminate depression and suicide,[83] and that vulnerable people would therefore not be sufficiently protected.

[108] In contrast, many denounced the limits imposed by the bill in permitting assistance only for patients whose natural death is characterized as reasonably foreseeable.[84] This would force grievously ill persons who are not at the end of life to endure intolerable suffering, which would constitute a violation of their right to security and integrity of the person.[85] In addition, a promise of possible legislative changes and improvements to the bill[86] would not assuage these peoples' sufferings.

[109] In May 2016, the House referred Bill C-14 to the House of Commons Standing Committee on Justice and Human Rights,[87] which studied over 100 amendments. Several proposals sought to remove[88] or more restrictively define[89] the reasonably foreseeable natural death requirement.

[110] Thereafter, the Standing Committee filed its report, proposing 16 amendments.[90] The House of Commons debated several motions for amendment, including one that would strike the reasonably foreseeable natural death requirement. After a debate, it was once again rejected.[91]

[111] The issue of the constitutional validity of the reasonably foreseeable natural death requirement was again addressed by several members of Parliament at the third reading of the bill. Finally, Bill C-14 was passed and referred to the Senate on May 31, 2016.

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[83] *Ibid.* (2 May 2016) at 2692 (Mr. Kmiec).

[84] *Ibid.* (3 May 2016) at 2759 (Mr. Lightbound), 2795 (Mr. Thériault), 2829 (Mr. Blaikie).

[85] *Ibid.* (3 May 2016) at 2758 (Mr. Lightbound).

[86] *Ibid.* (22 April 2016) at 2607-2608 (Mr. Rankin).

[87] Before this committee, the Minister of Justice reiterated that the bill was consistent with *Carter*, that the wording "natural death has become reasonably foreseeable" was a deliberate choice, that there were pressing reasons justifying this requirement, that there were no other viable options, and that the lack of time frame for this criterion allows flexibility to physicians. The Minister of Health added that the government considered not referring to the proximity of death or specifying a period of six to twelve months before death. Exhibit PGC-11: "Evidence. Standing Committee on Justice and Human Rights", *House of Commons*, 42-1, (2 May 2016) at 2 and 8 (Minister of Justice Wilson-Raybould) and at 10 (Minister of Health Philpott).

[88] *Ibid.* (2 May 2016) at 27 (Mr. Battista), 29 (Mr. Sekopet), *Ibid*. (9 May 2016) at 24-27, 30-31.

[89] *Ibid*. (9 May 2016) at 14-15, 29.

[90] Exhibit PGC-12: Standing Committee on Justice and Human Rights, Second report, 42-1 (11 May 2016).

[91] Exhibit PGC-13: "Government Orders. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)", *House of Commons Debates*, 42-1 (30 May 2016) at 3741–3754.

- **Senate**

[112] In April 2016, the Senate adopted a motion authorizing a preliminary study of the contents of Bill C-14 by the Standing Senate Committee on Justice and Constitutional Affairs.[92]

[113] In its report filed on May 17, 2016, the Senate Committee made ten recommendations, including the addition of the term “terminal illness” to the first criterion of the definition “grievous and irremediable medical condition.”[93] A small minority of the Senate Committee recommended striking s. 241.2(2) Cr. C., which defined the term “grievous and irremediable medical condition” in favour of using the formulation in *Carter*.[94]

[114] On May 31, 2016, the Senate officially received Bill C-14, which was read for the first time.[95] The following day, it received the Minister of Justice and the Minister of Health in plenary committee to present Bill C-14. On that occasion, the Minister of Justice reaffirmed that the federal law “must respect the legal principles set [out] in *Carter* but it does not have to mirror, exactly, the court’s wording to be constitutional.”[96] Indeed, since it was based on “different objectives and new evidence”, the federal law sought to propose “a new balance through a complex regulatory regime” that would be entitled to court deference.[97]

[115] After the second reading and the official referral of the bill to the Standing Senate Committee on Legal and Constitutional Affairs[98], the Committee reported the bill back to the Senate without amendments because it deemed it more judicious to present the amendments at the bill’s third reading.[99]

[116] The third reading debate began on June 8, 2016, when several of the proposed amendments were debated. A senator proposed an amendment to strike the definition of “grievous and irremediable medical condition”, which

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[92] Exhibit PGC-15: “Criminal Code. Bill to Amend—Legal and Constitutional Affairs Committee Authorized to Study Subject Matter”, *Senate Debates*, 42-1, (20 April 2016) at 536-538. Starting on May 4, 2016, the Senate Committee heard 66 witnesses and received numerous briefs.

[93] Section 241.2(2)(*a*) of the Cr. C. was meant to read: “(a) they have a serious and incurable terminal illness, disease or disability and have been determined to be at the end of life. ”. Exhibit PGC-18: Standing Senate Committee on Legal and Constitutional Affairs, *Senate Debates*, 42-1, 3rd report (17 May 2016).

[94] *Ibid.*

[95] Exhibit PGC-19: “Criminal Code. Bill to Amend”, 1st reading, *Senate Debates*, 42-1, (31 May 2016) at 741.

[96] Exhibit PGC-20: “Criminal Code. Bill to Amend—Legal and Constitutional Affairs Committee Authorized to Study Subject Matter Plenary Session”, *Senate Debates*, 42-1 (1 June 2016) at 744 (Minister of Justice Wilson-Raybould).

[97] *Ibid.*

[98] Exhibit PGC-20: “Criminal Code. Bill to Amend”, 2nd reading, *Senate Debates*, 42-1 (3 June 2016) at 854–880.

[99] Exhibit PGC-21: “Criminal Code. Bill to Amend–Presentation of the Fourth Report of the Standing Senate Committee on Legal and Constitutional Affairs”, 2nd reading, *Senate Debates*, 42-1 (7 June 2016) at 886.

contained the reasonably foreseeable natural death requirement.[100] The amendment was passed the same day.[101]

[117] Therefore, on June 15, 2016, the Senate passed Bill C-14 on third reading, without the reasonably foreseeable natural death requirement.[102]

- **Enactment of the federal statute**

[118] On June 16, 2016, the House of Commons rejected the amendment striking the definition of “grievous and irremediable medical condition” that contained the requirement for natural death to be reasonably foreseeable. The House of Commons was of the view that this amendment “would undermine objectives of Bill C-14 to recognize the significant and continuing public health issue of suicide, to guard against death being seen as a solution to all forms of suffering, and to counter negative perceptions about the quality of life of persons who are elderly, ill or disabled.” It was of the opinion that “C-14 strikes the right balance for Canadians between protection of vulnerable individuals and choice for those whose medical circumstances cause enduring and intolerable suffering as they approach death”.[103]

[119] Because the Senate did “not insist on its amendments”,[104] the House of Commons passed Bill C-14, which received royal assent and came into force on June 17, 2016. As a result, several provisions of the *Criminal Code* were amended[105] by the addition of ss. 241.1 to 241.4 respecting medical assistance in dying. Sections 241.2(1) and (2) more specifically, provide the following:

> Eligibility for medical assistance in dying
>
> **241.2 (1)** A person may receive medical assistance in dying only if they meet all of the following criteria:
>
> **(a)** they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;
>
> **(b)** they are at least 18 years of age and capable of making decisions with respect to their health;
>
> **(c)** they have a grievous and irremediable medical condition;
>
> **(d)** they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and

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[100] Exhibit PGC-22: “Criminal Code. Bill to Amend”, 3rd reading, *Senate Debates*, 42-1 (8 June 2016) at 938 (Mr. Joyal).

[101] *Ibid.* at 964.

[102] *Ibid*. (15 June 2016) at 1167.

[103] Exhibit PGC-24: “Messages to the Senate from the House of Commons”, *Journals of the House of Commons*, 42-1 (16 June 2016) at 651.

[104] Exhibit PGC-25: “Criminal Code. Bill to Amend–Message from Commons–Motion for Concurrence in Senate amendments and Non-Insistence upon Certain Senate Amendments Adopted”, *Senate Debates*, 42-1 (17 June 2016) at 1242.

[105] See s. 241 *Cr. C.* setting out the offence of aiding suicide.

> **(e)** they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.
>
> Grievous and irremediable medical condition
>
> **(2)** A person has a grievous and irremediable medical condition only if they meet all of the following criteria:
>
> **(a)** they have a serious and incurable illness, disease or disability;
>
> **(b)** they are in an advanced state of irreversible decline in capability;
>
> **(c)** that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
>
> **(d)** their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

2.4 Quebec: Legislative History of Bill 52 (*Act respecting end-of-life care*)

[120] Unlike the federal legislative process, the debate on medical aid in dying in Quebec lasted six years, from 2009 to 2015, and its scope and usefulness was emphasized multiple times during the passage of the federal statute.[106] The Quebec statute is not the provincial legislature's reaction to a court judgment, but rather a social response to the Quebec medical community's initiative that sought a paradigm shift towards a holistic approach to the issue of appropriate end-of-life care. Therefore, before Bill 52, which became the *Act respecting end-of-life care*, was introduced, several reports and research studies were produced on the subject.

Period prior to the introduction of Bill 52 (October 2009 – June 2013)

[121] Three important documents were produced during this period by (1) the Collège des médecins du Québec; (2) the Select Committee on Dying with Dignity; and (3) the Comité de juristes experts.

- **Collège des médecins du Québec (October 2009)**

[122] Drawing inspiration from the reflections of its Task Force on Clinical Ethics,[107] the Collège des médecins du Québec published a research document

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[106] Exhibit PGC-3: Parliament Canada, *Report of the Special Joint Committee on Physician-Assisted Dying, Medical Assistance in Dying: a Patient-Centred Approach* (February 25, 2016) at 7.

[107] Exhibit PGQ-2: Collège des médecins du Québec, *Pour des soins appropriés au début, tout au long et en fin de vie. Rapport du groupe de travail en éthique clinique* (17 october 2008).

in October 2009.[108] Therein, it proposed redirecting the debate on euthanasia[109] towards a perspective of "appropriate end-of-life care" given the many medical interventions possible. From that perspective, the challenge facing doctors of identifying the most appropriate care options both at the beginning of and throughout life remains just as relevant at the end of life. End-of-life care should therefore be addressed like all other types of care, with a focus on "a careful and thorough decision-making process involving all parties concerned" [110] in order to avoid aimless or futile treatment.

[123] This dynamic and complex process has two components: (1) communication between autonomous and responsible moral actors; and (2) the recognition of and respect for the role of these actors, i.e., acknowledgment of the possibility for the patient to refuse treatment, as well as for the doctor, whose role is not that of a mere agent, to refuse to provide health care services.[111]

[124] Citing article 58 of the *Code of ethics of physicians*,[112] the Collège noted "a new sensitivity" among the public and the medical profession ready to recognize the need for a frank and open discussion of the various types of care, up to euthanasia, which "could be considered to be a final step required to assure the provision of quality care".[113]

- **The National Assembly's Select Committee on Dying with Dignity (December 2009 – March 2012)**

[125] In December 2009, the National Assembly unanimously adopted a motion creating a Select Committee on Dying with Dignity[114], whose mandate was to make recommendations in response to the following questions: "What is our society's answer to the suffering experienced by some people at the end of life?

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[108] Exhibit PGQ-1: Collège des médecins du Québec, *Physicians, Appropriate Care and the Debate on Euthanasia. A Reflection* (16 October 2009).

[109] "Euthanasia" is the term the Collège des médecins uses in its document.

[110] Exhibit PGQ-1: Collège des médecins du Québec, *Physicians, Appropriate Care and the Debate on Euthanasia. A Reflection* (16 October 2009) at 7, 4-5. The Collège emphasizes "the significance of the decision-making process in the provision and management of care", since appropriate care, or in other words, a "proportioned, personalized and appropriate" treatment, means that "the decision making process has been properly and thoroughly conducted".

[111] Exhibit PGQ-2: Collège des médecins du Québec, *Pour des soins appropriés au début, tout au long et en fin de vie. Rapport du groupe de travail en éthique clinique* (17 October 2008) at 7.

[112] CQLR, c. M-9, r. 17, s. 58: A physician must, when the death of a patient appears to him to be inevitable, act so that the death occurs with dignity. He must also ensure that the patient obtains the appropriate support and relief.

[113] Exhibit PGQ-1: Collège des médecins du Québec, *Physicians, Appropriate Care and the Debate on Euthanasia. A Reflection* (October 16 2009) at 2.

[114] Exhibit PGQ-3: Québec, National Assembly, *Procès-verbal de l'Assemblée*, 39-1 (4 December 2009) "Affaires courantes" at 950-953.

How should we respond to requests for help to die? How can we ensure that people die with dignity?”[115]

[126] Like the Collège, the Select Committee observed “some trends in Québec society”[116] and noted the evolution of social values, medicine and the law that had encouraged and stimulated reflection on end-of-life care.[117]

[127] In March 2012, the Select Committee filed a unanimous report on a variety of types of end-of-life care, although euthanasia[118] occupies an important place within it. It formulated 24 recommendations on palliative care, palliative sedation, advance medical directives and medical aid in dying. On this latter subject in particular, the Committee recommended:

> that relevant legislation be amended to recognize medical aid in dying as appropriate end-of-life care if the request made by the person meets the following criteria as assessed by the physician:
>
> - The person is a Québec resident according to the *Health Insurance Act*;
> - The person is an adult able to consent to treatment under the law;
> - The person himself requests medical aid in dying after making a free and informed decision;
> - The person is suffering from a serious incurable disease;
> - The person is in an advanced state of weakening capability, with no chance at improvement;
> - The person has constant and unbearable physical and psychological suffering that cannot be eased under conditions he deems tolerable.[119]

[128] The criteria relating to the person’s medical condition – i.e., a serious incurable disease and an advanced state of weakening capability, with no chance at improvement – express the Select Committee’s clear objective to propose medical aid in dying “for people whose condition is irreversible and who

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[115] Exhibit PGQ-4: Québec, National Assembly, Select Committee on Dying With Dignity, *Report*, March 2012 at 11 and 95. During the proceedings, which lasted over two years, the Select Committee heard 32 experts, over 250 private citizens and representatives of organizations, received 273 briefs, and attended 21 meetings during its foreign mission in France, the Netherlands and Belgium.

[116] *Ibid.* at 121.

[117] *Ibid.* at 52.

[118] The Select Committee distinguishes euthanasia from assisted suicide or aid in dying. Euthanasia is defined as “[a]n act that involves deliberately causing the death of another person to put an end to that person’s suffering”, whereas assisted suicide is defined as “[t]he act of helping a person commit suicide by providing him with the means to do so or information on how to proceed, or both”. *Ibid*. at 17–18.

[119] *Ibid.* at 82 and 99.

are at the end of life”.[120] The Select Committee recognizes the challenge posed by the requirement of being at the end of life.[121]

[129] For the Select Committee, the end-of-life requirement appears to be a critical factor needed to exclude requests for medical aid in dying from certain categories of persons, such as individuals who are severely disabled as a result of an accident. Because people in this situation are not at the end of life and are not suffering from an illness, “medical aid in dying cannot be conceived as the final step in the continuum of care”.[122]

[130] In keeping with the evolution of social values, of the law and of medical practice,[123] medical aid in dying has become a “new option”[124] – “one more option”[125] – which, like other palliative care, is available on the continuum of care that is appropriate at the end of life.[126] This additional end-of-life care option is necessary because, although palliative care “is the best answer to the suffering of most end-of-life patients”[127], it has limits and cannot relieve the suffering of all such patients, for example, those with degenerative diseases.[128]

[131] The Select Committee also addressed some of the issues raised in this case, including informed consent to medical aid in dying, suicide prevention, the risk of abuse, and the trivialization of the procedure.

[132] Finally, in the trial judgment in *Carter*, the Honourable Lynn Smith considered the Select Committee’s recommendations.[129] The admission into evidence of those recommendations is explained by their relevance to the issue of the societal consensus on medical aid in dying.[130] In her analysis of the risks of decriminalization of medical aid in dying, Smith J. quoted the criteria proposed by the Select Committee, summarized the other recommendations,[131] and concluded that “the risks [of] physician-assisted death can be identified and very

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[120] *Ibid.* at 81.

[121] *Ibid.* at 81: “Determining whether a person is in fact at that stage is no easy task. Many factors must be taken into account, including the type of illness. For example, a terminal cancer patient may be deemed to be nearing the end of life when doctors estimate he has just a few days or weeks left. ... However, it could be different for a patient with a degenerative disease. Life expectancy in such a case could be a few weeks or months or more, depending on the disease and on the individual’s medical condition.”

[122] *Ibid.* at 92.

[123] *Ibid.* at 96.

[124] *Ibid.* at 95.

[125] *Ibid.* at. 47.

[126] *Ibid* at 50.

[127] *Ibid.* at 53-54. See also Exhibit PGQ-10: Québec, National Assembly, *Journal des débats*, 40-1 (22 October 2013) “ Adoption du principe du projet de loi n° 52 – Loi concernant les soins de fin de vie ”, at 5035 (Minister of Health and Social Services Hivon).

[128] Exhibit PGQ-4: Québec, National Assembly, Select Committee on Dying with Dignity, *Report*, March 2012 at 59, 77, and 95.

[129] *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (“*Carter BCSC*”).

[130] *Carter BCSC* at paras. 131–136.

[131] *Ibid.* at paras. 867–871.

substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced”.[132]

- **Comité de juristes experts (June 2012 – January 2013)**

[133] To implement the Select Committee’s recommendations, a three-member[133] panel of legal experts, the Comité de juristes experts, was formed in June 2012. Its report, submitted in January 2013, analyzes end-of-life patient’s decisions from the perspective of the criminal law, the civil law, and the *Charters.*[134] It proposes a new legal framework for end-of-life care practices[135] and considers the role of the Attorney General of Québec in the application of an eventual law circumscribing end-of-life care, including medical assistance in dying.[136]

[134] The Comité noted that despite the absolute prohibition against assisted suicide under the *Criminal Code*, euthanasia or assisted suicide is practiced to some degree surreptitiously and that no prosecutions had been brought in Quebec in the context of end-of-life care.[137]

[135] It recommended that all end-of-life care be circumscribed and managed by the health care system and that the rights of patients at the end of life be recognized by law. These rights should include the right to information, the right to confidentiality, the right to choose the place where one’s life will end, and above all, the right to decision-making autonomy. In the context of end-of-life care, a patient’s right to decision-making autonomy means the right [TRANSLATION] “to choose the moment and manner of dying, when death has become a probable outcome of his or her treatment”.[138] Decision-making autonomy also underpins the following rights, which the statute should set out: the right to refuse care, the right to interrupt treatment, the right to abstain from treatment, the right to palliative care, including terminal palliative sedation, and the right to medical aid in dying.[139]

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[132] *Ibid.* at para. 883, cited by the Supreme Court in *Carter* at para. 27.

[133] Mtre Jean-Pierre Ménard, who is now one of the lawyers for the applicants, Mtre Jean-Claude Hébert and Mtre Michelle Giroux.

[134] The Comité refers to *R. v. Morgentaler*, [1988] 1. S.C.R. 30, *Rodriguez v. British Columbia (Attorney General),* [1933] 3 S.C.R. 519 and *Carter BCSC* to support the argument that end-of-life decisions are included in the concept of freedom of the person; see Exhibit PGQ-7 : *Comité de juristes experts sur la mise en œuvre des recommandations de la Commission spéciale de l’Assemblée nationale sur la question de mourir dans la dignité*, Report, Summary, at 6.

[135] The Panel’s approach is similar to the Committee’s, which involved analyzing [TRANSLATION] “all end-of-life care from an integrated perspective”; Exhibit PGQ-8: news release, “Mourir dans la dignité – La ministre Hivon rend public le rapport du comité Ménard sur la mise en œuvre juridique des recommandations de la commission spéciale” (15 January 15 2013).

[136] *Ibid*. at 1.

[137] *Ibid.* at 3 and 9.

[138] *Ibid.* at 11.

[139] *Ibid*. at 12.

[136] Like the Select Committee, the Comité defines medical aid in dying as [TRANSLATION] “a new type of care” that is part of “the current evolution of patients’ rights at the end of life” and of the “continuum of end-of-life care”.[140]

Parliamentary proceedings on Bill 52 (June 2013 – June 2014)

[137] A few months later, in June 2013, Bill 52 was introduced in the National Assembly. At this first introduction stage, the end-of-life requirement was not explicitly set out as a condition for eligibility for medical aid in dying. According to s. 26 of the bill, to obtain medical aid in dying, the person must be of full age, be capable of giving consent to care, be an insured person,[141] suffer from an incurable serious illness, suffer from an advanced state of irreversible decline in capability, and suffer from constant and unbearable physical or psychological pain which cannot be relieved in a manner the person deems tolerable.[142]

[138] In early fall 2013, public hearings were held under the aegis of the Committee on Health and Social Services, during which several organizations, legal experts, physicians and professors were heard on the subject of the bill. For example, the Fédération des médecins omnipraticiens du Québec presented a brief in which it [TRANSLATION] “insists that MAID be available only in a situation of imminent death”.[143] It therefore recommended the end-of-life requirement be added to s. 26 of the bill.

[139] In response to this request, which was supported by other groups and organizations, s. 26 of the bill was amended to expressly include the notion of “end of life”.[144]

[140] When the bill was adopted in principle on October 22, 2013, Minister Hivon drew attention to [TRANSLATION] “the important democratic and citizen-led

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[140] *Ibid.* at 13. [TRANSLATION] “This new type of care is reserved for adults able to consent to care and Quebec residents within the meaning of the *Health Insurance Act*, whose medical condition indicates that they have a serious, incurable disease and that their medical condition is characterized by an advanced state of weakening capability, with no chance of improvement, and has constant and unbearable physical or psychological suffering that cannot be eased under conditions they deem tolerable”.

[141] Within the meaning of the *Heath Insurance Act*, CQLR c. A-29.

[142] Exhibit PGQ-10: Bill 52, *An Act respecting end-of-life care*, 1st Sess, 40th Leg, Quebec, 2013 (introduction).

[143] Exhibit PGQ-14: Fédération des médecins omnipraticiens du Québec, *Mémoire de la FMOQ présenté à la Commission de la santé et des services sociaux. Concernant le projet de loi n° 52 Loi concernant les soins de fin de vie* (17 September 2013) at 6.

[144] Exhibit PGQ-10: Quebec, National Assembly, Journal des débats, 40-1(28 November 2013) “Étude détaillée du projet de loi n° 52 – Loi concernant les soins de fin de vie (5)”, CSSS-65 at 52 (Minister of Health and Social Services Hivon): [TRANSLATION] “… In light of several comments that we received from people who were wondering whether any person could request medical aid in dying if they met all the criteria in section 26, so the answer is of course, it means that the person must be at the end of life. That goes without saying because it is the bill, the title of the bill. It’s right there in the first provision. So it was our understanding that it wasn’t necessary for every provision to repeat that we’re talking about someone at the end of life. But since the comment has been made several times, and it takes nothing away from it and obviously only affects people at the end of life, we’re making this amendment”.

process" that had led to the introduction of a bill that "seeks to give its proper place to the stage of life that is the end of life, by recognizing the right of individuals to all the care and support they need in their specific end-of-life situation":

> [TRANSLATION]
>
> It is a bill based on fundamental values, the values of solidarity, compassion, respect for the person and, of course, the protection of vulnerable persons, who are very important in our society. What we propose in this bill is really an integrated vision of support for people at the end of life, of the care that should be provided to persons at the end of life, in order to respond, as I was saying, to every situation that might present itself at this ultimate stage of life.[145]

[141] Repeatedly associated with the notion of the continuum of appropriate end-of-life care[146], medical aid in dying was presented as [TRANSLATION] "the final care provided on the continuum of care."[147] Support for the patient at all times and the presence of a physician are also crucial elements in order for medical aid in dying to be considered as a form of care. These elements also make it possible to distinguish medical aid in dying from assisted suicide, which is permitted in certain American states for persons with a prognosis of mortality in six months or less.[148] Moreover, Minister Hivon believed that the Quebec model combined the American approach, the requirement of being at the end of life but not necessarily suffering, with that of the Benelux countries, the need for constant and uncontrollable pain without necessarily being at the end of life, thereby offering [TRANSLATION] "the most stringent framework" and "the most circumscribed" of all the statutes permitting medical aid in dying.[149]

[142] The fear of the "slippery slope" and of the fact that medical aid in dying could be administered without an explicit request was also raised during consultations and the work preceding the enactment of the Quebec statute.[150]

[143] The protection of vulnerable persons was also a preoccupation. Without a legislative framework, the vulnerable would not be adequately protected. The [TRANSLATION] "excessively strict" framework of medical aid in dying, which pairs

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[145] Exhibit PGQ-10: Québec, National Assembly, Journal des débats, 40-1 (22 October 2013) "Adoption du principe du projet de loi n° 52 – Loi concernant les soins de fin de vie", at 5035 (Minister of Health and Social Services Hivon).

[146] See for example Exhibit PGQ-10: Québec, National Assembly, Journal des débats de la Commission permanente de la santé et des services sociaux, 40-1 (21, 26 November 2013) "Étude détaillée du projet de loi n° 52 – Loi concernant les soins de fin de vie (1) et (3)", at 5035 (Minister of Health and Social Services Hivon); *Journal des débats*, 40-1 (2 June 2014) "Adoption du projet de loi n° 52 – Loi concernant les soins de fin de vie" (Minister of Health and Social Services Barrette and Ms. Hivon).

[147] Exhibit PGQ-10 : Québec, National Assembly, *Journal des débats*, 40-1 (22 October 2013) "Adoption du principe du projet de loi n° 52 – Loi concernant les soins de fin de vie" at 5036 (ministre de la Santé et Services sociaux Hivon).

[148] *Ibid.*

[149] *Ibid*. at 5037 and 5039.

[150] *Ibid.* at 5039.

the requirements of being at the end of life and of suffering, would allow this objective to be achieved.[151]

[144] The need to define or clarify the notion of “end of life”[152] came up during the clause-by-clause consideration of Bill 52.[153] Although the National Assembly ultimately chose not to define the concept of end-of-life,[154] several definitions were added to s. 3, including that of “palliative care” and “medical aid in dying”, to clarify the idea that medical aid in dying is not included in palliative care.[155]

[145] The debate over the passage of Bill 52 began on February 20, 2014, but because of the elections, it was delayed until the next legislature. And again, the following points were emphasized: the excellence of the work that had been done, the lack of political partisanship, the humanity of the bill and the privilege of having taken part in this historic debate in Quebec. The National Assembly passed Bill 52 on June 5, 2014.

[146] The Quebec statute was assented to on June 10, 2014, and came into force a year and a half later, on December 10, 2015. Chronologically, its coming into force falls between the judgment in *Carter* and the enactment of the federal statute.

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[151] *Ibid.* at 5036. See also Exhibit PGQ-10 : Québec, National Assembly, *Journal des débats*, 40-1 (2 June 2014) “Adoption du projet de loi n° 52 – Loi concernant les soins de fin de vie” (Ms. Hivon).

[152] MNA Stéphanie Vallée proposed several definitions throughout the consideration of the bill, including the last one on January 16, 2014, the final day of the committee’s work. See Exhibit PGQ-10: clause-by-clause consideration, 16 January 2015 (Ms. Vallée).

[153] Minister Hivon explained that the terms [TRANSLATION] “inescapable”, “imminent” or “terminal” were not accepted because “depending on the type of illness, they do not refer to the same thing”. With no [TRANSLATION] “magic word“ or [TRANSLATION] “magic timeframe” to characterize the “end of life,” the Minister preferred to draw a comparison with people who are severely disabled or suffering from depression: [TRANSLATION] “The person is at the end of life, it’s quite clear, people understand that it isn’t a person with depression in his or her life. People understand that it’s not a severely disabled person or someone who’s paraplegic, because the context here is care, the continuum, the end of life with very, very specific criteria in 26”. Exhibit PGQ-10: Québec, National Assembly, *Journal des débats de la Commission permanente de la santé et des services sociaux*, 40-1 (21 November 2013) “Étude détaillée du projet de loi n° 52 – Loi concernant les soins de fin de vie (1*)*“, CSSS-66 at 8. See also Exhibit PGQ-10: Québec, National Assembly, *Journal des débats de la Commission permanente de la santé et des services sociaux*, 40-1 (29 November 2013) “Étude détaillée du projet de loi n° 52 – Loi concernant les soins de fin de vie (6*)*“, CSSS-66 at 8: [TRANSLATION] "’end of life’ says what it has to say and provides flexibility while still closing the door on cases where people are disabled, on cases where people are not at the end of life”.

[154] Minister Hivon emphasized that the lack of precision was not invoked in relation to palliative care and that a very precise definition [TRANSLATION] “is neither possible nor desirable”. Exhibit PGQ-10: Québec, National Assembly, *Journal des débats de la Commission permanente de la santé et des services sociaux*, 40-1 (28 November 2013) “Étude détaillée du projet de loi n° 52 – Loi concernant les soins de fin de vie (5*)*”, CSSS-65 at 28.

[155] Exhibit PGQ-10: Québec, National Assembly, *Journal des débats de la Commission permanente de la santé et des services sociaux*, 40-1 (21 November 2013) “Étude détaillée du projet de loi n° 52 – Loi concernant les soins de fin de vie (1*)*”, CSSS-61 at 22 *et seq.*

[147] The changes in Canada's legal landscape with respect to medical assistance in dying as a result of *Carter* and the enactment of the federal statute raised questions about the application of the Quebec statute in this new context,[156] but they remained unanswered by the Quebec legislature. Indeed, the Quebec statute has not been amended since medically-assisted dying was decriminalized in Canada.[157]

[148] From the outset, the possibility of a jurisdictional conflict was defused by the federal government. During the second reading of Bill C-14, the federal Minister of Justice, who was asked about the constitutional validity of the Quebec statute because it is more restrictive due to the end-of-life requirement, considered that there was no legislative conflict between the two statutes, given that they had been enacted within their separate areas of jurisdiction.[158]

[149] The co-existence of the two statutes continues to fuel debate, however. In its last report, the Commission sur les soins de fin de vie pointed out the differences between the federal and Quebec statutes, particularly as regards the eligibility criteria for medical assistance in dying ("end of life" versus "reasonably foreseeable natural death"; "serious and incurable illness" versus "serious and incurable illness, disease or disability"), the possibility of self-administering medical assistance in dying and the possibility of a nurse practitioner administering medical assistance in dying, as opposed to under the Quebec statute. These differences are sources [TRANSLATION] "of very difficult and complex situations for physicians, individuals at the end of life, and the public", and in the Commission's view, the harmonization of the two laws is crucial.[159]

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[156] For example, the Canadian Medical Protective Association, an organization that provides professional liability protection for Canadian physicians, considered the Quebec statute more restrictive than the federal statute and advised physicians in Quebec to "act in accordance with both the Criminal Code and provincial legislation, adhering to whichever requirements are more restrictive" (Exhibit P-23, Schedule 2, Communications from the Canadian Medical Protective Association (CMPA), "Medical Assistance in Dying and the Law: One Year Later", June 2017. Dr. Yves Robert, the secretary of the Collège des médecins du Québec was of the view that [TRANSLATION]"it would be 'a lot less complicated' for Quebec physicians 'not to have a federal statute than it would be to have one'". (Exhibit P-23, Schedule 3, Articles on the Collège des médecins du Québec (CMQ), Radio-Canada, "Le Collège des médecins critique l'approche d'Ottawa sur l'aide médicale à mourir" (12 May 2016).

[157] On June 24, 2017, one year after the coming into force of the federal statute, the Quebec Minister of Health and Social Services announced [TRANSLATION] "the start of reflection into the possible expansion of the Act". Exhibit P-38: Commission sur les soins de fin de vie, *Rapport sur la situation des soins de fin de vie au Québec*: *Du [10] décembre 2015 au 31 mars 2018* (Québec: Government of Quebec, 2019) at 55.

[158] Exhibit PGC-20: "Criminal Code. Bill to Amend—Legal and Constitutional Affairs Committee Authorized to Study Subject Matter Plenary Session", *Senate Debates*, 42-1 (1 June 2016) at 749 (Minister of Justice Wilson-Raybould).

[159] Exhibit P-38: Commission sur les soins de fin de vie, *Rapport sur la situation des soins de fin de vie au Québec* : *Du [10] décembre 2015 au 31 mars 2018* (Québec: Government of Quebec, 2019) at 52 and 82. The differences between the Quebec statute and Bill C-14 were also the subject of discussions referred to by the federal Minister of Health before the Standing Committee (Exhibit PGC-11: "Evidence. Standing Committee on Justice and Human Rights", *House of Commons*, 42-1 (2 May 2016) at 12 (Minister of Health Philpott):

[150] Whatever the case may be, since the federal legislation came into force, administrative formalities in Quebec have been adjusted[160] to make them consistent with the requirements in the *Criminal Code*.

[151] At the moment, s. 26 of the Quebec statute, of which subsection 3 of the first paragraph is impugned, remains in the following terms:

> 26. Only a patient who meets all of the following criteria may obtain medical aid in dying:
>
> (1) be an insured person within the meaning of the Health Insurance Act (chapter A-29);
>
> (2) be of full age and capable of giving consent to care;
>
> (3) be at the end of life;
>
> (4) suffer from a serious and incurable illness;
>
> (5) be in an advanced state of irreversible decline in capability; and
>
> (6) experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.
>
> The patient must request medical aid in dying themselves, in a free and informed manner, by means of the form prescribed by the Minister. The form must be dated and signed by the patient.
>
> The form must be signed in the presence of and countersigned by a health or social services professional; if the professional is not the attending physician, the signed form is to be given by the professional to the attending physician.

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[152] Thus, the Court is hearing challenges to provisions from both legislative regimes, one federal (s. 241.2(2)(*d*) of the *Criminal Code*) and the other provincial (subsection 3 of the first paragraph of s. 26 of the *Act respecting end-of-life care*), each of which uses its own terms to make an individual's eligibility to receive medical assistance in dying dependent on whether he or she is approaching death. These provisions are impugned, because they allegedly infringe ss. 7 and 15 of the *Charter*.

"We have had conversations with Quebec with respect to the fact that there are some distinctions between this legislation and their own. It was not an expression that was negative in any way, but it was simply an acknowledgement of the fact that they will be going back to look at whether or not they will choose to make any adjustments to their own legislation to address these inconsistencies."

[160] For example, the form used to officially request medical aid in dying contains a box for [TRANSLATION] "independent witnesses" and a reference to s. 241.2(5) of the *Criminal Code*, even though the Quebec legislation does not require this formality. According to paragraph 3 of s. 26 of the *Act respecting end-of-life care*, the person requesting medical aid in dying must sign the appropriate form in the presence of a health or social services professional, who then must then countersign.

[153] Since the legalization of this practice, the impugned requirements have been subject to multiple interpretations by legal experts, university professors,[161] colleges of physicians and surgeons,[162] organizations working in the field,[163] and even on one occasion, in the case law.[164] Some have been very critical,[165] while others have easily accommodated them.[166] Whatever the case may be, the

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[161] Authors Downie and Scallion concluded their exhaustive legislative interpretation as follows: "'Natural death has become reasonably foreseeable' **does not mean** that eligibility is limited to fatal conditions, being terminally ill, predicted survival of six or twelve months, or being 'at the end of life' or 'nearing the end of life.' There is no temporal proximity limit on eligibility for access to MAiD in Canada. Temporal proximity can be sufficient for concluding natural death is reasonably foreseeable but it is not necessary. It is not necessary to predict the length of time the patient has remaining. 'Natural death has become reasonably foreseeable' **means** that, in the professional opinion of the medical or nurse practitioner, taking into account all of the patient's medical circumstances, how or when the patient's natural death will occur is reasonably predictable." Jocelyn Downie & Kate Scallion, "Foreseeably Unclear: The Meaning of the 'Reasonably Foreseeable' Criterion for Access to Medical Assistance in Dying in Canada" (2018) 41 Dalhousie Law Journal 23 at 56. See also Thomas M.J. Bateman & Matthew LeBlanc, "Dialogue on Death: Parliament and the Courts on Medically-Assisted Dying" (2018) 85 S.C.L.R. (2d) 387 at 405: "Bill C-14's limiting clause narrows the period in which a legal MAiD regime would operate; it would require, so to speak, the shadow of death to be cast over the decision to terminate one's life."

[162] The Collège des médecins du Québec stated that the end of life requirement is not incompatible with that of reasonably foreseeable natural death because the Quebec legislature also did not specify a defined diagnosis, precisely in order to take into account the variability of the four types of end of life trajectories: (1) the trajectory of the accidental sudden death; (2) the trajectory of persons with incurable cancer (the illness may progress over many years, but the terminal phase is usually relatively foreseeable and lasts a few months); (3) the trajectory of persons suffering from chronic fatal circulatory and respiratory diseases (gradual decline over two to five years punctuated by episodes of acute deterioration and some moments of recuperation, with death that can be sudden and unexpected); (4) the trajectory of elderly and fragile persons and those suffering from dementia (gradual and prolonged decline, quite variable, from six to eight years). Exhibit PGQ-11: Collège des médecins du Quebec et al., *Medical aid in dying: practice and pharmacological guidelines*, November 2017 at 18 and Schedule 1. See also Exhibit P-24.2: College of Physicians & Surgeons of Nova Scotia, Professional Standard Regarding Medical Assistance in Dying, 14 December 2018 at 5 note 9: "natural death will be reasonably foreseeable if a medical or nurse practitioner is of the opinion that a patient's natural death will be sufficiently soon or that the patient's cause of natural death has become predictable".

[163] The CAMAP (The Canadian Association of MAID Assessors and Providers), an organization that groups together physicians involved in assessing and administering medical assistance in dying in Canada, published a guide to help assessors and practitioners interpret reasonably foreseeable natural death from a clinical point of view. (Exhibit P-24.3: CAMAP, Clinical Practice Guideline. The Clinical Interpretation of "Reasonably Foreseeable").

[164] *A.B. v. Canada (Attorney General)*, 2017 ONSC 3759 at para. 79: "what is a reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan."

[165] See the opinion of Dr. Naud, below.

[166] See the opinion of Dr. Rivard, below. See also Exhibit P-24.3: CAMAP, Clinical Practice Guideline. The Clinical Interpretation of "Reasonably Foreseeable". In spite of the semantic difficulties, CAMAP considers that "most clinicians, in particular family physicians, palliative care physicians and others working with patients with terminal illnesses or with the elderly, do in fact already have an understanding of [and would answer more readily] when a natural death is reasonably *predictable*. If the question "is the patient's natural death reasonably

impugned requirements are currently an integral part of the legislative regimes and, therefore, of the daily lives of physicians who practice medical assistance in dying in Canada. It is thus essential to understand how medical assistance in dying is practiced in the field in this country in order to analyze the impact and consequences of these requirements on the fundamental rights of the plaintiffs.

MEDICAL ASSISTANCE IN DYING IN CANADA

1. The Practice of Medical Assistance in Dying

[154] Unlike in the cases that have come before the courts in the past[167], there is clearly no question here of undertaking a theoretical or abstract analysis of the issues and the different aspects of medical assistance in dying or, more broadly, of euthanasia or assisted suicide.[168]

[155] Since there was an absolute prohibition against medical assistance in dying in Canada before 2015, certain parallels with foreign regimes permitting a form of euthanasia, or at times a purely theoretical concept of the process, formed the evidence base of the debate. This obviously left room for multiple interpretations, preconceived notions and conjectures.

[156] Since its legalization, medical assistance in dying has become an inescapable reality in our society, with a process and a practice in place now for more than three years. Many people emphasize its end result, since it is obviously irreversible and heavy in consequences. It is, however, a complete process, i.e., one that begins long before the final act and the passage from life to death. Above all, it is framed within a discussion involving the physician, the treatment team, the patient and, in many cases, the patient's loved ones.

[157] To properly grasp all the facets of this exceptional procedure, and to bring the law face-to-face with medical and social reality, it appears critical to the Court that the process be understood.

[158] Of all the experts heard at the hearing, only four actually had any practical knowledge of medical assistance in dying in Canada and in Quebec in the role of a physician involved in the process. The others had theoretical, intellectual and administrative knowledge, but had never taken part in an actual process or in its administration in any capacity whatsoever.

[159] The four physicians are described in the following sections. First, for the applicants:

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foreseeable?" is framed in a way that would be asked in other clinical situations, the meaning becomes clearer".

[167] See *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 and *Carter*.

[168] As in *Carter BCSC* and the Report of the Select Committee on Dying with Dignity, the term euthanasia should be understood as the act of intentionally causing the death of a person at that person's request in order to bring his or her suffering to an end, while the expression assisted suicide means deliberately ending one's life with the help of a person who provides the means to do so or information on how to proceed, or both.

- Dr. Alain Naud, family medicine and palliative care specialist. Tenured clinical professor at Université Laval[169]

[160] Dr. Naud has been involved in the medical assistance in dying process since its legalization. At the time he filed his report, he had provided this type of aid to approximately 65 individuals and had trained several physicians and professionals in the field. He is one of the specialists who assessed the eligibility of Mr. Truchon and Ms. Gladu in this case. He described in detail the procedures and the process, from the patient's written request for medical aid in dying to its administration and administrative follow-up.

[161] Dr. Naud is very critical of the reasonably foreseeable natural death requirement. According to him, Quebec physicians understand the meaning of "end of life", but they have no idea what "reasonably foreseeable natural death" means. He stated that he is [TRANSLATION] "comfortable"[170] with the application of the "end of life" criterion which has greater medical or clinical meaning, even if it is not defined in terms of prognosis,[171]but he is [TRANSLATION] "not comfortable" with the reasonably foreseeable natural death criterion.[172] In his view, this requirement is impossible to interpret, has no medical or clinical meaning, can be used to refuse a legitimate request or to accept an unfounded request, and is inconsistent with the end-of-life requirement in the Quebec statute.[173] Moreover, he considers it aberrant and [TRANSLATION] "completely incoherent" that a prognosis is not required in order to conclude that natural death is reasonably foreseeable.[174] He does not restrict eligibility to medical assistance in dying to a prognosis of six months. Some of the patients to whom he has administered that aid had a prognosis of twelve months. The longest prognosis he has established is eighteen months.[175]

[162] Using concrete examples and displaying great compassion, he was able to express to the Court the emotions that inevitably accompany these various stages and the profound respect he feels for his patients.

- Dr. James Downar, intensive and palliative care physician. Professor in the department of medicine of University of Toronto[176]

[163] Dr. Downar, who also holds a master's in bioethics, is very familiar with medical assistance in dying, given that he has administered about fifty requests in Ontario since the federal law was enacted. Like Dr. Naud, he provided a detailed description of the process from the first request to its administration.

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[169] Exhibit P-23: Expert report of Dr. Alain Naud, physician in family medicine, palliative care and medical aid in dying, dated July 13, 2018.

[170] Testimony of Dr. Naud, January 9, 2019, at 219.

[171] Exhibit P-23: Expert report of Dr. Naud at para. 127.

[172] Testimony of Dr. Naud, January 9, 2019, at 208, 218–220, 230.

[173] Exhibit P-23: Expert report of Dr. Naud at paras. 61, 76–77, 81, 108, 112, 126.

[174] *Ibid.* at para. 77 and testimony of Dr. Alain Naud, January 9, 2019, at 214–215, 218.

[175] Exhibit P-23: Expert report of Dr. Naud at paras. 67 and 108.

[176] Exhibit P-25: Expert report of Dr. James Downar. It should be noted that at the time of his testimony, Dr. Downar worked as chief of palliative care at the University of Ottawa and as a critical care member in Ottawa.

- Dr. Justine Dembo, psychiatrist at Sunnybrook Health Sciences Center and instructor at University of Toronto. Researcher and author in the field of medical assistance in dying since 2009[177]

[164] Dr. Dembo has practical experience in the field, having acted as the second physician evaluating the capacity to give consent in several medical assistance in dying cases since the enactment of the federal statute.[178]

[165] And for the Attorney General of Canada:

- Dr. Claude Rivard, family physician with an expertise in emergency care, intensive palliative care and medical assistance in dying[179]

[166] Dr. Rivard is the only witness for the defendants who was able to enlighten the Court on how the medical assistance in dying process actually unfolds, given his active practice in the field and in palliative care. At the hearing, he estimated that he has carried out 150 assessments and proceeded with 123 cases of medical aid in dying in Quebec since December 2015.

[167] His testimony echoes Dr. Naud's with respect to the broad steps in the process and the work required from doctors who provide medical assistance in dying. Their disagreements concern primarily the interpretation and application in practice of the requirement of reasonably foreseeable death.

[168] The reasonably foreseeable natural death requirement and the end-of-life requirement are synonymous for Dr. Rivard.[180]He associates reasonably foreseeable natural death to the time the patient enters a pre-terminal stage (death within three to six months) or a terminal stage (death within one month) of the illness.[181] He feels it is difficult for a clinician to determine end of life beyond six months, and is therefore of the view that [TRANSLATION] "a patient who has a survival rate of over six months is not at the end of life and their death is not reasonably foreseeable."[182] His practice appears to have evolved, however, and he no longer restricts the administration of medical assistance in dying to patients in the terminal stage.[183] Therefore, although he states that he is comfortable administering medical assistance in dying in cases where the prognosis is six months or less, he acknowledges that a rapid decline of the illness makes patients with a prognosis of up to eighteen months eligible.[184]

[169] Dr. Rivard also assessed Mr. Truchon and Ms. Gladu in this case. He was very frank in his testimony and provided clear explanations of the reasons he is

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[177] Exhibit P-24: Expert report of Dr. Justine Dembo, psychiatrist, June 9, 2018.

[178] Dr. Dembo stated that she needed approximately two hours and sometimes more to evaluate the patient's capacity.

[179] Exhibit PGC-66: Expert report of Dr. Claude Rivard, general practitioner, December 22, 2017 and up-to-date curriculum vitae.

[180] Testimony of Dr. Rivard, January 14, 2019, at 43 and 46. He even used the expression [TRANSLATION] "six of one, half a dozen of the other" to describe them.

[181] Exhibit PGC-66: Expert report of Dr. Rivard at para. 21.

[182] *Ibid*. at para. 42.

[183] Testimony of Dr. Rivard, January 14, 2019 at 76.

[184] *Ibid*. at 78.

opposed to the removal of the impugned statutory requirement from the medical assistance in dying process.

[170] The Court will refer to the testimony provided by these experts as it analyzes the evidence on the reasonably foreseeable death requirement in connection with the legislative objectives at issue. That being said, these experts are unanimous regarding the manner in which medical assistance in dying is received, evaluated and, if appropriate, administered: it is a highly rigorous and cautious process that requires the collaboration of many health professionals at various stages; it is a process that requires time, listening, a thorough evaluation of the situation and, above all, an approach focused on the person, the whole in accordance with federal[185] and provincial statutory requirements.[186]

[171] In that respect, while there may be some specific points of divergence, the descriptions provided by these physicians are consistent and, all in all, quite similar. Here are the practice's central tenets.

1.1 Origin of Requests for Medical Assistance in Dying

[172] The requests processed by physicians who provide medical assistance in dying do not come from out of the blue. The very large majority are from persons who are already hospitalized in the institution where those doctors practice. The others come from patients being treated in care facilities, clinics or at home, but who are followed by these physicians or an attending physician connected with the institution.

[173] To illustrate, approximately 70% of the requests that Dr. Naud receives are from patients who are already in palliative care at the CHUL in Québec City, while approximately 30% of the patients are in another department in the institution – for example, in cardiology, oncology or neurology– and are refusing palliative care.

[174] These patients are very well known by the professionals in the institution and, more specifically, by the physicians, nurses, pharmacists, psychologists, occupational therapists and social workers. They often have a significant medical history, and their record reveals the progress of the illness afflicting them. In this sense, and as Dr. Rivard testified, a request for medical assistance in dying made by a patient who is unknown to the institution – submitted from the emergency department, for example – has no chance of being considered.

[175] It is then the responsibility of the physician who receives the request to verify whether the patient meets the requirements of the law. To do so, the physician must, of course, use his or her clinical judgment, which requires an assessment of the patient's overall situation, rather than merely reference to the official diagnosis. The assessment is demanding and, when the answer is

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[185] Section 241.2(3) *et seq.* Cr. C.

[186] Section 29 *et seq.* of the Quebec statute.

positive, a second physician must, in turn, independently assess the patient's eligibility and provide a written opinion to confirm, if appropriate.[187]

1.2 The Stages of the Assessment

[176] Before anything else, the physician will verify that the written request for medical assistance in dying was dated and signed by the patient in front of witnesses.[188] He or she then performs a thorough analysis of the medical file, which can take several hours.[189] The file provides a great deal of information on the basic diagnosis, the progress of the illness, the associated medical conditions, current and past treatments, test and imaging results, the opinion of other colleagues, and information on the patient's human environment and psychological and emotional state.[190] At times, the treatments under way and the dosages prescribed make it possible to assess the patient's suffering.[191]

[177] In almost all cases, medical assistance in dying has already been discussed by the patient with several actors, such as the attending physician, the palliative care physician, specialists, social workers or spiritual care providers.[192]

[178] The physician then meets with the patient alone or in the presence of his or her loved ones. The meeting takes place essentially to verify the medical condition, the progress of the illness, the level of suffering, the reasons and motivations that led the patient to request medical assistance in dying and, at the same time, to assess the patient's capacity to consent.

[179] This stage is important – indeed, critical – because beyond consulting the contents of the medical record, making human contact and hearing expressions of motivations and of the degree of suffering allows doctors to better comprehend the patient's situation and grasp his or her values, convictions and fears.

[180] The experts state that, in almost all meetings, the patients spontaneously talk about the many types of psychological and physical suffering they can no longer endure and about their loss of autonomy and dignity. They express their fear at the prospect of dying in agony, either from smothering or in uncontrolled pain. They state that they have fought hard but that they have reached the end of the road, that the time left no longer has any meaning, and that they cannot go on suffering anymore. The composure, lucidity and determination shown by these patients was reported with a great deal of empathy and discernment by both Dr. Rivard and Dr. Naud.

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[187] Paragraphs 241.2(3)(*e*) and (*f*) Cr. C.; s. 29 para. 2 of the Quebec statute. A form for this purpose was also created by the Quebec Ministère de la santé et des services sociaux.

[188] Paragraphs 241.2(3)(*e*) and (*f*) Cr. C.; s. 29 para. 2 of the Quebec statute.

[189] Dr. Naud stated that he takes between 2.5 and 5 hours. Testimony of Dr. Naud, February 13, 2019, at 7. He took more than 10 hours to analyze Ms. Gladu's file. See also Dr. Downar's statement on all the elements he takes into account in his assessment of a patient's capacity. Testimony of Dr. Downar, February 7, 2019, at 88-92.

[190] Exhibit P-23: Expert report of Dr. Naud at paras. 17 *et seq.* and Exhibit PGC-66: Expert report of Dr. Rivard at paras. 16 *et seq.*

[191] Exhibit PGC-66: Expert report of Dr. Rivard at para. 20.

[192] Exhibit P-23: Expert report of Dr. Naud at para. 17.

[181] In their assessment, physicians have a duty to ensure that the person has made a voluntary request that, in particular, was not made as a result of external pressure, and that his or her consent is informed, i.e., after having been told of the means available to relieve the suffering, in particular, palliative care.[193] Frequently, they even have conversations with the patient's family members or close friends to verify these aspects.

[182] All of the physicians involved say they are fully able to assess the capacity of patients who request medical assistance in dying. The assessment is carried out continuously, throughout the process. The patient is informed that he or she must remain capable and that he or she may withdraw the request or change his or her mind at any time.

[183] After that, sometimes the physician will discuss matters more thoroughly with the attending physician or the treatment team to verify or confirm certain elements. The physician must then determine whether the patient's natural death seems reasonably foreseeable or evaluate his or her death trajectory on the basis of the clinical condition.

1.3 The Administration of Medical Assistance in Dying

[184] Once all these stages are complete, and once the patient becomes eligible after a second medical opinion is received, the final stage of administering medical assistance in dying takes place. Without any doubt, this is a very emotionally-charged moment for everyone involved: the patient, his or her family and loved ones, as well as for the physician responsible for the administration and the treatment team.

[185] In recounting their experience to the Court, the experts were able to express how serene, peaceful and sometimes even humorous this moment is. They systematically described it as a deliverance for the patient and a moment of great emotion for those close to them who have also been experiencing the illness, decline and suffering of their loved one for months, sometimes even years.

[186] It is generally the patient who sets the date of the procedure. He or she determines the time it will happen and who will be present. Dr. Naud arrives at least one hour before the agreed time, to reassure the patient that he is indeed there, to verify whether the patient has changed his or her mind, and to meet the family to explain how the procedure will unfold. He testified that the greatest fear of patients at this stage is that the doctor will not show up or that something postponing the procedure will happen.

[187] The doctor then leaves the patient with his or her family and returns a few minutes before the agreed time. The patient's consent is once again verified. Generally, the patient spontaneously says that he or she is ready.

[188] The injection procedure takes place in three phases. The first puts the patient to sleep and lasts about 8 minutes. The second sends the patient into a

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[193] Section 241.2(1)(*d*) Cr. C.

deep coma, much like during surgery. The third paralyzes the patient's muscles and causes respiratory arrest. [TRANSLATION] "The patient ... feels no suffering, no distress, no sensation of that".[194] [TRANSLATION] "It's easier for the family in terms of the grieving also, because there was no agony".[195]

[189] Once cardiac arrest has been observed, the physician auscultates the patient and pronounces the death. The physician generally leaves the room to allow the patient's loved ones to experience this moment together, returning about twenty minutes later. The physicians testified that it is a very emotional, very human, moment.

1.4 Administrative Formalities at the End of the MAID Process

[190] The administration of medication or substances causing the patient's death does not mean that the physician's work is done. Approximately two to three hours of administrative work follows. This last stage, regarding which only Dr. Naud testified, involves documenting the process from the official request for medical assistance in dying to the patient's death, in accordance with the provincial and federal rules.

[191] Within the next ten days, the physician must complete, file in the person's medical record[196] and send to several bodies[197] the Declaration of Information Relating to Medical Aid in Dying form developed by the Ministère de la Santé et des Services sociaux.[198] A more recent formality requires the physician to also fill out a federal form.

[192] The provincial form contains three parts detailing the procedure.

[193] In the first part, the physician must:

(a) enter the information about the person who requested medical aid in dying: date of birth, sex, validity of health insurance card;

(b) attest that the prescribed medical aid in dying request form was used: date, signature, presence of health services professional;

(c) describe the patient's medical condition: the main diagnosis and significant comorbidities, the estimated vital prognosis, the nature and description of the person's disabilities, the nature and description of physical or psychological suffering and the fact that it was constant and unbearable, the reasons why the suffering could not be relieved in a manner the person deemed tolerable;

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[194] Testimony of Dr. Naud, February 13, 2019, at 112.

[195] Testimony of Dr. Rivard, January 14, 2019, at 106.

[196] Section 32 of the Quebec statute.

[197] To the Commission sur les soins de fin de vie, to the Council of physicians, dentists and pharmacists of the institution, or to the Collège des médecins du Québec if the physician does not have privileges in the institution concerned.

[198] *Regulation respecting the procedure followed by the Commission sur les soins de fin de vie to assess compliance with the criteria for the administration of medical aid in dying and the information to be sent to the Commission for that purpose*, CQLR c. S-32.0001, r. 1, s. 5.

(d) detail the decision-making process: the reasons leading the physician to conclude that the person was capable based on recognized clinical criteria, taking into account the person's condition, the verification that the request was an informed one, ascertaining that the person was fully informed of several elements including his or her diagnosis and vital prognosis, the other available options for end-of-life care, the verifications made to ensure the request was made freely, the verification of the persistence of suffering and the constancy of the person's wish, the discussions between the physician and the care team in regular contact with the person, whether or not the person wanted the physician to speak with the person's close relations, the steps taken to make sure that the person had the opportunity to discuss the request with every person that he or she wished to contact, the opinion of the second physician confirming eligibility for medical aid in dying;

(e) provide information relating to the death: the date of administration of medical aid in dying, the date, time and location of the death.[199]

[194] The second part of the form concerns information about the physician who administered the medical aid in dying: his or her specialization and therapeutic relationship with the person, the medication protocol followed and the relationship with the pharmacist.

[195] Finally, the third part of the form contains information that identifies the physician who administered medical aid in dying and the physician who gave a second opinion, as well as information that allowed them to identify the person who received medical aid in dying.[200]

[196] The physician must send a copy of all parts of the form to the Council of physicians, dentists and pharmacists of which the physician is a member[201], or to the Collège des médecins du Québec if he or she practices in a private health facility.[202]The physician must also send a copy of parts 1 and 3 of the form to the Commission sur les soins de fin de vie.[203]

[197] In every case of medical aid in dying, the Commission verifies, based on the information received, whether the physician fulfilled his or her obligations under s. 29 of the Quebec statute.[204]

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[199] *Ibid.* s. 3.

[200] *Ibid*., ss. 2(2) and 4.

[201] Section 34 of the Quebec statute.

[202] Section 36 of the Quebec statute.

[203] Section 46 of the Quebec statute; *Regulation respecting the procedure followed by the Commission sur les soins de fin de vie to assess compliance with the criteria for the administration of medical aid in dying and the information to be sent to the Commission for that purpose*, CQLR c. S-32.0001, r. 1, s. 1.

[204] *Regulation respecting the procedure followed by the Commission sur les soins de fin de vie to assess compliance with the criteria for the administration of medical aid in dying and the information to be sent to the Commission for that purpose*, CQLR c. S-32.0001, r. 1, s. 9. The

[198] Since the coming into force of the *Regulations for the Monitoring of Medical Assistance in Dying* on November 1, 2018, Quebec physicians who administer medical aid in dying must also follow federal regulations respecting information collection and monitoring.[205] Consequently, within 30 days of the death, the physician must submit information about the patient, the physician and the request for medical assistance in dying to the Deputy Minister of Health and Social Services.

[199] To lighten the administrative burden on physicians and to avoid having them fill out two separate forms, a single electronic form for the declaration of information required under both the Quebec and federal regulation was designed and adopted in collaboration with the Commission sur les soins de fin de vie.[206]

1.5 Data Collected since the Application of Medical Assistance in Dying

- **In Quebec**

[200] Every year, the Collège des médecins du Québec must prepare a report on medical aid in dying administered by physicians exercising in a private health facility. This annual report[207] must be sent to the Commission sur les soins de fin de vie and must indicate the number of times medical aid in dying was administered by these physicians at the patient's home or in a palliative care hospice.[208]

[201] The Commission sur les soins de fin de vie must submit an annual report of its activities and a five-year report on the overall situation of end-of-life care in Quebec to the Minister of Health and Social services.[209] The Minister then tables these reports in the National Assembly.[210]

[202] The Commission has produced three annual reports of its activities for the periods of December 10, 2015, to June 30, 2016,[211] July 1, 2016, to June 30, 2017,[212] and July 1, 2017, to March 31, 2018.[213]

Commission found that 96% of medical assistance in dying cases for which a decision was rendered were administered in compliance with the requirements of the Quebec statute. Exhibit P-38: Commission sur les soins de fin de vie, *Rapport sur la situation des soins de fin de vie au Québec* : *Du [10] décembre 2015 au 31 mars 2018* (Québec: Government of Quebec, 2019) at 44-45.

[205] SOR/2018-166 (Can. Gaz. II) enacted under s. 241.31 Cr. C.

[206] Exhibit P-38: Commission sur les soins de fin de vie, *Rapport sur la situation des soins de fin de vie au Québec* : *Du [10] décembre 2015 au 31 mars 2018* (Québec: Government of Quebec, 2019) at 54.

[207] Until December 10, 2017, the report had to be sent every six months under s. 73 para. 2 of the Quebec statute.

[208] Section 37 of the Quebec statute.

[209] Section 42 para.1(4) and para. 3 of the Quebec statute.

[210] Section 43 of the Quebec statute.

[211] Exhibit P-27: Commission sur les soins de fin de vie, Rapport annuel d'activités, 10 décembre 2015 – 30 juin 2016, (Québec: Government of Quebec, 2016).

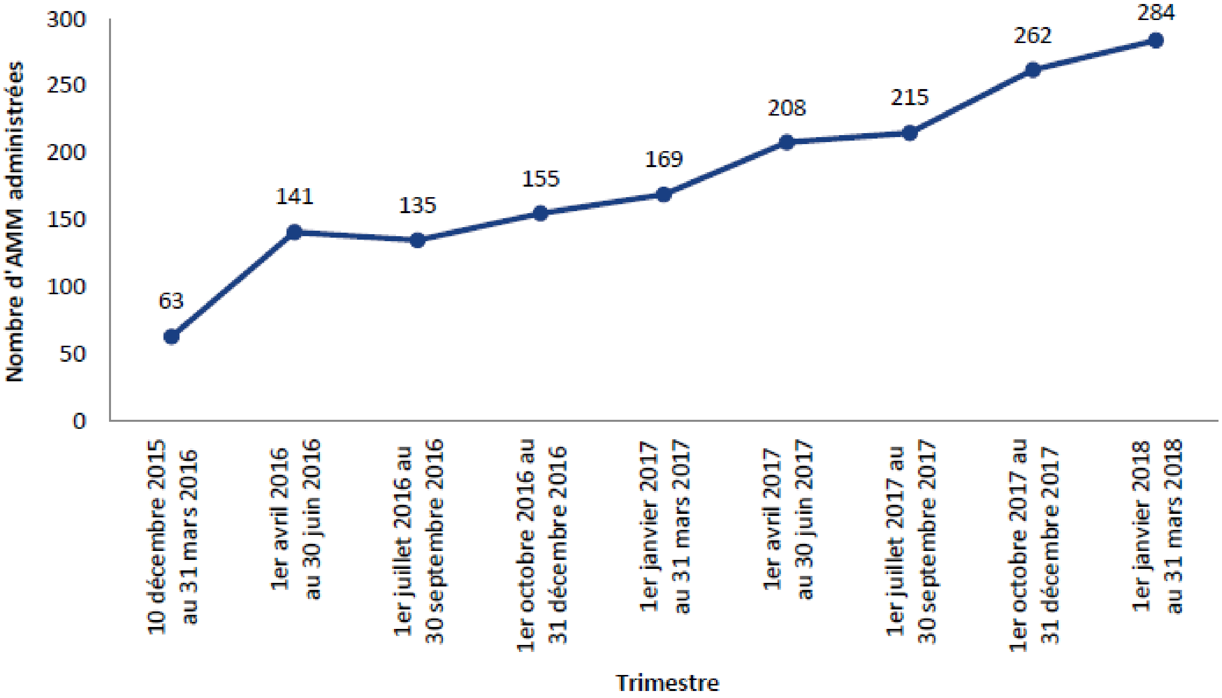
[212] Exhibit P-28: Commission sur les soins de fin de vie, Rapport annuel d'activités, 1 juillet 2016–30 juin 2017, (Québec: Government of Quebec, 2017).

[203] In April of this year, after this case was taken under advisement, the Commission tabled in the National Assembly its first report on the situation of end-of-life care in Quebec from the coming into force of the Quebec law until March 31, 2018.[214] The admission into evidence of this report was the subject of an objection by the Attorneys General. The objection was dismissed, and the report was admitted, as described in the section “Objections” of this judgment.

[204] According to the data compiled[215] by the Commission, since its legalization in Quebec, medical aid in dying has been administered to 1632 individuals.[216] This figure is broken down quarterly, making it possible for the Commission to find that [TRANSLATION] “the number of individuals who receive MAID has been increasing since the Act came into force. In 2017, the number of times MAID was administered rose by 73% in comparison with 2016”:[217]

Figure 6.1

Nombre d’AMM administrées selon le trimestre



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[213] Exhibit P-37: Commission sur les soins de fin de vie, Rapport annuel d’activités, 1 juillet, 2017– 31 mars 2018, (Québec: Government of Quebec, 2018).

[214] The Commission’s duty to send this report is set out in s. 75 of the provincial statute.

[215] The Commission compiles the data from declaration forms sent directly to the Commission and information sent by institutions and the Collège des médecins du Québec.

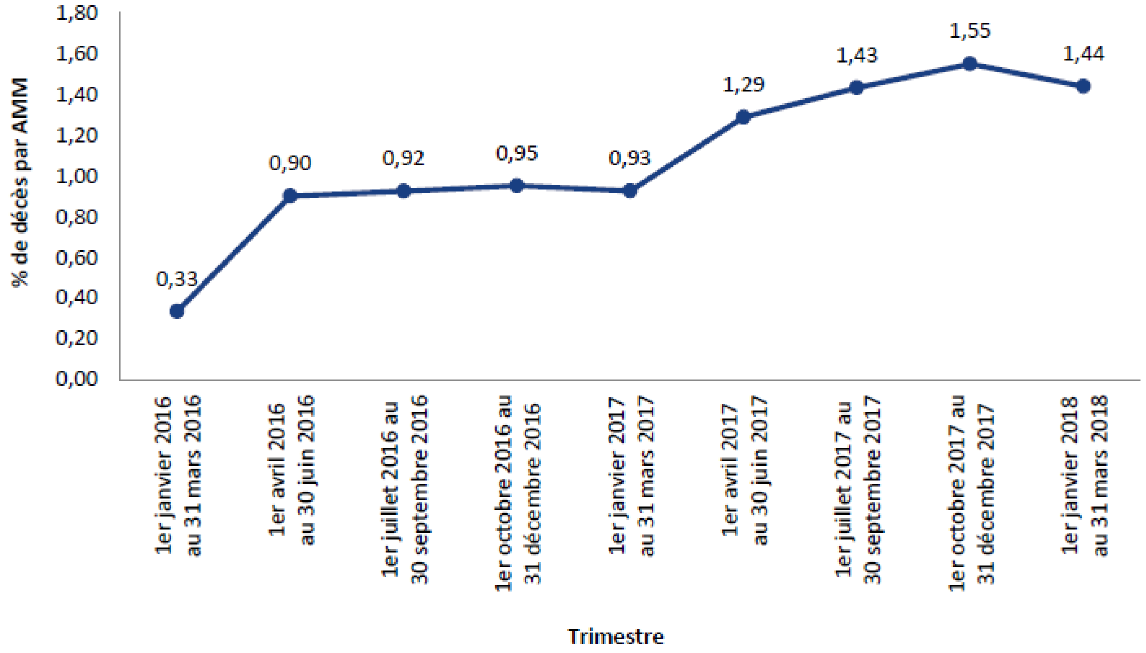
[216] Exhibit P-38: Commission sur les soins de fin de vie, *Rapport sur la situation des soins de fin de vie au Québec* : *Du [10] décembre 2015 au 31 mars 2018* (Québec: Government of Quebec, 2019) at 31.

[217] *Ibid.*

[205] According to the Commission, this significant increase in the number of cases of medical aid in dying is a sign of social acceptability.[218]

[206] When calculated as a percentage of the total number of deaths in Quebec between January 2016[219] and March 2018, death by medical aid in dying represented 1.09%, [TRANSLATION] “rising from 0.77% in 2016 to 1.29% in 2017”:[220]

Figure 6.3
Proportion de décès par AMM selon le trimestre



[207] The Commission compared these numbers with the situation in Canada and Belgium.[221] It found that, for the aforementioned period, the proportion of deaths by medical aid in dying in Quebec was [TRANSLATION] “slightly higher than that reported in Canada as a whole ... and slightly lower than that observed in Belgium”.[222]

[208] More precisely, since the coming into force of the federal statute in June 2016, death by medical assistance in dying in Canada has hovered between 0.6% to 0.9% for the period between June 2016 and June 2017, and was 1.07%

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[218] *Ibid*. at 53.

[219] The Commission noted an absence of data for the period between December 10 and 31, 2015.

[220] Exhibit P-38: Commission sur les soins de fin de vie, *Rapport sur la situation des soins de fin de vie au Québec : Du [10] décembre 2015 au 31 mars 2018* (Québec: Government of Quebec, 2019) at 33.

[221] The Belgian legislation respecting euthanasia has [TRANSLATION] “the most affinities with Quebec”. *Ibid*. at 8.

[222] *Ibid*. at 33.

between July and December 2017.[223] In Belgium, sixteen years after euthanasia was legalized, the proportion of related deaths was 1.9% in 2016 and 2.1% in 2017.[224]

[209] Citing a study published in 2016, the Commission stated that [TRANSLATION] "generally speaking, the proportion of deaths by euthanasia or medically assisted suicide ranges between 0.3% and 4.6% in countries where these acts are permitted."[225]

[210] The Commission's report also provides descriptive data on persons who received medical aid in dying in Quebec, again using an approach comparing Canada with Belgium. The following were the criteria for compiling the data indicated in the declaration forms:

(a) sex and age: men represent 53% and women 46%. The great majority of persons who received medical assistance in dying were between the ages of 60 and 89. This data is similar to that reported in Canada and Belgium;[226]

(b) the main diagnosis: 78% of people had cancer (compared with 63% in Canada and 65% in Belgium), 10% a neurodegenerative disease (similar in Canada), 6% lung disease, 4% heart or vascular disease, and the other 3% included kidney, liver, digestive, autoimmune and inflammatory diseases.[227] The Commission explained Quebec's slightly higher percentage of cancer as the main diagnosis as follows: [TRANSLATION] "only people with a serious and incurable disease are eligible for MAID in Quebec, while MAID is also permitted for individuals suffering from serious and irremediable medical conditions or disabilities in Canada and Belgium";[228]

(c) vital prognosis: 41% of persons had an estimated vital prognosis of 3 months or less, 24% of 1 month or less, 14% of 2 weeks or less, 11% of 6 months or less, while 7% had a qualitative prognosis ranging from a few days to a few months, 3% of 1 year or less, and 1% of more than 1 year. However, based on all of the information, the Commission was of the view that these persons were at the end of life.[229] This allowed the Commission to state that

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[223] *Ibid.* at 33 citing Exhibit P-31: Health Canada, *Third Interim Report on Medical Assistance in Dying in Canada*, (Ottawa, June 2018).

[224] *Ibid.* at 33, citing the *Huitième rapport aux Chambres législatives, années 2016-2017* by Belgium's Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie.

[225] *Ibid.* at 33 and note 38.

[226] *Ibid.* at 34-*35.*

[227] *Ibid.* at 35-36.

[228] *Ibid.* at 36.

[229] It was only in the first annual report of the Commission's activities that the members were of the view that the end of life requirement had not been respected in two cases. Exhibit P-27: Commission sur les soins de fin de vie, *Rapport annuel d'activités, 10 décembre 2015–30 juin 2016* (Québec: Government of Quebec, 2016) at 19.

[TRANSLATION] “a very large majority (90%) of persons who received MAID had an estimated vital prognosis of 6 months or less, and a large majority (79%) had 3 months or less”;[230]

(d) disabilities arising from serious and incurable illnesses were described using a wide variety of terms from one form to another, on a spectrum ranging from the inability to perform domestic tasks to complete dependence for daily activities and being completely bedridden. The Commission found that [TRANSLATION] “the most frequently reported disabilities are related to mobility (paralysis, for example), to transfers and moving around (for example, inability to leave home, inability to walk more than a few steps or a few metres without assistance, inability to perform transfers alone, bedridden most of the time), to elimination (for example, urinary or fecal incontinence), to hydration and nutrition (for example various types of dysphagia, up to and including the need to be fed by a tube) as well as to breathing difficulties (for example dyspnea, dependence on oxygen)”;[231]

(e) suffering varied from one person to the next, and the manner of reporting also varied from one physician to the next. The Commission stated that [TRANSLATION] “It is possible for a person to have experienced suffering that was not recorded in the form”.[232] However, the presence of both physical and psychological suffering is reported in 89% of cases, while physical suffering alone is recorded in 6% of the forms and psychological suffering alone is indicated in 5% of the forms submitted to the Commission. The Commission compared this data with the situation in Belgium where [TRANSLATION] “57% of people who received euthanasia in 2015-2016 were suffering both physically and psychologically, while 38% were experiencing physical suffering alone and 5% psychological suffering alone”.[233] The types of physical suffering most frequently mentioned in the forms were: pain, dyspnea or respiratory distress, nausea or vomiting, discomfort and pain associated with symptoms or complications or with interventions to relieve it. The main types of mental suffering reported [TRANSLATION] “include psychological, social and existential suffering” such as loss of meaning in life, the impossibility to perform meaningful actions, loss of dignity, loss of autonomy, loss of control, dependence on others, the perception of being a burden on one’s loved ones, loss of quality of life, fear of [TRANSLATION]“how death will come (for example, fear of further loss

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[230] Exhibit P-38: Commission sur les soins de fin de vie, *Rapport sur la situation des soins de fin de vie au Québec* : *Du [10] décembre 2015 au 31 mars 2018* (Québec: Government of Quebec, 2019) at 36.

[231] *Ibid.* at 37.

[232] *Ibid*.

[233] *Ibid.* at 37 and note 44.

> of autonomy, fear of being moved to a long term care facility, fear of losing cognitive capacity, fear of smothering, fear of living in agony or refusal to do so)".[234]

[211] Since June 2017, the Commission sur les soins de fin de vie must also retroactively analyze the reasons some requests for medical aid in dying have been rejected since December 10, 2015.[235] This data, however, can be found only in the records of patients who made written requests for medical aid in dying. The Commission therefore sought the collaboration of institutions that had this information in their possession, but it is impossible for it to obtain information about verbal requests for medical aid in dying or even about requests to physicians practicing in private health facilities.

[212] In the circumstances, the Commission warned that the data must be interpreted cautiously given its retrospective compilation and the proportion of missing data, which is as high as 16%. The implementation of the single electronic form will make the collection of this data easier in the future.[236]

[213] According to the information received from the institutions, between December 10, 2015, and March 31, 2018, there were 830 official written requests for medical aid in dying that were refused. This represents 34% of a total of 2,462 requests for medical aid in dying in Quebec in the same period.[237]

[214] The main reasons for refusal are: eligibility conditions were not met at the time of the request (23%), the person was eligible when the request was made but ceased to be during the process (20%), the person changed his or her mind (20%), or the person died before the end of the evaluation process (20%) or before medical aid in dying was administered (8%).[238]

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[234] *Ibid*. at 38.

[235] Exhibit P-37: Commission sur les soins de fin de vie, *Rapport annuel d'activités : 1er juillet 2017 – 31 mars 2018* (Québec, Government of Quebec, 2018) at 13.

[236] Exhibit P-38: Commission sur les soins de fin de vie, *Rapport sur la situation des soins de fin de vie au Québec : Du [10] décembre 2015 au 31 mars 2018* (Québec: Government of Quebec, 2019) at 55.

[237] *Ibid.* at 56.

[238] *Ibid.* at 61.

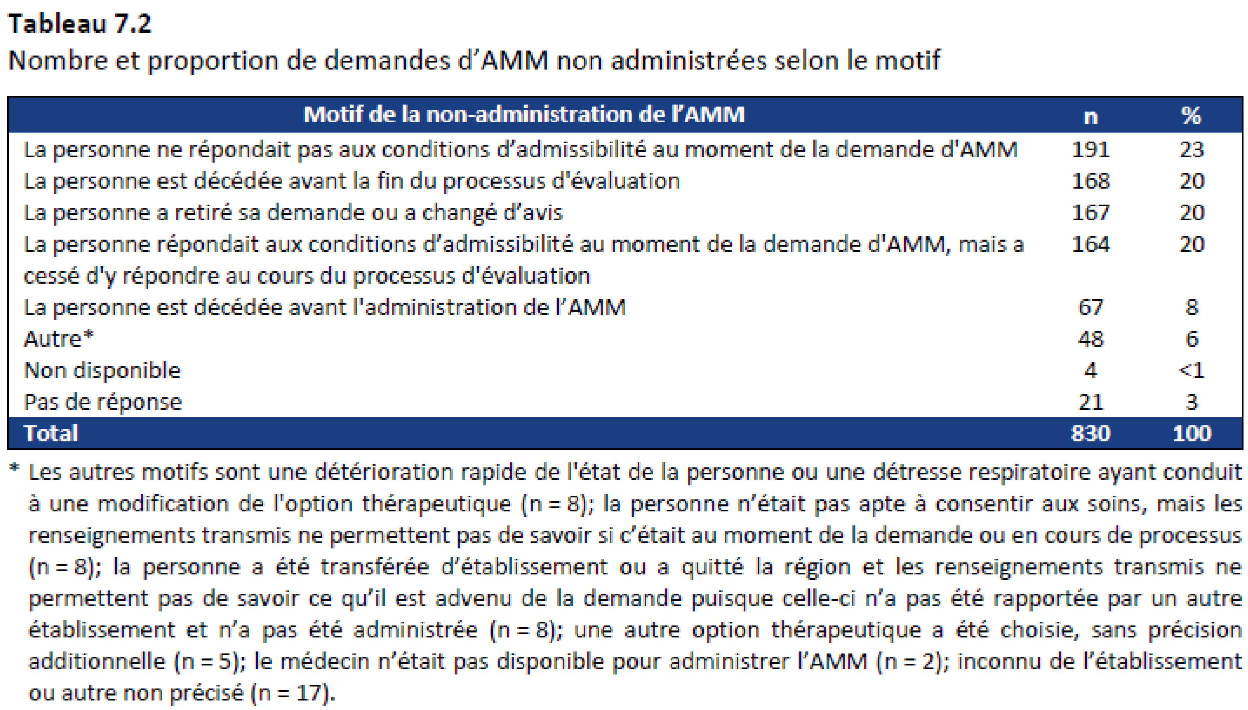

Tableau 7.2

Nombre et proportion de demandes d'AMM non administrées selon le motif

Motif de la non-administration de l'AMM	n	%
La personne ne répondait pas aux conditions d'admissibilité au moment de la demande d'AMM	191	23
La personne est décédée avant la fin du processus d'évaluation	168	20
La personne a retiré sa demande ou a changé d'avis	167	20
La personne répondait aux conditions d'admissibilité au moment de la demande d'AMM, mais a cessé d'y répondre au cours du processus d'évaluation	164	20
La personne est décédée avant l'administration de l'AMM	67	8
Autre*	48	6
Non disponible	4	<1
Pas de réponse	21	3
Total	**830**	**100**

* Les autres motifs sont une détérioration rapide de l'état de la personne ou une détresse respiratoire ayant conduit à une modification de l'option thérapeutique (n = 8); la personne n'était pas apte à consentir aux soins, mais les renseignements transmis ne permettent pas de savoir si c'était au moment de la demande ou en cours de processus (n = 8); la personne a été transférée d'établissement ou a quitté la région et les renseignements transmis ne permettent pas de savoir ce qu'il est advenu de la demande puisque celle-ci n'a pas été rapportée par un autre établissement et n'a pas été administrée (n = 8); une autre option thérapeutique a été choisie, sans précision additionnelle (n = 5); le médecin n'était pas disponible pour administrer l'AMM (n = 2); inconnu de l'établissement ou autre non précisé (n = 17).

[215] According to the data presented in table 7.2 of the report, the Commission found that just fewer than 400 people who were potentially eligible for medical aid in dying requested it but did not receive it.[239]

[216] The end-of-life requirement was the main obstacle for persons not eligible for medical aid in dying at the time of the request. Indeed, in 51% of cases, the person was not considered to be at the end of life. The percentages for the other unfulfilled eligibility requirements were: 30% incapable of giving consent to care, 25% without constant and intolerable physical or mental suffering, 19% without a serious and incurable illness, and 18% not in an advanced state of irreversible decline in capability.[240]

- **Federal**

[217] Section 13 of the *Regulations for the Monitoring of Medical Assistance in Dying*[241] sets out the duty of the federal Minister of Health to publish, at least once a year, a report based on the information gathered throughout the country. This report must contain information relating to requests for medical assistance in dying, in particular the number, the characteristics of the patients, the reasons for refusal, including which of the eligibility criteria were not met, and so on. This will provide a more complete portrait of the practice of medical assistance in dying in

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[239] *Ibid*.

[240] *Ibid.* at *62.*

[241] SOR/2018-166, C. Gaz II.

Canada. Currently not in force, this provision will come into effect on November 1, 2019.[242]

[218] The implementation of this Canada-wide monitoring system was preceded by the publication of three interim reports prepared by Health Canada from data submitted by the provincial governments. The interim reports compile data relating to medical assistance in dying in Canada in three six-month periods: June 17 to December 31, 2016 (first interim report)[243], January 1 to June 30, 2017 (second interim report)[244] and July 1 to December 31, 2017 (third interim report).[245]

[219] According to this data, the deaths that can be attributed to medical assistance in dying in Canada can be broken down as follows:

(a) June 17 - December 31, 2016: 803 cases, representing less than 0.6% of all deaths in Canada;[246]

(b) January 1 - June 30, 2017: 1179 cases, which represents a 46% increase from the previous period and 0.9% of all deaths in Canada;[247]

(c) July 1 - December 31, 2017: 1,525 cases, representing a 29.3% increase from the preceding period and 1.07% of all deaths in Canada.[248]

[220] When the cases of medical aid in dying administered in Quebec immediately after the Quebec statute came into force are considered, the number of cases of medical assistance in dying in Canada between December 10, 2015, and December 31, 2017, totals 3,714.[249]

[221] Despite the upward trend in the number of cases in Canada, the percentage “remains consistent with that of other international assisted dying regimes where between 0.3% to 4% of total deaths have been attributed to assisted death”.[250] In comparison, the data from the Netherlands (3.75% in

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[242] *Ibid.*, s. 17(2).

[243] Exhibit P-29: Health Canada, *First Interim Report on Medical Assistance in Dying in Canada* (Ottawa: April 2017).

[244] Exhibit P-30: Health Canada, *Second Interim Report on Medial Assistance in Dying in Canada* (Ottawa: October 2017).

[245] Exhibit P-31: Health Canada, *Third Interim Report on Medical Assistance in Dying in Canada* (Ottawa: June 2018).

[246] Exhibit P-29: Health Canada, *First Interim Report on Medical Assistance in Dying in Canada* (Ottawa: April 2017).

[247] Exhibit P-30: Health Canada, *Second Interim Report on Medical Assistance in Dying in Canada* (Ottawa: October 2017) at 5 and 8.

[248] Exhibit P-31: Health Canada, *Third Interim Report on Medical Assistance in Dying in Canada* (Ottawa: June 2018) at 5 and 7.

[249] *Ibid.*

[250] *Ibid*. at 8.

2015), Belgium (1.83% in 2015) and Oregon (0.37% in 2016) are recorded in the first interim report.[251]

[222] As noted above, the characteristics relating to the age, sex and diagnosis of people who received medical assistance in dying in Canada seem similar to those reported in Quebec.

[223] The age of Canadians who obtained this type of assistance is between 56 and 90 years, with an average age of approximately 73 years.[252] The breakdown by the sex of patients is evenly balanced, at 49% men and 51% women.[253]

[224] As in Quebec (78%) and elsewhere (76.9% in Oregon, 69% in Belgium, and 68% in the Netherlands), cancer is the most frequently mentioned medical condition, representing 65% of all cases of medical assistance in dying in Canada.[254]

[225] Finally, Health Canada gathered information from Alberta, Manitoba, Saskatchewan and Quebec relating to requests for medical assistance in dying that were refused. The same recommendation of caution in the interpretation of the data is made. The data obtained indicate that, "[o]f the 1,066 requests for medical assistance in dying reported by these provinces, approximately 8% were declined", with loss of competency and the failure to meet the reasonably foreseeable natural death criterion as the most frequently cited reasons.[255]

[226] One thus observes that there has been a general increase in requests, that the reasons for refusal are related to the impugned requirements and that the procedure that must be followed to be entitled to medical assistance in dying is onerous indeed.

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[227] In addition to this data, which sheds light on the practice of medical assistance in dying in this country, several national and international witnesses testified at the hearing to contextualize this information from a broader perspective, in connection with the present constitutional challenge. The Court will analyze their testimony, which represents a substantial portion of the evidence adduced.

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[251] Exhibit P-29: Health Canada, *First Interim Report on Medical Assistance in Dying in Canada* (Ottawa: April 2017).

[252] Exhibit P-31: Health Canada, *Third Interim Report on Medical Assistance in Dying in Canada* (Ottawa: June 2018), at 8; Exhibit P-30: Health Canada, *Second Interim Report on Medical Assistance in Dying in Canada* (Ottawa: October 2017) at 8; Exhibit P-29: Health Canada, *First Interim Report on Medical Assistance in Dying in Canada* (Ottawa: April 2017).

[253] Exhibit P-31: Health Canada, *Third Interim Report on Medical Assistance in Dying in Canada* (Ottawa, June 2018) at 8; Exhibit P-30: Health Canada, *Second Interim Report on Medical Assistance in Dying in Canada* (Ottawa: October 2017) at 6, Exhibit P-29: Health Canada, *First Interim Report on Medical Assistance in Dying in Canada* (Ottawa: April 2017).

[254] Exhibit P-31: Health Canada, *Third Interim Report on Medical Assistance in Dying in Canada* (Ottawa: June 2018) at 9.

[255] *Ibid.*

[228] The Court has decided to present all of the evidence submitted by the parties at this point to allow a better understanding of the facts and opinions submitted and to facilitate the reading of this judgment. Although traditionally the evidence is discussed as part of the analysis of the issues in dispute and in a certain order, the volume of the evidence and the convergence of the subjects addressed require the Court to depart from the traditional approach.

[229] This evidence concerns various aspects of the record. First and foremost, the Attorney General of Canada raises concerns regarding the need to protect vulnerable and suicidal persons and to ensure consistency with its message of suicide prevention. In the Attorney General's view, the requirement of reasonably foreseeable natural death makes it possible to achieve these objectives.

2. The Vulnerable Persons that the Requirements Seek to Protect

[230] The Attorney General of Canada called several witnesses to testify on the impact that the removal of the reasonably foreseeable natural death requirement would have on the vulnerable persons that the government wants to protect. It also submitted ample documentary evidence describing the same concerns, which the Court has reviewed.[256]

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[256] See in particular the following exhibits: PGC-4: Submissions to the Special Joint Committee on Physician-Assisted Dying; PGC-5 : Canada, Special Joint Committee on Physician-Assisted Dying, *Evidence*, 42-1, Nos. 1–3, 5–12 (18, 25–28 January, 1–4 February 2016); PGC-10: Submissions to the Standing Committee on Justice and Human Rights; PGC-11: Canada, *House of Commons*, Standing Committee on Justice and Human Rights, *Evidence*, 42-1, Nos. 10–18 (2–5, 9–11 May 2016); PGC-16: Submissions to the Senate Committee on Legal and Constitutional Affairs; PGC-17: Canada, Proceedings of the Standing Senate Committee on Legal and Constitutional Affairs, 42-1, Nos. 8–10 (4–5, 10–12 and 17 May 2016, 6–7 June 2016); PGC-55: Canadian Association for Community Living and People First of Canada, “Protecting Choice & Safeguarding Inclusion. A Proposal to Regulate Physician-Assisted Suicide and Voluntary Euthanasia in Canada” (September 2015); PGC-56: Canadian Association for Community Living, “Protect Vulnerable Persons in Bill C-14 Medical Assistance in Dying. A call to members of Parliament and Senators” (April 2016); PGC-58: Various organizations, Press Release, “A Call to Parliamentarians from the National Disability Rights Community "To Pass Bill C-14 to Ensure Constitutional Rights of Vulnerable Persons” (31 May 2016); PGC-59 : “Vulnerable Persons Standard/Norme sur la protection des personnes vulnérables” (2016); PGC-60: “Frequently asked questions about the Vulnerable Persons Standard” (18 March 2016); PGC-61: National Disability Rights Community Forum for Robust Safeguards in Bill C-14 (16 June 2016) (video); Exhibits PGC-75: Affidavit of Krista Wilcox (24 December 2018) and supporting exhibits (PGC-50A: Statistics Canada, *A demographic, employment and income profile of Canadians with disabilities aged 15 years and over, 2017*, by Stuart Morris, Gail Fawcett, Laurent Brisebois & Jeffrey Hughes (Ottawa: Statistics Canada, 28 November 2018); PGC-50B: Statistics Canada*, New Data on Disability in Canada, 2017*; PGC-50C: Statistics Canada, *Canadian Survey on Disability, 2017: Concepts and Methods Guide*, by Elisabeth Cloutier, Chantal Grondin & Amélie Lévesque, (Ottawa: Statistics Canada, 28 November 2018); PGC-50D: Statistics Canada, *Canadian Survey on Disability. The evolution of disability data in Canada: Keeping in step with a more inclusive Canada*, by Adele Furrie (Ottawa: Statistics Canada, 28 November 2018); PGC-47: *Convention on the Rights of Persons with Disabilities*, 13 December 2006, 2515 U.N.T.S. 3 (entered into force 3 May 2008, accession by Canada 10 April 2010); Exhibit PGC-48: United

[231] In addition to the five experts[257] who specifically considered the assessment of the plaintiffs' eligibility for medical assistance in dying in relation to the legislative requirements in force, the opinions of fourteen experts (the

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Nations Committee on the Rights of Persons with Disabilities, Consideration of reports submitted by States parties under article 35 of the Convention, Initial reports of States parties due in 2012 : Canada (February 11, 2014) CRPD/C/CAN/1; PGC-48A: United Nations Committee on the Rights of Persons with Disabilities, Consideration of reports submitted by States parties under article 35 of the Convention, List of issues in relation to the initial report of Canada. Addendum. Canada's reply to the UN List of Issues (March 3, 2017) CRPD/C/CAN/Q/1/Add.1; PGC-49: United Nations Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Canada (May 8, 2017) CRPD/C/CAN/CO/1); PGC-76: Affidavit of Isabel Giardino (7 January 2019) and supporting exhibits (PGC-33: *Federal Framework for Suicide Prevention Act*, S.C. 2012, c. 30; PGC-32: World Health Organization, *Preventing suicide. A global imperative* (Geneva: 2014); PGC-35: Government of Canada, *Overview of federal initiatives in suicide prevention* (Ottawa: February 2016); PGC-36 : Government of Canada, *The 2016 Progress Report on the Federal Framework for Suicide Prevention* (Ottawa: December 2016); PGC-37: Health Canada, *First Nations Mental Wellness Continuum Framework - Summary Report* (Ottawa: 2015); PGC-38: Inuit Tapiriit Kanatami, *National Inuit Suicide Prevention Strategy* (Ottawa: 2016); PGC-31: Mental Health Commission of Canada, *Changing Directions, Changing Lives: the Mental Health Strategy for Canada* (Calgary: 2012); PGC-36A: Government of Canada, *2018 Progress Report on the Federal Framework for Suicide Prevention* (Ottawa: 2018)); PGC-77: Affidavit of Ms. Skinner (20 December 2018) and supporting exhibits (PGC-34: Government of Canada, *The Federal Framework for Suicide Prevention* (Ottawa: 2016); PGC-39: Robin Skinner et al., "At-a-glance. A contextual analysis of the Suicide Surveillance Indicators" (2017) 37 Health Promotion and Chronic Disease Prevention in Canada 257; PGC-40: Robin Skinner et al., "Suicide in Canada: is Poisoning Misclassification an Issue?" (2016) 61 The Canadian Journal of Psychiatry 405; PGC-41: Robin Skinner, "Suicide and self-inflicted injury hospitalizations in Canada (1979 to 2014/15)" (2016) 36 Health Promotion and Chronic Disease Prevention in Canada 243); PGC-78: Exhibits in support of the testimony of Michael Bach (PGC-55, PGC-4, PGC-5, PGC-59, PGC-60, PGC-56, PGC-10, PGC-11, PGC-16, PGC-17, PGC-57, PGC-58, PGC-61); PGC-79: "Advisors to the Vulnerable Persons Standard" (September 2017); Exhibits in support of the testimony of Dr. Heber (PGC-42: Veterans Affairs Canada, *A Well-Being Construct for Veterans' Policy, Programming and Research*, Research Directorate Technical Report (Charlottetown: 2016); PGC-43: Government of Canada, *Joint Suicide Prevention Strategy of the Canadian Armed Forces and Veterans Affairs Canada* (Ottawa: 2017); PGC-44: James M. Thompson et al., "Mental Health of Canadian Armed Forces Veterans: review of population studies" (2016) 2 Journal of Military, Veteran and Family Health 70; PGC-45: James M. Thompson et al., "Roles of physical and mental health in suicidal ideation in Canadian Armed Force veterans" (2014) 105 Can J Public Health 109; PGC-46: Veterans Affairs Canada, 2017 Veteran Suicide Mortality Study (1976 to 2012) (Charlottetown: November 2017); PGC-62: Veterans Affairs Canada, *Suicide Prevention at Veterans Affairs Canada: Framework* (Charlottetown: 2010); PGC-80: Affidavit of Jean-Claude Therrien Pinette (4 February 2019) and supporting exhibits (PGC-63: First Nations of Quebec and Labrador Health and Social Services Commission, *Main findings of the 2015 Quebec First Nations Regional Health Survey*, (Wendake: FNQLHSSC, 2018).

[257] Dr. Naud and Dr. Turcotte submitted two reports concerning each of the plaintiffs: Exhibits P-23A: Expert report of Dr. Naud concerning Ms. Gladu, P-23B: Expert report of Dr. Naud concerning Mr. Truchon, P-6: Expert report of Dr. Turcotte concerning Mr. Truchon's medical condition and P-10: Expert report of Dr. Turcotte in connection with Ms. Gladu's medical condition. Exhibits P-5: Expert report of Dr. Giguère and P-11: Expert report of Dr. Aubé for the plaintiffs. Exhibit PGC-66: Expert report of Dr. Rivard for the Attorney General of Canada.

plaintiffs called four experts and the Attorney General of Canada called ten)[258] were also presented on various other issues related to medical assistance in dying, essentially to debate whether the reasonably foreseeable natural death requirement is a necessary and justified criterion to protect the vulnerable persons in our society.

[232] The evidence is substantial and specialized. It covers several subjects that are foreign to the plaintiffs, justified in part by the fact that the reasonably foreseeable natural death requirement goes beyond their own circumstances and is of interest to society at large. For example, all of the issues concerning suicide (in general and in various groups, such as members of the military, veterans or Indigenous peoples), the phenomenon of suicide contagion, and the issue of psychiatric illness as the only underlying medical condition for a request for medical assistance in dying, concern neither Mr. Truchon nor Ms. Gladu, who are not suicidal and do not suffer from any psychiatric condition.

[233] As well, this evidence is critical to the Attorney General in order to meet the important burden of justifying the measure adopted, as is the case in all constitutional challenges arising from the violation of a fundamental right.

[234] The evidence of the Attorney General of Quebec, which is exclusively documentary, consists mainly of reports by various authorities and the parliamentary proceedings prior to the enactment of the Quebec statute.

[235] The plaintiffs, for their part, filed two expert reports, those of Dr. James Downar and Dr. Justine Dembo, which, other than setting out their practical experience, seek primarily to respond to the various arguments and issues identified by the Attorney General's experts. In this regard, the evidence may appear somewhat unbalanced, in terms of both the number of experts retained by each party and the subjects addressed.

[236] The Court's analysis of the evidence will be divided into two main sections: the evidence regarding the intended legislative objectives of the impugned requirement in connection with the protection of vulnerable persons, and the evidence related to foreign regimes.

[237] In the first section, the Court will analyze the evidence in the following order:

1. **Persons who are vulnerable due to physical or intellectual disability**. In addition to the plaintiffs' experts, the Court will review the testimony of Dr. Rivard, Professor Shakespeare, Mr. Michael Bach and Ms. Krista Wilcox;
2. **Persons who are vulnerable to suicide and the phenomenon of suicide contagion**. In addition to the plaintiffs' experts, the Court will discuss the opinions issued by Dr. Sareen, Dr. Conwell, Dr.

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[258] That is, Dr. Naud, Dr. Downar, Dr. Dembo and Dr. van der Heide for the plaintiffs, and Dr. Rivard, Dr. Sareen, Dr. Sinyor, Dr. Conwell, Prof. Boer, Prof. Lemmens, Prof. Shakespeare, Dr. Kim, Dr. Gaind and Dr. Quill for the Attorney General of Canada.

Sinyor and Dr. Quill, as well as the testimony of Ms. Heber and Mr. Therrien Pinette on these same issues;

3. **Vulnerable persons whose psychiatric illness is the only medical condition underlying their request for medical assistance in dying**. In addition to the plaintiffs' experts, the Court will consider the opinions of Dr. Kim and Dr. Gain on behalf of the Attorney General.

[238] In the second section, the Court will examine the content of the evidence presented by the Attorney General concerning foreign systems, through experts Professor Boer, Professor Lemmens and Dr. Kim. It will then conclude with the testimony of Dr. van der Heide on behalf of the plaintiffs.

[239] At the outset, however, the Court will examine the concept, addressed numerous times during the hearing, of "vulnerable person", as described by the various witnesses, as well as the ability of physicians and the treatment team to properly assess the capacity of patients, whether vulnerable or not, who request medical assistance in dying. These two concepts transcend all the evidence adduced at trial.

2.1 The Concept of Vulnerable Person

[240] The concept of vulnerable person invoked by the defendants as the cornerstone of their positions is not defined in the legislation. This "person," however is at the heart of the current debate, because the impugned provision is, according to the Attorney General, essentially intended to ensure his or her protection by prohibiting medical assistance in dying for all persons who are not close to death.

[241] The Court notes that the Attorney General considers persons who are elderly, ill or disabled to be vulnerable[259], as well as persons who could be induced to end their lives in moments of weakness, who are suicidal or who cannot make a free and informed choice regarding decisions concerning their health.[260] It relies on two concepts of vulnerability: the first individual and the second collective.

[242] In regard to the latter, the evidence is indeed focussed on certain "groups of vulnerable persons". These consist of persons living with a physical or intellectual disability, persons suffering from a psychiatric illness or condition and groups of persons with a greater propensity for suicide, such as members of the military, veterans, and members of Indigenous communities.

[243] The issue of vulnerability was addressed by several of the Attorney General's experts in a more or less precise manner. They each have their own

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[259] See in particular the preamble to the federal statute.

[260] See in particular the Arguments of the Attorney General of Canada at 30–37. See also the Arguments of the interveners the Physicians' Alliance against Euthanasia and Living with Dignity at para. 47.

understanding of this notion according to the context in which they operate.[261] The Attorney General addressed this concept in three separate categories: persons who are vulnerable due to physical or intellectual disability, persons vulnerable to suicide and, finally, persons suffering from a psychiatric condition.

[244] It essentially submits that removing the reasonably foreseeable natural death requirement would undermine Parliament's objective of affirming the inherent and equal value of vulnerable persons' lives and of addressing and preventing suicide and would put vulnerable individuals at risk.[262]

[245] The plaintiffs' experts address the issue of vulnerable persons in a more general manner and submit that the concept remains very difficult, even impossible to identify, because vulnerability can be defined in several ways depending on various physical, psychological, socioeconomic or other factors.[263]

[246] They maintain that a person may very well find himself or herself in a position of vulnerability but still be capable of making personal decisions in his or her best interests. Consequently, an individualized approach to vulnerability that takes into account characteristics that are specific to the person, rather than labelling someone as a "vulnerable person" on the basis of their membership in a group, would be more appropriate.[264]

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[261] For example, testimony of Dr. Gaind, February 4, 2019, at 114: "… it's the vulnerable person whose insight or judgement is distorted who is potentially wrongly predicting things will not get better." Testimony of Dr. Sinyor, January 30, 2019, at 138–139: "I think the issue of vulnerability is not about who's disadvantaged, it's who's the vulnerable population." Testimony of Dr. Kim, January 28–29, 2019, at 34–35. He stated that women could be considered a vulnerable group and that "vulnerability is a very broad concept. … it means different things in different contexts." Testimony of Dr. Boer, January 15, 2019, at 105: "I think vulnerability in an ethical sense pertains to anyone, whether you live in a one room apartment or in a mansion with wood black and … wood black floor and a grand piano, it pertains to anyone who has lost the capacity to make the best out of something, which is … that's just terrible."

[262] Arguments of the Attorney General of Canada at 24, 27 and 30.

[263] Exhibits P-24: Dr. Dembo's report at paras. 10–12 and 18–24: "In the context of MAID, no single definition of the term 'vulnerable persons' has been established. The Canadian Vulnerable Persons Standard, developed by multiple concerned parties – mainly disability rights advocates - in response to the *Carter* decision in 2016, lists the following factors as major influences on vulnerability: lack of access to appropriate care; poverty; unemployment; ongoing abuse or violence; and 'psychosocial factors and mental health issues causing distorted insight and judgment.' Each of these factors absolutely affects vulnerability. That said, these same variables exist in terminal illness, just as they do in non-terminal illness"; P-25: Expert report of Dr. Downar at para. 35: "In published epidemiological studies, vulnerability is sometimes inferred on the basis of measurable socioeconomic factors such as income, education, race, age, health insurance and institutionalization"; Exhibit P-23: Dr. Naud's report at para. 53: [TRANSLATION] "Patients' vulnerability depends on their biopsychosocial condition, not their capacity to consent."

[264] See in particular Exhibit P-24: Dr. Dembo's report at para. 12: "Labelling entire groups as 'vulnerable' does not account for individual differences within those groups. It also perpetuates medical paternalism, in that the medical profession to makes decisions for entire groups of people, rather than letting each capable patient exercise his autonomy from within his her unique circumstances." See also Dr. Dembo's testimony, February 11, 2019, at 37–41.

[247] According to the plaintiffs, in the context of medical assistance in dying, a vulnerable person is akin to someone who does not have the capacity to express his or her needs and wishes, who cannot decide for himself or herself, or who is likely to be subjected to external pressure.[265]

[248] In this sense, the impugned requirements of a reasonably foreseeable natural death and being at the end of life do not protect vulnerable persons more than persons who are ineligible for medical assistance in dying, given the other safeguards in the legislation, whereas they do prevent certain persons, such as Ms. Gladu and Mr. Truchon, from choosing this path to put an end to their suffering. That could lead some towards suicide or even greater suffering.[266]

[249] While this may be a truism, the Court finds that, essentially, all human beings, regardless of their specific characteristics, have the potential to be or to become vulnerable at one point or another in their lives.

[250] In purely abstract terms, it is easy to understand that persons who request medical assistance in dying, like Mr. Truchon or Ms. Gladu, may correspond to a certain concept of vulnerability because they are seriously ill, have no hope of recovery or improvement and are suffering intolerably. Although some of these people appear very vulnerable because of their health conditions, they may nevertheless be fully capable of consenting to receive medical assistance in dying. This is where the weakness of the position of the Attorneys General lies.

[251] In this regard, the Supreme Court in *Carter* stated the following at paragraph 86:

> Canada conceded at trial that the law catches people outside this class: "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" (trial reasons, at para. 1136). The trial judge accepted that Ms. Taylor was such a person — competent, fully informed, and free from coercion or duress (para. 16). It follows that the limitation on their rights is in at least some cases not connected to the objective of protecting *vulnerable* persons. The blanket prohibition sweeps conduct into its ambit that is unrelated to the law's objective.

[252] The Court cannot accept the concept of collective vulnerability suggested by the Attorney General because the broad protection that results therefrom is too general an application of a precautionary principle. Vulnerability should not

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[265] For example, testimony of Dr. Downar, February 7, 2019, at 189; P-25: Expert report of Dr. Downar at para. 35: "Vulnerability can be defined in many ways, but it generally refers to someone who is not able to advocate for their own needs, someone who lacks decisional capacity, or someone who is susceptible to making decisions on the basis of external pressure"; P-24: Dr. Dembo's report at para. 10. See also her testimony of February 11, 2019, at 36 *et seq.*: "I think it is a very challenging term to define in this context, but from what I understand, the concept of vulnerable individual is someone who, through a set of circumstances, might be more susceptible to coercion or to distorted thinking of difficulties with autonomous decision-making."

[266] Exhibit P-23 : Report of Dr. Naud at paras. 83–85. See also Exhibit P-25: Expert report of Dr. Downar at para. 49.

be understood or assessed on the basis of a person’s belonging to a defined group, but rather on a case-by-case basis, at least for the purposes of an analysis under section 7 of the *Charter*. In other words, it is not the person’s identification with a group characterized as vulnerable – such as persons with disabilities, Indigenous persons or veterans – that should bring about the need to protect a person who requests medical assistance in dying but, rather, that person’s individual capacity to understand and consent in a free and informed manner to such a procedure, based on his or her specific characteristics.

[253] Therefore, the Court finds that, for a doctor working in the area of medical assistance in dying, a vulnerable person should be defined as a person who is incapable of consenting, who depends on others to make decisions regarding his or her care, or who may be the victim of pressure or abuse. These conditions are already included in the legislation.

2.2 The Capacity Assessment by the Physicians and the Treatment Team

[254] It is clear from the legislative regime in place that a patient’s capacity to consent to medical assistance in dying is a *sine qua non* condition to its administration.[267] The person making the request must be able to consent thereto in a free and informed manner, in addition to satisfying the other requirements.

[255] Physicians must make sure that the request is indeed being made freely, voluntarily, without undue pressure or coercion, and ensure that no person obtains such assistance without their knowledge or without having truly consented.[268]

[256] The Court notes that the experts who practise medical assistance in dying consider themselves fully able to assess the capacity of patients who make such

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[267] Paragraphs 241.2(1)(*b*), (*d*) and (*e*) Cr. C. provide that only a person who is capable of making decisions with respect to their health, who has made a voluntary request for medical assistance in dying (that, in particular, was not made as a result of external pressure) and who has given informed consent (after having been informed of the means that are available to relieve their suffering) is eligible to receive such assistance. Sections 26(2) and 29(1)(*a*) and (*b*) of the Quebec statute provide that a person who requests medical aid in dying must be capable of giving consent to care, and that the physician must make sure that the request is free and informed, that it is not made as a result of external pressure, and that the patient understands his or her prognosis and the other therapeutic possibilities and their consequences.

[268] Regarding whether end-of–life patients are capable of making an informed request for medical aid in dying, the Select Committee on Dying with Dignity considered that “it is important for medical practitioners to know how to identify signs of distress” such as depression that sometimes accompanies illness, isolation, lack of family support, etc. The Committee cautioned against confusing depression, in itself an illness, with the state of sadness and discouragement experienced by patients facing “a prognosis of imminent death.” In addition, it stated that consistency is required when referring to the capacity to consent to care: “if the end-of-life patient can give informed consent to receive or refuse care, even if it leads to death, then if follows that this patient is also able to ask for help to die.” Exhibit PGQ-4: Select Committee on Dying with Dignity, *Report* (Québec: March 2012) at 58.

requests without feeling the need to consult the opinion of a psychiatrist. They testified that the assessment of a patient’s mental capacity is a common medical procedure in their practice.

[257] As for Dr. Naud, he clearly explained how a patient’s capacity is assessed in such circumstances.

[258] He first specified that obtaining the patient’s free and informed consent is a requirement for all medical and surgical procedures, and even moreso when the medical procedure is irreversible, as in this case. The meeting with the patient allows the physician to assess, through discussion and specific questions, his or her capacity to receive medical assistance in dying, underlying motivation and knowledge of the steps taken and possible alternatives, if any.

[259] The assessment of the patient’s capacity is part of common medical practice in this country. It is performed in accordance with generally-accepted criteria in which physicians in Canada are well trained.[269] According to Dr. Naud, no other medical procedure, even irreversible,[270] is subject to such a consistent, rigorous and thorough assessment of competence as medical assistance in dying.

[260] He testified that it is a continuous process that starts at the first meeting with the physician, ends after the administration of medical assistance in dying and involves the entire treatment team, who knows the patient and supports him or her throughout the process.[271] In addition, a second assessment of capacity must be performed by another independent physician.

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[269] Exhibit P-23: Expert report of Dr. Naud at para. 55 *et seq.* He referred to [TRANSLATION] “the four cognitive skills and the five Nova Scotia criteria, which are well described in the MAID practice guide” of the Collège des médecins du Québec: 1) does the person understand the nature of the condition for which he or she is requesting MAID?; 2) does the person understand the nature and purpose of MAID; 3) does the person understand the risks and benefits of MAID (and of alternative care, including not proceeding with MAID)?; 4) does the person understand the risks and benefits of not proceeding with MAID?; 5) is the person’s capacity to understand affected by his or her illness? (PGQ-11: Collège des médecins du Québec et al., *L’aide médicale à mourir*. *Guide d’exercice et lignes directrices pharmacologiques* (Montreal: CMQ, November 2017 at 22). This is an application of the five criteria for assessing the capacity to consent to treatment set out in the Nova Scotia legislation (s. 52 of the *Hospital Act*, R.S.N.S. 1989, c. 208), also recommended by the Canadian Psychiatric Association. Those criteria are repeated in the Quebec case law (*Institut Philippe-Pinel de Montréal c. Blais*, [1991] R.J.Q. 1969 (S.C.)) in 1991. In 1994, the Court of Appeal confirmed this approach in *Institut Philippe-Pinel de Montréal c. G.(A.)*, [1994] R.J.Q. 2523 (C.A.), and in subsequent judgments (*X.Y. c. Hôpital général du Lakeshore*, 2017 QCCA 1465 at para. 5; *F.D. c. Centre universitaire de santé McGill (Hôpital Royal-Victoria)*, 2015 QCCA 1139; *C.L. c. Centre hospitalier de l'Université de Montréal*, 2014 QCCA 1371 at para. 11; *Centre hospitalier de l'Université de Montréal (CHUM) — Hôpital Notre-Dame c. G.C.*, 2010 QCCA 293 at para. 9; *M.B. c. Centre hospitalier Pierre-Le Gardeur*, [2004] R.J.Q. 792 at para. 39). On the issue of capacity assessment, see also Robert P. Kouri & Suzanne Philips-Nootens, *L'intégrité de la personne et le consentement aux soins*, 4th ed. (Montreal: Yvon Blais, 2017) at para. 219 *et seq.*

[270] Like an amputation or the withdrawal of vital treatment, for example.

[271] He is referring to physicians, nurses, social workers, pharmacists, physiotherapists, psychologists, nutritionists, etc.

[261] He declares himself absolutely able to assess the capacity of patients in such circumstances and comfortable doing so, without needing to call upon a psychiatrist's expertise, although he would not hesitate to do so if need be.

[262] Dr. Downar is very familiar with the process of medical assistance in dying, given that he has been involved in about fifty such cases since the enactment of the federal legislation. Like Dr. Naud, he described this process in detail from the initial request until its administration.

[263] All the assessments he performs are in accordance with strict practice standards accepted in Ontario.[272] The capacity assessment of a person who requests medical assistance in dying is carried out in a continuous manner by the medical staff involved with the patient and after a complete review of the medical record.[273] The assessment is rigorous and is the same whether or not the patient is at the end of his or her life.

[264] The fact that the law requires two separate medical capacity assessments is a standard that goes far beyond all those required for other types of decisions, even irreversible ones. Every patient is different and must be assessed on the basis of his or her specific characteristics, regardless of the nature of the illness or its stage.[274]

[265] While he acknowledges that the assessment of a patient's capacity is sometimes complex, he considers himself qualified and well trained to perform this task.

[266] Dr. Dembo has assessed several medical assistance in dying requests as the second assessing physician since the enactment of the federal statute.[275]

[267] Her report describes in detail the steps that are to be taken to assess the capacity of a person, including patients suffering from psychiatric conditions. In her practice, she applies the guidelines of the Canadian Psychiatric Association,[276] the College of Physicians and Surgeons of Ontario's policy on

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[272] He spoke of the Appelbaum criteria, which are similar to those set out in the Ontario legislation. Without citing it explicitly, he referred to the *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch. A, which provides in s. 4(1) that a person is capable with respect to a treatment if the person is able to understand the information that is relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision. Dr. Downar taught the course on capacity assessment offered by the Canadian Medical Association. Testimony of February 7, 2019, at 86 and 88.

[273] Testimony of Dr. Downar, February 7, 2019, at 89.

[274] Exhibit P-25: Expert report of Dr. Downar at para. 36.

[275] Dr. Dembo said she needs about two hours and sometimes more to assess a patient's capacity.

[276] Exhibit P-24: Expert report of Dr. Dembo at para 44: "… the main components of which the patient must be informed [are]: 1) The nature and purpose of the proposed treatment, the specific treatment modality and how it works and the reasons it is being proposed. 2) Likely benefits and risks of the proposed treatment; 3) The alternative treatments that exists. 4) Likely impact of the treatment on the patient's life; 5) Understanding of economic considerations related to the treatment. 6) The consequences of refusing the treatment."

medical assistance in dying[277] and the criteria developed by Appelbaum in 2007, which correspond to the accepted scientific literature and good medical practice.[278] She has also given conferences on patients' capacity assessment in the context of requests for medical assistance in dying. She specified that all persons, even those with psychiatric conditions, are presumed capable and that capacity must not be assessed in a global manner but, rather in light of the medical procedure sought and can also fluctuate over time.

[268] During her assessment, she performs a psychiatric evaluation if the patient has psychiatric symptoms or if there are indications to that effect. In other cases, if there are no signs that the patient is suffering from a psychiatric condition, she assesses his or her capacity, but nevertheless makes sure to verify, for example, that there are no undetected psychiatric illness or cognitive distortions.[279]

[269] The patients are informed that they have to remain capable until the end, that their capacity will be reassessed during the process until the final moment and that they can change their mind and withdraw their request at any time.

[270] Dr. Rivard's testimony was similar to Dr. Naud's with regard to the process followed to obtain medical assistance in dying, including the capacity assessment. He reviews the patient's complete medical record before meeting him or her. He talks with the patient, in particular, to determine whether he or she is on an end-of-life trajectory or not. In addition to performing a physical examination, he listens to the patients speak about the rationale of their decision and responds to their questions and concerns, if any.[280] These inform him about the patient's capacity.[281]

[271] Dr. Rivard states in no uncertain terms that he is comfortable assessing his patients' capacity without requiring the help of another expert.[282] He has had

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[277] Exhibit P-24: Expert report of Dr. Dembo at para. 47: "… the basic requirements for capacity are the ability to: 1. Understand the information relevant to making the decision, which includes: history, prognostic, treatment options, risks and benefits, risks and benefits of no treatment, understand that the consequence of MAID is death and irreversible. 2. Appreciate the reasonably foreseeable consequence of a decision or lack of a decision [which] means to appreciate how such a decision would apply to the self."

[278] Exhibit P-24: Expert report of Dr. Dembo at para. 48 and Table 1: "… I use, for the purposes of my capacity assessments, the guideline suggested by [Appelbaum] in his 2007 paper on the topic, in the New England Journal of Medicine, [which] was adapted from one developed earlier by Grisso & [Appelbaum] in 1998."

[279] She uses the expression "cognitive distortions."

[280] Exhibit PGC-66: Report of Dr. Rivard at paras. 30 and 33.

[281] *Ibid.* at para. 33: [TRANSLATION] "All patients are asking questions that inform us about their concerns but at the same time about their capacity to request MAID. The capacity to question themselves about how it is done, the personal preparation, the assessment of the second physician and the date on which MAID is desired are all elements that inform us about the patient's capacity to receive MAID."

[282] Testimony of Dr. Rivard, January 14, 2019, at 99, 167 and 168. He also added that in all the cases he has been involved in, there has never been disagreement between him and the second physician in regard to the patient's capacity.

to consult a psychiatrist in only two or three cases. He has refused several requests from patients he deemed to be incapable.[283]

[272] He specified that the determination of the capacity of a patient seeking medical assistance in dying is a medical responsibility. He clearly described the process he follows, which includes, *inter alia*, the guidelines provided by the Collège des médecins du Québec.[284] His approach is identical for all patients, regardless of their illness or condition.

[273] The Court finds that Canadian physicians are perfectly able to assess the capacity of patients who request medical assistance in dying and that there is currently no other medical procedure that is as strictly regulated in this regard, given that two formal assessments are required and the treatment team must ensure that the patient remains competent throughout the process and until the very end. Because physicians are able to assess an individual's decision-making ability, they can therefore determine whether they are dealing with a vulnerable person or not.[285]

2.3 Persons Who Are Vulnerable Due to Physical or Intellectual Disability

2.3.1 Professor Tom Shakespeare PhD[286]

[274] Professor Tom Shakespeare teaches and conducts research on disability[287] at Norwich Medical School at the University of East Anglia in the United Kingdom. He has been involved in many projects related to persons with disabilities and has published several books[288] on the subject. With the parties' agreement, the Court qualified him as an expert in research on disabilities with a specialization in the theoretical, sociological and bioethical aspects of disability.

[275] Professor Shakespeare is also a staunch defender of the rights of persons living with a disability and of the importance of promoting their autonomy and their inclusion in all spheres of society.[289] He testified at the request of the Attorney General of Canada.

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[283] *Ibid.* at 98–99.

[284] Exhibit PGQ-11: Collège des médecins du Québec et al., *L'aide médicale à mourir*. *Guide d'exercice et lignes directrices pharmacologiques* (Montreal: CMQ, November 2017) at 22. He also said that he follows the [TRANSLATION] "Nova Scotia criteria" (see note 278). PGC-66: Expert report of Dr. Rivard at para. 34.

[285] See in this regard the reasoning of the Supreme Court in *Carter* at para. 116.

[286] Exhibit PGC-68: Expert report of Professor Tom Shakespeare and up-to-date curriculum vitae.

[287] "Disability research in particular theoretical, sociological and bioethical aspects of disability."

[288] In particular Tom Shakespeare, *Disability Rights and Wrongs*, 2d ed. (London: Routledge, 2014) in which he addresses the theoretical, sociological and ethical aspects of disability, including the issue of assistance in dying. Exhibit PGC-68: Expert report of Professor Shakespeare at 40–107.

[289] Professor Shakespeare himself suffers from a congenital condition, that is, achondroplasia (a form of dwarfism). As a result of complications of this illness, for the past ten years, he has

[276] He stated that respect and exercise of autonomy remain fundamental for disabled people, allowing them to express their choices with respect to their dignity, assert their rights and make their voices heard.

[277] He explained that the concept of autonomy for persons with disabilities does not mean doing physically the same things as others but, rather exercising control over their lives. Although they might be dependant physically, autonomy comes from being socially independent nevertheless, particularly in the manner their choices are exercised.

[278] According to Professor Shakespeare, disabled persons experience a double disability: the disability that affects them physically and another that is social, being imposed on them by society, its organization and its attitude towards persons with disabilities. It is therefore essential, in his view, to have a societal model that affirms the inherent value of their lives, their equality and their contribution to society and that does not reinforce negative stereotypes in their regard.

[279] Professor Shakespeare submits that, paradoxically, although society assumes that disabled persons are unhappy and live a life of misery, this is just a perception and that reality is completely different. Persons with disabilities, especially those born with a disability, are often happy and believe they have a good quality of life.[290]

[280] As for persons who become handicapped over the course of their lives, he acknowledges that, at first, they experience a very difficult period during which they perceive their situation as being devoid of quality of life and hopeless. After some time, however, they become for the most part able to adapt and live a full life. "I am describing the state of the research. This is the disability paradox. The majority of people come to terms with disability over time, and end up with a possibility of leading a good life. There are issues that make life more difficult, pain and so forth, but people deal with those and find other meanings of life, and lead … a flourishing existence."[291] He estimates that the hopelessness these persons experience decreases after three months, although it remains high throughout the first year.[292]

[281] In his view, removing the requirement of reasonably foreseeable natural death would have negative consequences on persons living with disabilities.

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suffered from paralysis that requires him to use a wheelchair to move around. Testimony of Professor Shakespeare, February 1, 2019, at 14.

[290] Exhibit PGC-68: Expert report of Professor Tom Shakespeare at 108: Gary L. Albrecht & Patrick J. Devlieger, "The Disability Paradox: High Quality of Life against All Odds" (1999) 48 Social Science & Medicine 977, according to which 54% of persons living with a severe disability report having an excellent or good quality of life.

[291] Testimony of Professor Shakespeare, February 1, 2019, at 38. He referred to the "J Curve" to explain the phenomenon of persons with disabilities who experience great hopelessness and who then bounce back by successfully adapting to the situation after some time.

[292] Exhibit PGC-68: Expert report of Professor Shakespeare at para. 34 and his testimony at the hearing on February 1, 2019, at 84.

[282] First, it would inevitably lead to an increase in the number of persons likely to request such assistance. Professor Shakespeare believes that a majority of disabled persons meet the other eligibility criteria of the federal law simply due to their physical condition: they are disabled and have an incurable condition; they are certainly experiencing an irreversible decline in their capability; they are at an advanced stage and are suffering in a manner that sometimes cannot be relieved.

[283] Allowing medical assistance in dying outside of the temporal sphere of end of life would send the social message that disability is in itself a ground for requesting medical assistance in dying and, therefore that the life of a person with a disability is less valuable, further reinforcing the stigma against them.

[284] In particular, he stated that, in such a context, persons living with a disability risk not only being subject to social pressure, but also of receiving the implicit message that they would be better off dead, that their best option is to end their lives and that life with a disability is not worth living. Removing the reasonably foreseeable natural death requirement would thus increase the risk for disabled persons by making their death possible solely on the basis of their condition, when they could live a full and perhaps happy life for several more years.

[285] On the other hand, prohibiting persons whose death is not reasonably foreseeable from obtaining medical assistance in dying creates equal eligibility for medical assistance in dying for all, because in such a case this option is not available to persons living with a disability on the sole basis of their disability. According to Professor Shakespeare, the requirement should therefore remain in place for the well-being of disabled persons and for the recognition of the inherent value of their lives and quality of life.

[286] The Court accepts in part the testimony and evidence adduced by Professor Shakespeare. He presented his opinion in an eloquent and determined manner, while making important nuances when necessary. For example, he confirmed that his opinion does not necessarily represent that of the majority of disabled persons, who, generally speaking, are rather inclined to promote respect for decision-making autonomy under the principle of equality, even when the decision leads to death. In that regard, the plaintiffs are in fact perfect examples:

> Opinions on these issues are divided. While there may be a majority support for assisted dying, there is a vocal minority opposed, which means there is no settled consensus in society.[293]

[287] Finally, he also acknowledged that he is not aware of the empirical data regarding disabled persons who avail themselves of medical assistance in dying in Canada or elsewhere, for example, the studies submitted by Dr. van der Heide that found that in the Netherlands and in Oregon there is nothing indicating that persons with disabilities or persons suffering from chronic illnesses are more

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[293] Exhibit PGC-68: Expert report of Prof. Shakespeare at para. 28.

likely to request and receive medical assistance in dying than the rest of the population.[294]

2.3.2 Mr. Michael Bach

[288] Mr. Bach testified as a lay witness at the Attorney General of Canada's request. His eloquent and empathetic testimony was consistent with Professor Shakespeare's.

[289] Mr. Bach is the Managing Director of the Institutes for Research and Development on Inclusion and Society, whose mandate is to promote the inclusion in Canadian society of persons living with an intellectual disability, as well as their families, through research, policy development and training.

[290] Previously, for fifteen years he was the head of the Canadian Association for Community Living (CACL),[295] an intervenor in this case, whose mission consists of defending the rights of persons with intellectual disabilities, supporting their families and providing training to the principal actors in the community, including professors and employers, to properly meet their needs.

[291] The CACL was involved in the legislative process that led to Bill C-14 following the Supreme Court's decision in *Carter*. It was concerned by the government's legislative response, particularly due to the fact that disabled persons could be put at risk by the forthcoming regime. The CACL therefore made submissions before the various legislative committees to ensure that the reasonably foreseeable natural death requirement would be included in the federal provisions adopted by Parliament.[296]

[292] Two concerns in particular emerge from its work.[297] The first is that persons with disabilities are more likely to use medical assistance in dying as a means to end their lives because of their life situation.[298] The second and even more serious concern posits that the system could be designed in such a way that would facilitate their death by equating disability with a reason for requesting medical assistance in dying.

[293] According to Mr. Bach, on the one hand it is important to acknowledge under the fundamental principle of equality that persons living with intellectual

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[294] Exhibit P-26: Expert report of Dr. van der Heide at paras. 35 and 36.

[295] He held the positions of Executive Vice-President and President of the CACL.

[296] Exhibits PGC-10 at 71 and PGC-16 at 26: Canadian Association for Community Living, *Medical Assistance in Dying: A Private Request, a Public Act, Proposed Amendments to Bill C-14*, brief submitted to the House of Commons Standing Committee on Justice and Human Rights and to the Senate Standing Committee on Legal and Constitutional Affairs (May 2016).

[297] Exhibit PGC-55: The Canadian Association for Community Living and People First of Canada, *Protecting Choice & Safeguarding Inclusion*. *A Proposal to Regulate Physician-Assisted Suicide and Voluntary Euthanasia in Canada* (September 2015).

[298] Such as the fact that they suffer from a mental health condition, that they often live in a state of poverty or financial precariousness, that only 25-30% of them are employed, that they have a 3 to 4 times greater risk of being victims of violence than the rest of the population. See the testimony of Mr. Bach, February 5, 2019, at 104–105.

disabilities, like all other Canadians, want access to medical assistance in dying, and that their disability should not in itself be an obstacle to accessing a public service available to other citizens.[299] On the other hand, the inherent right to life of persons with disabilities must be supported and defended by establishing safeguards and interpreting them strictly. The system put in place must not promote their death but, on the contrary, protect them against discrimination and negative perceptions and promote their value and the respect owed to them by society.[300]

[294] The essence of these concerns was the subject of a presentation, first in February 2016 before the Special Joint Committee of the Senate and the House of Commons on Physician-Assisted Dying.[301] Mr. Bach explained that, at the time, his association was concerned by the trend it saw emerging in Canadian society against restricting medical assistance in dying to persons at the end of life.[302]

[295] Then, in April 2016, immediately after Bill C-14 was introduced, the CACL submitted a report intended for members of Parliament[303], and shortly thereafter, a document proposing amendments to Bill C-14 as introduced.[304] Among the many messages conveyed by the CACL on behalf of its members, one of the most important aimed at preserving the balance between the right to autonomy and ensuring that the legislation does not undermine vulnerable persons' protection by keeping the reasonably foreseeable natural death requirement in order to request and obtain medical assistance in dying.

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[299] *Ibid*. at 114.

[300] "Fair access must be enabled, while guarding against well-known risks of inducement under such systems." Exhibit PGC-16 at 27: Canadian Association for Community Living, *Medical Assistance in Dying: A Private Request, a Public Act, Proposed Amendments to Bill C-14*, brief submitted to the Senate Standing Committee on Legal and Constitutional Affairs (May 2016).

[301] See the section on the legislative history of Bill C-14. See exhibits PGC-4 at 100: The Canadian Association for Community Living, *Fair Access while Protecting Vulnerable Persons*: Recommendations to the Special Joint Parliamentary Committee on Physician-Assisted Dying (February 1, 2016) and PGC-5: Canada, Special Joint Committee on Physician-Assisted Dying, *Evidence*, 42-1, No. 12 (4 February 2016) at 16–17 (Mr. Bach).

[302] The CACL therefore set up a working group of several eminent professionals to develop standards for the protection of vulnerable persons, counterbalance the emerging trend and present another voice to the decision-makers, in particular with respect to the issue of the end of life.

[303] Exhibit PGC-56: The Canadian Association for Community Living, *Protect Vulnerable Persons in Bill C-14 Medical Assistance in Dying*. *A call to members of Parliament and Senators* (April 2016). The document highlights the thresholds of protection for persons with disabilities that they claim were not respected in Bill C-14, and the safeguards that should be modified or added to the legislation.

[304] Exhibit PGC-10 at 71: Canadian Association for Community Living, *Medical Assistance in Dying: A* Private Request*, a* Public Act*, Proposed Amendments to Bill C-14*, brief submitted to the House of Commons Standing Committee on Justice and Human Rights (May 2016). See also Exhibit PGC-11: Canada, House of Commons, Standing Committee on Justice and Human Rights, *Evidence*, 42-1, (3 May 2016) at 29–31 (Mr. Bach).

[296] Finally, the CACL also presented its position before the Senate Committee in May 2016.[305] As Mr. Bach noted*: "*Basically, our message was that Bill C-14 got the balance good enough. It was a good enough balance between autonomy and ensuring that the legislation did not undermine the protections and the rights of persons who could be vulnerable in the system. And it did that by having the end of life condition within it. That's how it got the balance right, and that was the message CACL (ACIC) wanted to communicate."[306]

[297] To summarize, the interventions of the CACL were focused on seeking the same access to medical assistance in dying for persons with intellectual disabilities[307] as other citizens have, while ensuring that the system put in place includes strict safeguards that value these persons' lives, rather than sending the message that living with a disability is, in itself, a reason to die and that this reason is accepted by society.

2.3.3 Ms. Krista Wilcox[308]

[298] The Attorney General of Canada filed a detailed affidavit prepared by Ms. Wilcox, Director General of Employment and Social Development Canada (ESDC).

[299] ESDC seeks to support and coordinate, within the government, between different governments, internationally and in the private and non-governmental sectors, the social and economic advancement of persons with disabilities. In particular, it develops and administers programs intended to break down barriers and foster inclusion, elaborates policies based on current data to respond to the challenges that arise and raises awareness within the government on issues related to disability.[309]

[300] In 2018, the Canadian government published the results of a survey on persons living with a disability[310] in the country on the basis of data gathered in

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[305] Exhibit PGC-16 at 27: Canadian Association for Community Living, *Medical Assistance in Dying: A* Private Request*, a* Public Act*, Proposed Amendments to Bill C-14*, brief submitted to the Senate Standing Committee on Legal and Constitutional Affairs (May 2016); Exhibit PGC-17: Canada, Proceedings of the Standing Senate Committee on Legal and Constitutional Affairs, 42-1, No. 9. (17 May 2016) at 9:58 (Mr. Bach).

[306] Testimony of Mr. Bach, February 5, 2019, at 137. See also Exhibits PGC-57: Canadian Association for Community Living/Association canadienne pour l'intégration communautaire, Press release "'Don't Let Vulnerable Canadians Down.' National Disability Community Urges Parliamentarians to Vote for Bill C-14" (24 May 2016); PGC-58: Various organizations, Press release, "A Call to Parliamentarians from the National Disability Rights Community 'To Pass Bill C-14 to Ensure Constitutional Rights of Vulnerable Persons'" (31 May 2016) and PGC-61: Video recording, "National Disability Rights Community Forum for Robust Safeguards in Bill C-14" (16 June 2016).

[307] Or other type of disability.

[308] Exhibit PGC-75: Affidavit of Ms. Krista Wilcox.

[309] ESDC also helps implement the recommendations of the United Nations *Convention on the Rights of Persons with Disabilities* throughout the country. Exhibit PGC-75: Affidavit of Ms. Wilcox at paras. 3–5.

[310] The French version uses the word "*incapacité*" in the sense of disability.

2017.[311] Ms. Wilcox's affidavit sets out the main findings of that survey. In particular, the Court notes that:

1. 22% of Canadians have at least one disability, which represents 6.2 million people. Of this number, 1.4 million have a very severe disability;
2. Of the 6.2 million persons with disabilities in the country, 13% are between 15 and 24 years old, and 38% are over 65 years old. Among the youth with at least one disability, 60% have a mental–health-related disability;
3. 1.6 million of these Canadians cannot afford the required aid, device or prescription medicine;
4. The higher the severity of the disability, the more the chance of being employed decreases. 76% of Canadians with mild disability are employed, whereas that percentage falls to 31% for those with severe disability;
5. Persons suffering from severe disabilities have a higher risk of living in poverty compared to other Canadians.[312]

[301] She noted that, in 2010, Canada ratified the United Nations *Convention on the Rights of Persons with Disabilities*, which recognizes the need to promote and protect the human rights of persons with disabilities.[313] Canada submitted its first report in February 2014, setting out several government policies and programs implemented in the country to ensure the inclusion of persons with disabilities and their full participation in Canadian society.[314]

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[311] Exhibits PGC-50A: Statistics Canada, *Canadian Survey on Disability. A demographic, employment and income profile of Canadians with disabilities aged 15 years and over, 2017*, by Stuart Morris et al. (Ottawa: Statistics Canada, 28 November 2018); PGC-50C: Canadian Survey on Disability*, 2017: Concepts and Methods Guide,* by Elisabeth Cloutier, Chantal Grondin & Amélie Lévesque (Ottawa: Statistics Canada, November 28, 2018) and PGC-50D: Statistics Canada, *Canadian Survey on Disability. The evolution of disability data in Canada: Keeping in step with a more inclusive Canada*, by Adele Furrie (Ottawa: Statistics Canada, 28 November 2018).

[312] Exhibits PGC-50B: Statistics Canada, *New Data on Disability in Canada, 2017* and PGC-75: Affidavit of Ms. Wilcox at paras. 14–16.

[313] Exhibit PGC-47: *Convention on the Rights of Persons with Disabilities*, 13 December 2006, 2515 U.N.T.S. 3 (entered into force in Canada 10 April 2010).

[314] Exhibit PGC-48: United Nations Committee on the Rights of Persons with Disabilities, Consideration of reports submitted by States parties under article 35 of the Convention, Initial reports of States parties due in 2012: Canada (February 11, 2014) CRPD/C/CAN/1. For a better idea of the measures implemented in the country, see paras. 45–52, 68–69 and 75–89; See also Exhibit PGC-75: Affidavit of Ms. Wilcox at para 20. Canada also submitted a second report in response to questions from the Committee on the Rights of Persons with Disabilities. Exhibit PGC-48A: United Nations Committee on the Rights of Persons with Disabilities, Consideration of reports submitted by States parties under article 35 of the Convention, List of issues in relation to Canada's initial report. Addendum. Canada's reply to the UN List of Issues (March 3, 2017) CRPD/C/CAN/Q/1/Add.1.

[302] In its final remarks concerning that report, the United Nations Committee on the Rights of Persons with Disabilities issued three recommendations in connection with the federal law authorizing medical assistance in dying:

> (a) Ensure persons who seek an assisted death have access to alternative courses of action and to a dignified life made possible with appropriate palliative care, disability support, home care and other social measures that support human flourishing;
>
> (b) Establish regulations pursuant to the law requiring collection and reporting of detailed information about each request and intervention for medical assistance in dying;
>
> (c) Develop a national data standard and an effective and independent mechanism to ensure that compliance with the law and regulations is strictly enforced and that no person with disability is subjected to external pressure.[315]

[303] The data submitted by Ms. Wilcox thus presents a demographical and statistical portrait of the situation of persons living with a disability or handicap in Canada and illustrates the government's desire to protect their rights and foster their inclusion as full-fledged citizens in society.

Analysis: Disabled and intellectually deficient persons

[304] The Court fully understands the warnings made by Professor Shakespeare and Mr. Bach regarding the potential danger related to the social normalization of medical assistance in dying and the possible societal perception of the inherent value of persons with physical or intellectual disabilities if the reasonably foreseeable natural death requirement is removed.

[305] However, the Court cannot disregard the fact that, like any other capable and well-informed person, disabled persons may have a rational and legitimate desire to end their lives because of their condition, but also, and especially, because of the enduring and intolerable suffering they are experiencing. While their physical or mental condition might possibly, in some cases, correspond to the legislative requirement of a grievous and irremediable medical condition, the person must also meet the other statutory requirements.

[306] The physical or mental condition of disabled persons is but one element among others that might render them admissible for medical assistance in dying. Their capacity to consent, the suffering they experience and that is objectivized, and the advanced decline of their capability are all relevant elements in the global assessment of the request. While caution is required, it is far from obvious that a person could or would want to receive medical assistance in dying solely because of his or her disability.

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[315] Exhibit PGC-49: United Nations Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Canada (May 8, 2017) CRPD/C/CAN/CO/1 at para. 24.

[307] Mr. Truchon's case is, in fact, a perfect example. His physical condition is but one of the elements that would justify granting his request. His ability to understand the process, to explain his underlying reasons and to consent were also assessed, as were the advanced and irreversible decline of his capability and his great suffering, which cannot be alleviated despite the efforts expended.

[308] Therefore, it is clear in this context that, for Professor Shakespeare and Mr. Bach, the reasonably foreseeable death requirement seeks to protect persons with disabilities from themselves and from social bias.

[309] In the Court's view, however, we cannot, in the name of the principle of protecting certain persons from themselves or of socially affirming the inherent value of life, deny medical assistance in dying to an entire community of persons with disabilities precisely because of their disability. That is what the legislator is doing indirectly by providing wide-ranging protection of certain groups instead of implementing strict structural conditions to ensure that such persons are well protected, should it deem it appropriate. Again, collective vulnerability cannot be conceptually used as a basis to refuse medical assistance in dying.

[310] Mr. Truchon and Ms. Gladu, who belong to this category of persons, want to be given the choice to decide for themselves. The Court agrees with this. To do otherwise could lead to discrimination against persons with disabilities on the sole basis of their disability. These people are full citizens and consequently have the same rights as all other citizens, especially those that involve making decisions of utmost importance to their bodily integrity and dignity as human beings. Respect for their individual freedom that is expressed thoughtfully, freely and clearly also contributes to the affirmation of the inherent value of their lives.

2.4 Persons Who Are Vulnerable to Suicide and the Phenomenon of Suicide Contagion

[311] According to the evidence, suicide is one of the main public health emergencies of the 21st century.[316] The federal government is going to considerable lengths to address this scourge, notably through a national framework for suicide prevention setting out strategic objectives, guiding principles and commitments on this issue.[317] As a result of these efforts, the

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[316] Exhibits PGC-70: Expert report of Dr. Mark Sinyor and up-to-date curriculum vitae at para. 18 and testimony of Dr. Sinyor, January 30, 2019, at 32–33; PGC-77: Affidavit of Ms. Robin Skinner at para. 23.

[317] Exhibits PGC-76: Affidavit of Ms. Isabel Giardino at para. 6; PGC-77: Affidavit of Ms. Skinner at para. 8–11. See also PGC-33: *Federal Framework for Suicide Prevention Act*, S.C. 2012, c. 30; PGC-34: Government of Canada, *The Federal Framework for Suicide Prevention* (Ottawa: 2016); PGC-35: Government of Canada, *Overview of federal initiatives in suicide prevention* (Ottawa: February 2016); PGC-36: Government of Canada, *The 2016 Progress Report on the Federal Framework for Suicide Prevention* (Ottawa: December 2016).

suicide rate in the country is today relatively stable and has even been decreasing slowly since 2000.[318]

[312] Approximately 4,000 people decide to take their own lives every year in Canada, and suicide is the second-leading cause of death among Canadians aged 15 to 34.[319] Among the principal risk factors are problems related to a physical condition,[320] such as a serious illness[321] or chronic pain, and symptoms or a diagnosis of a mental disorder.[322]

[313] In view of the foregoing, it is not surprising that certain groups appear to be more at risk overall of committing or attempting suicide. The evidence addresses the particular features of the groups among whom the prevalence of suicide remains above average in the general population. They consist of persons with disabilities, persons who are sick or in poor physical condition, persons suffering from a mental illness, the elderly, veterans, members of the military and members of Indigenous communities.[323]

[314] From all of the evidence, the Court notes and acknowledges the importance for our society to take every possible and necessary action to fight against this scourge through both the implementation of preventive measures and the contribution of social, medical and community resources.

[315] The experts and witnesses heard at trial or who filed affidavits on this issue all work tirelessly with the general population and various groups to counter this phenomenon, and their work certainly deserves to be recognized and applauded.

[316] The Court will first provide a brief portrait of the specific features of the various reports, testimony and affidavits that make up the crux of the Attorney General of Canada's evidence and of the responses from the plaintiffs' experts.

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[318] Exhibits PGC-77: Affidavit of Ms. Skinner at para. 18; PGC-40: Robin Skinner et al., "Suicide in Canada: Is Poisoning Misclassification an Issue?" (2016) 61 The Canadian Journal of Psychiatry 405.

[319] Suicide is the third leading cause of death among 35–44 year olds, the fourth among 45–54 year olds and the eighth among 55–64 year olds. Exhibit PGC-77: Affidavit of Ms. Skinner at para. 23; Exhibit PGC-41: Robin Skinner et al., "Suicide and self-inflicted injury hospitalizations in Canada (1979 to 2014/15)" (2016) 36 Health Promotion and Chronic Disease Prevention in Canada 243. See also PGC-70: Expert report of Dr. Sinyor at para. 18; PGC-77: Affidavit of Ms. Skinner at para. 14 *et seq.*; PGC- 76: Affidavit of Isabel Giardino at paras. 21 and 23.

[320] Exhibit PGC-69: Expert report of Dr. Jitender Sareen, Professor and Head of the Department of Psychiatry, and up-to-date curriculum vitae at 14–18 and 19–22.

[321] Such as cancer, diabetes, respiratory illness or cardiovascular disease. Exhibits PGC-77: Affidavit of Robin Skinner at para. 15 and PGC-39: Robin Skinner et al., "At-a-glance. A contextual analysis of the Suicide Surveillance Indicators" (2017) 37 Health Promotion and Chronic Disease Prevention in Canada 257.

[322] Such as mood disorders, anxiety disorders, schizophrenia, psychosis, post-traumatic stress or even eating disorders. Exhibits PGC-77: Affidavit of Ms. Skinner at para. 16 and PGC-39: Robin Skinner et al., "At-a-glance. A contextual analysis of the Suicide Surveillance Indicators" (2017) 37 Health Promotion and Chronic Disease Prevention in Canada 257.

[323] See in particular Exhibit PGC-76: Affidavit of Ms. Giardino at paras. 21–22. Paradoxically, however, middle-aged men are also identified as an at-risk group.

The Court will then review the documentary evidence and the evidence of the situation prevailing in foreign jurisdictions, before highlighting the key points for the purpose of its analysis.

Evidence of the Attorney General of Canada

[317] The Attorney General of Canada filed abundant evidence on the phenomenon of suicide and suicide contagion in connection with medical assistance in dying.[324] Eminent experts and witnesses directly involved in suicide prevention provided a complete portrait of the critical battle against suicide and the efforts made to prevent it, including the phenomenon of suicide contagion.

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[324] See note 256 and the exhibits in support of the testimony **(a)** of Dr. Sareen (PGC-69.1: J.M. Bolton et al., “Risk of suicide and suicide attempts associated with physical disorder: a population-based, balancing score-matched analysis” (2015) 45 Psychological Medicine 495; PGC-69.2: American Psychiatric Association, *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors* (2010); PGC-69.3: Jitender Sareen et al., “Trends in suicidal behaviour and use of mental health services in Canadian military and civilian population” (2016) 188 CMAJ 261; PGC-69.4: Veterans Affairs Canada, *2017 Veteran Suicide Mortality Study*: *1976 to 2012* (Charlottetown: November 2017); PGC-69.5 and PGC-45 (identical exhibits): James M. Thompson et al., “Roles of physical and mental health in suicidal ideation in Canadian Armed Force veterans” (2014) 105 Can J Public Health 109; PGC-69.6: Elizabeth G. Vandenkerhof et al., “Pain in Canadian Veterans: Analysis of data from the Survey on Transition to Civilian Life” (2015) 20 Pain Res Manag 89; PGC-69.7: Gregory E. Ratcliffe, “Chronic Pain Conditions and Suicidal Ideation and Suicide Attempts: An Epidemiologic Perspective” (2008) 24 Clin. J. Pain 204; PGC-69.8: Richard T. Oster et al., “Recent epidemiologic trends of diabetes mellitus among status Aboriginal adults” (2011) (183) CMAJ 803), **(b)** of Dr. Conwell (PGC-65.1: Annette Erlangsen, Elsebeth Stenager & Yeates Conwell, “Physical diseases as predictors of suicide in older adults: a nationwide register-based cohort study” (2015) 50 Social Psychiatry and Psychiatric Epidemiology 1427; PGC-65.2: David N. Juurlink et al., “Medical Illness and the Risk of Suicide in the Elderly” (2004) 164 Arch. Intern Med. 1179; PGC-65.3: Yeates Conwell et al., “Health status and suicide in the second half of life” (2010) 25 Int. J. Geriatr. Psychiatry 371; PGC-65.4: Yeates Conwell et al., “Age Differences in Behaviors Leading to Completed Suicide” (1998) 6 Am. J. Geriatr. Psychiatry 122; PGC-65.5: P.R. Duberstein et al., “Suicide at 50 years of age and older: perceived physical illness, family discord and financial strain” (2004) 34 Psychological Medicine 137 and P.R. Duberstein et al., Poor social integration and suicide: fact or artifact? A case-control study” (2004) 34 Psychological Medicine 1331), and **(c)** of Dr. Sinyor (PGC-70.1: David Albert Jones & David Paton, “How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?” (2015) 108 Southern Medical Journal 599; PGC-70.2: Matthew P. Lowe & Jocelyn Downie, “Does Legalization of Medical Assistance in Dying Affect Rates of Non-assisted Suicide?” (2017) 10 Journal of Ethics in Mental Health 1; PGC-70.3: Marianne C. Snijdewind et al., “Developments in the practice of physician-assisted dying: perceptions of physicians who had experience with complex cases” (2018) 44 J. Med. Ethics 292; PGC-70.4: Damiaan Denys, “Is Euthanasia Psychiatric Treatment? The Struggle with Death on Request in the Netherlands” (2018) 175 Am. J. Psychiatry 822; PGC-70.5: Nicole Steck et al., “Time-trends in assisted and unassisted suicides completed with different methods: Swiss National Cohort” (2015) 145 Swiss Medical Weekly 14153).

2.4.1 Dr. Jitender Sareen: Professor and Head of the Department of Psychiatry at the University of Manitoba[325]

[318] Dr. Sareen specializes in suicide prevention with members of the military, veterans, persons suffering from post-traumatic syndromes, First Nations communities in Manitoba and the homeless population.[326]

[319] His report sets out the negative impact that the withdrawal of the reasonably foreseeable natural death requirement would certainly have in his view on persons suffering from a physical illness or health condition[327] and in particular, the risks incurred by members of the military, veterans[328] and members of Indigenous communities,[329] who are more likely than the rest of the population to exhibit suicidal behaviour.

[320] In his view, without the requirement in question, many members of these groups who would otherwise engage in suicidal behaviour would become eligible for medical assistance in dying and could avail themselves of it to end their lives. As such, the state "would be actively facilitating it as a societal objective".[330]

[321] He considers it very difficult to distinguish suicide from medical assistance in dying, because he is of the opinion that medical assistance in dying is in itself a way to kill oneself.

[322] Moreover, in these circumstances, medical assistance in dying would undermine the suicide prevention efforts being made in this country. "Without the element of foreseeable death, the commitment to suicide prevention would necessarily be diminished, and rather than seeking to prevent suicide, Canada would be actively facilitating it as a societal objective. As well, such a change could, in my opinion, be expected to lead to more premature deaths – whether by

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[325] PGC-69: Expert report of Dr. Jitender Sareen and up-to-date curriculum vitae. He is also the Medical Director of the Mental Health Program for the Winnipeg Regional Health Authority, and he co-chairs an expert panel on suicide prevention in the Canadian Armed Forces. Dr. Sareen testified at the hearing.

[326] *Ibid*. at para. 6–8.

[327] Testimony of Dr. Sareen, January 31, 2019, at 29 to 34; Exhibit PGC-69.1: J.M. Bolton et al., "Risk of suicide and suicide attempts associated with physical disorder: a population-based, balancing score-matched analysis" (2015) 45 Psychological Medicine 495. In his report, Dr. Sareen also addressed the risk of suicide in connection with mental conditions and psychosocial stress factors. Exhibit PGC-69: Expert report of Dr. Sareen at para. 37. Testimony of Dr. Sareen, January 31, 2019, at 40 *et seq.* See also Exhibit PGC-69.3: Jitender Sareen et al., "Trends in suicidal behaviour and use of mental health services in Canadian military and civilian population" (2016) 188 CMAJ 261.

[328] See in particular Exhibits PGC-69.6: Elizabeth G. Vandenkerkhof et al., "Pain in Canadian Veterans: Analysis of data from the Survey on Transition to Civilian Life" (2015) 20 Pain Res Manag 89; PGC-45: James M. Thompson et al., "Roles of physical and mental health in suicidal ideation in Canadian Armed Force veterans" (2014) 105 Can J Public Health 109; Testimony of Dr. Sareen, January 31, 2019, at 48 *et seq.*

[329] Testimony of Dr. Sareen, January 31, 2019, at 52 *et seq.*; Exhibit PGC-69.8: Richard T. Oster et al., "Recent epidemiologic trends of diabetes mellitus among status Aboriginal adults" (2011) (183) CMAJ 803.

[330] Testimony of Dr. Sareen, January 31, 2019, at 28.

MAID or by suicide – than would be the case if the law remained in its current state."[331]

2.4.2 Dr. Yeates Conwell: Professor at University of Rochester, NY, in geriatric psychiatry and researcher and clinician in suicide prevention in older adults [332]

[323] Dr. Conwell clearly identified the factors associated with suicide in older adults, which often co-exist with a lack of access to adequate medical resources and services to treat these symptoms in this segment of the population.[333] In general, elderly people who wish to end their lives are ambivalent when faced with the choice, and many would choose a different solution if they were to receive the appropriate care.[334]

[324] Unlike the situation in other demographic groups, suicide among the elderly is rarely the result of an impulsive act; rather, it is thought out and planned, while using less violent methods.[335]

[325] If he were to receive a request for medical assistance in dying, he would address the situation and treat the patient as an individual at suicidal risk. In his view, the characteristics of a suicidal person and of someone who requests medical assistance in dying do not so much overlap as belong to one and the same category of persons at risk for taking their lives.[336]

[326] Dr. Conwell believes that without the reasonably foreseeable natural death requirement, which serves as an essential safeguard, many elderly people would die by opting for medical assistance in dying, having failed to find alternative solutions.[337] In addition, the social bias that victimizes the elderly would increase because the state would be sending them the message that killing themselves by obtaining medical assistance in dying was a good solution for them.

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[331] Exhibit PGC-69: Expert report of Dr. Sareen at para. 18. See also para. 15.

[332] Exhibit PGC-65: Expert report of Dr. Yeates Conwell and up-to-date curriculum vitae. Dr. Conwell has been practising for over 30 years. His numerous qualifications and the positions he has held or that he holds are set out in his curriculum vitae and at paras. 7–9 of his report. He practises his profession in the state of New York, however, where euthanasia in any form whatsoever is prohibited.

[333] *Ibid*. at para. 14–23: The suicide risk factors (grouped into six general domains) were described as the following: the demographic factor (gender, marital status, etc.), depression, physical illness, disability, social isolation and access to lethal means. These factors may fluctuate over time and are interdependent. He also stated that the baby-boomers cohort, born between 1946 and 1965, is vulnerable to suicide as they move into older adulthood. Testimony of Dr. Conwell, January 29, 2019, at 110–112 *et seq.*

[334] Exhibit PGC-65: Expert report of Dr. Conwell at paras. 27–29 and Testimony of Dr. Conwell, January 29, 2019.

[335] Exhibit PGC-65.4: Yeates Conwell et al., "Age Differences in Behaviors Leading to Completed Suicide" (1998) 6 Am. J. Geriatr. Psychiatry 122.

[336] Testimony of Dr. Conwell, January 29, 2019, at 157 to 159.

[337] Exhibit PGC-65: Expert report of Dr. Conwell at para. 32, 33–35 and 37. See also at 16: He is also of the view that authorizing medical assistance in dying only at the end of life reduces the number of errors and has less serious consequences because death is near in any event.

[327] He added: “Given that the risks for suicide overlap greatly with those that predispose a person to seek MAID, then the inclusion of the reasonable foreseeability criterion is the best means by which to minimize the likelihood that people will die unnecessarily with medical assistance. By removing the reasonable foreseeability criterion, Canada would greatly expand the time at which people in their most vulnerable state have access to assisted death, increasing the number of people who die unnecessarily when alternatives could, and in many cases would have been found. The foreseeability criterion serves to protect them.”[338]

2.4.3 Dr. Mark Sinyor: psychiatrist and researcher in suicide prevention, suicide contagion and suicide messaging[339]

[328] With supporting data, Dr. Sinyor described the scourge that suicide represents for all classes and all age groups in Canadian society and the importance of continuing to invest in the resources needed to prevent it.[340]

[329] Dr. Sinyor is a specialist in the well-known phenomenon of suicide contagion, whereby a vulnerable person identifies with another person who committed suicide and decides to emulate by acting on his or her suicidal thoughts.[341] Scientific studies show that the combined factors of knowledge of a suicide, either through media coverage of the event or in some other way[342], and identification with the person who committed suicide can lead vulnerable individuals to do the same.[343]

[330] In his view, there is no distinction between medical assistance in dying and suicide, except where death is reasonably foreseeable. Outside of this specific context, medical assistance in dying clearly constitutes suicide.[344] He

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[338] *Ibid.* at para. 40.

[339] Exhibit PGC-70: Expert report of Dr. Mark Sinyor, psychiatrist, and up-to-date curriculum vitae.

[340] *Ibid.* See para. 3: He reports that mental illness is an important contributor in the vast majority of suicide deaths.

[341] We must go back to 1774 when the book *The Sorrows of Young Werther* by Johann Wolfgang von Goethe was published to see the first appearance of the phenomenon of suicide contagion, still sometimes referred to today as “the Werther effect” or “*l’effet Werther*”.

[342] Media coverage and publicity of the event can occur in various ways: in the traditional media, on social media, by people in the person’s circle of family and friends, etc. It is not necessary for the reports to be sensational for the contagion to exist. Testimony of Dr. Sinyor, January 20, 2019, at 146–147. Moreover, to counter this phenomenon, policies have been adopted in Canada and elsewhere in the world on the way in which the media should report on suicides.

[343] For example, Dr. Sinyor stated that the suicide of American actor Robin Williams alone resulted in 1,800 other suicides. The phenomenon can also occur as a result of the suicide of persons who are not famous. For example, the suicide of a student of a school is likely to have repercussions on students at that school and even on other students who simply become aware of the event. Testimony of Dr. Sinyor, January 30, 2019, at 36–38; Exhibit PGC-70: Expert report of Dr. Sinyor at para. 24 *et seq.*

[344] Testimony of Dr. Sinyor, January 30, 2019, at 67: “[A]ny situation where you take your life on purpose is suicide according to a very strict definition.”; at 68: “If you remove the reasonable foreseeable death criterion and you allow people at all stages of life or any stage of life potentially to access MAID, my opinion is that it really is indistinguishable from suicide.”

can see a difference, however, when death is reasonably foreseeable, because the choice is not whether or not to live, but solely about when and how the death will occur.[345]

[331] To date, no study on the impact of medical assistance in dying on suicide contagion has been conducted in Canada or elsewhere in the world.[346] There is, therefore, no probative data in this regard.[347]

[332] Just like anything else, however, medical assistance in dying entails a risk of contagion. More widespread awareness of the practice *"*could potentially result in unassisted suicide*",* although, at this stage, this is only a potential harm and a hypothesis.[348]

[333] Dr. Sinyor stated that it seems possible to infer from some literature[349] that, in the countries that have legalized a form of euthanasia, the suicide rate remains stable or even shows a potential for increase.[350] Finally, he alleged that the removal of the reasonably foreseeable natural death requirement would send a normalization message from the government that suicide is an acceptable way

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[345] Exhibit PGC-70: Expert report of Dr. Sinyor at para. 21: "Death will happen regardless of their decisions. One could argue that physician-assisted death in this context should not be considered suicide as the patient is not truly choosing whether to live or die, only exercising a degree of control over a process that is already happening. The same is not true if a person's death is not foreseeable."

[346] Testimony of Dr. Sinyor, January 30, 2019, at 187 and 188: "So, at the time of the search, and actually, it remains today, I've still yet to be able to find, I haven't found a study in which the focus of the study was to determine whether contagion had occurred. Q: Just to be clear, there is no study. A. No, not to my knowledge." The other expert, Dr. Conwell, during his cross-examination on January 29, 2019, at 187, said that he has never witnessed suicide contagion in connection with medical assistance in dying.

[347] In fact, there is only one study in the world that indirectly considered the increase in suicide deaths following media coverage of a very famous case of euthanasia in Switzerland. Exhibit PGC-70: Expert report of Dr. Sinyor at para. 45, citing A. Frei et al. "The Werther effect and assisted suicide", (2003) 33 Suicide Life-Threatening Behavior 192. Dr. Sinyor did not hesitate to characterize it as insignificant, however: "It was too small. The numbers were too low to do statistical analysis, but at least there was some suggestion that there could have been some contagion effect." Testimony of Dr. Sinyor, January 30, 2019, at 70–71. Dr. Sinyor also participated in a study on the correlation between suicide cases reported in 13 publications available in Toronto and subsequent suicide cases between 2011 and 2014: Mark Sinyor et al., "The association between suicide deaths and putatively harmful and protective factors in media reports" (2018) 190 CMAJ 900. However, this study considered suicide contagion only prior to the legalization of medical assistance in dying in Canada. Testimony of Dr. Sinyor, January 30, 2019, at 76.

[348] Testimony of Dr. Sinyor, January 30, 2019, at 75.

[349] Exhibit PGC-70.1: David Albert Jones & David Paton, "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" (2015) 108 Southern Medical Journal 599; PGC-70.2: Matthew P. Lowe & Jocelyn Downie, "Does Legalization of Medical Assistance in Dying Affect Rates of Non-assisted Suicide?" (2017) 10 Journal of Ethics in Mental Health 1; Testimony of Dr. Sinyor, January 30, 2019, at 105–106: "[B]oth in my study in Canada and the Jones and Paton study in the United States, did not find that there was any associated reduction in suicides and showed a signal of potential increase and there is absolutely no literature available studying the relationship between the introduction of MAID without a reasonable foreseeable death criterion on non-assisted suicide."

[350] Testimony of Dr. Sinyor, January 30, 2019, at 92 *et seq.*

of coping with a difficult life and would undermine suicide-prevention efforts that have been made.[351] "MAID is already legal in Canada as a mean of alleviating suffering associated with end of life. Expansion of the use of MAID to include people whose deaths are not reasonably foreseeable has the potential to increase suicide contagion. That is because most people who have suicidal thoughts are experiencing suffering not at the end of life and are apt to identify with those seeking death to remedy that circumstance. Legal and governmental support for the notion that suicide is a potentially effective way of coping with suffering not at the end of life is at odds with modern efforts at suicide messaging and prevention. It undermines the narrative that people contemplating suicide must work to find other solutions and should seek help."[352]

2.4.4 Dr. Alexandra Heber, psychiatrist

[334] Dr. Heber testified in her capacity as Chief of Psychiatry of Veterans Affairs Canada, a position she has held since 2016. She described her previous experience as a psychiatrist for the Canadian Armed Forces, during which time she took part in ten post-suicide inquiries conducted among members of the military and their families.[353]

[335] In collaboration with international experts, she contributed to the preparation of a joint suicide prevention strategy aimed at identifying suicide risk factors among veterans and prevention strategies.[354]

[336] Veterans are more likely to act on suicidal thoughts than the rest of the population, due in particular to the physical and mental health problems from which they suffer and that constitute known suicide risk factors.[355] According to Dr. Heber, it is therefore essential that suicide prevention remain a priority among this population.[356]

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[351] Exhibit PGC-70: Expert report of Dr. Sinyor at 41 *et seq.*

[352] *Ibid.* at para. 5.

[353] Testimony of Dr. Alexandra Heber, February 6, 2019, at 9–12.

[354] Exhibit PGC-43: Government of Canada, *Canadian Armed Forces and Veterans Affairs Canada Joint Suicide Prevention Strategy* (Ottawa: 2017). Among the risk factors are mood and other psychiatric disorders, stressful life events, access to lethal means and imitation. In both serving members and veterans of the Canadian Armed Forces there is a strong degree of identification with each other. Testimony of Dr. Heber, February 6, 2019, at 34. See also Exhibits PGC-62: Veterans Affairs Canada, *Suicide Prevention at Veterans Affairs Canada: Framework* (Charlottetown, 2010) and PGC-42: Veterans Affairs Canada, *A Well-Being Construct for Veterans' Policy, Programming and Research*, Research Directorate Technical Report (Charlottetown: 2016) at 22.

[355] Exhibits PGC-44: James M. Thompson et al., "Mental Health of Canadian Armed Forces Veterans: review of population studies" (2016) 2 Journal of Military, Veteran and Family Health 70 at 79, table 3; PGC-45: James M. Thompson et al., "Roles of physical and mental health in suicidal ideation in Canadian Armed Forces Regular Force veterans" (2014) 105 Canadian Journal of Public Health 109. In particular, veterans suffer from back problems, arthritis and chronic pain. Of veterans who receive disability benefits for a mental health condition, 75% suffer from a post-traumatic stress syndrome. Testimony of Dr. Heber, February 6, 2019, at 17–21.

[356] Testimony of Dr. Heber, February 6, 2019, at 37 *et seq.*

2.4.5 Mr. Jean-Claude Therrien Pinette, Chief of Operations of the Assembly of First Nations Quebec-Labrador[357]

[337] Mr. Therrien Pinette testified by affidavit. The First Nations of Quebec conducted a Regional Health Survey in 21 communities of 8 nations. Among other things, the survey shows how significant the problem of suicide is in these communities.[358]

[338] Between 2000 and 2011, 32.2% of persons who committed suicide in these communities had a mental health problem, excluding those related to abuse and addiction.[359] Mr. Therrien Pinette related his own experience with several members of his community. He has seen over 20 suicides in his social circle, and he has witnessed the phenomenon of suicide contagion.[360]

[339] The data obtained through the Regional Health Survey reveals that the majority of adults age 35 and over have several chronic health problems, including diabetes, which affects close to one out of every four adults between the ages of 40 and 64.[361]

[340] The implementation of suicide-prevention measures and sound practices for intervention with suicidal persons remains essential in these communities.[362]

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[357] Exhibit PGC-80: Affidavit of Mr. Jean-Claude Therrien Pinette.

[358] Exhibit PGC-63: First Nations of Quebec and Labrador Health and Social Services Commission, *Main findings of the 2015 Quebec First Nations Regional Health Survey*, (Wendake: FNQLHSSC, 2018). The report consists of several subject-specific fact sheets related to the monitoring of health status and suicide prevention (Exhibit PGC-80C is an excerpt from Exhibit PGC-63). Initially a pilot survey in 1997, three phases were conducted in 2002, 2008 and 2015. Exhibit PGC-80: Affidavit of Mr. Therrien Pinette at para. 17. The 2015 data indicates that 5% of the population age 12 and up stated that they had seriously thought about suicide and that 2% had attempted suicide in the year preceding the survey, 10.2% of persons age 12 and up had attempted suicide over the course of their lives, and that number jumps to 38% among those suffering from moderate to severe psychological distress in the year preceding the survey. Exhibit PGC-63 at 67; Exhibit PGC-80: Affidavit of Mr. Therrien Pinette at paras. 21 to 25, which refer to pages 1 to 124 of Exhibit PGC-63.

[359] Exhibits PGC-80: Affidavit of Mr. Therrien Pinette at para. 30 and PGC-63: First Nations of Quebec and Labrador Health and Social Services Commission, *Main findings of the 2015 Quebec First Nations Regional Health Survey*, (Wendake: FNQLHSSC, 2018) at 125, 129, 137–138, 149–158. 19.1% of reports concerning persons who committed suicide indicate that a person close to the victim also committed suicide.

[360] Exhibit PGC-80: Affidavit of Mr. Therrien Pinette at paras. 1, 6–7.

[361] *Ibid*. at para. 23 and Exhibit PGC-63: First Nations of Quebec and Labrador Health and Social Services Commission, *Main findings of the 2015 Quebec First Nations Regional Health Survey*, (Wendake: FNQLHSSC, 2018) at 25–27.

[362] Exhibit PGC-80: Affidavit of Mr. Therrien Pinette at para. 31: This includes using the person’s spoken language, involving friends and family, integrating Indigenous spirituality and coordinating the various social, community and medical services.

2.4.6 Dr. Scott Y.H. Kim, Psychiatrist, Professor of psychiatry at the University of Michigan Medical School and Bioethicist[363]

[341] The crux of Dr. Kim's report will be addressed in the section on persons who are vulnerable in connection with their psychiatric condition as well as in the foreign regimes section. The plaintiffs objected to the filing of Dr. Kim's report. The Court dismissed the objection on the grounds outlined in the "Objections" section of this judgment. His report and testimony are therefore admitted into evidence.

[342] The Court understands from the analysis conducted by Dr. Kim on the issue of medical assistance in dying in relation to suicide that he considers it difficult to distinguish the two concepts, particularly when the patient's death is not reasonably foreseeable. Although he did not provide any specifics when addressing this issue, he is of the view that the evidence put forth in his report does not support the conclusion that suicide and medical assistance in dying can be easily distinguished.[364]

[343] He submits that medical assistance in dying provided when death is not reasonably foreseeable is actually just a way of dying, whereas the question that should instead be asked is whether or not it is appropriate to do so. He therefore equates assistance in dying with painless suicide: "However, when MAID is performed in persons who are not dying in any reasonably foreseeable future, the mere changing of the manner of death cannot speak to the issue of whether to provide MAID (i.e., deciding whether one lives or dies, not just how one dies) is appropriate or not. A painless suicide may be preferable to a painful one, but merely making it painless does not justify not attempting to prevent it. Thus, for MAID where death is not reasonably foreseeable, mere appeal to differences in manner of death begs the question whether MAID can be reliably and validly separated from suicides."[365]

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[363] Dr. Kim's report was filed as Exhibit PGC-71. Because Dr. Kim's report covers many subjects addressed during the hearing, only the portion dealing with the connection between suicide, suicide prevention and medical assistance in dying will be addressed in this section. Exhibit PGC-71: Expert report of Dr. Kim including Schedules A to G and up-to-date curriculum vitae at para. 343 *et seq.*

[364] *Ibid.* at para. 363: "MAID in the non-dying, including most psychiatric MAID, is about whether one lives or dies–just as it is in suicide. The evidence discussed in this report does not support the view that MAID and suicide are easily distinguishable in such situations, and actually supports the opposite view." Dr. Kim did not refer to any particular evidence to support this statement.

[365] *Ibid*. at para. 346. Moreover, the rest of Dr. Kim's opinion consist essentially of criticizing the position taken by the American Association of Suicidology (Exhibit P-33) with which he presumably disagrees and to which we will return.

2.4.7 Dr. Timothy E. Quill, Professor of geriatrics, palliative care and ethics, University of Rochester, NY[366]

[344] Dr. Quill practises palliative care in the state of New York, where no form of medical assistance in dying or assisted suicide is authorized.

[345] He notes that palliative care is in general very effective in alleviating patients' suffering and often allows them to prolong their life. Sometimes, patients who suffer terribly must be given high doses of medication, which causes them to become drowsy and not fully aware of their environment. Other than the administration of medication, there are two other end-of-life methods he uses in his practice: the stopping of active treatment and the voluntary stopping of eating and drinking, which he referred to by the acronym VSED.[367] The Court adopts this term for the purpose of this judgment.

[346] Dr. Quill described in great detail the steps that must be taken by patients who, due to their medical condition and suffering, wish to end their lives by completely stopping eating and drinking. It is a decision that requires great willpower since the process generally takes 10 to 14 days before death occurs. According to Dr. Quill, while it is relatively easy not to eat, fighting thirst is very difficult and causes intense suffering.

[347] The patient must be monitored, supported verbally and encouraged to persevere. If the patient drinks even a small quantity of water, the process can continue for a long period of time … even months.[368]

[348] Throughout the process and particularly in the last days, the patient becomes very weak, delirious and confused.[369] Dr. Quill testified that even if the patient loses his or her capacity to consent, if the patient asks to drink, he will let him or her drink.

[349] He recommends this option for his patients in palliative care whose death is not foreseeable or imminent and who are capable of consenting at the beginning of the process. He did not report having any problems assessing the capacity of patients who request VSED. He is hesitant to characterize VSED as suicide, but because the persons who chose this option are capable, do not have a mental illness and are suffering, he characterizes it as rational suicide.

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[366] Exhibit PGC-73: Expert report of Dr. Timothy E. Quill, Professor of geriatrics and up-to-date curriculum vitae. The Court loosely translated Dr. Quill's qualification in "Hospice and Palliative care" into French as [TRANSLATION] "Geriatrics and palliative care" given the distinction between "Hospice care" in the United States and the care provided to the elderly in our country.

[367] *Ibid*.

[368] Testimony of Dr. Quill, February 5, 2019, at 42–44; Exhibit PGC-73: Expert report of Dr. Quill at para. 10.

[369] He stated that the kidneys stop functioning and that electrolyte levels become completely unbalanced. See also Exhibit PGC-73.1: John W. Wax et al., "Voluntary Stopping Eating and Drinking" (2018) 66 J. Am. Geriatr. Soc. 441.

[350] In his view, it is a means available of hastening death for persons who are not at the end of life. The advantage lies in the fact that death is under the control of the patient, not the physician.

The plaintiffs' evidence

2.4.8 Dr. James Downar

[351] As a physician who evaluates patients requesting medical assistance in dying and who has significant clinical experience in intensive and palliative care, Dr. Downar is categorical that he would never confuse a suicidal patient with a patient who requests medical assistance in dying. In fact, he described the significant distinctions between the two concepts.[370] In his view, medical assistance in dying and suicide should be considered two separate realities:[371]

> The idea, right, is that there are concepts that seem to overlap, right? Like on a very superficial level, you may think that there is a lot in common between suicidality and a request for Medical Aid in Dying. In reality, when you dig even a small amount into understanding what these people are asking for, you see… and start to interview them, you will notice quite dramatic differences between the two in the cases that I have seen.[372]

[352] He explained that suicide is generally an impulsive act committed alone, whereas medical assistance in dying is the culmination of a carefully thought out process, discussed with the physician and the family. He also noted significant demographic differences between suicide and medical assistance in dying. Suicide is generally committed by younger men with a combination of mental health problems, addiction, chronic pain, relationship problems and financial difficulties, and who sometimes have little social support. Medical assistance in dying is mostly requested by elderly, educated people without mental health problems or addictions, who are being followed in the healthcare system, have a good social circle and are suffering from the final stages of an illness that is causing them suffering.[373]

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[370] Exhibit P-25: Expert report of Dr. James Downar, physician, and up-to-date curriculum vitae at para. 16 *et seq.*

[371] *Ibid.* at para. 16: "Medical assistance in dying (MAID) and unassisted suicide should be considered separate concepts."

[372] Testimony of Dr. Downar, February 7, 2019, at 96-97.

[373] Exhibit P-25: Expert report of Dr. Downar at para 16. This distinction was also noted by Dr. Turcotte at the hearing, February 7, 2019, at 96–97 and Dr. Naud at the hearing, February 12, 2019, at 166–167, who specified that suicidal patients tend to be younger, in good health, have an altered sensorium due to a mental condition or intoxication and do not talk about their thoughts of death with anyone but rather, at some point, commit the fatal impulsive act, sometimes as a cry for help. On the contrary, patients who request medical assistance in dying do not do so impulsively, but make this decision after a long process. They are usually elderly people who have been ill for a long time and are experiencing considerable suffering that the physicians are able to objectivize.

[353] As for the concept of suicide contagion, he has analyzed several national and foreign statistics[374] and concluded that the legalization of medical assistance in dying does not result in a phenomenon of suicide contagion. Finally, he refutes the idea that the removal of the reasonably foreseeable natural death requirement would result in a significant increase in the number of people who would avail themselves of medical assistance in dying.

2.4.9 Dr. Justine Dembo

[354] For Dr. Dembo, it is clear that removing the requirement in question would not have any impact on suicide, the efforts made to prevent suicide, or the phenomenon of suicide contagion because these concepts are completely separate from medical assistance in dying.[375]

[355] Patients who request medical assistance in dying would like to live but are fully aware that it is not possible in their current situations. They wish to put an end to their great suffering, in the manner and at the moment they choose, usually surrounded by their families. The decision is not made in haste and, to come to fruition, all steps and all safeguards provided in the legislation have to be scrupulously carried out.[376]

[356] Suicide, on the contrary, often appears violent and impulsive and is performed in secret as a way of bringing life's difficulties to an end. In her view, we cannot extrapolate the data obtained from the phenomenon of suicide contagion and apply it to medical assistance in dying.[377]

[357] Authorizing medical assistance in dying for patients who are not at the end of life or whose death is not reasonably foreseeable but who satisfy all the other legislative requirements would not undermine the efforts made to prevent and fight against suicide. "I do not believe that there would be any impact of removing the "reasonably foreseeable" criterion on suicide prevention in my practice. Suicide prevention is an essential part of any psychiatrist's practice, and the existence of MAID with or without a 'reasonably foreseeable' death does not undermine suicide prevention in any way. I would again remind the reader that MAID is not equivalent to suicide."[378]

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[374] Exhibit P-25: Expert report of Dr. Downar at para. 18 *et seq.* citing the data of the OECD and analyzing the article written by Jones & Paton (Exhibit PGC-70.1: David Albert Jones & David Paton "How Does Legalization of Physician-Assisted Suicide Affect Rates of Suicide?" (2015) 108 Southern Medical Journal 599) on the comparison between suicide rates in the American states that allow assisted suicide, and concluding that those who oppose the legalization of medical assistance in dying have interpreted it incorrectly.

[375] Exhibit P-24: Expert report of Dr. Dembo at paras. 2, 25, 32, 33 and 34.

[376] Testimony of Dr. Dembo, February 11, 2019, at 91–95.

[377] Exhibit P-24: Expert report of Dr. Dembo at paras. 2 and 25. Testimony of Dr. Dembo, February 11, 2019, at 98–103.

[378] Exhibit P-24: Expert report of Dr. Justine Dembo at para. 33.

The documentary evidence

[358] The Court has also reviewed the official statement issued by the American Association of Suicidology (AAS) titled: "'Suicide' is not the same as 'Physician Aid in Dying'"[379], which several experts commented on abundantly throughout the hearing.[380]

[359] The position of the AAS, whose mission is to prevent and fight against suicide, is clearly expressed in the executive summary:

> The American Association of Suicidology recognizes that the practice of physician aid in dying, also called physician assisted suicide, Death with Dignity, and medical aid in dying, is distinct from the behavior that has been traditionally and ordinarily described as "suicide", the tragic event our organization works so hard to prevent. Although there may be overlap between the two categories, legal physician assisted deaths should not be considered to be cases of suicide and are therefore a matter outside the central focus of AAS.[381]

[360] The AAS notes that one of the sources of the confusion between the two realities comes from the use of the expression "assisted suicide" to refer to medical assistance in dying, an expression that should never be used.[382]

[361] Moreover, contrary to what some of the Attorney General's experts claim, the Court finds that the statement of the AAS is not limited to the situation prevailing in certain U.S. states where only the self-administration of lethal medication supervised by a physician is permitted, but includes all the other legislation in the world that allows medical assistance in dying, including the European jurisdictions and Canada.[383]

[362] The AAS outlines 15 points of difference between suicide and medical assistance in dying. Although it acknowledges that there may be some overlap between the two, it identifies this particularly in cases of depression, mental illness and cognitive distortion. In these cases, the AAS suggests a consultation with a psychiatrist to ascertain patients' capacity, and if necessary, that they be

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[379] Exhibit P-33: American Association of Suicidology, "Statement of the American Association of Suicidology: 'Suicide' is not the same as 'Physician Aid in Dying'" (October 30, 2017).

[380] Drs. Kim, Gaind, Conwell, Naud, Downar, Dembo and Sareen.

[381] Exhibit P-33: American Association of Suicidology, "Statement of the American Association of Suicidology: 'Suicide' is not the same as 'Physician Aid in Dying'" (October 30, 2017) at 1, Executive summary.

[382] *Ibid.* at 4: "In fact, we believe that the term "physician-assisted suicide" in itself constitutes a critical reason why these distinct death categories are so often conflated, and should be deleted from use. Such deaths should not be considered to be cases of suicide and are therefore a matter outside the focus of the AAS."

[383] *Ibid.* at 1: "Beginning in the mid-1980's with legal tolerance in the Netherlands and in 1997 with the effective date of the Oregon Death with Dignity Act, physician aid in dying has become legal by statute or court decision in a number of American states **and international jurisdictions**. Although legal requirements vary from one jurisdiction to another, all require well-documented choice by patient and a serious medical reason for such a choice. … **in most European jurisdictions and in Canada**, physician administration of lethal medication is also permitted and is the predominant practice". See also points No. 1, 8, and 9, where the AAS makes the necessary distinctions regarding jurisdictions outside the United States.

screened out of the process and provided with services and treatment traditionally given to suicidal persons.[384]

[363] The 15 points of difference identified include:

> 2) In PAD [physician aid in dying], the person with a terminal illness does not necessarily want to die; he or she typically want desperately to live but cannot do so; the disease will take its course. Suicide, by contrast, even when marked by ambivalence, typically stems from seemingly unrelenting psychological pain and despair; the person cannot enjoy life or see that things may change in the future.
>
> 5) Suicide in the conventional sense often involves physical self-violence, as in gunshot wounding, self-hanging, jumping, self-cutting, self-drowning and the ingestion of substances or compounds that may cause painful death. PAD in contrast is intended to provide the physically easiest, least violent, least disfiguring, most peaceful form of death an already dying person could face.
>
> 8) Suicide in the ordinary, traditional sense is much more common among those with mental illness, where it may be a complex byproduct influenced by anhedonia, impaired thinking, cognitive distortion and constriction, impaired problem-solving, anxiety, perseveration, agitation, personality disorders, and/or helplessness and hopelessness. Under the PAD statutes, in contrast, mental illness that would affect the rationality of decision-making is screened-out, and where, as in European jurisdictions, PAD is legal in cases of unbearable suffering in intractable mental illness, heightened scrutiny is required. Evidence of depression and other mental illness is, by statute in the US, subject to evaluation by a psychiatrist or psychologist and, if it is determined to be influencing the decision, the patient is not qualified under the law.
>
> 11) Studies from Oregon and the Netherlands show that the impact of PAD on bereavement in family members tends to be less severe than in other deaths. In contrast, those bereaved by suicide deaths have higher rates of complicated grief and PTSD, and may be at higher risk for suicide themselves.
>
> 12) Death by suicide is often associated with substantial social stigma … . Where it is legal, PAD is typically well accepted within the community and society at large.
>
> 15) Unlike most cases of suicide, the person who has requested and receives aid in dying does not typically die alone and in despair, but, most frequently, where they wish, at home, with the comfort of his or her family.[385]

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[384] Exhibit P-33: American Association of Suicidology, “Statement of the American Association of Suicidology: ‘Suicide’ is not the same as ‘Physician Aid in Dying’” (October 30, 2017) at 4.

[385] *Ibid.* at 2–4. Besides those cited in the text of the judgment, see also the fact that medical aid in dying is a measure against impulsivity (point 6), that the patient is informed of all possible therapeutic alternatives for relieving his or her situation, including comfort care, palliative care and pain control (point 7), that the various factors that generally lead to suicide and that are

[364] Finally, the AAS notes that, in the case of suicide, psychiatric conditions and mental illness abound, whereas, in medical assistance in dying, such patients are identified and screened out of the process.[386]

[365] In Canada, the Groupe de recherche sur la souffrance psychique et l'aide médicale à mourir, in conjunction with the Collège des médecins du Québec, published a document titled : *Exploration de la souffrance psychique dans le cadre d'une demande d'aide médicale à mourir*[387]. There, it provides a table comparing medical aid in dying and suicidal ideas, which is worth reproducing here:

[TRANSLATION]

Table 2: Comparison between a request for MAID and the expression of suicidal ideas

	Request for MAID	**Expression of suicidal ideas**
Main characteristic	A considered desire to hasten one's death to end the suffering caused by an illness	An expressed desire to ends one's life generally caused by a mental health problem or occurring in the context of a difficult life situation
Related to mental health problem?	Sometimes	Almost always
Recommended response	Medical evaluation and decision-making process (governed by Law 2)	Assessment of dangerousness and implementation of protective measures if necessary

[366] Before the enactment of the Quebec statute, the Select Committee noted that the suicide rates did not increase and the abuses associated with the anticipated slippery slope had not been observed in countries that have legalized medical assistance in dying. Moreover, the Association québécoise de la prévention du suicide has not opposed the legalization of medical aid in dying.

[367] In addition, the Select Committee rejected the abuses argument that presupposed the complicity of physicians, health care system staff and the

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identified in the prevention measures implemented (childhood trauma, addiction, access to firearms, etc.) do not typically apply to those choosing medical aid in dying (point 13).

[386] *Ibid.* at 3, point 8: "Under the PAD (physician aid in dying) statutes, in contrast, mental illness that would affect the rationality of decision-making is screened out, and … in cases of unbearable suffering in intractable mental illness, heightened scrutiny is required. Evidence of depression and other mental illness is, by statute in the US, subject to evaluation by a psychiatrist or psychologist and, if it is determined to be influencing the decision, the patient is not qualified under the law." The Court notes that same situation prevails in Canada, with the necessary distinctions, such as the fact that consultation with a psychiatrist is possible but not mandatory.

[387] Exhibit P-23.2: CHUM & CRCHUM, Département de psychiatrie, Groupe de recherche sur la souffrance psychique et l'AMM, "Exploration de la souffrance psychique dans le cadre d'une demande d'aide médicale à mourir" (November 2017).

patients' families.[388] The members of the Select Committee said that, on the contrary, they were "reassured when [they] saw how strictly the practice was controlled, as well as how carefully" physicians approached medical assistance in dying in foreign jurisdictions.[389]

[368] As a result, these documents published by groups of experts in the field clearly show that there are many fundamental differences between suicide and a request for medical assistance in dying.

Evidence from foreign jurisdictions

[369] Put simply, the Court accepts that, in European jurisdictions where medical assistance in dying regimes are anchored in the principle of intolerable suffering, the connection between suicide and medical assistance in dying is neither easy nor straightforward to establish.[390]

[370] The empirical data provided by the witnesses establish that in the Netherlands, where, need we repeat it, no temporal guidelines are required for eligibility to obtain medical assistance in dying, 92% of assisted dying cases are administered to patients with less than six months' life expectancy.[391]

[371] Although the evidence establishes an increase in the number of medical assistance in dying cases where the survival prognosis is greater than six

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[388] Exhibit PGQ-4: Select Committee on Dying with Dignity, *Report* (Québec: March 2012) at 73–76.

[389] *Ibid.* at 73.

[390] See for example Exhibit PGC-64: Expert Report of Dr. Theo A. Boer, Medical Ethics Professor, at 18–23. Prof. Boer does not see any causal link between establishing a broader euthanasia scheme in the Netherlands and a lower suicide rate in that country. See para. 29: "… there seems to be no causal link between the possibility of euthanasia and lower suicide rates. First, impulsive suicides will continue to happen, especially given the relatively long procedures connected to euthanasia." He is of the view, however, that the availability of euthanasia might undermine suicide prevention efforts and prevent some patients from seeking help through treatment. See also Exhibit P-26: Expert Report of Dr. Agnes van der Heide, at para. 43 *et seq.* and testimony of Dr. van der Heide, January 16, 2019, at 96–97: "… there was virtually no one who related this [increase in the number of patients who committed suicide in 2017] to our euthanasia regulations and practice. So there is virtually… perhaps there are people who see this relation, but they are virtually absent in the general debate. And I think that that means that … that is related to the fact that people who commit suicide are in general very different from people who ask their physician to help them end their lives in the sense that patients who commit suicide are often younger, are often healthier and are also having a much longer life expectancy. … psychiatric disease is much more common among patients who commit suicide than among patients who ask their physician to help them in dying. So, in general, I think it's a different debate, a different practice that overlaps to a very little extent with the practice of euthanasia."

[391] Exhibit PGC-64.6: Boudewijn E. Chabot & Arnold Goedhart, "A survey of self-directed dying attended by proxies in the Dutch population", (2009) 68 Social Science & Medicine 1745 at 1749, table 4. Testimony of Dr. van der Heide, January 16, 2019, at 158; Exhibit PGC-64: Expert Report of Dr. Boer, at paras. 42–43. In 2015, 544 patients with a life expectancy greater than six months were administered euthanasia. It is reasonable to believe that in the other 8% of cases, a good proportion had prognoses of 7 to 18 months.

months, it is not sufficient to convince the Court that the Netherlands has a disproportionate number of such requests and that a parallel can therefore be drawn with the situation that would prevail in Canada should the reasonably foreseeable natural death requirement be removed.

[372] Finally, and although it draws no formal conclusion in this regard, the Court cannot but surmise that, while the experts have not observed any reduction in the suicide rates in countries that allow one form or another of euthanasia, this is perhaps because there is no formal connection between the two.

Analysis: people vulnerable to suicide and suicide contagion

[373] The Court has read the voluminous evidence presented by the Attorney General and paid careful attention to his witnesses who presented their view and analysis on the potential connection between suicide and medical assistance in dying. The Court takes from that the following common points:

1. Especially outside the reasonably foreseeable natural death requirement, they all equate medical assistance in dying with suicide, both in its definition and the way they would treat the patients;[392]
2. Medical assistance in dying is, in itself, a means of taking one’s life that is facilitated, even sanctioned, by the State;[393]
3. Removing the reasonably foreseeable natural death requirement would render many people who would otherwise be suicidal due to their existing physical or mental condition eligible for medical assistance in dying;[394]
4. Removing the requirement would certainly put vulnerable groups at risk.[395] Moreover, a good number of these people will die unnecessarily by failing to find an adequate alternative for their survival.
5. Removing the requirement would run counter to and undermine suicide prevention efforts across the country. Medical assistance in dying is directly opposed to these prevention efforts.[396]
6. Medical assistance in dying, when restricted to situations in which

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[392] According to these experts, suicide and medical assistance in dying are difficult to differentiate. Patients who request medical assistance in dying are suicidal or present a risk of suicide, especially in the absence of the reasonably foreseeable natural death requirement. Testimony of Dr. Sinyor, January 30, 2019, at 67; Testimony of Dr. Conwell, January 29, 2019, at 154–159; Testimony of Dr. Kim, January 28, 2019, and Exhibit PGC-71; Expert Report of Dr. Kim, at para. 346; Exhibit PGC-69: Expert Report of Dr. Sareen, at para.15 and testimony of Dr. Sareen, January 31, 2019, at 60. Some state that when natural death is reasonably foreseeable, it is less a question of living or dying, but more a question of when and how death will occur, which does not make it any less of a suicide in the strict sense of the word.

[393] Dr. Sareen, Dr. Sinyor and Dr. Conwell.

[394] Dr. Sareen and Dr. Conwell.

[395] Dr. Sareen and Dr. Conwell.

[396] Dr. Sareen and Dr. Sinyor.

> natural death is reasonably foreseeable, appears less serious because the person will die imminently in any event. In such a case, it involves determining how and when the person will die, rather than giving people a choice between living or dying.[397]

[374] The Court cannot accept the association made by these experts between the issue of suicide and medical assistance in dying, or the inferences they have drawn between the two. Here is why.

[375] First, the Court is astounded by the fact that the experts for the Attorney General of Canada had not even a basic knowledge of the practice of medical assistance in dying in Canada, which has nonetheless been legal throughout the country since 2016. None of them has participated in the request process for medical assistance in dying, either by assessing a patient or by providing such medical assistance. None of them has done any research on the subject or even tried to consult the data available in Canada.[398]

[376] Therefore, when they all state that there is no difference between suicide and medical assistance in dying, they are considering and presenting only one side of the story, one part of the equation. They compare the two issues without ever having analyzed, learned, or addressed the specifics of medical assistance in dying, its parameters, its eligibility criteria, or how it is practised in Canada.

[377] Their comparison therefore remains purely theoretical at best, and their opinion is based on biases[399] or a practice that does not correspond to reality.

[378] Moreover, each of them disregards, and even ignores, the safeguards provided in the legislation and the strict eligibility conditions involved in a request for medical assistance in dying, as though they did not exist or were of no importance in a scenario where lack of consent is suspected.[400]

[379] These experts cling solely to the fact that death results from a person's voluntary request in order to equate medical assistance in dying with suicide in every circumstance. Consequently, they erroneously assume, without further

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[397] Dr. Kim.

[398] See Dr. Sareen, Dr. Conwell, Dr. Sinyor, Dr. Kim and Dr. Gaind. Only Dr. Sareen and Dr. Gaind were involved in implementing intra-hospital policies given their administrative functions within their health institution, but they never had to participate in the process of medical assistance in dying as such. Cross-examination of Dr. Sareen, January 31, 2019, at 63–64: "I am not a consulting psychiatrist. … that's not my expertise. … but I was engaged in organizing the process and supporting the psychiatrists … if [they] run into any questions. … if a psychiatrist decides to not do MAID work, then it's my role and responsibility to recruit another psychiatrist." Dr. Sareen never read the third interim report on medical assistance in dying in Canada and is unaware of its content. Cross-examination of Dr. Sareen, January 31, 2019, at 65. Dr. Sinyor testified that he attended a presentation of the Canadian Psychiatric Association where one slide of the presentation concerned medical assistance in dying: "I was at a lecture of the Canadian Psychiatric Association annual conference this year where, … one of the other presenters, Marnin Heisel, had put up a slide of statistics of what happened, and that's the only thing I've seen". Cross-examination of Dr. Sinyor, January 30, 2019, at 186.

[399] Understood in the non-pejorative sense of the term.

[400] See in particular ss. 241.2(1), (2) and (3) Cr. C.

nuance, that every vulnerable or otherwise suicidal person suffering from a disease or disability could *ipso facto* go through the process of, and be granted, medical assistance in dying.

[380] Contrary to what is affirmed in *Carter*, none of them considers that there may be people who have a rational, considered and persistent wish to end their lives and who, moreover, are not vulnerable as such. And even if these people fall within a certain definition of vulnerability, they nonetheless have the capacity to make personal decisions concerning their life, their dignity and their own physical integrity.[401]

[381] The Court instead accepts the evidence adduced by the applicants that establishes that medical assistance in dying and suicide are two separate phenomena that belong to two different realities, although there may be certain points in common, such as the obvious one that they both lead to the person's voluntary death.[402]

[382] The Court thus finds that the evidence adduced by the applicants draws a more accurate portrait of the reality and differences between medical assistance in dying and suicide.

[383] The applicants' experts and Dr. Rivard, who all have personal experience with medical assistance in dying in their practice, all stated that they would not confuse one with the other and that they are two separate phenomena. Dr. Naud has treated many suicidal patients in his family medicine practice and does not see how one could equate the two phenomena.[403] Moreover, Dr. Rivard seemed astonished at the hearing that anyone could associate the two.

[384] In Quebec, these patients must be known to the medical team involved, make an official request on a form before witnesses, and meet two different physicians who will assess every facet of the request, including their capacity to consent.[404] Dr. Downar[405] and Dr. Dembo,[406] who assess patients requesting medical assistance in dying in their medical practice, unequivocally agreed with this assessment and confirmed that the two realities are clearly dissimilar. They claim that there is nothing to indicate that removing the impugned requirement

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[401] *Carter* at para. 86. Except for Dr. Quill, who believes that there may be three different types of suicide: suicides related to a mental health issue, heroic suicides and rational suicides. Testimony of Dr. Quill, February 5, 2019, at 73–80.

[402] See in particular the testimony of Dr. Downar, February 7, 2019, at 96–102 and 139.

[403] Testimony of Dr. Naud, February 12, 2019, at 166 when referring to medical assistance in dying: [TRANSLATION] “And it has nothing to do with a suicidal patient. … I mean, suicide is a totally different condition …”

[404] *Ibid*. at 168.

[405] Testimony of Dr. Downar, February 7, 2019, at 96–97: “The idea, right, is that there are concepts that seem to overlap, right? Like on a very superficial level, you may think that there is a lot in common between suicidality and a request for Medical Aid in Dying. In reality, when you dig even a small amount into understanding what these people are asking for, you see… and start to interview them, you will notice quite dramatic differences between the two(2) in the cases I have seen.”

[406] Exhibit P-24: Expert Report of Dr. Dembo, at 18 *et seq.* and testimony of Dr. Dembo, February 11, 2019, at 91–99.

will lead to an increase in requests for medical assistance in dying, influence the suicide rate in Canada, or undermine suicide prevention efforts.

[385] Finally, in the same vein, the Court also accepts the testimony of Dr. Quill[407] and of the psychologist, Ms. Malo[408], both of whom outlined the necessary distinctions between medical assistance in dying and suicide. In summary, the Court finds that the expert evidence filed by the applicants is clearly more conclusive in this area than that of the Attorney General of Canada.

2.5 Vulnerable Groups Based on Their Psychiatric Condition Alone

[386] As previously stated, while the applicants undeniably suffer from severe physical disabilities, this is not the case with regard to their mental condition. Neither Mr. Truchon nor Ms. Gladu has a psychiatric illness that could be related to their request for medical assistance in dying.

[387] Therefore, the relevance of any evidence adduced by the Attorney General of Canada on the subject of people who might avail themselves of medical assistance in dying based solely on a psychiatric illness is doubtful, to say the least.

2.5.1 Dr. Scott Y.H. Kim

[388] In his report, Dr. Kim seriously questions the physician’s ability to properly assess the capacity of patients requesting medical assistance in dying who are not at the end of life and having an underlying psychiatric condition. The essence of Dr. Kim’s report and testimony deals with the danger of extending access to medical assistance in dying to patients suffering from a psychiatric condition.

[389] He claims that, even though physicians regularly assess their patients’ capacity in the normal course of their practice, assessing people with a psychiatric condition remains difficult and always represents a challenge. It falls into a grey zone, which requires considerable clinical judgment.[409]

[390] The methods of assessing the capacity of patients with a psychiatric condition may, therefore, present difficulties for physicians, some of whom, moreover, would not be properly trained to perform this task.[410] According to Dr.

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[407] Dr. Quill, who assists patients in hospices to end their lives through VSED, does not consider VSED to be suicide.

[408] Testimony of Ms. Suzanne Malo, January 11, 2019, at 32 and 36–37: [TRANSLATION] “I do not consider a desire to commit suicide and a desire to die as being exactly the same thing clinically because the residents do not present the same way, and the psychological dynamic is not the same. … These people think, they listen to all the options … to alleviate both their physical pain, if that explains their desire to die, and their psychological pain, if applicable. Sometimes, they will agree to consult specialists if necessary. … These people will also often discuss it with their families.”

[409] See in particular Exhibit PGC-71: Expert Report of Dr. Kim, at para. 30.

[410] *Ibid.*, at para. 64 *et seq.* citing L. Seyfried, K.A. Ryan & S.Y.H. Kim, “Assessment of Decision-Making Capacity: Views and Experiences of Consultation Psychiatrists” (2013) 54 Psychosomatics 115.

Kim, these difficulties establish that capacity assessment cannot serve as a universal safeguard.

[391] He also disputes the idea that a refusal of, or a legitimate decision to stop, life-sustaining treatment is akin to a request for medical assistance in dying when death is not reasonably foreseeable from the perspective of assessing the patient's capacity to make that choice.[411]

[392] Dr. Kim claims that the current practice of assessing patient capacity is not adapted to the new reality of medical assistance in dying and therefore cannot serve as guidance for such an assessment when the people requesting medical assistance in dying are not at the end of life and have a psychiatric condition.[412] He feels that capacity assessment in these conditions represents "a unique set of considerations" and that "... the circumstances of evaluating the capacity of non-dying persons with psychiatric disorders seeking MAID will be such that current practice of capacity assessment cannot provide direct guidance for that novel context."[413]

[393] He presents a portrait of difficulties physicians might face when dealing with such requests from patients with a psychiatric condition.[414] Furthermore, removing the reasonably foreseeable natural death requirement would lead to an increase in the pool of candidates, some of whom would certainly be suffering from an undiagnosed or improperly treated psychiatric condition.[415] He claims that it is well known that the risk of incapacity is increased where many psychiatric issues exist.[416]

[394] Thus, by drawing a parallel with the situation in Belgium and the Netherlands, Dr. Kim claims that removing the reasonably foreseeable natural death requirement in Canada would increase the number of persons who will

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[411] Exhibit PGC-71: Expert Report of Dr. Kim, at para. 118: "Thus, although capacity evaluations of persons who refuse life-sustaining treatment are conducted in practice, and can involve persons with psychiatric disorders, they cannot be seen as an analogous practice of capacity assessment that can be transferred over to the context of MAID when death is not reasonably foreseeable."

[412] *Ibid.* at para. 28: "… current practice of capacity assessment cannot provide direct guidance for that novel context"*.*

[413] *Ibid.* at paras. 28 and 71 *et seq.* According to Dr. Kim, the nature and level of the patient's suffering, the criteria used to assess capacity and the threshold for determining capacity are often applied unequally and are not always clear to physicians. In this respect, he cited several studies. For example, see: S.Y.H. Kim et al., "Do clinicians follow a risk-sensitive model of capacity determination? An experimental video survey" (2006) 47 Psychosomatics 325; S.Y.H. Kim, "Variability of Judgments of Capacity: Experience of Capacity Evaluators in a Study of Research Consent Capacity" (2011) 52 Psychosomatics 346.

[414] Exhibit PGC-71: Expert Report of Dr. Kim, at paras. 58–64. Dr. Kim also submitted a 2013 article that suggests that some US physicians might be poorly trained to assess patient capacity: L. Seyfried, K.A. Ryan & S.Y.H. Kim, "Assessment of Decision-Making Capacity: Views and Experiences of Consultation Psychiatrists" (2013) 54 Psychosomatics 115.

[415] Exhibit PGC-71: Expert Report of Dr. Kim at para. 29.

[416] *Ibid.* at para. 30.

request such assistance, a majority of whom will have psychiatric conditions, and that this risks causing significant consequences for that population.[417]

[395] His analysis is based primarily on Belgian and Dutch data[418], which he analyzed and presented as being the prevailing situation in those countries and which he does not hesitate to describe as a "robust finding".[419]

[396] The data presented by Dr. Kim was drawn primarily from an article published by Belgian psychiatrist Dr. Lieve Thienpont, who, from 2007 to 2010, assessed 100 consecutive requests for euthanasia by patients with various psychiatric conditions.[420]

[397] Dr. Kim arrived at two main findings based on this data. The first is that women, as a potentially vulnerable group, appear to be overrepresented, with a rate of 73% of requests. The second questions the capacity assessment conducted by this psychiatrist, who found that every patient assessed had the capacity to consent to euthanasia.

[398] He also presented a study published in the *JAMA Psychiatry* journal in 2016, in which he participated in the Netherlands between 2011 and 2014, and which forms the basis of his report to the Court.[421] This article describes the case of 66 patients with a psychiatric condition and also concludes, among other things, that women are overrepresented.[422]

[399] The Court wishes to make several remarks about Dr. Kim's report and testimony in order to explain why it has decided to disregard them and not consider them in the present case.

[400] Dr. Kim is without a doubt a highly qualified psychiatrist, professor, author and bioethicist, both academically and professionally. While the Court appreciates his warnings throughout his testimony about physicians' ability to properly assess the capacity of people with psychiatric conditions, the Court notes that these are merely hypotheses or extrapolations from the data. The evidence on which he bases his opinion is either too insufficient or theoretical to be truly probative. It is, therefore, not reasonably possible to draw any inference regarding the current practice in Canada from this data.

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[417] *Ibid.* at para. 29.

[418] The Belgian data emerged from the study published by Belgian psychiatrist Thienpont and the Dutch data from the reports of the Regional Review Committees on euthanasia.

[419] Exhibit PGC-71: Expert Report of Dr. Kim at para. 147.

[420] *Ibid.* at par. 128 citing L. Thienpont *et al.*, "Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study" (2015) 5 BMJ Open 007454.

[421] Exhibit PGC-71: Expert Report of Dr. Kim, at para. 20: "I have studied the clinical, ethical, and oversight issues surrounding the practice of medically induced deaths of patients requesting euthanasia. My empirical work on euthanasia in the Netherlands (published in JAMA Psychiatry and in Psychosomatics) …" citing S. Kim *et al.,* "Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011 to 2014" (2016) 73 JAMA Psychiatry 362.

[422] See in particular Exhibit PGC-71: Expert Report of Dr. Kim, at para. 129 citing S. Kim *et al.*, "Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011 to 2014" (2016) 73 JAMA Psychiatry 362.

[401] More specifically, the Court cannot, based on two foreign studies conducted on 100 and 63 patients respectively and all suffering from psychiatric illnesses, draw any probative conclusion whatsoever on the practice of capacity assessment in Canada. Nor can it, as did Dr. Kim, elevate anecdotal and still-marginal cases to the rank of broad principles applicable to the situation prevailing in Canada.[423] Moreover, the testimony of the applicants' expert, Dr. van der Heide, contradicts these arguments and rightly urges the Court to consider Dr. Thienpont's study and conclusions with much caution.

[402] Furthermore, although he was very confident during his examination in chief, on cross-examination Dr. Kim often hesitated before answering even simple introductory questions. Above all, it became clear during his cross-examination that he has very little knowledge, if any at all, about medical assistance in dying in Canada, the criteria of the federal or provincial legislation, local data, or even the existence of the Commission des soins de fin de vie, one of the objectives of which is precisely to analyze, compile and publish up-to-date data on capacity assessment. Moreover, he was also unable to confirm simple facts about the applicants themselves, such as, for example, whether they were suffering from a psychiatric condition that could possibly defeat their application for medical assistance in dying. He even went so far as to qualify the possibility that Mr. Truchon might be suffering from a psychiatric condition as a "detail", even though he then added that it would not be a "trivial detail".[424]

[403] In reply to the question as to whether the difficulties he raised regarding the capacity assessment of patients who apply for medical assistance in dying and who may in fact be suffering from a psychiatric condition are the same in Canada as abroad, he answered: "I don't know about what's happening in Canada. … Because there are no data in Canada".[425]

[404] For the Court, this places some of his observations within the ranks of mere conjecture or anecdote, such as the over-representation of women in euthanasia applications based on a psychiatric condition, which he nonetheless unhesitatingly described, at the risk of repetition, as "robust findings".[426]

[405] As he rather astonishingly stated on cross-examination, he draws no conclusions from the data (particularly that taken from Dr. Thienpont's study) he nevertheless cites throughout his report, even though he raised concerns about this data.[427]

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[423] Dr. Kim acknowledged that even in the Netherlands the percentage of patients with a psychiatric condition who were administered euthanasia is low. The reality is that in 2016 in the Netherlands, 60 cases were identified out of approximately 6,000 applications. Cross-examination of Dr. Kim, January 29, 2019, at 39.

[424] *Ibid.* at 23.

[425] *Ibid.* at 32.

[426] *Ibid.* at 34.

[427] Dr. Kim uses the term "concerns": "… and what you just described, I believe, is the data, the conclusions… sorry, I didn't draw any conclusions so much as to raise concerns that, if this is true, then, there are certain things that should be seriously considered". Cross-examination of Dr. Kim, January 29, 2019, at 33.

[406] Finally, and more generally, although interesting and certainly relevant, the issue of psychiatric illnesses as the sole condition granting access to a request for medical assistance in dying is but one facet of the reality of people who might request medical assistance in dying. The Attorney General is mistaken on the importance to be assigned to the issue of the presence of psychiatric illnesses under the legislative provisions currently in force, because the Attorney General confuses the person's capacity to consent with the presence of a diagnosed mental illness. The only thing that is relevant for the Court's purposes is the determination of capacity taking into consideration the presence of any illness. Once again, the overwhelming evidence, on a balance of probabilities, does not at this time raise any doubt as to the quality of the process for assessing the capacity of a patient who has requested medical assistance in dying in Canada, whether or not the patient is suffering from a psychiatric condition.[428]

[407] For all these reasons, the Court does not accept the evidence presented by Dr. Kim.

2.5.2 Dr. Karandeep Sonu Gaind, Head of Department of Psychiatry and Medical Director of the Mental Health Program at Humber River Hospital, Toronto[429]

[408] Dr. Gaind's report is based on the hypothesis that people might be tempted to request medical assistance in dying when they are suffering only from an underlying psychiatric condition, with no other illness or physical condition.[430] Dr. Gaind's report was filed subject to an objection. The Court rejects the objection for the reasons set out in the section "Objections" of the judgment and allows Dr. Gaind's report and testimony to be filed.

[409] In this specific context, Dr. Gaind discusses the impact that psychiatric symptoms can have on patients' perception of suffering and their decision-making capacity. Since suffering remains highly subjective, a patient who is depressed or has another psychiatric illness is more likely to perceive stress and everyday challenges as overwhelming, even insurmountable. In this regard, the perception and characterization of the patient's suffering as more or less tolerable can be affected by the illness itself.[431]

[410] The psychiatric symptoms felt by a person can also affect the decision-making cognitive process. Psychiatric symptoms can cause cognitive distortions

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[428] Moreover, Dr. Kim never claimed that it is impossible to properly assess this kind of patient. He claimed that the assessment is more complicated.

[429] Exhibit PGC-72: Expert Report of Dr. Sonu Gaind, Chief of Psychiatry, Medical Director of Mental Health, Humber River Hospital, and up-to-date *curriculum vitae*.

[430] Dr. Kim also addressed this scenario in his report, but in relation to the assessment of capacity to consent to such a request.

[431] Exhibit PGC-72: Expert Report of Dr. Gaind, at paras. 17–21 and 33–37.

and negative emotions that influence decision-making process, even if the person still has full legal capacity.[432]

[411] According to Dr. Gaind, suffering due to a psychiatric illness can be caused not only by the illness, as such, but also by various external psychosocial factors.[433] It then becomes difficult for a physician to determine with certainty whether the suffering expressed by a patient applying for medical assistance in dying is actually related to the illness or whether it is perhaps also explained by external factors.

[412] In Dr. Gaind's view, this situation creates a potential danger of a shift towards the possibility of no longer attributing the intolerable suffering to the illness itself but, rather, to all sorts of external factors. At that point, physicians would not be best placed to conduct this assessment, which would, moreover, leave much room for arbitrary interpretation and for subjective, inconsistent application.

[413] In his opinion, it is therefore vital to keep the reasonably foreseeable natural death requirement in the legislation in order to counter this situation.

[414] Dr. Gaind also believes that it is impossible to determine with certainty whether or not a psychiatric illness in a given case is irremediable, unlike many physical diseases.[434] Therefore, he feels that people with psychiatric illnesses should not be eligible based on the current legislative criteria.

Analysis: Vulnerable groups based on their psychiatric condition alone

[415] The Court would like to state its appreciation for the compassion, devotion, attention and concern for his patients' suffering that marks Dr. Gaind's testimony. As was the case for Dr. Kim, in addition to the previous remarks and, once again, although he appears highly qualified, the Court can only find that he goes too far in the conclusions he draws from the assumptions he presented. In addition, they are at odds with all the testimony heard from physicians who practice in the field[435] and are not based on practical experience.[436]

[416] While it is true that the assessment of a person's mental capacity may sometimes present a challenge for physicians, and that the fears expressed by

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[432] *Ibid.* at paras. 22–40.

[433] *Ibid.* at paras. 50–57, 61–62 and 79. For example, Dr. Gaind described stigma and discrimination, poverty, low self-esteem, isolation, and inadequate resources. He said that suffering can also be related to social, economic and existential factors.

[434] He said that even though there is no consensus within the medical community in this regard, it is impossible to predict the evolution of a psychiatric illness with certainty. See Exhibit PGC-72: Expert Report of Dr. Gaind, at paras. 42–44 and 50–53.

[435] See in particular the testimony at the hearing of Dr. Downar, Dr. Dembo, Dr. Naud, Dr. Rivard and Dr. Turcotte.

[436] Dr. Kim does not treat patients. He sometimes interacts with patients during specific bioethical clinical assessments. He estimates that 70% of his time is spent on research and 30% is divided between ethical consultations and administrative tasks. He is the duty psychiatrist for patient consultations 2 months a year, but has never assessed a request for medical assistance in dying. Cross-examination of Dr. Kim, January 29, 2019, at 7–9.

Dr. Kim and Dr. Gaind could, in fact, occur in a psychiatric patient[437], there is no reason to believe that the members of the medical community who conduct such assessments are not aware of the potential particularities and difficulties raised and are not up-to-date in their practice in this respect.[438]

[417] Unlike Dr. Kim, who believes that outside the context of end of life the capacity assessment of non-dying patients requesting medical assistance in dying is a unique process, the Court, like the Supreme Court, believes instead that the assessment of the person's capacity to request such assistance is similar to that sought when withholding or withdrawing life-sustaining treatment. The Court concludes that the decisive factor is based not so much on the temporal connection with natural death, but instead on the fact that the decision leads to death. Whether or not the person requesting assistance in dying is at the end of life does not constitute a clinical criterion in the assessment of the patient's capacity to make such a decision.

[418] Based on the evidence, the Court finds that, because a person's decision in these circumstances leads to death, which is a grievous and irreversible consequence, the assessment of the person's capacity to consent to medical assistance in dying is all the more rigorous. It requires two independent physicians, who in practice seek the opinion of a psychiatrist when necessary.[439]

[419] As well, this is not an assessment that physicians must perform in the context of an emergency. On the contrary, the evidence establishes that they take the necessary time to conduct a full and rigorous assessment, with access to the patient's medical history and the assistance of a support team.[440]

[420] Therefore, and despite what Dr. Kim claims, nothing establishes that it is impossible to reliably assess the mental capacity of patients with a psychiatric condition. The Supreme Court reached this same finding in *Carter*.[441] The Attorney General of Canada has failed to establish that the situation in Canada has changed since then.

[421] Last, it bears repeating that neither *Carter* nor the federal legislation excludes people with a psychiatric condition from requesting and being granted medical assistance in dying like any other Canadian who meets the legislative

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[437] For example, cognitive distortions, subjectivity of the suffering expressed, or an undiagnosed or improperly treated psychiatric condition.

[438] In fact, the fears expressed by Dr. Kim and Dr. Gaind concerning the risks associated with assessing the capacity to consent are well known in the medical community and by physicians who intervene in the process of assessing a request for medical assistance in dying. Testimony of Dr. Downar, February 7, 2019, at 93–96.

[439] To this effect, Dr. Downar concludes that the assessment of a person's decision-making capacity by two physicians "…is already a standard way above every other medical decision that is being made." Testimony of Dr. Downar, February 7, 2019, at 107.

[440] *Ibid.* at 106–107; Testimony of Dr. Naud, February 12, 2019, at 265 [TRANSLATION] "… of all the patients to whom I have provided medical aid in dying, there were two (2) whom I referred for a psychiatric consultation. I did not need to do so for all the others because I was very comfortable assessing them. The second physician confirmed this. The other physicians in the record confirmed this. This was confirmed by the social worker when she met with them."

[441] *Carter* at paras. 104–106.

requirements. These people are, therefore, eligible, regardless of their official diagnosis, once they are deemed competent by two independent physicians and meet the other legal requirements.

[422] The Court concludes that physicians in Canada are able to conduct such an assessment and eliminate non-eligible patients, not because they have a psychiatric illness, but because they do not have the capacity to decide and make this fundamental choice due to their mental condition.[442]

3. Comparison with Certain Foreign Regimes

[423] In addition to the data currently available in Canada, the Court heard from a number of experts on the situation in certain foreign jurisdictions that allow one form or another of euthanasia. Heavy emphasis was placed on the Netherlands and Belgium, the first countries to have legalized the practice over twenty years ago. In both these countries, euthanasia and assisted suicide are not restricted to people at the end of life or whose death is reasonably foreseeable.[443]

[424] The data from the American states, the state of Victoria in Australia and Colombia were also discussed, but more superficially. All these states have a regime that imposes time limits for access to assisted suicide.[444] In the American states, individuals must be suffering from a terminal illness with a life prognosis of six months or less.[445] In Australia, life prognosis cannot exceed six months[446], and in Colombia, the patient must be in the terminal stage of the illness and maintain the request for 25 days.[447]

[425] Before considering this evidence in more detail, the Court wishes to make the following remarks. First, although some aspects are comparable to our own, none of the foreign regimes is identical to the one currently in force in Canada, and each of them was designed and based on its own cultural and social specificities. Comparisons and conflations with our regime must therefore be approached with caution.

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[442] Under the application of the criteria set out in the legislation, the case law or the doctrine referred to in notes 269, 272 and 284.

[443] Exhibit PGC-67.1, tabs 1, 6 and 7: [Belgian] *Loi relative à l'euthanasie*, May 28, 2002; [Dutch] *Criminal Code*, ss. 293-294; *Dutch Act on termination of life on request and assisted suicide*.

[444] Exhibit PGC-67: Expert Report of Dr. Trudo Lemmens, Professor, dated March 26, 2018, and up-to-date curriculum vitae, at 19 – 31. Exhibit PGC-67.1: Compilation of statutes, regulations and case law governing euthanasia and assisted suicide schemes worldwide.

[445] Exhibit PGC-67.1, tabs 8–14: *The Oregon Death with Dignity Act*, s. 127.800 §1.01(12); *The Washington Death with Dignity Act*, s. 70.245.010 (12); *Baxter v. Montana*, 2009 MT 449; Vermont Act No. 39, *Patient Choice at the End of Life Act*, § 5281(*a*)(10); *California End of Life Option Act*, s. 443.1(*q*); *D.C. Act 21-577 Death with Dignity Act of 2016*, s. 2(16); *Colorado End-of-Life Option Act*, s. 48, 25-48-102(12).

[446] Exhibit PGC-67.1, tab 3: *Voluntary Assisted Dying Act 2017, No. 61 of 2017*, s. 9(1)(*d*)(iii).

[447] Exhibit PGC-67.1, tabs 4 and 5: *Republic of Colombia Constitutional Court Sentence #C-239/97 REF Expedient #D-1490*; *Ministry of Health and Social Protection – Resolution Number 1216 of April 20, 2015*.

[426] Second, data and scholarly analyses were submitted to the Court on subjects that, although highly interesting at first glance, sometimes do not concern either the applicants' situation or the issue to be decided by the Court. For example, the analysis of new euthanasia practices outside the traditional sphere in the Netherlands and Belgium and, to a certain extent, cases of patients whose request for euthanasia is based solely on their psychiatric condition. The Court will assume that these cases were to warn it of the potential abuses in Canada.

[427] Last, the experience abroad, with all the necessary distinctions, no longer carries the weight it once did. The primary focus now should be the findings drawn from the experience in Canada, an experience modelled on our own social and cultural reality and reflecting the successes and flaws of a regime put in place by Parliament and the legislature.

[428] Four experts testified before the Court, including three for the Attorney General of Canada: Professor Boer, Professor Lemmens and Dr. Kim. The applicants called epidemiologist Dr. van der Heide.

Evidence of the Attorney General of Canada

3.1 Dr. Theo A. Boer, Professor of Health Care Ethics at Kampen Theological University in the Netherlands[448]

[429] Dr. Boer, a Dutch bioethicist specialized in end-of-life decisions, filed a report on the evolution of euthanasia practised in the traditional sphere and on the most recent or expected developments departing from this sphere.[449]

[430] He confirmed that euthanasia appears well established in Dutch society.[450] Dutch legislation does not contain any requirement for end of life, terminal illness, or irreversible decline in capability. The legislation is essentially based on the unbearable suffering people can endure at any stage of their life.

[431] The legal criteria have not changed for over twenty years and are broadly worded. A physician must: (1) be satisfied that the patient's request is voluntary and well-considered; (2) be satisfied that the patient's suffering is lasting and unbearable; (3) adequately inform the patient about his or her situation and prognosis; (4) have concluded, together with the patient, that there is no other alternative and that the suffering cannot be alleviated; (5) consult a second independent physician; (6) perform the euthanasia him or herself according to due medical care.

[432] Not only is there no requirement that the person be experiencing an irreversible decline in capability, it should be noted that, unlike our regime, the

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[448] Exhibits PGC-64: Expert Report of Dr. Theo A. Boer, dated February 8, 2018, and up-to-date curriculum vitae.

[449] *Ibid*. and PGC-64.1: Theo Boer, *Some research limitations of the 2017 Governmental Evaluation*, December 17, 2018.

[450] It finds its origins in Dutch Protestantism, which advocates that it is better to intervene and guide a situation rather than to prohibit it, according to Dr. Boer and Dr. van der Heide.

second physician's opinion is not binding, and euthanasia is even available to a certain category of minors[451] and on the basis of advance medical directives.

[433] The primary objective of the Dutch legislation is to protect physicians, rather than to affirm the right and autonomy of the person making the request. Physicians must report on an anonymous basis any euthanasia performed to the public authorities, who will collect the data and ensure that the exercise was performed with due care. According to Dr. Boer, physicians are very conscientious.

[434] A neutral committee, the RRC,[452] records the data and publishes it in a report every five years for study and statistical purposes, making it possible for the practice to be constantly assessed throughout the country. If the committee finds a breach of due medical care, it can forward the file to the Public Prosecutor.

[435] Following the official enactment of the legislation in 1994[453], the number of requests increased and then stabilized in subsequent years. Since 2007, however, Dr. Boer has observed a continuous increase in the number of cases that he is unable to explain. Today, euthanasia accounts for 4.5% of deaths in the Netherlands.

[436] In the Netherlands, euthanasia is still primarily practised in classic cases of patients with cancer, AIDS or other fatal illnesses, in the days, weeks or months leading up to their expected natural death. He noted, however, that in recent years the practice has changed and has moved toward non-traditional spheres, such as psychiatric illness or dementia, as well as cases featuring social considerations, such as loneliness, age, inability to face life's challenges or "life complete", the latter being the opinion and belief of people who feel that they have arrived at the end of their life and simply no longer wish to continue.

[437] While these non-traditional cases remain marginal, they are, nevertheless, a source of debate in Dutch society. From an ethical perspective, Dr. Boer believes that the reasonably foreseeable natural death requirement would protect Canada against any risk of abuse, such as those he feels these new cases in the Netherlands represent.

[438] With respect to the relationship between suicide and euthanasia, Dr. Boer stated that there is no data supporting a relationship between the practice of euthanasia and a decrease in the suicide rate. In other words, the availability of euthanasia has not resulted in a decreased number of suicides in the Netherlands.

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[451] In the Netherlands, euthanasia is available to 12-year old minors with the parents' consent and 16-year old minors with the parents' opinion. In Belgium, euthanasia is available to emancipated minors.

[452] Five Regional Review Committees exist nationwide that review all reported cases of euthanasia or assisted suicide based on due medical care.

[453] Euthanasia was legalized in 1994 in a schedule to the *Burial and Cremation Act*. A separate law dedicated to euthanasia was enacted in 2001. That said, the practice of euthanasia was tolerated as of the mid-80s.

3.2 Mr. Trudo Lemmens, Professor at Faculty of Law and Dalla Lana School of Public Health & Joint Center for Bioethics, University of Toronto[454]

[439] Professor Lemmens was the second witness called by the Attorney General of Canada to testify about the experience in other countries. A law professor at the University of Toronto and an expert in health law, comparative law and medical ethics in end-of-life care, he is knowledgeable on the various euthanasia regimes worldwide and the Belgian regime in particular.[455]

[440] His substantial and voluminous report covers a number of topics, including a review of the various foreign regimes, the Belgian and Dutch data, where euthanasia is not restricted to terminal or end-of-life situations, his fears regarding the ability of physicians to properly assess subjective criteria such as patient suffering and capacity, particularly where the patient has a psychiatric condition, the increase of euthanasia in non-traditional spheres where, for example, suffering is not physical but strictly existential, and the importance of safeguards to avoid errors.

[441] It is his opinion that euthanasia should always remain an exceptional procedure in a society that permits such a practice and that important safeguards are crucial to avoid errors and to protect vulnerable people who may consider it in a moment of weakness.

[442] He states that, if euthanasia became available independently of the end-of-life stage, people with a mental illness could then avail themselves of it based on their mental illness alone and that it would therefore be very difficult to ensure their free and informed consent and to distinguish this practice from suicide. Without the reasonably foreseeable natural death requirement, suffering will become the primary criterion to consider when assessing a request for medical assistance in dying. Not only is this criterion subjective, it is also likely to broaden the pool of eligible candidates even more, as is presently the case in Belgium.

[443] Professor Lemmens claims that broader access for people who are not in the terminal stage of their illness must be weighed against the promotion of important social values. He states that a regime that does not limit itself to the end-of-life criterion opens the door to possible errors and the normalization of the practice, which would have a direct impact on the perceived value of the life of vulnerable groups, such as the elderly, the ill, or people with disabilities.

[444] He noted an increase in the number of requests for euthanasia in these jurisdictions in recent years, an increase in the number of euthanasia cases outside the specific context of end of life, and an increase in the number of requests based on mental illness. He attributes these developments to two possible causes: either the public is better informed, or the practice has become normalized, which might influence how both individuals and society perceive the situation and what is expected from each in terms of social acceptance.

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[454] Exhibit PGC-67: Expert Report of Dr. Trudo Lemmens, March 26, 2018, and up-to-date curriculum vitae.

[455] *Ibid*.

[445] In Belgium, the percentage of people who are administered euthanasia even though they were not suffering from a terminal illness has been increasing, reaching 14.79% in 2015. There is nothing to indicate that this increase will stabilize.[456] Moreover, 4.6% of all deaths in the Flemish region of Belgium are due to euthanasia, which exceeds the 4.5% rate of deaths by euthanasia in 2015 in the Netherlands.[457]

[446] Based on his own experience and interpretation of the scientific literature, Professor Lemmens questions the safeguards in place in the foreign regimes, including physician assessment, consultations with a second physician, assessment of the patient's decision-making autonomy and the subsequent process for disclosing and reporting information to authorities. He believes that Canada should be prudent.

3.3 Dr. Scott Y. H. Kim, Psychiatrist

[447] The Court has already addressed the evidence submitted by Dr. Kim concerning his analysis of capacity assessment of patients with mental illnesses in Belgium and the Netherlands and the practice of euthanasia of these same patients who base their application on a psychiatric condition.[458]There is no need to revisit it.

Evidence of the applicants

3.4 Dr. Agnes van der Heide, Epidemiologist and Professor, Department of Public Health, Erasmus MC, University Medical Centre Rotterdam[459]

[448] Dr. van der Heide is an epidemiologist, professor, and researcher in the field of euthanasia and palliative care in the Netherlands. Since 1995, without interruption, she has participated in collecting and analyzing information and studies published every five years in her country. She thus has extensive knowledge of the data collected in the Netherlands and Belgium in this field. Without taking anything away from Professor Boer and Professor Lemmens, the first two experts called by the Attorney General of Canada, the Court particularly appreciated Dr. van der Heide's testimony, which was frank, objective and consistently based on empirical data.[460]

[449] She claims that there has never been a debate about an end-of-life requirement in the Netherlands, because the regime is based primarily on the idea that unbearable suffering is not solely an attribute of the end of life. There are many cases where suffering occurs outside a person's final moments, and Dutch society considers it imperative to offer a solution. She added that it is also often difficult to correctly estimate a patient's life expectancy.

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[456] *Ibid*. at para. 139.
[457] *Ibid*. at paras. 94–95.
[458] Exhibit PGC-71: Expert Report of Dr. Kim.
[459] Exhibit P-26: Expert Report of Dr. Agnes van der Heide, July 24, 2018, and up-to-date curriculum vitae.
[460] *Ibid*.

[450] While the number of euthanasia cases is rising, and in 2015 accounted for 4.5% of all deaths in the country, it is still largely administered to patients with terminal illnesses and limited life expectancy. She confirmed that there have been more controversial cases, where euthanasia, due to the broad wording of the legislation, has extended beyond the traditional sphere. This is the case particularly for people with a mental illness, dementia, or cases known as “life complete”. Although these situations are currently still marginal, they are nonetheless cause for debate within Dutch society on whether euthanasia should be available to these non-traditional cases.

[451] She believes that there is no evidence establishing that the practice of euthanasia in the Netherlands or Belgium has created a heightened risk for vulnerable groups or has been increasing amongst such individuals. She acknowledges, however, that she has no reliable data on the possible existence of any implicit or social pressure to administer euthanasia to vulnerable people.

[452] Two analyses conducted on the subject in 2008 and 2015 do not, however, reflect any increase in euthanasia cases in this category or indicate that vulnerable people requested or were granted authorization in a moment of weakness. Quite the contrary:

> … After careful scrutiny of all available data we found that rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for elderly, women, the uninsured (inapplicable in the Netherlands, where all individuals are insured), people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk were people with AIDS. Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges.[461]

[453] In the Netherlands, as in the United States, the evidence reveals that the majority of people who apply for assistance in dying are educated, are not from a minority community and are socially and economically well off.

[454] Aside from the fact that society appears to be better informed about existing practices, this finding also led Dr. van der Heide to relate the general increase in requests for euthanasia since 2007 to the fact that the aging baby-boomer generation has always valued, even demanded, autonomy and control over their own lives and environment. The control that members of this generation wish to exercise over their death is no exception to the culture of control over their life and destiny.[462]

[455] She emphasized that no one in the Netherlands has ever made any direct or formal link between euthanasia and suicide, and that there is no data linking

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[461] *Ibid*. at para. 35.

[462] This interpretation was also confirmed by Dr. Conwell during his testimony on January 29, 2019, at 110–111.

the two. Suicide remains a major social issue in her country, however, the actions implemented through various public health measures and policies to fight it never refer to or establish a cause and effect relationship with euthanasia, which has now been practised for nearly three decades.

[456] Last, she stated that the regime works well, is supported by the population, and physicians take their role very seriously, proceeding with caution and being able to properly assess the cases they accept. The safeguards are effective. There is no evidence that the Netherlands or Belgium are on a slippery slope[463], in particular with respect to the possibility of euthanasia being administered to people without their consent.[464]

[457] Any breach of the legislative criteria between 2012 and 2016 is listed in a table in her report. For the most part, such cases appear to be due to problems with the administration of the procedure. Dr. van der Heide stated that vigilance is clearly still required to ensure that the most vulnerable members of society remain valued.

Analysis: Comparison with certain foreign regimes

[458] The Court concludes that the evidence does not support the argument that the prevailing situation in foreign jurisdictions includes heightened risks, abuse, or reflects a morally or ethically unacceptable practice that could have repercussions or be imported into Canada.

[459] It does not establish that vulnerable populations in the Netherlands or Belgium are actually at greater risk of requesting and being administered euthanasia, or that physicians might have difficulty assessing the free and informed consent of patients, even those with a psychiatric condition. The fact that doubts have been raised is one thing, but any possible “slippery slope” remains theoretical. While it is clear that we must remain vigilant and ensure that the practice always remains at an optimal level, the evidence adduced does not support this hypothesis. Nor does it support the existence of a link between euthanasia and the rate of suicide in these societies.

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[463] Exhibit P-26: Expert Report of Dr. Agnes van der Heide at para. 42: “A preliminary conclusion from the data might be that the large majority of the Dutch and Belgian population and of Dutch and Belgian physicians support a system in which physician aid in dying is an option, and that they generally do not want to restrict this option to patients who will be dying in the foreseeable future. In both countries, the practice concerns a limited but rising number of patients with a longer life expectancy. Whether this means that the ‘sanctity of life’ principle is trivialized is hard to say, but there seems to be broad awareness in both countries, more demonstrably so in the Netherlands, that a practice of physician aid in dying is not self-evident and represents a significant societal challenge that should be carefully regulated, managed and controlled.” She noted an increase in euthanasia cases to 8% in the Netherlands and to 14.7% in 2013 in Belgium, for patients whose life prognosis was six months and more.

[464] *Ibid*. at para. 46: “The frequency of administering potentially lethal medication without the patient having explicitly requested for it has also decreased in Belgium. In 1998, the percentage of all deaths in which this practice occurred was 3.5%. The percentage dropped to 1.5% in 2001, 1.8% in 2007 and 1.7% in 2013.”

[460] In other words, the argument about the danger to vulnerable groups is based more on a strict application of the precautionary principle, since the reality is that there is no evidence linking medical assistance in dying to the alleged danger to vulnerable groups. It then becomes difficult to explain to people such as the applicants that they must be denied medial aid in dying in the name of a mere hypothesis positing the vulnerability of some otherwise unidentified people.

[461] In the Court's view, the fact that some interpret the absolute number of euthanasia cases in these jurisdictions, or its increase, as a warning sign is more the result of a value judgment. Some view it as a problem in itself, while others, who are of the opposite opinion, view it as an affirmation of personal autonomy to counter a medical culture of therapeutic obstinacy that has long prevailed in certain societies. Several factors might also explain this situation. It is risky, to say the least, to draw a parallel here with any potential future trend in Canada. It stands to reason that, when a completely new regime begins in the wake of a total prohibition, there is an upswing in the number of cases, because the starting point is zero. Nothing indicates, however, that after several years Canada will not follow the data collected abroad in terms of percentage of deaths associated with medical assistance in dying.

[462] We must also exercise caution before claiming that the trends in the Netherlands and Belgium will be transposed to Canada if the reasonably foreseeable natural death requirement is removed from the legislation. The safeguards in our country differ from those in Belgium or the Netherlands.

[463] In *Carter*, the Supreme Court adopted the trial judge's assessment of the various inferences drawn from these same foreign regimes:

> [107] As to the risk to vulnerable populations (such as the elderly and disabled), the trial judge found that there was no evidence from permissive jurisdictions that people with disabilities are at heightened risk of accessing physician-assisted dying (paras. 852 and 1242).She thus rejected the contention that unconscious bias by physicians would undermine the assessment process (para. 1129). The trial judge found there was no evidence of inordinate impact on socially vulnerable populations in the permissive jurisdictions, and that in some cases palliative care actually improved post-legalization (para. 731). She also found that while the evidence suggested that the law had both negative and positive impacts on physicians, it did support the conclusion that physicians were better able to provide overall end-of-life treatment once assisted death was legalized (para. 1271). Finally, she found no compelling evidence that a permissive regime in Canada would result in a "practical slippery slope" (para. 1241).[465]

[464] As the Supreme Court stated in 2015, there is no indication that a permissive regime in Canada with properly designed and administered

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[465] *Carter* at para. 107.

safeguards cannot protect vulnerable people from abuse and error.[466] That remains the case today.

[465] The evidence in this case does not lead the Court to conclude that the situation in these foreign jurisdictions has since changed or evolved in a way that modifies the assessment of the situation made in *Carter*. The evidence instead demonstrates that the situation remains stable. Even though a small number of euthanasia cases outside the traditional sphere has been observed in certain regimes, nothing indicates that, with the regime in place in Canada, even in the absence of the reasonably foreseeable natural death requirement, the same problem will occur here, or that the safeguards in place will not be adequate.

4. Conclusions on the Evidence

[466] From the evidence as a whole, the Court concludes as follows:

1. Medical assistance in dying as practised in Canada is a strict and rigorous process that, in itself, displays no obvious weakness;
2. The physicians involved are able to assess the patients' capacity to consent and identify signs of ambivalence, mental disorders affecting or likely to affect the decision-making process, or cases of coercion or abuse;
3. The vulnerability of a person requesting medical assistance in dying must be assessed exclusively on a case-by-case basis, according to the characteristics of the person and not based on a reference group of so-called "vulnerable persons". Beyond the various factors of vulnerability that physicians are able to objectify or identify, the patient's ability to understand and to consent is ultimately the decisive factor, in addition to the other legal criteria;
4. The physicians involved are able to distinguish a suicidal patient from a patient seeking medical assistance in dying. Moreover, there are important distinctions between suicide and medical assistance in dying with respect to both the characteristics of the people involved and the reasons that motivate them;
5. Neither the national data in Canada or Quebec nor the foreign data indicate any abuse, slippery slope or even heightened risks for vulnerable people when imminent end of life is not an eligibility criterion for medical assistance in dying.

THE ISSUES

1. Has *Carter* created a constitutional right to medical assistance in dying?

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[466] *Ibid*. at paras. 105 and 107. The same applies to the ability of physicians to properly assess the capacity to consent of people applying for medical assistance in dying. See also paras. 104–106.

2. Does the reasonably foreseeable natural death requirement in s. 241.2(2)(*d*) of the *Criminal Code* infringe s. 7 of the *Charter,* which guarantees the right to life, liberty and security of the person?

3. If so, is the infringement of the applicants' fundamental rights justified under s. 1 of the *Charter*?

4. Does the reasonably foreseeable natural death requirement in s. 241.2(2)(*d*) of the *Criminal Code* infringe s. 15 of the *Charter,* which guarantees the right to equal treatment?

5. If so, is the infringement of the applicants' fundamental right justified under s. 1 of the *Charter*?

6. Is subsection 3 of the first paragraph of s. 26 of the *Act respecting end-of-life care* unconstitutional by virtue of these same principles?

7. Can the Attorneys General obtain a suspension of the declaration that these provisions are inoperative and, if necessary, can the applicants be granted a constitutional exemption?

ANALYSIS

1. Has *Carter* Created a Constitutional Right to Medical Assistance in Dying?

[467] In 2015, the Supreme Court's decision in *Carter* resolved the broad legal and social debate surrounding the legalization of a certain form of assisted suicide or euthanasia in Canada, which began over twenty years earlier. It laid the foundation for a new permissive regime that includes important guarantees and safeguards.

[468] Previously, a highly divided Supreme Court in *Rodriguez*[467] had upheld the general prohibition against assisted suicide in Canada. However, despite that decision, the country continued to debate the legalization of a certain form of euthanasia, and Canadian society's social and ethical evolution has since been marked by an increasing willingness to revisit our relationship with death and end-of-life care.

[469] In 1983, well before *Rodriguez*, the Canadian Law Reform Commission had already noted that "the legal profession, the public and those working in the health professions are in favour of legal reforms or at least clarifications in the area of euthanasia, aiding suicide and cessation of treatment".[468] Between 1991 and 2010, several draft bills and studies on the subject were debated in the House of Commons. The Senate submitted a report in 1995 on assisted suicide

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[467] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519.

[468] Law Reform Commission of Canada*, Report of the on Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada,1983) at 9.

and euthanasia.[469] In 2011, the Royal Society of Canada also published its report in favour of a certain degree of openness[470]. In 2012, in Quebec, the Select Committee on Dying with Dignity[471] tabled its report in the National Assembly, which served as the springboard for the enactment of the *Act respecting end-of-life care* that, for the first time in the country, provided for medical aid in dying as end-of-life care.

[470] Meanwhile, society condemned a form of medical practice expressing therapeutic obstinacy and was aware of developments in foreign jurisdictions that had decided to allow euthanasia.

[471] This historical context led to *Carter*, when, in 2012, the Honourable Lynn Smith of the Supreme Court of British Columbia heard a constitutional challenge to the *Criminal Code* provisions prohibiting assisted dying.

[472] Of course, many remain opposed to any form of opening to or legalization of medical assistance in dying, either on cultural or religious grounds, or because they fear a change in the social paradigm of our relationship with death and, in particular, major shifts to the detriment of the most vulnerable persons in our society.

[473] Also, during these same years, the case law on the principles of self-determination, autonomy and human dignity was evolving through a number of major Supreme Court decisions that attest to the rising importance of these values in our law. This trend had already been identified in *Jones*,[472] *Morgentaler*[473] and *Rodriguez*,[474] but was subsequently consolidated in *Blencoe*,[475] *Chaoulli*[476] and *PHS Community Services Society*.[477]

[474] Thus, more than two decades after *Rodriguez*, the Supreme Court in *Carter* agreed to review the issue once again and analyze the rights enshrined in the Charter in light of social progress and with the goal of striking a balance between values that at first glance appear to be competing, namely, the autonomy, liberty and dignity of adults who wish to end their lives due to a grievous and irreversible medical condition, on the one hand, and the protection of the lives of vulnerable persons, on the other.

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[469] The Special Senate Committee on Euthanasia and Assisted Suicide, Of Life and Death: Final Report (June 1995), online: < https://sencanada.ca/content/sen/committee/351/euth/rep/lad-tc-e.htm>.

[470] The Royal Society of Canada, *End-of-Life Decision Making* (Ottawa: November 2011) online: <https://rsc-src.ca/en/end-life-decision-making>.

[471] Exhibit PGQ-4: Quebec National Assembly, *Select Committee on Dying with Dignity* (March 2012).

[472] *R. v. Jones,* [1986] 2 S.C.R. 284, where autonomy is expressed through the notions of dignity, liberty and security. This was the first time that a subjective approach to this notion emerged.

[473] *R. v. Morgentaler,* [1988] 1 S.C.R. 30, where the principle of autonomy of the person was reaffirmed by establishing a direct link between human dignity and bodily autonomy.

[474] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519.

[475] *Blencoe v. British Columbia (Human Rights Commission),* [2000] 2 S.C.R. 307.

[476] *Chaoulli v. Quebec (Attorney General),* [2005] 1 S.C.R. 791.

[477] *Canada (Attorney General) v. PHS Community Services Society*, [2011] 3 S.C.R. 134.

[475] In this sense, *Carter* reaffirms the scope of the individual rights of life, liberty and security of the person and lays the foundation for the legalization of medical assistance in dying throughout Canada. It is, therefore, impossible to ignore it. As such, the teachings of the Supreme Court will guide the Court here.

1.1 Interpretation of *Carter*: Positions of the Parties

[476] The applicants ask the Court to conclude that the legal principles developed by the Supreme Court in *Carter* are now enshrined in the Canadian Constitution and the *Charter*, and that the legislative regime enacted in response to this decision is unconstitutional, in that it requires their natural death to be reasonably foreseeable. They note that the Supreme Court urged Parliament and the provincial legislatures to enact, should they so choose, "legislation consistent with the constitutional parameters set out in [its] reasons".[478] Based on their analysis, the applicants conclude that this was not done.

[477] Given that the Supreme Court's ruling does not require that a person's natural death be reasonably foreseeable to request assistance in dying, the addition of such a requirement, therefore, appears to the applicants to be inconsistent with the constitutional parameters developed by the Supreme Court. This is so because it restricts access to this assistance for many Canadians who, like themselves, otherwise satisfy all the criteria in *Carter* and is, for all practical purposes, tantamount to a total prohibition in their cases. They submit that, in so doing, the federal legislation takes away the right granted to them by the Supreme Court and reinstates, for people in their condition, a regime of prohibition.

[478] They add that the constitutional parameters developed in *Carter* are a minimum threshold that the legislature had to respect in order for the legislative regime on the matter to be constitutional.

[479] With respect to the provincial legislation that preceded *Carter*, they submit that Quebec legislators had an obligation to amend the law so that it complied with the Supreme Court requirements. Their failure to do so means that the end-of-life requirement is unconstitutional.

[480] The Attorneys General dispute these arguments. They contend that the reasonably foreseeable natural death and end-of-life requirements are entirely consistent with the spirit of *Carter,* in that they correspond to the factual circumstances of the main protagonist, Gloria Taylor, who was in the terminal stage of a neurodegenerative disease at the time she joined the litigation before the British Columbia Supreme Court.

[481] This argument relies on the fact that, in its judgement, the Supreme Court noted several times that its reasons were limited to the case of Ms. Taylor and people in her situation, meaning those who were dying or close to death, since, according to the Attorneys General, Ms. Taylor's life prognosis was approximately one year. Because the Supreme Court also stressed the

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[478] *Carter* at para. 126.

similarities between medical assistance in dying and other end-of-life choices and decisions, it therefore placed this assistance in the terminal stage of life.

[482] They maintain that the legislative regime enacted by Parliament did not create a positive right to medical assistance in dying for citizens. The legislator instead designed a criminal legislative regime that creates exemptions from the offences of culpable homicide[479] and aiding suicide for medical practitioners and nurse practitioners[480] providing medical assistance in dying in compliance with the new section 241.2 Cr. C.

1.2 Interpretation of the Case Law: *Canada (Attorney General) v. E.F.*, 2016 ABCA 155

[483] Before analyzing the scope of *Carter*, certain decisions rendered throughout the country may be relevant, although none of them address constitutional issues, in particular, the decision by the Court of Appeal of Alberta in *Canada (Attorney General) v. E.F.*[481]

[484] There, the plaintiff sought authorization for medical assistance in dying during the period extending the suspension of the declaration of invalidity ordered by the Supreme Court on January 15, 2016.[482] The Court of Appeal of Alberta had to determine whether the plaintiff's medical condition must be terminal in order to grant the authorization.

[485] As indicated earlier, by then, the Supreme Court had granted the Government of Canada an additional four months to legislate before the *Carter* declaration that sections 14 and 241(*b*) Cr. C. were invalid took effect. In so doing, it also granted a constitutional exemption to people such as E.F. who wished to receive medical assistance in dying and who met the criteria set out in paragraph 127 of the judgment.[483]

[486] In its judgment on the constitutional exemption, the Supreme Court stated the following:

> [6] This is the first time the Court has been asked to consider whether to grant individual exemptions during an *extension* of a suspension of a declaration of invalidity. Parliament was given one year to determine what, if any, legislative response was appropriate. **In agreeing that more time is needed, we do not at the same time see any need to unfairly prolong the suffering of those who meet the clear criteria we set out in *Carter***. An exemption can mitigate the severe harm that may be occasioned to those adults who have a grievous, intolerable and irremediable medical condition by making a remedy available now pending Parliament's response. The prejudice to the rights flowing from the four-month extension outweighs countervailing considerations.

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[479] Section 227 Cr. C.

[480] Section 241(1) Cr. C.

[481] 2016 ABCA 155.

[482] *Carter v. Canada (Attorney General)*, [2016] 1 S.C.R. 13.

[483] The Court had also granted a constitutional exemption to the government of Quebec with respect to requests for medical aid in dying in the province.

> Moreover, the grant of an exemption from the extension to Quebec raises concerns of fairness and equality across the country. **We would, as a result, grant the request for an exemption so that those who wish to seek assistance from a physician in accordance with the criteria set out in para. 127 of our reasons in *Carter*, may apply to the superior court of their jurisdiction for relief during the extended period of suspension.** Requiring judicial authorization during that interim period ensures compliance with the rule of law and provides an effective safeguard against potential risks to vulnerable people.[484]
>
> [Emphasis added.]

[487] E.F. therefore sought judicial authorization for medical assistance in dying during this period. She had the capacity to consent and suffered from a severe but not terminal medical condition. While the issue before the Court of Appeal of Alberta required it to ensure that E.F. met the criteria in paragraph 127 of *Carter*, and not rule on a constitutional dispute, the Court was categorical in its interpretation of the eligibility principles for medical assistance in dying set out in *Carter*. It based its reasoning on two separate elements.

[488] It first stated that it was erroneous to read into the last two sentences of para. 127 of *Carter* (“The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought.”) an intention by the Supreme Court to limit the right, to create a new criterion or to restrict access to medical assistance in dying exclusively to people in the same factual circumstances as Ms. Taylor.

[489] This declaration should instead be understood as an acknowledgment that there might be other factual circumstances that were not at issue in *Carter* – for example, minors or advance medical directives – which the Supreme Court did not address.[485] It should, therefore, not be construed as limiting access to medical assistance in dying only to people near death.

[490] As regards the second element, it is appropriate to reproduce the Court’s own words:

> 40. Any attempt to read in or infer additional limitations to those expressly set out in paragraph 127 must respect the balance of competing values struck by the court - balancing the sanctity of life, broadly speaking, and society’s interest in protecting the vulnerable against the *Charter* rights of an individual to personal autonomy without state intervention, including autonomy over personal decisions regarding one’s life and bodily integrity. Given the importance of the interests at stake, **it is not permissible to conclude that certain people, whose circumstances meet the criteria set out in the *Carter 2015* declaration and who are not expressly excluded from it, nevertheless can be inferentially excluded.** …

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[484] *Carter v. Canada (Attorney General)*, [2016] 1 S.C.R. 13.

[485] *Canada (Attorney General) v. E.F.*, 2016 ABCA 155, at para. 34.

> 41. **In summary, the declaration of invalidity in *Carter 2015* does not require that the applicant be terminally ill to qualify for the authorization. The decision itself is clear. No words in it suggest otherwise. If the court had wanted it to be thus, they would have said so clearly and unequivocally. They did not**. The interpretation urged on us by Canada is not sustainable having regard to the fundamental premise of *Carter* itself as expressed in its opening paragraph, and does not accord with the trial judgment, the breadth of the record at trial, and the recommended safeguards that were ultimately upheld by the Supreme Court of Canada.[486]
>
> [Emphasis added.]

[491] Although the Court is not bound by that judgment, it fully endorses the principles stated therein.

[492] It should also be mentioned that, during the exemption period[487], at least 15 requests were submitted and granted by courts nationwide.[488] Among these requests, three of them, including *E.F.*'s request, involved people who were not near death. Nevertheless, given that the courts held that the requirements of para. 127 of *Carter* were met, the requests of the persons who were not at the end of their lives were granted.[489]

1.3 Interpretation of *Carter*: Analysis

[493] The following three paragraphs from *Carter*[490] reflect particularly well the underpinnings of the reasoning and the parameters set out by the Supreme Court:

> [1] It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two

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[486] *Ibid*. at paras. 40–41.

[487] The interim period was from February 6, 2015, to June 6, 2015.

[488] *HS(Re)*, 2016 ABQB 121; *A.B. v. Canada (Attorney General)*, 2016 ONSC 1912; *Patient v. Attorney General of Canada*, 2016 MBQB 63; *A.B. v. Ontario (Attorney General)*, 2016 ONSC 2188; *A.A. (Re)*, 2016 BCSC 570; *W.V. v. Canada (Attorney General)*, 2016 ONSC 2302; *CD v. Canada (Attorney General)*, 2016 ONSC 2431; *EF v. Canada (Attorney General)*, 2016 ONSC 2790; *Canada (Attorney General) v. E.F.*, 2016 ABCA 155; *Patient 0518 v. RHA 0518, Physician A0518 and Physician C0518*, 2016 SKGB 176; *M.N. v. Canada (Attorney General)*, 2016 ONSC 3346; *I.J. v. Canada (Attorney General)*, 2016 ONSC 3380; *H.H. (Re)*, 2016 BCSC 971; *Tuckwell (Re)*, 2016 ABQB 302; *O.P. v. Canada (Attorney General)*, 2016 ONSC 3956.

[489] See for example *I.J. v. Canada (Attorney General)*, 2016 ONSC 3380 at paras. 18–19: "In *A.B. v. Canada*, while I said that it would be sufficient that a person's grievous medical condition was life-threatening or terminal, I did not say that a terminal illness was a necessary precondition for a constitutional exemption. The gravamen of a grievous and irremediable medical condition is not whether the illness, disease, or disability is terminal but the grievousness is the threat the medical condition poses to a person's life and its interference with the quality of that person's life." See also *H.H. (Re)*, 2016 BCSC 971 at paras. 5 and 25.

[490] The principles stated in para. 127 of the decision are also repeated in paras. 4 and 147 of the decision.

> options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.
>
> [126] We have concluded that the laws prohibiting a physician's assistance in terminating life (*Criminal Code*, s. 241(*b*) and s. 14) infringe Ms. Taylor's s. 7 rights to life, liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice, and that the infringement is not justified under s. 1 of the *Charter*. To the extent that the impugned laws deny the s. 7 rights of people like Ms. Taylor they are void by operation of s. 52 of the *Constitution Act, 1982*. It is for Parliament and the provincial legislatures to respond, should they so choose, by enacting legislation consistent with the constitutional parameters set out in these reasons.
>
> [127] The appropriate remedy is therefore a declaration that s. 241(*b*) and s. 14 of the *Criminal Code* are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought.

[494] After analyzing the parties' respective arguments in this regard, the Court concludes that the position of the Attorneys General, based in part in the last two sentences in paragraph 127 of the judgment, is erroneous and that it cannot be accepted for several reasons.

[495] First, the criteria in paragraph 127 are clear. The Supreme Court neither expressly nor implicitly limits or restricts access to medical assistance in dying exclusively to people whose natural death is reasonably foreseeable or who are at the end of life. Had the Supreme Court wanted to establish or impose a temporal relationship between the administration of medical assistance in dying and the imminence of death, it would certainly have stated it explicitly in its reasons for judgment, whereas it actually took great care to set out the conditions giving rise to access.

[496] Second, medical assistance in dying exists in Canada primarily so that those who make this choice avoid a life of suffering. The "cruel choice" referred to by the Supreme Court between taking one's life prematurely or suffering until one's natural death occurs is not linked to the terminal nature of the medical condition causing the suffering. A suffering person lives in a cruel situation, regardless of the terminal stage of his or her illness. Paradoxically, the more distant in time the death appears, the more cruel the situation.

[497] In the Court's view, the basis of the ruling in *Carter* is not the proximity of death or the temporal relationship with the expected natural death but, instead, the respect for the person's wishes, the preservation of the person's dignity and, above all, the alleviation of the person's intolerable suffering associated with a grievous and irremediable illness. The rationale is to allow a person suffering from a grievous and irremediable medical condition, who no longer has any hope of improvement, to end his or her suffering and to avoid living until the final agonizing breaths have been drawn, should the person so desire.

> [68] … This [requesting medical assistance in dying] is a decision that is rooted in their [some people's] control over their bodily integrity; it represents their deeply personal response to serious pain and suffering. By denying them the opportunity to make that choice, the prohibition impinges on their liberty and security of the person.[491]

[498] Last, the argument that Ms. Taylor, the applicant in *Carter*, was in the final stages of her disease changes nothing. If this were an important restriction or limitation to be considered, the Supreme Court had the clear opportunity to say so. The Court does not conclude from the numerous excerpts of the judgment cited[492] by the Attorney General of Canada his conclusion that there is an implied indication that medical assistance in dying should be limited to people in the same circumstances as Ms. Taylor. The language in the declaration of invalidity is broad, and the definition of the words "grievous and irremediable illness" clearly does not exclude those that are not terminal. No person could seriously claim that Mr. Truchon and Ms. Gladu are suffering from medical conditions that are neither grievous nor irremediable.

[499] The Court concludes that neither paragraph 127 of *Carter* nor the decision as a whole, in letter or in spirit, can be interpreted as limiting access to medical assistance in dying to people near death. Rather, it finds that it should be construed as providing access to any person who meets the Supreme Court's clear requirements, whether or not death is reasonably foreseeable.

[500] The Court's finding is the same when it is asked to infer that the Supreme Court, by drawing parallels with other end-of-life decisions, necessarily associated medical assistance in dying with the proximity of death. There are many situations where patients who are neither dying nor in the terminal stage of their life refuse life-saving treatment or stop life-sustaining treatment.

[501] Consequently, the statutory requirement for a reasonably foreseeable natural death in s. 241.2(2)(*d*) Cr. C. and that of end of life in subsection 3 of the first paragraph of s. 26 of the Quebec legislation are both clearly inconsistent with the parameters set out by the Supreme Court in *Carter*. They deprive people with medical conditions similar to those of the applicants of the possibility granted in *Carter* to access medical assistance in dying.

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[491] *Carter* at para. 68.

[492] During arguments, the Attorney General of Canada referred more specifically to paras. 11, 12, 42, 56, 65, 66, 70, 86 and 126 of *Carter*.

1.4 Scope and Consequences of This Interpretation

[502] That said, the Court must now determine whether these requirements are in and of themselves unconstitutional. In other words, even if they are inconsistent with the *Carter* parameters, are they *de facto* unconstitutional, as the applicants submit? The Court does not think so.

[503] The mere fact that the federal statute includes additional requirements or conditions not found in *Carter* does not render it unconstitutional, as such.[493] The applicants' burden of proving that their section 7 and 15 *Charter* rights have been infringed is not lesser simply because the impugned provisions are not in perfect harmony with *Carter*.

[504] The Supreme Court has already confirmed the constitutionality of provisions enacted by the legislature in response to some of its judgments, even though they differed from its teachings.[494]

[505] *Mills*[495] remains the governing authority in the matter. In that case, the accused challenged the constitutionality of *Criminal Code* provisions dealing with the production of records in sexual offence proceedings. The legislative provisions at issue had been enacted in response to *O'Connor*[496], where a majority of the Supreme Court created a less restrictive evidentiary disclosure regime than the one that existed at the time. By applying the concept of "*Charter* dialogue"[497] to the relationship between the courts and legislatures, the Supreme Court confirmed that Parliament could design a different legislative regime as long as it remains constitutional:

> [55] The respondent and several supporting interveners argue that Bill C-46 is unconstitutional to the extent that it establishes a regime for production that differs from or is inconsistent with that established by the majority in *O'Connor*. However, it does not follow from the fact that a law passed by Parliament differs from a regime envisaged by the Court in the absence of a statutory scheme, that Parliament's law is unconstitutional. Parliament may build on the Court's decision, and develop a different

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[493] Hamish Stewart, "Constitutional Aspects of Canada's New Medically-Assisted Dying Law", (2018) 85 S.C.L.R. (2d) 435 at 452.

[494] Professor Peter W. Hogg refers to these Supreme Court judgments as "second look cases". See Peter W. Hogg, *Constitutional Law of Canada*, 5th ed., vol. 2 (Toronto: Thomson Reuters, 2007) loose-leaf, updated in 2017, at para. 36.5(*b*), at 36 - 14.2 *et seq.*

[495] *R. v. Mills,* [1999] 3 S.C.R. 668.

[496] *R. v. O'Connor,* [1995] 4 S.C.R. 411.

[497] The metaphor "*Charter* dialogue" was introduced in 1997 by authors Peter W. Hogg and Allison A. Bushell, "The *Charter* Dialogue Between Courts and Legislatures," (1997) 35 Osgoode Hall L.J. 75. They did not expect the attention it would receive in the case law or doctrine. Later, the authors clarified the meaning of the metaphor: "In '*Charter* Dialogue,' we referred to the sequence of new laws following Charter decisions as a '*Charter* dialogue' between the courts and legislatures. By this, we did not mean that the courts and legislatures were literally 'talking' to each other. We made it clear that all that we meant by the dialogue metaphor was that the court decisions in *Charter* cases usually left room for a legislative response, and usually received a legislative response." Peter W. Hogg, Allison A. Bushell Thorton & Wade K. Wright, *"Charter* Dialogue Revisited – Or "Much Ado About Metaphors"", (2007) 45 Osgoode Hall L.J. 1, at 4.

> scheme as long as it remains constitutional. Just as Parliament must respect the Court's rulings, so the Court must respect Parliament's determination that the judicial scheme can be improved. **To insist on slavish conformity would belie the mutual respect that underpins the relationship between the courts and legislature that is so essential to our constitutional democracy** ….[498]
>
> [Emphasis added.]

[506] The Attorney General of Canada raises *Mills* to justify Parliament's attempt to respond, through Bill C-14, to the concerns expressed by certain vulnerable groups and to underline the particular deference the Court must show in such circumstances:[499]

> [58] … Courts do not hold a monopoly on the protection and promotion of rights and freedoms; Parliament also plays a role in this regard and is often able to act as a significant ally for vulnerable groups. … If constitutional democracy is meant to ensure that due regard is given to the voices of those vulnerable to being overlooked by the majority, then this court has an obligation to consider respectfully Parliament's attempt to respond to such voices.[500]

[507] The Court will address the issue of judicial deference as part of its analysis under section 1 of the *Charter*. At this stage, it will merely paraphrase the Supreme Court's clarification in *Canada (Attorney General) v. JTI-Macdonald Corp.*[501]: the mere fact that Bill C-41 represents Parliament's response to *Carter* does not weigh in favour of or against deference.[502] If the Court finds that the applicants' fundamental rights have been infringed, the Attorney General must nevertheless justify any infringement under section 1 of the *Charter*.

[508] Therefore, at this stage of the analysis, the Court cannot accept the applicants' argument and conclude that the legislative regime at issue is unconstitutional solely because it differs from the *Carter* parameters. The Court acknowledges Parliament's absolute sovereignty in this matter and that the exercise of legislative authority is essential for our democracy to function.

[509] Without denying the difficulty of the legislature's task, recognized in *Carter*, to legislate as it deems appropriate in a matter as novel as medical assistance in dying, the fact remains that it is for the Court to review the constitutionality of legislation, whether enacted in response to a "dialogue" initiated by the Supreme Court, as is the case for the federal legislation, or following a parliamentary initiative, such as the Quebec legislation.

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[498] *R. v. Mills,* [1999] 3 S.C.R. 668 at para. 55.

[499] Written submissions by the Attorney General of Canada, at paras. 140 and 141.

[500] *R. v. Mills,* [1999] 3 S.C.R. 668 at para. 58.

[501] [2007] 2 S.C.R. 610.

[502] *Ibid*. at para. 11, citing Peter W. Hogg, Allison A. Bushell Thorton & Wade K. Wright, "Charter Dialogue Revisited – Or "Much Ado About Metaphors"", (2007) 45 Osgoode Hall L.J. 1, at 47–48. See also Kent Roach, "Sharpening the Dialogue Debate: The Next Decade of Scholarship", (2007) 45 Osgoode Hall L.J. 169 at 175.

[510] Consequently, the Court must review the constitutionality of s. 241.2(2)(*d*) of the *Criminal Code* and subsection 3 of the first paragraph of s. 26 of the *Act respecting end-of-life care* based on sections 7 and 15 of the *Charter*.

2. **Does the Reasonably Foreseeable Natural Death Requirement, Set out in s. 241.2(2)(*d*) of the *Criminal Code,* Infringe Section 7 of the *Charter*, Which Protects the Rights to Life, Liberty and Security of the Person?**

[511] Section 7 of the *Canadian Charter of Rights and Freedoms* states:

> 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.

[512] In order to establish that a section 7 *Charter* right has been infringed, applicants must complete two steps. They must first demonstrate that the statute or measure taken by the state deprives them of or interferes with their right to life, liberty or security of the person. If successful, they must then persuade the Court that the deprivation or interference at issue infringes the principles of fundamental justice. Section 7 does not guarantee that a statute will never intrude on a person’s life, liberty or security, only that it will not do so in violation of the principles of fundamental justice.

[513] The rights to life, liberty and security of the person have been interpreted many times by the courts and often go together, even though they are separate rights.[503] That said, only one of these rights need be infringed in order to justify a finding of a section 7 violation. The Court will now review this provision’s meaning and analyze its scope in light of the evidence adduced in this case.

2.1 The Right to Life

[514] In *Carter*, the Supreme Court itself specifically circumscribed the notion of the right to life in section 7 of the *Charter* with regards to the absolute prohibition against assisted suicide in Canada. It concluded that the right to life is in question where the law or state action “imposes death or an increased risk of death on a person, either directly or indirectly”.[504]

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[503] *Miller et al. v. The Queen*, [1977] 2 S.C.R. 680; *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486, *R. v. Morgentaler*, [1988] 1 S.C.R. 30; *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307; *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791; *Canada (Attorney General) v. PHS Community Services Society*, [2011] 3 S.C.R. 134 etc.

[504] *Carter* at para. 62. As noted by certain authors, while this formulation of the right to life might appear broad, it is not broad enough to include notions such as personal autonomy, quality of life, self-determination and dignity, that the Supreme Court prefers to treat as likely to be engaged by an infringement of the right to liberty or security of the person. See in particular Hamish Stewart, *Fundamental Justice. Section 7 of the Canadian Charter of Rights and Freedoms*, 2nd. ed. (Toronto: Irwin Law, 2019) at 71.

[515] The Supreme Court recognized in *Carter* that the prohibition against medical assistance in dying engaged the right to life and that, even though this right is without a doubt defined primarily as “a right not to die”,[505] it does not, however, create a duty to live. Otherwise, it would lead to a questioning of the legality of any consent to the withdrawal, termination or refusal of lifesaving or life-sustaining treatment.

[516] It therefore concluded that the prohibition against medical assistance in dying in s. 241(*b*) Cr. C. infringed the right to life because it had the effect of forcing some individuals to take their own lives prematurely for fear that they would be incapable of doing so when they reached the point where suffering was intolerable.[506]

[517] The applicants submit mainly essentially the same argument. They claim that the reasonably foreseeable natural death requirement is tantamount to a prohibition of medical assistance in dying for any person who, like them, is not at the end of life. In this sense, it forces some of these individuals to take charge of their own destiny and take hasty steps to end their lives prematurely out of fear that they will no longer be physically able to do so once their suffering becomes intolerable. Consequently, they claim that the reasonably foreseeable natural death requirement exposes them to a heightened risk of death and, therefore, infringes on their *Charter* right to life.

[518] The Attorney General of Canada argues that the right to life is not engaged in this case because, contrary to the situation in *Carter*, no one is being forced to end his or her life prematurely. On the contrary, the Attorney General of Canada believes that the applicants wish to end their lives with medical assistance by challenging the criterion of a reasonably foreseeable natural death on the ground that it forces them to prolong their lives by delaying their eligibility. While these individuals may indeed suffer during this period, this does not support the argument that the effect of the requirement at issue shortens their lives.

[519] The Court cannot agree with the Attorney General of Canada’s arguments. The reasonably foreseeable natural death requirement clearly prohibits eligibility for medical assistance in dying for every person who is not near to death, like Mr. Truchon or Ms. Gladu.

[520] The uncontradicted persuasive evidence establishes that, if this requirement is upheld, Ms. Gladu’s intention is to travel to Switzerland to die and Mr. Truchon’s is to voluntarily die of hunger and thirst because, given his condition, he has no other less painful means to kill himself.

[521] The conclusion is the same even if, as the Attorney General of Canada submits, the legal requirement may have a *de facto* effect of prolonging the life of some people who would otherwise request medical assistance in dying. On the contrary, due to the prolongation of their life and the accompanying suffering,

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[505] *Carter* at para. 61 citing *Carter BCSC* at para. 1322.

[506] *Carter* at para. 57.

some patients will be inclined to end things prematurely, and often in a degrading or violent manner, before being in mortal agony, or having completely lost their dignity or being in the final stage of life.

[522] The reasonably foreseeable natural death requirement thus exposes individuals such as Mr. Truchon or Ms. Gladu to a heightened risk of death. It therefore infringes their right to life under section 7 of the *Charter*.

2.2 Rights to Liberty and Security of the Person

[523] In 1988, in *Morgentaler*[507], the Supreme Court had already identified the markers of an infringement of the right to liberty, quoting John Stuart Mill: "Each is the proper guardian of his own health, whether bodily or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves than by compelling each to live as seems good to the rest. Liberty in a free and democratic society does not require the state to approve the personal decisions made by its citizens; it does, however, require the state to respect them"*.*

[524] The concern for the protection of an individual's autonomy and dignity underlies these two rights, especially when applied to medical decisions and interferences with bodily integrity. Liberty "protects the right to make fundamental personal choices free from state interference" and security "encompasses a notion of personal autonomy involving . . . control over one's bodily integrity free from state interference...and it is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering".[508]

[525] The applicants ask the Court to follow the ruling in *Carter*, whereby the prohibition against medical assistance in dying violates the rights to liberty and security of the person, in that it[509]:

1. interferes with fundamentally important and personal medical decision-making, thereby imposing pain and stress by depriving people of control over their bodily integrity;
2. leaves people to suffer physical or psychological pain and imposes stress on them by prohibiting access to medical assistance in dying;
3. deprives people suffering from a grievous and irremediable illness of the opportunity to make important choices to preserve their dignity and personal integrity, choices that are consistent with their lifelong values.

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[507] *R. v. Morgentaler*, [1988] 1 S.C.R. 30 at 167.

[508] *Carter* at para. 64 citing *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307 at paras. 54, 55–57; *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 at 587–588; *R. v. Morgentaler*, [1998] 1 S.C.R. 30; *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46 at para. 58; *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791 at para. 43.

[509] *Carter* at paras. 65 and 66.

[526] According to the Supreme Court, it is incongruous, to say the least, that people may legally request palliative sedation or stop treatment, including eating, drinking or respiratory assistance, but are nonetheless prohibited from requesting medical assistance in dying. Competent adults have long enjoyed the right in Canada to decide their own fate and to direct the course of their own medical care[510], even if their decision inevitably leads to their death.

[527] Based on these principles, the applicants submit that the fact that they cannot access medical assistance in dying because of the reasonably foreseeable natural death requirement infringes on their freedom of choice and on their exercise of autonomy.

[528] It also deprives them of their dignity and forces them to suffer while awaiting death, or to opt for a solution that will ultimately cause them greater suffering before they die: to kill themselves using another more often violent and traumatic means, or to take steps with the hope that they will become eligible for medical assistance in dying but which will cause them greater suffering in the interim. In Mr. Truchon’s case, for example, recourse to VSED may cause his condition to deteriorate and, after further suffering, ultimately make him eligible for medical assistance in dying, if he still has the capacity to confirm his consent at the appropriate time. That is a cruel path.

[529] The Attorney General of Canada maintains that only people who are physically incapable of making decisions regarding their bodily integrity and who are suffering yet cannot request medical assistance in dying because their natural death is not reasonably foreseeable will see their section 7 rights infringed.[511] Such infringement, however, is consistent with the principles of fundamental justice, or, if it is not, is justified under section 1 of the *Charter*.

[530] For people who do not fall within this limited category, the Attorney General of Canada submits that nothing prevents them from exercising their autonomy, because they can end their own lives themselves, without any state intervention. His criticism of people in the same situation as the applicants is that they are demanding a way to end their lives that does not have the effect of infringing on their liberty or security.

[531] Last, he submits that the principles laid down in *Carter* are limited to people already at the end of life because the Supreme Court drew a comparison with individuals dependant on life-sustaining equipment or treatment, artificial nutrition or hydration, or palliative sedation, i.e., clearly at the end of life, and who are in fact exercising a choice on how to die. According to the Attorney General, that is the fundamental basis of that judgment. Since Ms. Taylor was at the end of life, the Supreme Court’s statements must be understood as referring only to this very precise category of people.

[532] For the reasons previously explained, the Court concludes that the Supreme Court’s statements are general in nature and are not limited to people

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[510] *Carter* at para. 67.

[511] Arguments of the Attorney General of Canada at para. 35.

already in the terminal stage of their lives. Instead, they are intended to recognize the decision-making autonomy and the right of every person to make medical decisions affecting his or her own body, regardless of the timing and potential consequences of those decisions.

[533] In this case, the applicants' position must be accepted. Mr. Truchon and Ms. Gladu are prevented from making this fundamental decision and from exercising this highly private decision-making autonomy that reflects their value and dignity as human beings. They do not control their physical integrity because the state, through the reasonably foreseeable natural death requirement, prevents them from accessing medical assistance in dying and, above all, forces them to endure painful physical and psychological suffering.

[534] Therefore, the state, by enacting the reasonably foreseeable natural death requirement, directly interferes with their physical integrity, causes them physical and psychological pain and deprives them of the opportunity to make a fundamental decision that respects their personal dignity and integrity.

[535] The Court has no hesitation in concluding that the reasonably foreseeable natural death requirement infringes Mr. Truchon and Ms. Gladu's rights to liberty and security, protected by section 7 of the *Charter*.

2.3 Principles of Fundamental Justice

[536] Although section 7 does not list the principles of fundamental justice, Canadian case law has defined the minimum constitutional requirements that must be met by a law that restricts a person's rights to life, liberty and security.[512]

[537] The Courts are currently guided by three central principles, although others exist.[513] A law that impinges upon a person's rights to life, liberty or security must not be arbitrary, overbroad, or have consequences that are grossly disproportionate to its object.[514]

[538] The applicants submit that the federal statute is tainted by each of these flaws, but they focus primarily on the fact that it is overly broad.[515]

[539] The interveners Association québécoise pour le droit de mourir dans la dignité and Dying with Dignity Canada raise as an alternative argument the fundamental principle of vagueness. They argue that [TRANSLATION] "the provision is contrary to the principles of fundamental justice and therefore unconstitutional

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[512] *Canada (Attorney General) v. Bedford*, [2013] 3 S.C.R. 1101 at para. 94; *Carter* at para. 71 *et seq.*

[513] *Carter* at paras. 72, 91–92. The Supreme Court refused to determine that "parity" is a principle of fundamental justice. See also Hamish Stewart, *Fundamental Justice. Section 7 of the Canadian Charter of Rights and Freedoms*, 2nd ed. (Toronto: Irwin Law, 2019), at 136 *et seq*, and 191 *et seq.*

[514] *Carter* at para. 72.

[515] Originating application for declaratory judgment at para. 231. In their written submissions, they address only its overbreadth, and in their reply they discuss the three principles of fundamental justice cited in the text.

due to its vagueness, the lack of any real uniform medical definition and the unequal access to MAID".[516]

[540] The Attorney General of Canada considers that the reasonably foreseeable natural death requirement is not overbroad, arbitrary, grossly disproportionate or unconstitutional due to the vagueness of its wording.

[541] Each of these principles of fundamental justice should be assessed in its context and in relation to the object of the impugned provision to determine whether the constitutional requirements have nonetheless been met.

[542] At this stage, the analysis should be conducted specifically from the perspective of an infringement of the applicants' fundamental rights. The issue is whether the applicants have successfully established that their life, liberty or security has been violated in a manner that is inconsistent with the principles of fundamental justice. This violation should not be assessed in relation to competing social, religious or cultural interests, or by opposing them to the broad public benefits conferred by the impugned law.[517]

[543] The Supreme Court adopts an individualistic interpretation of the principles of fundamental justice, despite the existing connection between the means advanced by the legislature and the objectives ultimately sought. In *Bedford*[518], the Supreme Court established the following principle by recalling that the analysis must focus on the rights of the claimants themselves:

> [123] All three principles — arbitrariness, overbreadth, and gross disproportionality — compare the rights infringement caused by the law with the objective of the law, not with the law's effectiveness. That is, they do not look to how well the law achieves its object, or to how much of the population the law benefits. They do not consider ancillary benefits to the general population. Furthermore, none of the principles measure the percentage of the population that is negatively impacted. The analysis is qualitative, not quantitative. **The question under s. 7 is whether *anyone's* life, liberty or security of the person has been denied by a law that is inherently bad; a grossly disproportionate, overbroad, or arbitrary effect on one person is sufficient to establish a breach of s. 7.**
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> [Emphasis added]

[544] It is, therefore, clear that at this stage the focus must be on the restriction of Mr. Truchon's and Ms. Gladu's rights to life, liberty and security, rather than on the general social repercussions and society's interests as a whole. A grossly

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[516] Arguments of interveners Association québécoise pour le droit de mourir dans la dignité and Dying with Dignity Canada at para. 88.

[517] *Carter* at para. 79. The central point is to determine the impact of a legislative measure on the fundamental rights set out in s. 7 of the *Charter* on the person claiming the violation, and not on the broader social objectives the measure seeks to remedy. To this effect, see also, Hamish Stewart, *Fundamental Justice. Section 7 of the Canadian Charter of Rights and Freedoms*, 2nd ed. (Toronto: Irwin Law, 2019) at 150.

[518] *Canada (Attorney General) v. Bedford*, [2013] 3 S.C.R. 1101 at para. 123.

disproportionate, overbroad or arbitrary effect on one person is sufficient to establish a breach of a section 7 *Charter* right.[519]

[545] In fact, and as recognized by the Attorney General of Canada, the effect of the criterion of a reasonably foreseeable natural death on people other than the applicants whose characteristics are related to the objects of the law should be reviewed at the section 1 *Charter* stage, if necessary.[520]

[546] To determine whether the state has violated the principles of fundamental justice, the Court must first identify the object of the impugned provision.[521] Determining the object of the law is essential, because the analysis of the principles of fundamental justice involves a comparison with this object.[522]

The object of the impugned provision

[547] The parties rightly insist on the importance of properly identifying the object of the impugned federal provision before conducting the *Charter* analysis.

[548] In an earlier judgment in this case, the Court stated that it did not have to examine the entire new legislative regime put in place by Parliament in the wake of *Carter*, or even all of the law's objectives, if there should happen to be many, that are not related to the impugned provision.[523]

[549] The Court, in fact, assumed that the new legislative regime is constitutional, or at least is presumed to be so at this stage, and that it need only review the reasonably foreseeable natural death requirement.

[550] The applicants allege that Parliament's sole true objective is the same as that identified in *Carter*, namely to protect vulnerable persons from being induced to end their lives in a moment of weakness.[524]

[551] The Attorney General of Canada submits that the new legislative regime has three objectives, two of which differ from the one that existed at the time the absolute prohibition was in force in Canada.[525] These three objectives are formulated as follows:

1. That it is important to affirm the inherent and equal value of every person's life and to avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled;

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[519] *Ibid.* at paras. 123–125 and 127.

[520] Arguments of the Attorney General of Canada at para. 83.

[521] *Carter* at para. 73; *R. v. Moriarity*, [2015] 3 S.C.R. 485 at para. 24; *R. v. Safarzadeh-Markhali*, [2016] 1 S.C.R. 180 at para. 24.

[522] *Carter* at para. 73.

[523] *Truchon c. Procureur général du Canada*, 2018 QCCS 317 at paras. 25–26.

[524] Written submissions of applicants at paras. 349 and 354; Reply of applicants at para. 289.

[525] It is noteworthy that in *Carter,* the Supreme Court determined that the purpose of the legislation was to protect vulnerable persons from being induced to commit suicide at a time of weakness and rejected the other proposed purpose of the "preservation of life" as too broad and representing instead an animating social principle rather than a purpose as such. *Carter* at paras. 74–77 and 86. See also Outline of the Attorney General of Canada, February 19, 2019, at 8.

2. That suicide is a significant public health issue that can have lasting and harmful effects on individuals, families and communities;[526]
3. That vulnerable persons must be protected from being induced, in moments of weakness, to end their lives.

[552] The Court assumes that the Attorney General considers that the three objectives identified cover both the entire new legislative regime and the impugned provision of a reasonably foreseeable natural death.[527]

[553] It is well established that, for the purposes of both a section 7 and a section 1 *Charter* analysis, the Court must identify the object of the impugned measure, because the applicants must prove, and the state must justify, the infringement of fundamental rights by this measure, not by the entire legislative regime. The Supreme Court noted in *RJR-MacDonald Inc. v. Canada (Attorney General)* and in various subsequent decisions[528], including *Carter*, that "the [relevant] objective... is the objective of the infringing measure"[529] or of the limitation[530] and that an objective that is too broadly stated "has the potential to short-circuit the analysis."[531]

[554] The Court is further guided by the Supreme Court's judgments in *Moriarity*[532] and *Safarzadeh-Markhali*[533] regarding the approach for properly characterizing Parliament's purpose:

(a) the law's purpose is distinct from the means used to achieve that purpose;

(b) the law's purpose should be characterized at the appropriate level of generality, namely, neither overly broad nor overly narrow;

(c) the statement of purpose should be both precise and succinct and the courts should focus on the purpose of the challenged statutory provision;

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[526] Outline of the Attorney General of Canada, February 19, 2019, at 8 and Arguments of the Attorney General of Canada at para. 12. It should be noted, however, that the third objective is formulated differently in the AGC's Arguments [TRANSLATION]: "To protect public health by ensuring consistency and an effective approach to suicide prevention measures".

[527] In para. 12 of its arguments, the Attorney General of Canada refers to these objectives as being those of the new legislation and of the reasonably foreseeable natural death requirement.

[528] *Toronto Star Newspapers Ltd*. *v*. *Canada*, [2010] 1 S.C.R. 721 at para. 20 citing *RJR-MacDonald Inc. v*. *Canada (Attorney General)*, [1995] 3 S.C.R. 199 at para. 144; *R. v. K.R.J.*, [2016] 1 S.C.R. 906 at para. 62 citing *Toronto Star Newspapers Ltd*. *v*. *Canada*, [2010] 1 S.C.R. 721 at para. 20. In these judgments, the Supreme Court principles on identifying the objective of the law are set out at the stage of s. 1 of the *Charter* analysis.

[529] *RJR-MacDonald Inc. v*. *Canada (Attorney General)*, [1995] 3 S.C.R. [199] at para. 144.

[530] *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux*, [2018] 1 S.C.R. 464 at para. 45 citing *RJR-MacDonald Inc. v*. *Canada (Attorney General)*, [1995] 3 S.C.R. 199 at para. 144.

[531] *Carter* at para. 77 citing *RJR-MacDonald Inc. v*. *Canada (Attorney General)*, [1995] 3 S.C.R. 199 at para. 144.

[532] *R. v*. *Moriarity*, [2015] 3 S.C.R. 485 at paras. 27–31.

[533] *R. v. Safarzadeh‑Markhali*, [2016] 1 S.C.R. 180, at paras. 26–29 and 31.

(d) at this stage, the legislative objective should be taken "at face value", meaning appropriate and lawful;

(e) to do so, courts look to the measure's statement of purpose in the legislation, if any, as well as the text, context, and scheme of the legislation, and any extrinsic evidence such as legislative history and evolution.

[555] That said, the Court cannot accept the two first objectives advanced by the Attorney General regarding the affirmation of the inherent and equal value of every person's life and the importance of preventing suicide. As in *Carter*, the Court finds that these objectives are overbroad and are instead vehicles used to affirm social values or stakes.[534]

[556] After having analyzed the new legislative regime, the challenged statutory provision, the parliamentary debates and the parties' submissions, the Court finds that the objective of s. 241.2(2)(*d*) Cr. C. is to protect vulnerable persons who might be induced to end their lives in a moment of weakness, by preventing errors when assessing requests for medical assistance in dying.

[557] The impugned infringing measure lies in the exclusion of persons with a grievous and irremediable medical condition[535] from eligibility for such assistance due to the fact that their natural death is not reasonably foreseeable.

[558] The preamble to the federal statute[536] is drafted using the words "reasonably foreseeable death", "grievous and irremediable medical condition", "enduring and intolerable suffering" and "competent adults" in proximity to the words "robust safeguards", "inherent value of every person's life", "vulnerable persons in need of protection" and "suicide".[537]

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[534] This excerpt from the Minister of Justice's speech is eloquent in this regard: "Before eligibility for medical assistance in dying is extended beyond persons who are suffering intolerably and in a state of decline toward death, which is what the *Carter* decision was about, we need to be absolutely confident that we would not be putting vulnerable people at risk. We need to be confident that we are not undermining important policy goals and/or societal values such as supporting Canadians with physical or mental disabilities to live out healthy lives and fully participate in our society". Exhibits PGC-9: "Government Orders. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)", *House of Commons Debates*, 42-1 (22 April 2016) at 2581 (Minister of Justice Wilson-Raybould).

[535] As defined in ss. 241.2(2)(*a*) to (*c*) Cr. C.

[536] Whereas the Parliament of Canada recognizes the autonomy of persons who have a grievous and irremediable medical condition that causes them enduring and intolerable suffering and who wish to seek medical assistance in dying; … in light of the above considerations, permitting access to medical assistance in dying for competent adults whose deaths are reasonably foreseeable strikes the most appropriate balance between the autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other.

[537] Whereas robust safeguards, reflecting the irrevocable nature of ending a life, are essential to prevent errors and abuse in the provision of medical assistance in dying; it is important to affirm the inherent and equal value of every person's life and to avoid encouraging negative perceptions of the quality of life of persons who are elderly, ill or disabled; vulnerable persons must be protected from being induced, in moments of weakness, to end their lives; suicide is

[559] Therefore, Parliament correlates several eligibility criteria for medical assistance in dying set out in s. 241.2 Cr. C.[538], the safeguards and the affirmation of certain social values and stakes, all of which converge toward the general objective of the federal statute, which is to strike "the most appropriate balance between the autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other".[539]

[560] In this context, and considering the scheme of the legislation, the reasonably foreseeable natural death requirement in the impugned provision is clearly anchored in the protection of vulnerable persons. Moreover, the Minister of Justice establishes the connection between the risks related to medical assistance in dying specifically for vulnerable persons and the possibility of controlling these risks in the case of dying patients:

> We have listened to those who say that permitting medical assistance in dying as a response to suffering in life, as opposed to suffering in the dying process, will put already vulnerable individuals at greater risk. We recognize that medical assistance in dying will in many respects fundamentally change our medical culture and our society. It is appropriate in this context to focus our attention on facilitating personal autonomy in the dying process where the risks to the vulnerable are manageable.[540]

[561] This is the basis on which the Minister considered that in order to protect the vulnerable, it is necessary to restrict eligibility for this assistance by imposing the challenged requirement.[541] Parliament felt that "it [made] sense" to limit medical assistance in dying to people whose death is reasonably foreseeable, given the fear that medical assistance in dying will be seen as "an appropriate response to a life with disability", or even that its availability will induce vulnerable people to inadvertently choose a premature death. This would allow physicians to "draw on their ... knowledge, training, and expertise in addressing these

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a significant public health issue that can have lasting and harmful effects on individuals, families and communities.

[538] Including that of a reasonably foreseeable natural death.

[539] This object of Bill C-14 was confirmed by the Minister of Justice during the parliamentary work leading up the passage of the statute: "What we sought to do in providing eligibility criteria and further defining what the Supreme Court of Canada didn't do in terms of "grievous and irremediable" was to put elements around what that means. Those elements in this proposed legislation would need to be taken into account as part of the broad medical circumstances of a particular individual. The aim or the object of our legislation is to draw a balance between personal autonomy and the protection of the vulnerable. That's why we put these criteria in place". Exhibit PGC-11: "Evidence. Standing Committee on Justice and Human Rights", *House of Commons*, 42-1 (2 May 2016) at 7 (Minister of Justice Wilson-Raybould).

[540] Exhibits PGC-9: "Government Orders. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)", *House of Commons Debates*, 42-1 (22 April 2016) at 2580 and 2581 (Justice Minister Wilson-Raybould).

[541] Exhibit PGC-11: "Evidence. Standing Committee on Justice and Human Rights", *House of Commons,* 42-1 (2 May 2016) at 2 and 8 (Minister of Justice Wilson-Raybould).

challenging circumstances" where the free choice of Canadians might be compromised.[542]

[562] The reasonably foreseeable natural death requirement was, therefore, also seen as a means of managing the potential risks for vulnerable persons, be they elderly, ill, disabled or suicidal, once medical assistance in dying was legalized in Canada. This requirement can be construed as both an eligibility criterion and a safeguard that seeks specifically to ensure the protection of vulnerable persons, who might be induced to end their lives in a moment of weakness, by limiting access to this type of assistance for everyone and by granting it to only those who are truly facing death.

[563] In practical terms, Parliament sought to limit potential errors that could be committed when assessing people's eligibility and their consequences by imposing a temporal restriction on access to medical assistance in dying. As many of the Attorney General's experts observed, providing medical assistance in dying to a person who will die in the coming days or weeks in any event has less of an impact than to a person who could still live for many years.

[564] With this object in mind, the Court will now analyze the principles of fundamental justice.

Arbitrariness

[565] A legislative provision is arbitrary when it fails to allow its object to be achieved and when there is no rational connection between its object and the limit it imposes on the rights guaranteed by section 7 of the *Charter*. In such circumstances, it is arbitrary because it limits rights without furthering "the public good that is said to be the object of the law".[543]

[566] *Carter* determined that the absolute prohibition against medical assistance in dying was not arbitrary because it furthered the achievement of the statute's object, which was to protect vulnerable persons from ending their lives in times of weakness.[544] In this sense, the prohibition was connected to Parliament's objective.

[567] Given that the Court has found that the object of the reasonably foreseeable natural death requirement is similar to the one identified in *Carter*, to protect vulnerable persons who might be induced to end their lives in a moment of weakness, it concludes that the provision is not arbitrary. It appears possible to consider that there is nonetheless a certain rational connection between this object and the impugned provision. The reasonably foreseeable natural death requirement furthers the achievement of the object to protect certain vulnerable persons, by preventing them from ending their lives in a moment of weakness.

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[542] Exhibits PGC-9: "Government Orders. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)", *House of Commons Debates*, 42-1 (22 April 2016) at 2581 (Minister of Justice Wilson-Raybould).

[543] *Carter* at paras. 83 and 84. See also *Canada (Attorney General) v. Bedford*, [2013] 3 S.C.R. 1101 at para. 111.

[544] *Carter* at para. 84.

[568] It also has the effect of reducing the number of individuals potentially eligible for medical assistance in dying, and by virtue of this fact, theoretically minimizes the possibility of error when assessing eligibility for medical assistance in dying based on the criteria of the current regime.

[569] The reasonably foreseeable natural death requirement is, therefore, not arbitrary.

Overbreadth

[570] A legislative provision is overbroad when it goes too far in trying to achieve its object. In short, the overbreadth analysis considers whether a law, when it takes away fundamental rights in a way that generally supports the object of the law, exceeds what is required and, at the same time, denies or restricts the rights of some individuals in a way that is no longer related to the achievement of its object.[545]

[571] In *Carter,* the Supreme Court held that the absolute prohibition against medical assistance in dying was overbroad in relation to the object of protecting vulnerable persons from being induced to commit suicide in a moment of weakness, because it applied generally and non-exclusively to people outside this class. Several competent and fully informed persons, such as Ms. Taylor, who might entertain a rational wish to end their own lives were prevented from doing so due to the prohibition.

[572] The Supreme Court also decided that in some cases the limitation on these persons was not connected to the object of protecting vulnerable persons and that it "sweeps conduct into its ambit that is unrelated to the law's objective".[546]

[573] That is also the case here. The state-imposed limitation that death be reasonably foreseeable before medical assistance in dying may be requested is overbroad. It is so because it prevents some people, competent and fully informed, such as Mr. Truchon and Ms. Gladu, who meet every other protective condition of the law and who express a rational desire to end the suffering caused by their grievous and irremediable condition, from requesting such assistance.

[574] In this sense, the limitation largely exceeds the object to such an extent that it has no real connection to the object of protecting vulnerable persons who might be induced to end their lives in a moment of weakness. It instead forces them to make the cruel choice described by the Supreme Court, by imposing that they either suffer intolerably for an undefined period that could last months, even years, or that they take their own lives their own way, all to satisfy a general precautionary principle.

[575] Therefore, the Court cannot accept the Attorney General's proposal that the purpose of the impugned requirement is, in fact, to protect the applicants

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[545] *Canada (Attorney General) v. Bedford*, [2013] 3 S.C.R. 1101 and *Carter* at para. 85.

[546] *Carter* at para. 86.

[TRANSLATION] "when they find that their life is no longer worth living due to an increased dependence on others, self-stigmatization and life suffering. Their vulnerability is not based on any lack of decision-making capacity, but on the possibility that they might be induced to end their lives using a system put in place by the legislation".[547] The evidence reveals, however, that the applicants do not correspond to that statement.

[576] On the contrary, the object of the legislation is precisely to allow people who meet the state-imposed conditions to request medical assistance in dying. It is admitted that the applicants, having been examined and assessed by several experts, meet every legal requirement except for the one regarding end of life. There is no question of a potential error regarding their eligibility or of protecting them as vulnerable persons due to their medical condition.

[577] The Court concludes that the reasonably foreseeable natural death requirement is overbroad as regards the applicants.

Grossly disproportionate

[578] Last, this third principle of fundamental justice is infringed if the impact of the restriction on the applicants' life, liberty or security is grossly disproportionate to the object of the measure.[548] To analyze this principle, it is therefore necessary to compare the measure's object "taken at face value"[549] with its deleterious effects on Mr. Truchon and Ms. Gladu's rights to determine whether this impact is completely out of sync with the object of the law.[550]

[579] This is a delicate balancing exercise where the object of the law might not be proportionate to its consequences while maintaining a certain connection with the consequences or its impact. In other words, even though the object of the legislative provision might be disproportionate in relation to the impact, it could still be consistent with this principle of fundamental justice. It cannot, however, be grossly disproportionate, such that it loses all connection to its object.

[580] The Attorney General argues that the effects of the impugned measure are not grossly disproportionate to its object because most of the people who might contemplate requesting medical assistance in dying due to their medical condition and their suffering will eventually become eligible. The measure provides that the applicants will have access to medical assistance in dying once they reach the final stage of their life.

[581] Moreover, the legislation gives the applicants the free choice to live or to die. It denies them only a means to die [TRANSLATION] "supported by the state ... until they have reached the trajectory to their natural death".[551]

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[547] Arguments of the Attorney General of Canada at para. 92.

[548] *Carter* at paras. 89–90.

[549] "de prime abord".

[550] *Canada (Attorney General) v. Bedford*, [2013] 3 S.C.R. 1101 at para. 125 and *Carter* at para. 89.

[551] Arguments of the Attorney General of Canada at paras. 62–70.

[582] The Court cannot agree with this reasoning and concludes that the provision's prejudicial effects on the applicants' life, liberty and security are very serious and therefore grossly disproportionate to its object. It deprives the applicants of their fundamental choice regarding appropriate care, of their self-determination and of their right to decide the time of their death. Furthermore, it forces them to continue living while experiencing intolerable and pointless suffering, given the irremediable nature of their afflictions.

[583] This requirement therefore creates an actual state-imposed obligation to live. In the Court's opinion, this is precisely what the Supreme Court wished to avoid for some of our fellow citizens.

[584] The basis of *Carter* is to allow competent individuals to end their intolerable suffering when they have a serious and incurable illness with no hope of improvement and are powerless in the face of an advanced state of irreversible decline in capability. The principle stated by the Supreme Court is not to require that people continue to live against their will until, after a given period, they naturally reach the stage of imminent death where they can request medical assistance in dying, after having suffered pointlessly and at the cost of the total denial of their dignity.

[585] The Court, therefore, concludes that the impugned requirement is disproportionate to the measure's object.

[586] Given the foregoing, the Court does not consider it necessary to determine the impugned requirement's vagueness as a principle of fundamental justice.[552]

Conclusion on the principles of fundamental justice

[587] In sum, the Court concludes that the reasonably foreseeable natural death requirement is overbroad and disproportionate, such that it is inconsistent with the principles of fundamental justice and infringes Mr. Truchon and Ms. Gladu's rights protected by section 7 of the *Charter*.

[588] It is, therefore, up to the Attorney General to establish, on a balance of probabilities, that this infringement of Mr. Truchon's and Ms. Gladu's fundamental rights is justified under section 1 of the *Charter*.

3. <u>Is the Infringement of the Applicants' Fundamental Rights under Section 7 of the *Charter* Justified by Section 1?</u>

[589] Section 1 of the *Charter* is of vital importance in Canadian society and our legal system. It guarantees respect for the rights and freedoms set out in the

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[552] The Court notes, however, that the Canadian Medical Protective Association, which represents Canadian physicians in matters of professional liability insurance, received over one thousand enquiries in the first 18 months after the federal legislation entered into force, caused by the uncertainty due, in part, to a lack of clarity surrounding the expression "reasonably foreseeable death". Exhibit P-23, Schedule 2, Communications of the Canadian Medical Protective Association (CMPA), *Medical assistance in dying: Where do we stand two years later?*, June 2018.

Charter and provides the circumstances in which they may nonetheless be limited or restricted:

> **1.** 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.

[590] In *Oakes*[553], the Supreme Court first developed the procedure to determine whether the infringement of a right guaranteed by the *Charter* is justified under section 1.[554]

[591] To succeed, the Attorney General must establish that the law's object is pressing and substantial and that the means chosen are proportional to that object. A law is proportionate to its object if:

1. the means adopted are rationally connected to the object – the rational connection test;
2. it minimally impairs the right in question – the minimal impairment test;
3. there is proportionality between the deleterious and salutary effects of the law – the proportionality test.[555]

[592] From the outset, justifying a violation of the fundamental rights set out in section 7 of the *Charter* is an arduous process, first, because the rights to life, liberty and security of the person are not easily outweighed by competing social interests and, second, because a statute that does not respect the principles of fundamental justice is *de facto* intrinsically flawed and, therefore, difficult to justify.

[593] Despite these obstacles, it is nonetheless possible to make this demonstration.[556] The analyses the courts must perform under sections 7 and 1 of the *Charter* are, in fact, different.[557]

[594] The first distinction lies in the fact that the object of the legislative provision is scrutinized when examining the principles of fundamental justice, while it is the object and effect of the infringement of the right in question that is analyzed under section 1. While these two objects may, in fact, be connected, they may also differ. The second distinction falls within the court's analysis under section 7, which considers the specific rights of the individuals challenging the law, while

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[553] *R. v. Oakes*, [1986] 1 S.C.R. 103.

[554] *Ibid*.

[555] See in particular *Carter* at para. 94.

[556] The case law of the Supreme Court has evolved in this regard. While initially in *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486, Wilson J. had virtually closed the door to any possible justification of a s. 7 infringement, subsequent decisions have tempered that principle: *Canada (Attorney General) v. Bedford*, [2013] 3 S.C.R. 1101, *Carter*, *R. v. Safarzadeh‑Markhali*, [2016] 1 S.C.R. 180.

[557] *Canada (Attorney General) v. Bedford*, [2013] 3 S.C.R. 1101 at para. 125; *R. v. Smith*, [2015] 2 S.C.R. 602 at para. 29.

under section 1, the broader interests of society are reviewed.[558] Thus, a section 1 analysis can include practical considerations[559] or considerations related to the law's enforcement.[560]

[595] As author Hamish Stewart observed, however, it is not an easy task for the Attorney General:

> … remarkably, a majority of the Supreme Court of Canada has never found an infringement of the section 7 right to be justified under section 1. The Court has often expressly stated that infringements of section 7 rights are very difficult to justify under section 1.[561]

[596] In general, section 1 of the *Charter* does not require that the limit on the right be perfectly calibrated when judged in hindsight, but, rather, that it be reasonable and demonstrably justified, as stated by the majority of the Supreme Court in *Hutterian Brethren*[562]:

> [37] 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. ... 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 *Canada (Attorney General) v. JTI-Macdonald Corp.*, 2007 SCC 30 (CanLII), [2007] 2 S.C.R. 610, at para. 43, *per* McLachlin C.J.

[597] The Court will therefore analyze the impugned infringing measure to determine whether, in light of the principles set out in *Oakes*[563], it can be justified under section 1 of the *Charter*.

Limit prescribed by law

[598] There is no doubt here that the limitation of the applicants' rights is prescribed by a provision in the *Criminal Code*.[564]

Pressing and substantial object of the statutory provision

[599] It is important to remember that the object of the challenged statutory provision, as identified under the section 7 analysis, is to protect vulnerable

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[558] Hamish Stewart, Fundamental Justice. *Section 7 of the Canadian Charter of Rights and Freedoms*, 2nd ed. (Toronto: Irwin Law, 2019), chapter 6.

[559] *Carter* at para. 82.

[560] *Canada (Attorney General) v. Bedford*, [2013] 3 S.C.R. 1101 at para. 113.

[561] *Ibid.* at 351.

[562] *Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 S.C.R. 567.

[563] *R. v. Oakes*, [1986] 1 S.C.R. 103.

[564] Section 241.2(2)(*d*) Cr. C.

persons from being induced to end their lives in a moment of weakness. Although the elements considered for the purposes of section 7 and 1 *Charter* analyses are not always the same[565], the object of the impugned provision remains unchanged.[566]

[600] The Attorney General urges the Court to accept that the object of the challenged statutory provision is pressing and substantial because it seeks to divert and protect vulnerable persons from a means to end their lives. The applicants defer to the Court on this question.

[601] The Court understands and agrees that the protection of vulnerable persons, even in the context of a legislative regime that includes considerable safeguards, may be pressing and substantial given the implications at stake and the fact that death is a possible consequence.

Proportionality of the law

[602] Before analyzing the three components of the proportionality criterion as defined by *Oakes*[567], the question arises as to the standard of deference the Court should accord the legislature in this case.

Deference

[603] It goes without saying that the review of a law's proportionality is not rigid to the extent that a section 1 *Charter* justification becomes tantamount to getting a camel to pass through the eye of a needle.[568] The legislature's solution does not have to be perfect. There may be several alternatives concerning a social issue, hence the importance of showing the legislature the appropriate deference.[569]

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[565] Hamish Stewart, Fundamental Justice. Section 7 of the Canadian Charter of Rights and Freedoms, 2nd ed. (Toronto: Irwin Law, 2019) at 353.

[566] *R. v. Smith*, [2015] 2 S.C.R. 602 at para. 29; Mark Carter, "Section 7 and 1 of the Charter after Bedford, Carter, and Smith: Different Questions, Same Answers?", (2017) 64 C.L.Q. 108.

[567] *R. v. Oakes*, [1986] 1 S.C.R. 103.

[568] Peter W. Hogg, Constitutional Law of Canada, 5th ed., vol. 2 (Toronto: Thomson Reuters, 2007) loose-leaf, updated in 2009, at para. 38.11(*b*), at 38–39: "In view of the ease with which a less drastic alternative to virtually any law could be imagined, the process of s.1 justification looked like the camel passing through the eye of the needle".

[569] The terms used by the Supreme Court vary from decision to decision, but the essence remains the same: "a legislature must be given reasonable room to manoeuvre to meet these conflicting pressures" (*R. v. Edwards Books*, [1986] 2 S.C.R. 713 at 795 cited in *Reference re ss. 193 and 195.1(1)(*c*) of the criminal code (Man.)*, [1990] 1 S.C.R. 1123 at 1196–1197); "to allow a margin of appreciation to the government despite the fact that less intrusive measures, … were available" (*Irwin Toy Ltd. v. Quebec (Attorney General.)*, [1989] 1 S.C.R. 927 at 999–1000); "a flexible approach to the proportionality test" (*United States of America v. Cotroni*, [1989] 1 S.C.R. 1469 at 1489); "[t]he courts must accord some leeway to the legislator" (*RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199 at para. 160); "a degree of deference" (*Harvey v. New Brunswick (Attorney General)*, [1996] 2 S.C.R. 876 at para. 47), particularly where "the problem Parliament is tackling is a complex social problem" (*Canada (Attorney General) v. JTI-Macdonald Corp.*, [2007] 2 S.C.R. 610 at para. 43).

[604] The Attorney General of Canada urges the Court to show a “high degree of deference”[570] to Parliament’s choice, because, in his view, it is undoubtedly a “complex regulatory response to a social problem”[571] or, at least, it concerns complex human behaviour.[572]

[605] The applicants submit that, even though the impugned requirement concerns competing social principles, Parliament is not owed any special deference because, in reality, the impugned requirement imposes an absolute prohibition against medical assistance in dying for every person in the same situation as themselves. They add that their argument is especially relevant, since the existing legislative regime is not a response consistent with *Carter*.[573]

[606] The reasonably foreseeable natural death requirement includes certain particularities. On the one hand, it falls within the regime governing medical assistance in dying in Canada, which obviously involves complex notions of social policy and weighs in favour of deference to Parliament. On the other hand, the Court must assess the validity of a *Criminal Code* provision whose breach could directly threaten the liberty of physicians who fail to comply therewith. This reduces the deference owed by the Court. A strict application of *Hutterian Brethren*[574] is, therefore, not as clear as the Attorney General claims.

[607] Next, the complexity of a regulatory response[575] cannot result from its mere enactment by Parliament. When the regime regulating medical assistance in dying is compared to absolute prohibition, any response provided may well appear or seem complex.

[608] In this case, without minimizing the work done by Parliament in a very short time frame, the Court cannot overlook the fact that the complex social issue regulated by Parliament had previously been subjected to a thorough and detailed social and constitutional analysis in *Carter*, and that the eligibility requirements set out in its legislation are a more restrictive version of the parameters established by the Supreme Court.

[609] Last, the Court must point out that the federal regime on medical assistance in dying, and more specifically the reasonably foreseeable natural death requirement, is not a concrete solution to a social problem or social ill.[576]

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[570] Arguments of the Attorney General of Canada at paras. 109–110, citing *Carter* at para. 98.

[571] Arguments of the Attorney General of Canada at para. 108 citing *Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 S.C.R. 567 at paras. 37, 53 and *Frank v. Canada (Attorney General)*, 2019 SCC 1 at para. 43.

[572] See the Arguments of the Attorney General of Canada at 22 *et seq.*

[573] Written submissions of the applicants, at para. 673 *et seq.*

[574] *Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 S.C.R. 567 at para. 37.

[575] The case law does not define the notion of “complex regulatory response”. The Court, therefore, cannot rely on any established principle or precedent to review the reasonably foreseeable natural death requirement from this perspective. The exercise remains comparative and depends on the circumstances of each case.

[576] The Court rejects the position of the interveners Collectif des médecins contre l’euthanasie and Living with Dignity who state that [TRANSLATION] “medical assistance in dying, even limited to people at the end of life, is and remains the lesser ill, but still an ill”. Arguments of the Collectif des médecins contre l’euthanasie and Living with Dignity at para. 6.

Viewed from this perspective, the impugned provision appears to be a measure to prevent suicide[577], which, indeed, is a real social problem, but whose connection to medical assistance in dying must be rejected in the Court's view. Medical assistance in dying has been practised in Canada since 2015 and is a response to the recognition of the right to autonomy, and not a complex regulatory response to counter our society's ills. Moreover, nothing in the evidence establishes that medical assistance in dying is subject to abuses within this highly regulated regime.

[610] Given the foregoing, and to quote Professor Hogg, the Court "[is] willing to defer to the legislative choice on the basis that the choice was within a margin of appreciation, a zone of discretion in which reasonable legislators could disagree while still respecting the *Charter* right".[578] A degree of deference to Parliament is therefore appropriate here.

Rational connection

[611] The Attorney General of Canada must establish that the reasonably foreseeable natural death requirement is rationally connected to the legislative object sought. This analysis is similar to the analysis of arbitrariness conducted in a section 7 *Charter* analysis, that is, it must persuade the Court that there is a causal connection between the infringement and the benefit sought "on the basis of reason or logic".[579]

[612] When, as in this case, the issue falls within a social, rather than a scientific, realm, there is no need for tangible evidence. Inferential reasoning, premised on logic and common sense, is sufficient for the Attorney General of Canada to discharge the burden.[580]

[613] In *Carter*, the Supreme Court decided that, where an activity – such as medical assistance in dying – poses certain risks, prohibition of the activity in question is a rational method of curtailing these risks.[581]

[614] The same applies here, where prohibiting medical assistance in dying outside the temporal sphere of end of life or when natural death is not reasonably foreseeable is a rational method of protecting at least some vulnerable persons who might wish to end their lives in a moment of weakness.[582]

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[577] Which is the specific purpose of the *Act respecting a Federal Framework for Suicide Prevention*, S.C. 2012, c. 30.

[578] Peter W. Hogg, *Constitutional Law of Canada*, 5th ed., vol. 2 (Toronto: Thomson Reuters, 2007) loose-leaf, updated in 2017, at para. 38.11(*b*), at 38–43.

[579] *RJR-MacDonald Inc*. *v*. *Canada (Attorney General)*, [1995] 3 S.C.R. 199 at para. 153, also adopted in *Carter* at para. 99. See also *R*. *v*. *Smith*, [2015] 2 S.C.R. 602 at para. 29.

[580] *Frank v*. *Canada (Attorney General)*, 2019 SCC 1 at para. 64.

[581] *Carter* at para. 100.

[582] See the Arguments of the Attorney General of Canada at para. 113. [TRANSLATION] "Prohibiting medical assistance in dying outside the end of life is clearly a rational method of protecting vulnerable persons who are not at end of life and who might be induced to commit suicide in a moment of weakness".

[615] Therefore, a rational connection exists between the reasonably foreseeable natural death requirement that prohibits medical assistance in dying outside the temporal sphere of end of life and the provision’s object, which is to protect vulnerable persons.

Minimal impairment

[616] The minimal impairment analysis ensures that the deprivation of *Charter* rights is confined to what is reasonable to achieve the legislative objective. In this sense, the Court must determine, in light of the evidence adduced, whether the limitation on the rights at issue is reasonably adapted to the object, or, as the Supreme Court stated, whether there are less harmful means of achieving the chosen objective:

> [102] … The burden is on the government to show the absence of less drastic means of achieving the objective “in a real and substantial manner”. The analysis at this stage is meant to ensure that the deprivation of Charter rights is confined to what is reasonably necessary to achieve the state’s object.[583]

[617] Given all the evidence adduced and analyzed, the Court concludes that the Attorney General has not discharged his burden of proving that the reasonably foreseeable natural death requirement minimally impairs the rights protected by section 7 of the *Charter* and is confined to what is reasonably necessary to substantially achieve Parliament’s objective.[584]

[618] The Attorney General has not established that the reasonably foreseeable natural death requirement is the least drastic method of protecting vulnerable persons who might be induced to end their lives in a moment of weakness.

[619] The Court accepts from the evidence that physicians are capable of assessing, with the necessary diligence:

1. the capacity, lack of ambivalence and deep convictions that motivate a person to request medical assistance in dying, on a case-by-case basis;
2. the presence of any possible coercion or external pressure on the patient;
3. the advanced state of irreversible decline in capability;
4. that presence of enduring intolerable suffering related to the person’s condition that cannot be relieved under conditions that the person deems acceptable;
5. that the person who made the request is suicidal with or without an underlying psychiatric condition.

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[583] *Carter* at para. 102 citing *Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 S.C.R. 567 at paras. 53–55.

[584] *Carter* at para. 115.

[620] The evidence presented does not convince the Court that, without the reasonably foreseeable natural death requirement, Canada will see an exponential or unreasonable spike in the number of requests for medical assistance in dying, especially from vulnerable persons, which would lead to a slippery slope.

[621] The Court instead accepts that the other eligibility criteria and safeguards already in place in the legislation are sufficient to ensure that the system can provide medical assistance in dying to individuals who are entitled to it.

[622] The reasonably foreseeable natural death requirement deprives part of the Canadian population of the opportunity to request such assistance under the guise of protecting vulnerable persons and reducing the possibility of errors. The Attorney General has not successfully established that this measure is reasonable and minimal.

[623] Clearly, no system other than total and absolute prohibition will ever be able to prevent every error. That said, these possible errors can also exist for a dying person and are, therefore, not exclusive to people whose death is not reasonably foreseeable.

[624] The evidence establishes that the assessment process in this country is rigorous, that the risk of error in assessing capacity is neither tangible nor real and that the objective empirical data shows that, since medical assistance was legalized in Canada, the proportion of deaths due to this method are similar to those observed in other countries where this assistance is available. In fact, in Canada[585] and in Quebec[586], the percentage of cases of medical assistance in dying compared to total deaths falls within the limits of the 0.3% and 4.6% reported in foreign countries.[587]

Proportionality of the effects

[625] This involves weighing the impact of the infringing measure's requirement on protected rights against the beneficial effect of the law in terms of the public good.[588]

[626] The Attorney General admitted that the effects of the challenged provision may be serious for many people who are suffering, due to the fact that their natural death is not reasonably foreseeable.[589] He added, however, that the

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[585] Between July 1 and December 31, 2017, deaths by medical assistance in dying represented 1.07% of all deaths in Canada. Exhibit P-31: Health Canada, *Third Interim Report on Medical Assistance in Dying in Canada* (Ottawa: June 2018) at 5, 8 and 9.

[586] Between January 2016 and March 2018, deaths by medical aid in dying represented 1.09% of all deaths in Quebec. Exhibit P-38: Commission sur les soins de fin de vie, *Rapport sur la situation des soins de fin de vie au Québec*: *Du [10] décembre 2015 au 31 mars 2018* (Québec: Government of Quebec, 2019) at 33.

[587] Exhibit P-3: Health Canada, *Third Interim Report on Medical Assistance in Dying in Canada* (Ottawa: June 2018) at 9.

[588] *Carter* at para. 122, see also *Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 S.C.R. 567 at para. 77.

[589] Arguments of the Attorney General of Canada at para. 159.

deleterious effects are substantially less compared to the general prohibition that existed before the law's enactment, because the new legislative regime does not prevent people who wish to do so from ending their lives without assistance or from obtaining the appropriate care to relieve their suffering in the interim.[590] The Court finds this proposal paradoxical at the very least, and difficult to support, given that the Attorney General submits that the object of the challenged provision is precisely to protect vulnerable persons from suicide.

[627] Moreover, the Attorney General submits that the measure's salutary effects are considerable. In the Attorney General's view, this measure affirms the intrinsic equal value of every life, regardless of disability or disease. It furthers a consistent understanding that suicide is a public health tragedy that must be avoided at all costs. Finally, it acts as an important guarantee for vulnerable persons who would find themselves at risk if medical assistance in dying were not limited to the end of life.[591]

[628] The Attorney General concludes that the measure is proportionate when it prohibits medical assistance in dying in circumstances where the risks to vulnerable individuals and society in general are highest.[592]

> [TRANSLATION]
>
> The current law responds to *Carter* by creating a regime for medical assistance in dying that respects individual autonomy as much as possible without endangering the government's objectives to affirm the equal value and dignity of every person's life, regardless of age, health condition or disability, to maintain a consistent approach to suicide prevention and to protect vulnerable persons in a moment of weakness.[593]

[629] The applicants have difficulty identifying any salutary effect in the impugned provision. They submit in the most general manner that the benefits are marginal compared to the extent of the inconveniences, which are [TRANSLATION] "real and significant and largely exceed the hypothetical and unproven benefits perceived by the government".[594]

[630] The Court can perceive how the reasonably foreseeable natural death requirement may, from the Attorney General of Canada's perspective, have general salutary effects that preserve the life of persons who are not near death and who would nonetheless like to end their lives given their conditions. This

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[590] *Ibid.* at para. 161. The Attorney General of Canada also referred to the testimony of Dr. Quill, who said that in the state of New York, which does not allow any form of euthanasia, voluntary stopping of eating and drinking is available to anyone who is not at end of life and wishes to accelerate death. Testimony of Dr. Quill, February 5, 2019 at 35–36, 38–39 and 45–46.

[591] The Attorney General of Canada referred more specifically to persons who might be influenced in moments of weakness to use medical assistance in dying due either to undue external pressure, self-stigmatization or cognitive distortions. In this regard, see Arguments of the Attorney General of Canada at para. 160.

[592] *Ibid.* at para. 163.

[593] *Ibid.* at para. 165.

[594] Written submissions of the applicants at paras. 732 and 740.

criterion would, therefore, have the effect of excluding suicidal people or those with a psychiatric condition who would like to use this method to end their days although they are not eligible under the other statutory criteria.

[631] In the Court’s opinion, however, the deleterious effects on persons who, like Mr. Truchon and Ms. Gladu, are not dying, but whose condition remains serious and irreversible, are in an advanced state of irreversible decline in capability without any hope of improvement and who, above all, experience enduring and intolerable physical or psychological suffering, are by far greater than the expected benefits to society as a whole, given the sufficiency of the other legislative safeguards.

[632] The reasonably foreseeable natural death requirement deprives persons such as the applicants from exercising their autonomy and from their choice to end their life when and how they choose, which must nonetheless remain an entirely fundamental personal decision.

[633] This requirement compels them to end their lives while they are still physically capable of doing so, or to take steps that are sometimes premature or will make them suffer and languish[595] so that they become eligible for medical assistance in dying to avoid the agony that awaits them. In this respect, it denies them their right to a dignified and serene death.

[634] Also and above all, the requirement forces these persons to continue a life that no longer has any meaning for them, in conditions they consider undignified and at the cost of intolerable suffering. In so requiring, the state sends them the message that the expression of their wishes and their devastating suffering are neither important nor considered.

[635] The applicants have established that the imposed requirement denies persons who are disabled and grievously ill the right to make fundamental decisions, and this, out of a desire to protect them. Yet these persons have the same rights to self-determination and dignity as any other person. By seeking to protect them from themselves, and by denying them the right to express that autonomy, the state is sending the message that it does not consider them to be persons truly capable of making decisions.

[636] The evidence adduced by the applicants, which the Court accepts, establishes instead that the legislative regime in place is fully able, even without the challenged requirement, of screening and identifying persons who do not meet the other eligibility criteria, such as incompetent or suicidal persons.

[637] The Court concludes that the challenged provision has serious effects on persons who, like Mr. Truchon and Ms. Gladu, are not dying, and that the expected benefits of such a measure fall far short of exceeding the deleterious effects it creates.

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[595] Such as, for example, the voluntary stopping of eating and drinking.

[638] For all these reasons, the Court concludes that the reasonably foreseeable natural death requirement in s. 241.2(2)(*d*) of the *Criminal Code* violates section 7 of the *Charter* and is not justified under section 1.

4. Does the Reasonably Foreseeable Natural Death Requirement Set out in s. 241.2(2)(*d*) of the *Criminal Code* Infringe Section 15 of the *Charter*, Which Guarantees Equal Treatment?

4.1 General Principles

[639] While the arguments at the hearing were primarily focused on the right to life, liberty and security of the person in section 7 of the *Charter*, the right to equality under section 15 is also included in the constitutional challenge.

[640] Section 15 of the *Charter* enshrines the right to equality, and is worded as follows:

> **15.** (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.

[641] Since *Andrews*[596], the Supreme Court has reworked the lexicon related to the analytical criteria of section 15 applications on a number of occasions.[597] A constant remains, however, in that formal equality based on the model of identical or analogous treatment of individuals has been rejected. It is now well

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[596] *Andrews* v. *Law Society of British Columbia*, [1989] 1 S.C.R. 143. This is the first Supreme Court judgment based on s. 15.

[597] Subsequent decisions which applied the model in *Andrews* resulted in *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497, which unified the Supreme Court's divided approach by developing a threefold criteria. One of these three aspects was the effect on the relevant person or group's human dignity. Criticized for having added this aspect and for having allowed a certain return to formal equality, the criterion was reworded in *R. v. Kapp*, [2008] 2 S.C.R. 483 as a twofold one: (1) does the law create a distinction based on an enumerated or analogous ground; and (2) does the distinction create a disadvantage by perpetuating prejudice or stereotype. Moreover, the point-by-point analysis of the four contextual criteria set out in *Law* is no longer necessary. This two-step analytical framework and the rejection of a rigid approach when considering the relevant factors was confirmed by the Supreme Court in *Withler v. Canada (Attorney General)*, [2011] 1 S.C.R. 396. In *Quebec (Attorney General) v. A*, [2013] 1 S.C.R. 61, Abella J. stated that the notions of prejudice and stereotyping are not discrete elements which impose an additional requirement on claimants to prove that a distinction will perpetuate prejudicial or stereotypical attitudes toward them. Even though the test remains the same, these notions are not reproduced *verbatim* in the test recently set out in *Kahkewistahaw First Nation v. Taypotat*, [2015] 2 S.C.R. 548 and *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux*, [2018] 1 S.C.R. 464.

settled that "equality is not about sameness, and ss. 15(1) does not protect a right to identical treatment"[598] because, depending on the circumstances, differential treatment may be discriminatory or, on the contrary, necessary to combat discrimination.

[642] The fundamental standard underlying section 15 of the *Charter* is based on substantive equality[599], which goes "behind the facade of similarities and differences"[600] and is grounded in the idea that individuals are recognized at law "as human beings equally deserving of concern, respect and consideration".[601]

[643] In order to determine whether the challenged statutory provision infringes section 15 of the *Charter*, the Court must conduct a two-step analysis[602]:

1. Does the law, on its face or in its impact, create a distinction based on enumerated or analogous grounds?
2. If so, does the law impose burdens or deny a benefit in a manner that has the effect of reinforcing, perpetuating or exacerbating the disadvantage?[603]

[644] The line between the two steps is important in relation to the elements the Court must consider. The first seeks only, in the absence of enumerated or analogous grounds, to screen out claims "having nothing to do with substantive equality".[604] At this stage, the analysis focuses only on the grounds on which the distinction is based, without taking into account other factors.[605] Furthermore, while the establishment of a distinction remains an intrinsically comparative exercise, a "mirror comparator" group is not necessary because an analysis based on a comparison with such a group "does not assure a result that captures

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[598] *Withler v. Canada (Attorney General)*, [2011] 1 S.C.R. 396 at para. 31.

[599] *Ibid.* at para. 2 recently cited in *R. v. Barton*, 2019 SCC 33 at para. 202. See also *R. v. Kapp*, [2008] 2 S.C.R. 483 at para. 16.

[600] *Withler v. Canada (Attorney General)*, [2011] 1 S.C.R. 396 at para. 39.

[601] *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143 at 171 cited in *R. v. Kapp*, [2008] 2 S.C.R. 483 at para. 15.

[602] Moreover, this corresponds to the definition of discrimination established by McIntyre J. in *Andrews:* "… 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.…".

[603] *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux*, [2018] 1 S.C.R. 464 at para. 25 citing *Kahkewistahaw First Nation v. Taypotat*, [2015] 2 S.C.R. 548 at paras. 19–20.

[604] Lynn Smith & William Black, "The Equality Rights", (2013) 62 S.C.L.R. (2d) 301 at 336 cited in *Kahkewistahaw First Nation v. Taypotat*, [2015] 2 S.C.R. 548 at para. 19 and *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux*, [2018] 1 S.C.R. 464 at para. 26.

[605] *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux*, [2018] 1 S.C.R. 464 at para 26. Thus, challenging other requirements of the current law such as, for example capacity assessment of a person who requests medical assistance in dying, would not necessarily or at first glance be based on an enumerated or analogous ground set out in s. 15.

the wrong to which s. 15(1) is directed” and “may fail to capture substantive inequality”.[606]

[645] The second step in the analysis is to determine the discriminatory effect of the distinction. At this stage, it is not necessary “or desirable to apply a step-by-step consideration”[607] of the four factors developed in *Law*[608], namely: (1) a pre-existing disadvantage, stereotyping, prejudice, or vulnerability experienced by the claimant; (2) the correspondence, or lack thereof, between the ground or grounds on which the claim is based and the actual need, capacity, or circumstances of the claimant or others; (3) the ameliorative purpose or effects of the impugned law upon a more disadvantaged person or group in society; and (4) the nature and scope of the interest affected by the impugned law. Some of these factors may nonetheless be pertinent, such as any “social, political, economic and historical factors concerning the group”.[609] Instead, the analysis is “a flexible and contextual inquiry into whether a distinction has the effect of perpetuating arbitrary disadvantage on the claimant because of his or her membership in an enumerated or analogous group”.[610]

[646] Last, it is also unnecessary, at this stage in the analysis, to assess the reasonableness of the legislative distinction and, implicitly, whether the legislature was “well motivated” when it decided to deny a group a benefit provided for by law. These elements will be analyzed under section 1, if necessary, when the state has to justify the section 15 infringement.[611]

[647] The right to equality has already been scrutinized twice in the specific context of medical assistance in dying: first, by the Supreme Court in *Rodriguez*[612] and, subsequently, in the trial judgment in *Carter*.

[648] In 1993, Lamer C.J., dissenting in *Rodriguez*, was the only member of the Supreme Court to analyze the prohibition against assisted suicide under section 15 of the *Charter*.[613] He felt that the prohibition against assisted suicide created an inequality by preventing persons with a physical handicap from putting an end to their life without assistance, contrary to the other members of the public. As suicide or attempted suicide had ceased to be a crime in Canada since 1972[614],

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[606] *Withler v. Canada (Attorney General),* [2011] 1 S.C.R. 396 at paras. 40, 60 cited in *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux*, [2018] 1 S.C.R. 464 at para. 27.

[607] *Quebec (Attorney General) v. Alliance du personnel professionnel et technique de la santé et des services sociaux*, [2018] 1 S.C.R. 464 at para. 28.

[608] *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497.

[609] *Withler v. Canada (Attorney General)*, [2011] 1 S.C.R. 396 at para. 39.

[610] *Quebec (Attorney General) v. A,* [2013] 1 S.C.R. 61 at para. 331.

[611] *Ibid.* at para. 333 citing *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143 at 182.

[612] *Rodriguez v. British Columbia (Attorney General),* [1993] 3 S.C.R. 519.

[613] The five majority judges felt it was preferable not to decide the issue raised by the application of s. 15, but rather to assume that the prohibition against assisted suicide infringed s. 15, since any infringement was clearly justified under s. 1. The dissenting judges, L’Heureux-Dubé and McLachlin JJ., felt that s. 15 did not apply to the case, and only Cory J. agreed with the reasons given by Lamer C.J.

[614] *Criminal Law Amendment Act*,*1972,* S.C. 1972, c.13, s. 16.

this inequality was imposed on persons unable to end their lives because of a physical disability. The physical disability, therefore, constituted a burden or disadvantage because it limited the ability of the disabled to take fundamental personal decisions regarding their lives and limited their right to self-determination.[615]

[649] Still in the specific context of medical assistance in dying, in *Carter*, the Supreme Court of British Columbia minutely analyzed the prohibition against medical assistance in dying under section 15 of the *Charter* and concluded that the *Criminal Code* provision violated that provision and was not justified under section 1. The Supreme Court of Canada determined that the legislative provision violated the rights protected by section 7 of the *Charter*, without pursuing its analysis under section 15.

[650] Certain arguments raised in *Carter BCSC* before the British Columbia Supreme Court were reiterated in the present case by both the applicants and the defendants.

[651] By applying the principles set out above, the applicants must first establish that the reasonably foreseeable natural death requirement creates a distinction based on an enumerated or analogous ground. Second, they must convince the Court that this distinction imposes a burden or denies them an advantage that perpetuates the disadvantage.

4.2 On Its Face or in Its Impact, Does the Reasonably Foreseeable Natural Death Requirement Create a Distinction Based on an Enumerated or Analogous Ground?

[652] Physical disability is a ground specifically listed in s. 15(1) of the *Charter* and is raised by the applicants in this case. They submit, with respect to both the federal and provincial statutes[616], that limiting medical assistance in dying to individuals at the end of life creates an unjustifiable distinction based on physical disability[617] in two respects:

1. Between persons who, like the applicants, suffer from a grievous and irremediable illness but whose death is not reasonably foreseeable and who cannot access medical assistance in dying, and other persons suffering from a grievous and irremediable illness whose death is reasonably foreseeable. In short, a distinction between two groups of persons based on whether or not their health condition or disability or the nature thereof places them on a trajectory close to

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[615] *Rodriguez v. British Columbia (Attorney General),* [1993] 3 S.C.R. 519 at 530-580 (dissenting opinion of Lamer C.J). It should be noted that according to Lamer C.J., Ms. Rodriguez was not deprived of the advantage of committing suicide (as she had not argued that suicide was a benefit) but instead that of choosing suicide or of deciding herself on the conduct of her life.

[616] Originating application for declaratory judgment at para. 233 *et seq*; Arguments of the applicants at para. 413.

[617] Originating application for declaratory judgment at para. 237.

death;[618]

2. Between persons who, like Mr. Truchon, are deprived of the ability to legally end their lives unassisted due to their physical disability and persons able to end their lives unassisted who can decide to commit suicide legally.[619] Even if there are disabled persons who have access to certain limited methods despite their disability, the distinction is nonetheless real, since these methods are not without risk or suffering;

[653] The Attorney General of Canada acknowledges that the impugned measure creates a distinction.[620] He makes, however, three observations in this regard.

1. The reasonably foreseeable natural death requirement does not create a distinction based on the nature of the health issues or disabilities. Given that, in theory, any person will end up reaching the point where his or her death is reasonably foreseeable, the distinction refers to the time when medical assistance in dying becomes available, which is not an enumerated or analogous ground.[621] In the Court's view, this proposal is specious to say the least;
2. The reasonably foreseeable natural death requirement does not exclude persons with severe physical disabilities;[622]
3. Persons who do not meet the requirement are not forced to continue living, because they are free and have the ability to end their lives, either by traditional methods of suicide or by VSED.[623] This argument was reiterated by interveners CACL and CCD, who consider that all Canadians who are not at end of life are treated equally because they [TRANSLATION] "are in the same position, meaning they can end their lives only by using one of the traditional methods of suicide". In this sense, the applicants would actually seek [TRANSLATION] "an easier method of suicide than that of other Canadians".[624]

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[618] *Ibid.* at paras. 234(a) and 235(a); Arguments of the applicants at paras. 394–396, 400–405. See also Arguments of the interveners Association québécoise pour le droit de mourir dans la dignité and Dying with Dignity Canada at paras. 141(a), 142(a), 143, and 148(a).

[619] Originating application for declaratory judgment at paras. 234(b) and 235(b); Arguments of the applicants at paras. 397–398 and 411–412. See also Arguments of the interveners Association québécoise pour le droit de mourir dans la dignité and Dying with Dignity Canada at paras. 141(b), 142(b), 144 and 148(b).

[620] Arguments of the Attorney General of Canada at para. 174.

[621] *Ibid.* at paras. 170 and 197. See also the Brief of interveners Canadian Association for Community Living and Council of Canadians with Disabilities at para. 118.

[622] Arguments of the Attorney General of Canada at para. 171.

[623] *Ibid.* at paras. 172–173. This argument was also raised by the Attorney General of Canada in *Carter BCSC* at paras. 1049, 1069 and 1075.

[624] Brief of interveners Canadian Association for Community Living and Council of Canadians with Disabilities at para. 118. This argument once again amounts, wrongfully in the Court's view, to equating medical assistance in dying to suicide.

[654] For the reasons that follow, the Court concludes that the impugned requirement creates a distinction based on physical disability. Because of their own physical condition, the applicants cannot obtain medical assistance in dying, despite the fact that they meet all the other legal requirements and are deprived of the opportunity of dying in conditions that would be available if they were at the end of life.

[655] The Attorney General of Canada's two first arguments – which in summary are that the reasonably foreseeable natural death requirement does not distinguish the disabled because they are excluded like every other person who is not dying – rely on the principle of formal equality, rejected by the Supreme Court, and fail to consider the concrete effect of this requirement on the applicants. The Court therefore rejects these arguments.

[656] The third argument concerning the ability of the disabled to commit suicide or to opt for an easier method of suicide warrants some remarks.

[657] First, the Court finds it repugnant to prefer that individuals such as the applicants should be forced to depend on VSED to become eligible for medical assistance in dying or to end their lives. While the law as drafted does not force the applicants to live, it nonetheless forces them to choose between suffering, suffering even more or committing suicide.

[658] In a society such as ours, where human dignity and compassion toward the suffering of others are fundamental values, a statement to the effect that persons like the applicants can always commit suicide if they no longer wish to continue suffering atrociously until the day when their death becomes reasonably foreseeable is troubling, to say the least. The additional suffering that ensues from VSED, for example, then becomes a sort of condition for access to medical assistance in dying. The net effect of this proposal is that by taking this position the Attorney General is encouraging people who cannot commit suicide to do it nonetheless. This not only constitutes a criminal offence in Canada, but also leads to a dead end.

[659] As developed in *Rodriguez* and *Carter*, there is, in fact, a distinction between Mr. Truchon, deprived of the choice to commit suicide due to his physical condition, and other persons, who have that option. The concrete effect of the reasonably foreseeable natural death requirement for Mr. Truchon is tantamount to a total prohibition against medical assistance in dying and to the application of the general regime in ss. 14 and 241(1)(*b*) Cr. C. In other words, due to his physical disability and the fact that his natural death is not near, Mr. Truchon must receive assistance from another person in order to end his life. That is a crime in this country.

[660] This distinction persists despite the fact that there are disabled persons who can commit suicide using regular or traditional methods[625] or that VSED is available to everyone, precisely because these individuals are forced to use this

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[625] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 at 556–557.

method that, it bears repeating, leads to a slow, difficult and painful death.[626] As was so aptly stated by McLachlin C.J. in *Lavoie*[627], discrimination created by law is not mitigated by the fact that a person can adapt or modify his or her behaviour.

[661] To affirm that the applicants are seeking an easier method of suicide and a gentler death falls instead within the discourse of the social construct of disability that the government and the interveners are in fact seeking to combat.[628] The Court has rejected the idea that medical assistance in dying is tantamount to suicide. Mr. Truchon’s and Ms. Gladu’s request for medical assistance in dying are not requests to facilitate suicide motivated by the fact that, because of their physical disability, society considers them to be people lacking dignity who would be better off dead. The applicants have always fully lived their lives with a physical disability. What they are truly seeking is for the law to recognize equally the suffering, dignity and, ultimately, the autonomy of people like themselves who have grievous and irremediable medical conditions, without hierarchy and regardless of whether or not death is imminent.

[662] Even if the foregoing is in itself sufficient to dispose of this first stage in the analysis, the Court wishes to add that the effect of the impugned requirement also creates a distinction based on the type or nature of the disability. As noted by the Supreme Court, disability is characterized by a virtually infinite variety that leads to “distinctions drawn between various disabilities”.[629] Therefore, distinctions may exist between members of the same group based on their type of disability.[630] That is the case here.

[663] Thus, within a limited class of disabled persons who are suffering intolerably, a person with a serious and incurable handicap on a trajectory to death is eligible for medical assistance in dying as opposed to a person who, like the applicants, suffers from a disability that is every bit as serious and incurable but is not close to death. The applicants’ type of physical disability, which does not have the effect of rendering their natural death reasonably foreseeable, thus prevents them from choosing their end of life, whereas other people just as physically disabled but whose death is close have that legal option.

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[626] *Carter BCSC* at paras. 1070–1076.

[627] *Lavoie v. Canada*, [2002] 1 S.C.R. 769 at para. 5. McLachlin C.J. dissented, but not on this point.

[628] See in particular the Brief of interveners Canadian Association for Community Living and Council of Canadians with Disabilities at para. 117.

[629] *Nova Scotia (Workers' Compensation Board) v. Martin; Nova Scotia (Workers' Compensation Board) v. Laseur*, [2003] 2 S.C.R. 504 at para. 81.

[630] Parliament did not limit eligibility for medical assistance in dying to the physically disabled to avoid discriminating against people with a mental disorder. Exhibit PGC-11: “Evidence, House of Commons, Standing Committee on Justice and Human Rights”, 42-1 (2 May 2016) at 2 (Minister of Justice Wilson-Raybould). The reasonably foreseeable natural death requirement, however, was a means to exclude “people suffering from mental illness alone”. Exhibit PGC-17: Proceedings of the Senate Standing Committee on Legal and Constitutional Affairs, 42-1 (6 May 2016) Issue No. 8, at 8:51 (Minister of Health Philpott).

[664] Lastly, in their arguments the applicants also raised a distinction based on age.[631] Given the Court's conclusions on the ground of physical disability, it does not find it necessary to address this new ground.

[665] The Court answers in the affirmative the question posed in the first step of the analysis. It must therefore now determine whether the impugned provision has a discriminatory effect in that it reinforces, perpetuates or exacerbates the disadvantage suffered by the applicants.

4.3 Does the Reasonably Foreseeable Natural Death Requirement Impose a Burden or Deny an Advantage?

[666] The applicants submit that the distinction created by the reasonably foreseeable natural death requirement is discriminatory, in that the discrimination that had been removed by *Carter* was recreated by Parliament in violation of their dignity and their right to autonomy. They are now compelled to suffer. Moreover, the impugned requirement perpetuates the stereotype that the physically disabled do not have the capacity to exercise decision-making autonomy over their body and their life and, therefore, must be protected.[632]

[667] The Attorney General submits that the distinction is not discriminatory because the requirement at issue takes into consideration the situation, characteristics and actual needs of disabled persons like the applicants in a way that respects their value as human beings.[633] The challenged provision does not perpetuate any arbitrary disadvantage and would not reflect any stereotypical premises based on the capacity or the autonomy of the physically disabled.

[668] The Attorney General adds that the removal of the impugned requirement would instead create an advantage for the disabled by giving them access to the [TRANSLATION] "easiest"[634] method of suicide, unavailable to people who are not disabled[635], and would send a negative message that would [TRANSLATION] "reinforce and entrench stereotypes about the quality of life and value of the lives of the disabled".[636]

[669] To determine whether the distinction created by the reasonably foreseeable natural death requirement is discriminatory in its object or in its

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[631] Arguments of the applicants at paras. 406–410. The Court notes the similarity between Ms. Carter's and Mr. Truchon's diagnoses, and the Minister of Justice's statements that Ms. Carter's death "had become reasonably foreseeable by virtue of her age and frailty". See Exhibit PGC-20: "Criminal Code. Bill to Amend – Consideration on Subject Matter in Committee of the Whole", *Senate Debates*, 42-1 (1 June 2016) at 746 (Minister of Justice Wilson-Raybould).

[632] Arguments of the applicants at paras. 414–425. See also *Carter BCSC* at para. 1088.

[633] Arguments of the Attorney General of Canada at paras. 14, 181.

[634] Arguments of the Attorney General of Canada, at para. 193. See also the Arguments of interveners Collectif des médecins contre l'euthanasie and Living with Dignity at para. 145; Brief of the Christian Legal Fellowship at para. 58.

[635] For Professor Shakespeare, the reasonably foreseeable natural death requirement "equalizes the situation between people with disabilities and others". See his testimony, February 1, 2019, at 52.

[636] Arguments of the Attorney General of Canada at paras. 193, 203.

impact, the Court must consider several relevant factors during its contextual analysis, including any pre-existing stereotypes or prejudices regarding the physically disabled and the manner in which the challenged provision takes into consideration the applicants' actual characteristics and needs.[637] As well, by considering all of these factors and by balancing the individual and social interests at issue the Court will determine whether the distinction created by the legislative measure between the applicants and other people discriminates by perpetuating disadvantage or prejudice to the applicants or by stereotyping them.[638]

[670] It is undisputed that the physically disabled face stereotypes and prejudices.[639]

[671] Much like the Supreme Court of British Columbia, the Court believes that it is important to acknowledge that people, whether born with a physical disability or who acquire it later, have to deal not only with a disadvantage, but also with stereotypes and prejudices in society.

[672] As adduced into evidence, society often perceives the disabled as being incapable, due to their physical disability, of making the [TRANSLATION] "right decisions" concerning their body and their life, hence their vulnerability and need for state protection from their [TRANSLATION] "poor choices", including, for example, a request for medical assistance in dying motivated by the disability. Similarly, society views the physical disability as a loss of dignity and a diminished quality of life for the disabled, which makes their desire to die understandable. Both perceptions involve "a problematic response of society" and "unfortunately, by the state itself" when faced with physical disability.[640]

[673] In this context of pre-existing stereotypes or prejudices, the Court concludes that the challenged requirement does not consider the applicants' personal circumstances, characteristics and actual needs in a manner that respects their value as human beings as compared to other people to whom the law grants medical assistance in dying or recognizes the right to legally commit suicide.

[674] The Court concludes that the reasonably foreseeable natural death requirement perpetuates prejudice and disadvantage for the applicants and the physically disabled precisely because of this personal characteristic.

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[637] *Withler v. Canada (Attorney General)*, [2011] 1 S.C.R. 396 at para. 38; *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 at paras. 69–71. It is well settled that the law will not be discriminatory if it takes into account the actual characteristics and needs of the claimants in a manner that respects their dignity. Conversely, a law that reflects stereotypical premises, perpetuates disadvantage or fails to take into account the claimants' actual needs will be considered discriminatory.

[638] *Withler v. Canada (Attorney General)*, [2011] 1 S.C.R. 396 at para. 71.

[639] Arguments of the Attorney General of Canada at para. 178. Re-amended Defence of the Attorney General of Canada at para. 193.

[640] *Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703 at paras. 30–34.

[675] The Attorney General also raises the powerlessness and limits of the criminal law with respect to physically-able individuals who can commit suicide – hence the decriminalization of attempted suicide – to explain that the burden imposed by the *Criminal Code* on the physically disabled [TRANSLATION] "is not due to a failure to consider their needs or their abilities".[641]

[676] The Court does not accept this argument. In *Rodriguez*, Lamer C.J. wrote that "the repeal of the offence of attempted suicide demonstrates that Parliament will no longer preserve human life at the cost of depriving physically able individuals of their right to self-determination".[642] Similarly, the Supreme Court in *Carter* affirmed that "the law has come to recognize that, in certain circumstances, an individual's [fundamental] choice about the end of her life is entitled to respect".[643] In the current state of the law, taking into consideration the needs and capability of the physically disabled necessarily involves taking into account their right to self-determination, including any obstacles to its actual exercise.

[677] Lastly, the Attorney General again argues that, outside the trajectory of death, medical assistance in dying is tantamount to suicide and that the challenged requirement [TRANSLATION] "reflects the fundamental differences between assisted death and suicide and the fundamental differences between MAID as an 'end-of-life' option and a medically-facilitated death in answer to a difficult life when life is not otherwise approaching its end".[644]

[678] The Court has already rejected that argument, but, nonetheless, finds it necessary to add the following clarification. The requirement at issue reveals a legislative regime within which suffering takes a back seat to the temporal connection with death. Where natural death is not reasonably foreseeable, the consent and suffering of the disabled are worthy only of the sympathy of Parliament, which has adopted a protectionist policy towards every such person, regardless of his or her personal situation. As soon as death approaches, however, the state is prepared to recognize the right to autonomy. This is a flagrant contradiction of the fundamental principles concerning respect for the autonomy of competent people, and it is this unequal recognition of the right to autonomy and dignity that is discriminatory in this case.

[679] The illustrious jurist and philosopher Ronald Dworkin eloquently described the concept of the right to equality applicable here[645]:

> … Government must treat those whom it governs with concern, that is, as human beings who are capable of suffering and frustration, and with respect, that is, as human beings who are capable of forming and acting

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[641] Arguments of the Attorney General of Canada at paras. 195–196. See also the Arguments of the interveners Collectif des médecins contre l'euthanasie and Living with Dignity at para. 117.

[642] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 at 561.

[643] *Carter* at para. 63.

[644] Arguments of the Attorney General of Canada at para. 204.

[645] Ronald Dworkin, *Taking Rights Seriously* (Cambridge, Mass.: Harvard University Press, 1977) at 272–273.

> on intelligent conceptions of how their lives should be lived. Government must not only treat people with concern and respect, but with equal concern and respect. …
>
> [Emphasis added.]

[680] With respect, the connection established by Parliament between the reasonably foreseeable natural death requirement and the vulnerability of every disabled person betrays a paternalistic view of people like the applicants. Due to their disability, the state considers it unlikely[646] that such people can express valid consent to medical assistance in dying because their autonomy is necessarily compromised by their vulnerability.[647] In the words of the Attorney General, the difficulty in [TRANSLATION] "determining the cause of suffering for a person" who is physically disabled, [TRANSLATION] "combined with stereotypes ... that associate physical dependency with the loss of dignity and quality of life, heightens the risk that disabled people will request and be considered eligible for MAID, when their desire to die is the result of self-stigmatism, unsatisfied needs, diminished capacity for resilience, depressive symptoms or subtle social pressures".[648]

[681] By seeking to counter only one of the stereotypes that the disabled face – vulnerability – the challenged provision perhaps perpetuates another probably more pernicious stereotype: the inability to consent fully to medical assistance in dying. Yet the evidence amply establishes that Mr. Truchon is fully capable of exercising fundamental choices concerning his life and his death. As a consequence, he is deprived of the exercise of these choices essential to his dignity as a human being due to his personal characteristics that the challenged provision does not consider. He can neither commit suicide by a method of his own choosing[649] nor legally request this assistance.

[682] Individuals in the same position as Mr. Truchon must be allowed to exercise full autonomy not only at the end of life, but also at any moment during their life, even if this means death, where the other eligibility conditions for medical assistance in dying are met.

[683] The Court thus concludes that s. 241.2(2)(*d*) of the *Criminal Code* clearly infringes the applicants' right to equality.

[684] The Attorney General must now establish that the violation of the applicants' right to equality is justified under section 1 of the *Charter*.

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[646] Denise Réaume, "Dignity, Choice, and Circumstances", in Christopher McCrudden, ed., *Understanding Human Dignity* (Oxford: Proceedings of the British Academy/Oxford University Press, 2013) 539 at 540: "Governments tend to understand dignity as simple respect for choice, and when that seems implausible, they shift to patronizing people as incapable of choice".

[647] Arguments of the Attorney General of Canada at para. 205.

[648] *Ibid.* at para. 202. See also *Carter BCSC* at paras. 1118 and 1126–1129.

[649] Once again, *Lavoie v. Canada*, [2002] 1 S.C.R. 769 rendered by the Supreme Court states that the fact that a person can modify his or her behaviour to avoid discrimination does not negate its discriminatory effect.

5. **Is the Violation of the Applicants' Fundamental Right Set out in Section 15 of the *Charter* Justified under Section 1?**

[685] Given that the Court's analysis and conclusions regarding the justification of the section 7 *Charter* violation also applies to this section, the Court will merely state the following with respect to section 15.

[686] The Attorney General justifies the impugned requirement by the support received from certain disabled rights defence groups who argue that it is necessary to protect vulnerable persons.[650] While the Attorney General acknowledges that the community of disabled persons is not monolithic, he nonetheless believes that the law cannot realistically correspond to the needs of each member of this diversified group.[651]

[687] The Attorney General states that, even if the requirement's removal corresponded to the needs of individuals in the applicants' situation, it would inevitably compromise the interests of many other people who are also physically disabled.[652] The state cannot enact measures customized for every situation and the impugned requirement is the only solution to this problem [TRANSLATION] "that cannot be solved by an individualized assessment or by another safeguard".[653]

[688] While Parliament's objective is assuredly laudable, i.e., to protect vulnerable persons from being induced to request medical assistance in dying in a moment of weakness, the concrete effect of this requirement is to deny the applicants the right to avail themselves of this assistance, or of the opportunity to end their lives, by ignoring their decision-making autonomy. Moreover, it is not the Court's role to verify whether other possible protections exist, but only to determine whether the one at issue here is or is not consistent with the *Charter*.

[689] As previously stated, it is not whether the person is or is not at the end of life that guarantees true consent to medical assistance in dying. The challenged requirement depends more on the social acceptability of offering this assistance to dying people than on the inability of physicians to identify the risks associated with the practice of medical assistance in dying. What is more, the evidence does not show that physicians cannot identify individuals whose social, economic or other type of vulnerability motivate their requests for medical assistance in dying.

[690] For all these reasons, the Court concludes that the reasonably foreseeable natural death requirement set out in s. 241.2(2)(*d*) Cr. C. does not meet the standard of minimal impairment and proportionality of effects. It therefore infringes section 15 of the *Charter* and is not justified under section 1.

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[650] Arguments of the Attorney General of Canada at paras. 192 and 209; see also Exhibit PGC-20: "Criminal Code. Bill to Amend – Consideration on Subject Matter in Committee of the Whole", *Senate Debates*, 42-1 (1 June 2016) at 744 (Minister of Justice Wilson-Raybould).

[651] Arguments of the Attorney General of Canada at paras. 198 and 210.

[652] *Ibid.* at 54.

[653] *Ibid.* at para. 199. In fact, in the eyes of Parliament, the requirement at issue is part of "a critical set of safeguards that are designed to give Canadians confidence that life will be ended only where there is a genuine and firm wish of the person". PG-20: "Criminal Code. Bill to Amend – Consideration on Subject Matter in Committee of the Whole", *Senate Debates*, 42-1 (1 June 2016) at 744 (Minister of Justice Wilson-Raybould).

6. Is Subsection 3 of the First Paragraph of s. 26 of the *Act respecting end-of-life care* Unconstitutional by Virtue of the Same Principles?

[691] The applicants claim that the end-of-life requirement in the Quebec statute infringes their protected rights under both section 7[654] and section 15 of the *Charter*. Their constitutional challenge of the provincial statute is timid, however, compared to the challenge to the requirement in the federal statute. Their submissions concerning the section 7 infringement are limited to stating the main object of the Quebec statute, which is to establish a framework for end-of-life care, as opposed to protecting vulnerable persons.[655] With respect to the section 15 infringement, they submit that the arguments raised regarding discrimination based on physical disability and age concerning the federal statute apply to the end-of-life criterion in the Quebec statute.[656]

[692] In defence, the Attorney General of Quebec relies primarily on the arguments of her federal counterpart, with emphasis placed on the foundation and genesis of the requirement at issue.[657] The Attorney General also claims that the statute is consistent with *Carter*[658], that suicide prevention and the need to avoid sending a social message that devalues life are secondary purposes of the Quebec legislation[659], and that the end-of-life criterion does not create any discriminatory distinction because it applies to every person at the end of life, including the physically disabled.[660]

[693] Before analyzing the end-of-life criterion in light of the constitutional law principles stated above, the Court would like to pause and offer some general comments about the Quebec statute.

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[694] First, the Court recognizes the democratic, non-partisan effort that resulted in the enactment of the Quebec statute[661], a statute that is undeniably [TRANSLATION] “an important advancement for the dignity and self-determination of individuals at the end of life”.[662] In so doing, the Quebec legislature opted for

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[654] Originating application at para. 231.

[655] Summary of Arguments of the applicants at paras. 355–356.

[656] *Ibid.* at paras. 413, 424–425.

[657] Written Arguments by the Attorney General of Québec at para. 114.

[658] *Ibid.* at para. 118; Defence of the Attorney General of Quebec at paras. 43,85.

[659] Defence of the Attorney General of Quebec at paras. 66 and 88.

[660] *Ibid.* at para. 89.

[661] See the section on Legislative History of the *Act respecting end-of-life care* at paras. [120]-[151] of this judgment.

[662] Exhibit PGQ-10: Québec, National Assembly, *Journal des débats*, 40-1 (22 October 2013) “Adoption du principe du projet de loi n° 52 – *Loi concernant les soins de fin de vie*”, at 5038 (Minister of Health and Social Services Hivon citing the Barreau du Québec).

the most restrictive regime in the world by combining the Benelux model, focused on suffering, with the U.S. model, focused on the end of life.[663]

[695] The provincial statute's enactment and coming into force must be situated chronologically within the sequence of *Carter* and the enactment of the federal statute. On January 16, 2014, while the Standing Committee on Health and Social Services was completing a detailed study of Bill 52, the Supreme Court granted leave to appeal in *Carter*. On March 19, 2014, the Attorney General of Quebec filed a notice of intervention before the Supreme Court in *Carter* on the issue of the provincial jurisdiction over health.[664]

[696] At the same time *Carter* was advancing before the Supreme Court, on June 10, 2014, the National Assembly assented to the *Act respecting end-of-life care.*[665] Under section 78, it was to come into force no later than on December 10, 2015. During the 18-month preparation period before the Quebec statute came into force, the Supreme Court heard *Carter* on October 15, 2014, and rendered its decision on February 6, 2015.

[697] It bears repeating that, between August and November 2015, the 11 provinces and territories created an Advisory Group to develop recommendations in response to *Carter* with a view to a standardized approach to the implementation of medical assistance in dying in Canada. Quebec did not participate in the work of this group of experts, but its approach to regulating medical aid in dying was nonetheless considered.[666] That said, the Advisory Group instead decided to adopt the eligibility criteria established by the Supreme Court in *Carter* for medical assistance in dying.

[698] Several days before the provincial statute was to come into force in December 2015, the Attorney General of Canada asked the Supreme Court to extend the suspension of the declaration of unconstitutionality issued in *Carter*. At that time, Quebec requested that it be excluded from the suspension, and this was granted by the majority judges.[667]

[699] The Attorney General of Quebec's intervention in *Carter*, its absence from the Advisory Group and its request for an exemption suggest that the Quebec government believed that it had legislated within its jurisdiction over health. This

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[663] *Ibid.* See also Exhibit PGQ-10: Québec, National Assembly, *Journal des débats*, 40-1 (24 October 2013), "Adoption du principe du projet de loi n° 52 – *Loi concernant les soins de fin de vie*", at 5180 (Minister of Health and Social Services Hivon).

[664] The Attorney General of Quebec stated that it was possible to define a precise core for the provincial power over health "as the power to establish the kind of health care offered to patients and supervise the process of consent required for that care". See *Carter* at para. 52.

[665] S.Q. 2014, c. 2.

[666] Exhibit PGC-2: *Final Report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying*, November 30, 2015, at 19 and 51. The Advisory Group felt that physician-assisted dying "fits within a continuum of end-of-life services" and that it "should be treated as one appropriate medical practice within a continuum of services available at the end-of-life".

[667] See the section on Motion seeking an order extending the suspension of the declaration of constitutional invalidity (January 2016), at paras. [94]-[99] of this judgment.

is apparently why it did not want to respond to *Carter* despite the clear parameters it established.

[700] It might be argued that the Quebec government was waiting for the federal statute to come into force in order to decide if it would be appropriate to amend its statute. This did not happen, however. Its failure to act became even more obvious when Parliament enacted a more permissive regime than the one in Quebec, without any legislative response from the Quebec government. Everyone agrees that, as established by the evidence, the reasonably foreseeable natural death requirement is a broader criterion than that of the end of life.[668] As a result, the criticisms regarding these incongruities have been continuously repeated within the Quebec medical and public spheres since the federal statute came into force on June 17, 2016. Quebecers, the pioneers in physician-assisted dying in Canada, are today subject to the most restrictive eligibility conditions in the country, because medical aid in dying in Quebec is governed by a statute that exclusively covers persons at the end of life.

[701] The Attorney General of Quebec emphasizes the statute's genesis to anchor the intrinsic connection between the end of life and medical aid in dying in Quebec. Recognizing that the statute came into force at a time that reflected a certain social context, it is today being applied in a society that is evolving and is influenced by factors the legislature did not anticipate at the time it was enacted, which was prior to *Carter.* The Quebec statute was designed in a manner that would allow it to co-exist with the absolute prohibition against assisted suicide, but it is producing its effects in an environment that has been completely transformed by the decriminalization of medical assistance in dying in Canada.

[702] After the exemption granted by the Supreme Court in January 2016, non-dying Quebecers found themselves ineligible for this aid, while in the other provinces it was available with court approval to Canadians in the same situation based on the parameters established by the Supreme Court.[669] The federal statute's enactment replaced the applicable criteria set out by the Supreme Court, but the Quebec regime still remains the most restrictive.

[703] The Quebec statute clearly cannot be applied in a totally hermetic framework, shielded from the repercussions of *Carter* or from the new federal legislative landscape that necessarily has an impact on its effect. In this sense, the fact that the provincial statute predates *Carter* and the federal statute explains, but does not justify, its current impact. The Court must, therefore, analyze its actual effect on the applicants in this new legal context - and not the one contemplated by the Quebec legislature in a completely different setting.

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[668] Exhibit PGC-20: "Criminal Code. Bill to Amend – Consideration on Subject Matter in Committee of the Whole", *Senate Debates*, 42-1 (1 June 2016) at 768 (Minister of Health Philpott): "… there is a difference between end of life and reasonable foreseeability … reasonable foreseeability is less rigid than legislation that might talk about end of life".

[669] See the section on Interpretation of *Carter*, at paras. [483] *et seq.* of this judgment.

[704] Given that the applicants' arguments concern the effects of the challenged provision, the Court will begin its constitutional review with the section 15 *Charter* analysis.

[705] The Court applies the legal principles and reasons set out in its analysis of the federal statute, *mutatis mutandis,* to that of the provincial statute, which leads it to conclude that the end-of-life criterion violates section 15 of the *Charter* and is not justified within the meaning of section 1.

[706] The Attorney General raises the same arguments as her federal counterpart with respect to formal equality, namely, that the applicants are treated equally with every person who is not at the end of life[670], as well as with the physically disabled, because, when they are at the end of life, they will have access to the same care offered by the provincial statute to other citizens.[671] She adds that the end-of-life criterion is not an enumerated or analogous ground, because it is not an immutable personal characteristic. It is, instead, an [TRANSLATION] "evolving and variable" notion based on each individual's biomedical condition.[672]

[707] The Court finds that the end-of-life criterion creates by its impact a distinction based on the type of serious and incurable illness. It is thus based on physical disability, within the meaning of section 15 of the *Charter*.[673] Again, the distinction occurs within a very limited group of individuals with serious and incurable illnesses and in an advanced state of irreversible decline in capability who are suffering unbearably. *A contrario*, the distinction is not measured in comparison to the group of persons suffering from any one illness. In these circumstances, individuals at the end of life are entitled to care to relieve their suffering, as opposed to other individuals who are suffering as much due to an illness that is as serious and incurable, but who are not at the end of life.

[708] Like the reasonably foreseeable natural death requirement, and for the same reasons, the end-of-life criterion creates a discriminatory distinction in its impact because, ultimately, it denies the applicants equal recognition of their human dignity.

[709] The Attorney General of Quebec submits that the advantage[674] claimed by the applicants is not provided for by the law. Her argument is based on *Auton*[675], where autistic children and their parents claimed that the British Columbia

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[670] Written submissions by the Attorney General of Quebec at para. 141.

[671] *Ibid.* at para. 144.

[672] *Ibid.* at para. 146.

[673] *Nova Scotia (Workers' Compensation Board) v. Martin; Nova Scotia (Workers' Compensation Board) v. Lasseur*, [2003] 2 S.C.R. 504.

[674] The Attorney General of Quebec used the expression [TRANSLATION] "medical aid sought" to describe the medical act or treatment sought by the applicants.

[675] *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657. The government of British Columbia and the Attorney General of Canada raised this decision in *Carter BCSC* at paras. 1051–1064, in support of their argument that medical assistance in dying was not a benefit provided for by a provincial or federal law and that, consequently, there was no distinction based on an enumerated ground.

government's failure to fund behavioural therapy for autism violated section 15 of the *Charter*. In that judgment, the Supreme Court stated that the claim was for funding for a "medically necessary" treatment and asked whether the law in fact provided anyone with all medically required treatment. As the law did not fund the therapy for autistic children, the Supreme Court concluded that "the benefit here claimed — funding for all medically required services — was not provided for by the law".[676]

[710] As stated in *Carter BCSC*, that decision does not apply to this case. First, the right to receive end-of-life care, including medical aid in dying, is provided for in section 4 of the Quebec statute. Therefore, every person whose condition requires it has the right to receive medical aid in dying, subject to the specific requirements established in section 26.

[711] Second, and above all, it is important to keep in mind the raison d'être for the [TRANSLATION] "last care" sought by the applicants. The Quebec legislature provided people who are dying with the right to receive medical aid in dying primarily to relieve their suffering, not because they are dying. Contrary to what the Attorney General of Quebec submits[677], it is not the end of life but, rather, the suffering of persons at the end of life that is the very foundation of medical aid in dying within the meaning of the Quebec statute. In the absence of suffering, medical aid in dying is not care.

[712] As expressed by Minister Hivon when justifying the choice of the word "care" in the definition of medical aid in dying[678], the patient does not seek this aid [TRANSLATION] "to die", but [TRANSLATION] "to stop suffering". Medical aid in dying [TRANSLATION] "is a question of [unbearable] suffering"[679] that we want to relieve out of respect for human dignity, and not an [TRANSLATION] "intervention" to bring about a person's death[680]:

> [TRANSLATION]
>
> ... in section 26, it is very clear, suffering is central to the criteria; it's central to the whole scheme. In Oregon, in the United States, it is not the suffering, I say it often, it is the fact of being at the end of life. It is important that we have both. Suffering is fundamental, and therefore appears [in the definition of medical aid in dying in section 3], as well as the relief of suffering.[681]

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[676] *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657 at para. 35.

[677] Written submissions by the Attorney General of Quebec at para. 5.

[678] Section 3(6) of the Quebec statute.

[679] Exhibit PGQ-10: Quebec, National Assembly, Journal des débats de la Commission permanente de la santé et des services sociaux, 40-1 (21 November 2013) "Étude détaillée du projet de loi n° 52 – Loi concernant les soins de fin de vie (1)", CSSS-61 at 42 (Minister of Health and Social Services Hivon).

[680] Exhibit PGQ-10: Quebec, National Assembly, Journal des débats de la Commission permanente de la santé et des services sociaux, 40-1 (26 November 2013), "Étude détaillée du projet de loi n° 52 – Loi concernant les soins de fin de vie (3)", CSSS-63 at 22–23 (Minister of Health and Social Services Hivon).

[681] *Ibid.*, CSSS-63 at 24.

[713] Lastly, the applicants are not asking that the Quebec statute be broadened to create an advantage not provided for by that law. They are demanding nothing more than the same respect, the same recognition of their dignity and the same compassion, i.e., substantive equality with respect to the values underlying medical aid in dying.

[714] The Court notes that the Quebec legislature was not indifferent to the potential for discrimination based on type of illness, but it did not address this issue from the perspective of the end-of-life criterion. When studying the criterion of serious and incurable illness, Minister Hivon explained that cancer and degenerative diseases sprang to mind when this criterion is raised, but that other medical conditions, such as chronic pulmonary diseases, were not excluded. Indeed Ms. Gladu's illness was used as an illustration in this respect.[682] This appeared to reassure Minister Hivon that [TRANSLATION] "there will be no discrimination" because [TRANSLATION] "it is the illness, the characterization of the illness as serious and incurable, the advanced state of irreversible decline, the suffering, that will lead to eligibility".[683]

[715] Mr. Truchon and Ms. Gladu meet all these restrictive criteria, but they are still not eligible for medical aid in dying. By designing the [TRANSLATION] "strictest" and [TRANSLATION] "most regulated" medical aid in dying regime[684] based on both the end of life and the suffering associated with serious and incurable illnesses and on the irreversible decline in capability, the Quebec statute denies the [TRANSLATION] "final aid" in very specific cases where these two models fail to intersect. While in the majority of situations covered by the statute the serious and incurable illness, the irreversible decline and the associated suffering place the patient at the end of life, there are other cases, such as those of the applicants, where there is no correlation between these criteria. The end-of-life criterion then prevails and obscures the issue of suffering.

[716] Given the foregoing, the impugned provision in the current context, i.e., the post-*Carter* period, discriminates in its impact in the present case. The right to autonomy recognized by the Supreme Court in *Carter* is not separate from the right recognized by the Quebec statute. The constitutional power within which the federal and Quebec governments may respectively legislate, criminal or health, should have no impact on the nature or scope of this right. On the contrary, respect for human dignity is the common thread found in the Supreme Court's

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[682] Exhibit PGQ-10: Quebec, National Assembly, Journal des débats de la Commission permanente de la santé et des services sociaux, 40-1 (2 December 2013) "Étude détaillée du projet de loi n° 52 – Loi concernant les soins de fin de vie (7)", CSSS-67 at 20 (Minister of Health and Social Services Hivon) [TRANSLATION]: "In fact, there was one person who visited us during the parliamentary committee and she very clearly explained, given this very serious chronic pulmonary disease, how much she suffered every time she took a breath, and that person was Ms. Gladu, referred to by our colleague from Mille-Îles during her speech when it was adopted in principle".

[683] *Ibid.*

[684] Exhibit PGQ-10: Quebec, National Assembly, Journal des débats, 40-1 (22 and 24 October 2013, "Adoption du principe du projet de loi n° 52 – Loi concernant les soins de fin de vie", at 5037, 5039 and 5180 (Minister of Health and Social Services Hivon).

reasoning in *Carter* and the work of the Quebec legislature. By limiting the access of dying persons to care that respects their dignity and autonomy, the end-of-life criterion produces the same unequal treatment as the impugned federal requirement, i.e., unequal recognition of the right to autonomy of persons with a serious and incurable illness.

[717] The fact that the Quebec statute was designed [TRANSLATION] "specifically around the issue of end-of-life care" does not shield it from its discriminatory effects. As victims of pre-existing stereotypes and prejudice based on their physical disability, the applicants have been denied care specifically designed for their exceptional situations, except for the end of life factor. Again, they are both protected from themselves due to the nature of the care and devalued by a legislative measure that claims to consider their actual characteristics without really doing so.

[718] As the Court concludes that subsection 3 of the first paragraph of s. 26 of the provincial statute violates the right to equality, the Attorney General of Quebec must now establish that the violation is justified under section 1 of the *Charter*.[685]

[719] In this regard, the Attorney General submits that the end-of-life criterion is a rational means that is a minimal impairment and proportionate in the pursuit of the objectives of the Quebec statute.[686]

[720] The Court accepts from the evidence that the genesis of the bill and the work preceding and surrounding its passage reveal the Quebec legislature's approach. It legislated based on the premise that it is pointless to suffer, hence the need to identify the appropriate care to relieve the suffering of dying persons. The law's objective, as stated in section 1, is eloquent in this respect:

> 1. The purpose of this Act is to ensure that end-of-life patients are provided care that is respectful of their dignity and their autonomy. The Act establishes the rights of such patients as well as the organization of and a framework for end-of-life care so that everyone may have access, throughout the continuum of care, to quality care that is appropriate to their needs, including prevention and relief of suffering.
>
> In addition, the Act recognizes the primacy of freely and clearly expressed wishes with respect to care, in particular by establishing an advance medical directives regime.

[721] The Court also places the end-of-life criterion in the legislative framework that existed at the time the statute was enacted. In other words, by regulating medical aid in dying in a law concerning persons at the end of life, the Quebec

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[685] No one disputes the urgent and real nature of the impugned provision's legislative objective. The same applies to the rational connection between the end-of-life criterion and the legislative objective sought.

[686] The Attorney General again identified a primary objective and two secondary objectives. The primary objective is to ensure end-of-life patients are provided care that is respectful of their dignity and their autonomy. The secondary objectives are to not compromise suicide prevention and to not devalue life. Written submissions by the Attorney General of Quebec at paras. 150 and 152.

legislature was able to define aid in dying as care in the same way as palliative care, for example[687], without challenging the *Criminal Code*'s application in Quebec.

[722] The Attorney General of Quebec again emphasized the inseparable connection between the end-of-life criterion and the medical aid in dying care: [TRANSLATION]: ... "because MAID occurs at the end of life, and because it is part of the other end-of-life medical practices and decisions, MAID can be considered as appropriate care that falls within the practise of medicine".[688]

[723] The Court notes that these are the same medical practices and decisions referred to by the Attorney General of Quebec that also led to the decriminalization of medical assistance in dying in Canada under the *Criminal Code* provisions, without medical assistance in dying being considered as care.

[724] Moreover, the Attorney General of Quebec's argument again minimizes, even obscures, the importance of the criterion of suffering in the statute's objective. At the risk of repeating itself, the Court reiterates that medical aid in dying is not care because it is provided at the end of life; it is care because it relieves the suffering of people at the end of life.

[725] The law's object is therefore twofold: the end of life and the recognition of dignity and autonomy. The appropriate care, related to the suffering and decision-making autonomy, is not determined by the end-of-life criterion. Consequently, the Court accepts that one of the statute's objects is to recognize the dignity and right to autonomy of end-of-life patients by ensuring the appropriate care.

[726] The issue then becomes whether the end-of-life criterion is a minimal impairment of the applicants' right to equality.

[727] Like Canada, Quebec claims that its law is a complex regulatory regime and that the Court, therefore, owes it great deference.[689]

[728] While again commending the legislature for having enacted ground-breaking legislation following a lengthy process of reflection and debate, its failure to explain why it did not react to the Supreme Court's ruling in *Carter* weighs against granting it great deference. Considered from this perspective, "[i]nertia cannot be used as an argument to justify deference".[690]

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[687] Medical aid in dying is the only new care set out in the Quebec statute because palliative care, including continuous palliative sedation, existed and was already being provided in Quebec. See Exhibit PGQ-10: Quebec, National Assembly, Journal des débats de la Commission permanente de la santé et des services sociaux, 40-1 (27 and 28 November 2013) "Étude détaillée du projet de loi n° 52 – Loi concernant les soins de fin de vie (4) et (5)", CSSS-64 at 23 and CSSS-65 at 33 (Minister of Health and Social Services Hivon).

[688] Defence of the Attorney General of Quebec at para. 39.

[689] Written arguments of the Attorney General of Quebec at para. 149.

[690] *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791 at para. 97. Naturally, this case does not involve any procrastination over many years or a situation that keeps deteriorating. That said, the applicants' daily suffering and loss of meaning to their lives slows down time, and will continue until they become eligible for medical assistance in dying.

[729] In 2015, when the Supreme Court invited Parliament and the provincial legislatures to "respond, should they so choose, by enacting legislation consistent with the constitutional parameters set out in"[691] *Carter*, Quebec could not just stand idly by and ignore the new backdrop against which its law on medical aid in dying was set.

[730] In its impact[692], the end-of-life criterion does not recognize the needs and particular situation of patients like the applicants. The impugned provision denies patients with a serious and incurable illness in an advanced state of irreversible decline in capability and who experience constant unbearable and intolerable suffering the right to care that would cut short their suffering. In addition, for the reasons stated in the analysis of the federal statute, the Attorney General of Quebec's arguments on the statute's secondary objectives, namely, suicide prevention and concern for the social message devaluing life, fail to establish that the means the Quebec legislature continues to favour to achieve the statute's purpose is a minimal impairment or is proportional.

[731] The end-of-life criterion does not minimally impair the applicants' right to equality, nor is it consistent with the standard of the proportionality of effects, because it prevents the applicants from being recognized by the law "as human beings or as members of Canadian [and Quebec] society, equally capable and equally deserving of concern, respect and consideration".[693]

[732] In light of the foregoing, the Court concludes that subsection 3 of the first paragraph of s. 26 of the *Act respecting end-of-life care* violates section 15 of the *Charter* and is not justified under section 1.

[733] Finally, and given the remarks on the particular situation of the provincial statute, the Court need not examine the impugned provision in light of section 7.

Declarations of unconstitutionality of the challenged provisions

[734] The Court concludes that the legislative provision requiring a reasonably foreseeable natural death (s.241(2)(*d*) of the *Criminal Code*) infringes the rights of Mr. Jean Truchon and Ms. Nicole Gladu to life, liberty and security of the person protected by section 7 of the *Charter* in a manner that is inconsistent with the principles of fundamental justice. The same is true for their right to equality protected by section 15. The Court also concludes that these infringements are not justified under section 1 of the *Charter*.

[735] The Court concludes that the provision requiring that a patient be at the end of life (subsection 3 of the first paragraph of s. 26 of the *Act respecting end-of-life care*) infringes Mr. Jean Truchon's and Ms. Nicole Gladu's right to equality

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[691] *Carter* at para. 126.

[692] A provision may be inconsistent with the *Charter* either because of its purpose or its effect. See *R. v. Ferguson*, [2008] 1 S.C.R. 96 at para. 59 citing *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295 and *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713.

[693] *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 at para. 51.

protected by section 15 of the *Charter*, and that this infringement is not justified under section 1 of the *Charter*.

[736] Pursuant to s. 52(1) of the *Charter*, these provisions are of no force or effect.

7. Are the Attorneys General Entitled to Have the Declaration that These Provisions Are Inoperative Suspended and, If So, Are the Applicants Entitled to a Constitutional Exemption?

[737] The unconstitutionality of the challenged provisions engages the application of s. 52(1) of the *Constitution Act, 1982*[694]:

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

[738] Given that there exists "a range of possible remedies"[695], the remedies sought by the parties differ particularly with respect to the possible suspension of the effect of the Court's declaration of invalidity.

[739] The applicants ask the Court: 1) to declare that the impugned provisions are invalid; 2) to declare that they are eligible for medical assistance in dying; 3) to order the provisional execution of the judgment or any other measure to execute this judgment in their respect; 4) in the alternative, to grant a personal constitutional exemption during the period in which the effects of the judgment are suspended.[696]

[740] The Attorneys General ask the Court to suspend the declaration of invalidity for a period of 12 months to allow Parliament and the provincial legislatures to design legislation consistent with the constitutional parameters established by the Court in this case.[697] They also object to the applicants' request for a constitutional exemption and submit that they should wait for the legislative measures of a new regime to establish their eligibility for medical assistance in dying.

[741] For the following reasons, the Court suspends the effect of the declaration of constitutional invalidity for a period of six months and grants the applicants a constitutional exemption during this period.

[742] In *Schachter*[698], Lamer C.J. described the situations when the effect of a declaration of invalidity should be temporarily suspended, namely "where the

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[694] Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

[695] *R. v. Demers*, [2004] 2 S.C.R. 489 at para. 56 citing *Schachter v. Canada*, [1992] 2 S.C.R. 679. In *Schachter*, the Supreme Court stated that "[d]epending upon the circumstances, a court may simply strike down, it may strike down and temporarily suspend the declaration of invalidity, or it may resort to the techniques of reading down or reading in".

[696] Originating application at paras. 252, 253 and 262; Written submissions of the applicants at 137; Reply of the applicants at paras. 365, 366 and 376.

[697] Arguments of the Attorney General of Canada at para. 212 *et seq.*; written arguments of the Attorney General of Quebec at para. 155.

[698] *Schachter v. Canada*, [1992] 2 S.C.R. 679 at 715–716.

[immediate] striking down of a provision poses a potential danger to the public ... or otherwise threatens the rule of law", or even where striking down the law immediately would deprive deserving persons of benefits without providing them to applicant. In the latter case, a suspension allows the government "to determine whether to cancel or extend the benefits". Lamer C.J. added that whether or not to suspend depends on the effect of the declaration of invalidity on the public, not on "considerations of the role of the courts and the legislature".[699]

[743] The case law has evolved since that judgment, and the suspension of a declaration of invalidity seems to have become another aspect of the dialogue doctrine[700], which allows the courts to acknowledge the legislature's social policy role by granting it the opportunity to amend its legislation before it becomes of no force or effect.[701]

[744] Given the particular circumstances of this debate, the Court will grant both legislatures a suspension of the declaration of invalidity for a period of six months. As Parliament opted to enact a legislative regime essentially based on the parameters set out by the Supreme Court, with the added reasonably foreseeable natural death requirement, its unconstitutionality returns the law to the state it was in Canada following *Carter* and, therefore, creates no legal vacuum. Furthermore, a complete legislative debate took place at both the federal and provincial levels, so any possible responses should be easy to identify. Finally, this suspension period will allow Parliament and the legislature to coordinate in order to avoid perpetuating the existing incongruities in medical assistance in dying in Quebec.

[745] The Court will now address the constitutional exemption requested by Mr. Truchon and Ms. Gladu.

[746] The Court rejects the Attorney General of Canada's "mechanical reading"[702] of *Demers*[703], whereby the courts are precluded from granting a remedy based on s. 24(1) of the *Charter* during the period of the suspended declaration of invalidity. This case, like *Carter BCSC*[704], is an exceptional case "where an additional remedy based on s. 24(1) is necessary to grant an effective remedy"[705] to the applicants during the suspension period":

> Another area where constitutional exemptions could be justified is where they are used as a temporary remedy to exempt a successful *Charter*

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[699] *Ibid.* at 717.

[700] Peter W. Hogg, *Constitutional Law of Canada*, 5th ed., vol. 2 (Toronto: Thomson Reuters, 2007) loose-leaf, updated in 2015, at para. 36.5(*c*), at 36-18.1: "[The] dialogue rationale has supplanted the emergency rationale as a sufficient basis for the suspension of a declaration of invalidity. The new rationale is simply that, in many cases where the Court has found a law to be unconstitutional, the Court would prefer the legislature to design the appropriate remedy".

[701] Kent Roach, *Constitutional Remedies in Canada*, 2nd ed. (Toronto: Thomson Reuters, 1994) loose-leaf, updated in April 2013 at para. 14.1530.

[702] *Ibid.* updated in December 2016 at para. 14.940.

[703] *R. v. Demers*, [2004] 2 S.C.R. 489 at para. 62.

[704] *Carter BCSC* at para. 1411.

[705] *R. v. Ferguson*, [2008] 1 S.C.R. 96 at para. 63 citing *R. v. Demers*, [2004] 2 S.C.R. 489.

> applicant or others similarly situated from a suspended declaration of invalidity. Such exemptions could be used to prevent irreparable harm during the period of a suspended declaration of invalidity. The use of such exemptions as a temporary remedy during this time would not run afoul of the court's concern in *Ferguson* about creating permanent uncertainty in laws. It would also not evade the courts' obligation to strike down unconstitutional laws under s. 52(1).[706]

[747] In the words of the Supreme Court when it extended the suspension in *Carter*, the Court does not see “any need to unfairly prolong the suffering”[707] of the applicants and continue the infringement of their fundamental rights protected by the *Charter*. That said, the Court cannot declare the applicants eligible for medical assistance in dying at this moment. Their personal situations are not frozen in time and clearly may have evolved since the hearing. Their capacity to consent, their suffering and their medical condition should be re-assessed to determine whether they are eligible based on the legislative requirements in force, except for the reasonably foreseeable natural death and end of life requirements.

VARIA

1. **Objections**

[748] Two main objections remain to be decided in this case. The first concerns the admissibility into evidence of three of the Attorney General of Canada’s expert reports, those of Dr. Kim, Dr. Gaind and Dr. Quill.

[749] In a case management judgment rendered on February 1, 2018[708], the Court limited the number of expert reports that the Attorney General of Canada could file to seven out of the initial thirteen announced.

[750] In July 2018, the applicants disclosed their expert reports to the parties and to the Court. In September 2018, before the case was ready for trial, the Attorney General filed an application for leave to produce these three additional expert reports, primarily to answer [TRANSLATION] “new issues raised by the applicants”[709] so that the Court would benefit from complete evidence.

[751] Following discussions with the parties, the Court agreed that the decision whether to accept them would be deferred to the merits. At the hearing, the applicants informed the Court that they no longer objected to the production of Dr. Quill’s expert report. The Court now must decide whether to admit the expert reports of Dr. Kim and Dr. Gaind, both of whom testified at the hearing. Moreover, this judgment analyzes their testimony.

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[706] Kent Roach, *Constitutional Remedies in Canada*, 2nd ed. (Toronto: Thomson Reuters, 1994) loose-leaf updated in December 2015, at para. 14.910.

[707] *Carter v. Canada (Attorney General)*, [2016] 1 S.C.R. 13 at para. 6.

[708] *Truchon c. Procureur général du Canada*, 2018 QCCS 317.

[709] Application of the Attorney General of Canada for leave to produce additional expert reports, dated September 6, 2018.

[752] As the Attorney General rightly submits, the Court's judgment setting the number of authorized expert reports was primarily a case management measure intended primarily to ensure respect for the principle of proportionality set out in the *Code of Civil Procedure.*[710] Under this same *Code*, case management measures may be revised by the Court and must be considered flexibly and according to the particularities and evolution of each case.[711]

[753] In this context, Dr. Kim's and Dr. Gaind's reports are relevant to various aspects of the case, for example, the social reality in foreign jurisdictions, patients with a psychiatric condition or suicide prevention.

[754] In view of the foregoing, the Tribunal overrules the objection and allows the reports to be filed into evidence.

[755] The second objection concerns the Commission sur les soins de fin de vie's latest report[712], filed by the applicants after this case was taken under advisement. The parties submitted in writing to the Court their respective positions in this regard.[713]

[756] The document in question basically contains the updated Quebec statistics and findings of the Commission, whose role under the statute[714] is precisely to collate and comment on the data collected. The Commission's previous reports were all filed into evidence with the parties' consent. The Court considers that the Commission's latest report is relevant to this dispute. The objection is overruled and the report is filed into evidence.

2. Legal Costs

[757] The applicants ask that the case be granted with costs.

[758] The Court will grant costs.

3. English Version of the Judgment

[759] The present judgment was rendered in French, but it could possibly have an impact across the country. As a result, the Court has caused it to be translated into English and the present document constitutes the official English translation.

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[710] CQLR, c. C-25.01.

[711] See particularly, *Attorney General of Canada c. 555 Carrière Holdings Inc./Gestion 555 Carrière inc.*, 2017 QCCS 1841 and *Pop c. Boulanger*, 2017 QCCA 1009.

[712] Exhibit P-38: Commission sur les soins de fin de vie, *Rapport sur la situation des soins de fin de vie au Québec*: *Du [10] décembre 2015 au 31 mars 2018* (Québec: Government of Quebec, 2019).

[713] Letter from the applicants, May 2, 2019; Letter from the Attorneys General, May 8, 2019; Letter from the interveners Collectif des médecins contre l'euthanasie and Living with Dignity, May 7, 2019.

[714] Sections 42 and 44 of the Quebec statute.

CONCLUSIONS

[760] The Court has been a privileged witness to the important social debate that unfolded before it. It would first like to sincerely thank counsel who, despite considerable time constraints, respected the schedule and presented both their evidence and their arguments skillfully and clearly. It is also important to acknowledge the courtesy displayed throughout the hearing, both towards each other and towards the Court.

[761] The Court has nothing but praise for the quality of the expert witnesses who came to instruct the Court and who actively contributed to deepening the debate. They all deserve to be commended for the quality of the work they are carrying out in their respective area of expertise. The Court would like to commend in particular the experts who support and work directly with vulnerable or ill persons for their commitment, dedication and compassion.

[762] Last, there would not have been a social debate had it not been for the courage and determination of two exceptional individuals, Mr. Jean Truchon and Ms. Nicole Gladu, who carried this cause on their shoulders. The Court will remain forever marked by their testimony and wishes express its deepest respect for them.

FOR THESE REASONS, THE COURT:

[763] **GRANTS** in part the application;

[764] **DECLARES** that s. 241.2(2)(*d*) of the *Criminal Code* violates section 7 of the *Canadian Charter* because it is inconsistent with the principles of fundamental justice and cannot be justified under section 1 of the *Canadian Charter*;

[765] **DECLARES** that s. 241.2(2)(*d*) of the *Criminal Code* and subsection 3 of the first paragraph of s. 26 of the *Act respecting end-of-life care* violate section 15 of the *Canadian Charter* and cannot be justified under section 1 of the *Canadian Charter*;

[766] **DECLARES** that s. 241.2(2)(*d*) of the *Criminal Code* and subsection 3 of the first paragraph of s. 26 of the *Act respecting end-of-life care* are of no force or effect;

[767] **SUSPENDS** the declaration of inapplicability of s. 241.2(2)(*d*) of the *Criminal Code* and subsection 3 of the first paragraph of s. 26 of the *Act respecting end-of-life care* for a period of six months as of this judgment;

[768] **GRANTS** Mr. Jean Truchon and Ms. Nicole Gladu a constitutional exemption from the inapplicability throughout the period of constitutional exemption granted to the legislatures;

[769] **DECLARES** para. 768 of this judgment enforceable, notwithstanding appeal;

[770] **THE WHOLE,** with legal costs.

CHRISTINE BAUDOUIN, J.S.C.

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Dates of hearing: January 7, 8, 9, 10, 11, 14, 15, 16, 17, 28, 29, 30 and 31, 2019
-and-
February 1, 4, 5, 6, 7, 8, 11, 12, 13, 18, 19, 20, 21, 22, 25, 26, 27 and 28, 2019.

SCHEDULE

Criminal Code, R.S.C. (1985), c. C-46, ss. 241.1–241.4

Medical Assistance in Dying

Definitions

241.1 The following definitions apply in this section and in sections 241.2 to 241.4.

medical assistance in dying means

> **(a)** the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
>
> **(b)** the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death. (*aide médicale à mourir*)

medical practitioner means a person who is entitled to practise medicine under the laws of a province. (*médecin*)

nurse practitioner means a registered nurse who, under the laws of a province, is entitled to practise as a nurse practitioner — or under an equivalent designation — and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients. (*infirmier praticien*)

pharmacist means a person who is entitled to practise pharmacy under the laws of a province. (*pharmacien*)

Eligibility for medical assistance in dying

241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:

> **(a)** they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;
>
> **(b)** they are at least 18 years of age and capable of making decisions with respect to their health;
>
> **(c)** they have a grievous and irremediable medical condition;
>
> **(d)** they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and

(e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Grievous and irremediable medical condition

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

(a) they have a serious and incurable illness, disease or disability;

(b) they are in an advanced state of irreversible decline in capability;

(c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

(d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

Safeguards

(3) Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must

(a) be of the opinion that the person meets all of the criteria set out in subsection (1);

(b) ensure that the person's request for medical assistance in dying was

(i) made in writing and signed and dated by the person or by another person under subsection (4), and

(ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;

(c) be satisfied that the request was signed and dated by the person — or by another person under subsection (4) — before two independent witnesses who then also signed and dated the request;

(d) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;

(e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);

(f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent;

(g) ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided or — if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person’s death, or the loss of their capacity to provide informed consent, is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;

(h) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying; and

(i) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.

Unable to sign

(4) If the person requesting medical assistance in dying is unable to sign and date the request, another person — who is at least 18 years of age, who understands the nature of the request for medical assistance in dying and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person’s death — may do so in the person’s presence, on the person’s behalf and under the person’s express direction.

Independent witness

(5) Any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying may act as an independent witness, except if they

(a) know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person’s death;

(b) are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides;

(c) are directly involved in providing health care services to the person making the request; or

(d) directly provide personal care to the person making the request.

Independence — medical practitioners and nurse practitioners

(6) The medical practitioner or nurse practitioner providing medical assistance in dying and the medical practitioner or nurse practitioner who provides the opinion referred to in paragraph (3)(e) are independent if they

(a) are not a mentor to the other practitioner or responsible for supervising their work;

(b) do not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or

(c) do not know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.

Reasonable knowledge, care and skill

(7) Medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards.

Informing pharmacist

(8) The medical practitioner or nurse practitioner who, in providing medical assistance in dying, prescribes or obtains a substance for that purpose must, before any pharmacist dispenses the substance, inform the pharmacist that the substance is intended for that purpose.

Clarification

(9) For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying.

Failure to comply with safeguards

241.3 A medical practitioner or nurse practitioner who, in providing medical assistance in dying, knowingly fails to comply with all of the requirements set out in paragraphs 241.2(3)(b) to (i) and subsection 241.2(8) is guilty of an offence and is liable

(a) on conviction on indictment, to a term of imprisonment of not more than five years; or

(b) on summary conviction, to a term of imprisonment of not more than 18 months.

Filing information — medical practitioner or nurse practitioner

241.31 (1) Unless they are exempted under regulations made under subsection (3), a medical practitioner or nurse practitioner who receives a written request for medical assistance in dying must, in accordance with those regulations, provide the information required by those regulations to the recipient designated in those regulations.

Filing information — pharmacist

(2) Unless they are exempted under regulations made under subsection (3), a pharmacist who dispenses a substance in connection with the provision of medical assistance in dying must, in accordance with those regulations, provide the information required by those regulations to the recipient designated in those regulations.

Regulations

(3) The Minister of Health must make regulations that he or she considers necessary

(a) respecting the provision and collection, for the purpose of monitoring medical assistance in dying, of information relating to requests for, and the provision of, medical assistance in dying, including

(i) the information to be provided, at various stages, by medical practitioners or nurse practitioners and by pharmacists, or by a class of any of them,

(ii) the form, manner and time in which the information must be provided,

(iii) the designation of a person as the recipient of the information, and

(iv) the collection of information from coroners and medical examiners;

(b) respecting the use of that information, including its analysis and interpretation, its protection and its publication and other disclosure;

(c) respecting the disposal of that information; and

(d) exempting, on any terms that may be specified, a class of persons from the requirement set out in subsection (1) or (2).

Guidelines — information on death certificates

(3.1) The Minister of Health, after consultation with representatives of the provincial governments responsible for health, must establish guidelines on the information to be included on death certificates in cases where medical assistance in dying has been provided, which may include the way in which to clearly identify medical assistance in dying as the manner of death, as well as the illness, disease or disability that prompted the request for medical assistance in dying.

Offence and punishment

(4) A medical practitioner or nurse practitioner who knowingly fails to comply with subsection (1), or a pharmacist who knowingly fails to comply with subsection (2),

(a) is guilty of an indictable offence and liable to a term of imprisonment of not more than two years; or

(b) is guilty of an offence punishable on summary conviction.

Offence and punishment

(5) Everyone who knowingly contravenes the regulations made under subsection (3)

(a) is guilty of an indictable offence and liable to a term of imprisonment of not more than two years; or

(b) is guilty of an offence punishable on summary conviction.

Forgery

241.4 (1) Everyone commits an offence who commits forgery in relation to a request for medical assistance in dying.

Destruction of documents

(2) Everyone commits an offence who destroys a document that relates to a request for medical assistance in dying with intent to interfere with

(a) another **person's** access to medical assistance in dying;

(b) the lawful assessment of a request for medical assistance in dying;

(c) another person invoking an exemption under any of subsections 227(1) or (2), 241(2) to (5) or 245(2); or

(d) the provision by a person of information under section 241.31.

Punishment

(3) Everyone who commits an offence under subsection (1) or (2) is liable

(a) on conviction on indictment, to a term of imprisonment of not more than five years; or

(b) on summary conviction, to a term of imprisonment of not more than 18 months.

Definition of document

(4) In subsection (2), *document* has the same meaning as in section 321.

Act respecting end-of-life care, RLRQ, c. S-32.0001, ss. 26–32

MEDICAL AID IN DYING

26. Only a patient who meets all of the following criteria may obtain medical aid in dying:

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

The patient must request medical aid in dying themselves, in a free and informed manner, by means of the form prescribed by the Minister. The form must be dated and signed by the patient.

The form must be signed in the presence of and countersigned by a health or social services professional; if the professional is not the attending physician, the signed form is to be given by the professional to the attending physician.

27. If the patient requesting medical aid in dying cannot date and sign the form referred to in section 26 because the patient cannot write or is physically incapable of doing so, a third person may do so in the patient's presence. The third person may not be a member of the team responsible for caring for the patient, a minor or a person of full age incapable of giving consent.

28. A patient may, at any time and by any means, withdraw their request for medical aid in dying.

A patient may also, at any time and by any means, request that the administration of medical aid in dying be put off.

29. Before administering medical aid in dying, the physician must

(1) be of the opinion that the patient meets all the criteria of section 26, after, among other things,
  (*a*) making sure that the request is being made freely, in particular by ascertaining that it is not being made as a result of external pressure;

> (*b*) making sure that the request is an informed one, in particular by informing the patient of the prognosis for the illness and of other therapeutic possibilities and their consequences;
>
> (*c*) verifying the persistence of suffering and that the wish to obtain medical aid in dying remains unchanged, by talking with the patient at reasonably spaced intervals given the progress of the patient's condition;
>
> (*d*) discussing the patient's request with any members of the care team who are in regular contact with the patient; and
>
> (*e*) discussing the patient's request with the patient's close relations, if the patient so wishes;

(2) make sure that the patient has had the opportunity to discuss the request with the persons they wished to contact; and

(3) obtain the opinion of a second physician confirming that the criteria set out in section 26 have been met.

The physician consulted must be independent of both the patient requesting medical aid in dying and the physician seeking the second medical opinion. The physician consulted must consult the patient's record, examine the patient and provide the opinion in writing.

30. If a physician determines, subsequent to the application of section 29, that medical aid in dying may be administered to a patient requesting it, the physician must administer such aid personally and take care of and stay with the patient until death ensues.

If the physician determines that medical aid in dying cannot be administered, the physician must inform the patient of the reasons for that decision.

31. A physician practising in a centre operated by an institution who refuses a request for medical aid in dying for a reason not based on section 29 must, as soon as possible, notify the executive director of the institution or any other person designated by the executive director and forward the request form given to the physician, if that is the case, to the executive director or designated person. The executive director of the institution or designated person must then take the necessary steps to find, as soon as possible, another physician willing to deal with the request in accordance with section 29.

If the physician who receives the request practises in a private health facility and does not provide medical aid in dying, the physician must, as soon as possible, notify the executive director of the local authority referred to in section 99.4 of the Act respecting health services and social services (chapter S-4.2) that serves the territory in which the patient making the request resides, or notify the person designated by the executive director. The physician forwards the request form received, if that is the case, to the executive director or designated person and the steps mentioned in the first paragraph must be taken.

If no local authority serves the territory in which the patient resides, the notice referred to in the second paragraph is forwarded to the executive director of the institution operating a local community service centre in the territory or the person designated by the executive director.

32. All information and documents in connection with a request for medical aid in dying, regardless of whether the physician administers it or not, including the form used to request such aid, the reasons for the physician's decision and, where applicable, the opinion of the physician consulted, must be recorded or filed in the patient's record.

A decision to withdraw a request for medical aid in dying or to put off the administration of such aid must also be recorded in the patient's record.

* * * * *