No. S112688
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

LEE CARTER, HOLLIS JOHNSON, DR. WILLIAM SHOICHET, THE BRITISH COLUMBIA CIVIL LIBERTIES ASSOCIATION and GLORIA TAYLOR

PLAINTIFFS

AND:

ATTORNEY GENERAL OF CANADA

DEFENDANT

AND:

ATTORNEY GENERAL OF BRITISH COLUMBIA

Party pursuant to the *Constitutional Question Act*, R.S.B.C. 1996, c. 68

AND:

FAREWELL FOUNDATION FOR THE RIGHT TO DIE (Represented by Russel Ogden, Erling Christensen, Laurence Cattoire, John Lowman and Paul Zollmann), THE CHRISTIAN LEGAL FELLOWSHIP, CANADIAN UNITARIAN COUNCIL, EUTHANASIA PREVENTION COALITION and EUTHANASIA PREVENTION COALITION – BRITISH COLUMBIA and AD HOC COALITION OF PEOPLE WITH DISABILITIES WHO ARE SUPPORTIVE OF PHYSICIAN-ASSISTED DYING (As Represented by Jeanette Andersen, Margaret Birrell, Donald Danbrook, Michelle Des Lauriers, Zofja (Zosia) Anna Ettenberg, Craig Langston, and Paul A. Spiers)

INTERVENORS

WRITTEN SUBMISSIONS OF THE PLAINTIFFS
Plaintiffs' Application – Rule 9-7

Counsel for the Plaintiffs

Joseph J. Arvay, Q.C. and Alison M. Latimer
Arvay Finlay
1350 - 355 Burrard Street
Vancouver BC V6C 2G8
Tel: 604.689.4421   Fax: 604.687.1941
-and -
Sheila M. Tucker
Davis LLP
Suite 2800 Park Place
666 Burrard Street
Vancouver BC V6C 2Z7
Tel: 604.643.2980   Fax: 604.605.3781

Counsel for the Attorney General of British Columbia

George H. Copley, Q.C.
The Ministry of Attorney General
Legal Services Branch
6th Floor – 1001 Douglas Street
PO Box 9280 Stn Prov Govt
Victoria BC V8W 9J7
Tel: 604.643.2980   Fax: 604.605.3781

Counsel for the Defendant

Donnaree Nygard and Keith Reimer
Department of Justice Canada
900 – 840 Howe Street
Vancouver BC V6Z 2S9
Tel: 604.666.3049   Fax: 604.775.5942

Time: 9:45 am
Date: 14 Nov 2011
Place of Hearing: Vancouver BC
Time Estimate: 20 days

Counsel for the Intervenor, Farewell Foundation for the Right to Die (represented by Russel Ogden, Erling Christensen, Laurence Cattoire, John Lowman, and Paul Zollmann)

Jason B. Gratl
Gratl & Company
302 - 560 Beatty Street
Vancouver BC V6B 2L3
Tel: 604.694.1919 Fax: 604.608.1919

Counsel for the Intervenor, Canadian Unitarian Council

Tim Dickson
Farris, Vaughan, Wills & Murphy LLP
25th Floor, 700 West Georgia Street
Vancouver BC V7Y 1B3
Tel: 604.661.9341 Fax: 604.661.9349
Email: tdickson@farris.com

Counsel for the Intervenor, Ad Hoc Coalition of People With Disabilities Who are Supportive of Physician-Assisted Dying (as represented by Jeanette Andersen, Margaret Birrell, Donald Danbrook, Michelle Des Lauriers, Zofja (Zosia) Anna Ettenberg, Craig Langston, and Paul A. Spiers)

Angus M. Gunn, Jr.
Borden Ladner Gervais LLP
1200 Waterfront Centre
200 Burrard Street
P.O. Box 48600
Vancouver BC V7X 1T2
Tel: 604.640.4084 Fax: 604.622.5915
Email: agunn@blg.com

Counsel for the Intervenor, The Christian Legal Fellowship

Gerald D. Chipeur, Q.C.
Miller Thomson LLP
3000, 700 - 9th Avenue SW
Calgary AB T2P 3V4
Tel: 403.298.2434 Fax: 403.262.0007
Email: gchipeur@millerthomson.com
-and -
Matthew Morawski
Miller Thomson LLP
Robson Court, 1000-840 Howe Street
Vancouver BC V6Z 2M1
Tel: 604.643.1213 Fax: 604.643.1200
Email: mmorawski@millerthomson.com

Counsel for the Intervenor, Euthanasia Prevention Coalition and Euthanasia Prevention Coalition – British Columbia

Joel V. Payne
Fasken Martineau DuMoulin LLP
2900 – 550 Burrard Street
Vancouver BC V6C 0A3
Tel: 604.631.4779 Fax: 604.631.3232
Email: jpayne@fasken.com
-and -
Hugh R. Scher
Scher Law Professional Corporation
Suite 210, 69 Bloor Street East
Toronto ON M4W 1A9
Tel: 416.969.1812 Fax: 416.969.1815
Email: hugh@sdlaw.ca

INDEX

PAGE

WRITTEN SUBMISSIONS OF THE PLAINTIFFS

INTRODUCTION

1. This case involves the rights of a distinct but significant group of Canadians - those so unfortunate as to have an irremediable medical condition that causes them intolerable suffering. Such are those living with the diseases we well know and fear - ALS, Huntington's, ravaging cancer. But also those with rarer conditions, like the bluntly but aptly named "Locked-In Syndrome" - a condition capable of transforming the body into the breathing equivalent of a medieval dungeon. And within this unfortunate grouping, yet another, those who believe there are states of being that are literally worse than death, and who wish to embrace the latter in the time, manner and circumstances of their own choosing.

2. This desire is explained by Gloria Taylor, who has ALS, in her affidavit:

> 43. What I want is to be able to die in a manner that is consistent with the way that I lived my life. I want to be able to exercise control and die with dignity and with my sense of self and personal integrity intact. I want to be able to experience my death as part of my life and part of my expression of that life. I do not want the manner of my death to undermine the values that I lived my life in accordance with.…
>
> 44. I am dying. I do not want to, but I am going to die: that is a fact. I can accept death because I recognize it as part of life. What I fear is a death that negates, as opposed to concludes, my life.…

Taylor #2, paras. 43-44, Record Vol. 3, Tab 34

and by Leslie LaForest, who has anal cancer, in her own affidavit:

> 53. I would have much preferred to have the fortune of good health for a lifetime. But I do not have that, so I simply ask to exit this life quickly, painlessly and with the dignity I choose. Who has the right to say when and how an ill individual dies? Should it be left to society, comprised mostly of people who are not dying? Or should it be left to the ill person who is, simply put, doing the actual dying? It is my fervent belief that no one has the right to tell me how, when and where my dying ought to occur.

LaForest #1, para. 53, Record Vol. 1, Tab 14

3. The evidence before this Court - expert and lay - is that the members of this latter group are generally characterized by strength and vibrancy of personality and by a lifelong desire to exercise meaningful power over their lives. This group is, in this litigation, well-represented by

Kay Carter and Gloria Taylor, two formidable women determined to have a say in a defining event in their lives - their deaths.

4. There is obviously a valid concern that only genuine and enduring requests by capable persons result in physician-assisted dying. However, the evidence demonstrates that it is more than possible to distinguish between the depressed and the determined as applicants. Experts with experience in assessing competence for medical-decision making purposes have testified that decision-making capacity can be accurately assessed, even in the seriously ill. Similarly, the evidence establishes that clinical depression can be accurately diagnosed, even in the seriously ill. There is also evidence establishing that it is entirely possible for an assessor to determine whether a request is voluntary, and whether it is the result of a rational decision-making process. Thus, the evidence establishes that autonomous requests worthy of respect can be identified as such.

5. The question then, is whether these autonomous requests can be honoured?

6. The evidence before the Court establishes that these requests can be honoured in the context of a regulated assisted-dying regime. A growing number of jurisdictions permit physician-assisted dying. The Court has been provided with extensive expert evidence regarding those jurisdictions - evidence from physicians actually working in those jurisdictions and from researchers who have extensively studied those systems. This evidence demonstrates that the jurisdictions that have chosen to permit and regulate physician-assisted dying - the Netherlands, Belgium, Luxemburg, Oregon and Washington - have systems in place that provide significant safeguards and which are working well.

7. Indeed, the evidence is that even in Switzerland, where it is legal for anyone to provide altruistic assistance in dying, when assistance in dying is provided in a hospital, the medical institutions itself may closely regulate the process. Dr. Pereira, who had worked in a hospital in Switzerland, testified that the hospital imposed the following safeguards by policy:

> The patient must have the capacity and competence to make the request him or herself and provide consent. The patient's requests must be persistent. The patient must have a terminal illness. Assessment by the hospital psychiatry and palliative care service are mandatory. Once all of these criteria have been met a formal request is made to the hospital's medical administration who then appoint

> a committee that confirms that the criteria have been met and makes the final decision. The commission consists of a physician member of the direction medical, a representative of the nursing administration and two members of the institution's clinical ethics committee. One of these persons will see the patient. If the request is accepted by this committee the patient may receive the lethal prescription form his or her attending physician in the hospital if he or she is in an agreement or from an external person such as member of Exit or Dignatas. Therefore staff members are not obliged to provide AS.

Pereira Cross (Nov. 23), p. 101, l. 3 to p. 102, l. 26, SuppRecord Vol. 34, Tab 141

8. Dr. Pereira agreed that if there was to be physician-assisted dying permitted in a country, then these were "very sensible criteria."

Pereira Cross (Nov. 23), p. 101, l. 3 to p. 102, l. 26, SuppRecord Vol. 34, Tab 141

9. Thus, the evidence establishes that regulated regimes can address all reasonable concerns about access to physician-assisted dying. The various safeguards used in the systems described in the evidence include, for example: requirements for written requests; requirements for repeated requests; minimum waiting periods; capacity evaluations; requirements that a second opinion be obtained on diagnosis, prognosis, available treatments and capacity; a palliative care consultation; a psychiatric consultation; and physician reporting requirements.

10. It is true that no medical regime is perfect in the sense of being absolutely infallible. There can be a learning curve for administrative compliance and the evidence discloses imperfect, but steadily increasing reporting compliance in Belgium and the Netherlands. There is also evidence that the Oregon system was latterly improved by implementing best practices regarding screening practices for assessing whether a psychiatric consultation should be required. However, as Dr. Angell noted, all human endeavour, even in the medical field, inherently involves some risk.

11. The government's own expert witness, Dr. Pereira in fact said all medical procedures pose the risk of the "slippery slope", yet agreed that we as society have not chosen to ban the procedure because of that risk. Indeed he endorsed the following view with respect to the use of terminal sedation:

> … Could it be that light sedation has no effect on survival and that sudden deep sedation does? … I doubt that these questions will be answerable by randomized controlled study… If there were enough patients who refused sedation for the

> management of catastrophic symptoms at the end of life, a matched cohort study may provide the answer. In the meantime, we need not be paralyzed by uncertainty. Medicine is not a science of certainty, rather it is characterized by uncertainties. Clinicians, patients and their families are challenged to find pragmatic, and ethically appropriate, best options despite that uncertainty exists.

Pereira Cross, Trial Exhibit 36, SuppRecord Vol. 34, Tab 140/36 (emphasis added)

12. That said, the evidence discloses that the risks associated with regulated physician-assisted dying are, in fact, considerably less than those that are currently accepted under the Canadian system with respect to other end-of-life medical decisions. Most Canadians now die as a result of a refusal, withholding or withdrawal of medical treatment. The evidence establishes that a patient decision to refuse, withhold or withdraw life sustaining treatment is not subject to any formal review process, notwithstanding that the same factors said to complicate decision-making in the context of physician-assisted dying exist there are well: the patient is seriously ill, capacity and mental illness may be issues, the family may have expressed views on the decision, and there will be patient-physician discussion about the decision. But in the context of refusal or withdrawal, there is not only no process for vetting the patient’s decision, the life-ending act need not even be reported as such. The practice of terminal sedation, which on the evidence can also hasten death, is also carried on in the absence of regulation and oversight. Further, in both of these contexts, the decision may be made by a substituted decision-maker - adding yet another significant level of risk.

13. The real-life impact of the distinction the law draws between chosen death by refusal or withdrawal of treatment and chosen death by physician-assisted dying is also addressed in the evidence. In her affidavit, Gloria Taylor states:

> 41. I also cannot understand why it is permissible for my friend, who is on kidney dialysis, to say “enough it enough” and make the decision to die. I cannot understand why the law respects his wish and decision to die, but does not do the same for me. We are equally competent. I do not understand how or why it is the role of government to say that his choice results in a “natural” death, but my choice would not.

Taylor #2, para. 41, Record Vol. 3, Tab 34

and Tony Nicklinson, who has Locked-In Syndrome as a result of a stroke, says in his Witness Statement:

> 3. … Am I grateful that the Athens doctors saved my life? No, I am not. If I had my time again, and knew then what I know now, I would not have called the ambulance but let nature take its course. I was given no choice as to whether or not I wanted to be saved. However, I do concede that it was a fair assumption given that I had asked for the ambulance and associated medical staff.
>
> 4. What I object to is having my right to choose taken away from me after I had been saved. It seem to me that if my right to choose life or death at the time of initial crisis is reasonably taken away it is only fair to have the right to choose back when one gets over the initial crisis and have time to reflect.

Nicklinson #1, Exhibit F, paras. 3-4, Record Vol. 2, Tab 15

14. The evidence before this Court also discloses that, where there is an absolute prohibition, studies reveal that physician-assisted dying in response to express patient requests is carried on as an illegal and unregulated practice. The studies that have been done on such jurisdictions indicate that this conduct occurs at a fairly consistent rate across the various jurisdictions studied.

Battin #1, para. 23, Record Vol. 6, Tab 51

Starks #1, paras. 15, 32, Exhibits H, I, Record Vol. 6, Tab 53

Starks #2, para. 21, Record Vol. 25, Tab 107

Syme #1, paras. 3, 6-7, 10, Record Vol. 1, Tab 12

Owens #1, para. 5, Exhibits B, C, Record Vol. 25, Tab 106

Librach #1, para. 15, Record Vol. 1, Tab 11

Cordover #1, para. 49, Record Vol. 3, Tab 24

Ganzini #1, para. 8, Exhibit C, Record Vol. 2, Tab 23

Ganzini #2, para. 30, Record Vol. 26, Tab 111

Barrette #1, Exhibit B, p. 5, Record Vol. 4, Tab 36

Battin #1, paras. 23, 41, Record Vol. 6, Tab 51

Angell #1, Exhibit C, pp. 39-40, Record Vol. 7, Tab 54

Welch #1, paras. 10, 17, Record Vol. 9, Tab 64

Kimsma #1, para. 18, Record Vol. 8, Tab 63

Deliens #1, paras. 10-12, Exhibit C, Record Vol. 7, Tab 57

Bereza #1, paras. 21-22, 74, Record Vol. 10, Tab 73

15. Their evidence reveals that prohibition creates back alleys for assisted dying, just as prohibition once did for abortion. There is no reason to assume that assisted dying is not currently happening in Canada - that it, in fact, does happen here is one of the many lessons of the *Sue Rodriguez* case. The evidence also discloses that unqualified and unregulated

not-for-profit groups are currently shepherding the Canadian ill and their helpers through those alleys on a regular basis.

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

16. Finally, there is evidence providing a rigorous ethical analysis, the arguments for and against physician-assisted dying. This evidence thoroughly and meticulously canvasses the ethical assertions that are commonly advanced against physician-assisted dying and demonstrates that there is no sustainable ethical objection. That said, ethics can only inform, not determine, the legal analysis. The question of whether the restriction of physician-assisted dying by means of the absolute prohibition established by Impugned Provisions of the *Criminal Code* is one of constitutional law and obviously for this Court to decide.

17. However, we believe that, once the Court has had an opportunity to work through the rich record that is before it, the Court will conclude that the legal resolution in this case should, in fact, mirror the ethical one. It is our position that the Governments have failed to demonstrate any basis for denying people like Kay Carter and Gloria Taylor - people who are grievously and irremediably ill - the very fundamental right to choose, for themselves, the time and way they wish to die.

WHY *RODRIGUEZ* IS NOT BINDING ON THIS COURT

18. It is respectfully submitted that the decision of the majority in *Rodriguez* is not binding on this Court and for several reasons.

19. Firstly, it hardly needs to be said that the decision could be overruled by the Supreme Court of Canada itself.

20. Rothstein J., in reasons concurring in the result, in *Fraser* held, “the authorities are abundant that this Court may overrule its own decisions, and indeed it has done so on numerous occasions.”[1] He then reviewed the “plethora of criteria for courts to consider in deciding between upholding precedent and correcting error,”[2] at least three of which are indicated in the case at bar:

---

[1] *Ontario (Attorney General) v. Fraser*, [2011] 2 S.C.R. 3, 2011 SCC 20 [*Fraser*], para. 129

[2] *Fraser*, at para. 133

a. Have facts so changed, or come to be seen so differently, as to have robbed the old rule of significant application or justification?[3]

b. Are there subsequent developments in the law that undermine the validity of the precedent?[4]

c. Are foundational principles of human and civil rights involved?[5]

21. As to whether a trial court can decline to follow a decision of the Supreme Court of Canada, the most recent and comprehensive decision on point is that of Madam Justice Himel in *Bedford*. She had to decide whether the decision of the Supreme Court of Canada in the *Prostitution Reference*[6] was binding on her. She held that it was "*prima facie* binding" (at para. 66), but then went on to conclude that she was not bound. Excerpts from her judgment are set out below in some detail as they are for the most part apposite to the case at Bar:

> **69** The applicants make a number of arguments in favour of reconsidering the issues addressed by the *Prostitution Reference*. First, the applicants contend that this case deals with legal arguments that were not considered by the Court in 1990….
>
> **70** The applicants point out that s. 7 jurisprudence has greatly developed since 1990 by subsequent decisions of the Supreme Court which have recognized the constitutional "vices" of arbitrariness, overbreadth, and gross disproportionality: … The applicants argue that in light of the evolution of the principles of fundamental justice, the new arguments ought to be heard.
>
> **71** Second, the applicants submit that the context in which this case is being heard has changed dramatically. In part, as a result of the serial murders of prostitutes in Vancouver's Downtown Eastside, as well as the work of advocacy groups and academics, new light has been shed upon the violence faced by prostitutes in Canada. Although undoubtedly present in 1990, the issue of harm faced by prostitutes is forefront in the present case, and supported by two decades of new research.
>
> **72** Third, the applicants argue that the 1990 decision was a reference, whereas this court is hearing these arguments by way of application with the benefit of a full factual record. Twenty years ago, the Supreme Court did not have most of the empirical evidence that is before this court when it decided that the communicating provision was a reasonable limit on freedom of expression.

---

[3] *Fraser*, at para. 136
[4] *Fraser*, at para. 134
[5] *Fraser*, at para. 137
[6] *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.),* [1990] 1 S.C.R. 1123

This evidence is said to reveal a material change in circumstances, which demonstrates that the law cannot be reasonably justified. Furthermore, the applicants take the position that the evidence that the international legal context has evolved in the last two decades suggests that the communicating provision no longer represents a minimal impairment of s. 2(*b*) of the *Charter*.

…

75 I am persuaded that I am not foreclosed from hearing the challenge based on s. 7 of the *Charter* as the issues argued in this case are different than those argued in the *Prostitution Reference*. Although "the principles of fundamental justice are to be found in the basic tenets of our legal system" (*Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486, *per* Lamer J. at p. 503), the principles at issue in this case were not clearly articulated as such when the reference was heard. The jurisprudence on s. 7 of the *Charter* has evolved considerably in the last two decades.

76 I am also persuaded that I may reconsider whether s. 213(1)(*c*) of the *Criminal Code* is in violation of s. 2(*b*) of the *Charter*.

77 There is an implicit need for courts to reconsider constitutional interpretation in particular due to the difficult process of constitutional amendment that serves as the only alternative to judicial reconsideration: see J.D. Murphy and R. Rueter, *Stare Decisis in Commonwealth Appellate Courts* (Toronto: Butterworths, 1981), and P. Hogg, *Constitutional Law in Canada*, *supra*, at 8.7. The constitution is a "living tree capable of growth and expansion within its natural limits," and the rights therein ought to be subject to changing judicial interpretations over time: see *Edwards v. Attorney-General for Canada*, [1930] A.C. 124 at p. 136 (P.C.), *per* Lord Sankey.

78 It is clear that the Supreme Court has the authority to revisit its previous decisions: *Minister of Indian Affairs and Northern Development v. Ranville*, [1982] 2 S.C.R. 518; *R. v. Bernard*, [1988] 2 S.C.R. 833, *per* Dickson C.J.; *R. v. Chaulk*, [1990] 3 S.C.R. 1303, *per* Lamer C.J; *R. v. Salituro*, [1991] 3 S.C.R. 654. Lower courts must only do so in very limited circumstances.

79 In *Wakeford v. Canada (Attorney General)* (2001), 81 C.R.R. (2d) 342, 2001 CanLII 28318 (Ont. Sup. Ct.), aff'd (2001), 156 O.A.C. 385, leave to appeal to S.C.C. refused, [2002] S.C.C.A. No. 72, Swinton J. commented as follows at para. 14:

> It is true that the Supreme Court of Canada has the power to overrule its past decisions. However, a lower Court should not be quick to assume that it will do so, given the importance of the principle of *stare decisis* in our legal system. In my view, on a motion such as this, where there is a decision of the Supreme Court squarely on point, there must be some indication - either in the facts pleaded or in the decisions of the Supreme Court - that the prior decision may be open for reconsideration....

80 In *Wakeford v. Canada*, there was no indication that the Supreme Court decision at issue was open to reconsideration due to a shift in the jurisprudence.

Furthermore, there were no new developments in public policy or new facts that may have called into question the basis for the Supreme Court decision, so that there would be a realistic possibility that the decision might change, should it be reconsidered.

81 In *David Polowin Real Estate Ltd. v. Dominion of Canada General Insurance Co.*, *supra*, at paras. 124-25, Laskin J.A. discussed the circumstances that would lead the Supreme Court to revisit one of its own decisions:

> In *Bernard* [[1988] 2 S.C.R. 833], *Chaulk* [[1990] 3 S.C.R. 1303], *Salituro* [[1991] 3 S.C.R. 654], and other cases, the Supreme Court has articulated five factors that would allow it to overrule one of its previous decisions: where a previous decision does not reflect the values of the *Canadian Charter of Rights and Freedoms*; where a previous decision is inconsistent with or "attenuated" by a later decision of the Court; where the social, political, or economic assumptions underlying a previous decision are no longer valid in contemporary society; where the previous state of the law was uncertain or where a previous decision caused uncertainty; and, in criminal cases, where the result of overruling is to establish a rule favourable to the accused.
>
> These five factors were not meant to be a comprehensive list, nor need they all be present to justify overruling a previous decision. Instead, as Lamer C.J.C. said in *Chaulk* at p. 1353 S.C.R., "They are... guidelines to assist this Court in exercising its discretion." But overruling a previous decision based on one or more of these five factors promotes the interests of justice and the court's own sense of justice by bringing judge-made law into line with constitutional, legislative, or social changes, by removing conflicts and uncertainties in the law, or by protecting individual liberty.

82 In *Leeson v. University of Regina* (2007), 301 Sask. R. 316, 2007 SKQB 252, Laing C.J. cited Laskin J.A.'s reasoning, and outlined when a lower court may revisit the decisions of a higher court at para. 9:

> ... there are reasons why earlier decisions can and should be revisited, and necessarily such revisitations must commence at the trial court level.... The position of the applicants is that [the Supreme Court decision at issue] should be revisited because in the 17 years since it was decided, the social, political or economic assumptions underlying the decision are no longer valid. When such change is alleged, and there are at least some facts alleged which support such change, it is not appropriate to prevent the matter from proceeding on the basis of *stare decisis*.

83 In my view, the s. 1 analysis conducted in the *Prostitution Reference* ought to be revisited given the breadth of evidence that has been gathered over the course of the intervening twenty years. Furthermore, it may be that the social, political, and economic assumptions underlying the *Prostitution Reference* are no longer valid today. Indeed, several western democracies have made legal reforms decriminalizing prostitution to varying degrees. As well, the type of expression at issue in this case is different from that considered in the *Prostitution Reference*.

> Here, the expression at issue is that which would allow prostitutes to screen potential clients for a propensity for violence. I conclude, therefore, that it is appropriate in this case to decide these issues based upon the voluminous record before me. As will become evident following a review of the evidence filed by the parties, there is a substantial amount of research that was not before the Supreme Court in 1990.

***Bedford v. Canada (Attorney General*) (2010), 327 D.L.R. (4th) 52, 2010 ONSC 4264 [*Bedford*], paras. 69-72, 75-83**

22. There are very similar reasons why this Court is not bound by *Rodriguez*.

23. First, Justice Sopinka's articulation and application of the principle of fundamental justice that laws not be arbitrary incorporated "societal" interests which it is now clear are more properly considered under s. 1 of the *Charter* not s. 7.

24. In *Rodriguez*, the majority concluded that in arriving at the principles of fundamental justice, it was appropriate to balance the interests of the state and those of the individual *within* the s. 7 analysis.[7] This approach to the s. 7 analysis led the majority to conclude that the deprivation was not arbitrary or unfair such that s. 7 was not breached. Justice McLachlin, as she then was, for the dissent, disagreed holding that justifications for an infringement of the *Charter* simply "have no place in the s. 7 analysis that must be undertaken in this appeal."[8] She held that "[t]he state will always bear the burden of establishing the propriety of an arbitrary legislative scheme, once a complainant has shown it is arbitrary."[9] Such justification, she held, must happen under s. 1.

25. The Court has since refined its approach under s. 7 making clear that societal interests are only valuable in *arriving at,* or *elucidating,* or *delineating* the principle of fundamental justice; however, once the principle of fundamental justice has been elucidated, societal interests play no *balancing* role under s. 7. In *Malmo-Levine* the majority held:

> **96** We do not think that these authorities should be taken as suggesting that courts engage in a free-standing inquiry under s. 7 into whether a particular legislative measure "strikes the right balance" between individual and societal interests in general, or that achieving the right balance is itself an overarching principle of fundamental justice. Such a general undertaking to balance

---

[7] *Rodriguez*, para. 146.
[8] *Rodriguez*, para. 207
[9] *Rodriguez*, para. 208

> individual and societal interests, *independent of any identified principle of fundamental justice*, would entirely collapse the s. 1 inquiry into s. 7. The procedural implications of such a collapse are significant.…
>
> …
>
> **98** The balancing of individual and societal interests within s. 7 is only relevant when elucidating a particular principle of fundamental justice. As Sopinka J. explained in *Rodriguez*, *supra*, "**in arriving at these principles [of fundamental justice]**, a balancing of the interest of the state and the individual is required" (pp. 592-93 (emphasis added)). <u>Once the principle of fundamental justice has been elucidated, however, it is not within the ambit of s. 7 to bring into account such "societal interests" as health care costs.</u> Those considerations will be looked at, if at all, under s. 1. As Lamer C.J. commented in *R. v. Swain*, [1991] 1 S.C.R. 933, at p. 977:
>
> > It is not appropriate for the state to thwart the exercise of the accused's right by attempting to bring societal interests into the principles of fundamental justice and to thereby limit an accused's s. 7 rights. Societal interests are to be dealt with under s. 1 of the *Charter* where the Crown has the burden of proving that the impugned law is demonstrably justified in a free and democratic society.
>
> **99** The principles of fundamental justice asserted by the appellants include the contentions that their conduct should only be the subject of criminal sanction to the extent it harms others, that the state cannot infringe their interests in an arbitrary or irrational manner, or impose criminal sanctions that are disproportionate to the importance of the state interest sought to be protected. Implicit in each of these principles is, of course, the recognition that the appellants do not live in isolation but are part of a larger society. <u>The delineation of the principles of fundamental justice must inevitably take into account the social nature of our collective existence. To that limited extent, societal values play a role in the delineation of the boundaries of the rights and principles in question.</u>

***R. v. Malmo-Levine; R. v. Caine*, [2003] 3 S.C.R. 571, 2003 SCC 74 [*Malmo-Levine*], paras. 96, 98-99 (bold and italicized emphasis in original, underline emphasis added)**

26. It is very likely that this difference in approach to societal interests in *Rodriguez* had a significant if not decisive impact on the outcome of the case.

27. Second, none of the Justices explicitly recognized, let alone applied, the two principles of fundamental justice that have subsequently been recognized and which now play a pivotal role in the analysis of fundamental principles under s. 7: the doctrines of overbreadth and gross disproportionality. These latterly developed principles have been determinative in any number

of cases as will be explained later in these submissions. There is good reason to believe that they will be determinative here.

28. Third, insofar as the majority in *Rodriguez* considered s. 1 of the *Charter*, it is significant that the decision of the Supreme Court in *Hutterian Brethren of Wilson Colony*[10] now calls for a more rigorous analysis than was performed by the majority.

29. Fourth, the evidence that was before the Court in *Rodriguez* simply bears no comparison to the record that is before this Court as Affidavit #2 of Christine Fairey made 18 Oct 2011 (Record Vol. 21-25, Tab 97) makes obvious.

30. And the evidence that the majority did rely on in support of its conclusion that there is "a foundation in the legal tradition and societal beliefs which are said to be represented by the prohibition" is simply not the evidence before this Court.[11]

31. For instance Sopinka J. considered the law in other countries and held:

> **163** A brief review of the legislative situation in other Western democracies demonstrates that in general, the approach taken is very similar to that which currently exists in Canada. <u>Nowhere is assisted suicide expressly permitted</u>, and most countries have provisions expressly dealing with assisted suicide which are at least as restrictive as our s. 241…
>
> …
>
> **167** … assisted suicide similar to that in s. 241 is the norm among Western democracies, and such a prohibition has never been adjudged to be unconstitutional or contrary to fundamental human rights….

***Rodriguez*, paras. 163, 167**

Of course this is no longer the case. Subsequent to *Rodriguez*, the following countries and states have done away with the absolute prohibition against assisted dying by legislation: Oregon, Belgium, Washington and Luxembourg; or by the judiciary: Montana and Columbia. In addition, the Netherlands codified its judicially developed regulation of assisted suicide and euthanasia and the United Kingdom has adopted a prosecution policy which makes clear that assisted dying will not be prosecuted in certain cases.

---

[10] *Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 S.C.R. 567, 2009 SCC 37 [*Hutterian*]

[11] *Rodriguez*, para. 148

Lewis #1, paras. 13-80, Exhibits E-M, Record Vol. 8, Tab 61

32. There have also been changes in Canada. For example, the BC Crown Prosecutor Policy Manual now recognizes that even if there is a substantial likelihood of conviction, the Crown can exercise its discretion not to prosecute by reference to three factors: (1) the importance of supporting proper professional and ethical standards within the health care profession; (2) society's interest in protection of vulnerable persons, and (3) society's interest in protecting the sanctity of human life recognizing this does not require life to be preserved at all costs.

Plaintiffs' Notice to Admit #1, dated 18 Oct 2011, Appendix "A", SuppRecord Vol. 30, Tab 124A

33. This is in itself a remarkable policy as it would appear to allow for the exercise of discretion not to prosecute a person who has violated the assisted suicide provision where it is consistent with the ethics of the medical profession – and there is much in the evidence which reveals that many doctors hold that ethical view – where the deceased is not vulnerable – as was the case with Sue Rodriguez – and in seeming contradiction to the principle of the near absolute sanctity of life espoused by the majority in *Rodriguez*.

34. This Crown policy thus would seem to in itself undermine the force of the *Rodriguez* decision and yet it has been said many times that the exercise of Crown discretion to relieve against an unconstitutional law is no antidote to an unconstitutional law.

***Ontario v. Canadian Pacific Ltd.*, [1995] 2 S.C.R. 1031, para. 19**

***R. v. Bain*, [1992] 1 S.C.R. 91, para. 8**

35. Justice Sopinka also placed some significance on the positions of various medical associations. He said:

> **175** I also place some significance in the fact that the official position of various medical associations is against decriminalizing assisted suicide (Canadian Medical Association, British Medical Association, Council of Ethical and Judicial Affairs of the American Medical Association, World Medical Association and the American Nurses Association).

***Rodriguez*, para. 175**

36. The evidence in this case is somewhat different. We have learned that the American Medical Association represents only 20% of physicians in the U.S. and its position is obviously

at odds with the physicians in many states, both those that have legalized physician-assisted suicide and even those that have not.

Angell Cross, pp. 65-67, 69, SuppRecord Vol. 33, Tab 136
Trial Exhibit 69, p. 306, SuppRecord Vol. 36, Tab 143/69

37. As well, the evidence in this case reveals that a number of very reputable medical associations either have endorsed physician-assisted death in some circumstances or are taking a position of “studied neutrality.”

Miller #1, para. 7, Record Vol. 3, Tab 26
Bosshard #1, para. 34, Exhibit E, Record Vol. 4, Tab 39
Ganzini #2, para. 55, Record Vol. 26, Tab 111

38. Finally, Justice Sopinka thought some heed should be paid to what he considered to be “a consensus… by Canadians in general” which he held was not “that the autonomy interest of those wishing to kill themselves is paramount to the state interest in protecting the life of its citizens.”[12]

39. We accept that constitutional rights should not be determined by opinion polls, or in the words of Justice McLachlin, “taking the pulse of the nation”[13] and we also fully acknowledge the limitations of opinion polls. But to the extent that Justice Sopinka’s decision was based on his understanding of the consensus of Canadians on this matter, then that consensus has clearly shifted from 1993 and, indeed, there is broad public support for assisted dying both within Canada and in other Western Democracies.

Canseco #1, Exhibits C-D, Record Vol. 3, Tab 30
Shimshon #1, Exhibit C, pp. 30-34, Record Vol. 7, Tab 59
Starks #1, para. 32, Record Vol. 6, Tab 53
Angell #1, Exhibit C, p. 39, Record Vol. 7, Tab 54
Deliens #1, paras. 47-51, Exhibit M, Record Vol. 7, Tab 57
Canseco Cross, Exhibits 1 and 2, SuppRecord Vol. 30, Tab 126/1-2
Trial Exhibit 67, Royal Society Report, pp. 26-27, SuppRecord Vol. 36, Tab 143/67

40. It is submitted that given the passage of time, the new evidence, the new social context, the evolving jurisprudence and the fact that foundational principles of human and civil rights are

---

[12] *Rodriguez*, para. 155
[13] *Rodriguez*, para. 224

involved, this Court is able to consider the constitutional issues in this case unimpeded by the doctrine of *stare decisis*.

41. Finally, it must be noted that there is nothing in *Rodriguez* which would in anyway prevent this Court from finding that the Plaintiffs' s. 15 rights have been violated. While Chief Justice Lamer's favourable ruling on this basis was in dissent, the majority was prepared to assume that s. 15 was infringed and moved directly to the s. 1 analysis. McLachlin J. (as she then was) declined to consider the issue. Justice Cory agreed with the Chief Justice. Therefore, it is submitted that this Court is free to embark on a fresh hearing of this matter and should also show some deference to Chief Justice Lamer, the only justice to develop an analysis on this issue.

SECTION 7

42. Section 7 of the *Charter* provides:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

***Canadian Charter of Rights and Freedoms*, s. 7, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [the *Charter*]**

43. The Supreme Court of Canada has articulated the correct approach to s. 7 as follows:

> [84] The inquiry into the validity of legislation under s. 7 of the *Charter* requires us to ask: (1) whether ss. 4(1) or 5(1) of the *CDSA* limit the right of the claimants to life, liberty or security of the person (i.e. the "deprivation" or "engagement" issue); and (2) if so, whether that limitation is in accordance with the principles of fundamental justice: *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791, at para. 109, *per* McLachlin C.J. and Major J., *R. v. Malmo-Levine*, at para. 83.

***Canada (Attorney General) v. PHS Community Services Society* (2011), 336 D.L.R. (4th) 385, 2011 SCC 44 [*PHS_SCC*], para. 84**

The Deprivation/Engagement

44. The restrictions imposed under the Impugned Provisions, to the extent that they operate to prohibit physician-assisted dying, result in a deprivation of the s. 7 rights of individuals to life, liberty and security of the person.

45. The right to life is engaged and infringed by state-imposed restrictions that both deprive an individual of life and deprive an individual of the right to make and carry out the decision to end one's own life.

46. The right to liberty is engaged and infringed by state interference with the right of the individual to a protected sphere of autonomy over decisions of fundamental personal importance. The choice to live or die, and to control the when and how of one's death, are decisions of profound and fundamental personal importance.

47. The right to security of the person is engaged and infringed by state-imposed restrictions on the right and ability of an individual to make and act upon decisions concerning his or her own body, to exercise control over matters fundamental to his or her physical, emotional and psychological integrity, and by the resultant impairment to his or her human dignity.

48. Thus with respect to grievously and irremediably ill individuals, each of the s. 7 rights is violated individually and in combination. That these three rights work in combination was recognized by the majority of the Supreme Court of Canada in *Rodriguez* when Sopinka J. held:

> **126** None of these values prevail a priori over the others. All must be taken into account in determining the content of the principles of fundamental justice and there is no basis for imposing a greater burden on the propounder of one value as against that imposed on another.

***Rodriguez*, para. l26**

49. In addition, prosecution and the threat of prosecution under the Impugned Provisions engage the right to liberty of a person who assists or supports a grievously and irremediably ill person to obtain physician-assisted dying services.

50. A constitutionally permissible law is one that permits physician-assisted dying for the grievously and irremediably ill. A law that does not allow for this practice violates all three s. 7 rights as these are informed by the underlying values of autonomy and mercy.

i. Life

51. The right to life is engaged by the Impugned Provisions that deprive Gloria Taylor and other grievously and irremediably ill individuals of the right to make and carry out the decision to end their own life.

52. Plaintiff Gloria Taylor, described this issue as follows:

> 43. What I want is to be able to die in a manner that is consistent with the way that I lived my life. I want to be able to exercise control and die with dignity and with my sense of self and personal integrity intact. I want to be able to experience my death as part of my life and part of my expression of that life. I do not want the manner of my death to undermine the values that I lived my life in accordance with. I do not need the government to dictate for me how I should spend the last moments of my life or how I should die.
>
> 44. I am dying. I do not want to, but I am going to die; that is a fact. I can accept death because I recognize it as a part of life. What I fear is a death that negates, as opposed to concludes, my life. I do not want to die slowly, piece by piece. I do not want to waste away unconscious in a hospital bed. I do not want to die wracked with pain. It is very important to me that my family, and my granddaughter in particular, have final memories that capture me as I really am - not as someone I cannot identify with and have no desire to become.
>
> 45. I have pre-arranged my cremation. I have chosen songs I would like played at my service and am designing a memorial program. I am working on a eulogy, which my cousin has agreed to read aloud for me at the service. We create ourselves through our lives. These acts are part of my creation of the person I want to be and the person I want others to see and remember me as. I want my death to be part of that creation as well. As Sue Rodriguez asked before me - whose life is it anyway?

Taylor #2, paras. 43-45, Record Vol. 3, Tab 34

53. Further, the Impugned Provisions further engage the right to life because they cause some grievously and irremediably ill people to end their own lives earlier than they would like to, or contemplate doing so, acting out of fear that the progression of their illness will prevent them from ending it later.

Pellizzari #1, para. 7, Record Vol. 1, Tab 7

Shapray #1, paras. 16-18, Record Vol. 1, Tab 10

LaForest #1, paras. 39-45, Record Vol. 1, Tab 14

Bracken #1, para. 18, Record Vol. 3, Tab 28

P. Fenker #1, para. 20, Record Vol. 5, Tab 44

54. This is a significant burden because it robs these individuals of their life prematurely, but also of the *quality* of their remaining life. Professor Sumner has also set out why the right to life necessarily includes consideration of the quality of life:

> Normally we assume that death is one of the worst fates that can befall us, which is why in both ethics and law the causing of death is taken to be such a serious matter. But what makes death such a bad thing in the normal case is what it takes away from us--the continuation of a life worth living. The disvalue of death is therefore a direct function of the value of the life thereby lost. This is the deprivation account of the badness of death: death is bad for us by virtue of depriving us of the goods of continued life. On this account showing that death would be bad for a person requires a comparison between two possible futures for that person: the one in which he dies and the one in which he lives on. If the goods of further life would outweigh the evils then it would be better for the person to continue living, and death would therefore be a harm to him since it would deprive him of this good future.
>
> The deprivation account has an important implication for the discussion of end-of-life treatment options. If death is a bad thing - a harm - when it deprives a person of a continued good life, then it can be a good thing - a benefit - when it saves a person from a continued bad one (a life, let us say, which would be full of unavoidable suffering). On the deprivation account death is not always harmful or something to be feared; it can be beneficial or something to be embraced. Whether it harms or benefits depends on the circumstances of the person's life - and, in particular, on the expected quality of the person's continued life. If someone's prospects are sufficiently bleak then death can be a welcome release.
>
> This condition may well be satisfied by a patient with an incurable illness who is already in the dying process and who is experiencing suffering severe enough to warrant consideration of any of the four end-of-life treatment options. Someone in these circumstances may reach the entirely reasonable conclusion that continuation of his life will not be a benefit to him and may actually be a harm. In that case, death can be a deliverance from a further life which, in the patient's own view of the matter, has become no longer worth living. To put the matter another way: in these dire circumstances hastening death can be in the best interest of the patient.

Sumner #1, pp. 47-48, see also pp. 65-72, Record Vol. 5, Tab 45

55. That the Impugned Provisions rob the grievously and irremediably ill of their quality of life was expressed perhaps most eloquently by Elayne Shapray who suffers from secondary progressive multiple sclerosis and who deposed as follows:

> 16. I understand that suicide is no longer a crime in Canada. The irony of the current situation as I experience it is that an able-bodied person can commit suicide in a lawful manner but somebody such as myself, who is unable by reason of their disability to do so, cannot. The means available to me to terminate my

> life unassisted at this time, if I was so inclined, are extremely limited and would likely involve violent, painful or personally terrifying outcomes. I consider the option of taking my own life by conventional "suicide" means, assuming that I was otherwise physically and emotionally able to do so, not only to be dangerous and inhumane, but also likely to be extremely traumatic to my family and my friends.
>
> 17. I live in dread of the day when I will have been robbed of all meaningful quality of life by the progression of my disease. I fear that I will not have the option that others have of ending ones' own life. I wish to have the choice of a dignified, physician-assisted termination of my life at the time of my choosing rather than being terrified daily about how I may end up simply because at a future date there would be no one able to legally help me.
>
> 18. The current state of the law deprives me of the freedom to choose how and when I would end my life. The current law may cause me to initiate a premature termination of my life simply because if I wait until I am ready to do so, I may be unable to do so, in any humane fashion, without asking my loved ones to put themselves at legal risk.

Shapray #1, paras. 16-18, Record Vol. 1, Tab 10

56. As Chief Justice McEachern held in his powerful dissent in *Rodriguez*:

> 51 It would be wrong, in my view, to judge this case as a contest between life and death. The *Charter* is not concerned only with the fact of life, but also with the quality and dignity of life. In my view, death and the way we die is a part of life itself.

Rodriguez v. British Columbia (Attorney General) **(1993), 76 B.C.L.R. (2d) 145 (B.C.C.A.), para. 51**

57. To much the same effect are these words from Cory J.'s dissent in *Rodriguez:*

> 231 The life of an individual must include dying. Dying is the final act in the drama of life. If, as I believe, dying is an integral part of living, then as a part of life it is entitled to the constitutional protection provided by s. 7. It follows that the right to die with dignity should be as well protected as is any other aspect of the right to life. State prohibitions that would force a dreadful, painful death on a rational but incapacitated terminally ill patient are an affront to human dignity.

Rodriguez**, para. 231**

ii. Liberty (Autonomy and Self-Determination)

58. The right to liberty is engaged by state interference with the right of grievously and irremediably ill individuals to a protected sphere of autonomy over decisions of fundamental personal importance.

59. In *Morgentaler* Wilson J., concurring in the result, explained:

> **230** Thus, an aspect of the respect for human dignity on which the *Charter* is founded is the right to make fundamental personal decisions without interference from the state. This right is a critical component of the right to liberty. Liberty, as was noted in Singh, is a phrase capable of a broad range of meaning. <u>In my view, this right, properly construed, grants the individual a degree of autonomy in making decisions of fundamental personal importance.</u>

***R. v. Morgentaler*, [1988] 1 S.C.R. 30, para. 230 [emphasis added], see also paras. 225-240**

see also *Siemens v. Manitoba (Attorney General)*, [2003] 1 S.C.R. 6, 2003 SCC 3, para. 45

***Malmo-Levine*, para. 85**

***A.C. v. Manitoba (Director of Child and Family Services)*, [2009] 2 S.C.R. 181, 2009 SCC 30, para. 217 per Binnie J., dissenting, but not on this point**

***Reference re: Criminal Code of Canada*, 2011 BCSC 1588, paras. 1131-34, 1178**

60. Many individuals suffer from diagnosed conditions, which are fatal, degenerative, and/or have no cure or effective treatment and want choice in dying.

Taylor #1, Record Vol. 1, Tab 4; Amended Notice of Civil Claim, filed 15 Aug 2011, paras. 33, 55, Record Vol. 26, Tab 118

Taylor #2, paras. 11-12, 32, Record Vol. 3, Tab 34

Pellizzari #1, paras. 4, 7, Record Vol. 1, Tab 7

Leeking #1, para. 1, Record Vol. 1, Tab 9

Shapray #1, paras. 8-9, Record Vol. 1, Tab 10

LaForest #1, paras. 2-3, 20-21, 27, Record Vol. 1, Tab 14

Nicklinson #1, Exhibit B, p. 12, Exhibit C, p. 14, Exhibit F, paras. 2, 5, Record Vol. 2, Tab 15

Carter #1, paras. 6-8, Record Vol. 2, Tab 21

Cordover #1, paras. 3, 5, Record Vol. 3, Tab 24

Reisler #1, para. 6, Record Vol. 3, Tab 27

Bracken #1, para. 8, Record Vol. 3, Tab 28

P. Fenker #1, paras. 1, 6, 21, Record Vol. 5, Tab 44

Zwart #1, paras. 5, 34, Record Vol. 5, Tab 46

Petrie #1, para. 1, Record Vol. 5, Tab 48

Connell #1, para. 7, Record Vol. 5, Tab 41

Eighmey #1, para. 4, Record Vol. 5, Tab 43

Dixon #1, para. 15, Record Vol. 7, Tab 58

G. Fenker #1, paras. 2, 7, Record Vol. 26, Tab 114

Meckling #1, paras. 9, 25, Record Vol. 3, Tab 33

Bystrom #1, para. 6, Exhibits C-D, Record Vol. 5, Tab 40

Cohen #1, paras. 6-7, 12, Record Vol. 7, Tab 55

Cohen #2, paras. 7, 10, Record Vol. 7, Tab 56

61. The question is whether this is the kind of decision of fundamental personal importance, which engages personal autonomy and which should attract *Charter* protection.

62. The recent report of the Royal Society of Canada on "*End-of-Life Decision Making*" expounds on the various conceptions of autonomy - or self-determination - and its relevance to the question of physician assisted dying.

63. The Royal Society concluded, "whether we look at the matter historically, philosophically or by adverting to the practice of the Canadian Supreme Court, it seems clear that the value of autonomy occupies a paramount place among the values of Canada's constitutional order."

Royal Society Report, p. 42, Trial Exhibit 67, SuppRecord Vol. 36, Tab 143

64. After considering different conceptions of autonomy – from one end of the spectrum that allows one to do what he wishes, to the other more paternalistic end where autonomous wills should be "universalizable" - the Panel settled on a middle ground as follows:

> Clearly, a morally attractive and operationalizable conception of autonomy would need to strike a reasonable middle ground between these two extremes. In deciding what conception of autonomy to make central to the argument of this Report, the Panel was once again guided by the concern that it should connect with values that are already deeply enshrined in central Canadian institutional commitments, and it should avoid imposing values that are not already settled parts of our ethical landscape. In this context, the Panel has chosen to be guided by the doctrine of *informed choice* that constitutes a central pillar of contemporary health ethics and of Canadian health law. Informed choice is grounded in autonomy; it seeks to apply the abstract value of autonomous decision making to the context of health care. It requires that competent patients must not be subjected to treatment unless they have consented to it. That consent is subject to three conditions: first, it must be uncoerced; second, it must result from the decision making capacity of a cognitively competent individual; and third, it must be informed. A conception of autonomy can thus be read in informed choice as the cornerstone of modern medical ethics and Canadian health law. An autonomous person would, according to this conception, be a substantively cognitively competent and uncoerced individual who arrives at his or her

> decisions after having been offered relevant information about the decision at hand.

Royal Society Report, p. 43, Trial Exhibit 67, SuppRecord Vol. 36, Tab 143

65. The Royal Society concluded that because autonomy is a central constitutional value, "then it quite clearly grounds the right to request assistance in dying according to one's considered and stable views about when one's own life is not worth living any longer."

Royal Society Report, p. 45, Trial Exhibit 67, SuppRecord Vol. 36, Tab 143

66. The Royal Society's conclusion is one we wholeheartedly adopt as support for the proposition that the Impugned Provisions deprive Gloria Taylor and all other Canadians who wish to have the choice to die at the time and manner of their choosing, of their liberty:

> Deciding how one will die clearly belongs to the choices that ought to be protected by the state, given our commitment to individual autonomy. The manner of our dying indeed reflects our sense of what is important just as much as do the other central decisions in our lives. Indeed it seems contradictory to deny a person the right to live according to the values she thinks most important at the moment of her death after having put in place institutional mechanisms allowing her to follow these vales in all other decisions of her life.

Royal Society Report, p. 45, Trial Exhibit 67, SuppRecord Vol. 36, Tab 143

67. Autonomy is not only a value that concerns philosophers, or constitutional law professors. It is at the heart of medicine.

Battin #1, paras. 43-48, Record Vol. 6, Tab 51

Syme #1, paras. 11-12, Record Vol. 1, Tab 12

Angell #1, paras. 8, 10, 15, 19, Exhibit C, p. 40, Record Vol. 7, Tab 54

Cohen #2, para. 19, Record Vol. 7, Tab 56

Kimsma #1, Exhibit D, p. 47, Record Vol. 8, Tab 63

Preston #1, paras. 14-16, 19-22, Exhibit A, Record Vol. 25, Tab 99

Rasmussen #1, paras. 27-30, 32-36, Record Vol. 25, Tab 102

Smith #2, para. 19, Record Vol. 25, Tab 109

Battin #2, paras. 9, 18, Record Vol. 26, Tab 113

68. Dr. Tom Preston explained autonomy based on his 35 years as a cardiologist where patients have had to make life and death decisions as well as his personal experience working with patients and physicians under the Washington and Oregon *Death with Dignity* statutes. He deposed in part as follows:

> The principle of autonomy is a fundamental principle in support of physician aid in dying although it is not the only principle at stake. The autonomy argument for physician aid in dying can be stated as follows: There is a moral reason to respect others' autonomous choices, and this reason gains strength as the importance of the choice under consideration increases. An autonomous decision to hasten one's death is a profoundly important decision for a terminally ill person that involves his or her most significant values. There is therefore an extraordinarily strong moral reason not to restrict such a decision. This reason becomes even stronger when provisions are in place to ensure that the choice is indeed highly autonomous and not coerced.

Preston #1, para. 22, Record Vol. 25, Tab 99

69. Dr. Marcia Angell deposed as follows:

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

Angell #1, para. 8, Record Vol. 7, Tab 54

70. We will seek permission of the Court to refer to excerpts in the chapters of the book that pertain to the value of "autonomy" written by Professor McLean that were struck as evidence to nonetheless be relied on as academic legal authority.

McLean #1, pp. 61-63 and 66-69, Record Vol. 26, Tab 115

71. Thus to truly respect autonomy we must ensure that choice is informed and not coerced. In this case, we are comforted that this choice is informed because we know that many of these people have access to a variety of health care and social services including palliative and hospice care.

Taylor #1, Record Vol. 1, Tab 4; Amended Notice of Civil Claim, paras. 36-37, 42, 45, Record Vol. 26, Tab 118

Taylor #2, paras. 14-17, 23-25, Record Vol. 3, Tab 34

Crowley #1, paras. 10-11, Record Vol. 1, Tab 5

Leeking #1, paras. 6, 9-10, 15, Record Vol. 1, Tab 9

Nicklinson #1, Exhibit C, p. 23, Record Vol. 2, Tab 15

Carter #1, paras. 11, 21, Record Vol. 2, Tab 21

Cordover #1, paras. 8, 14-16, Record Vol. 3, Tab 24

Johnson #1, para. 10, Record Vol. 3, Tab 25

Reisler #1, paras. 8, 10-12, 14-17, Record Vol. 3, Tab 27

Zwart #1, paras. 6, 8-9, Record Vol. 5, Tab 46

Librach #1, para. 12, Record Vol. 1, Tab 11

Shoichet #1, para. 6, Record Vol. 2, Tab 16

Ganzini #1, paras. 13, 46, Exhibit H, Record Vol. 2, Tab 23

Bystrom #1, paras. 10-12, Exhibit D, p. 31, Record Vol. 5, Tab 40

Starks #1, para. 24, Exhibit F, p. 70, Record Vol. 6, Tab 53

Upshur #1, para. 12, Record Vol. 10, Tab 69

Angell #1, para. 39, Record Vol. 7, Tab 54

Ganzini #2, paras. 39-40, Record Vol. 26, Tab 111

72. It is also apparent that the choice is not coerced as many of these people have strong social support.

Taylor #1, Record Vol. 1, Tab 4; Amended Notice of Civil Claim, paras. 32, 39, 41-43, Record Vol. 26, Tab 118

Taylor #2, paras. 3, 7, 17, 20, Record Vol. 3, Tab 34

Leeking #1, para. 21, Record Vol. 1, Tab 9

LaForest #1, paras. 9, 53-54, Record Vol. 1, Tab 14

Cordover #1, paras. 10, 12, 23, 36-39, Record Vol. 3, Tab 24

Johnson #1, para. 7, Record Vol. 3, Tab 25

Reisler #1, paras. 2-3, 9, Record Vol. 3, Tab 27

P. Fenker #1, paras. 2, 16, Record Vol. 5, Tab 44

Zwart #1, paras. 3, 18, 27-29, Record Vol. 5, Tab 46

Carter #2, para. 5, Record Vol. 25, Tab 104

Angell #1, para. 39, Record Vol. 7, Tab 54

73. Further, these people’s wishes are not covert rather they are open to input from others and many of these people discuss their wishes with their families and friends.

Taylor #2, para. 32, Record Vol. 3, Tab 34

Pellizzari #1, para. 7, Record Vol. 1, Tab 7

Shapray #1, para. 19, Record Vol. 1, Tab 10

LaForest #1, paras. 15, 36, Record Vol. 1, Tab 14

Carter #1, paras. 13, 20, Record Vol. 2, Tab 21

Reisler #1, para. 17, Record Vol. 3, Tab 27

Cordover #1, paras. 7, 34, Record Vol. 3, Tab 24

Petrie #1, para. 14, Record Vol. 5, Tab 48

G. Fenker #1, para. 7, Record Vol. 26, Tab 114

74. These people are not depressed but rather are positive people who love life, have a variety of interests and hobbies and are independent, courageous, active and strong willed by nature. In other words, they have the cognitive and emotional resources to get over many hurdles. The decision to seek physician-assisted dying is not impulsive and rather often discussed over long periods of time and is often consistent with the fundamentally personal values and principles they have held for their entire lives.

Pellizzari #1, paras. 4-5, Record Vol. 1, Tab 7

Leeking #1, paras. 21-23, Record Vol. 1, Tab 9

LaForest #1, paras. 5-12, 46-50, Record Vol. 1, Tab 14

Carter #1, paras. 14-15, Record Vol. 2, Tab 21

Carter #2, paras. 4-7, 10, Record Vol. 25, Tab 104

Cordover #1, paras. 15, 47-48, Record Vol. 3, Tab 24

Johnson #1, paras. 4-8, 12-13, Record Vol. 3, Tab 25

Reisler #1, paras. 4-5, 10, Record Vol. 3, Tab 27

Bracken #1, paras. 9, 19, 21, Record Vol. 3, Tab 28

Taylor #2, paras. 4-10, 19, 21, 35-36, 43-45, Record Vol. 3, Tab 34

P. Fenker #1, para. 19, Record Vol. 5, Tab 44

Zwart #1, paras. 9-10, 14-15, 17, 19, 27, Record Vol. 5, Tab 46

Ganzini #1, paras. 27, 37, Exhibit W, Record Vol. 2, Tab 23

Bell #1, para. 7, Record Vol. 5, Tab 49

Starks #1, paras. 20-21, 23-24, 26, 31, 35, 38, Exhibit C, p. 42, Exhibit D, pp. 53, 56-59 and Tables 2 and 3, Exhibit F, pp. 70-71, 75-76, Exhibit I, p. 120, Record Vol. 6, Tab 53

Cohen #1, paras. 13, 14, 19, Record Vol. 7, Tab 55

Kimsma #1, paras. 41(a)-(b), Record Vol. 8, Tab 63

Rasmussen #1, para. 31, Record Vol. 25, Tab 102

Starks #2, paras. 9, 11, 15, Record Vol. 25, Tab 107

Werth #1, paras. 55(a), 57, Record Vol. 25, Tab 110

Battin #2, paras. 12-13, Record Vol. 26, Tab 113

Ganzini #2, paras. 9, 43, 49, Record Vol. 26, Tab 111

75. And it is unquestionable that these choices are of fundamental personal importance to these individuals and derive from values they have developed and held over a lifetime. Many of these people lose the ability to do every day activities and activities that give their lives meaning and enjoyment. An assessment of what gives one's life meaning and enjoyment is, of course, of the most fundamental and personal nature.

Taylor #1, Record Vol. 1, Tab 4; Amended Notice of Civil Claim, paras. 33-36, 38, 40-41, 44, Record Vol. 26, Tab 118

Leeking #1, paras. 11-18, Record Vol. 1, Tab 9

Shapray #1, paras. 10-13, Record Vol. 1, Tab 10

Nicklinson #1, Exhibit C, p. 22-23, Exhibit F, paras. 2, 14, Record Vol. 2, Tab 15

Carter #1, paras. 9-12, Record Vol. 2, Tab 21

Carter #2, paras. 3, 8, Record Vol. 25, Tab 104

Cordover #1, paras. 6, 17, 26-28, 30-31, 33, Record Vol. 3, Tab 24

Johnson #1, paras. 9-11, Record Vol. 3, Tab 25

Reisler #1, para. 13, Record Vol. 3, Tab 27

Taylor #2, paras. 13, 18, 22-24, Record Vol. 3, Tab 34

P. Fenker #1, paras. 3-4, 8-12, 15, 18, Record Vol. 5, Tab 44

Zwart #1, paras. 4, 7, 11-12, 15-18, Record Vol. 5, Tab 46

Petrie #1, paras. 3-11, Record Vol. 5, Tab 48

G. Fenker #1, para. 3, Record Vol. 26, Tab 114

Meckling #1, paras. 11, 14-16, 18-19, 21-24, 27, Record Vol. 3, Tab 33

Bystrom #1, paras. 7-8, 13, Exhibit D, p. 30, Record Vol. 5, Tab 40

Cohen #1, paras. 7-11, 13, 15-16, Record Vol. 7, Tab 55

Cohen #2, paras. 8, 10,11, 13, Record Vol. 7, Tab 56

76. Many people's views on and desire for a hastened death are influenced by very personal experiences they have had watching loved ones suffer and die.

LaForest #1, paras. 28-35, Record Vol. 1, Tab 14

Cordover #1, para. 7, Record Vol. 3, Tab 24

Leeking #1, paras. 24-27, 30, Record Vol. 1, Tab 9

Bracken #1, paras. 3-7, 9, 22, Record Vol. 3, Tab 28

Zwart #1, paras. 20-25, 30, 32, Record Vol. 5, Tab 46

Starks #1, para. 23, Exhibit F, p. 70, Record Vol. 6, Tab 53

Bernheim #1, para. 14, Record Vol. 4, Tab 37

77. While there is much evidence in the record about the importance of autonomy and thus the liberty to choose how and when to end one's life, we set out only two illustrations. The first from the Plaintiff, Lee Carter, who described the importance of self-determination to her mother Kay:

> 14. I was completely convinced of the sincerity of Kay's wish [to terminate her life]. I was not personally shocked by Kay's stated desire to end her life as it was a subject that we had previously discussed and I had always known her to be a very strong-willed and independent person. In her early years, for example, mom hated being poor and took on menial and sometimes demeaning jobs in order to earn extra spending money. Other later examples of Kay's independence include: hiking Mt. Kilimanjaro with my father and I when she was at the age of 50; going alone to the Russian Summer Olympics in protest of the USA boycott; going back to Simon Fraser University in her 50's for ESL accreditation; joining, through the University of British Columbia, the first official Canadian group to go to China; unilaterally deciding to paint derelict park benches on Bowen Island; beautifying a grubby public space near her home (an act for which she was nominated for the Silent Hero Award (North Vancouver)); joining Toastmasters to allay her fears around public speaking; and, of course, her decision to travel to Switzerland to die with dignity. In her last 20 years she continued to belong to a book club, play the recorder with a group called the "Pickled Onions", walk the sea wall, and participate in several 'discussion' groups. In her younger years, Kay had been a qualified elementary school teacher and had worked in that profession prior to marrying my father. She raised seven children with my father. Ten years after my father died, Kay sold the family home and moved into an apartment. She later moved into a suite in one of my sisters' homes, but she continued to drive, and lead an active and independent life. In my mind, these examples are all consistent with Kay's independent nature.
>
> 15. Given the way she had lived her life and consistent with her values throughout her life, it was not surprising to me that Kay would find a state of dependence and the loss of control and privacy an intolerable indignity. Being in control of her life was of paramount importance to Kay and a consistent thread that ran throughout the entirety of her life. As such, Kay was a classy, proud, self-determined and autonomous woman who enjoyed being in charge of herself, her time and her life. Kay told me that the idea of lying about in an adult diaper was completely repugnant to her. She said and I believe that she was truly horrified by her vision of her future - a vision she said she could see in detail just by looking around her at the care facility. Sometimes when Kay was reading the obituaries, she would express jealousy at the people who had died. "Aren't they the lucky ones?", she would say.

Carter #1, paras. 14-15, Record Vol. 2, Tab 21

78. The second affiant who made the same point in her own way was Nica Cordover, widow of Robert Cordover who died of ALS. She deposed as follows:

> 46. To understand Robert's position and life-ending journey one needs to know something about him, his personality, likes and dislikes; a potted characterization of him because **a man is someone, not a cipher.**
>
> 47. He was a brilliantly intelligent and intellectual Renaissance man, equally at home in the arts and sciences, a potter, sculptor, chef, marine scientist, science researcher. His first degree was in Philosophy, his Masters degree in Oceanography. He spoke six languages. Robert was a great raconteur with wit, always building the tension in his stories until the denouement broke us down in tears of laughter. He was a prawn farming specialist, a fisheries author, seaweed researcher, a teacher – above all ***a communicator*** - a person unable to walk down a street without giving you a treatise on the flora, fauna, architecture and history of the area. If any one of our children developed a fifth of his knowledge, they would be educated indeed. He was always looking to learn something new, never hesitant at trying to develop a new skill (though some things failed him - like playing saxophone and singing in the choir). He believed a day of living was wasted if he didn't learn something new or teach something new to another.
>
> 48. Robert told me and I believed that for him life was more than just breathing, existing. Life was learning, doing, being involved. Above all, living was about communicating. He loved solitude and quiet that allowed him to read, learn and think. But he loved company – to teach, to share humour, to share knowledge. He knew his illness would leave him incommunicado but still breathing. Trapped in a paralysed body. A living hell. A nightmare. Worse, this nightmare of extended dying would have no raison d'être. He told me and I believed that he felt there was no value to a life of mere existence, merely breathing: not to him, nor to anyone. He told me and I believed that he believed that for others, it would only impose a burden (even if it were one they were willing to bear). For himself – it achieved nothing. He had no religious belief that dictated it was good to suffer. He had no hope of remission, improvement or delay, just the inexorable decline into full silent paralysis. Not even able to complain or praise. A daily grind of being attended to, unable to communicate or to do anything. Unable to give.

Cordover #1, paras. 46-48, Record Vol. 3, Tab 24

79. Thus for many people, the desire to have a hastened death arises from experiences of a fundamentally personal nature, or is related to principles and values of a fundamentally personal nature. When Sue Rodriguez and Gloria Taylor ask, "whose life is it anyway," they are expressing their view of the fundamentally personal nature of the decision to hasten death.

Security of the Person

80. In *Rodriguez,* eight of the nine justices (Lamer C.J. declining to decide the case under s. 7) held that s. 241 of the *Criminal Code* deprived Ms. Rodriguez of the security of her person.

***Rodriguez*, per Lamer C.J. dissenting, para. 35, per Sopinka paras. 122, 136-37, per McLachlin dissenting but not on this issue, paras. 197-98, 200**

81. The majority explained:

> **136** In my view, then, the judgments of this Court in *Morgentaler* can be seen to encompass a notion of personal autonomy involving, at the very least, control over one's bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress. In *Reference re ss. 193 and 195.1(1)(c) of the Criminal Code* (Man.), supra, Lamer J. also expressed this view, stating at p. 1177 that "[s]ection 7 is also implicated when the state restricts individuals' security of the person by interfering with, or removing from them, control over their physical or mental integrity". There is no question, then, that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these.
>
> **137** The effect of the prohibition in s. 241(b) is to prevent the appellant from having assistance to commit suicide when she is no longer able to do so on her own. She fears that she will be required to live until the deterioration from her disease is such that she will die as a result of choking, suffocation or pneumonia caused by aspiration of food or secretions. She will be totally dependent upon machines to perform her bodily functions and completely dependent upon others. Throughout this time, she will remain mentally competent and able to appreciate all that is happening to her. Although palliative care may be available to ease the pain and other physical discomfort which she will experience, the appellant fears the sedating effects of such drugs and argues, in any event, that they will not prevent the psychological and emotional distress which will result from being in a situation of utter dependence and loss of dignity. That there is a right to choose how one's body will be dealt with, even in the context of beneficial medical treatment, has long been recognized by the common law. To impose medical treatment on one who refuses it constitutes battery, and our common law has recognized the right to demand that medical treatment which would extend life be withheld or withdrawn. In my view, these considerations lead to the conclusion that the prohibition in s. 241(b) deprives the appellant of autonomy over her person and causes her physical pain and psychological stress in a manner which impinges on the security of her person. The appellant's security interest (considered in the context of the life and liberty interest) is therefore engaged, and it is necessary to determine whether there has been any deprivation thereof that is not in accordance with the principles of fundamental justice.

***Rodriguez*, paras. 136-37**

82. And so it is in this case. The Impugned Provisions cause physical pain and psychological stress and also deep suffering in a way that impinges security of the person. Suffering is a somewhat distinct concept that was described by Dr. Eric Cassell as follows:

> 12. Suffering is associated most commonly with pain or other physical afflictions. It is now accepted that pain and suffering are distinct and different. In general, very severe pain results in suffering more because, aside from the distress itself, of the fears for what will follow that severe pain often generates. The magnitude of pain is only one factor in the distress it causes. People will tolerate even very severe pain if they know and do not fear its significance - what it is – and they know it will end or that it can be controlled. Pain of a lesser degree may be poorly tolerated and lead to suffering if it appears to be endless or it is considered by the person to have a dire meaning such as cancer. Suffering may follow from pain even when it is no longer present. Patients who have pain secondary to metastatic disease to the bone may have dreadfully severe pain where suffering follows from both the severity and its meaning (that it is cancer and death will probably follow). Even when the pain has been completely relieved (e.g., by radiation), however, suffering may be precipitated or continue because of the fear of its recurrence. I have used pain as the inciting cause of suffering, but suffering may follow from any symptom - dyspnea, profound diarrhea or vomiting, neurological symptoms, even weakness or fatigue in certain circumstances - if it disrupts the person sufficiently. Suffering may result, therefore, from helplessness itself, or hopelessness, or fear.

Cassell #1, para. 12, Record Vol. 2, Tab 22

83. With respect to suffering, the uncontested evidence is that non-physical suffering whether it be described as existential, psychological or psychosocial is every bit as deserving of aggressive intervention as is physical suffering. Dr. Chochinov, for instance in his (we say misplaced) criticism of the Royal Society Report) said this:

> … Not physical sources of suffering are every bit as profound, every bit as real, and need every bit as much vigilance and attention as any other aspect of suffering including, of course, physical aspects of suffering.

Chochinov Cross, p. 54, ll. 9-14, SuppRecord Vol. 35, Tab 143

84. Many grievously and irremediably ill people who want choice in dying suffer significant physical and psychological distress, anger, fear and physical distress during the progression of their condition including loss of function, side effects of treatment, loss of independence, loss of dignity, pain, and loss of sense of self. This suffering is imposed on these individuals by the Impugned Provisions that prohibit them from obtaining assistance to end their lives.

85. So, for example, Grace Fenker deposed:

> 6. Beginning in September, Peter became increasingly distressed with his poor quality of life. He rarely felt well enough to go outside in his power wheelchair, so he was largely confined to the house. He had no independence and

> he was frequently in pain. He often asked me, “Why am I still here?” and “What kind of life is this?” We saw his doctor several times in September and October, and during these visits he asked about ways to terminate his life. For example, once he asked the doctor what would happen if he took all the codeine pills he had been prescribed. Once he asked if the doctor could give him an injection that would make him go to sleep and die. He also asked the doctor how long it would take to die if he stopped eating and drinking.
>
> 7. Peter and I had many discussions about death during his last months, and he told me that he no longer wanted to be alive. He frequently said that humans show animals that are suffering greater compassion. Based on our conversations, I believe that in these final months that Peter would have chosen to have a medically-assisted death if the option had been available to him.
>
> 8. On Thursday, October 13, 2011, Peter woke up at 6:30 a.m. He told me he could no longer stay in bed because he was in pain throughout his back, spine and stomach. Peter did not have any muscles left to hold his organs in place, so he often experienced pain of this sort. I gave him some Tylenol 3 but it did not work. He told me that he did not want me to leave his side. There was fear in his eyes. He kept asking me to help him. I felt terrible because I did not know what I could do for him. By 9 a.m. his pain had gotten worse. I had never seen him in such pain. He told me that it was unbearable. He pleaded with me to shoot him or to strangle him with a rope. I was shocked and frightened and I told him I could not do that. I called the ambulance because I realized that this was worse than it had ever been, and that he could not handle it anymore.

G. Fenker #1, paras. 6-8, Record Vol. 26, Tab 114

86. Peter Fenker suffered horribly for four and half more days before his death. His widow Grace Fenker deposed:

> 23. It has been almost two weeks since his death. I will never forget those terrible four and a half days in the hospital. It was a horror to watch Peter labour to die. Four days may not sound like a long time, but it is a painful eternity when you are helplessly watching your beloved husband suffer. I will never forget the pleading look in his eyes as he asked me to help him and there was nothing I could do.
>
> 24. Peter never wanted his life to end that way. I will always feel bitter that his wish for a medically assisted death was never granted to him.

G. Fenker #1, paras. 23-24, Record Vol. 26, Tab 114

see also Pellizzari #1, paras. 7-9, Record Vol. 1, Tab 7

Nicklinson #1, Exhibit F, pp. 36-38, paras. 2-15, Record Vol. 2, Tab 15

Cordover #1, paras. 14, 26-33, 40, 48, 51-53, 60, 62-63, Record Vol. 3, Tab 24

Johnson #1, paras. 10-11, Record Vol. 3, Tab 25

Reisler #1, paras. 6-18, Record Vol. 3, Tab 27

Dixon #1, paras. 14-23, Record Vol. 7, Tab 58

Syme #1, paras. 6, 10, Record Vol. 1, Tab 12

Boisvert #1, paras. 11-12, 14-17, Record Vol. 4, Tab 38

Starks #1, paras. 23, 26, Exhibit E, pp. 62-65, Exhibit F, pp. 70-76, Exhibit I, pp. 131, 138-42, Record Vol. 6, Tab 53

Cohen #2, para. 19, Record Vol. 7, Tab 56

Deliens #1, para. 17, Exhibit E, Record Vol. 7, Tab 57

Rasmussen #1, paras. 19-20, Record Vol. 25, Tab 102

87. For many others who may not be ready to choose physician assistance to hasten their death, their suffering is already for most of us unimaginable. For these individuals there will or may come a point in time when the suffering is for them unbearable and they will want the option of physician assistance in dying. Leslie LaForest is one such person:

> 22. As a patient, I have had to submit to a number of embarrassing and dehumanizing procedures. A recent treatment session required lying on a table with my butt wide open, with people standing around and putting fluids and dyes in my anus. No one who is healthy and dynamic can understand what this feels like. Unless you have been there yourself, you have no idea what it is like to be lying on a medical table, having a tumour in your anus be measured for radiation. It is horrific, embarrassing, frustrating and painful to be sick and dying.
>
> 23. I have been told that I will likely experience a number of alarming side effects. Radiation and chemotherapy will wipe out my red and white blood cells to dangerous levels, leaving me susceptible to infections, moulds and severe fatigue. The radiation may lead to severely burned skin. My doctors have told me to expect burning of my vulva, anus, bowel, vaginal canal and bladder. This cannot be avoided as I am being irradiated right through the pelvis.
>
> 24. If I survive the cancer, I may end up with permanent scarring of my bowel and anus resulting in diarrhea and incontinence. My vulva and vaginal canal will likely shrink and be scarred making intercourse painful in the future. My bladder may be damaged and require, like the vagina, dilators to stretch out badly scarred tissue, and stents to hold open vessels and canals that have collapsed.
>
> 25. I asked my oncologist what would happen if I decided not to have this painful treatment. They told me this was not an option. They described that death by this type of disease is ugly. It is not a way anyone would want to die. It would take time and I would die in agony, regardless of pain medication and therapies that currently exist. They described how my legs would swell to gross proportion as the poisons and toxins built up in my system. And the tumour would continue to grow to explosive proportions blocking off the bowel which will begin to twist and contort under pressure. I would ooze putrescence and mucous, blood and fecal matter out of every orifice. No amount of drugs they assured me would deal with the “break through” pain.

> 26. I decided that I would undergo the treatments to try to avoid an awful death, and also because my daughter is just starting university in the fall, and I wanted to make sure that she could take her first steps into adulthood unencumbered by that nightmare. Even if I were to only get another year, I want that time.
>
> 27. Of course, there is the possibility that even despite all my best attempts to beat this disease, I might not be one of the lucky ones. The normal course of incurable anal cancer is that the tumour in the rectal area infects local nodes, which go on to involve the lymphatic system. These nodes enter the bloodstream and are quickly spread to the adrenal glands, then to the liver and lungs, and then if you survive long enough, into the brain. It was easy for me to deduce that if I am not lucky this first time around, I have months, maybe years of medical torture and agony to face before hitting the end of this vicious disease. Now if you were to take my place in this story, can you understand why I might want to skip the last chapter?

LaForest #1, paras. 22-27, Record Vol. 1, Tab 14

see also Taylor #1, Record Vol. 1, Tab 4; Amended Notice of Civil Claim, filed 15 Aug 2011, paras. 47-48, Record Vol. 26, Tab 118

Shapray #1, paras. 11-14, 21, Record Vol. 1, Tab 10

Carter #1, paras. 9-12, Record Vol. 2, Tab 21

Taylor #2, paras. 23-24, 27-28, 36, Record Vol. 3, Tab 34

P. Fenker #1, paras. 7-15, 17, Record Vol. 5, Tab 44

Zwart #1, paras. 13, 15-18, Record Vol. 5, Tab 46

Cohen #2, paras. 6, 8-9, 12-13, Record Vol. 7, Tab 56

Welch #1, para. 12, Record Vol. 9, Tab 64

Rasmussen #1, paras. 21-23, Record Vol. 25, Tab 102

88. The Impugned Provisions also impose distress at the prospect of this suffering and at the prospect of losing the ability to end their lives without assistance, and fear that their loved ones will be prosecuted if they assist them.

Morcos Examination, p. 18, SuppRecord Vol. 30, Tab 125

Nicklinson #1, Exhibit F, para. 15, Record Vol. 2, Tab 15

Cordover #1, para. 18, Record Vol. 3, Tab 24

Taylor #1, Record Vol. 1, Tab 4; Amended Notice of Civil Claim, filed 15 Aug 2011, paras. 46, 49-50, 52, Record Vol. 26, Tab 118

Pellizzari #1, para. 7, Record Vol. 1, Tab 7

Leeking #1, paras. 20, 29, Record Vol. 1, Tab 9

Shapray #1, paras. 14-17, Record Vol. 1, Tab 10

LaForest #1, para. 27, Record Vol. 1, Tab 14
Carter #1, paras. 26, 31, 45, Record Vol. 2, Tab 21
Carter #2, para. 9, Record Vol. 25, Tab 104
Johnson #1, paras. 9, 16, Record Vol. 3, Tab 25
Bracken #1, para. 10, Record Vol. 3, Tab 28
Taylor #2, paras. 26, 29, 31, 36, 40, 42, Record Vol. 3, Tab 34
P. Fenker #1, para. 18, Record Vol. 5, Tab 44
Zwart #1, paras. 28-30, 33, Record Vol. 5, Tab 46
Petrie #1, paras. 12-16, Record Vol. 5, Tab 48

89. Some people, including most physicians with experience in palliative and end-of-life care, acknowledge that some pain and suffering cannot be palliated absent terminal sedation or death and that despite outstanding palliative care, there will always be individuals who want or need the option of assisted suicide or euthanasia.

Syme #1, para. 11, Record Vol. 1, Tab 12
Shoichet #1, para. 6, Record Vol. 2, Tab 16
Speckart #1, para. 3, Record Vol. 2, Tab 19
LaForest #1, para. 25, Record Vol. 1, Tab 14
Cassell #1, paras. 13-14, Record Vol. 2, Tab 22
Bruce #1, para. 9, Exhibit C, pp. 49-50, Record Vol. 3, Tab 29
Boisvert #1, para. 12, Record Vol. 4, Tab 38
Boisvert #2, para. 6, Record Vol. 25, Tab 103
Jackson #1, para. 15, Record Vol. 5, Tab 47
Angell #1, paras. 9, 14, Exhibit C, p. 40, Record Vol. 7, Tab 54
Cohen #2, para. 17, Record Vol. 7, Tab 56
Upshur #1, para. 12, Record Vol. 10, Tab 69
Kimsma #1, Exhibit D, p. 39, Record Vol. 8, Tab 63
Ashby #1, para. 12, Record Vol. 4, Tab 35
Rasmussen #1, paras. 9-24, 37, Record Vol. 25, Tab 102
Battin #2, paras. 27, 32, Record Vol. 26, Tab 113
Downing #1, paras. 49-50, 81-83, Record Vol. 14, Tab 78
Downing Cross, p. 5, ll. 3-11; p. 14, l. 36 to p. 15, l. 22, SuppRecord Vol. 31, Tab 130
McGregor #1, paras. 44-45, Record Vol. 10, Tab 68
Bereza #1, paras. 35-36, 54-55, Record Vol. 10, Tab 73

Chochinov Report, paras. 41, 43, Record Vol. 11, Tab 74
Gallagher Report, p. 4, ll. 22-29; p. 5, ll. 16-17; p. 14, ll. 4-6, Record Vol. 11, Tab 75
Pereira Report, para. 31, Record Vol. 20, Tab 96
Pereira Cross (Nov. 22), p. 31, ll. 10-20, SuppRecord Vol. 34, Tab 140

90. While palliative care can provide much comfort to grievously and irremediably ill people, there are some people for whom palliative care is not a viable option. Some people make the autonomous choice to refuse certain palliative measures, including terminal sedation, for a variety of reasons.

Nicklinson #1, Exhibit C, pp. 24-25, Exhibit F, para. 5, Record Vol. 2, Tab 15
Renaud #1, para. 7, Record Vol. 2, Tab 18
LaForest #1, paras. 51-52, Record Vol. 1, Tab 14
Cordover #1, paras. 51-52, Record Vol. 3, Tab 24
Miller #1, para. 8, Record Vol. 3, Tab 26
Taylor #2, paras. 37-39, Record Vol. 3, Tab 34
G. Fenker #1, paras. 5, 13, Record Vol. 26, Tab 114
Shoichet #1, para. 6, Record Vol. 2, Tab 16
Boisvert #1, para. 15, Record Vol. 4, Tab 38
Starks #1, Exhibit F, p. 70, Record Vol. 6, Tab 53
Battin #1, para. 26, Record Vol. 6, Tab 51
Rasmussen #1, paras. 16-17, Record Vol. 25, Tab 102
Battin #2, paras. 32-35, Record Vol. 26, Tab 113
Ganzini #2, para. 54, Record Vol. 26, Tab 111
Downing #1, para. 52, Record Vol. 14, Tab 78
Downing Cross, p. 5, ll. 3-11, SuppRecord Vol. 31, Tab 130
Bereza #1, paras. 35, 49, Record Vol. 10, Tab 73

91. So for example, for people like Anthony Nicklinson who has locked-in syndrome, palliative care is simply not available because he is not terminally ill. His wife explained:

> SA: Another question. I think I know the answer to this but, has he actually had any contact with palliative care? Has there been any palliative care input into his condition, into his medical or nursing care?
>
> JN: What do you mean palliative care exactly?
>
> Prof SA: That's a good question, but, I think you read out from him a question about palliative care, so he must have some idea. But let's just say specialised

> services for the care of dying people; sort of people that work in hospices for example.
>
> JN: He's not dying! He is not dying! This is the problem, you know he is not dying, he would wish to have cancer or something but he is not dying. He could outlive us all.
>
> SA: So he would say and you would say that palliative care isn't an answer for his condition?
>
> JN: Well no. He doesn't need palliative care. He could live for another 20-25 years like this.

Nicklinson #1, Exhibit C, pp. 24-25, Record Vol. 2, Tab 15

92. Dr. William Shoichet has explained some people's hesitance to avail themselves of palliative care:

> Palliative care has not been a viable option for some of my patients. Some of my patients have told me, and I verily believed, that for them palliative care involves an undue and unacceptable prolongation of a fate that cannot be avoided. I have also observed that while palliative care can eliminate most physical pain, it cannot always. Further, with any strong pain medication there are side effects that will be unacceptable to some patients. This is because it involves a change in the sensorium, which is to say it changes their state of consciousness or mental awareness to an unacceptable degree.· Some of my patients have told me and I have verily believed, that it is their deeply held desire to meet their death with a clear head. Most importantly palliative care cannot always address the needs of some of my patients who wish to end their lives with the privacy, dignity and autonomy that they lived those same lives.

Shoichet #1, para. 9, Record Vol. 2, Tab 16

93. For others, various forms of palliative care are simply unacceptable. They are unacceptable because:

a. some people are suffering intractably and yet are too far from death to receive the only treatment such as terminal sedation that can relieve their suffering,

Downing Cross, p. 2, l. 43 to p. 3, l. 17; p. 21, l. 38 to p. 22, l. 32; Exhibits H, I, SuppRecord Vol. 31, Tab 130

McGregor Cross, p. 19, l. 19 to p. 20 l. 17, Exhibits H-L, SuppRecord Vol. 32, Tab 135

Pereira Cross (Nov. 22), p. 40, ll. 12-25, SuppRecord Vol. 34, Tab 140

Syme #1, para. 17, Record Vol. 1, Tab 12

Bruce #1, para. 12, Exhibit C, p. 53, Record Vol. 3, Tab 29

Boisvert #1, para. 13, Record Vol. 4, Tab 38

b. other patients suffer intolerably and do not want to continue to suffer as multiple treatment options are attempted each of which takes time and has side effects;

Rasmussen #1, para. 16, Record Vol. 25, Tab 102

c. some people value maintaining control, consciousness, a sense of dignity, a sense of themselves and the ability to communicate and reflect at end-of-life;

LaForest #1, paras. 51-52, Record Vol. 1, Tab 14
Cordover #1, paras. 51-52, Record Vol. 3, Tab 24
Taylor #2, para. 37, Record Vol. 3, Tab 34
Shoichet #1, para. 9, Record Vol. 2, Tab 16
Boisvert #1, para. 15, Record Vol. 4, Tab 38
Battin #1, para. 26, Record Vol. 6, Tab 51
Battin #2, paras. 32-35, Record Vol. 26, Tab 113

d. some people feel such treatment inappropriately prolongs the dying process;

Shoichet #1, para. 9, Record Vol. 2, Tab 16
Starks #1, Exhibit F, p. 70, Record Vol. 6, Tab 53

e. some people do not want to feel impaired and tired;

G. Fenker #1, paras. 5, 13, Record Vol. 26, Tab 114
Shoichet #1, para. 9, Record Vol. 2, Tab 16

f. some feel that the burden that some forms of care exact on their family is unacceptable;

Renaud #1, para. 7, Record Vol. 2, Tab 18
Cordover #1, para. 52, Record Vol. 3, Tab 24
Miller #1, para. 8, Record Vol. 3, Tab 26
Taylor #2, para. 39, Record Vol. 3, Tab 34
Starks #1, Exhibit F, p. 70, Record Vol. 6, Tab 53
Rasmussen #1, para. 17, Record Vol. 25, Tab 102

g. some people feel it lacks closure;

Taylor #2, para. 37, Record Vol. 3, Tab 34

h. some people fear they that despite being sedated, they will remain conscious but paralyzed and unable to communicate.

Taylor #2, para. 38, Record Vol. 3, Tab 34

Downing Cross, p. 39, ll. 16-34, SuppRecord Vol. 31, Tab 130

McGregor Cross, pp. 22-25, Exhibit 9, see also pp. 25-27, Exhibit 10, SuppRecord Vol. 32, Tab 135

Pereira Cross (Nov. 22), p. 40, l. 47 to p. 51, l. 30, SuppRecord Vol. 34, Tab 140

94. So for example, Gloria Taylor has deposed:

> 37. While I appreciate that others may feel differently about it, personally, I find the idea of terminal sedation repugnant. I do not understand how anyone could assert that it is a viable alternative to physician-assisted dying. I cannot believe that any rational person would want that end for themselves or anyone they care about. I can understand that, if you allow a person's suffering to become completely overwhelming, there will be a point where terminal sedation is better than soldiering on, but I cannot see how anyone, approaching death rationally and while still able to evaluate their options, could choose to die that way. It is not rational to choose to waste away slowly while unconscious, but still alive. There is no closure in that, no dignity.
>
> 38. The idea that I might, even though in an induced coma, be able to hear people and things going on around me as I lay wasting is a terrifying thought to me. And if it is correct to say that I would not have any sensation at all of being alive while in that coma, then I do not see why I cannot instead have the dignity and closure of actually being dead.
>
> 39. I do not want my last conscious thought to be worrying about what will happen - to my body and my family - once I am in the coma. I believe terminal sedation would horrify and traumatize my 11 year old granddaughter. We are extremely close and I believe that if I was not dead but rather sedated, she would insist on visiting and staying with me and, if denied the right to do so, would feel guilty about not staying and resentful of those who prevented her from doing so. Either way, her mind would be filled with visions of my body wasting away while I was "alive." I cannot stand the idea of putting her through that. I believe that would be cruel to my granddaughter. I could not feel at peace knowing that that was what I was leaving her, and my other family members, to go through.

Taylor #2, paras. 37-39, Record Vol. 3, Tab 34

95. Thus the Impugned Provisions impose both physical and psychological suffering on these individuals by barring what may be the only form of relief acceptable to them – a hastened death.

96. Another way in which the Impugned Provisions engage the security of the person interests of grievously and irremediably ill people is because of their chilling effect on health practitioner pain management. The evidence in this case establishes that some patients receive less analgesia and sedation than would be ideal for their comfort because of health care provider

fear of the way in which higher doses might be perceived or for fear of peer criticism. The dying process can be unnecessarily prolonged and suffering unnecessarily induced by inappropriately low doses of analgesics and sedatives which do not address symptoms.

Cook #1, para. 15, Record Vol. 9, Tab 66
Boisvert #1, para. 13, Record Vol. 4, Tab 38
Bereza #1, paras. 43-44, Record Vol. 10, Tab 73
Gallagher Report, p. 10, ll. 16-18, Record Vol. 11, Tab 75
Downing #1, para. 54, Record Vol. 14, Tab 78

97. Some people are relieved and palliated to know that they have the option of assisted dying even if they chose not to use it. For some people this option leads to a sense of empowerment, respect, courage to continue and hope. The Impugned Provisions deprive these people of an important palliative measure, whether they would ultimately chose to avail themselves of the lethal medication or not.

Morcos Examination, QQ. 31-32, SuppRecord Vol. 30, Tab 125
Syme #1, paras. 6(l)-(m), 13, Record Vol. 1, Tab 12
Nicklinson #1, Exhibit E, para. 12, Record Vol. 2, Tab 15
Renaud #1, para. 8, Record Vol. 2, Tab 18
Cordover #1, paras. 24-25, 51, 57, Record Vol. 3, Tab 24
Bracken #1, para. 18, Record Vol. 3, Tab 28
Eighmey #1, para. 8, Record Vol. 5, Tab 43
Jackson #1, paras. 17-18, Record Vol. 5, Tab 47
Petrie #1, paras. 14, 16-17, Record Vol. 5, Tab 48
Morris #1, para. 43, Record Vol. 5, Tab 50
Kimsma #1, Exhibit D, p. 37, Record Vol. 8, Tab 63
Starks #1, Exhibit C, p. 46, Exhibit F, p. 71, Record Vol. 6, Tab 53
Ashby #1, para. 19, Record Vol. 4, Tab 35
Starks #2, paras. 7, 11, Record Vol. 25, Tab 107
Werth #1, para. 51, Record Vol. 25, Tab 110
Ganzini #2, para. 11, Record Vol. 26, Tab 111

98. The Impugned Provisions engage the security of the person of all of these individuals because they contribute to the suffering these individuals face, be it physical and/or psychological.

Rodriguez, para. 128

99. The right to liberty of a person who assists or supports a grievously and irremediably ill person to obtain physician-assisted dying services is engaged by prosecution and the threat of prosecution under the Impugned Provisions.

100. This fact is admitted by Canada and the Province.

AGC Amended Response to Amended Civil Claim, dated 16 Sep, 2011, Legal Basis, para. 9, Record Vol. 26, Tab 120

AGBC Amended Response to Amended Civil Claim, dated 15 Sep, 2011, Legal Basis, para. 7, Record Vol. 26, Tab 119

101. The right to liberty of persons who assist or support a grievously and irremediably ill person to obtain physician-assisted dying services must necessarily be protected in order to give meaning to the s. 7 life, liberty and security of the person rights of grievously and irremediably ill persons.

Summary on Deprivation/Engagement

102. Thus, the Impugned Provisions engaged the life, liberty and security of the person interests of grievously and irremediably ill persons like Gloria Taylor and Kay Carter. They also engage the liberty interests of those individuals who do help or would help a grievously and irremediably ill person to hasten their death.

SECTION 15

103. The Plaintiffs assert that the absolute prohibition against assisted dying created by the Impugned Provisions imposes a disproportionate burden to persons who are materially and physically disabled, resulting in discrimination based on the enumerated ground of disability contrary to s. 15 of the *Charter*. Section 15(1) provides:

> 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.

Charter, s. 15(1)

104. In *Withler*, the Supreme Court of Canada recently clarified that the two-step test to be applied in assessing a s. 15 claim is as follows:

> (1) Does the law create a distinction based on an enumerated or analogous ground?
>
> (2) Does the distinction create a disadvantage by perpetuating prejudice or stereotyping?

Withler v. Canada (Attorney General), [2011] 1 S.C.R. 396, 2011 SCC 12 [_Withler_], para. 30

See also _R. v. Kapp_, [2008] 2 S.C.R. 483, 2008 SCC 41, at para. 17

Distinction Based on an Enumerated Ground

105. The Court explained that at the first step of the analysis, claimants must show that "the law, on its face <u>or in its apparent effect</u>, creates a distinction on the basis of an enumerated or analogous ground."

Withler, para. 68 (emphasis added)

106. The Province says:

> To choose as a ~~comparator~~ comparison group all persons who are physically able to commit suicide without any reference to their psychological and emotional fitness to actually carry out the act of committing suicide does not align the ~~comparator~~ comparison group with the benefit sought, assistance in committing suicide. ~~It is an error of law to fail to choose a comparator group that omits any relation or reference to the benefit sought~~. The impugned law does not create a distinction, on its face or in effect, on the basis of an enumerated or analogous ground.

AGBC Amended Response to Amended Civil Claim, Legal Basis, para. 34, Record Vol. 26, Tab 119

107. While the Province has tried to mute its reliance on "comparator groups" by calling them "comparison groups," the analysis the Province urges – an analysis with a myopic focus on identifying a group which mirrors the characteristics of the claimants save for the distinction – is the same. The form of analysis proffered by the Province comes from the decision of the SCC in *Hodge* where Justice Binnie said:

> **23** The appropriate comparator group is the one which mirrors the characteristics of the claimant (or claimant group) relevant to the benefit or advantage sought…

Hodge v. Canada (Minister of Human Resources Development), [2004] 3 S.C.R. 357, 2004 SCC 65, para. 23

108. And from the following passage in *Auton* to the same effect:

> **53** Third, the comparator group should mirror the characteristics of the claimant or claimant group relevant to the benefit or advantage sought, except for the personal characteristic related to the enumerated or analogous ground raised as the basis for the discrimination: *Hodge*, *supra*, at para. 23. The comparator must align with both the benefit and the "universe of people potentially entitled" to it and the alleged ground of discrimination: *Hodge*, at paras. 25 and 31.

***Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657, 2004 SCC 78 [*Auton*], para. 53**

109. There are a number of responses to the Province's plea. First, the quest for the "mirror comparator" was rejected by the Supreme Court of Canada in *Withler*. This was the subject of a rather extensive discussion as follows:

> **55** This brings us to the critical jurisprudential issue in this appeal. Basing the s. 15(1) analysis on a comparison between the claimant group and a mirror comparator group has been criticized on the basis that a comparator group approach to s. 15(1) may substitute a formal "treat likes alike" analysis for the substantive equality analysis that has from the beginning been the focus of s. 15(1) jurisprudence. We agree with the concerns.
>
> **56** One concern is that the use of mirror comparator groups as an analytical tool may mean that the definition of the comparator group determines the analysis and the outcome (Peter Hogg, *Constitutional Law of Canada* (5th ed. Supp.), vol. 2, at p. 55-34). As a result, factors going to discrimination — whether the distinction creates a disadvantage or perpetuates prejudice or stereotyping — may be eliminated or marginalized.
>
> **57** Another concern is that the focus on a precisely corresponding, or "like" comparator group, becomes a search for sameness, rather than a search for disadvantage, again occluding the real issue - whether the law disadvantages the claimant or perpetuates a stigmatized view of the claimant.
>
> **58** A further concern is that allowing a mirror comparator group to determine the outcome overlooks the fact that a claimant may be impacted by many interwoven grounds of discrimination. Confining the analysis to a rigid comparison between the claimant and a group that mirrors it except for one characteristic may fail to account for more nuanced experiences of discrimination….
>
> **59** Finally, it has been argued that finding the "right" comparator group places an unfair burden on claimants (Daphne Gilbert and Diana Majury, "Critical Comparisons: The Supreme Court of Canada Dooms Section 15" (2006), 24 *Windsor Y.B. Access Just.* 111, at p. 138). First, finding a mirror group may be impossible, as the essence of an individual's or group's equality claim may be that, in light of their distinct needs and circumstances, no one is like them for the purposes of comparison. As Margot Young warns:

> > If there is no counterpart in the experience or profile of those closer to the centre, the marginalization and dispossession of our most unequal will be missed. These cases will seem simple individual instances of personal failure, oddity or happenstance.
> >
> > ("Blissed Out: Section 15 at Twenty", in Sheila McIntyre and Sanda Rodgers, eds., *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms* (2006), 45, at p. 63)
>
> Second, it may be difficult to decide what characteristics must be "mirrored". Rational people may differ on what characteristics are relevant, as this case illustrates. The concern with claimants spending time and money in a pre-trial search for the appropriate comparator group is exacerbated by the possibility that trial judges may or may not accept the claimant's choice, and compounded by the fact that appeal courts may adopt a different comparator group later in the proceedings. When the appropriate comparator group is redefined by a court, the claimant may be unable to establish his or her claim because the record was created in anticipation of comparison with a different group.
>
> **60** In summary, a mirror comparator group analysis may fail to capture substantive inequality, may become a search for sameness, may shortcut the second stage of the substantive equality analysis, and may be difficult to apply. In all these ways, such an approach may fail to identify - and, indeed, thwart the identification of - the discrimination at which s. 15 is aimed. The question then is how comparison figures in the s. 15(1) analysis.

***Withler*, paras. 55-60**

110. Thus heavy reliance on comparator or comparison groups is faulted. But comparison still has a role to play in the s. 15 analysis in elucidating a distinction. In *Withler*, the Court explained the significance of the word "distinction":

> **62** The role of comparison at the first step is to establish a "distinction". Inherent in the word "distinction" is the idea that the claimant is treated differently than others. Comparison is thus engaged, in that the claimant asserts that he or she is denied a benefit that others are granted or carries a burden that others do not, by reason of a personal characteristic that falls within the enumerated or analogous grounds of s. 15(1).
>
> **63** It is unnecessary to pinpoint a particular group that precisely corresponds to the claimant group except for the personal characteristic or characteristics alleged to ground the discrimination. Provided that the claimant establishes a distinction based on one or more enumerated or analogous grounds, the claim should proceed to the second step of the analysis. This provides the flexibility required to accommodate claims based on intersecting grounds of discrimination. It also avoids the problem of eliminating claims at the outset because no precisely corresponding group can be posited.

***Withler*, paras. 62-63**

111. The jurisprudence is also clear that s. 15 protects everyone not only from direct discrimination, but indirect. The Court in *Withler* explained it this way:

> **64** In some cases, identifying the distinction will be relatively straightforward, because a law will, on its face, make a distinction on the basis of an enumerated or analogous ground (direct discrimination). This will often occur in cases involving government benefits, as in *Law*, *Lovelace* and *Hodge*. <u>In other cases, establishing the distinction will be more difficult, because what is alleged is indirect discrimination: that although the law purports to treat everyone the same, it has a disproportionately negative impact on a group or individual that can be identified by factors relating to enumerated or analogous grounds.</u> Thus in *Granovsky*, the Court noted that "[t]he CPP contribution requirements, which on their face applied the same set of rules to all contributors, operated unequally in their effect on persons who want to work but whose disabilities prevent them from working" (para. 43). In that kind of case, the claimant will have more work to do at the first step. Historical or sociological disadvantage may assist in demonstrating that the law imposes a burden or denies a benefit to the claimant that is not imposed on or denied to others. The focus will be on the effect of the law and the situation of the claimant group.

***Withler*, para. 64 (emphasis added)**

112. The Supreme Court of Canada in *Eldridge* explained how adverse effects discrimination is especially relevant in the case of disability with specific reference to the dissent of the Chief Justice in *Rodriguez:*

> **64** Adverse effects discrimination is especially relevant in the case of disability. The government will rarely single out disabled persons for discriminatory treatment. More common are laws of general application that have a disparate impact on the disabled. This was recognized by the Chief Justice in his dissenting opinion in *Rodriguez, supra*, where he held that the law criminalizing assisted suicide violated s. 15(1) of the *Charter* by discriminating on the basis of physical disability. There, a majority of the Court determined, *inter alia*, that the law was saved by s. 1 of the *Charter*, assuming without deciding that it infringed s. 15(1). While I refrain from commenting on the correctness of the Chief Justice's conclusion on the application of s. 15(1) in that case, I endorse his general approach to the scope of that provision, which he set out as follows, at p. 549:
>
>> Not only does s. 15(1) require the government to exercise greater caution in making express or direct distinctions based on personal characteristics, but legislation equally applicable to everyone is also capable of infringing the right to equality enshrined in that provision, and so of having to be justified in terms of s. 1. Even in imposing generally applicable provisions, the government must take into account differences which in fact exist between individuals and so far as possible ensure that the

> provisions adopted will not have a greater impact on certain classes of persons due to irrelevant personal characteristics than on the public as a whole. In other words, to promote the objective of the more equal society, s. 15(1) acts as a bar to the executive enacting provisions without taking into account their possible impact on already disadvantaged classes of persons.

***Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, para. 64**

113. In this case, the Impugned Provisions on their face prohibit everyone from having the assistance to end their life.

114. The Plaintiffs argue that these provisions have a disproportionate impact on those who are so physically disabled, that the disability renders them unable to act alone to carry out their decision to die.

115. In *Rodriguez*, Chief Justice Lamer described the disproportionate impact of the law as being both a denial of a benefit and the imposition of a burden:

> **48** In applying these rules which I have just stated, I have concluded that s. 241(*b*) of the *Criminal Code* infringes the right to equality contained in s. 15(1) of the *Charter*. Section 241(*b*) creates an inequality since it prevents persons physically unable to end their lives <u>unassisted from choosing suicide when that option is in principle available to other members of the public</u>. This inequality is moreover imposed on persons unable to end their lives unassisted solely because of a physical disability, a personal characteristic which is among the grounds of discrimination listed in s. 15(1) of the *Charter*. Furthermore, in my opinion the inequality may be characterized <u>as a burden or disadvantage</u>, since it limits the ability of those who are subject to this inequality to take and act upon fundamental decisions regarding their lives and persons. For them, the principle of self-determination has been limited.

***Rodriguez*, para. 48 (emphasis added)**

116. Lamer C.J. elaborated on why s. 241(b) of the *Criminal Code* constituted a disadvantage or burden:

> **56** Does the fact that one is unable to commit suicide in accordance with law constitute a disadvantage or burden giving rise to application of s. 15(1) of the *Charter*?
>
> **57** First, it should be pointed out that the advantage which the appellant claims to be deprived of is not the option of committing suicide as such. She does not argue that suicide is a benefit which she is deprived of by the effect of s. 241(*b*) of the *Criminal Code*. What the appellant is arguing is that she will be

> deprived of the right to <u>choose</u> suicide, of her ability to decide on the conduct of her life herself.
>
> …
>
> **59** Can the right to choose at issue here, that is the right to choose suicide, be described as an advantage of which the appellant is being deprived? In my opinion, the Court should answer this question without reference to the philosophical and theological considerations fuelling the debate on the morality of suicide or euthanasia. It should consider the question before it from a legal perspective - *Tremblay v. Daigle*, [1989] 2 S.C.R. 530 - while keeping in mind that the *Charter* has established the essentially secular nature of Canadian society and the central place of freedom of conscience in the operation of our institutions….
>
> …
>
> **61** Like the *Charter* itself in several of its provisions, therefore, the common law recognized the fundamental importance of individual autonomy and self-determination in our legal system. That does not mean that these values are absolute. However, in my opinion s. 15(1) requires that limitations on these fundamental values should be distributed with a measure of equality.
>
> **62** In this connection, and without expressing any opinion on the moral value of suicide, I am forced to conclude that the fact that persons unable to end their own lives cannot choose suicide because they do not legally have access to assistance is - in legal terms - a disadvantage giving rise to the application of s. 15(1) of the *Charter*.…

***Rodriguez*, paras. 56-57, 59, 61-62**

117. That reasoning is as compelling today as it was in 1993 and entirely consistent with the jurisprudence under the *Charter* today.

118. The Impugned Provisions have a disproportionate impact on persons who because of physical disability are unable to act on the decision to end their lives as compared to those, who not being so disabled, are able to undertake that act of self-determination whenever they so choose.

119. The evidence is clear that there are individuals who wish to end their lives but who because of having a grievous and irremediable illness that is materially disabling, cannot commit suicide without assistance.

Syme #1, para. 12, Record Vol. 1, Tab 12

Nicklinson #1, para. 10, Exhibit B, p. 10, Exhibit C, pp. 26-28, Exhibit E, paras. 2, 5, Exhibit F, paras. 6-7, 9, 12-13, Record Vol. 2, Tab 15

P. Fenker #1, para. 20, Record Vol. 5, Tab 44

Morris #1, para. 49, Record Vol. 5, Tab 50

Morcos Examination, QQ. 11, 15, 17-22, 27, SuppRecord Vol. 30, Tab 125

Meckling #1, para. 29, Record Vol. 3, Tab 33

Angell #1, para. 22, Record Vol. 7, Tab 54

Cook #1, para. 32, Record Vol. 9, Tab 66

120. Anthony Nicklinson is one such individual. He suffers from locked-in syndrome and has deposed as follows:

> 12. I don't want to die in a foreign country where assisted suicide is legal – even if getting there were realistic for me. I want to end my days in the comfort of my own home – is that too much to ask? Why can't I? If you really have my best interests at heart, and the interests of thousands of others who would take advantage of a change in the law, you would help me to restore choice. If that were the case, I may not exercise my right immediately, just having the same right as those who are able bodied may be sufficient. I would know that I could have help to die when I am ready. That would be a great comfort – knowing that I can be released when it gets too much for me.
>
> 13. Governments of all complexions speak about not discriminating against minorities, the disabled and so on. Well, I am being discriminated against because I am totally physically disabled. I am not equal under the law and I don't have the same choices as someone who is not. Is that fair?

Nicklinson #1, Exhibit F, paras. 12-13, Record Vol. 2, Tab 15

121. Other individuals have grievous and irremediable illnesses that have the *prospect* of rendering them unable to commit suicide without assistance at the time of their choosing.

Taylor #1, Record Vol. 1, Tab 4; Amended Notice of Civil Claim, filed 15 Aug 2011, paras. 33, 55, Record Vol. 26, Tab 118

Taylor #2, paras. 11-12, 32, Record Vol. 3, Tab 34

Pellizzari #1, paras. 4, 7, Record Vol. 1, Tab 7

Leeking #1, para. 1, Record Vol. 1, Tab 9

Shapray #1, paras. 8-9, Record Vol. 1, Tab 10

Carter #1, paras. 6-8, Record Vol. 2, Tab 21

Cordover #1, paras. 3, 5, Record Vol. 3, Tab 24

Reisler #1, Record Vol. 3, Tab 27

Reisler #1, para. 6, Record Vol. 3, Tab 27

Zwart #1, paras. 5, 34, Record Vol. 5, Tab 46

Petrie #1, para. 1, Record Vol. 5, Tab 48

G. Fenker #1, paras. 2, 7, Record Vol. 26, Tab 114

122. For example, Gloria Taylor suffers from ALS and Kay Carter suffered from spinal stenosis. Dr. Scott Meckling has deposed that in his opinion, highly symptomatic ALS and severe inoperable spinal stenosis, are two conditions among others, that "have the potential to render a sufferer sufficiently disabled to be incapable of obtaining the means necessary for and/or carrying out positive physical acts required to cause their own death without the assistance of a third party." Dr. Deborah Cook has corroborated that ALS is one among many conditions that could render an individual incapable of committing suicide without assistance.

Meckling #1, para. 29, Record Vol. 3, Tab 33
Cook #1, para. 32, Record Vol. 9, Tab 66

123. Thus, Gloria and many other grievously and irremediably ill people either are, or may one day be, incapable of ending their own lives when they decide the time has come, just as Kay Carter was rendered incapable of ending her own life at the time she chose to do so.

124. It is no answer to say that Gloria Taylor and others like her can opt to end their lives now; that they can choose to act before their progressive disability renders them unable to act unassisted. As the law allows the able bodied to make that decision at the time of their choosing, the law cannot require those who are facing degenerative illness to take action to die sooner than they would otherwise choose to do so. It is the essence of the decision to die as an act of self-determination that requires the act be undertaken at the time of the person's own choosing. To oblige disabled persons to do so earlier than they wish is not a solution, but rather an additional burden. Further, even if some people with disabling conditions could commit suicide earlier than they wished to, there will still be those whose disability arrives suddenly, by traumatic event, and who simply will not have any meaningful "window" for taking pre-emptive action.

125. The Province says that s. 15 is not violated because "the appropriate ~~comparator~~ comparison group in this case ~~are~~ is all those people who are not physically disabled who are seeking and need assistance in committing suicide" (para. 32 of Amended Response to Amended Notice of Civil Claim, Record Vol. 26, Tab 119). The Province, in other words, argues that the purpose and effect of the Impugned Provisions is to prevent anyone, disabled or able bodied, from seeking assistance in suicide and to criminalize those who would assist. The "universe" of persons affected by the Impugned Provisions is, according to the Province, everyone who seeks or needs assistance in committing suicide and hence the comparison group, according to the Province, is not those who are

physically able to commit suicide on their own without assistance, but rather those who are not physically disabled but still need assistance to commit suicide.

126. Assuming, *arguendo*, that the purpose of the Impugned Provisions is as stated by the Province, and leaving aside the fact that the Province is still improperly deploying the “mirror comparator” analysis, the Province’s analysis fails to pay any regard to the disproportionate impact of the law on the physically disabled.

127. The Province says: “Not everyone who is physically able to commit suicide can or will do so without assistance. Any number of emotional or psychological reasons may inhibit the non-disabled person from committing suicide without assistance” (para. 33 of Amended Response to Amended Notice of Civil Claim, Record Vol. 26, Tab 119).

128. We take no issue with that as far as it goes. And we do not claim that the Impugned Provisions are discriminatory insofar as they criminalize assisted suicide for those who are not physically disabled. Whether these other people could make out a claim of discrimination would of course need to be assessed at the second stage of analysis under s. 15, and that is simply not the Plaintiffs’ case.

***Withler*, paras. 62-63**

129. Referring back to the Supreme Court of Canada’s decision in *Withler*, cited above, all that the Plaintiffs need to establish at this stage of the s. 15 analysis is that the law has a disproportionate impact on the basis of physical disability. The fact that there may be “people who are not physically disabled who are seeking and need assistance in committing suicide” (AGBC Amended Response to Amended Notice of Civil Claim, para. 32, Record Vol. 26, Tab 119) who are also impacted by the Impugned Provisions does nothing to detract from the claim that the law has a disproportionate impact on those who have physical disabilities that render chosen death impossible without assistance.

130. Another way in which this burden manifests is that some people who are becoming progressively disabled may end their lives earlier than they would otherwise want to, or contemplate doing so, acting out of fear that the progression of their disability will prevent them from ending it later. This is a significant burden; it obliges these people to purchase autonomy

using their lifespan as tender. Further, the fear and worry about being able to act itself impacts the *quality* of their remaining life.

Pellizzari #1, para. 7, Record Vol. 1, Tab 7
Shapray #1, paras. 16-18, Record Vol. 1, Tab 10
LaForest #1, paras. 39-45, Record Vol. 1, Tab 14
Bracken #1, para. 18, Record Vol. 3, Tab 28
P. Fenker #1, para. 20, Record Vol. 5, Tab 44

131. Because of the Impugned Provisions, people with material physical disabilities endure psychological suffering that able-bodied people do not have to endure – that is the Impugned Provisions impose upon those people who are unable by reason of material physical disability to end their lives unassisted the difficult choice between exposing loved ones to criminal sanctions or forgoing any attempt to be autonomous with respect to their choice to die.

Morcos Examination, p. 18, SuppRecord Vol. 30, Tab 125
Leeking #1, para. 29, Record Vol. 1, Tab 9
Shapray #1, para. 18, Record Vol. 1, Tab 10
Nicklinson #1, Exhibit B, p. 12, Record Vol. 2, Tab 15
Cordover #1, paras. 18, 41-45, 53, 60-63, Record Vol. 3, Tab 24
Petrie #1, para. 15, Record Vol. 5, Tab 48
Carter #1, paras. 33, 44, Exhibit L, Record Vol. 2, Tab 21
Johnson #1, paras. 14-15, 17, 22, Exhibit A, Record Vol. 3, Tab 25
Zwart #1, para. 33, Record Vol. 5, Tab 46
Morris #1, paras. 39, 45-47, Record Vol. 5, Tab 50
Starks #1, para. 29, Exhibit C, pp. 43-46, Exhibit G, pp. 80, 86-96, Record Vol. 6, Tab 53
Starks #2, para. 21, Record Vol. 25, Tab 107

132. The Impugned Provisions impose a related burden and disadvantage on those loved ones who cannot assist their loved ones to die. Some of these families are very distressed and traumatized by witnessing the unpalliated suffering of their loved ones at end-of-life, a suffering that they know their loved ones did not value.

Cohen #2, para. 17, Record Vol. 7, Tab 56
Dixon #1, paras. 18-19, 22, Record Vol. 7, Tab 58
G. Fenker #1, paras. 10-11, 13-24, Record Vol. 26, Tab 114

133. This final burden was articulated by Grace Fenker as follows:

> 23. It has been almost two weeks since his death. I will never forget those terrible four and a half days in the hospital. It was a horror to watch Peter labour to die. Four days may not sound like a long time, but it is a painful eternity when you are helplessly watching your beloved husband suffer. I will never forget the pleading look in his eyes as he asked me to help him and there was nothing I could do.
>
> 24. Peter never wanted his life to end that way. I will always feel bitter that his wish for a medically assisted death was never granted to him.

G. Fenker #1, paras. 23-24, see also paras. 6-22, Record Vol. 26, Tab 114

134. In *Benner* and *McIvor*, the Supreme Court of Canada and the BC Court of Appeal recognized disadvantage and discrimination related to a personal characteristic of a person's family can amount to discrimination against other family members. In *Benner*, the provisions denied citizenship privileges due to the sex of a Canadian parent. In *McIvor*, the provisions denied Indian status due to the sex of his Indian parent or grandparent.

***Benner v. Canada (Secretary of State)*, [1997] 1 S.C.R. 358**

***McIvor v. Canada (Registrar, Indian and Northern Affairs)* (2009), 306 D.L.R. (4th) 193, 2009 BCCA 153**

Disadvantage By Perpetuating Prejudice and Stereotyping – Substantive Inequality

135. A distinction based on an enumerated or analogous ground is not by itself sufficient for a violation of s. 15(1). The question at the second step is: does the distinction create a disadvantage by perpetuating prejudice or stereotyping? This, of course, is a question about discrimination.

136. In *Withler*, the Court explained:

> **65** The analysis at the second step is an inquiry into whether the law works substantive inequality, by perpetuating disadvantage or prejudice, or by stereotyping in a way that does not correspond to actual characteristics or circumstances. At this step, comparison may bolster the contextual understanding of a claimant's place within a legislative scheme and society at large, and thus help to determine whether the impugned law or decision perpetuates disadvantage or stereotyping. The probative value of comparative evidence, viewed in this contextual sense, will depend on the circumstances.…
>
> **66** The particular contextual factors relevant to the substantive equality inquiry at the second step will vary with the nature of the case. A rigid template

> risks consideration of irrelevant matters on the one hand, or overlooking relevant considerations on the other: *Kapp*. Factors such as those developed in *Law* - pre-existing disadvantage, correspondence with actual characteristics, impact on other groups and the nature of the interest affected - may be helpful. However, they need not be expressly canvassed in every case in order to fully and properly determine whether a particular distinction is discriminatory (see *Ermineskin Indian Band*; *A.C. v. Manitoba*; *Hutterian Brethren*). Just as there will be cases where each and every factor need not be canvassed, so too will there be cases where factors not contemplated in *Law* will be pertinent to the analysis. At the end of the day, all factors that are relevant to the analysis should be considered. As Wilson J. said in *Turpin*,
>
>> In determining whether there is discrimination on grounds relating to the personal characteristics of the individual or group, it is important to look not only at the impugned legislation which has created a distinction that violates the right to equality but also to the larger social, political and legal context. [p. 1331]

***Withler*, paras. 65-66**

137. With this important context in mind, we turn now to a consideration of the factors articulated in *Law* and applied in most jurisprudence under s. 15 of the *Charter* - pre-existing disadvantage, correspondence with actual characteristics, ameliorative purpose and the nature of the interest affected.

***Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 [*Law*]**

Pre-Existing Disadvantage

138. With respect to this contextual factor, the majority in *Law* said this:

> **63** As has been consistently recognized throughout this Court's jurisprudence, probably the most compelling factor favouring a conclusion that differential treatment imposed by legislation is truly discriminatory will be, where it exists, pre-existing disadvantage, vulnerability, stereotyping, or prejudice experienced by the individual or group: see, e.g., *Andrews*, *supra*, at pp. 151-53, *per* Wilson J., p. 183, *per* McIntyre J., pp. 195-97, *per* La Forest J.; *Turpin*, *supra*, at pp. 1331-33; *Swain*, *supra*, at p. 992, *per* Lamer C.J.; *Miron*, *supra*, at paras. 147-48, *per* McLachlin J.; *Eaton*, *supra*, at para. 66. These factors are relevant because, to the extent that the claimant is already subject to unfair circumstances or treatment in society by virtue of personal characteristics or circumstances, persons like him or her have often not been given equal concern, respect, and consideration. It is logical to conclude that, in most cases, further differential treatment will contribute to the perpetuation or promotion of their unfair social characterization, and will have a more severe impact upon them, since they are already vulnerable.

***Law*, para. 63**

139. It is clear, and uncontradicted, that disabled people face pre-existing disadvantage, vulnerability, stereotyping, and prejudice in Canadian society.

140. This fact was explained by Canada's expert, Catherine Frazee, in part, as follows:

> 33. Disabled people have a distinct experience. We are perceived as less fortunate than nondisabled people and assigned a diminished status in everyday life – these perceptions and status shape our experience, both when we are lively and autonomous and when we are fragile and vulnerable.
>
> 34. Disability rights advocates have for decades fought against negative stereotypes, discriminatory barriers and persistent cultural devaluation in the effort to achieve equality. Discrimination on the basis of disability – both direct and systemic – is pervasive and persistent. As acknowledged by the Supreme Court of Canada in the *Eldridge* decision:
>
>> It is an unfortunate truth that the history of disabled persons in Canada is largely one of exclusion and marginalization. Persons with disabilities have too often been excluded from the labour force, denied access to opportunities for social interaction and advancement, subjected to invidious stereotyping and relegated to institutions…

Frazee Report, paras. 33-34, Record Vol. 18, Tab 87

see also McLean #1, Exhibit B, para. 2, Record Vol. 26, Tab 115

141. Further differential treatment will contribute to the perpetuation or promotion of the unfair social characterization of disabled people, and will have a more severe impact upon them.

142. One stereotypical line of thinking that is perpetuated and promoted by the additional burden that the Impugned Provisions impose on disabled individuals is that disabled people are not capable of making autonomous choices. Unfortunately some disability rights and disability organizations may be unwittingly feeding into that stereotypical thinking. Sheila McLean and Laura Williamson explain:

> 21. Ells further opines that:
>
>> People living with disabilities are particularly vulnerable to the failure of others to recognize their authority to make and act on decisions, thus impeding the ability of disabled people to govern important aspects of their lives. Numerous factors can contribute to this vulnerability. Because authority in health care contexts depends in part on competence, an incorrect assessment of competence contributes to the failure to recognise authority. For example, communication barriers, caused either by physical

> processes (e.g. aphasia), attitudinal processes (e.g. bias), or confounding conditions (e.g. depression), may suggest the presence of incompetence and non-authority when someone is actually competent and has authority. Further, a lack of ability to enact one's decisions might be falsely assumed to indicate a lack of authority.
>
> 22. We agree with that opinion.

McLean #1, Exhibit B, paras. 21-22, Record Vol. 26, Tab 115

143. This problematic stereotype, a failure to recognize authority to make and act on decisions, has also been noted by Canada's witness, Rhonda Wiebe.

Wiebe #1, para. 18, Record Vol. 9, Tab 65

Lack of Correspondence

144. In *Law*, the majority emphasized that it will generally be more difficult to establish discrimination to the extent that the law takes into account the claimant's actual situation in a manner that respects his or her value as a human being or member of Canadian society, and less difficult to do so where the law fails to take into account the claimant's actual situation.

145. The Court held:

> **70** It is thus necessary to analyze in a purposive manner the ground upon which the s. 15(1) claim is based when determining whether discrimination has been established. As a general matter, as stated by McIntyre J. in *Andrews*, *supra*, and by Sopinka J. in *Eaton*, *supra*, and referred to above, <u>legislation which takes into account the actual needs, capacity, or circumstances of the claimant and others with similar traits in a manner that respects their value as human beings and members of Canadian society will be less likely to have a negative effect on human dignity</u>. This is not to say that the mere fact of impugned legislation's having to some degree taken into account the actual situation of persons like the claimant will be sufficient to defeat a s. 15(1) claim. <u>The focus must always remain upon the central question of whether, viewed from the perspective of the claimant, the differential treatment imposed by the legislation has the effect of violating human dignity.</u> The fact that the impugned legislation may achieve a valid social purpose for one group of individuals cannot function to deny an equality claim where the effects of the legislation upon another person or group conflict with the purpose of the s. 15(1) guarantee. In line with the reasons of McIntyre J. and Sopinka J., I mean simply to state that it will be easier to establish discrimination to the extent that impugned legislation fails to take into account a claimant's actual situation, and more difficult to establish discrimination to the extent that legislation properly accommodates the claimant's needs, capacities, and circumstances.

Law, para. 70 (emphasis added)

146. Here, the Impugned Provisions do not correspond at all, let alone in any meaningful respect, with the needs and circumstances of the disabled.

147. Canada says that the Impugned Provisions seek to prevent vulnerable populations, such as people with disabilities, from being coerced or unduly influenced into hastening their death against their true wishes or from being permitted to hasten their death at a time of depression.

148. However, the fact is that the situation of people with disability does not render apparently autonomous decisions, including decisions to seek an assisted death, less than fully autonomous. Such an assumption does not correspond with the needs and circumstances of disabled people, rather it feeds discriminatory attitudes.

McLean #1, Exhibit B, paras. 14-24, Record Vol. 26, Tab 115
Williamson #1, Exhibit B, paras. 14-24, Record Vol. 26, Tab 116

149. So for example, Sheila McLean and Laura Williamson opine:

> 15. We do not dispute the claim that people with disabilities may be regarded by some as living 'less than desirable lives'; nor do we deny that discrimination can and does occur, in the healthcare as well as other settings. However, while this may affect how other people would make decisions *on behalf of people* with disabilities (although arguably if our proposal that respect for persons should take centre stage were accepted, this would be less of a problem) there is little logic in suggesting that people with disabilities are less able than non-disabled people to make decisions *for themselves* that reflect their own considered and competent opinions.
>
> 16. Silvers, for example, opines and we agree that making any such assumption feeds rather than starves discriminatory attitudes, saying that '[c]haracterizing people with disabilities as incompetent, easily coerced, and inclined to end their lives places them in the roles to which they have been confined by disability discrimination. She further contends that:
>
> > There was no reason to accept the claim that the judgment of individuals with disabilities is so incapacitated by the exclusion and isolation they face as to make them incompetent and incapable of self-determination. Moreover, despite acknowledging the systematic marginalization that people with disabilities endure, it seems wrong to think that having any kind of disability means being cognitively or psychologically disabled by society. To do so is to equate being disabled in any way with being globally debilitated.
>
> 17. We adopt that opinion.

McLean #1, Exhibit B, paras. 15-17, Record Vol. 26, Tab 115

Williamson #1, Exhibit B, paras. 15-17, Record Vol. 26, Tab 116

150. Equally, the stereotypical assumption that disabled people are more likely to be suicidal and thus at risk in a scheme that regulates assisted dying does not correspond to the actual circumstances of disabled people. Sheila McLean and Laura Williamson opine:

> 18. Nor is there reason to believe that people with disability are more likely to be suicidal or to seek an assisted death. As Silvers notes, '[n]oticeably absent from the current discussion about assisted suicide are data showing that people with disabilities are more apt to end their lives than other classes of people. Indeed, in the US state of Oregon, where physician assisted suicide is legalised in certain circumstances, the consistent majority of those obtaining a lethal prescription are suffering from cancer, and while cancer is accepted as a 'disability' in some countries, such as the United Kingdom, it is clear that it is not to this group of people with disability that the rhetoric of the disability organisations is primarily addressed.
>
> 19. In addition, we must be careful to distinguish between situations where autonomy is ignored or overridden and those where people wish to make their own decisions. As Shakespeare says and we agree:
>
>> ... it is important to distinguish situations where the autonomy of disabled people is undermined (abuse of 'do not resuscitate' notices, non-voluntary euthanasia) from situations where disabled or terminally ill people themselves are exercising their autonomy by requesting assistance with death, or withdrawal of treatment (advance directives, assisted suicide). A failure to draw relevant distinctions and a failure to engage with the clinical realities undermines many disability rights critiques.

McLean #1, Exhibit B, paras. 18-19, Record Vol. 26, Tab 115

Williamson #1, Exhibit B, paras. 18-19, Record Vol. 26, Tab 116

see also Mishara Report, para. 26, Record Vol. 15, Tab 83

151. And the evidence in this case supports this opinion because:

a. many, if not all, of the lay witnesses suffering from disabling conditions in this case are clearly not depressed;

Pellizzari #1, paras. 4-5, Record Vol. 1, Tab 7

Carter #1, paras. 14-15, Record Vol. 2, Tab 21

Carter #2, paras. 4-7, 10, Record Vol. 25, Tab 104

Cordover #1, paras. 15, 47-48, Record Vol. 3, Tab 24

Johnson #1, paras. 4-8, 12-13, Record Vol. 3, Tab 25

Reisler #1, paras. 4-5, 10, Record Vol. 3, Tab 27
Taylor #2, paras. 4-10, 19, 21, 35-36, 43-45, Record Vol. 3, Tab 34
P. Fenker #1, para. 19, Record Vol. 5, Tab 44
Zwart #1, paras. 9-10, 14-15, 17, 19, 27, Record Vol. 5, Tab 46
Cohen #1, paras. 13-14, 19, Record Vol. 7, Tab 55

b. the evidence from other jurisdictions demonstrates that vulnerable populations, such as the disabled, are not disproportionately impacted by the liberalization of the laws on assisted dying;

Renaud #1, para. 5, Record Vol. 2, Tab 18
Ganzini #1, Exhibit W, Record Vol. 2, Tab 23
Ganzini Cross, p. 88, l. 30 to p. 90, l. 7, SuppRecord Vol. 32, Tab 134
Miller #1, para. 5, Record Vol. 3, Tab 26
Bernheim #1, para. 12, Exhibits C, D, Record Vol. 4, Tab 37
Eighmey #1, para. 5, Record Vol. 5, Tab 43
Battin #1, paras. 14-15, Exhibit C, Record Vol. 6, Tab 51
Angell #1, para. 17, Record Vol. 7, Tab 54
Deliens #1, para. 20, Exhibit F, p. 80, Record Vol. 7, Tab 57
Deliens Cross, p. 24, l. 21 to p. 26, l. 22, SuppRecord Vol. 34, Tab 141
van Delden #1, para. 18, Record Vol. 7, Tab 60
Kimsma #1, para. 41(a), Record Vol. 8, Tab 63

c. the evidence from other jurisdictions demonstrates that most people who access assisted schemes do not suffer from a disabling condition, instead most have cancer.

Renaud #1, Exhibit A, p. 2, Record Vol. 2, Tab 18
Miller #1, Exhibit A, p. 1, Record Vol. 3, Tab 26
van Delden #1, para. 17, Record Vol. 7, Tab 60
Deliens #1, paras. 17, 19, 23, 25, 28 Exhibits E-G, Record Vol. 7, Tab 57
Bosshard #1, para. 48, Exhibit L, Record Vol. 4, Tab 39
Starks #1, Exhibit C, p. 44 (Table 1), Exhibit I, p. 116, Record Vol. 6, Tab 53

Ameliorative Purpose

152. In *Law*, this factor was described:

> **72** … An ameliorative purpose or effect which accords with the purpose of s. 15(1) of the *Charter* will likely not violate the human dignity of more advantaged individuals where the exclusion of these more advantaged individuals largely corresponds to the greater need or the different circumstances experienced by the disadvantaged group being targeted by the legislation….

***Law*, para. 72**

153. It is clear from this description that this factor is to be considered in cases where a more advantaged group of individuals is making a discrimination claim in comparison to a less advantaged group of individuals in the context where the legislation targets the less advantaged individuals. This factor has no application to this case since the claimants are severely disabled and the law does not allow the government to pit one group of disadvantaged person against another to see who is more disadvantaged: although the Court recognizes that in some cases it can be a "factor".

***Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703, 2000 SCC 28 [*Granovsky*], para. 67**

wee also *Auton*, at para. 54

154. That said, it would appear that what is at the heart of this case is the claim by the government and the intervenor Euthanasia Prevention Coalition that the purpose or effect of the Impugned Provisions are to protect the disabled **all of whom are vulnerable whether they realize it or not** based on the "social model" of disability - a claim that in our submission is certainly not one that is supported by all disabled people and, in our respectful submission, is patronizing and infantilizing – and a radical conception of s. 15 of the *Charter* that the Supreme Court of Canada has rejected.

155. The Court in *Granovsky* understood the social model of disability and that it had a proper place in s. 15 analysis. Justice Binnie for the Court said:

> **30** The bedrock of the appellant's argument is that many of the difficulties confronting persons with disabilities in everyday life do not flow ineluctably from the individual's condition at all but are located in the problematic response of society to that condition. A proper analysis necessitates unbundling the impairment from the reaction of society *to* the impairment, and a recognition that much discrimination is socially constructed. See, e.g., D. Pothier, "Miles to Go: Some Personal Reflections on the Social Construction of Disability" (1992), 14 *Dalhousie L.J.* 526. Exclusion and marginalization are generally not created by the individual with disabilities but are created by the economic and social

> environment and, unfortunately, by the state itself. Problematic responses include, in the case of government action, legislation which discriminates *in its effect* against persons with disabilities, and thoughtless administrative oversight. The appellant says that his treatment by the CPP shows the inequality that can result when government enacts social programs with inadequate attention, at the design stage, for the true circumstances of people with disabilities.
>
> …
>
> **33** The *Charter* is not a magic wand that can eliminate physical or mental impairments, nor is it expected to create the illusion of doing so. Nor can it alleviate or eliminate the functional limitations truly created by the impairment. <u>What s. 15 of the *Charter* can do, and it is a role of immense importance, is address the way in which the state responds to people with disabilities. Section 15(1) ensures that governments may not, intentionally or through a failure of appropriate accommodation, stigmatize the underlying physical or mental impairment, or attribute functional limitations to the individual that the underlying physical or mental impairment does not entail, or fail to recognize the added burdens which persons with disabilities may encounter in achieving self-fulfilment in a world relentlessly oriented to the able-bodied.</u>
>
> **34** It is therefore useful to keep distinct the component of disability that may be said to be located in an individual, namely the aspects of physical or mental impairment, and functional limitation, and on the other hand the other component, namely, the socially constructed handicap that is not located in the individual at all but in the society in which the individual is obliged to go about his or her everyday tasks.

***Granovsky*, paras. 30, 33-34 (emphasis added)**

156. It, however, takes the social model of disability too far if it can be used to allow Parliament to enact laws that **burden severely disabled individuals and attribute to them functional limitations that they do not have** simply on the theory that disability is often socially constructed. It is one thing to **prevent** Parliament from imposing burdens on the disabled that may be based on socially constructed limitations; it is entirely another matter to allow Parliament to **impose** burdens on the disabled because of a fear that socially constructed ideas or limitations can somehow overwhelm individual choice and decision making. If this argument has any place, it will be in the context of s. 1, and there it will fail as well.

Nature of the Interest Affected

157. Another contextual factor to determine whether the law is discriminatory is the nature of the benefit. In *Law*, the Court said this:

> **74** A further contextual factor which may be relevant in appropriate cases in determining whether the claimant's dignity has been violated will be the nature and scope of the interest affected by the legislation. This point was well explained by L'Heureux-Dubé J. in *Egan*, *supra*, at paras. 63-64. As she noted, at para. 63, "[i]f all other things are equal, the more severe and localized the... consequences on the affected group, the more likely that the distinction responsible for these consequences is discriminatory within the meaning of s. 15 of the *Charter*". L'Heureux-Dubé J. explained, at para. 64, that the discriminatory calibre of differential treatment cannot be fully appreciated without evaluating <u>not only the economic but also the constitutional and societal significance attributed to the interest or interests adversely affected by the legislation in question</u>. Moreover, it is relevant to consider whether the distinction restricts access to a fundamental social institution, or affects "a basic aspect of full membership in Canadian society", or "constitute[s] a complete non-recognition of a particular group".

***Law*, para. 74 (emphasis added)**

158. The interests at stake in this case are fundamental. With respect to all materially physically disabled people, the issue goes to the right to make such fundamental choices about one's own body and life.

159. We have set out in detail the way in which the Impugned Laws deprive persons of their life, liberty and security of person in the context of the s. 7 arguments and so we will not repeat them here. But those are indeed the vital interests at stake.

The Special Case of Physician-Assisted Dying

160. As noted above, with respect to all materially physically disabled people, the discrimination in question limits the right to make fundamental choices about one's own body and life. However, with respect to those who are, in addition to being materially physically disabled, suffering intolerably, the right being denied has a further characteristic. For these people, the right being denied is the right to determine for oneself the point at which that suffering has rendered life a state worse than death.

161. For those in the latter category, the denial is not merely a denial of autonomy, it is a denial of a right to avail oneself of the chosen means for relief of that suffering.

162. Further, there is evidence that the decision to seek physician-assisted dying is generally a considered decision that reflects and embodies the personal values accumulated over a lifetime.

LaForest #1, para. 5, Record Vol. 1, Tab 14

Carter #1, paras. 14-15, Record Vol. 2, Tab 21

Carter #2, para. 10, Record Vol. 25, Tab 104

Cordover #1, paras. 15, 47-48, Record Vol. 3, Tab 24

Johnson #1, paras. 12-13, Record Vol. 3, Tab 25

Bracken #1, para. 21, Record Vol. 3, Tab 28

Taylor #2, paras. 4-10, 19, 21, 35-36, 43-45, Record Vol. 3, Tab 34

Ganzini #1, para. 37, Record Vol. 2, Tab 23

Bell #1, para. 7, Record Vol. 5, Tab 49

Starks #1, para. 23, Exhibit E, p. 65, Exhibit F, pp. 70-71, 75-76, Exhibit I, p. 120, Record Vol. 6, Tab 53

Starks #2, paras. 9, 11, 15, Record Vol. 25, Tab 107

Werth #1, paras. 55(a), 57, Record Vol. 25, Tab 110

Battin #21, paras. 12-13, Record Vol. 26, Tab 113

Ganzini #2, paras. 9, 43, 49, Record Vol. 26, Tab 111

163. Further, with respect to physician-assisted dying in particular, the prohibition also disproportionately erects barriers to open communication between physicians and materially physically disabled individuals. This barrier exists because the disabled individuals must seek out assistance from a physician to end their lives, and when they do so the responses they receive are often inadequate, and dismissive. These responses can damage the physician-patient relationship by causing feelings of distress, frustration and isolation.

Cordover #1, paras. 11-13, 35, 44, 63, Record Vol. 3, Tab 24

Petrie #1, paras. 14, 17, Record Vol. 5, Tab 48

Morris #1, paras. 38, 47, Record Vol. 5, Tab 50

Starks #1, Exhibit C, pp. 43-45, Record Vol. 6, Tab 53

164. This is a very serious concern because many individuals raise the issue of assisted dying as a gateway to discuss dying more broadly. This fact raises the real concern that the Impugned Provisions create disparity in access to appropriate health care for disabled people.

Ganzini #1, paras. 21, 25, Exhibits Q, U, Record Vol. 2, Tab 23

Starks #1, paras. 17-18, Exhibit C, pp. 44-46, Record Vol. 6, Tab 53

Cohen #2, paras. 21-22, Record Vol. 7, Tab 56

Chochinov Report, para. 45, Record Vol. 11, Tab 74

Conclusion

165. On the basis of the above arguments, it is therefore submitted that the violation of s. 15 is made out. The Impugned Provisions create a distinction that has a disproportionate impact on those who are physically disabled such that the disability renders them unable to act alone to carry out their decision to die. The distinction is one that perpetuates prejudice or stereotyping pre-existing disadvantage. The impact of the discrimination is particularly onerous in the context of disabled people who are seeking physician-assisted suicide in order to relieve unbearable suffering arising from a grievous and irremediable illness.

OVERBREADTH

166. Overbreadth analysis looks at the means chosen by the state in relation to its purpose. In considering whether a legislative provision is overbroad, a court must ask the question: "are those means necessary to achieve the State objective?"

***R. v. Heywood*, [1994] 3 S.C.R. 761 [*Heywood*], para. 49**

167. None of the Justices referred to the doctrine of overbreadth in *Rodriguez*. This is likely explained by the fact that the doctrine did not take hold until a year later, when the *Heywood* decision was rendered.

168. Interestingly, some of what Justice McLachlin said about principle of arbitrariness in *Rodriguez* foreshadowed the Court's forthcoming recognition of overbreadth. She said:

> **206** … It is argued that the denial to Sue Rodriguez of the capacity to treat her body in a way available to the physically able is justified because to permit assisted suicide will open the doors, if not the floodgates, to the killing of disabled persons who may not truly consent to death. The argument is essentially this. There may be no reason on the facts of Sue Rodriguez's case for denying to her the choice to end her life, a choice that those physically able have available to them. Nevertheless, she must be denied that choice because of the danger that other people may wrongfully abuse the power they have over the weak and ill, and may end the lives of these persons against their consent. Thus, Sue Rodriguez is asked to bear the burden of the chance that other people in other situations may act criminally to kill others or improperly sway them to suicide. She is asked to serve as a scapegoat.
>
> **207** … When one is considering whether a law breaches the principles of fundamental justice under s. 7 by reason of arbitrariness, <u>the focus is on whether a</u>

> legislative scheme infringes a particular person's protected interests in a way that cannot be justified having regard to the objective of this scheme. The principles of fundamental justice require that each person, considered individually, be treated fairly by the law. The fear that abuse may arise if an individual is permitted that which she is wrongly denied plays no part at this initial stage. In short, it does not accord with the principles of fundamental justice that Sue Rodriguez be disallowed what is available to others merely because it is possible that other people, at some other time, may suffer, not what she seeks, but an act of killing without true consent.

***Rodriguez*, paras. 206-07 (emphasis added)**

169. The foregoing passage suggests that if the principle of arbitrariness is used not only to challenge and strike down laws for their "facial invalidity" but also "as applied" - which is clearly how it was used in the *PHS* case[14] - then there may be little difference between the doctrines of arbitrariness and overbreadth in some cases. Indeed, in *Heywood* the Court said this:

> **49** Overbreadth analysis looks at the means chosen by the state in relation to its purpose. In considering whether a legislative provision is overbroad, a court must ask the question: are those means necessary to achieve the State objective? If the State, in pursuing a legitimate objective, uses means which are broader than is necessary to accomplish that objective, the principles of fundamental justice will be violated because the individual's rights will have been limited for no reason. The effect of overbreadth is that in some applications the law is arbitrary or disproportionate.

***Heywood*, para. 49 (emphasis added)**

170. While overbreadth was not addressed as a principle of fundamental justice in the *Rodriguez*, Sopinka J., for the majority, stated as follows in the context of its analysis under s. 1:

> **188** The foregoing is also the answer to the submission that the impugned legislation is overbroad. There is no halfway measure that could be relied upon with assurance to fully achieve the legislation's purpose; first, because the purpose extends to the protection of the life of the terminally ill. Part of this purpose, as I have explained above, is to discourage the terminally ill from choosing death over life. Secondly, even if the latter consideration can be stripped from the legislative purpose, we have no assurance that the exception can be made to limit the taking of life to those who are terminally ill and genuinely desire death.

***Rodriguez*, para. 188 (emphasis added)**

---

[14] *PHS Community Services Society v. Canada (Attorney General)* (2008), 293 D.L.R. (4th) 392, 2008 BCSC 661; upheld on appeal (2010), 314 D.L.R. (4th) 209, 2010 BCCA 15; appeal dismissed at SCC (2011), 336 D.L.R. (4th) 385, 2011 SCC 44

171. We will begin with the two points expressly raised by Sopinka J. in the above paragraph. We will then discuss the assisted dying regimes operating in other jurisdictions.

The Rodriguez Overbreadth Holding

i. Existing End of Life Care Policy and Practice

172. With regard to the assertion that "the purpose extends to the protection of the lives of the terminally ill," this point will be addressed at length in our argument under "Arbitrariness". However, our position in brief for overbreadth purposes is that the broader context of end-of-life care in Canada demonstrates that the state has not, in fact, chosen to make the protection of life an absolute value in this context.

173. Terminal sedation, opioids, and the withholding and withdrawal of treatment all have the potential to hasten a patient's death. All are capable of being misused or even abused. However, the absolute prohibition of these has not been adjudged necessary to protect life and the vulnerable. In such cases, the response has not been to ban the treatment by resort to the criminal law, but rather to seek improved management through best practices.

174. The use of best practices to manage risk in this context is a broadly accepted approach, including by physicians themselves.

Pereira Cross (Nov. 22), p. 64, l. 14 to p. 65, l. 25; p. 72, ll. 2-15 (Nov. 23); p. 109, l. 38 to p. 110, l. 29, Supp Record Vol. 34, Tabs 140-41

McGregor Cross, pp. 15-16, Supp Record Vol. 32, Tab 135

Ganzini Cross, p. 98 l. 28 to p. 99 l. 27, Supp Record Vol. 32, Tab 134

175. It is also a realistic balance to strike. No human endeavour, including medical acts, is without risks, but society accepts that in some circumstances and with vigorous safeguards, the reasons for doing the act outweigh the risks.

Ganzini #1, paras. 42-43, Record Vol. 2, Tab 23

Angell #1, paras. 16, 17, Record Vol. 7, Tab 54

Pereira Cross (Nov 22), p. 35, l. 28 to p. 36 l. 10 and Exhibit 36; p. 72, ll. 2-15, SuppRecord Vol. 34, Tab 140

176. While it may be the case that complete deregulation of physician-assisted dying would be insufficient to meet the state's legitimate interest in protecting the lives of patients, the complete prohibition of physician-assisted dying under force of the criminal law goes far beyond what is necessary to protect that interest.

ii. Limiting Exception to The Ill and Those Who Genuinely Desire Death

Restricting Access to Those Who are Ill

177. Any exception to the prohibition against physician-assisted dying can be effectively limited to those who are grievously and irremediably ill. Expert witnesses have deposed that the risk of misdiagnosis of grievous and irremediable illness is very low and, in any event, is no higher in the context of physician-assisted dying than in withholding or withdrawal of life-sustaining treatment or terminal sedation.

Meckling #1, para. 26, Record Vol. 3, Tab 33
Upshur #1, para. 9, Record Vol. 10, Tab 69
van Delden #1, para. 32, Record Vol. 7, Tab 60

178. The risk that the state of medical science could change to provide an effective treatment for a grievously and irremediably ill person between the time the person accessed assisted dying and the time they would have died is vanishingly small or nil and, in any event, no higher than in the context of withholding or withdrawal of treatment or terminal sedation.

Upshur #1, para. 10, Record Vol. 10, Tab 69
van Delden #1, para. 33, Record Vol. 7, Tab 60

Restricting Access to Those With Genuine Desire

179. It is important to appreciate that the decision to end one's life by accessing a lethal prescription is not as cognitively demanding as many other medical decisions for which consent is routinely given (e.g., whether to undertake a particular surgery).

Ganzini #2, para. 46, Record Vol. 26, Tab 111

180. Further, health care professionals regularly assess, and are of the opinion that it is possible to accurately ascertain, decision-making capacity (including voluntariness) for medical decision-making purposes. These professionals are capable of making these assessments in

patients, including those with serious and terminal diseases and/or neurological disorders. The kinds of decisions already being addressed in these contexts include potentially life-ending decisions such as consent to refusal of medical treatments that may hasten or result in death. The fact that the assessment of capacity for medical decision-making purposes takes time and skill is no deterrent to physicians completing this task, and there are instruments considered appropriate for use as a part of the process of making such determinations.

Klein #1, paras. 15-16, Record Vol. 1, Tab 8
Ganzini #1, paras. 10, 12, Exhibits E and G, Record Vol. 2, Tab 23
Upshur #1, para. 11, Record Vol. 10, Tab 69
Donnelly #1, paras. 10, 16-17, Record Vol. 6, Tab 52
Donnelly #2, paras. 7-8, 13, 23, 35, Record Vol. 25, Tab 105
Cohen #1, paras. 17-20, Exhibit C, Record Vol. 7, Tab 55
Kimsma #1, para. 41(c), Record Vol. 8, Tab 63
Smith #1, paras. 7, 10, 28 Exhibit C, Record Vol. 8, Tab 62
Smith #2, paras. 5, 14, Record Vol. 25, Tab 109
Starks #1, para. 34, Record Vol. 6, Tab 53

181. Some causes of cognitive impairment can be difficult to diagnose in elderly and other patients; however, *cause* of incapacity is irrelevant to *assessment* of capacity. Further, the existence of cognitive impairment is not determinative of the capacity issue. Whatever the possible cause of any loss of executive function, the question to be determined by assessment is whether there has been a loss of executive function (including decision making) and, if so, whether there is a resulting lack of capacity for purposes of medical-decision making.

Donnelly #2, paras. 17-18, 24, 34, Record Vol. 25, Tab 105
Smith #2, paras. 17-18, Record Vol. 25, Tab 109

182. There are established criteria for evaluating informed consent in relation to medical decision-making. Valid consent should include, *inter alia*, understanding a range of available options and the consequences of each option. It is the physician's role to ensure the patient is adequately informed.

Ganzini #1, para. 37, Record Vol. 2, Tab 23
Donnelly #1, paras. 12-13, Record Vol. 6, Tab 52
Donnelly #2, paras. 5, 25, Record Vol. 25, Tab 105

Smith #1, paras. 10-11, 15, 18-22, Exhibits C, D, Record Vol. 8, Tab 62
Smith #2, para. 6, Record Vol. 25, Tab 109
Downing Cross, p. 33, l. 4 to p. 34, l. 1, SuppRecord Vol. 31, Tab 130

183. There is an existing standard for assessing capacity for medical-decision making purposes. The standard is the ability to provide informed consent. The evaluation of the ability to provide informed consent is based on the patient's ability to comprehend and retain information, to weigh the information, including alternative approaches, to reach a decision, and to communicate that decision.

Donnelly #1, paras. 11 and 12, Record Vol. 6, Tab 52
Downing Cross, p. 33, ll. 4-35, SuppRecord Vol. 31, Tab 130

184. The criteria for evaluating capacity for informed consent for purposes of medical decision-making do not vary. However, the level of scrutiny applied for purposes of assessing informed consent varies with the seriousness of the consequences of the medical decision in question. The decision to access physician-assisted dying would attract the most rigorous level of scrutiny, and assessment in this context may involve gathering collateral information from family, friends or other physicians about the patient's past history of values and response to stress.

Donnelly #1, paras. 12-15, Record Vol. 6, Tab 52
Ganzini #1, para. 42, Record Vol. 2, Tab 23
Donnelly #2, paras. 4-7, 26, 28, 30, Record Vol. 25, Tab 105
Smith #1, paras. 24-26, Record Vol. 8, Tab 62
Ganzini #2, para. 44, Record Vol. 26, Tab 111

185. The standard of informed consent is currently used for other medical decisions that have potentially life ending consequences. However, if the state wanted to set, by statute, a different standard specifically for use with respect to consent for physician-assisted dying, it could do so. In the event, a specific standard for assessing capacity in the context of decision-making in relation to physician-assisted dying was established, physicians could be expected to use that standard.

Donnelly #2, para. 31, Record Vol. 25, Tab 105

Voluntariness

186. The question of whether the patient is making a voluntary decision or acting under undue influence or coercion is always relevant to the assessment of consent.

Donnelly #1, paras. 11 and 12, Record Vol. 6, Tab 52

187. An assessor must try to detect subtle coercion. If it is so subtle as to be unidentifiable, the assessor can only follow identified criteria. In medicine, at some point a concern has to be verifiable otherwise it is simply not evidence based. This is no different in the context of physician-assisted dying than in the context of an assessment relating to a patient decision to decline or direct the withdrawal of life-sustaining care.

Donnelly #2, para. 33, Record Vol. 25, Tab 105
Ganzini #2, para. 44, Record Vol. 26, Tab 111

188. It is not likely possible to physically force a person to orally ingest a lethal concoction of the type used for physician-assisted dying in Oregon, and there are no documented instances of this occurring.

Ganzini #1, para. 37, Record Vol. 2, Tab 23
Ganzini #2, para. 51, Record Vol. 26, Tab 111
Ganzini Cross, p. 100, ll. 13-20, SuppRecord Vol. 32, Tab 134

189. The amount of time, dedication and effort required to negotiate a carefully regulated physician-assisted dying regime can itself constitute an effective mechanism for vetting out patients who are less than fully and genuinely committed to accessing physician-assisted dying. If the requirements for proceeding through the system are substantial, patient inertia and indifference are likely sufficient to thwart the process.

Ganzini #1, para. 43, Record Vol. 2, Tab 23

Depression

190. The evidence indicates that it is readily possible to detect forms of major depressive disorder in the context of a capacity assessment that is carried out with heightened scrutiny, even where the patient is seriously or terminally ill.

Donnelly #2, paras. 21-22, Record Vol. 25, Tab 105

Battin #1, para. 37, Record Vol. 6, Tab 51

191. Major depressive disorder can be reliably diagnosed in 10-20% of terminally ill patients with the counterpart, 80-90% being capable of being reliably diagnosed as not having major depressive disorder.

Ganzini #1, paras. 38, 40, Record Vol. 2, Tab 23
Ganzini #2, para. 9, Record Vol. 26, Tab 111

192. Mental health professionals have a range of views on how the presence of depression should be addressed in the specific context of assessing capacity for purposes of obtaining physician-assisted dying. Some health care professionals believe that where a depressive order is diagnosed, the patient should be further assessed to determine whether the person still has decision-making capacity. Some professionals take the position that a patient who has a major depressive disorder should be disqualified from physician-assisted dying, meaning that unless their depression is treatable and is successfully treated, the patient should be considered incapable of consenting to physician-assisted dying.

Ganzini #1, paras. 40-41, Exhibit EE, Record Vol. 2, Tab 23
Starks #1, para. 36, Exhibit D, p. 53, Record Vol. 6, Tab 53
Smith #1, paras. 12-14 and 21, Record Vol. 8, Tab 62
Donnelly #1, para. 14, Record Vol. 6, Tab 52
Donnelly #2, paras. 12, 18, Record Vol. 25, Tab 105
Werth #1, para. 40(b), Record Vol. 25, Tab 110

193. Risk of incompetence due to depression is the same whether the patient is making a decision to refuse or direct the withdrawal of life-sustaining treatment, to consent to terminal sedation or to request a physician-assisted suicide.

Smith #1, para. 29, Record Vol. 8, Tab 62

194. Existential distress is not a mental disorder and may or may not be accompanied by depression.

Donnelly #2, paras. 19-20, Record Vol. 25, Tab 105

195. A request for assisted death is dissimilar from a wish for suicide. The differences include the motivations for seeking death, the relative impulsiveness of the decision, and the availability for consultation, discussion and consideration with objective and significant others. Most mental

health professionals accept that the desire for assisted death can be a “rational end-of-life decision” for a seriously or terminally ill person. Several health associations have distinguished between suicide and assisted death.

Ashby #1, Exhibit E, p. 75, Record Vol. 4, Tab 35

Battin #1, paras. 28, 38, Record Vol. 6, Tab 51

Battin #2, paras. 11-14, 20, 28-29, Exhibit B, Record Vol. 26, Tab 113

Smith #1, para. 25, Record Vol. 8, Tab 62

Kimsma #1, para. 41(b), Record Vol. 8, Tab 63

Starks #2, paras. 5-6, 9-11, Record Vol. 25, Tab 107

Werth #1, paras. 20-33, 38-39, 40(d), 41, 47-49, 59-60, Exhibits B, C, Record Vol. 25, Tab 110

Ganzini #2, para. 20, Record Vol. 26, Tab 111

196. Where a patient is being cared for by a multi-disciplinary team, the medical structure itself may enable a broader assessment of patient capacity. For example, for patients in hospice, there are many levels of review of the decisions regarding assisted dying potentially offering avenues to address any concerns regarding undue influence or voluntariness.

Ganzini #1, para. 16, Exhibit L, Record Vol. 2, Tab 23

Informed as to Alternative Treatments

197. It is, in all medical-decision making, the rule and duty of the physician to ensure the patient is adequately informed of their treatment options to make the decision in issue.

Smith #2, para. 6, Record Vol. 25, Tab 109

198. With respect to treatment options that relate to palliative care, some family physicians have sufficient palliative care expertise to advise a patient of the alternative palliative care treatments.

Chochinov Cross, p. 60, l. 24 to p. 61, l. 7, SuppRecord Vol. 35, Tab 143

199. Palliative care specialists are willing and able to share their expertise with family physicians by means of consultations. It would be possible to set up a group of palliative care specialists to act as a palliative care consultation group to assist physicians across Canada.

Chochinov Cross, p. 66, l. 25 to p. 67, l. 22, SuppRecord Vol. 35, Tab 143

200. In view of all of the above, the limitation of physician-assisted dying to patients with a "genuine" desire for hastened death in the sense of being the voluntary decision of a patient with capacity to provide informed consent for medical decision-making purposes, is one that can be adequately safeguarded.

International Experience

201. In our submission, the evidence before the Court regarding the systems set up in other jurisdictions demonstrates that it is possible to design a regulatory regime for physician-assisted dying that would provide effective and adequate safeguards to ensure that access was limited to a qualifying subset of persons.

202. The fact that other jurisdictions are successfully protecting the vulnerable in the context of permissive regimes supports the submission that an absolute prohibition is not necessary to protect the vulnerable.

203. There are now a number of jurisdictions where there is no absolute prohibition against assisted dying: Oregon State, Washington State, the Netherlands, Belgium, Luxembourg, Switzerland, Montana and Columbia.

Lewis #1, Record Vol. 8, Tab 61

Columbia
Michalowski #1, paras. 6-15, Exhibits C-G, Record Vol. 9, Tab 67[

Montana
Connell #1, paras. 6, 8-15, Exhibits C-D, Record Vol. 5, Tab 41

Netherlands
Legemaate #1, paras. 8-26, Exhibits C-G, Record Vol. 3, Tab 32

Switzerland
Bosshard #1, paras. 9-33, Exhibits C-D, Record Vol. 4, Tab 39

204. Many of these jurisdictions have legislated or judicially developed safeguards in place that cover a range of issues including: the type of assistance permitted, conditions that qualify for assistance in dying, the way in which a request may be made, the age of a patient, diagnosis, requirements for consultations and referrals, who may assist, reporting and scrutiny.

Lewis #1, Exhibit D, Record Vol. 8, Tab 61

Belgium
Deliens #1, paras. 8, 40-46 Exhibits K, L, Record Vol. 7, Tab 57

Oregon
Renaud #1, paras. 4, 8, Record Vol. 2, Tab 18

Crumpacker #1, paras. 2-13, Record Vol. 5, Tab 42

Crumpacker #2, paras. 3-9, Exhibits A-G, Record Vol. 25, Tab 101

Ganzini #1, paras. 7, 42-43, Record Vol. 2, Tab 23

Werth #1, paras. 36-37, Record Vol. 25, Tab 110

Battin #2, para. 16, Exhibit C, Record Vol. 26, Tab 113

Ganzini #2, paras. 12, 14, 26, 31, Record Vol. 26, Tab 111

Washington
Miller #1, para. 4, Record Vol. 3, Tab 26

Angell #1, para. 39, Record Vol. 7, Tab 54

Starks #1, Exhibits H and I, pp. 105-112, 121-130, Record Vol. 6, Tab 53

Netherlands
Kimsma #1, paras. 12-17, 20-21, 24-26, 30-36, Exhibit D, pp. 34-36, 40-46, 48-51, Record Vol. 8, Tab 63

van Delden #1, paras. 19-22, Record Vol. 7, Tab 60

Legemaate #1, paras. 15-19, 25-26, Record Vol. 3, Tab 32

Battin #2, para. 23, Record Vol. 26, Tab 113

Switzerland
Bosshard #1, para. 37, Record Vol. 4, Tab 39

205. Some of these jurisdictions also have procedures and systems in place to support physicians asked to participate in physician-assisted dying. This support relates to legal questions as well as emotional and ethical questions.

Renaud #1, paras. 2-3, Record Vol. 2, Tab 18

Miller #1, para. 3, Record Vol. 3, Tab 26

Kimsma #1, paras. 37-40, Exhibit D, p. 41, Record Vol. 8, Tab 63

Legemaate #1, para. 19, Record Vol. 3, Tab 32

Preston #1, para. 12, Record Vol. 25, Tab 99

206. The empirical evidence collected in these jurisdictions demonstrates that these safeguards are generally being met.

Lewis #1, Exhibit D especially pp. 142-57, Record Vol. 8, Tab 61

Ashby #1, para. 17, Record Vol. 4, Tab 35

Washington
Angell #1, paras. 37-38, Record Vol. 7, Tab 54

Starks #2, para. 20, Record Vol. 25, Tab 107

Oregon
Battin #1, para. 35, Record Vol. 6, Tab 51

Ganzini #2, para. 60, Record Vol. 26, Tab 111

Belgium
Deliens #1, para. 52, Record Vol. 7, Tab 57

Bernheim #1, para. 22, Record Vol. 4, Tab 37

Switzerland
Bosshard #1, para. 43, Exhibit C, Record Vol. 4, Tab 39

207. In at least some of these jurisdictions, assistance in dying is far more carefully regulated than other end-of-life practices such as withdrawal of treatment and terminal sedation.

Battin #1, para. 39, Record Vol. 6, Tab 51

208. The experience from these other jurisdictions demonstrates that many people who inquire about assistance in dying do not obtain assistance in dying.

Oregon
Renaud #1, para. 3, Record Vol. 2, Tab 18

Eighmey #1, para. 7, Record Vol. 5, Tab 43

Rasmussen #1, para. 41, Record Vol. 25, Tab 102

Netherlands
van Delden #1, para. 15, Record Vol. 7, Tab 60

Battin #1, para. 24, Record Vol. 6, Tab 51

Belgium
Deliens #1, para. 19, Exhibit F, Record Vol. 7, Tab 57

209. In fact, only a small number of people access assisted dying each year in these jurisdictions.

Ashby #1, para. 14, Record Vol. 4, Tab 35

Oregon
Renaud #1, para. 8, Exhibit A, p. 1, Record Vol. 2, Tab 18

Ganzini #1, para. 7, Record Vol. 2, Tab 23

Battin #1, para. 40, Record Vol. 6, Tab 51 *[also Netherlands]*

Rasmussen #1, para. 41, Record Vol. 25, Tab 102

Ganzini #2, para. 33, Record Vol. 26, Tab 111

Washington
Miller #1, Exhibit A, p. 1, Record Vol. 3, Tab 26

Starks #1, Exhibit I, pp. 114-15, Record Vol. 6, Tab 53

Starks #2, para. 12, Record Vol. 25, Tab 107

Netherlands
van Delden #1, paras. 14-15, Record Vol. 7, Tab 60

Switzerland
Bosshard #1, paras. 42, 49, Exhibit M, Record Vol. 4, Tab 39

210. Some individuals die from underlying causes before their assisted death is carried out despite having accessed a lethal prescription for a variety of reasons, including later inability to use the medication and/or the fact that they perceive the prescription as a kind of insurance policy and the facts that would trigger ingestion never arose.

Oregon
Renaud #1, para. 8, Exhibit A, p. 2, Record Vol. 2, Tab 18

Eighmey #1, para. 8, Record Vol. 5, Tab 43

Werth #1, para. 40(c), Record Vol. 25, Tab 110

Battin #2, para. 15, Record Vol. 26, Tab 113

Ganzini #2, paras. 17, 49, Record Vol. 26, Tab 111

Washington
Miller #1, para. 9, Exhibit A, p. 1, Record Vol. 3, Tab 26

Starks #2, para. 15, Record Vol. 25, Tab 107

Netherlands
Kimsma #1, Exhibit D, p. 37, Record Vol. 8, Tab 63

Belgium
Deliens #1, para. 19, Exhibit F, Record Vol. 7, Tab 57

211. There is no evidence that physician-assisted dying has resulted in “suicide contagion” among irremediably or terminally ill persons. To the contrary, the Oregon experience demonstrates that the numbers of people seeking physician-assisted dying have remained both small and relatively consistent over the span of time that Oregon statute has been in effect.

Rasmussen #1, para. 41, Record Vol. 25, Tab 102

Werth #1, paras. 47, 53-54, Record Vol. 25, Tab 110

Battin #2, paras. 21, 30, Record Vol. 26, Tab 113

212. There is no evidence that suggests that permissive regimes negatively impact suicide prevention programs or that such programs cease or lessen after legalization.

Ganzini #2, para. 62, Record Vol. 26, Tab 111

213. There is no reason to expect that vulnerable populations are at heightened risk in these jurisdictions. In fact, compared to background populations, vulnerable populations, such as the

elderly, women, the uninsured, 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 are not put at risk by such legislation. Instead, most people who seek aid in dying are enrolled in hospice, white, married, have college education or higher, and have health insurance.

Angell #1, para. 17, Record Vol. 7, Tab 54

Oregon
Renaud #1, paras. 4-6, Exhibit A, p. 2, Record Vol. 2, Tab 18

Eighmey #1, para. 5, Exhibit C, Record Vol. 5, Tab 43

Jackson #1, para. 16, Record Vol. 5, Tab 47

Battin #1, paras. 12-20, 33-34, Exhibit C, Exhibit F, Record Vol. 6, Tab 51

Ganzini #1, paras. 7, 27, 46, 48, Exhibits W, Exhibit DD, Record Vol. 2, Tab 23

Ganzini #2, paras. 7, 25, 29, 37, 58, Record Vol. 26, Tab 111

Washington
Miller #1, para. 5, Exhibit A, pp. 1, 6, 9, Record Vol. 3, Tab 26

Starks #1, Exhibit C, p. 44 (Table 1), Exhibit D, pp. 53-54, Exhibit E, p. 62, Exhibit F, p. 70, Exhibit I, pp. 115, 119, Record Vol. 6, Tab 53

Netherlands
Kimsma #1, paras. 41(a), (d), Exhibit D, p. 39, Record Vol. 8, Tab 63

van Delden #1, paras. 18, 34, Record Vol. 7, Tab 60

Belgium
Deliens #1, paras. 19-20, 25, 28, Exhibits F, G, H, Record Vol. 7, Tab 57

Ashby #1, Exhibit D, Record Vol. 4, Tab 35

Bernheim #1, paras. 8, 12, 20 Exhibits C, G, Record Vol. 4, Tab 37

214. The intent to hasten death is not a consequence of non-availability of palliative care; rather, palliative care does not always meet patient’s needs.

Owens #1, paras. 10-11, Exhibit B, pp. 4-5, Exhibit C, Record Vol. 25, Tab 106

215. People with disabilities are not more likely to be suicidal and not more likely to seek an assisted death than people without disabilities; in fact, most people who seek aid in dying do not have disabling conditions, they have cancer.

McLean #1, Exhibit B, para. 18, Record Vol. 26, Tab 115

Williamson #1, Exhibit B, para. 18, Record Vol. 26, Tab 116

Starks #1, Exhibit I, p. 116, Record Vol. 6, Tab 53

van Delden #1, para. 17, Record Vol. 7, Tab 60

Deliens #1, paras. 17, 28, Exhibits E, H, Record Vol. 7, Tab 57

Mishara Report, para. 26, Record Vol. 15, Tab 83

216. Requests for aid in dying are almost never motivated by any one single cause or determining factor. Most people who seek aid in dying in jurisdictions where a medical model of assisted dying is in place are motivated by desire to control the circumstances of their death and die at home, worries about loss of dignity and future loss of independence, quality of life and self-care ability. Worries about physical symptoms and experiences in the future are more important than same at time of request.

Angell #1, Exhibit C, pp. 41-42, Record Vol. 7, Tab 54

Ashby #1, para. 18, Exhibits E, F, Record Vol. 4, Tab 35

Boisvert #2, para. 10, Record Vol. 25, Tab 103

Washington
Miller #1, pp. 1, 7, Record Vol. 3, Tab 26

Starks #1, Exhibit E, p. 65, Exhibit F, p. 70, Exhibit I, p. 118, Record Vol. 6, Tab 53

Starks #2, para. 14, Record Vol. 25, Tab 107

Oregon
Renaud #1, paras. 4-6, Exhibit A, p. 2, Record Vol. 2, Tab 18

Eighmey #1, Exhibit C, Record Vol. 5, Tab 43

Ganzini #1, paras. 16, 19, 28, 30, 45, Exhibits K, L, O, X, Z, Record Vol. 2, Tab 23

Battin #1, para. 36, Record Vol. 6, Tab 51

Werth #1, Record Vol. 25, paras. 56-58, Tab 110

Battin #2, para. 19, Record Vol. 26, Tab 113

Netherlands
van Delden #1, para. 16, Record Vol. 7, Tab 60

Belgium
Deliens #1, para. 19, Exhibit F, Record Vol. 7, Tab 57

217. The least important motivators in jurisdictions where a medical model of assisted dying is in place include depression (most people who make such requests are not depressed), pain, lack of social support and fear of being a financial drain on family. The fact that most people accessing assisted death are not depressed is one reason why psychiatric referrals have dropped off in Oregon. And while the current practice under the Oregon statute may fail to protect some patients who do have major depressive disorder and whose choices are potentially influenced by

depression from receiving a lethal prescription, these people might be screened out following mental health evaluations.

Starks #2, para. 9, Record Vol. 25, Tab 107

Oregon
Battin #1, paras. 34, 36, Record Vol. 6, Tab 51

Ganzini #1, paras. 16, 29-30, 39, 45, Exhibits K, X, Y, Z, Record Vol. 2, Tab 23

Ganzini #2, paras. 7, 9, 13, 18, 22, 37-38, 40, 42, 47, 56-57, Record Vol. 26, Tab 111

Ganzini Cross, p. 98, l. 30 to p. 99, l. 27, SuppRecord Vol. 32, Tab 134

Switzerland
Bosshard #1, para. 48, Exhibit L, Record Vol. 4, Tab 39

218. The families of people who seek aid in dying are also protected in these regimes.

219. First, many people's loved ones support, in a non-coercive way, their choice to have an assisted death at the time of their choosing.

Ganzini #1, paras. 19, 26, Exhibits O, V, Record Vol. 2, Tab 23

Battin #2, para. 10, Exhibit A, Record Vol. 26, Tab 113

See also:
Taylor #1, Record Vol. 1, Tab 4; Amended Notice of Civil Claim, filed 15 Aug 2011, para. 51, Record Vol. 26, Tab 118

Taylor #2, paras. 30, 32, Record Vol. 3, Tab 34

Crowley #1, paras. 5-12, Record Vol. 1, Tab 5

Pellizzari #1, Record Vol. 1, Tab 7

Shapray #1, paras. 19-20, Record Vol. 1, Tab 10

Nicklinson #1, Exhibit C, pp. 18, 20-21, Exhibit E, para. 10, Record Vol. 2, Tab 15

LaForest #1, para. 36, Record Vol. 1, Tab 14

Carter #1, para. 22, Exhibit D, Record Vol. 2, Tab 21

Cordover #1, paras. 12, 59, Record Vol. 3, Tab 24

Johnson #1, paras. 19-21, Record Vol. 3, Tab 25

220. While mandatory family notification and involvement is problematic in a legal regime where there is no legal prohibition against assisted death, nevertheless, most people do notify a family member. The impact of potential choices on others frequently informs the exercise of personal autonomy.

Werth #1, paras. 55(b), (c), Record Vol. 25, Tab 110

Battin #2, paras. 5-8, Record Vol. 26, Tab 113

221. Family opposition is a strong predictor of a patient not receiving physician-assisted dying.

Ganzini #1, para. 16, Exhibit K, Record Vol. 2, Tab 23

222. Most nurses do not rate family caregivers of people seeking aid in dying as more burdened than family caregivers of other hospice patients. In fact, nurses reported that families found more positive meaning in caring for these people.

Ganzini #1, para. 16, Record Vol. 2, Tab 23

223. Many families have very positive experiences with participating in their loved one's death in a supported environment. Pursuit of aid in dying does not have negative effects on surviving family members and may be associated with benefits such as: higher quality ratings on symptom control, greater preparation and acceptance of death, a feeling that their loved ones choices were honored and less likely regrets about how their loved one died. Participation in assisted dying tends to foster and affirm both familial and societal relationships.

Ganzini #1, paras. 31-32, Exhibits AA, BB, Record Vol. 2, Tab 23

Werth #1, para. 55(c), Record Vol. 25, Tab 110

Battin #2, para. 16, Exhibit C, Record Vol. 26, Tab 113

224. In addition to fostering familial and societal relationships, the ability to request physician assistance in death does not and/or would not have a negative impact on the physician-patient relationship.

Smith #2, para. 7, Record Vol. 25, Tab 109

Oregon
Rasmussen #1, paras. 41, Record Vol. 25, Tab 102

Netherlands
Kimsma #1, paras. 27(c)-(d), Record Vol. 8, Tab 63

van Delden #1, paras. 27-29, Record Vol. 7, Tab 60

Belgium
Bernheim #1, para. 19, Exhibit G, Record Vol. 4, Tab 37

225. Permissive regimes do not negatively impact palliative care. Assisted dying and palliative care are not mutually exclusive, rather they are complimentary. Jurisdictions with access to assisted dying also have palliative care and following the removal of the absolute ban on assisted dying, there has been improvement in end-of-life care including increased and

intensified pain and symptom alleviation, increased patient involvement in decision making, increased consultation among health care colleagues, improved palliative care and increased referrals to hospice and palliative care. Inquiring about assisted-death does not put an end to exploring ways to improve a patient's condition

Boisvert #2, para. 11, Record Vol. 25, Tab 103

Angell #1, para. 14, Record Vol. 7, Tab 54

Oregon
Ganzini #1, paras. 15, 18, Exhibits J, N, Record Vol. 2, Tab 23

Battin #1, paras. 30-32, Record Vol. 6, Tab 51

Eighmey #1, paras. 6-7, Record Vol. 5, Tab 43

Jackson #1, para. 19, Record Vol. 5, Tab 47

Starks #2, para. 24, Record Vol. 25, Tab 107

Ganzini #2, paras. 48, 61, Record Vol. 26, Tab 111

Washington
Miller #1, para. 6, Record Vol. 3, Tab 26

Starks #2, paras. 16, 19, Record Vol. 25, Tab 107

Netherlands
Kimsma #1, para. 29, Record Vol. 8, Tab 63

van Delden #1, paras. 30-31, Record Vol. 7, Tab 60

Owens #1, paras. 5, 20, Record Vol. 25, Tab 106

Battin #2, paras. 23, 26, Record Vol. 26, Tab 113

Belgium
Deliens #1, paras. 38-39, 52, Exhibit J, Record Vol. 7, Tab 57

Bernheim #1, paras. 12-14, 16, 18, 21-22, Exhibits C, D, G, Record Vol. 4, Tab 37

Bereza #1, para. 27, Record Vol. 10, Tab 73

226. Liberalization of the laws does not lead to routinization of the practice of assisted dying. In fact, health care professionals struggle with requests for assistance in dying and these requests are very emotional and not easy. Physicians can and do refuse some such requests. Regardless of whether they prescribe or not, physicians do not express major regrets about these decisions.

Oregon and Washington
Ganzini #1, paras. 21, 25, Exhibits Q, U, Record Vol. 2, Tab 23

Starks #2, paras. 25-26, Record Vol. 25, Tab 107

Netherlands
Kimsma #1, paras. 27(b)-(d), 41(a), Exhibit D, pp. 37-38, Record Vol. 8, Tab 63

227. The incidence of end-of-life decisions in medical practice does not increase during and after legalization. Incidence of alleviation of pain and symptom without life-shortening intentions increases during legalization. Non-treatment decisions remained stable. The incidence of euthanasia, life-terminating acts without explicit request of the patient ("LAWER") and administration of pain medication with life shortening co-intention, decreases during legalization.

Deliens #1, para. 15, Exhibit D, Record Vol. 7, Tab 57

Ashby #1, para. 17, Exhibit D, Record Vol. 4, Tab 35

Battin #1, paras. 23, 41, Record Vol. 6, Tab 51

228. There is a tendency to discuss all end-of-life decisions, except non-treatment, more frequently with patients, their relatives and nurses in a legalized environment.

Belgium
Deliens #1, para. 15, Exhibit D, Record Vol. 7, Tab 57

229. After legalization, the percentage of deaths in which life-ending drugs are used remains relatively stable.

Oregon
Werth #1, para. 52, Record Vol. 25, Tab 110

Battin #2, para. 22, Record Vol. 26, Tab 113

Ganzini #2, para. 33, Record Vol. 26, Tab 111

Ganzini Cross, p. 68, l. 11 to p. 72, l. 47; p. 97, ll. 2-29, SuppRecord Vol. 32, Tab 134

Belgium
Deliens #1, para. 22, Exhibit G, Record Vol. 7, Tab 57

Ashby #1, Exhibit D, Record Vol. 4, Tab 35

Bernheim #1, paras. 14, 16, Record Vol. 4, Tab 37

230. The care with which physician-assisted dying is carried out improves after legalization.

Bernheim #1, paras. 14, 20, Exhibit G, Record Vol. 4, Tab 37

231. There are incidences of LAWER. However, in many of these cases only opioids are administered (the life shortening effect of opioids is a subject of speculation) and others can be described as terminal sedation. In many cases, the patient was comatose or had dementia. The decision was discussed with colleagues, nursing staff or relatives in many cases. In many of these cases, the patient was suffering to a high degree and/or had previously expressed a desire

for hastened death if suffering became unbearable. In most cases, life was shortened by a short period of time. The occurrence of these cases decreases over time of legalization.

Netherlands
van Delden #1, paras. 23, 25, Record Vol. 7, Tab 60

Belgium
Deliens #1, paras. 23-24, 26, 31-36, Exhibits G, I, Record Vol. 7, Tab 57

Ashby #1, Exhibit D, Record Vol. 4, Tab 35

Bernheim #1, paras. 14, 16, 20, Exhibit G, Record Vol. 4, Tab 37

Keown Cross, p. 51, ll. 1-13, SuppRecord Vol. 33, Tab 139

232. In any event, it cannot be said that legalization of physician assisted dying causes LAWER – a point fairly conceded by Professor Keown. The most he could say was that legalization did not reduce the incidence of LAWER.

Keown Cross, p. 58, ll. 3-16, see also pp. 58-62, SuppRecord Vol. 33, Tab 139

233. However, even that opinion is flawed since in the Netherlands the rate of LAWER is decreasing with time and in Belgium the rate of LAWER has been demonstrated to be lower after legalization than before.

van Delden #1, paras. 23-26, Record Vol. 7, Tab 60

Keown Cross, p. 51, ll. 4-13; p. 60, l. 33 to p. 61, l. 23; Exhibits 26-29, SuppRecord Vol. 33, Tab 139

Deliens #1, Exhibits C-D, G, Record Vol. 7, Tab 57

Pereira Cross (Nov. 23), p. 53, l. 17 to p. 62, l. 33; Exhibits 44-45, SuppRecord Vol. 34, Tab 141

234. The best available evidence suggests that the percentage of LAWER in jurisdictions where physician-assisted death is absolutely prohibited, is similar if not higher to the percentage of such deaths in jurisdictions where there is no absolute prohibition.

Owens #1, paras. 5, 9-18, Exhibit C, Record Vol. 25, Tab 106

Keown Cross, Exhibits 26-29, SuppRecord Vol. 33, Tab 139

235. Legalizing one form of assisted dying hence does not lead to the slippery slope in terms of increasing expansion of euthanasia from last resort to non-voluntary or involuntary cases as the government witnesses such as Dr. Pereira and Dr. Hendin deposed.

Angell #1, para. 16, Record Vol. 7, Tab 54

Netherlands
van Delden #1, para. 35, Record Vol. 7, Tab 60

Battin #1, paras. 24-25, Record Vol. 6, Tab 51

Belgium
Deliens #1, paras. 17, 22, Exhibits E, G, Record Vol. 7, Tab 57

Ashby #1, Exhibit D, Record Vol. 4, Tab 35

Bernheim #1, paras. 8, 20, 22, Exhibit G, Record Vol. 4, Tab 37

Battin #2, paras. 40-42, Record Vol. 26, Tab 113

Oregon
Ganzini #2, para. 32, Record Vol. 26, Tab 111

236. Finally, there is no evidence of a single case of diversion and lethal medications have little value on the street market.

Ganzini #2, para. 52, Record Vol. 26, Tab 111

237. In light of all of the above, it simply cannot be maintained that the vulnerable cannot be protected under a regulated, permissive regime. The Impugned Provisions are thus overbroad.

238. The overbreadth principle is akin to the minimal impairment branch of the *Oakes* analysis. As the majority of the Supreme Court cautioned in *Hutterian*, and adapting those comments to s. 7, claimants need not prove the alternative to the blanket prohibition would *exactly* achieve the government's objective so long as it would achieve it in *a real and substantial manner*. This test incorporates the necessary deference to Parliament.

GROSS DISPROPORTIONALITY

239. A gross disproportionality analysis proceeds by first determining whether the impugned law pursues a legitimate state interest, and then by considering the gravity of the alleged *Charter* infringement in relation to the state interest pursued.

***Malmo-Levine*, para. 169**

240. In *Malmo-Levine* the majority held:

> **169** … In other words, if the use of the criminal law were shown by the appellants to be grossly disproportionate in its effects on accused persons, when considered in light of the objective of protecting them from the harm caused by marihuana use, the prohibition would be contrary to fundamental justice and s. 7 of the *Charter*.

***Malmo-Levine*, para. 169**

241. The majority rejected that there was any role for balancing societal and individual interests within s. 7 when it held:

> (c) The Balance of Salutary and Deleterious Effects
>
> **179** Finally, the appellants say that the prohibition is disproportionate to the state's interest because its negative consequences are grossly disproportionate to its positive features, if any.
>
> **180** In this connection, Braidwood J.A. reproduced a summary of the evidence of harm to society resulting from the prohibition itself…
>
> **181** In effect, the exercise undertaken by Braidwood J.A. was to balance the law's salutary and deleterious effects. In our view, with respect, that is a function that is more properly reserved for s. 1. These are the types of social and economic harms that generally have no place in s. 7.
>
> **182** The appellants were correct to criticize the government's attempted wholesale importation of "societal interests" from s. 1 to s. 7 to try to support the constitutional validity of the prohibition. In our view, the appellants should equally be stopped from importing the "salutary/deleterious" effects balance from s. 1 in order to try to justify the opposite conclusion.

***Malmo-Levine*, paras. 179-82**

242. More recently, in *PHS*, the Supreme Court of Canada reasoned:

> **133** The application of the possession prohibition to Insite is also grossly disproportionate in its effects. Gross disproportionality describes state actions or legislative responses to a problem that are so extreme as to be disproportionate to any legitimate government interest: *Malmo-Levine*, at para. 143. Insite saves lives. Its benefits have been proven. There has been no discernable negative impact on the public safety and health objectives of Canada during its eight years of operation. The effect of denying the services of Insite to the population it serves is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics.

***PHS_SCC*, para. 133**

243. Although the Court did not explicitly overrule its decision in *Malmo-Levine* that it is not for the government (or the citizen) to balance the salutary effects of the law as against its deleterious effects at this stage of the s. 7 analysis, the Court's reference to the "benefits" that Canada might derive from the impugned law would seem to be a clear departure from the approach in *Malmo-Levine*. This may be explainable because the Court was in the unusual position of having the benefit of the studies from Insite as a "pilot project". Seeing that Insite

"works", the Court was able find gross disproportionality between the effect the law would have on the addicts, if it was upheld, and the government interest of "presenting a uniform stance on the possession of narcotics."

244. It is possible that in so doing, the Court implicitly overruled *Malmo-Levine*. Or it is possible that it merely carved out an exception to the general rule that no balancing should occur within s. 7 for those rare circumstances where the Court is able to conclude credible studies have addressed and documented the benefits and the harms in question and thus removed the analysis from the realm of generalized policy trade-offs. In either case, the outcome is the same, and that is that this Court can balance the known benefits of a liberalized regime against the known harms of an absolute prohibition.

245. The Court has the benefit of evidence of years of meticulous study and research as to the working and operation of regimes that allow various forms of physician-assisted dying, including studies that documented the baseline conduct that pre-existed legislation such that comparisons could be made to post-legislation data (e.g., Belgium).

246. Like *PHS,* these regimes – these experiments if you will in physician assisted dying – are "working". To not allow a similar regime to exist in Canada will cause untold and *certain* suffering to those Canadians who need the option of physician assistance in dying, an outcome which is grossly disproportionate to any *speculative* benefit that Canada might derive from presenting a uniform stance on preventing physician assisted dying no matter the circumstances and no matter the terms, conditions and safeguards which can be put in place.

247. What is clear, notwithstanding what might be seen to be a different approach in *PHS,* is that it is not open to the government at this stage of the analysis to incorporate, as Sopinka J. did in *Rodriguez,* "societal interests" as an answer to the gross disproportionality of the law. If that has any place, it is in s. 1 and for reasons that we will explain in reply, it will fail there as well.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.

Dated: 01 Dec 2011

Joseph J. Arvay, Q.C., Sheila M. Tucker,
Alison M. Latimer and Grace Pastine

List of Authorities

Tab	**Description**
	Cases
1	*A.C. v. Manitoba (Director of Child and Family Services)*, [2009] 2 S.C.R. 181, 2009 SCC 30
2	*Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 S.C.R. 567, 2009 SCC 37
3	*Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657, 2004 SCC 78
4	*Bedford v. Canada (Attorney General*) (2010), 327 D.L.R. (4th) 52, 2010 ONSC 4264
5	*Benner v. Canada (Secretary of State)*, [1997] 1 S.C.R. 358
6	*Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624
7	*Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703, 2000 SCC 28
8	*Hodge v. Canada (Minister of Human Resources Development)*, [2004] 3 S.C.R. 357, 2004 SCC 65
9	*Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497
10	*McIvor v. Canada (Registrar, Indian and Northern Affairs)* (2009), 306 D.L.R. (4th) 193, 2009 BCCA 153
11	*Ontario v. Canadian Pacific Ltd.*, [1995] 2 S.C.R. 1031
12	*Ontario (Attorney General) v. Fraser*, [2011] 2 S.C.R. 3, 2011 SCC 20
13	*PHS Community Services Society v. Canada (Attorney General)* (2008), 293 D.L.R. (4th) 392, 2008 BCSC 661; upheld on appeal (2010), 314 D.L.R. (4th) 209, 2010 BCCA 15; appeal at SCC dismissed (2011), 336 D.L.R. (4th) 385, 2011 SCC 44
14	*R. v. Bain*, [1992] 1 S.C.R. 91
15	*R. v. Heywood*, [1994] 3 S.C.R. 761
16	*R. v. Kapp*, [2008] 2 S.C.R. 483, 2008 SCC 41
17	*R. v. Malmo-Levine; R. v. Caine*, [2003] 3 S.C.R. 571, 2003 SCC 74
18	*R. v. Morgentaler*, [1988] 1 S.C.R. 30

Tab	**Description**
19	*Reference re: Criminal Code of Canada*, 2011 BCSC 1588
20	*Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man.),* [1990] 1 S.C.R. 1123
21	*Rodriguez v. British Columbia (Attorney General)* (1993), 76 B.C.L.R. (2d) 145 (B.C.C.A.)
22	*Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519
23	*Siemens v. Manitoba (Attorney General)*, [2003] 1 S.C.R. 6, 2003 SCC 3
24	*Withler v. Canada (Attorney General)*, [2011] 1 S.C.R. 396, 2011 SCC 12
	Statutes
25	*Canadian Charter of Rights and Freedoms*, ss. 1, 7, 15, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11