CITATION: A.B. v. Canada (Attorney General), 2016 ONSC 1912
COURT FILE NO.: CV-16-00AD001-00ES
DATE: 20160317

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	)	
A.B.	)	*Andrew Faith* and *Emma Carver*, for the Applicant
Applicant	)	
– and –	)	
ATTORNEY GENERAL OF CANADA, ATTORNEY GENERAL OF ONTARIO, DR. DOE and DR. DOE	)	*Joseph Cheng* for the Attorney General of Canada
	)	*Zachary Green* for the Attorney General of Ontario
Respondents	)	*Erica J. Baron*, for Dr. Doe and Dr. Doe
	)	**HEARD:** March 17, 2016

PERELL, J.

REASONS FOR DECISION

A. INTRODUCTION

[1] A.B., who is an 81-year-old gentleman with advanced-stage aggressive lymphoma, brings an application for a declaration that he satisfies the criteria for the constitutional exemption granted in *Carter v. Canada (Attorney General)*, 2016 SCC 4 ("*Carter-2016*"), for a physician-assisted death.

[2] A.B. also seeks a declaration that the circumstances of his death does not require notification to the coroner under the *Coroners Act*, R.S.O. 1990, c. C.37.

[3] A confidentiality order was granted for this application and is to be continued. See *A.B. v. Canada*, 2016 ONSC 1571.

[4] This is the first application of this kind in Ontario and the second in Canada. Justice Martin of the Alberta Court of Queen's Bench, in an erudite and insightful decision reported as *Re H.S.*, 2016 ABQB 197, decided the first such application on February 29, 2016.

[5] The Respondents the Attorney General of Canada and the Attorney General of Ontario take no position on this application. The Respondent physicians support the application.

[6] For the reasons that follow, I grant the application.

B. LEGAL BACKGROUND

1. The Criterion for Physician-Assisted Death

[7] It has been, and it remains until June 6, 2016, a crime in Canada to assist another person in ending his or her own life. This criminal law prohibition applies to circumstances where a patient requests a physician provide or administer medication that intentionally brings about the patient's death.

[8] In *Carter v. Canada (Attorney General)*, 2015 SCC 5 ("*Carter-2015*"), the Supreme Court of Canada decided that sections 14 and 241(b) of the *Criminal Code*, R.S.C., 1985, c. C-46, the provisions of the *Criminal Code* that would prohibit physician-assisted death, violate an individual's right to life, liberty and security of the person contrary to s. 7 of the *Canadian Charter of Rights and Freedoms*, 1982, (the "*Charter*").

[9] The Supreme Court of Canada struck down these *Criminal Code* provisions that stood in the way of a physician-assisted death. The Supreme Court of Canada at para. 40 of *Carter-2015* defined "physician assisted death" or "physician assisted dying" as "... the situation where a physician provides or administers medication that intentionally brings about the patient's death, at the request of the patient."

[10] However, the Court suspended the operation of its Order, which struck down the legislation for one year to allow the federal government, which has jurisdiction over the criminal law, to enact a new law that would not offend the *Charter*. The federal government also needed time to co-ordinate its legislative efforts with the provinces, which have a concurrent jurisdiction about health law and the regulation health professionals.

[11] In *Carter-2015*, the unanimous Supreme Court of Canada reviewed the extensive factual and legal record that had been before the lower courts. See: *Carter v. Canada (Attorney General)*, 2013 BCCA 435 (Finch C.J.B.C. and Newbury and Saunders JJ.A.) and *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (Smith J.). The Supreme Court of Canada reconsidered its previous decision in *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, in which a divided Court had refused to strike down the *Criminal Code* provisions that stood in the way of a physician-assisted death for Mrs. Rodriguez, who suffered from amyotrophic lateral sclerosis ("ALS"). And, in *Carter-2015*, the Supreme Court reviewed legislative initiatives in eight Western democracies that now permit assistance in dying.

[12] In *Re H.S.*, *supra* at paras. 23-31, Justice Martin provides a helpful analysis of the Supreme Court's decision in *Carter-2015*. Justice Martin stated:

> 23. The Court framed the issue in this way at para. 1:
>
> > It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.
>
> 24. The Supreme Court agreed with the trial judge that the prohibition on assisted dying infringed Ms. Taylor's s. 7 rights by interfering with fundamentally important personal medical decision-

making, imposing pain and psychological stress and depriving her of control over her bodily integrity. She was denied the opportunity to make a choice that may be very important to her sense of dignity and personal integrity and that is consistent with her lifelong values and life experiences. Ms. Taylor's security of her person was also impaired as she was forced to suffer physical and psychological pain.

25. The Supreme Court recognized at para. 67 that the law has long protected patient autonomy and medical decision-making. The Court said the right to decide one's own fate entitles adults to direct the course of their own medical care and underlies the concept of informed consent and s. 7's guarantee of liberty and security of the person.

26. The s. 7 liberty interests are engaged when the state affects important and fundamental life choices. People seeking physician assisted death do so out of deeply personal and fundamental beliefs about how they wish to live or cease to live. Such a decision is rooted in their control over their bodily integrity and represents their deeply personal response to serious pain and suffering. The Supreme Court held that by denying them the opportunity to make that choice, the prohibition infringes on their liberty and security of the person. While s. 7 recognizes the value of life, it also honours the role autonomy and dignity play at the end of that life.

27. At para. 66 the Supreme Court said:

> An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The law allows people in this situation to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment, but denies them the right to request a physician's assistance in dying. This interferes with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty. And, by leaving people like Ms. Taylor to endure intolerable suffering, it impinges on their security of the person.

28. The Court then canvassed the principles of fundamental justice and concluded that the prohibition on assisted dying was overbroad. While the impact of the prohibition was severe, they made no finding in regards to gross disproportionality.

29. The Court found the impugned provisions could not be saved under s. 1. The Court accepted that the purpose or object of the impugned criminal prohibition against assisted death is to protect vulnerable persons from being induced to take their own lives in times of weakness. The Court explicitly rejected a submission that the purpose of the prohibition should be defined as simply "the preservation of life." While protecting the vulnerable was a legitimate purpose, the prohibition was not a reasonable limit on the applicant's s. 7 rights because an absolute prohibition is not minimally impairing. The Supreme Court stated at para. 117 that the risks associated with physician assisted death could be managed by a carefully designed and monitored system of safeguards.

30. As a result of these findings, the Supreme Court of Canada struck down those provisions of the *Criminal Code* prohibiting physician assisted death, stating at para. 127:

> The appropriate remedy is therefore a declaration that s. 241(b) and s. 14 of the *Criminal Code* are void insofar as they prohibit physician assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. "Irremediable," it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician assisted dying may be sought.

> 31. The Supreme Court suspended its declaration of invalidity for 12 months, ending February 6, 2016.

[13] Because of the intervention of a very lengthy general election that saw the election of a new government, the federal government was unable to meet the February 6, 2016 deadline, and the new government applied to the Supreme Court for an extension of the suspension of the declaration of invalidity that was sustaining the continued operation of the unconstitutional *Criminal Code* provisions.

[14] Meanwhile, although the federal government was unable to formulate its response to *Carter-2015*, the Québec government enacted *An Act Respecting End-of-Life Care*, CQLR c S-32.0001 to govern physician-assisted dying in that province. The statute came into force in December 2015.

[15] Québec's *Act* permits medical aid in dying to patients who meet the criteria set out in s. 26 of the *Act*. In particular, eligible patients must: (1) be of full age; (2) be capable of giving consent to care; (3) be an insured person within the meaning of the *Health Insurance Act*, RSQ c A-29; (4) be at the end of life; (5) suffer from a serious and incurable illness; (6) be in an advanced state of irreversible decline in capability; and (7) experience constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable.

[16] Section 29 of Québec's *Act* sets out prerequisites that the physician must satisfy before he or she may provide medical aid in dying. The prerequisites include: (1) taking steps to ensure a patient meets and continues to meet the criteria set out in s. 26; (2) verifying the reliability of the patient's consent; (3) informing patients of their prognosis and alternative therapies that may be available; (4) verifying the persistence of a patient's suffering; (5) confirming at regular intervals that the patient still wishes to die; (6) discussing the request with members of the patient's care team; (7) discussing the request with the patient's close relations if the patient so wishes; (8) ensuring that patients have had an opportunity to discuss the request with anyone they wish to contact; and (9) obtaining a second physician's opinion as to whether the criteria in s. 26 have been met. Section 30 of Québec's *Act* requires the physician who ensured that all of these conditions were met to personally administer medical aid in dying to the patient and to stay with the patient until death.

[17] The federal government's request for an extension was made in *Carter-2016*. In *Carter-2016*, the Supreme Court was unanimous in granting an extension of the suspension of the declaration of constitutional invalidity to June 6, 2016.

[18] However, the Supreme Court was divided on what should happen in this interim four-month period to persons seeking physician-assisted death in Québec and elsewhere. Four judges were of the view that the *status quo* should remain. However, the majority of five judges granted constitutional exemptions for the Québec regime, and the majority granted constitutional exemptions for individuals in the balance of the country who could satisfy the criteria established by the unanimous Court in *Carter-2015*. At para. 6, the majority stated:

> 6. This is the first time the Court has been asked to consider whether to grant individual exemptions during an *extension* of a suspension of a declaration of invalidity. Parliament was given one year to determine what, if any, legislative response was appropriate. In agreeing that more time is needed, we do not at the same time see any need to unfairly prolong the suffering of those who meet the clear criteria we set out in [*Carter-2015*]. An exemption can mitigate the

> severe harm that may be occasioned to those adults who have a grievous, intolerable and irremediable medical condition by making a remedy available now pending Parliament's response. The prejudice to the rights flowing from the four-month extension outweighs countervailing considerations. Moreover, the grant of an exemption from the extension to Québec raises concerns of fairness and equality across the country. We would, as a result, grant the request for an exemption so that those who wish to seek assistance from a physician in accordance with the criteria set out in para. 127 of our reasons in [*Carter-2015*] may apply to the superior court of their jurisdiction for relief during the extended period of suspension. Requiring judicial authorization during that interim period ensures compliance with the rule of law and provides an effective safeguard against potential risks to vulnerable people.

[19] Thus, in *Carter-2016*, on January 6, 2016, the Supreme Court extended its suspension to June 6, 2016 on terms that there was an individual constitutional exemption from the continued operation of the unconstitutional *Criminal Code* provisions for adult persons.

[20] In *Carter-2016,* the Supreme Court ruled that individuals wishing to avail themselves of the personal constitutional exemption may apply to the superior court of their jurisdiction for relief. Thus, the role given to superior courts across the country is to hear individual applications and determine whether an applicant satisfies the criteria of para. 127 of *Carter-2015*.

[21] Paragraph 127 of *Carter-2015* states:

> 127. The appropriate remedy is therefore a declaration that s. 241(b) and s. 14 of the *Criminal Code* are void insofar as they prohibit physician assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. "Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual. The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician assisted dying may be sought.

[22] I extract five criteria from para. 127 of *Carter-2015*; namely: (1) the person is a competent adult person; (2) the person has a grievous and irremediable medical condition including an illness, disease or disability; (3) the person's condition is causing him or her to endure intolerable suffering; (4) his or her suffering cannot be alleviated by any treatment available that he or she finds acceptable; and, (5) the person clearly consents to the termination of life.

[23] For the superior courts to properly carry out their role after *Carter-2016,* each of the five criteria require some elucidation or explanation.

[24] With respect to the first criterion, the common law definition of capacity in the context of making decisions about medical treatment is the ability to understand the nature, the purpose, and the consequences of the proposed treatment: *Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre,* 2013 SCC 53. Under the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A, a patient is presumed to be competent. However, for the first criterion to be satisfied, the matter of capacity must be proven, not assumed.

[25] With respect to the second criterion, a grievous medical condition connotes that the person's medical condition greatly or enormously interferes with the quality of that person's life and is in the range of critical, life-threatening, or terminal. An irremediable medical condition connotes that the medical condition is permanent and irreversible. Like the first criterion, this criterion must be proven to the satisfaction of the court.

[26] With respect to the third criterion, there must be a causal connection between the person's medical condition and the person's suffering from enduring, intolerable pain. There are two elements here, the first being that the person is suffering grievous pain and the second element being that the medical condition is the predominant source of that suffering. Because pain is influenced by subjective or idiosyncratic features, the evidence to satisfy this third criterion will be a mixture of subjective and objective medical evidence.

[27] With respect to the fourth criterion, it is the pain and suffering, not the medical condition that cannot be alleviated by any treatment acceptable to the person. Once again, there is both an objective and subjective element to this criterion. Objectively, there may or may not be effective treatments to alleviate and manage the person's pain but, if there are treatments, they must be subjectively acceptable to the person.

[28] With respect to the fifth criterion, under s. 11 (1) of the *Health Care Consent Act, 1996*, consent to treatment requires the following: (1) the consent must relate to the treatment; (2) the consent must be informed; (3) the consent must be given voluntarily; and (4) the consent must not be obtained through misrepresentation or fraud.

2. The Practice Advisory

[29] In anticipation of applications being brought pursuant to *Carter-2016* by individuals in Ontario's Superior Court of Justice, the Chief Justice of the Superior Court directed that a Practice Advisory providing procedural and evidentiary guidelines be prepared and published. Similar efforts were made or are being made by the superior courts in other provinces including British Columbia and Nova Scotia.

[30] The Ontario Practice Advisory provides procedural and evidentiary guidelines. For present purposes, the following provisions of the Advisory are pertinent:

> *Practice Advisory – Application for Judicial Authorization of Physician Assisted Death*
>
> In *Carter v. Canada (Attorney General)*, 2016 SCC 4, the Supreme Court of Canada directed that applications may be brought to provincial superior courts for exemptions from the *Criminal Code* prohibition against physician assisted death, in accordance with the criteria set out in *Carter v. Canada (Attorney General)*, 2015 SCC 5 [*Carter* (2015)].
>
> This Practice Advisory is intended to provide guidance to counsel and parties who intend to bring applications to the Superior Court for an exemption to the *Criminal Code* prohibition against physician assisted death. The direction provided in this advisory is always subject to any orders made by the presiding judge on the application. In addition, this Practice Advisory refers to the types of evidence discussed in *Carter* (2015) to assist counsel and parties. However, the onus rests with the applicant to confirm and meet the evidentiary requirements set out in *Carter* (2015).
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> ….
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> *Evidence about the Applicant*
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> 9. The application record should include an affidavit from the applicant concerning,
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> a. the applicant's birth date;
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> b. the applicant's place of residence and the duration of that residency;
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> c. the applicant's medical condition (illness, disease, or disability);

d. whether as a result of his or her medical condition, the applicant is suffering enduring intolerable pain or distress that cannot be alleviated by any treatment acceptable to the applicant;

e. the reasons for the applicant's request for an authorization of a physician assisted death;

f. whether the applicant commenced the application after having been fully informed about his or her medical condition (illness, disease, or disability), diagnosis, prognosis, treatment options, palliative care options, the risks associated with the treatment and palliative care options, and the risks associated with a physician assisted death;

g. the manner and means and timing of the physician assisted death for which the applicant seeks an authorization;

h. whether the applicant is aware that his or her request for an authorization for a physician assisted death may be withdrawn at any time; and

i. whether the applicant is aware that if the authorization is granted, the decision to use or not use the authorization is entirely the applicant's decision to make.

Evidence of the Attending Physician

10. The application record should include an affidavit from the applicant's attending physician addressing whether,

a. the applicant has a grievous irremediable medical condition (illness, disease, or disability) that causes suffering;

b. as a result of his or her medical condition, the applicant is suffering enduring intolerable pain or distress that cannot be alleviated by any treatment acceptable to the applicant;

c. the applicant was fully informed about his or her medical condition (illness, disease, or disability), diagnosis, prognosis, treatment options, palliative care options, the risks associated with the treatment and palliative care options, and the risks associated with a physician assisted death;

d. the applicant has the mental capacity to make a clear, free, and informed decision about a physician assisted death;

e. the applicant is or will be physically incapable of ending his or her life without a physician assisted death;

f. the applicant consents without coercion, undue influence, or ambivalence to a physician assisted death;

g. the applicant is aware that his or her request for an authorization for a physician assisted death may be withdrawn at any time;

h. the applicant makes the request for authorization for a physician assisted death freely and voluntarily; and

i. the applicant is aware that if the authorization is granted, the decision to use or not use the authorization is entirely the applicant's decision to make.

Evidence of the Consulting Psychiatrist

11. The application record should include an affidavit from the applicant's consulting psychiatrist addressing whether,

> a. the applicant has a grievous irremediable medical condition (illness, disease, or disability) that causes the applicant to suffer;
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> b. the applicant has the mental capacity to make a clear, free, and informed decision about a physician assisted death;
>
> c. the applicant consents without coercion, undue influence, or ambivalence to a physician assisted death;
>
> d. the applicant is aware that his or her request for an authorization for a physician assisted death may be withdrawn at any time;
>
> e. the applicant makes the request for authorization for a physician assisted death freely and voluntarily; and
>
> f. the applicant is aware that if the authorization is granted, the decision to use or not use the authorization is entirely the applicant's decision to make.

Evidence of Physician Proposed to Assist Death

The application record should include an affidavit from the physician who is proposed to be the physician authorized to assist death, who may be the applicant's attending physician or another physician, addressing,

> a. the manner and means and timing of the physician assisted death;
>
> b. whether the physician providing assistance is willing to assist the applicant in dying if that act were authorized by court order;
>
> c. whether the physician believes that his or her providing assistance would be clearly consistent with the applicant's wishes; and
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> d. whether the physician understands that the decision to use or not use the authorization is entirely the applicant's decision to make.

[31] The Ontario Practice Advisory offers advice on such issues as notice, confidentiality, and the type, amount and form of evidence, as well as matters of timing and scheduling. The Advisory is legislative, but it is not legislation or substantive binding law and rather it is adjectival or adjunctive of the substantive law.

[32] The substantive law for physician-assisted death derives from *Carter-2015* and *Carter-2016*, which directs the superior courts to determine whether an individual applicant meets the *Carter-2015* criteria. In *Carter-2016*, the Supreme Court of Canada did not prescribe what evidence would or should satisfy the criteria, and the Practice Advisory is aimed at giving some guidance about what evidence a court is likely to require with respect to the *Carter-2015* criteria. But the Advisory is no more than suggestions, and ultimately it is up to the application judge to make his or her own determination based on the *Carter-2015* criteria. I agree with Justice Martin in *Re H.S.*, *supra* at paras. 88 and 92, where she states:

> 88. Under accepted general principles, the claimant carries the burden to establish that she falls within the constitutional exemption granted in *Carter-2016*. She is entitled to meet her burden

> based on any form of admissible, authentic and reliable evidence. The motions judge retains the discretion to accept all, some or none of the admissible evidence.
>
> ….
>
> 92. Based on *Carter-2016*, I conclude that I am entitled to take a flexible approach to the evidence on this kind of application. I note that I am bound only by the Supreme Court's directive and not by the Ontario, British Columbia or Québec approaches. It will be up to the individual judge in an individual case to assess the admissibility, authenticity and reliability of the evidence before him or her.

C. THE ROLE OF THE COURT

[33] An application for a physician-assisted death imposes a solemn responsibility on the superior courts across this country. In *Carter-2016*, the majority of the Supreme Court stated at para. 6: "Requiring judicial authorization during that interim period ensures compliance with the rule of law and provides an effective safeguard against potential risks to vulnerable people."

[34] The responsibility to ensure compliance with the rule of law, which is an everyday occupation and preoccupation of the court, is, however, not a routine matter in the context of an application for a physician-assisted death. The court's role in enforcing the rule of law is a special and not routine exercise in at least five ways.

- First, while the court typically employs an adversarial system of adjudication, an application for a physician-assisted death is more investigatory than adversarial. The role of the court is to investigate and to be satisfied that the criteria for a physician-assisted death are satisfied. There may be no opponents or adversaries in an assisted death application, but regardless of whether there is opposition or whether there is consent and concurrence by the persons before the court, the court's role is not to decide a dispute, its role is to determine whether the criteria for an assisted death are satisfied.
- Second, the court is not engaged in its *parens patriae* jurisdiction, where the court acts for the protection of those who cannot care for themselves. The *parens patriae* jurisdiction is essentially protective and does not create substantive rights nor change the means by which claims are determined: *Wu Estate v. Zurich Insurance Co.*, [2006] O.J. No. 1939 (Ont. C.A.); *Tsaoussis (Litigation Guardian of) v. Baetz*, [1998] O.J. No. 3516, 41 O.R. (3d) 257 at 268 (Ont. C.A.), leave to appeal refused [1998] S.C.C.A. No. 518 (S.C.C.).
- Third, the court has no discretion. If the applicant satisfies the criteria, he or she is entitled to the constitutional exemption for a physician-assisted death.
- Fourth, the court is not dispensing justice. A physician-assisted death application is not a matter of granting awards and remedies to victims or righteous persons or of punishing wrongdoers; it is a matter of investigating and determining whether the criteria for a physician-assisted death are satisfied.
- Fifth, it is by investigating and determining whether the criteria for a physician-assisted death are satisfied that the court will fulfill its mission of providing an effective safeguard against potential risks to vulnerable people. The criteria have within them safeguards to ensure that the applicant is not being coerced, controlled, or manipulated and safeguards to ensure that the applicant is making a fully-informed decision in the exercise of his or her personal autonomy, personal dignity, and free will. The criteria emphasize the

personal autonomy of the applicant and that the decision is a decision of a competent adult person that clearly consents to the termination of life.

D. EVIDENTIARY BACKGROUND

[35] This application for a physician-assisted death was supported by affidavits from A.B., from his wife, his daughter, his hematologist, his palliative care physician, a geriatric psychiatrist, and a legal assistant at his legal counsel's firm providing an exchange of correspondence with Dr. Dick Huyer, the Chief Coroner for Ontario.

E. THE CIRCUMSTANCES OF A.B.

[36] A.B. was born in Europe in 1935, migrated at a young age to Africa, where he found employment and met his to-be wife, whom he describes as the love of his life. They married, started several successful businesses and had three children, a daughter, and two sons. They have been married for 37 years.

[37] In 1976, civil war and political unrest led to A.B. and his wife losing everything and to their departure from Africa to begin again in Canada, which welcomed them along with their hopes of a safe and prosperous future. A.B.'s hopes were realized. He set to work, lived a successful life, enjoyed a home and a cottage, was blessed by a loving, caring, and close family, and after 63 years of working as both an employee and later as an employer in several industries, he retired with the new preoccupation of helping to raise a grandson and three granddaughters.

[38] It seems his health was fine, save for bypass surgery in his late sixties from which he recovered. However, in July 2012, he was diagnosed with advanced stage aggressive diffuse large B-cell lymphoma. He came under the care of his oncologist hematologist who prescribed chemotherapy. The treatments began in September 2012. There were severe side effects and hospitalization. The cancer was not cured, leading to his decision in September 2013 to begin palliative oral chemotherapy.

[39] The palliative care was helpful, and A.B.'s symptoms and pain were controlled until November 2015, when his muscular pain severely worsened. By December 2015, the pain, fatigue, nausea, and weakness were becoming extreme. The pain from the cancer in his spine was radiating pain throughout his body, and in January 2016, a radiation oncologist, prescribed radiation. Around this time, A.B. came under the care of a palliative care physician.

[40] A.B.'s hematologist has been his treating physician since 2012. The hematologist's current prognosis for A.B. is that the progress of A.B's cancer will now quicken and it will cause him extreme pain and suffering. A.B.'s life expectancy is less than three months.

[41] Currently, A.B. is suffering severe pain, despite receiving pain medication and narcotics. A.B. deposes that his suffering is intolerable and unbearable. He no longer has control over his bowels and bladder. He cannot stand or sit without assistance. He is mentally alert and lucid, but he cannot manage any activities.

[42] A.B. understands that his cancer is not responding to treatment and is incurable, and in January 2016, he made the decision to request a physician-assisted death. I quote the two concluding paragraphs of his affidavit:

> For all of my love of life I do not fear death. In the early stages of the disease I fought back hard as

> long as there was hope for recovery. I held out hope that I would be able to improve my well-being. Only when the pain became too much to bear and it became evident that there was no positive outcome did I turn my focus to managing my own death. I have a strong wish to die with dignity at the time of my choosing.
>
> I have made this decision of my own free will, and have not been influenced or coerced by anyone. I understand that my request for physician assisted death may be withdrawn at any time, and that even if the court allows me to receive a physician assisted death, I do not need to go through with it. The decision is mine alone. I am fully aware that my request for physician assisted death can be withdrawn at any time.

[43] A.B. has asked his hematologist and his palliative care physician for assistance in accessing a physician-assisted death. The hematologist and the palliative care physician have both reviewed the Ontario College of Physicians and Surgeons Interim Guidelines on Physician Assisted Death and both believe that A.B. meets the criteria for assistance.

[44] On February 29, 2016, the geriatric psychiatrist performed a capacity assessment of A.B. and the psychiatrist also conducted insight, judgment, and cognition assessments of A.B. Based on the definition of capacity in the *Health Care Consent Act, 1996, supra*, which requires that a patient is able to understand the information that is relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision, the opinion of the geriatric psychiatrist is that A.B. has the capacity to make a decision about physician-assisted death.

[45] The hematologist, the palliative care physician, and the geriatric psychiatrist, respectively, deposed that they had reviewed the Practice Advisory issued by this Court. I quote from the palliative physician's affidavit:

> In response to the criteria set out in the practice advisory issued by the Ontario Superior Court of Justice related to applications for physician assisted death, which I have reviewed:
>
> (a) I confirm that it is my opinion that AB has a grievous irremediable medical condition that causes suffering.
>
> (b) Based on my experience, observation, and interactions with AB, he is suffering enduring intolerable pain, fatigue and nausea that cannot be and has not been alleviated by any treatment acceptable to him.
>
> (c) I was not the physician who diagnosed AB's medical condition. Based on the medical records available to me and based on my interactions with AB, I can confirm that AB was advised of his diagnosis by the diagnosing physician. I have discussed AB's condition with him and I believe based on those discussions that he understands that he has a grievous irremediable medical condition, the prognosis, treatment options, palliative care options, and the risks associated with a physician assisted death.
>
> (d) AB currently makes his own medical decisions pursuant to the *Health Care Consent Act*. While I have not been designated a capacity assessor, I have not observed anything to call into question AB's mental capacity to make a clear, free and informed decision about physician assisted death.
>
> (e) AB wishes the assistance of a physician in his death.
>
> (f) AB has advised me that he wishes and consents to physician assisted death. I have not observed any undue influence, coercion, or ambivalence.
>
> (g) I have advised AB that his request for an authorization for a physician assisted death may be

> withdrawn at any time. AB advised me that he understood my advice and I believe him.
>
> (h) I have asked AB whether he makes the request for authorization for a physician assisted death freely and voluntarily. He has advised me that he does and I believe him.
>
> (i) I have advised AB that if the authorization is granted, the decision to use or not use the authorization is entirely AB's decision to make. AB advised me that he understood my advice and I believe he did.

[46] The hematologist, who along with the palliative care physician is prepared to provide a physician-assisted death, described the nature of the assistance. He deposed:

> I am willing, in collaboration with [the palliative care physician] to assist AB in dying if that act were authorized by court order. I would be willing to provide a prescription for oral pentobarbital or secobarbital in a dose that would cause death if ingested by AB; however, based on inquiries I have made I do not believe these drugs are currently available in Ontario in an oral dose of this amount. Therefore, I am also willing to assist AB in dying by following, in collaboration with [the palliative care physician], the "Quebec protocol" a copy of which is attached hereto and marked as Exhibit "B" with any appropriate or necessary modifications agreed to by AB.

[47] During the course of the argument, I was advised that the Québec protocol, which involves the intravenous application of drugs, will be followed should AB decide to use the authorization for a physician assisted death.

F. DISCUSSION AND ANALYSIS

1. The Application for a Physician-Assisted Death

[48] As the discussion above has repeatedly noted, the matter to be determined is whether the circumstances of A.B. satisfy the criteria for a physician-assisted death as specified by the Supreme Court in *Carter-2016*, which criteria were derived from *Carter*-2015.

[49] Having reviewed the evidentiary record, I conclude that A.B. satisfies the criteria; namely: (1) he is a competent adult person; (2) he has a grievous and irremediable medical condition including an illness, disease or disability; (3) his condition is causing him to suffer enduring intolerable suffering; (4) his suffering cannot be alleviated by any treatment available to him that he finds acceptable; and (5) he clearly consents to the termination of life.

[50] I am also satisfied by the evidence that: (1) A.B. is a resident of Ontario; (2) he commenced his application after having been fully informed about his medical condition, diagnosis, prognosis, treatment options, and palliative care options; (3) he is aware that his request for an authorization for a physician-assisted death may be withdrawn at any time; (4) he is aware that if the authorization is granted, the decision to use or not use the authorization is entirely his to make; and (5) he consents without coercion, undue influence, or ambivalence to a physician-assisted death.

[51] I am satisfied that there are physicians willing to assist A.B. in dying if a physician-assisted death were authorized by court order and that the physicians believe that providing assistance would clearly be consistent with A.B.'s wishes and that they understand that the decision to use or not use the authorization is entirely A.B.'s decision to make.

[52] I, therefore, grant A.B. a declaration that he satisfies the criteria for the constitutional exemption granted in *Carter-2016* for a physician-assisted death.

2. Ancillary Relief and Notification to the Coroner

[53] A.B. and his family are concerned that the physicians who will provide him with a physician-assisted death are required, pursuant to the *Coroners Act*, to notify the coroner of the circumstances of his death. The notification, in turn, would lead to the coroner issuing a warrant to seize A.B.'s body and then conducting an autopsy including the dissection of his corpse.

[54] Pursuant *O. Reg. 1094* enacted pursuant to the *Vital Statistics Act*, R.S.O. 1990, c. V.4, physicians are obligated to sign a medical certificate of death. Subsections 35 (2) and (4) of the regulation state:

> (2) Subject to subsections (3) and (4), any legally qualified medical practitioner who has been in attendance during the last illness of a deceased person or who has sufficient knowledge of the last illness shall immediately after the death complete and sign a medical certificate of death in the form approved by the Registrar General, stating the cause of death.
>
> …
>
> (4) In the case of a death of which the coroner is required to be notified under section 10 of the *Coroners Act*, the coroner notified shall, as soon as the cause of death is known, complete and sign a medical certificate of death in the form approved by the Registrar General, stating the cause of death according to the classification of diseases adopted by reference in section 70.

[55] Section 10 of the *Coroners Act* provides:

> *Duty to give information*
>
> 10. (1) Every person who has reason to believe that a deceased person died,
>
> …
>
> (f) from any cause other than disease; or
>
> (g) under such circumstances as may require investigation,
>
> shall immediately notify a coroner or a police officer of the facts and circumstances relating to the death, and where a police officer is notified he or she shall in turn immediately notify the coroner of such facts and circumstances.

[56] Pursuant to s. 15 of the *Coroners Act*, where a coroner is informed that there is a deceased person within his or her jurisdiction and that there is reason to believe that the person died in any of the circumstances mentioned in s. 10, the coroner must issue a warrant to take the body and must examine the body.

[57] The Chief Coroner may also do so at his or her own volition, if there is reason to believe a person has died in any of the circumstances in s. 10(1). The Coroner can then make such investigation as, in its opinion, is necessary in the public interest.

[58] Sections 15, 16, and 31(1) of the *Coroners Act* state:

> *Coroner's investigation*
>
> 15(1) Where a coroner is informed that there is in his or her jurisdiction the body of a person and that there is reason to believe that the person died in any of the circumstances mentioned in section 10, the coroner shall issue a warrant to take possession of the body and shall examine the body and make such investigation as, in the opinion of the coroner, is necessary in the public interest to

enable the coroner,

(a) to determine the answers to the questions set out in subsection 31 (1);

(b) to determine whether or not an inquest is necessary; and

(c) to collect and analyze information about the death in order to prevent further deaths in similar circumstances.

Idem

(2) Where the Chief Coroner has reason to believe that a person died in any of the circumstances mentioned in section 10 and no warrant has been issued to take possession of the body, he or she may issue the warrant or direct any coroner to do so.

Jurisdiction

(3) After the issue of the warrant, no other coroner shall issue a warrant or interfere in the case, except the Chief Coroner.

Expert assistance

(4) Subject to the approval of the Chief Coroner, a coroner may obtain assistance or retain expert services for all or any part of his or her investigation or inquest.

….

Investigative powers

16. (1) A coroner may,

(a) examine or take possession of any dead body, or both; and

…

Delegation of powers

(3) A coroner may authorize a legally qualified medical practitioner or a police officer to exercise all or any of the coroner's powers under subsection (1).

Idem

(4) A coroner may, where in his or her opinion it is necessary for the purposes of the investigation, authorize a legally qualified medical practitioner or a police officer to exercise all or any of the coroner's powers under clauses (2) (a), (b) and (c) but, where such power is conditional on the belief of the coroner, the requisite belief shall be that of the coroner personally.

….

Purposes of inquest

31. (1) Where an inquest is held, it shall inquire into the circumstances of the death and determine,

(a) who the deceased was;

(b) how the deceased came to his or her death;

(c) when the deceased came to his or her death;

> (d) where the deceased came to his or her death; and
>
> (e) by what means the deceased came to his or her death.

[59] In the immediate case, A.B.'s counsel communicated with Dr. Dick Huyer, the Chief Coroner, about the circumstances of A.B.'s application for a physician-assisted death, and in an email message dated March 9, 2016, Dr. Huyer advised that should the coroner be notified of A.B.'s death, then pursuant to s. 15 of the *Coroners Act*, the coroner will take possession of the body and undertake an investigation to the extent that it is necessary. The coroner also indicated that if the circumstances of A.B.'s physician-assisted death raised concerns about potential drug toxicity that typically involve a police-assisted investigation. The email from the Chief Coroner stated:

> In general, when investigating deaths where concerns are present about potential drug toxicity Ontario's death investigation system will typically involve the local police service to assist with the investigation, complete an autopsy and request completion of toxicology testing.
>
> If a report is received by the Coroner regarding A.B.'s death, the investigation may include an autopsy that would include external and internal examinations, likely including dissection of the body. Should an autopsy be felt to be necessary, the process would likely be complete within 2-3 days after the death. Should the death occur on a weekend, the autopsy would likely not be completed until the following Monday. The investigation would likely include toxicology testing with results received up to 2-3 months after the death.

[60] Dr. Huyer stated in his email message that if the Coroner becomes involved with a physician-assisted death, the Coroner cannot determine in advance whether an autopsy will be necessary, even following receipt of a judicial authorization pursuant to *Carter-2016*.

[61] A.B. seeks a declaration that the Coroner need not be notified, and he submits that following his death, notice is not required under s. 10(1) of the *Corners Act* because: (a) his death would not be a death from a cause other than by disease under s. 10(1)(f); and (b) his death would not be a circumstance that requires investigation under s. 10(1)(g).

[62] I agree with this submission.

[63] In his factum A.B. provides an elaborate argument of statutory interpretation to the conclusion that the circumstances of a physician-assisted death would not be a circumstance where a person would have reason to believe that a deceased person died from any cause other than the disease. The elaborate argument is an ultimate-cause argument leading to the conclusion that while the immediate cause of death might be cardiac arrest or the shutting down of the body's vital organs, the antecedent cause of death is the ingestion of drugs that caused the heart or organs to stop, but the ultimate cause of death is the underlying disease that was the ultimate source of the consequences that followed.

[64] A.B. makes the following argument at paras. 101, 102 and 107 of his factum:

> 101. In the applicant's submission, the "cause" of death in s. 10 of the *Coroners Act* must be intended to refer to the substantive and underlying cause of death, rather than the immediate cause. This is based on (1) the plain and ordinary meaning of the words of the provision; (2) the purpose of the *Coroners Act*; (3) the absurdity that would result to hold otherwise; and (4) the underlying principles articulated in *Carter*. In this case, where the physician assisted death will be authorized by court order pursuant to the criteria established in *Carter*, the underlying cause of death will be disease – specifically, lymphoma.

> 102. First, on the plain and ordinary meaning of the words, the circumstances of the applicant's death would not constitute a death caused "other than" by disease. The Supreme Court's decision in *Carter-2015* makes clear that physician assisted death is a response to a grievous terminal illness that causes intolerable suffering. In this way, the death itself is caused by the underlying disease, given that it must be shown that it is the patient's irremediable condition that causes intolerable suffering necessitating medical aid in dying. Similarly, in *Carter-2016*, the Supreme Court held that "an exemption can mitigate the severe harm that may be occasioned to those adults who have a grievous, intolerable and irremediable medical condition." This reinforces the notion that physician assisted death is a means to remedy the underlying suffering caused by the medical condition.
>
> ….
>
> 107. In short, since the medication administered by a physician to bring upon death is a consequence of – and treatment for – the underlying medical condition, the death should properly be viewed as caused by disease. Even if injection of medication is viewed as a cause of death, it still does not follow the death would be "from any cause *other than* disease".

[65] While I agree that this argument, which focuses on the physician-assisted death as a form of treatment, is sound in the circumstances of a terminal disease such as ALS (as was the circumstance in *Carter-2015*), or a terminal disease such as advanced-stage aggressive lymphoma (as is the circumstance in the immediate case), I have my doubts about whether the argument applies in the circumstances of a permanent and grievous but not imminently life-threatening disability. A.B.'s argument, however, does cover the circumstances of his case.

[66] In any event, I also rely on two other arguments to come to the conclusion that s. 10(1)(f) is not engaged in the case at bar. The first of these arguments, which focuses on the court's authorizing the physician-assisted death, is that given the criteria of a physician-assisted death as established by *Carter-2015* and *Carter-2016*, which criteria connect the availability of physician assistance to a grievous and irremediable illness, disease, or disability, it is tautological that the cause of death is the illness, disease, or disability. Put somewhat differently, the constitutional exemption is itself a product or consequence derivative of the illness, disease or disability, and, thus, a person would not have reason to believe that the deceased person died from a cause other than the illness, disease, or disability.

[67] The second argument, which is a mutually independent argument, is that to the extent that the provisions of the *Coroners Act* interfere with the rights of a person granted a constitutional exemption pursuant to the *Charter*, the statutory provisions must be interpreted in a way to comply with the *Charter*. This second argument is an application of the principle of statutory interpretation that it is presumed that legislation complies with constitutional law including the *Charter*.

[68] Where legislation permits two equal interpretations, the Court should adopt the interpretation that accords with *Charter* values: *Slaight Communications Inc. v. Davidson*, [1989] 1 S.C.R. 1038 at para. 90; *Ontario Human Rights Commission v. Christian Horizons*, 2010 ONSC 2105 (Div. Ct.) at para. 69; *R. v. Zundel*, [1992] 2 S.C.R. 731 at p. 771; *Application under s. 83.28 of the Criminal Code (Re)*, 2004 SCC 42 at para. 35; *R. v. Tse*, 2012 SCC 16 at para. 20.

[69] A.B. comes close to making a similar argument at para. 115 of his factum, as follows:

> Finally, we note that the Supreme Court characterized physician assisted death as a way to protect the dignity and autonomy of individuals. If this court interprets physician assisted death as an

> independent and underlying cause of death, the outcome would impede individuals from exercising a constitutional right. Rather than pass peacefully, potential applicants would be forced to face the knowledge that their bodies would be seized by the coroner and possibly dissected. This prospect is equally troubling and devastating to the family members of potential applicants. Interpreting "cause" of death in s. 10(1)(f) to mean "underlying cause of death", which in this case is lymphoma, avoids such a callous and intrusive outcome.

[70] I, therefore, conclude that s. 10(1)(f) of the *Coroners Act* is not engaged, and I turn now to A.B.'s argument that s. 10(1)(g) of the *Act* does not require a person to notify the coroner because the circumstance of a physician-assisted death is not a circumstance that might require an investigation in the public interest. I agree with this argument, which can be simply stated.

[71] The more precise but still straightforward version of this argument is that no investigation of a physician-assisted death is necessary because there is no need to enable the coroner: (a) to determine the answers to the questions set out in subsection 31 (1) of the *Coroners Act*; (b) to determine whether or not an inquest is necessary; or (c) to collect and analyze information about the death in order to prevent further deaths in similar circumstances. Put shortly, there is no need to conduct an investigation pursuant to s. 15 of the *Coroners Act* because the information to be gathered by that investigation is already known or because no useful public purpose would be served by gathering the information. Further, again, there is also the factor that the coroner's investigation would interfere with A.B.'s rights under the *Charter*.

[72] I, therefore, grant the request for a declaration that the circumstances of A.B.'s death, as authorized by this Court's order, do not constitute any of the circumstances of s. 10 of the *Coroners Act*.

G. CONCLUSION

[73] For the above reasons, I grant the relief requested as set out in the draft order.

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Perell, J.

Released: March 17, 2016

CITATION: A.B. v. Canada (Attorney General), 2016 ONSC 1912
COURT FILE NO.: CV-16-00AD001-00ES
DATE: 20160317

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

A.B.

Applicant

– and –

ATTORNEY GENERAL OF CANADA, ATTORNEY GENERAL OF ONTARIO, DR. DOE and DR. DOE

Respondents

REASONS FOR DECISION

PERELL J.

Released: March 17, 2016