This is the 2nd affidavit
of Sharon Cohen in this case
and it was made on 30 Aug 2011

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

INTERVENOR

AFFIDAVIT

I, **SHARON COHEN**, neurologist, of 1 Valleybrook Drive, Suite 400, in the City of Toronto, in the Province of Ontario, SWEAR (OR AFFIRM) THAT:

1. I have personal knowledge of the facts and matters hereinafter deposed to, save and except where same are stated to be made on information and belief, and where so stated, I verily believe them to be true.

2. Attached hereto and marked as **Exhibit A** to this my affidavit is a true copy of my current *curriculum vitae*.

3. I graduated from the University of Toronto with a DSP degree (with honours) from the Graduate Program in Speech Pathology at the University of Toronto in 1979. I received an MD

degree (with honours) from the University of Toronto, Faculty of Medicine in 1986. I completed the Neurology Residency Program at the University of Toronto, Faculty of Medicine in 1990. I completed a Behavioural Neurology Fellowship at the Rotman Research Institute & Baycrest Centre for Geriatric Care, at the University of Toronto in 1992.

4. I am currently an assistant professor in the University of Toronto, Division of Neurology with a cross appointment in the Graduate Department of Speech Language Pathology. I am a behavioural neurologist by subspecialty fellowship training. My practice focus is disorders of cognition, mood and behaviour. I am the Medical Director of Toronto Memory Program, an out-patient medical facility for dementia care and research. I hold consultant status at the North York General Hospital Department of Medicine and act as team neurologist for the North York General Hospital Genetics Department's Huntington's disease multidisciplinary clinic.

5. I have been asked by the law firm of Arvay Finlay to provide an opinion related to my area of expertise as a neurologist and my experience with patients with neurological disorders on the issue of physician-assisted dying as medical treatment for competent patients who are grievously and irremediably ill and who wish to die in order to alleviate their suffering. I make this affidavit in response to those questions as set out in their letter to me dated August 28, 2011 and which is attached and marked as **Exhibit B** to this my affidavit.

Neurological Conditions

6. There are many grievous and irremediable neurological conditions that, in my opinion, have the potential to cause significant and enduring physical, psychological and/or psychosocial suffering to an affected individual prior to death.

7. There are several hundred known neurological diseases. While there may be various types of treatment available for some of these diseases, few are curable and many cause prolonged disability. Of those neurological diseases that are grievous and irremediable, many are fatal. Some of these diseases are caused by faulty genes, whereas others are the result of degenerative diseases, vascular processes, toxic, metabolic or infectious conditions, traumatic injury and other insults to the brain, spinal cord, nerves and muscles.

8. Grievous and irremediable neurological diseases manifest in symptoms that cause enduring physical, psychological and/or psychosocial suffering prior to death. The major categories of symptoms that are encountered in grievous and irremediable neurological diseases are the following:

a. *Disturbances of motor control* – Patients may experience muscle weakness or paralysis, uncoordinated movement, involuntary movements such as tremors, and difficulty initiating movement. Disturbances of motor control may affect any muscle in the body and may cause patients to lose basic mobility and function such as rolling over in bed, sitting, walking, swallowing, breathing, turning the head or moving the eyes. Motor disturbance alone may reduce individuals to a bedridden state wherein they have no autonomy over their physical state.

b. *Impairment of cognitive abilities* – Patients may lose the ability to concentrate and attend to information; to reason; to remember facts, events, and routines; to recognize objects, people or faces; or to interpret information. They may lose the ability to make sense of the world around them, to recognize who they are, and to distinguish reality from imagination. These cognitive losses render individuals incapable of surviving without full time care and supervision.

c. *Communication impairment* Patients may lose the ability to generate meaningful verbal or written language communication and to understand spoken and written language. The loss of communication abilities leads to loss of intellectual and social development, social isolation, and loss of autonomy.

d. *Behavioural impairment* Patients may experience changes in mood and behaviour, including: depression, mania, anxiety, fear, panic, delusions, hallucinations, paranoia, apathy, poor impulse control, agitation and uncontrolled anger.

e. *Loss of sensation* Patients may experience loss of sensation rendering them unable to perceive or reflexly respond to touch, pain, temperature and joint

position sense. This in turn leads to impaired fine tuning of movements and to injuries (e.g. burns) due to misjudgment of the environment.

f. *Loss of special senses* – Blindness and deafness are the most disabling of the losses of special senses. These conditions deprive the individual of his or her major sources of information about the world around him or her including the social aspects of their world.

g. *Loss of bowel and bladder control* – Patients may lose the ability to sense when they need to pass urine or move their bowels, they may lose the ability to control the place and timing of the emptying of their bladder or passing of stool. As a result, they may experience repeated secondary infections, pain and social isolation.

h. *Loss of sexual functioning* – Patients may lose sexual functioning.

i. *Compromised consciousness* Patients may experience decreased levels of alertness, episodes of reduced or altered consciousness and disturbances of sleep. Secondary problems include traumatic injury from falls and exhaustion from sleep disorders.

9. While any one of the above categories of neurological symptoms can cause enduring disability, many neurological diseases result in more than one of the above symptom categories leading to disability upon disability.

10. Amyotrophic lateral sclerosis (ALS) is a grievous and irremediable progressive neurological disease that causes muscle weakness and eventually progresses to near total paralysis. Although cognition and sensation are generally intact, patients become increasingly incapacitated; they lose the ability to use their hands and feet; the ability to walk, to chew and swallow; the ability to make their speech intelligible to others; and, ultimately, the ability to breathe. In most cases, weakness progresses rapidly, carrying a fully autonomous adult through a journey of initially isolated weakness to near total paralysis and death within approximately three years. At the end stages of the disease, patients may remain fully awake and alert, with normal insight, emotions and sensation, but locked-in, unable to move, unable to chew and

swallow and thereby maintain their nutrition, and unable to clear secretions from the respiratory tract and to breathe effectively. Death generally results from respiratory failure or secondary infection such as pneumonia.

11. Huntington's disease is another grievous and irremediable progressive neurological disease. Unlike ALS, motor disturbance is generally combined with behavioural and cognitive disturbance. Suffering on the part of the patient and family results from each of these symptom types and endures for a longer time period, on average 15 years. Involuntary movement develops insidiously and become increasingly prominent. These movements interfere with normal movement and cause impairment of fine and gross motor control, poor balance, falls, unintelligible speech, difficulty swallowing and difficulty moving the eyes. In addition to motor symptoms, patients with Huntington's disease often develop cognitive impairment which may progress to frank dementia and become manifest by impaired attention, memory, insight and judgment among other cognitive domains affected. Behavioural (psychiatric) symptoms may be prominent as well, ranging from depression to antisocial behaviour. It is not unusual for patients with Huntington's disease to be misjudged as drunk on account of their unsteady gait and to become involved with police and the criminal justice system on account of offenses arising from their poor insight, judgment and altered behaviour.

12. ALS and Huntington's disease are but two of the many grievous and irremediable neurological diseases which are capable of causing a patient enduring physical, psychological and/or psychosocial pain prior to death. Patients with grievous and irremediable neurological diseases frequently experience a loss of autonomy, a loss of dignity, a loss of privacy and social isolation and stigmatization. Depending on the disease in question, the duration of physical, psychological and/or psychosocial pain prior to death may be a period of months, it may be a period of years.

13. Impairment in physical functioning can severely limit the individual's capacity for daily living activities which, in health, are generally taken for granted. Personal mobility and the capacity to be a productive member of the family or the community diminishes as does the capacity to work. Activities such as getting dressed or lifting a spoonful of food to the mouth can become impossible. Patients experience profound distress, anxiety, and despair as they

witness their disease engulf them; they understand correctly that there is nothing that can be done to reverse or slow down their demise. With the loss of autonomy comes a loss of dignity. Patients become vulnerable; they are at the mercy of others to do everything for them. Patients lose privacy as even their most intimate bodily functions must be managed and attended to by others. Patients experience distress as they lose control over their ability to make choices, plan ahead and order their lives. For example, if a home care aide works only between certain hours, the patient must eat at a certain time regardless of whether or not he is hungry. Many neurological diseases also result in social stigma and isolation. Individuals with abnormal movements, irregular gait, slurred speech or other irregularities in their appearance have trouble fitting in due to embarrassment and the perception that others view them as unintelligent and undesirable to be with. Behavioural and cognitive problems may further affect an individual's ability to form and maintain relationships.

Physician-Assisted Dying

14. In my opinion, physician-assisted dying as it is described in the Amended Notice of Civil Claim is a form of medical treatment. It may be an appropriate form of medical treatment for patients with grievous and irremediable neurological conditions that cause significant suffering that cannot be alleviated. Physician-assisted dying is appropriate if there are safeguards in place to ensure that this treatment option is only available to mentally competent adults who are capable of making health care decisions about end of life care.

15. I believe that physician-assisted dying should be a treatment option available to competent patients who have a grievous diagnosed medical condition that is irremediable and which causes the patient suffering. The professional commitment of physicians is to sustain life and relieve suffering. Allowing unremitted suffering contravenes a physician's professional ethical obligations. If a physician cannot adequately treat or cure or otherwise remedy an illness, the physician has an ethical obligation to alleviate the suffering it is causing. For some patients who are grievously and irremediably ill, existence becomes a misery – an unbearable state wherein it is no longer possible to derive any pleasure from living. In this situation, physician-assisted dying is compatible with the physician's duty to relieve suffering and is a compassionate response to that suffering.

16. Patients with degenerative neurological conditions, such as Parkinson's disease, or ALS, often die from secondary complications such as pneumonia, infected bed sores, choking, suffocation or trauma. Some patients fall and break their bones until they are eventually bedridden. Each new injury or infection carves off a piece of the individual's health and well-being in a relentless downward trajectory.

17. I have witnessed a number of patients with grievous and irremediable neurological diseases who have already experienced prolonged suffering, die slow and terrible deaths. I have witnessed patients with grievous and irremediable neurological conditions at the end of life gasping for breath as they slowly drowned in their own secretions or choked on their own saliva. These patients appeared extremely uncomfortable, agitated and restless. Some patients explicitly told me that they were experiencing discomfort and pain. I have seen patients turn blue because they cannot get enough air. Some appeared terrified. For some of these patients, this slow and painful march to death lasted days. Some patients experienced multiple episodes of choking and a feeling of suffocation over a period of weeks. These deaths were extremely traumatic for both the patient and their family. Sometimes patients are provided sedation to the point of semi-consciousness so they are made more comfortable as they struggle for breath. Nonetheless, they may linger in a state of dying for hours to days with families standing by in distressed states that may take years to recover from. In my opinion, physician-assisted dying should have been an available treatment option in these situations. With all my training as a physician, I cannot accept that it is right to allow patients to die in this immeasurably cruel and useless fashion if to do so is against the patients' wishes.

18. Nor do I think it is right to allow grievously and irremediably ill patients to suffer against their wishes if they are far from death but their suffering is protracted over time and life is no longer bearable to them as may be the case for bedridden individuals or those facing major loss of autonomy.

19. It is my opinion that physicians must respect patients' autonomy, including patients' decisions about the timing and manner of death. Competent adults with grievous and irremediable neurological diseases should be allowed to determine for themselves the line between acceptable and unacceptable levels of suffering. It is not for me to say when a patient's

suffering has become unbearable and life has lost all meaning; this is a deeply personal and private choice. Many patients find satisfaction and pleasure in their lives even though it is not the more ideal life they expected or hoped for themselves. Many patients carry on through great adversity and suffering, and find meaning even in a protracted disease and death. However, many patients reach a threshold with their disease beyond which life is no longer gratifying for them. Many of these patients have told me that they look forward to their deaths.

20. In my opinion, the *Criminal Code*'s blanket prohibition against physician-assisted suicide interferes with the patient-physician relationship by depriving patients of an important treatment option. It deprives physicians of the ability to alleviate suffering by providing what may be an appropriate medical treatment in certain circumstances. It creates a climate of secrecy and fear that interferes with the physician/patient relationship by hindering open dialogue. If patients are fearful to speak to me about their end of life options, I lose the opportunity to offer reassurance, comfort and support. I lose the opportunity to provide information, relieve misconceptions and show compassion.

21. One of my patients confessed to me that he had been thinking about taking his life because he did not want to experience the end stages of his disease. He told me he had been thinking about how and when to kill himself for years. He told me he did not discuss the issue with me because he was fearful he might lose my support as his physician. For years he did not discuss the issue with anyone. Once we started to discuss the issue, he told me what scared him most about his disease and the inevitable changes he was not willing to accept. I was able to speak frankly with him about the likely trajectory of his disease and when he might start to experience the symptoms he was seeking to avoid.

22. It has been my experience as a physician that patients are often extremely relieved to have a physician listen to their problems. Patients who are suffering from grievous and irremediable neurological disease often express stress, trauma and despair. Simply listening without judgment or reproach can be therapeutically beneficial for the patient. Indeed, since many neurological diseases have no cure or treatment, listening is sometimes the only relief a physician is able to offer. The blanket prohibition against physician-assisted dying discourages patients who are contemplating a hastened death from talking to their physicians, further

isolating these patients. After all, if patients cannot speak openly and honestly to their doctors about end of life issues, then who will they speak to? The burden of secrecy is yet another burden that the already suffering patient is forced to bear.

23. As a physician, I do not believe there is any ethical distinction between withdrawing, at a patient's direction, life-sustaining treatment with the knowledge that death will result and acting, at a patient's informed request, to bring about death in order to alleviate suffering. Either way, the patient is making an independent choice to die. Competent patients have the legal right to refuse treatment that will prolong their deaths. For patients who are suffering but who are not dependent on life support, such as respirators or dialysis, refusing treatment will not hasten death quickly. To treat these patients equitably and compassionately we should offer physician-assisted dying as it is their only option to hasten death.

24. I certify that I am aware of my duty as an expert witness to assist the court, and not to be an advocate for any party. I have given this affidavit in conformity with that duty. If I am called on to give further testimony, it will be in conformity with that duty.

SWORN (OR AFFIRMED) BEFORE ME)
at Toronto, Ontario, on 30 Aug 2011)
)
)
A Notary in and for the Province of Ontario)

SHARON COHEN

Jeffrey Michael Goldberg, a Commissioner, etc.,
City of Toronto, for
G & G Partnership, LLP, Chartered Accountants.
Expires August 7, 2013.

Jeffrey Michael Goldberg, a Commissioner, etc.,
City of Toronto, for
G & G Partnership, LLP, Chartered Accountants.
Expires August 7, 2013.

Toronto Memory Program

Curriculum Vitae 2011

SHARON COHEN, MD FRCPC
Behavioural Neurologist and Medical Director
cohen@memorydisorders.ca

Medical Licensure:
Ontario License CPSO 58734
Canadian Specialist License RCPSC 420751
CMPA Membership 893293

EDUCATION

1990-1992 Behavioural Neurology Fellowship, Rotman Research Institute & Bayerest Centre for Geriatric Care, University of Toronto (Fellowship certificate 1992)
1987-1990 Neurology Residency Program, Faculty of Medicine, U. Toronto (FRCPC 1992)
1982-1986 M.D. Program, Faculty of Medicine, U. Toronto (Honours MD 1986)
1977-1979 Graduate Program in Speech Pathology, U. Toronto (Honours DSP 1979)
1974-1977 Bachelor of Arts, University of Toronto (Honours BA 1977)

CURRENT POSITIONS

Primary:
2004-present Medical Director, Toronto Memory Program, Canada
1996-present Principal Investigator, Clinical Trials, Toronto Memory Program, Canada
1993-present Assistant Professor, Dept of Medicine (Neurology), University of Toronto
1980-present Assistant Professor, Graduate Dept Speech Pathology, University of Toronto
Ancillary:
2010-present Site supervisor, Care of the Elderly Fellowship Trainees, University of Toronto
2009-present Ontario Telehealth Dementia Care Provider to Underserviced Ontario
1999-present Consultant Neurologist, Huntington Disease Clinic, North York General Hospital
1992-present Consultant Neurologist, North York General Hospital, Toronto

PAST POSITIONS

2007-2009 Principal Investigator, Phase I trial activity, Kendle (DecisionLine), Toronto
2003-2006 Consultant Neurologist, Kawartha Regional Memory Clinic, Peterborough, Ontario
2003-2005 Mentor, Ontario Alzheimer's Strategy, Ontario College Family Physicians, Toronto
1997-2003 Behavioural Neurologist, North York Gen Hospital Srs' Health Centre, Toronto
1992-2003 Active Staff Neurologist, Dept. of Medicine, North York General Hospital, Toronto
1979-1982 Clinical Co-ordinator, Speech Pathology, North York General Hospital, Toronto
1979-1980 Dept Head, Speech Pathology Services, Our Lady of Mercy Hospital, Toronto

PROFESSIONAL COMMITTEE WORK

Toronto Memory Program
-Executive Committee (chair), Business Development (chair): SOP Committee (past chair to 2010); Research Committee (past chair to 2009), Education Committee (past chair to 2010)
University of Toronto Behavioural Neurology Section
-Executive Committee member 1998-present
Consortium of Canadian Centres for Clinical Cognitive Research (C5R)
-Executive Council Member 2007-present
North York General Hospital
- Department of Medicine Education Committee (member 1989-2005; chair 1996-1998)
- Department of Medicine Liaison to Resident Education Committee (1995-1998)
Heart & Stroke Foundation of Ontario
-Professional Education Advisory Committee member (1998 – 2002)

PROFESSIONAL ASSOCIATION MEMBERSHIP

Ontario Telehealth Network (2008-present)
University of Toronto Behavioural Neurology Section (1998-present)
Consortium of Canadian Centres for Clinical Cognitive Research (C5R) (1996-present)
Canadian Stroke Consortium (1996-2007)
Royal College of Physicians and Surgeons of Canada (1992-present)
Canadian Neurological Sciences Federation (1992-present)
Ontario Medical Association (1991-present)
American Academy of Neurology (1990-present)
Canadian Medical Protection Association (1988-present)

CLINICAL RESEARCH ACTIVITIES

PreTrial Consulting:
2007-ongoing Independent advisor and consultant for clinical trial protocols and programs under development (clients: Novartis; Janssen Ortho; Johnson & Johnson; GlaxoSmithKline; Pfizer; Rengenera Pharma Ltd; Roche; Lundbeck; ElMindA Ltd; Debiopharm; Elan; TauRx; Sanofi-Aventis; Kendle Early Stage)

2007-ongoing C5R Scientific Protocol Reviewer for Phase 1 to Phase 3 Sponsor Initiated Clinical Treatment Trials in Dementia

National Coordinating Investigator for Canadian Sites:
Randomised, double-blind, parallel-group, placebo-controlled, fixed-dose study of Lu AE58054 in patients with moderate Alzheimer's disease treated with donepezil. Lundbeck Phase II:12936A. Sept. 2009-ongoing.

Steering Committee Member:
A naturalistic, prospective, open-label, multi-centre, post-marketing observational study, designed to examine the effect of Exelon Patch (rivastigmine), a dual cholinesterase (ChE) inhibitor, in patients with mild to moderate Alzheimer's disease. Novartis Inc Phase IV: EMBRACE. Oct. 2008-ongoing.

Lead Investigator:
A Randomized, Placebo-Controlled, Double Blind, Dose-Escalation Study of the Safety, Tolerability, Pharmacokinetics, Pharmacodynamics, and Immunogenicity of a single Intravenous Dose of PF-04360365 (RN1219) in Adults with Mild-to-Moderate Alzheimer's Disease. Pfizer Phase I: A9951001. Oct 2006-Nov 2009.

Principal Investigator for Canada:
A Pilot study to assess a switch from twice daily galantamine to once daily, extended release galantamine in patients with mild to moderate Alzheimer's dementia. Janssen-Ortho Inc Phase IV: GAL-ALZ-4008. Jun 2005-Aug 2006.

Investigator Meeting Participant (last 2 years listed):

July 2011	Pfizer 3133K1-3000-WW. Paris
June 2011	ELND005-AD201 and AD251. Chicago
Mar 2011	Genentech ABI:4859g. New York City
Jan 2011	Sanofi DRI10734. Phoenix, USA
Mar 2010	Novartis CAD106 A2203. Frankfurt Germany
Nov 2009	Pfizer B1451006 (Constellation). Montreal.
Oct 2009	Lundbeck 12936A. Barcelona, Spain
May 2009	Eli Lilly LY2062430 LZAM. Miami, USA.
Mar 2009	Servier CL2-38093-005. Paris, France.
Jan 2009	Pfizer A9951002. Boston, USA

Principal Investigator, Toronto Memory Program site (last 5 years listed):
A Multicenter, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group Efficacy and Safety Trial of Bapineuzumab (AAB-001, ELN115727) in Subjects With Mild to Moderate Alzheimer Disease Who Are Apolipoprotein E4 Non-Carriers. Pfizer Phase III: 3133K1-3000-WW. Jan 2011-ongoing.

A multinational, multicenter, randomized, double-blind, parallel-group, placebo-controlled study of the effect on cognitive performance, safety, and tolerability of SAR110894D at the doses of 0.5 mg, 2 mg, and 5 mg/day for 24 weeks in patients with mild to moderate Alzheimer's disease on stable donepezil therapy. Sanofi Aventis Phase II: DRI10734. Dec 2010-ongoing.

A multicenter, randomized, double-blind, placebo-controlled, parallel-group, study to evaluate the efficacy and safety of MABT5102A in patients with mild to moderate Alzheimer's disease. Genentech Phase II: ABE4869g. Nov 2010-ongoing.

A multicentre, double-blind, placebo-controlled, crossover study to assess the efficacy and safety of PF-03654746 in subjects with mild to moderate Alzheimer's disease on stable donepezil therapy. Pfizer Phase II: A8801012. Nov 2010-Dec 2010.

Continued Efficacy and Safety Monitoring of Solanezumab, an Anti-Amyloid Beta Antibody in Patients with Alzheimers Disease. Eli Lilly H8A-MC-LZAO (Open label extension to H8A-MC-LZAM). Oct 2010-ongoing.

A randomized, double-blind, placebo-controlled, two dose arm, parallel study of the safety and effectiveness of immune globulin intravenous (Human), 10% (IGIV, 10%) for the treatment of mild-to-moderate AD. Baxter Healthcare Corp. Phase III: 160701 (GAP). Mar 2010-ongoing.

A 90 wk, multi-center, randomized, double-blind, placebo-controlled study in patients with mild AD to investigate the safety, tolerability and Abeta-specific antibody response following repeated IM injections of adjuvanted CAD106. Novartis Phase IIa: CAD106A2203. Feb 2010-ongoing.

Open-label extension for patients completing semagacestat Phase III double blind studies (H6L-MC-LFAN or H6L-MC-LFBC). Eli Lilly H6L-MC-LFBF. Jan 2010-Dec 2010

A multicenter, double-blind, long-term safety and tolerability treatment trial of Bapineuzumab (AAB 001, ELN115727) in Subjects with Alzheimer's Disease who participated in study ELN115727-301 or in study ELN115727-302. Janssen AI: ELN115727-351. Dec 2009-ongoing.

Randomized, double-blind, placebo-controlled study to evaluate safety and tolerability of Dimebon in subjects with AD with reduced CYP2D6 metabolism. Pfizer Phase II: B1451051. Dec 2009-Jun 2010.

Randomised, double-blind, parallel-group, placebo-controlled, fixed-dose study of Lu AE58054 in patients with moderate AD treated with donepezil. Lundbeck Phase II: 12936A. Sept 2009-ongoing.

A Long-Term Follow-Up Study of Oral ELND005 (AZD-103) in Subjects with Alzheimer's Disease. Elan ELND005-AD251 (Open label extension to ELND005-AD201). Aug 2009-June 2010.

Multi center randomized double-blind placebo controlled 26 wk trial to evaluate efficacy and safety of Dimebon in moderate-to-severe Alzheimer's disease. Pfizer Phase III: B1451006. Jul 2009-Jun 2010.

A randomized double blind placebo controlled study to investigate efficacy and safety of T-817MAa in mild to moderate AD. Toyama Chemical Co. Ltd. Phase IIa: AA4437420. Jun 2009-ongoing.

An open label study of the safety and tolerability of ST101 in subjects with Alzheimer's disease. Sonexa Therapeutics ST101-A001-401. June 2009-August 2011.

Effect of LY2062430, an anti-amyloid beta monoclonal antibody, on the progression of Alzheimer's disease as compared with placebo. Eli Lilly Phase III: H8A-MC-LZAM. April 2009-ongoing.

An international, multi-centre, randomized, double-blind, placebo-controlled study of safety and efficacy of S 38093 versus placebo administered for 12 weeks in patients with mild to moderate Alzheimer's disease. Servier Phase IIa: CL2-38093-005. Jan 2009-Nov 2009.

A double-blind, placebo-controlled preliminary study of the efficacy, safety and tolerability of ST101 tablets in the treatment of AD. Sonexa Therapeutics Phase II: ST101-A001-201. Jan 2009-Dec 2010

A double-blind, placebo-controlled preliminary study of the efficacy, safety and tolerability of ST101 tablets in the treatment of Alzheimer's disease in subjects concurrently receiving donepezil. Sonexa Therapeutics Phase II: ST101-A001-202. Jan 2009-August 2011.

A dose ranging, randomized, double-blind, parallel-group placebo-controlled multi-center study of RO5313534 used as add-on to donepezil treatment in patients with mild to moderate symptoms of Alzheimer's Disease. Roche Phase IIb: WN22018. Dec 2008-Apr 2011.

Effect of LY450139, a γ-Secretase inhibitor, on the progression of Alzheimer's disease as compared with placebo. Eli Lilly Phase III: H6L-MC-LFBC. Dec 2008-August 2011.

A multicenter, randomized, double blind, placebo-controlled study of the safety, tolerability, and pharmacokinetics of multiple doses of PF-04360365 in patients with mild to moderate Alzheimer's disease. Pfizer Phase II: A9951002. Nov 2008-ongoing.

A 4-wk, parallel-group, randomized, double-blind, placebo-controlled, adaptive proof of concept study of AQW051 at up to 3 dose levels for the treatment of patients with mild Alzheimer's disease or Mild Cognitive Impairment (amnestic MCI). Novartis Phase IIa: CAQW051A 3104. Jun 2008-Feb 2009.

A fixed dose study of SB-742457 versus placebo when added to existing donepezil treatment in subjects with mild to moderate Alzheimer's disease. GSK Phase IIb: AZ3110866. Jun 2008-Aug 2010.

A Multicenter, Randomized, Double-Blind, Placebo-Controlled, Parallel Group, Efficacy and Safety Trial of Bapineuzumab (AAB 001, ELN115727) in Patients with Mild to Moderate Alzheimer's Disease who are ApoE∈4 non-Carriers. Janssen AI Phase III: ELN115727-301. Jan 2008-ongoing.

A Multicenter, Randomized, Double-Blind, Placebo-Controlled, Parallel Group, Efficacy and Safety Trial of Bapineuzumab (AAB 001, ELN115727) in Patients with Mild to Moderate Alzheimer's Disease who are Apolipoprotein E∈4 Carriers. Elan Phase III: ELN115727-302. Jan 2008-Jan 2009.

A Randomized, Double-Blind, Placebo-Controlled, Dose-Ranging, Safety and Efficacy Study of Oral ELND005 (AZD-103) in Alzheimer's disease. Elan Phase II: ELND005-AD201. Jan 2008-Jun 2010.

A 52-week open-label extension study of the long-term safety and efficacy of rosiglitazone extended-release (RSG XR) as adjunctive therapy to acetylcholinesterase inhibitors in subjects with mild-to-moderate Alzheimer's disease. GlaxoSmithKline AVA102675 (REFLECT-4). Jun 2007- Jun 2009.

A 48 wk multicentre randomized double blind parallel group evaluation of the comparative efficacy, safety, and tolerability of Exelon 10 and 15 cm^2 patch in patients with AD showing cognitive decline during an initial open label treatment phase. Novartis Phase IIIb: CENA713D2340. Sept 2007-August 2011.

A multicenter double blind double dummy placebo controlled parallel group randomized phase IIb proof of concept study with 3 oral dose groups of AZD3480 or donepezil during 12 weeks treatment in patients with Alzheimer's disease. AstraZeneca Phase IIb: D3690C300010. Jun 2007-Jan 2009.

EXPanded evaLuation Of Clinical Results with Exelon with added Compliance And REtention Intervention. Novartis. Phase IV Protocol: EXPLORE with added CARE. Feb 2007-May 2008.

A 6-month, randomized, double-blind, double-dummy, oral donepezil controlled study on the safety and efficacy of repeated monthly subcutaneous injections of a sustained-release implant of ZT-1 in

patients with moderate AD. Debiopharm Phase IIb: DEB-ZTSR-201.Oct 2006-Jul 2009.

Open-Label Trial of Donepezil in Vascular & Mixed Dementia. PfizerA2501026. Sept 2006-Jan 2008.

A 54-week, double-blind, randomized, placebo-controlled, parallel-group study to investigate the effects of rosiglitazone (extended release tablets) as adjunctive therapy to acetylcholinesterase inhibitors on cognition and overall clinical response in APOE E4-stratified subjects with mild to moderate Alzheimer's disease (REFLECT-3). GlaxoSmithKline AVA102670.Aug 2006-Feb 2009.

Open-label study of the effect of daily treatment with MPC-7869 in subjects with dementia of the Alzheimer's type. Myriad Pharmaceuticals, Inc. Protocol MPC-7869-05-009.01. Jul 2006-Feb 2009.

An open-label Extension of the Phase III study CL-758007 with Alzhemed in Patients with Alzheimer's Disease. Neurochem Inc. Protocol CL-75017. Apr 2006-Jun 2008.

Multinational, randomized, double blind, placebo controlled study of the effect of daily treatment with MPC-7869 on cognition, activities of daily living and global function in mild dementia of the Alzheimer's Type. Myriad Pharmaceuticals, Inc. Phase III: MPC-7869-05-010.01.Apr 2006-Feb 2009.

A double-blind placebo-controlled study of VP4896 for treatment of mild-to-moderate Alzheimer's disease.Voyager Pharma Corp Phase III: VP-AD-301. Aug 2005-Jan 2007.

A pilot study to assess a switch from twice daily galantamine to once daily extended release galantamine in mild to moderate AD. JOI Inc Phase IV:GAL-ALZ-4008. Jun 2005-Aug 2006.

An international, multicentre, 3 parallel groups, randomized, double-blind, placebo controlled study of efficacy of 15 mg and 50 mg. of S 18986 on cognitive symptoms in mild cognitive impairment patients treated over a 12-month oral administration period. Servier Inc Phase II. May 2005-Feb 2006.

EXPLORE: Expanded Evaluation of Clinical Results with Exelon. Phase IV. Novartis Pharmaceuticals Canada Inc. May 2005-2007.

A 1-year, double-blind, randomized, placebo-controlled, study of Rasagiline 1 mg and 2 mg added to Aricept 10 mg daily in patients with mild to moderate dementia of the Alzheimer's type. Eisai TVP-1012-A001-201. Nov 2004-June 2007.

A randomized, double-blind, placebo-controlled, safety and efficacy evaluation of ONO 2506PO in patients with mild to moderate AD. ONO Pharma Inc Phase II: ONO2506POU. Nov 2004-Aug 2007.

A multicenter, randomized, double-blind, placebo-controlled, and parallel study of the efficacy and safety of Alzhemed in patients with mild to moderate Alzheimer's disease. Neurochem Inc Phase III: CL-758007. Sept 2004-Jun 2007.

An Open-label Extension Study Examining the Safety and Tolerability of Memantine in Patients with Moderate to Severe Dementia of the Alzheimer's Type Having Completed Study No. 10158. Lundbeck Canada Inc. protocol 10252. Jun 2004-Nov 2010.

Long-Term Safety Extension of Phase II EFC5286 of SR57667B in Patients with mild-to-moderate Alzheimer's disease. Sanofi ALTIMMEX LTS 5283. June 2004-Mar 2007.

A multicenter, multinational, randomized, double-blind, placebo-controlled, efficacy, safety and tolerability study of SR57667B in patients with mild-to-moderate Alzheimer's disease. Sanofi sponsored ALTIMMA Phase II: EFC5286. Jan 2003-Oct 2006.

A randomised, double-blind, parallel-group study examining the efficacy and safety of Memantine on behavioural symptoms in patients with moderate to severe dementia of the Alzheimer's type. Lundbeck Canada Inc Phase III: 10158. Oct 2003-Nov 2010.

A randomized, multicenter, double-blind, placebo-controlled, 18-month study of the efficacy of Xaliproden in patients with mild-to-moderate dementia of the Alzheimer's type. Sanofi EFC 2946. Oct 2003-Sept 2007. Extension study Feb 2006-2007.

A multicenter, randomized, double-blind, placebo-controlled study of the effect of daily treatment with MPC-7869 on cognitive and global function in mild to moderate AD. Myriad Pharmaceutical Phase II: MPC-7869-03-003-01 plus optional follow-on MPC-7869-03-003.03). Oct 2003-Aug 2006.

A 24-wk multi-center, randomised, double-blind, placebo-controlled evaluation of efficacy, safety and tolerability of Donepezil Hydrochloride (E2020) in patients with dementia associated with cerebrovascular disease. Eisai Protocol E2020-A001-319. Dec 2002-Jan 2006.

CLINICAL TEACHING

Undergraduate Medical Teaching

1992-present PGY4 Elective students. University of Toronto & Foreign Medical Schools

Post Graduate Medical Teaching

2010-present Care of the Elderly Specialty Fellows, University of Toronto
2004-present Movement Disorders Fellows, North York General Hospital Huntington Disease Clinic
1996-present Geriatric Medicine Residents, University of Toronto
1992-present Family Practice Residents, University of Toronto

University of Toronto Graduate Department of Speech Pathology

1991-2006 SPP1534 Motor Speech Disorders, Core Lectures

Postgraduate Preceptorships 2004 – present:

Full day courses in dementia for: Family Physicians; Medical Specialists; RNs; Pharma Representatives

Lectures Given 2010-present:

July 13/11 Paradigm Shift in Alzheimer's Disease: New Diagnostic Criteria and Implications for Care. Barrie, Ontario.
June 23/11 The Connection between Stress, Exercise and Brain Health. Bernard Betel Wellness Lecture Series. Toronto
June 22/11 Posterior Cortical Atrophy. Toronto Memory Program Clinic Rounds. Toronto
June 20/11 Alzheimer's Disease: Changing Perspectives. OTN presentation to Ontario MDs

June 6/11	Paradigm Shift in Assessing and Treating Alzheimer's Disease. Toronto Memory Program MD Open House. Toronto
May 5/11	Advances in Treatment for Alzheimer's Disease. Guest Speaker at: The Fourth Anne Johnston Event. POINT (People and Organizations in North Toronto)
Apr 28/11	Rivastigmine Patch: New Clinical Insights. EMBRACE Study Interim Analysis. Webinar Presentation to physicians
Apr 27/11	New Diagnostic Criteria for AD. Toronto Memory Program Clinic Rounds
Apr 27/11	Neuro-Imaging in AD Clinical Trials. Toronto Memory Program Clinic Rounds
Apr 27/11	AE/SAE reporting in AD Clinical Trials. Toronto Memory Program Clinic Rounds
Apr 26/11	EMBRACE Study Interim Analysis. Webinar Presentation to Pharmaceutical Representatives
April 7/11	Dementia: Stages, Symptoms and Implications. Elder Mediation Training Program. Toronto
Apr 2/11	Latest Advances in the Treatment of Alzheimer's Disease. Closing the Gaps in Geriatric Care, 2011 Inaugural Geriatric Clinic Day. Southlake Regional Health Centre
Mar 18/11	Immunotherapy in Alzheimer's Disease: Past, Present, Future. IUGM/CESCO. Le defi de l'intervention aupres des personnes atteintes de la maladie d'Alzheimer. Montreal.
Mar 2/11	It's Not All AD - Case-Based Learning. Toronto Memory Program Clinic Rounds.
Jan 22/11	It's Not All Alzheimer's Disease. NYGH Family Medicine Clinic Day
Jan 26/11	Brain Healthy Living. Elder Connection Meeting
Jan 21/11	More Than Memory: Advances in Alzheimer's Disease. Toronto Rotary Club
Dec 7/10	New Treatment Approaches in AD. NYGH Medical Grand Rounds
Dec 8/11	Advances in the Treatment of Alzheimer's Disease. Toronto Seniors Council AGM
Nov 25/10	Latest Advances in Treatment of AD. Revera Knowledge Exchange. Toronto
Nov 15/10	Highlights of the 11th International Geneva/Springfield Symposium. Specialists CME
Oct 5/10	EMBRACE IA Results. Toronto Exelon Patch Family Physician Consultant Meeting
Jun 16/10	Immunotherapy for AD: Past, Present, Future. BNS Educational Evening, U.Toronto
Apr 29/10	Working Together Toward Improved Treatment for AD. Family Med CME. Oshawa
Apr 27/10	Identifying and Managing Early Alzheimer's Disease. Family Medicine CME. Toronto
Apr 5/10	Symptomatic Rx vs. Disease Modification. KRMC-TMP 2nd Research-Clinic Day. Kawartha.
Mar 23/10	Alzheimer's Disease Primer. Toronto Memory Program Clinic Rounds. Toronto
Feb19/10	Immunotherapy in AD. JC Richardson Neurology Subspecialty Day. U. Toronto
Feb 1/10	Publicly Funded Drugs for AD. Presentation to H. Stephenson. Dep. Minister Health
Jan 27/10	Ridding the Brain of Amyloid. Elder Connection Meeting. Toronto

MEDIA INTERVIEWS (2009-present)

Mar 22/11	CBC Radio. White Coat, Black Art. Host: Dr. Brian Goldman
Feb 26/11	CFRB. Ask The Expert Host: Iain Grant
Jan 8/11	CFRB Talk Radio. Host: Ted Woloshyn
Sept 15/10	Zoomer Radio AM 740. Host: Dale Goldhawk
Mar 15/10	CP24 Talk TV Health. Host: Dr. Karl Kabasele
Sept 21/09	CBC Radio. World Alzheimer Week: Ask the Expert (live interviews aired on CBC national outlets: Toronto, Vancouver, New Brunswick, Winnipeg, Thunder Bay)

PUBLICATIONS

Benefits of Rivastigmine patch as assessed by physicians and caregivers: An Interm Analysis. Black

SE, Cohen S, Gauthier S, Robillard A, Rehel B, de Takacsy F, Schecter R. Poster Presentation, Canadian Geriatric Society 31st Annual Scientific Meeting. Vancouver. April 16, 2011
Understanding Amyloid in Alzheimer's Disease. Cohen, S. Help's Here. Spring/Summer 2011.

Safety and Pharmacokinetics Following a Single Infusion of the Anti-Amyloid mAb Ponezumab (PF-04360365) in Patients with Mild-to-Moderate Alzheimer's Disease: Final Results. Landen JW., Zhao Q., Cohen S., Borrie M., Woodward M., Billing Jr. C.B., Alvey C., Kupiec J.W., Bednar M.M. Poster presentation at International Conference on Alzheimer's Disease (ICAD) Jul 10--15. 2010, Hawaii.

Recent Advances in the Treatment of Alzheimer Disease. Bouchard RW, Cohen S, Dian L, Robillard A. NeuroSens Supplement 1, Jun 2. 2010.

Ask-The-Expert Program. Optimizing AD Management in Canada.CME Video Program. Novartis. March 18/10

100 Years After Alzheimer: Contemporary Neurology Practice Assessment of Referrals for Dementia. Chow T., Binder C., Cohen S., Smyth S., Robillard A. American Journal of Alzheimer's Disease and Other Dementias®, Vol. 23, No. 6, 516-527, 2009.

Not on the Face Alone: Perception of Contextualized Face Expressions in Huntington's Disease. Aviezer H., Bentin S., Hassin RR., Meschino WS., Kennedy J., Esmail S., Cohen S., Moscovitch M. Brain 2009 Jun; 132(pt6):1633-44. Epub 2009 May 18.

Utility of a Mandatory Standardized Dementia Referral Form Across Neurology Practices Within the Greater Toronto Area. Cohen, S, Martinez, M, Sansom, P, and the Neurology Referral Project Working Group. Poster presentation at 5th Canadian Conference on Dementia. Oct 2009.

The Benefits of Participation in Alzheimer's Research. Cohen, S. Help's Here. Spring/Summer 2009.

Exploring the Frontier of Physician Perception in Dementia Practice: Neurologists' Views and Results of a Patient Audit. Robillard A., Cohen S., Binder C., Hew H., Correia J. Poster Presentation, CGS Annual Scientific Meeting April 21, 2007.

Train the Trainer Slide Kit. Optimal Management of AD-Related Symptoms: A Focus on Mood & Behaviour. Revised Edition. 2005.

Cohen, S., Freedman, M. Cognitive and Behavioral Changes in Parkinson-Plus Syndromes. In: Weiner WJ, Lang AE, eds, Advances in Neurology, Behavioral Neurology of Movement Disorders. Second Edition, Raven Press: New York. 2005

Cohen S., Chan G. In the News - Update on Pharmacologic Treatment of Alzheimer's Disease. RGP Elders News, March 1998, Vol. 1, No. 1.

Freedman, M., Rewilak, D., Xerri, T., Cohen, S., Gordon, AS., Shandling, M., Logan, A.G. L-deprenyl in Alzheimer's Disease: Cognitive and Behavioural Effects. Neurology, Mar 1998, vol. 50.

Cohen, S., Freedman, M. Cognitive and Behavioral Changes in Parkinson-Plus Syndromes. In:

ARVAY FINLAY
BARRISTERS

Reply to: Joseph J. Arvay, Q.C.
jarvay@arvayfinlay.com

Our File No: 2734-001

August 28, 2011

This is Exhibit B referred to in the Affidavit of Sharon Cohen sworn (or affirmed) before me on 30 Aug 2011.

A Notary in and for the Province of Ontario

Jeffrey Michael Goldberg, a Commissioner, etc., City of Toronto, for G & G Partnership, LLP, Chartered Accountants. Expires August 7, 2013.

VIA EMAIL

Dr. Sharon Cohen
Suite 4001 Valleybrook Drive
Toronto Ontario, M3B 257

Attention: Dr. Sharon Cohen

Dear Dr. Cohen:

Re: *Carter et al. v. Attorney General of Canada*
SCBC Vancouver Registry No. S112688

As you know we represent the BC Civil Liberties Association and a number of affected individuals who have recently launched a legal challenge to the laws that make it a criminal offense in Canada to seek the assistance of a physician to die with dignity. The legal challenge will seek to allow grievously and irremediably ill, mentally competent adults to receive medical assistance to hasten death under certain specific safeguards. I have attached a copy of the Amended Notice of Civil Claim setting out the legal issues in the proceeding.

We write to confirm your discussion with Grace Pastine regarding your willingness to provide us with an expert opinion for the trial of this action. Specifically we ask you to answer the following questions:

Questions Posed

1. Are there any grievous and irremediable neurological conditions that, in your opinion, have the potential to cause significant and enduring physical, psychological and/or psychosocial suffering prior to death?

2. If so, could you please provide some examples and, for each example, a description of how that condition progresses through to time of death?

3. In your opinion, can physician-assisted dying, as defined in the Amended Notice of Claim, be an appropriate medical treatment option for patients suffering from such conditions? If so, in what circumstances do you believe it should be an available treatment option?

1350 - 355 Burrard Street, Vancouver BC V6C 2G8
Telephone 604.689.4421 Facsimile 604.687.1941
www.arvayfinlay.com

Weiner W.J., Lang A.E., eds. Advances in Neurology, Behavioral Neurology of Movement Disorders, Volume 65, Raven Press: New York 1995.

Square-Storer, P., Roy, E.A., Hogg, S. The Apraxias and Their Dissociation from Aphasia. In G. Hammond (ed.), Advances in Psychology, Cerebral Control of Speech and Limb Movements, Elsevier North-Holland, 1990.

Roy, E.A., Square-Storer, P.A., Hogg, S., Adams, S. Analysis of Task Demands in Apraxia, International Journal of Neuroscience, 1991, vol. 56.

Cohen, S., Freedman M. Piecing Together the Signs of Alzheimer's Disease. Canadian Journal of Diagnosis, March 1991.

Cohen, S., Freedman, M. Neurologic Assessment of Competency in the Elderly. Canadian Family Physician, Sept. 1992 edition.

PARTICIPANT IN COMMUNITY INITIATIVES FOR MENTAL HEALTH

June 2011	Toronto Memory Program in support of NYGH 2nd Annual Seniors Expo
May 2011	Toronto Memory Program in support of 10th Annual Bernard Betel Community Health Fair
2006-2011	Toronto Memory Program Team for: Walk for Memories, Alzheimer Society of Toronto
2009-2010	Toronto Memory Program Food Drive, Toronto
2010	Toronto Memory Program walker: Straight to the Streets (clothing the homeless), Toronto
2009-2010	Toronto Memory Program sites for: Coffee Break, Alzheimer Society of Canada
2010	Toronto Memory Program in support of elder care: Seniors' Expo, NYGH, Toronto
2009-2010	Toronto Memory Program sites for: National Memory Screening Day, Alzheimer Foundation for Caregiving in Canada

4. In your opinion, does the *Criminal Code*'s blanket prohibition against assisted suicide interfere with the patient-physician relationship by restricting available treatment options? If so, how?

5. In your opinion, is there any ethical distinction between a physician's withdrawal of life-sustaining treatment at the informed direction of a patient and a physician's participation in physician-assisted dying at the informed request of a patient?

If there are any facts or assumptions that you rely on in providing your opinion you should state them clearly.

We confirm that you have provided us with a copy of your current *curriculum vitae* for purposes of attachment to your expert opinion in order to demonstrate your expertise and experience with the subject matters addressed in your opinion.

Thank you for your willingness to work on this important matter and for assisting us in preparing these materials as soon as possible. The hearing of this case is set for four weeks commencing November 14, 2011. While your attendance at the hearing will not be necessary it is possible that you will be asked to submit to a cross-examination sometime in October. If that occurs we will endeavour to find a time and place that is convenient to you and to have the cross-examination conducted by video-conference.

Finally, there is the matter of compensating you for your time and effort in preparing this opinion. I hope that Professor Downie mentioned this earlier in one of her discussions with you, but if she did not, I do apologize and will set it out clearly for you now. Due to our clients' financial constraints, expert witnesses in this action will not be paid at this time. The same applies to the lawyers who are all working *pro bono* on this file. At the end of the trial, we will seek an order that costs of the trial, including any fees payable to expert witnesses, be borne by the Crown. If the Court finds in favour of our clients' claim, there is every likelihood that these costs will be paid. If the Court rules against our client, then there is still a chance that these costs will be ordered but there is certainly no guarantee that this will occur. I hope that this arrangement is acceptable to you.

Please note that pursuant to the British Columbia Supreme Court Civil Rules, your report must be signed and must include a certification in the following terms:

> I certify that:
>
> (a) I am aware that, in giving an opinion to the court, I have a duty to assist the court and not to be an advocate for any party;
>
> (b) this report has been made in conformity with that duty; and
>
> (c) I will, if called on to give oral or written testimony, give that testimony in conformity with that duty.

Thank you for your willingness to work on this important matter and for assisting us in preparing these materials as soon as possible.

Finally, this matter is confidential and privileged at this time. Please do not discuss this matter with anyone other than our legal team.

Yours truly,

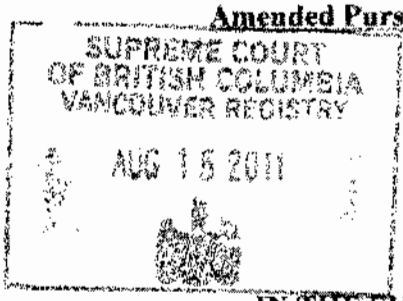
ARVAY FINLAY

Per:

Joseph J. Arvay, Q.C.

JJA/sy

Amended Pursuant to the Consent Order dated August 12, 2011
Original filed on April 26, 2011



No. S112688
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

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

PLAINTIFFS

AND:

ATTORNEY GENERAL OF CANADA

DEFENDANT

AMENDED NOTICE OF CIVIL CLAIM

Name and address of each Plaintiff:

Lee Carter, Hollis Johnson, Dr. William Shoichet,
~~and~~ The British Columbia Civil Liberties Association
and Gloria Taylor
c/o Arvay Finlay
1350 – 355 Burrard Street
Vancouver BC V6C 2G8

Name and address of each Defendant:

Attorney General of Canada
900 - 840 Howe Street
Vancouver BC V6Z 2S9

This action has been started by the plaintiff(s) for the relief set out in Part 2 below.

If you intend to respond to this action, you or your lawyer must

(a) file a response to civil claim in Form 2 in the above-named registry of this court within the time for response to civil claim described below, and

(b) serve a copy of the filed response to civil claim on the plaintiff.

If you intend to make a counterclaim, you or your lawyer must

(a) file a response to civil claim in Form 2 and a counterclaim in Form 3 in the above-named registry of this court within the time for response to civil claim described below, and

(b) serve a copy of the filed response to civil claim and counterclaim on the plaintiff and on any new parties named in the counterclaim.

JUDGMENT MAY BE PRONOUNCED AGAINST YOU IF YOU FAIL to file the response to civil claim within the time for response to civil claim described below.

Time for response to civil claim

A response to civil claim must be filed and served on the plaintiff(s),

(a) if you reside anywhere in Canada, within 21 days after the date on which a copy of the filed notice of civil claim was served on you,

(b) if you reside in the United States of America, within 35 days after the date on which a copy of the filed notice of civil claim was served on you,

(c) if you reside elsewhere, within 49 days after the date on which a copy of the filed notice of civil claim was served on you, or

(d) if the time for response to civil claim has been set by order of the court, within that time.

CLAIM OF THE PLAINTIFFS

Part 1: STATEMENT OF FACTS

The Parties

1. The Plaintiff Lee Carter ("Lee"), age 64, is a retired flight attendant who lives in Fort Langley, British Columbia.

2. The Plaintiff Hollis Johnson ("Hollis"), age 67, is an instructor in criminology at Kwantlen Polytechnic University who lives in Fort Langley, British Columbia.

3. The Plaintiff Gloria Taylor ("Gloria"), age 63, is a part-time property manager and a residential care worker (on leave) who lives in Westbank, British Columbia.

~~34~~. The Plaintiff Dr. William Shoichet ("Dr. Shoichet"), age 63, is a family medical practitioner who lives in Victoria, British Columbia.

~~45~~. The Plaintiff the British Columbia Civil Liberties Association (the "BCCLA") is a non-profit, advocacy group incorporated in 1963 pursuant to British Columbia's *Society Act*, R.S.B.C. 1996, c. 433, with a registered office located at 550 - 1188 West Georgia Street, Vancouver, British Columbia, V6E 4A2.

~~56~~. The Defendant Attorney General of Canada ("Canada") has an address for service at 900 - 840 Howe Street, Vancouver, British Columbia, V6Z 2S9.

Definitions

"Physician-Assisted Suicide"

~~67~~. For purposes of this claim, "physician-assisted suicide" means an assisted suicide where assistance to obtain or administer medication or other treatment that intentionally brings about the patient's own death is provided by a medical practitioner, as that term is defined in s. 29 of the *Interpretation Act*, R.S.B.C. 1996, c. 238, or by a person acting under the general supervision of a medical practitioner, to a grievously and irremediably ill patient in the context of a patient-physician relationship.

"Consensual Physician-Assisted Death"

~~7~~8. For purposes of this claim, "consensual physician-assisted death" means the administration of medication or other treatment that intentionally brings about a patient's death by the act of a medical practitioner, as that term is defined in s. 29 of the *Interpretation Act*, or by the act of a person acting under the general supervision of a medical practitioner, at the request of a grievously and irremediably ill patient in the context of a patient-physician relationship.

"Physician-Assisted Dying"

~~89~~. For purposes of this claim, "physician-assisted suicide" and "consensual physician-assisted death" will be collectively defined as "physician-assisted dying."

"Impugned Provisions"

~~9~~10. This claim challenges the constitutional validity or applicability of the provisions of the *Criminal Code*, R.S.C., 1985, c. C-46, that prohibit physician-assisted dying, including those provisions that render someone criminally liable for aiding or counselling same or otherwise render someone a party to a criminal offence for arranging, supporting or otherwise participating in physician-assisted dying. Those provisions are ss. 14, 21, 22, 222 and 241 of the *Criminal Code* (the "impugned provisions").

Lee and Hollis

~~10~~11. Lee and Hollis are married to one another. Kathleen Carter ("Kay") was Lee's mother and Hollis's mother-in-law.

~~11~~12. Kay was born in 1920 and died on January 15, 2010, at the Dignitas clinic in Forch, Switzerland. Her death was caused by the voluntary, but assisted, ingestion of a lethal dose of sodium pentobarbital prescribed for that purpose by a qualified Swiss physician.

~~12~~13. In 2008, Kay, who was then residing in the Lynn Valley Care Centre in North Vancouver, British Columbia, was diagnosed with spinal stenosis.

~~13~~14. Spinal stenosis involves a narrowing of the spine which can put pressure on the spinal cord or spinal nerves at the point of compression. Depending on the nerves affected, severe spinal stenosis can cause pain or numbness in the legs, back, shoulders and arms, limb weakness and incoordination, loss of sensation in the extremities, impairment or loss of bladder and bowel function and paralysis.

~~14~~15. Although her thinking and speaking capacities remained clear, Kay's physical condition deteriorated steadily due to degeneration of the nerves and spinal column. By August 2009, Kay needed the assistance of an aid for dressing, toileting and most of her daily activities. She had extremely limited movement in her hands. Her right hand no longer functioned properly and although she was occasionally able to eat some of her meals without assistance, for the most part she could not eat without help. Kay was unable to walk and was confined to a wheelchair. She could not move herself in the wheelchair. If

she was lying flat, she needed assistance to sit up. She also suffered chronic pain, which was treated with a series of daily medications. Her neurologist told her that her condition would eventually reduce her to lying flat in bed, completely unable to move.

~~15~~16. For a period of time prior to the end of her life, Kay wore diapers because she required assistance to go to the washroom and assistance was often untimely. Towards the end of her life, Kay was incontinent.

~~16~~17. Kay expressed concern that her condition was rendering her trapped in her own body and stripped of her independence. Kay stated that she did not want to live her life in that condition.

~~17~~18. On or about July 26, 2009, Kay reached the firm conclusion that she wished to terminate her life as soon as possible by means of physician-assisted suicide. She then began to inform her immediate family, including Lee and Hollis, of her wish to die with dignity by means of physician-assisted suicide. Kay expressed a desire to end her life in Canada, but was aware that assisting suicide is a criminal offence in Canada. Kay asked Lee and Hollis to support and assist her in arranging a physician-assisted suicide in Switzerland and to support her and assist her to travel to Switzerland for that purpose.

~~18~~19. Lee and Hollis discussed the fact that assisting Kay to terminate her life in Switzerland could expose them to criminal charges in Canada. They resolved to assist Kay and to assume the risk of prosecution in order to help Kay fulfil her wish to die with dignity, with minimal suffering, at the time of her choosing.

~~19~~20. Lee contacted Dignitas and assisted and supported Kay to make an application for membership in Dignitas. Dignitas requested that Kay write a letter in order to introduce herself. Kay dictated the letter to a family member. Dignitas also requested a "Letter of Support" signed by Kay's children; it was signed by all seven. Kay dictated a letter to Lee requesting Dignitas to perform the assisted suicide. Lee and Hollis assisted and supported Kay by obtaining the other documentation required by Dignitas, including her prognosis and diagnosis, the long version of her birth certificate, detailed information on the persons accompanying Kay, a data sheet for the authorities, detailed information

about Kay's family and children, confirmation that the persons accompanying Kay would be available to testify to local authorities after her death, passport photocopies of everyone accompanying Kay, a passport photograph of Kay, and a letter from a doctor or lawyer confirming that Kay was of sound mind.

~~20~~21. Kay's health was deteriorating rapidly, and she became concerned that she would be unable to travel to Switzerland. Lee and Hollis assisted and supported Kay by making the flight and other arrangements necessary to enable her to do so. With Lee and Hollis' assistance, Kay obtained an executive-first class seat for the flight, as she required a seat that would allow her to lie flat. Lee and Hollis accompanied Kay to Switzerland so that she could make the trip.

~~21~~22. In Switzerland, Dignitas arranged for the two medical consultations required as a precondition to assisted suicide under Swiss law. Following the second consultation, the Swiss physician approved Kay's request for an assisted suicide.

~~22~~23. While in Switzerland, Kay wrote a farewell letter to friends explaining that she had chosen to die with dignity. Kay dictated the letter and Lee typed and printed it. Kay's letter explained that she alone had made the choice to end her life, and that her trip to Switzerland was filled with laughter and fond reminiscences. Kay signed the letter herself. Lee had 125 copies made and mailed them out to the persons Kay indicated on a review of her address book.

~~23~~24. Lee and Hollis and two of Kay's other children (the "accompanying family members") accompanied Kay to the Dignitas clinic. At the clinic, a Dignitas staff member, "Erica", repeatedly asked Kay to confirm her desire to terminate her life. Kay repeatedly and decisively stated that she was ready and wished to proceed. Notwithstanding her difficulties with her hands, Kay signed the authorizing paperwork provided by the Dignitas staff.

~~24~~25. The accompanying family members remained with Kay at the Dignitas clinic. When Kay was moved from her wheelchair to a bed, the accompanying family members positioned themselves around her, entwining their arms around Kay and each other. The

accompanying family members witnessed Erica dispense a lethal dose of sodium pentobarbital to Kay. The sodium pentobarbital was dissolved into liquid in a drinking glass. Due to Kay's difficulties with her hands, Erica helped hold the glass and Kay drank the medication using a straw. The Swiss physician had advised Kay to eat some chocolate after the sodium pentobarbital in order to cut its bitterness. Lee purchased some fine Swiss chocolate for this purpose, and Kay and the accompanying family members each had some after Kay drank the sodium pentobarbital. Kay fell unconscious within minutes. As Erica advised the accompanying family members that Kay could still hear them talking, they reminisced about their father and other family memories. Kay was pronounced dead approximately 20 minutes later.

~~25~~26. The accompanying family members remained at the Dignitas clinic to sign additional paperwork. Swiss medical and police officials attended. A Swiss police officer asked them questions about Kay's illness and her deterioration and, before leaving, shook their hands. The accompanying family members then returned to Zurich. Lee and Hollis arranged for Kay's ashes to remain in Switzerland, scattered in a forest, in accordance with Kay's wishes.

~~26~~27. The financial costs incurred in travelling to Switzerland from Vancouver, maintaining accommodations in Switzerland, obtaining the services of the Swiss physician, and obtaining the services of Dignitas were considerable. Kay's costs in these respects were paid by Kay from her remaining life's savings.

~~27~~28. After Lee and Hollis agreed to assist Kay to obtain a physician-assisted suicide in Switzerland, Kay, Lee, Hollis and the other family members kept Kay's intentions and plan secret. They did so out of fear that the Canadian police would intervene and stop the plan from being carried out and also out of concern that the assistance that Lee and Hollis were providing to Kay constituted a criminal offence under Canadian law.

~~28~~29. Lee and Hollis continue to fear that the assistance they provided to Kay may render them subject to criminal prosecution in Canada.

~~29~~30. Lee and Hollis have experienced censure and criticism from third parties who consider Lee and Hollis to have committed a criminal offence by assisting Kay.

~~30~~31. Lee and Hollis each want the option of being able to arrange and legally obtain, in Canada, physician-assisted dying services for themselves, for each other and for other loved ones, in the event that either of them or any other loved one should suffer a grievous and irremediable illness and wish to end the suffering and die with dignity.

Gloria

32. Gloria is a divorced mother of two sons, aged 36 and 38. Her younger son lives in Westbank, and the older about an hour away by car. Gloria has an 11 year old granddaughter, with whom she is very close. Gloria also has an 83 year old mother living in Castlegar, British Columbia.

33. Gloria has amyotrophic lateral sclerosis ("ALS"). ALS, which is also known as Lou Gehrig's disease, is a fatal neurodegenerative disease. People with ALS become progressively paralyzed due to the degeneration of the upper and lower motor neurons in the brain and spinal cord. Eighty percent of people with ALS die within two to five years of diagnosis. ALS has no known cure or effective treatment.

34. ALS frequently begins with weakness and/or cramping in the hands, feet or limbs. As the disease advances, muscles progressively weaken until paralysis sets in. Progressed ALS generally impacts the abilities to chew, swallow, speak and breathe. Respiratory failure is the most common cause of death for people with ALS.

35. Gloria began to experience symptoms in 2003, in the form of cramping in her hands, feet and limbs, but her condition was not diagnosed at that time. In or about 2006, she began to experience severe muscle cramping and spasms in her hands. Her hands would cramp into fists and her fingers would need to be physically peeled open again. She also started to experience fasciculation - muscular twitching involving small, localized involuntary muscle contractions - in her hands and throughout her body. Later that year, Gloria began to have difficulty with tasks requiring fine motor skills and hand strength, such as, for example, using keys or holding a pen.

36. In the summer of 2009, Gloria's right pinky finger "dropped", leaving her unable to straighten that finger. In September 2009, she was referred to a neurologist for a basic neurological examination. That neurologist referred her to a consulting neurologist at the Kelowna General Hospital. On December 9, 2009, after a series of tests, the consulting neurologist diagnosed Gloria with ALS.

37. The consulting neurologist then referred Gloria to another neurologist, Dr. Hannah Briemberg, at the ALS Centre in Vancouver's GF Strong Rehabilitation Hospital. The ALS Centre's medical team carried out a comprehensive assessment, review and consultation that ultimately confirmed the ALS diagnosis.

38. By the time Gloria attended the ALS Centre, her muscles had begun to atrophy. She had difficulty using her right hand due to fasciculation and muscle degeneration. She had extreme difficulty walking and suffered generalized body weakness. She often felt cold, particularly in her hands and arms, and experienced difficulty breathing. Dr. Briemberg concluded that these symptoms indicated the disease's course was significantly progressed. On or about January 26, 2010, Dr. Briemberg opined that Gloria was likely be paralyzed in six months and likely to die within the year.

39. Following her diagnosis, Gloria founded a Kelowna support group for people living with ALS and their caregivers, the "Living with ALS Group." The group meets monthly, with a meeting generally consisting of a guest lecturer and a social hour where members can discuss their experiences, hopes and fears.

40. Gloria has fared better than predicted by Dr. Briemberg. Gloria's doctor is impressed by her resilience. That said, in most respects, Gloria's condition has continued to steadily deteriorate since diagnosis. She is no longer able to lift herself up from most chairs, and uses a power lift chair to assist her with standing up. The muscles in her feet and toes have atrophied, and she now has difficulty lifting the front of her foot, resulting in a condition known as "footdrop." Footdrop makes it very difficult for Gloria to walk and has caused her to suffer serious falls. At present, she uses a walker and, when particularly weak, a wheelchair. All of the fingers on Gloria's right hand, with the exception of the index finger, have now "dropped" and cannot be straightened. On her

left hand, her pinky finger and her ring finger have also "dropped." She experiences shaking in her hands. She also suffers constant involuntary muscle cramps throughout her body.

41. Despite her increasing disability, Gloria continues to live by herself and as independently as possible. Although Gloria went on disability leave from her position as a residential care worker effective March 2010, at present, she remains able to fulfil her role as part-time property manager for the mobile home park where she resides. She spends part of most weekends with her granddaughter. She has been teaching her granddaughter to cook and sew. Gloria is an avid cook and food enthusiast. At her granddaughter's request, she is compiling a cookbook of all her granddaughter's favourite dishes and various family recipes that reflect their shared heritage. Gloria and her granddaughter sometimes go together to local restaurants for lunch or dinner. Sometimes they picnic, go to movies, visit sightseeing destinations, or go out for ice cream together.

42. Gloria typically spends many hours a day communicating by phone or email with her family, friends, doctors and others. She meets with a physiotherapist once or twice a month, and usually attends several medical appointments each month. Several times a week she goes into town to get groceries or run comparable errands. In addition to her granddaughter and other family, Gloria regularly visits in person with her friends and former work colleagues.

43. Gloria is committed to a number of causes and activities and presently remains very actively involved in these. In addition to keeping up her membership in community groups she belonged to prior to her diagnosis, Gloria participates in local campaigns to raise money for ALS medical research and services to support those living with ALS and their families. Gloria sits on the board of the Association For Injured Motorcyclists, Interior B.C. Chapter. In association with that group and local business sponsors, Gloria organized a motorcycle ride to benefit the ALS Society of BC. Gloria is currently a key participant in an ALS fundraising campaign undertaken by a Kelowna business as part of its 25th anniversary celebration.

44. However, Gloria's disability is steadily impacting on her ability to do these things. She is losing the ability to perform basic household and personal tasks. She can no longer peel vegetables or open jars. She finds it challenging to dress herself, and has started wearing dresses every day to make dressing simpler. She has difficulty brushing her teeth, combing her hair and carrying out similar personal tasks. She can only type on her computer keyboard with her left hand and has difficulty using a mouse. She is no longer able to keep her house up to the standard she desires and is unable to perform yard work, such as the planting of flowers. She is concerned that her deterioration will soon impact on her ability to spend quality time with her granddaughter.

45. Gloria hopes to remain in her own home as long as possible. She has reconfigured and re-outfitted her home to this end. Her washroom has been made handicapped-accessible and she has gotten a hospital bed at home so she can sleep with her chest elevated. The ALS Society of British Columbia has provided her with computer hardware and software to enable her to operate the computer without her hands.

46. Gloria is fearful about the progression of her disease. She does not know which functions will be impacted next. She fears losing her ability to get out of bed and the ability to speak. As ALS generally affects the ability to control the muscles used to breathe, she uses a respiratory ventilator when sleeping and sometimes in the evening while she is watching television. She fears that she will eventually suffocate and die struggling for air.

47. Gloria currently experiences pain, for which she takes prescribed medications. She sleeps on her side in order to breathe better, but the resulting body stress causes her hips to ache. Minor bumps and injuries can be very painful due to her loss of the muscle density that usually cushions bones from everyday impacts. Even resting her arms on a recliner chair can cause pain due to muscle deterioration.

48. Using her muscles in stretching or reaching motions sometimes causes excruciating pain and a tearing feeling in the muscles. At present, this pain subsides fairly quickly; however, Gloria believes lasting pain at the same level would be unbearable. Although

aware that increased pain might be addressed with additional narcotics and analgesics. Gloria has no desire to live her life out in a drug-induced haze.

49. Gloria is terrified of losing control of her bodily functions. She has already experienced incontinence on several occasions while at home. She is concerned that these episodes will become more frequent, occur outside her home, or that she will lose her ability to clean herself when they do occur. The prospect of being fully incontinent mortifies her.

50. Gloria has always been very independent. One of her greatest fears is to be reduced to a condition where she must rely on others for all of her needs. She does not want to live in a bedridden state, stripped of her dignity and independence.

51. Shortly after Gloria was diagnosed with ALS, she decided that she wanted to die when the suffering and indignity of her disease became too much for her. Gloria has informed her family and close friends of this desire. Her sons, mother, sisters and closest friends all strongly support her right to make the decision to die and have told her that they do not want to see her suffer against her wishes.

52. Gloria does not want to end her life while she finds it still worth living, but is concerned that her deteriorating condition will render her unable to die without assistance. She is concerned that if she waits too long to act alone and then must ask a friend or family member to assist, that person will be subject to criminal prosecution.

53. Gloria does not want her life to end violently. Gloria does not want her mode of death to impose trauma on her family members.

54. Gloria is aware that assisted suicide is legal in Switzerland. Gloria is not financially able to travel to Switzerland and obtain assisted suicide services there.

55. Gloria wants to be able to obtain physician-assisted dying services in Canada should she resolve to end her suffering and die with dignity. She wants the legal right to die peacefully, at the time of her own choosing, in the embrace of her family and friends.

Dr. Shoichet

3456. Dr. Shoichet is a licensed medical practitioner and a member in good standing of the British Columbia College of Physicians and Surgeons. Dr. Shoichet carries on a family medical practice in Victoria, British Columbia.

3257. Dr. Shoichet graduated from medical school in 1971. After graduation he worked on Salt Spring Island, in Ottawa and in Victoria as an emergency room doctor until 1980. Since November 1980, Dr. Shoichet has been in family practice in Victoria. In the course of his practice, Dr. Shoichet has provided medical care to a number of patients suffering from grievous and irremediable illnesses, including, *inter alia*, cancer, chronic renal and/or cardiac failure, and degenerative neurologic diseases such as Huntington's disease and multiple sclerosis.

3358. Some of Dr. Shoichet's grievously and irremediably ill patients suffered greatly from the effects of their illnesses and experienced severe and/or chronic pain, inability to take care of their own basic physical needs and desires, inability to act independently, and severe loss of privacy and dignity.

3459. If the impugned provisions were repealed or struck down as unconstitutional, Dr. Shoichet would be willing to participate in physician-assisted dying for capable grievously and irremediably ill patients where satisfied it constituted appropriate medical care in the circumstances. Dr. Shoichet would require that he be satisfied the patient in question was fully informed, had given due and proper consideration to the issue, and was expressing a continuing and genuine desire for death.

3560. Dr. Shoichet considers end of life care an important part of his compassionate, moral, ethical and professional duty and role as a physician treating grievously and irremediably ill patients. Dr. Shoichet considers the ability to participate in physician-assisted dying on request, in appropriate circumstances and where there are all the necessary safeguards in place, an important component of the provision of health care to grievously and irremediably ill patients.

The BCCLA

~~36~~61. The objects of the BCCLA include the promotion, defence, sustainment and extension of civil liberties and human rights in British Columbia and Canada. To that end, the BCCLA prepares position papers, engages in public education, assists individuals to address violations of their rights and takes legal action as a plaintiff.

~~37~~62. In addition to the BCCLA's long standing interest in matters of patient's rights and health policy, the BCCLA has been extensively involved in advocacy and education in respect to end of life choices, including assisted suicide and voluntary euthanasia.

~~38~~63. The BCCLA has consistently opposed the criminalization of assisted suicide and voluntary euthanasia arguing that the principles of liberty, autonomy and equality, as well as the humanitarian commitment to preventing unnecessary suffering and to preserving the dignity of the individual, justify decriminalization.

~~39~~64. The BCCLA has sufficient interest to be granted public interest standing, in that:

a. this claim raises a serious challenge to the constitutional validity and applicability of the impugned provisions in the context of physician-assisted dying;

b. the BCCLA has a demonstrated, serious and genuine interest in the subject matter of this litigation;

c. the issue of whether there is a constitutional right to physician-assisted dying is relevant to all Canadians, regardless of their current state of health, given the frequency of the occurrence of diseases capable of causing grievous and irremediable illness and related suffering, and the speed of onset and quickness of course of many such diseases;

d. the BCCLA is comprised of thousands of members any of whom may one day wish or need to avail themselves or their loved ones of physician-assisted dying services; and

e. while directly affected patients could, in theory, bring their own cases to court, it is unreasonable to expect grievously and irremediably, and often terminally, ill persons, in light of their particular personal circumstances, to bring on and carry through to completion, a lengthy and involved legal challenge of the type set out in this claim.

The Impugned Provisions

4065. Section 241 of the *Criminal Code* makes it an indictable offence, liable to imprisonment for a term not exceeding fourteen years to: (a) counsel, or (b) aid or abet, a person to commit suicide.

4166. Section 22(3) of the *Criminal Code* defines "counsel" to include "procure." Aiding means assisting.

4267. Section 14 of the *Criminal Code* provides that no person is entitled to have death inflicted on him, and such consent does not affect the criminal liability of any person that inflicts death on the consenting person.

4368. Section 21(1)(b) of the *Criminal Code* renders a person who does or omits to do anything for purposes of aiding any person to commit an offence, a party to the offence. Section 21(2) renders persons acting with a common intention to carry out an unlawful purpose and to assist each other in carrying out that purpose, a party to any offence committed as a probable consequence.

4469. Sections 22(1) and (2) of the *Criminal Code* renders a person who counsels another person to be a party to an offence, where the person counselled is thereafter a party to an offence, also a party to the offence.

4570. Section 222 of the *Criminal Code* states, in part, as follows:

> 222 (1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.
>
> (2) Homicide is culpable or not culpable.
>
> (3) Homicide that is not culpable is not an offence.

(4) Culpable homicide is murder or manslaughter or infanticide.

(5) A person commits culpable homicide when he causes the death of a human being,

(a) by means of an unlawful act…

End of Life Care

4671. Canadian courts recognize the common law right of patients to refuse consent to medical treatment, or to demand that treatment, once commenced, be withdrawn or discontinued. This right has been specifically recognized even where the refusal of or withdrawal from treatment will result in certain death.

4772. Capable adults can enter into representation agreements with respect to future treatment in the event that they become incapable. In British Columbia, this is governed by the *Representation Agreement Act*, R.S.B.C. 1996, c. 405, which allows "adults to arrange in advance how, when and by whom, decisions about their health care, personal care or financial affairs or about other matters will be made if they become incapable of making decisions independently." The *Representation Agreement Act* also allows capable adults to consent in advance, or to refuse in advance, specified kinds of health care including life-supporting health care or treatment.

4873. In British Columbia, where an adult does not have a representation agreement, the *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, prescribes a list of third parties from whom a health care provider may obtain substitute consent to provide major or minor health care to an adult who is incapable. This health care can include the decision to refuse consent to health care necessary to preserve life in prescribed circumstances.

Relevant Social Norms

4974. A significant number of countries now authorize physician-assisted suicide or consensual physician-assisted death or both.

Part 2: RELIEF SOUGHT

The Plaintiffs seek the following relief:

1. a declaration that the impugned provisions do not apply to physician-assisted dying on the basis of ss. 92(7), (13) and (16), or any combination thereof, of the *Constitution Act, 1867 (U.K.)*, 30 & 31 Vict., c. 3, reprinted in R.S.C. 1985, App. II, No. 5 (the "*Constitution Act, 1867*"), and the doctrine of interjurisdictional immunity;

2. a declaration that to the extent that the impugned provisions prohibit physician-assisted dying, they unjustifiably infringe s. 7 of the *Canadian Charter of Rights and Freedoms* (the "*Charter*"), Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 (the "*Constitution Act, 1982*") and are, to that extent, of no force and effect;

3. a declaration that to the extent that the impugned provisions prohibit physician-assisted dying, they unjustifiably infringe s. 15 of the *Charter* and are, to that extent, of no force and effect;

4. the effect of the declarations of constitutional invalidity or inapplicability be suspended for a period of six months, with the exception that for Gloria and her physician there be an immediate constitutional exemption so as to allow her to avail herself of a physician assisted death at such time and subject to such terms and conditions that the Court allows or requires;

5. that such declarations be given retroactive effect at least in the case of the conduct engaged in by Lee and Hollis as described herein so that they not be at further risk of prosecution;

6. in the event that a decision on the merits cannot be made in a timely manner, an interlocutory injunction exempting Gloria and her physician from the application of the impugned provisions on such terms and conditions as the Court allows or requires;

67. costs, including special costs and applicable taxes on those costs; and

~~7~~8. such further and other relief as this Honourable Court deems meet and just.

Part 3: LEGAL BASIS

1. The Plaintiffs rely on:

   a. the *Constitution Act, 1867* and, in particular, ss. 91 and 92 thereof;

   b. s. 52 of the *Constitution Act 1982*, and

   c. the *Charter* and, in particular, ss. 1, 7, 15, and 24 thereof.

Division of Powers

2. The treatment and management of the physical and emotional suffering of a grievously and irremediably ill patient and, in particular, the determination of capability and consent for purposes of physician-assisted dying to end that suffering, are matters relating to health care, the regulation and delivery of health services, the practice of medicine, and regulation of the patient-physician relationship. These are matters within the exclusive jurisdiction of the Province of British Columbia on the basis of ss. 92(7), (13) and (16), or any combination thereof, of the *Constitution Act, 1867*.

3. The doctrine of interjurisdictional immunity applies to confer the limited grant of immunity from the impugned provisions required to allow physician-assisted dying to fall within the jurisdiction of the Province of British Columbia as an exercise of its core powers relating to health care, the regulation and delivery of health services, the practice of medicine, and the regulation of the patient-physician relationship.

***Charter*, Section 7**

4. Section 7 of the *Charter* states as follows:

> 7. 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.

The Grievously and Irremediably Ill Patient

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

6. 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.

7. 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.

8. Canada has, by means of the impugned provisions, restricted the ability of grievously and irremediably ill patients to obtain the physician-assisted dying services required to manage their death in a humane and dignified manner and thus, to determine, for themselves, the when and how of the experience of death.

9. 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.

10. Kay was deprived of her s. 7 rights of life, liberty and security of the person by the existence and operation of the impugned provisions.

11. For the same reasons, the impugned provisions deprive Lee, Hollis, Gloria and all British Columbians, as represented in this proceeding by the BCCLA, of their s. 7 rights to life, liberty and security of person.

Person Assisting

12. 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.

13. The restrictions imposed under the impugned provisions, to the extent that they operate to prohibit a person from assisting or supporting a grievously and irremediably ill person to obtain physician-assisted dying services, result in a deprivation of the assisting person's s. 7 right to liberty.

14. 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.

Physician Assisting

15. The right to liberty of a physician who seeks to provide physician-assisted dying services to a grievously and irremediably ill patient is engaged by prosecution and threat of prosecution under the impugned provisions.

16. The restrictions imposed under the impugned provisions, to the extent that they operate to prohibit a physician from providing physician-assisted dying services to a grievously and irremediably ill patient, result in a deprivation of the physician's s. 7 right to liberty.

17. The right to liberty of a physician must necessarily be protected in order to give meaning to the s. 7 life, liberty and security rights of grievously and irremediably ill patients to obtain physician-assisted dying services.

Principles of Fundamental Justice

18. The application of the impugned provisions to physician-assisted dying is arbitrary. The legal distinction by which the law enables, facilitates and protects the right and ability of grievously and irremediably ill persons, even once they are no longer capable or by

means of a substitute decision-maker, to direct a physician to remove, withdraw or discontinue life-sustaining care or treatment, but deprives, by means of criminal prohibition, capable grievously and irremediably ill persons of the right and ability to choose to die using physician-assisted dying services, is arbitrary.

19. The impugned provisions are, in the context of physician-assisted dying, overbroad in that they prohibit more conduct than is necessary to achieve the state objective. Physician-assisted dying services can be sufficiently and effectively regulated to limit their availability to patients who are capable, grievously and irremediably ill, and genuinely desire death.

20. The impugned provisions are, in the context of physician-assisted dying, grossly disproportionate. The gravity of the infringements on the *Charter* rights of grievously and irremediably ill persons who are thereby denied access to physician-assisted dying services are grossly disproportionate to the benefit and legislative purpose of the law.

***Charter*, Section 15**

21. Section 15(1) of the *Charter* reads as follows:

> 15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

22. The impugned provisions infringe the right to equality under s. 15(1).

23. These prohibitions create inequality by preventing persons unable by reason of material physical disability to end their lives unassisted from having the choice and ability to die when that option is available to other members of the public. Persons unable to act to die without assistance are deprived of the ability to choose and carry out their death in any lawful way, whereas the impugned provisions do not have that same effect on persons of requisite physical ability.

24. This inequality is imposed on the materially physically disabled by reason of their physical disability, which is a personal characteristic listed as an enumerated ground of discrimination under s. 15(1).

25. This inequality is a burden or disadvantage, as it limits the ability of those subject to the inequality to make and act upon decisions that are fundamental to their lives and persons. This disadvantage perpetuates prejudice and stereotyping about individuals with physical disabilities.

26. The impugned provisions operated to deprive Kay of the equal protection and benefit of the law by their discriminatory operation on and application to her by reason of her physical disability.

27. By virtue of the nature of ALS and Gloria's steadily deteriorating physical condition, the impugned provisions will, for the same reasons, operate to deprive Gloria of the equal protection and benefit of the law.

~~27~~28. For the same reasons, the impugned provisions deprive all materially physically disabled British Columbians, as represented in this proceeding by the BCCLA, of their rights to the equal benefit and protection of the law.

***Charter*, Section 1**

~~28~~29. Section 1 of the *Charter* reads as follows:

> 1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

~~29~~30. The said infringements of s. 7 and s. 15 cannot be justified pursuant to the criteria of s. 1, the burden of proof of which lies on Canada.

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Place of trial:	Vancouver, British Columbia
The address of registry is:	800 Smithe Street, Vancouver BC V6Z 2C5

Dated: ~~26 Apr 2011~~ 15 Aug 2011

"Joseph J. Arvay, Q.C."

Signature of
☐ plaintiffs ☒ lawyer for plaintiffs
JOSEPH J. ARVAY, Q.C.

Rule 7-1 (1) of the Supreme Court Civil Rules states:

1. (1) Unless all parties of record consent or the court otherwise orders, each party of record to an action must, within 35 days after the end of the pleading period,
   (a) prepare a list of documents in Form 22 that lists
      (i) all documents that are or have been in the party's possession or control and that could, if available, be used by any party at trial to prove or disprove a material fact, and
      (ii) all other documents to which the party intends to refer at trial, and
   (b) serve the list on all parties of record.

APPENDIX

[*The following information is provided for data collection purposes only and is of no legal effect.*]

Part 1: CONCISE SUMMARY OF NATURE OF CLAIM:

A challenge to the constitutional validity or applicability of the provisions of the *Criminal Code*, R.S.C., 1985, c. C-46, that prohibit physician-assisted dying, including those provisions that render someone criminally liable for aiding or counselling same or otherwise render someone a party to a criminal offence for arranging, supporting or otherwise participating in physician-assisted dying.

Part 2: THIS CLAIM ARISES FROM THE FOLLOWING:

[*Check one box below for the case type that best describes this case.*]

A personal injury arising out of:

☐ a motor vehicle accident
☐ medical malpractice
☐ another cause

A dispute concerning:

☐ contaminated sites
☐ construction defects
☐ real property (real estate)
☐ personal property
☐ the provision of goods or services or other general commercial matters
☐ investment losses
☐ the lending of money
☐ an employment relationship
☐ a will or other issues concerning the probate of an estate
☒ a matter not listed here

Part 3: THIS CLAIM INVOLVES:

[*Check all boxes below that apply to this case*]

☐ a class action
☐ maritime law
☐ aboriginal law
☒ constitutional law
☐ conflict of laws
☐ none of the above
☐ do not know

Part 4: Enactments relied upon:

Canadian Charter of Rights and Freedoms, Part I of the *Constitution Act, 1982*
Constitution Act, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11
Constitution Act, 1867 (U.K.), 30 & 31 Vict., c. 3, reprinted in R.S.C. 1985, App. II, No. 5