SUPREME COURT OF CANADA

CITATION: Carter *v.* Canada (Attorney General), 2015 SCC 5 **DATE:** 20150206
DOCKET: 35591

BETWEEN:

Lee Carter, Hollis Johnson, William Shoichet,
British Columbia Civil Liberties Association and Gloria Taylor
Appellants
and
Attorney General of Canada
Respondent

AND BETWEEN:

Lee Carter, Hollis Johnson, William Shoichet,
British Columbia Civil Liberties Association and Gloria Taylor
Appellants
and
Attorney General of Canada and Attorney General of British Columbia
Respondents
- and -
Attorney General of Ontario, Attorney General of Quebec,
Council of Canadians with Disabilities, Canadian Association for Community Living, Christian Legal Fellowship, Canadian HIV/AIDS Legal Network, HIV & AIDS Legal Clinic Ontario, Association for Reformed Political Action Canada, Physicians' Alliance against Euthanasia, Evangelical Fellowship of Canada,
Christian Medical and Dental Society of Canada, Canadian Federation of Catholic Physicians' Societies, Dying With Dignity, Canadian Medical Association,
Catholic Health Alliance of Canada, Criminal Lawyers' Association (Ontario), Farewell Foundation for the Right to Die, Association québécoise pour le droit de mourir dans la dignité, Canadian Civil Liberties Association, Catholic Civil Rights League,
Faith and Freedom Alliance, Protection of Conscience Project, Alliance of People With Disabilities Who are Supportive of Legal Assisted Dying Society, Canadian Unitarian Council, Euthanasia Prevention Coalition and Euthanasia Prevention Coalition — British Columbia
Interveners

CORAM: McLachlin C.J. and LeBel, Abella, Rothstein, Cromwell, Moldaver, Karakatsanis, Wagner and Gascon JJ.

REASONS FOR JUDGMENT: The Court
(paras. 1 to 148)

CARTER *v.* CANADA (ATTORNEY GENERAL)

Lee Carter, Hollis Johnson, William Shoichet,
British Columbia Civil Liberties Association and Gloria Taylor *Appellants*

v.

Attorney General of Canada *Respondent*

- and -

Lee Carter, Hollis Johnson, William Shoichet,
British Columbia Civil Liberties Association and Gloria Taylor *Appellants*

v.

Attorney General of Canada and
Attorney General of British Columbia *Respondents*

and

Attorney General of Ontario,
Attorney General of Quebec,
Council of Canadians with Disabilities,
Canadian Association for Community Living,
Christian Legal Fellowship,
Canadian HIV/AIDS Legal Network,
HIV & AIDS Legal Clinic Ontario,
Association for Reformed Political Action Canada,
Physicians' Alliance against Euthanasia,
Evangelical Fellowship of Canada,

Christian Medical and Dental Society of Canada,
Canadian Federation of Catholic Physicians' Societies,
Dying With Dignity,
Canadian Medical Association,
Catholic Health Alliance of Canada,
Criminal Lawyers' Association (Ontario),
Farewell Foundation for the Right to Die,
Association québécoise pour le droit de mourir dans la dignité,
Canadian Civil Liberties Association,
Catholic Civil Rights League,
Faith and Freedom Alliance,
Protection of Conscience Project,
Alliance of People With Disabilities Who are Supportive of Legal Assisted Dying Society,
Canadian Unitarian Council,
Euthanasia Prevention Coalition and
Euthanasia Prevention Coalition — British Columbia *Interveners*

Indexed as: Carter *v.* Canada (Attorney General)

2015 SCC 5

File No.: 35591.

2014: October 15; 2015: February 6.

Present: McLachlin C.J. and LeBel, Abella, Rothstein, Cromwell, Moldaver, Karakatsanis, Wagner and Gascon JJ.

ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA

Constitutional law — Division of powers — Interjurisdictional immunity — Criminal Code provisions prohibiting physician-assisted dying — Whether

prohibition interferes with protected core of provincial jurisdiction over health — Constitution Act, 1867, ss. 91(27), 92(7), (13) and (16).

Constitutional law — Charter of Rights — Right to life, liberty and security of the person — Fundamental justice — Competent adult with grievous and irremediable medical condition causing enduring suffering consenting to termination of life with physician assistance — Whether Criminal Code provisions prohibiting physician-assisted dying infringe s. 7 of Canadian Charter of Rights and Freedoms — If so, whether infringement justifiable under s. 1 of Charter — Criminal Code, R.S.C. 1985, c. C-46, ss. 14, 241(b).

Constitutional law — Charter of Rights — Remedy — Constitutional exemption — Availability — Constitutional challenge of Criminal Code provisions prohibiting physician-assisted dying seeking declaration of invalidity of provisions and free-standing constitutional exemption for claimants — Whether constitutional exemption under s. 24(1) of Canadian Charter of Rights and Freedoms should be granted.

Courts — Costs — Special costs — Principles governing exercise of courts' discretionary power to grant special costs on full indemnity basis — Trial judge awarding special costs to successful plaintiffs on basis that award justified by public interest, and ordering Attorney General intervening as of right to pay amount proportional to participation in proceedings — Whether special costs should be

awarded to cover entire expense of bringing case before courts — Whether award against Attorney General justified.

Section 241(*b*) of the *Criminal Code* says that everyone who aids or abets a person in committing suicide commits an indictable offence, and s. 14 says that no person may consent to death being inflicted on them. Together, these provisions prohibit the provision of assistance in dying in Canada. After T was diagnosed with a fatal neurodegenerative disease in 2009, she challenged the constitutionality of the *Criminal Code* provisions prohibiting assistance in dying. She was joined in her claim by C and J, who had assisted C's mother in achieving her goal of dying with dignity by taking her to Switzerland to use the services of an assisted suicide clinic; a physician who would be willing to participate in physician-assisted dying if it were no longer prohibited; and the British Columbia Civil Liberties Association. The Attorney General of British Columbia participated in the constitutional litigation as of right.

The trial judge found that the prohibition against physician-assisted dying violates the s. 7 rights of competent adults who are suffering intolerably as a result of a grievous and irremediable medical condition and concluded that this infringement is not justified under s. 1 of the *Charter*. She declared the prohibition unconstitutional, granted a one-year suspension of invalidity and provided T with a constitutional exemption. She awarded special costs in favour of the plaintiffs on the ground that this was justified by the public interest in resolving the legal issues raised by the case,

and awarded 10 percent of the costs against the Attorney General of British Columbia in light of the full and active role it assumed in the proceedings.

The majority of the Court of Appeal allowed the appeal on the ground that the trial judge was bound to follow this Court's decision in *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, where a majority of the Court upheld the blanket prohibition on assisted suicide. The dissenting judge found no errors in the trial judge's assessment of *stare decisis*, her application of s. 7 or the corresponding analysis under s. 1. However, he concluded that the trial judge was bound by the conclusion in *Rodriguez* that any s. 15 infringement was saved by s. 1.

Held: The appeal should be allowed. Section 241(*b*) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect to the extent that 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. The declaration of invalidity is suspended for 12 months. Special costs on a full indemnity basis are awarded against Canada throughout. The Attorney General of British Columbia will bear responsibility for 10 percent of the costs at trial on a full indemnity basis and will pay the costs associated with its presence at the appellate levels on a party and party basis.

The trial judge was entitled to revisit this Court's decision in *Rodriguez*. Trial courts may reconsider settled rulings of higher courts in two situations: (1) where a new legal issue is raised; and (2) where there is a change in the circumstances or evidence that fundamentally shifts the parameters of the debate. Here, both conditions were met. The argument before the trial judge involved a different legal conception of s. 7 than that prevailing when *Rodriguez* was decided. In particular, the law relating to the principles of overbreadth and gross disproportionality had materially advanced since *Rodriguez*. The matrix of legislative and social facts in this case also differed from the evidence before the Court in *Rodriguez*.

The prohibition on assisted suicide is, in general, a valid exercise of the federal criminal law power under s. 91(27) of the *Constitution Act, 1867*, and it does not impair the protected core of the provincial jurisdiction over health. Health is an area of concurrent jurisdiction, which suggests that aspects of physician-assisted dying may be the subject of valid legislation by both levels of government, depending on the circumstances and the focus of the legislation. On the basis of the record, the interjurisdictional immunity claim cannot succeed.

Insofar as they prohibit physician-assisted dying for competent adults who seek such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering, ss. 241(*b*) and 14 of the *Criminal Code* deprive these adults of their right to life, liberty and security of the person under s. 7

of the *Charter*. The right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly. Here, the prohibition deprives some individuals of life, as it has the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable. The rights to liberty and security of the person, which deal with concerns about autonomy and quality of life, are also engaged. An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The prohibition denies people in this situation the right to make decisions concerning their bodily integrity and medical care and thus trenches on their liberty. And by leaving them to endure intolerable suffering, it impinges on their security of the person.

The prohibition on physician-assisted dying infringes the right to life, liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice. The object of the prohibition is not, broadly, to preserve life whatever the circumstances, but more specifically to protect vulnerable persons from being induced to commit suicide at a time of weakness. Since a total ban on assisted suicide clearly helps achieve this object, individuals' rights are not deprived arbitrarily. However, the prohibition catches people outside the class of protected persons. It follows that the limitation on their rights is in at least some cases not connected to the objective and that the prohibition is thus overbroad. It is unnecessary to decide whether the prohibition also violates the principle against gross disproportionality.

Having concluded that the prohibition on physician-assisted dying violates s. 7, it is unnecessary to consider whether it deprives adults who are physically disabled of their right to equal treatment under s. 15 of the *Charter*.

Sections 241(*b*) and 14 of the *Criminal Code* are not saved by s. 1 of the *Charter*. While the limit is prescribed by law and the law has a pressing and substantial objective, the prohibition is not proportionate to the objective. An absolute prohibition on physician-assisted dying is rationally connected to the goal of protecting the vulnerable from taking their life in times of weakness, because prohibiting an activity that poses certain risks is a rational method of curtailing the risks. However, as the trial judge found, the evidence does not support the contention that a blanket prohibition is necessary in order to substantially meet the government's objective. The trial judge made no palpable and overriding error in concluding, on the basis of evidence from scientists, medical practitioners and others who are familiar with end-of-life decision-making in Canada and abroad, that a permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error. It was also open to her to conclude that vulnerability can be assessed on an individual basis, using the procedures that physicians apply in their assessment of informed consent and decision capacity in the context of medical decision-making more generally. The absolute prohibition is therefore not minimally impairing. Given this conclusion, it is not necessary to weigh the impacts of the law on protected rights against the beneficial effect of the law in terms of the greater public good.

The appropriate remedy is not to grant a free-standing constitutional exemption, but rather to issue a declaration of invalidity and to suspend it for 12 months. Nothing in this declaration would compel physicians to provide assistance in dying. The *Charter* rights of patients and physicians will need to be reconciled in any legislative and regulatory response to this judgment.

The appellants are entitled to an award of special costs on a full indemnity basis to cover the entire expense of bringing this case before the courts. A court may depart from the usual rule on costs and award special costs where two criteria are met. First, the case must involve matters of public interest that are truly exceptional. It is not enough that the issues raised have not been previously resolved or that they transcend individual interests of the successful litigant: they must also have a significant and widespread societal impact. Second, in addition to showing that they have no personal, proprietary or pecuniary interest in the litigation that would justify the proceedings on economic grounds, the plaintiffs must show that it would not have been possible to effectively pursue the litigation in question with private funding. Finally, only those costs that are shown to be reasonable and prudent will be covered by the award of special costs. Here, the trial judge did not err in awarding special costs in the truly exceptional circumstances of this case. It was also open to her to award 10 percent of the costs against the Attorney General of British Columbia in light of the full and active role it played in the proceedings. The trial judge was in the best position to determine the role taken by that Attorney General and the extent to which it shared carriage of the case.

Cases Cited

Distinguished: *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519; **applied:** *Canada (Attorney General) v. Bedford*, 2013 SCC 72, [2013] 3 S.C.R. 1101; **disapproved:** *Victoria (City) v. Adams*, 2009 BCCA 563, 100 B.C.L.R. (4th) 28; **referred to:** *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997); *Pretty v. United Kingdom*, No. 2346/02, ECHR 2002-III; *Fleming v. Ireland*, [2013] IESC 19 (BAILII); *R. (on the application of Nicklinson) v. Ministry of Justice*, [2014] UKSC 38, [2014] 3 All E.R. 843; *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, [2009] 2 S.C.R. 567; *R. v. Ferguson*, 2008 SCC 6, [2008] 1 S.C.R. 96; *Ontario (Attorney General) v. Fraser*, 2011 SCC 20, [2011] 2 S.C.R. 3; *Canadian Western Bank v. Alberta*, 2007 SCC 22, [2007] 2 S.C.R. 3; *Tsilhqot'in Nation v. British Columbia*, 2014 SCC 44, [2014] 2 S.C.R. 256; *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, [2011] 3 S.C.R. 134; *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199; *Schneider v. The Queen*, [1982] 2 S.C.R. 112; *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791; *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 S.C.R. 307; *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46; *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181; *R. v. Parker* (2000), 49 O.R. (3d) 481; *Fleming v. Reid* (1991), 4 O.R. (3d) 74; *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119; *Malette v. Shulman* (1990), 72 O.R. (2d) 417; *Nancy B. v. Hôtel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385;

Charkaoui v. Canada (Citizenship and Immigration), 2007 SCC 9, [2007] 1 S.C.R. 350; *R. v. Swain*, [1991] 1 S.C.R. 933; *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486; *Suresh v. Canada (Minister of Citizenship and Immigration)*, 2002 SCC 1, [2002] 1 S.C.R. 3; *R. v. Oakes*, [1986] 1 S.C.R. 103; *Saskatchewan (Human Rights Commission) v. Whatcott*, 2013 SCC 11, [2013] 1 S.C.R. 467; *R. v. Morgentaler*, [1988] 1 S.C.R. 30; *Little Sisters Book and Art Emporium v. Canada (Commissioner of Customs and Revenue)*, 2007 SCC 2, [2007] 1 S.C.R. 38; *Finney v. Barreau du Québec*, 2004 SCC 36, [2004] 2 S.C.R. 17; *British Columbia (Minister of Forests) v. Okanagan Indian Band*, 2003 SCC 71, [2003] 3 S.C.R. 371; *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315; *Hegeman v. Carter*, 2008 NWTSC 48, 74 C.P.C. (6th) 112; *Polglase v. Polglase* (1979), 18 B.C.L.R. 294.

Statutes and Regulations Cited

Act respecting end-of-life care, CQLR, c. S-32.0001 [not yet in force].

Canadian Charter of Rights and Freedoms, ss. 1, 7, 15.

Constitution Act, 1867, ss. 91, 92.

Constitution Act, 1982, s. 52.

Criminal Code, R.S.C. 1985, c. C-46, ss. 14, 21, 22, 212(1)(*j*), 222, 241.

Authors Cited

Singleton, Thomas J. "The Principles of Fundamental Justice, Societal Interests and Section 1 of the Charter" (1995), 74 *Can. Bar Rev*. 446.

APPEAL from a judgment of the British Columbia Court of Appeal (Finch C.J.B.C. and Newbury and Saunders JJ.A.), 2013 BCCA 435, 51 B.C.L.R. (5th) 213, 302 C.C.C. (3d) 26, 365 D.L.R. (4th) 351, 293 C.R.R. (2d) 109, 345 B.C.A.C. 232, 589 W.A.C. 232, [2014] 1 W.W.R. 211, [2013] B.C.J. No. 2227 (QL), 2013 CarswellBC 3051 (WL Can.), setting aside decisions of Smith J., 2012 BCSC 886, 287 C.C.C. (3d) 1, 261 C.R.R. (2d) 1, [2012] B.C.J. No. 1196 (QL), 2012 CarswellBC 1752 (WL Can.); and 2012 BCSC 1587, 271 C.R.R. (2d) 224, [2012] B.C.J. No. 2259 (QL), 2012 CarswellBC 3388 (WL Can.). Appeal allowed.

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Jean-Yves Bernard and *Sylvain Leboeuf*, for the intervener the Attorney General of Quebec.

David Baker and *Emily Shepard*, for the interveners the Council of Canadians with Disabilities and the Canadian Association for Community Living.

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Written submissions only by *Gordon Capern*, *Michael Fenrick*, *Richard Elliott* and *Ryan Peck*, for the interveners the Canadian HIV/AIDS Legal Network and the HIV & AIDS Legal Clinic Ontario.

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Pierre Bienvenu, *Andres C. Garin* and *Vincent Rochette*, for the intervener the Physicians' Alliance against Euthanasia.

Geoffrey Trotter, for the intervener the Evangelical Fellowship of Canada.

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Written submissions only by *Cynthia Petersen* and *Kelly Doctor*, for the intervener Dying With Dignity.

Harry Underwood and *Jessica Prince*, for the intervener the Canadian Medical Association.

Albertos Polizogopoulos and *Russell G. Gibson*, for the intervener the Catholic Health Alliance of Canada.

Marlys A. Edwardh and *Daniel Sheppard*, for the intervener the Criminal Lawyers' Association (Ontario).

Jason B. Gratl, for the interveners the Farewell Foundation for the Right to Die and Association québécoise pour le droit de mourir dans la dignité.

Christopher D. Bredt and *Margot Finley*, for the intervener the Canadian Civil Liberties Association.

Robert W. Staley, *Ranjan K. Agarwal*, *Jack R. Maslen* and *Philip H. Horgan*, for the interveners the Catholic Civil Rights League, the Faith and Freedom Alliance and the Protection of Conscience Project.

Angus M. Gunn, Q.C., and *Duncan A. W. Ault*, for the intervener the Alliance Of People With Disabilities Who are Supportive of Legal Assisted Dying Society.

Tim Dickson and *Ryan J. M. Androsoff*, for the intervener the Canadian Unitarian Council.

Hugh R. Scher, for the interveners the Euthanasia Prevention Coalition and the Euthanasia Prevention Coalition — British Columbia.

The following is the judgment delivered by

THE COURT —

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I. Introduction

[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.

[2] The question on this appeal is whether the criminal prohibition that puts a person to this choice violates her *Charter* rights to life, liberty and security of the person (s. 7) and to equal treatment by and under the law (s. 15). This is a question that asks us to balance competing values of great importance. On the one hand stands the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable.

[3] The trial judge found that the prohibition violates the s.7 rights of competent adults who are suffering intolerably as a result of a grievous and irremediable medical condition. She concluded that this infringement is not justified under s. 1 of the *Charter*. We agree. The trial judge's findings were based on an exhaustive review of the extensive record before her. The evidence supports her conclusion that the violation of the right to life, liberty and security of the person guaranteed by s. 7 of the *Charter* is severe. It also supports her finding that a

properly administered regulatory regime is capable of protecting the vulnerable from abuse or error.

[4] We conclude that the prohibition on physician-assisted dying is void insofar as it deprives a competent adult of such assistance where (1) the person affected clearly consents to the termination of life; and (2) the person 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. We therefore allow the appeal.

II. Background

[5] In Canada, aiding or abetting a person to commit suicide is a criminal offence: see s. 241(*b*) of the *Criminal Code*, R.S.C. 1985, c. C-46. This means that a person cannot seek a physician-assisted death. Twenty-one years ago, this Court upheld this blanket prohibition on assisted suicide by a slim majority: *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519. Sopinka J., writing for five justices, held that the prohibition did not violate s. 7 of the *Canadian Charter of Rights and Freedoms*, and that if it violated s. 15, this was justified under s. 1, as there was "no halfway measure that could be relied upon with assurance" to protect the vulnerable (p. 614). Four justices disagreed. McLachlin J. (as she then was), with L'Heureux-Dubé J. concurring, concluded that the prohibition violated s. 7 of the *Charter* and was not justified under s. 1. Lamer C.J. held that the prohibition violated

s. 15 of the *Charter* and was not saved under s. 1. Cory J. agreed that the prohibition violated both ss. 7 and 15 and could not be justified.

[6] Despite the Court's decision in *Rodriguez*, the debate over physician-assisted dying continued. Between 1991 and 2010, the House of Commons and its committees debated no less than six private member's bills seeking to decriminalize assisted suicide. None was passed. While opponents to legalization emphasized the inadequacy of safeguards and the potential to devalue human life, a vocal minority spoke in favour of reform, highlighting the importance of dignity and autonomy and the limits of palliative care in addressing suffering. The Senate considered the matter as well, issuing a report on assisted suicide and euthanasia in 1995. The majority expressed concerns about the risk of abuse under a permissive regime and the need for respect for life. A minority supported an exemption to the prohibition in some circumstances.

[7] More recent reports have come down in favour of reform. In 2011, the Royal Society of Canada published a report on end-of-life decision-making and recommended that the *Criminal Code* be modified to permit assistance in dying in some circumstances. The Quebec National Assembly's Select Committee on Dying with Dignity issued a report in 2012, recommending amendments to legislation to recognize medical aid in dying as appropriate end-of-life care (now codified in *An Act respecting end-of-life care*, CQLR, c. S-32.0001 (not yet in force)).

[8] The legislative landscape on the issue of physician-assisted death has changed in the two decades since *Rodriguez*. In 1993 Sopinka J. noted that no other Western democracy expressly permitted assistance in dying. By 2010, however, eight jurisdictions permitted some form of assisted dying: the Netherlands, Belgium, Luxembourg, Switzerland, Oregon, Washington, Montana and Colombia. The process of legalization began in 1994, when Oregon, as a result of a citizens' initiative, altered its laws to permit medical aid in dying for a person suffering from a terminal disease. Colombia followed in 1997, after a decision of the constitutional court. The Dutch Parliament established a regulatory regime for assisted dying in 2002; Belgium quickly adopted a similar regime, with Luxembourg joining in 2009. Together, these regimes have produced a body of evidence about the practical and legal workings of physician-assisted death and the efficacy of safeguards for the vulnerable.

[9] Nevertheless, physician-assisted dying remains a criminal offence in most Western countries, and a number of courts have upheld the prohibition on such assistance in the face of constitutional and human rights challenges: see, e.g., *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997); *Pretty v. United Kingdom*, No. 2346/02, ECHR 2002-III; and *Fleming v. Ireland*, [2013] IESC 19 (BAILII). In a recent decision, a majority of the Supreme Court of the United Kingdom accepted that the absolute prohibition on assisted dying breached the claimants' rights, but found the evidence on safeguards insufficient; the court concluded that Parliament should be given an opportunity to debate and amend

the legislation based on the court's provisional views (see *R. (on the application of Nicklinson) v. Ministry of Justice*, [2014] UKSC 38, [2014] 3 All E.R. 843).

[10] The debate in the public arena reflects the ongoing debate in the legislative sphere. Some medical practitioners see legal change as a natural extension of the principle of patient autonomy, while others fear derogation from the principles of medical ethics. Some people with disabilities oppose the legalization of assisted dying, arguing that it implicitly devalues their lives and renders them vulnerable to unwanted assistance in dying, as medical professionals assume that a disabled patient "leans towards death at a sharper angle than the acutely ill — but otherwise non-disabled — patient" (2012 BCSC 886, 287 C.C.C. (3d) 1, at para. 811). Other people with disabilities take the opposite view, arguing that a regime which permits control over the manner of one's death respects, rather than threatens, their autonomy and dignity, and that the legalization of physician-assisted suicide will protect them by establishing stronger safeguards and oversight for end-of-life medical care.

[11] The impetus for this case arose in 2009, when Gloria Taylor was diagnosed with a fatal neurodegenerative disease, amyotrophic lateral sclerosis (or ALS), which causes progressive muscle weakness. ALS patients first lose the ability to use their hands and feet, then the ability to walk, chew, swallow, speak and, eventually, breathe. Like Sue Rodriguez before her, Gloria Taylor did "not want to die slowly, piece by piece" or "wracked with pain," and brought a claim before the British Columbia Supreme Court challenging the constitutionality of the *Criminal*

Code provisions that prohibit assistance in dying, specifically ss. 14, 21, 22, 222 and 241. She was joined in her claim by Lee Carter and Hollis Johnson, who had assisted Ms. Carter's mother, Kathleen ("Kay") Carter, in achieving her goal of dying with dignity by taking her to Switzerland to use the services of DIGNITAS, an assisted-suicide clinic; Dr. William Shoichet, a physician from British Columbia who would be willing to participate in physician-assisted dying if it were no longer prohibited; and the British Columbia Civil Liberties Association, which has a long-standing interest in patients' rights and health policy and has conducted advocacy and education with respect to end-of-life choices, including assisted suicide.

[12] By 2010, Ms. Taylor's condition had deteriorated to the point that she required a wheelchair to go more than a short distance and was suffering pain from muscle deterioration. She required home support for assistance with the daily tasks of living, something that she described as an assault on her privacy, dignity and self-esteem. She continued to pursue an independent life despite her illness, but found that she was steadily losing the ability to participate fully in that life. Ms. Taylor informed her family and friends of a desire to obtain a physician-assisted death. She did not want to "live in a bedridden state, stripped of dignity and independence", she said; nor did she want an "ugly death". This is how she explained her desire to seek a physician-assisted death:

> I do not want my life to end violently. I do not want my mode of death to be traumatic for my family members. I want the legal right to die peacefully, at the time of my own choosing, in the embrace of my family and friends.

> I know that I am dying, but I am far from depressed. I have some down time - that is part and parcel of the experience of knowing that you are terminal. But there is still a lot of good in my life; there are still things, like special times with my granddaughter and family, that bring me extreme joy. I will not waste any of my remaining time being depressed. I intend to get every bit of happiness I can wring from what is left of my life so long as it remains a life of quality; but I do not want to live a life without quality. There will come a point when I will know that enough is enough. I cannot say precisely when that time will be. It is not a question of "when I can't walk" or "when I can't talk." There is no pre-set trigger moment. I just know that, globally, there will be some point in time when I will be able to say – "this is it, this is the point where life is just not worthwhile." When that time comes, I want to be able to call my family together, tell them of my decision, say a dignified good-bye and obtain final closure - for me and for them.
>
> My present quality of life is impaired by the fact that I am unable to say for certain that I will have the right to ask for physician-assisted dying when that "enough is enough" moment arrives. I live in apprehension that my death will be slow, difficult, unpleasant, painful, undignified and inconsistent with the values and principles I have tried to live by. . . .
>
> [. . .]
>
> . . . What I fear is a death that negates, as opposed to concludes, my life. I do not want to die slowly, piece by piece. I do not want to waste away unconscious in a hospital bed. I do not want to die wracked with pain.

[13] Ms. Taylor, however, knew she would be unable to request a physician-assisted death when the time came, because of the *Criminal Code* prohibition and the fact that she lacked the financial resources to travel to Switzerland, where assisted suicide is legal and available to non-residents. This left her with what she described as the "cruel choice" between killing herself while she was still physically capable of doing so, or giving up the ability to exercise any control over the manner and timing of her death.

[14] Other witnesses also described the "horrible" choice faced by a person suffering from a grievous and irremediable illness. The stories in the affidavits vary in their details: some witnesses described the progression of degenerative illnesses like motor neuron diseases or Huntington's disease, while others described the agony of treatment and the fear of a gruesome death from advanced-stage cancer. Yet running through the evidence of all the witnesses is a constant theme — that they suffer from the knowledge that they lack the ability to bring a peaceful end to their lives at a time and in a manner of their own choosing.

[15] Some describe how they had considered seeking out the traditional modes of suicide but found that choice, too, repugnant:

> I was going to blow my head off. I have a gun and I seriously considered doing it. I decided that I could not do that to my family. It would be horrible to put them through something like that. . . . I want a better choice than that.

A number of the witnesses made clear that they — or their loved ones — had considered or in fact committed suicide earlier than they would have chosen to die if physician-assisted death had been available to them. One woman noted that the conventional methods of suicide, such as carbon monoxide asphyxiation, slitting of the wrists or overdosing on street drugs, would require that she end her life "while I am still able bodied and capable of taking my life, well ahead of when I actually need to leave this life".

[16] Still other witnesses described their situation in terms of a choice between a protracted or painful death and exposing their loved ones to prosecution for assisting them in ending their lives. Speaking of himself and his wife, one man said: "[w]e both face this reality, that we have only two terrible and imperfect options, with a sense of horror and loathing."

[17] Ms. Carter and Mr. Johnson described Kay Carter's journey to assisted suicide in Switzerland and their role in facilitating that process. Kay was diagnosed in 2008 with spinal stenosis, a condition that results in the progressive compression of the spinal cord. By mid-2009, her physical condition had deteriorated to the point that she required assistance with virtually all of her daily activities. She had extremely limited mobility and suffered from chronic pain. As her illness progressed, Kay informed her family that she did not wish to live out her life as an "ironing board", lying flat in bed. She asked her daughter, Lee Carter, and her daughter's husband, Hollis Johnson, to support and assist her in arranging an assisted suicide in Switzerland, and to travel there with her for that purpose. Although aware that assisting Kay could expose them both to prosecution in Canada, they agreed to assist her. In early 2010, they attended a clinic in Switzerland operated by DIGNITAS, a Swiss "death with dignity" organization. Kay took the prescribed dose of sodium pentobarbital while surrounded by her family, and passed away within 20 minutes.

[18] Ms. Carter and Mr. Johnson found the process of planning and arranging for Kay's trip to Switzerland difficult, in part because their activities had to be kept

secret due to the potential for criminal sanctions. While they have not faced prosecution in Canada following Kay's death, Ms. Carter and Mr. Johnson are of the view that Kay ought to have been able to obtain a physician-assisted suicide at home, surrounded by her family and friends, rather than undergoing the stressful and expensive process of arranging for the procedure overseas. Accordingly, they joined Ms. Taylor in pressing for the legalization of physician-assisted death.

III. Statutory Provisions

[19] The appellants challenge the constitutionality of the following provisions of the *Criminal Code*:

> **14.** No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.
>
> **21.** (1) Every one is a party to an offence who
>
> . . .
>
> (*b*) does or omits to do anything for the purpose of aiding any person to commit it; or
>
> . . .
>
> (2) Where two or more persons form an intention in common to carry out an unlawful purpose and to assist each other therein and any one of them, in carrying out the common purpose, commits an offence, each of them who knew or ought to have known that the commission of the offence would be a probable consequence of carrying out the common purpose is a party to that offence.
>
> **22.** (1) Where a person counsels another person to be a party to an offence and that other person is afterwards a party to that offence, the person who counselled is a party to that offence, notwithstanding that the

offence was committed in a way different from that which was counselled.

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

(3) For the purposes of this Act, "counsel" includes procure, solicit or incite.

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;

. . .

241. Every one who

(*a*) counsels a person to commit suicide, or

(*b*) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

[20] In our view, two of these provisions are at the core of the constitutional challenge: s. 241(*b*), which says that everyone who aids or abets a person in committing suicide commits an indictable offence, and s. 14, which says that no person may consent to death being inflicted on them. It is these two provisions that prohibit the provision of assistance in dying. Sections 21, 22, and 222 are only

engaged so long as the provision of assistance in dying is itself an "unlawful act" or offence. Section 241(*a*) does not contribute to the prohibition on assisted suicide.

[21] The *Charter* states:

> **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.
>
> **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.
>
> **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.

IV. Judicial History

A. *British Columbia Supreme Court, 2012 BCSC 886, 287 C.C.C. (3d) 1*

[22] The action was brought by way of summary trial before Smith J. in the British Columbia Supreme Court. While the majority of the evidence was presented in affidavit form, a number of the expert witnesses were cross-examined, both prior to trial and before the trial judge. The record was voluminous: the trial judge canvassed evidence from Canada and from the permissive jurisdictions on medical ethics and

current end-of-life practices, the risks associated with assisted suicide, and the feasibility of safeguards.

[23] The trial judge began by reviewing the current state of the law and practice in Canada regarding end-of-life care. She found that current unregulated end-of-life practices in Canada — such as the administration of palliative sedation and the withholding or withdrawal of lifesaving or life-sustaining medical treatment — can have the effect of hastening death and that there is a strong societal consensus that these practices are ethically acceptable (para. 357). After considering the evidence of physicians and ethicists, she found that the "preponderance of the evidence from ethicists is that there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death" (para. 335). Finally, she found that there are qualified Canadian physicians who would find it ethical to assist a patient in dying if that act were not prohibited by law (para. 319).

[24] Based on these findings, the trial judge concluded that, while there is no clear societal consensus on physician-assisted dying, there is a strong consensus that it would only be ethical with respect to voluntary adults who are competent, informed, grievously and irremediably ill, and where the assistance is "clearly consistent with the patient's wishes and best interests, and [provided] in order to relieve suffering" (para. 358).

[25] The trial judge then turned to the evidence from the regimes that permit physician-assisted dying. She reviewed the safeguards in place in each jurisdiction and considered the effectiveness of each regulatory regime. In each system, she found general compliance with regulations, although she noted some room for improvement. The evidence from Oregon and the Netherlands showed that a system can be designed to protect the socially vulnerable. Expert evidence established that the "predicted abuse and disproportionate impact on vulnerable populations has not materialized" in Belgium, the Netherlands and Oregon (para. 684). She concluded that

> although none of the systems has achieved perfection, empirical researchers and practitioners who have experience in those systems are of the view that they work well in protecting patients from abuse while allowing competent patients to choose the timing of their deaths. [para. 685]

While stressing the need for caution in drawing conclusions for Canada based on foreign experience, the trial judge found that "weak inference[s]" could be drawn about the effectiveness of safeguards and the potential degree of compliance with any permissive regime (para. 683).

[26] Based on the evidence from the permissive jurisdictions, the trial judge also rejected the argument that the legalization of physician-assisted dying would impede the development of palliative care in the country, finding that the effects of a permissive regime, while speculative, would "not necessarily be negative" (para. 736). Similarly, she concluded that any changes in the physician-patient

relationship following legalization "could prove to be neutral or for the good" (para. 746).

[27] The trial judge then considered the risks of a permissive regime and the feasibility of implementing safeguards to address those risks. After reviewing the evidence tendered by physicians and experts in patient assessment, she concluded that physicians were capable of reliably assessing patient competence, including in the context of life-and-death decisions (para. 798). She found that it was possible to detect coercion, undue influence, and ambivalence as part of this assessment process (paras. 815, 843). She also found that the informed consent standard could be applied in the context of physician-assisted death, so long as care was taken to "ensure a patient is properly informed of her diagnosis and prognosis" and the treatment options described included all reasonable palliative care interventions (para. 831). Ultimately, she concluded that the risks of physician-assisted death "can be identified and very substantially minimized through a carefully-designed system" that imposes strict limits that are scrupulously monitored and enforced (para. 883).

[28] Having reviewed the copious evidence before her, the trial judge concluded that the decision in *Rodriguez* did not prevent her from reviewing the constitutionality of the impugned provisions, because (1) the majority in *Rodriguez* did not address the right to life; (2) the principles of overbreadth and gross disproportionality had not been identified at the time of the decision in *Rodriguez* and thus were not addressed in that decision; (3) the majority only "assumed" a violation

of s. 15; and (4) the decision in *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, [2009] 2 S.C.R. 567, represented a "substantive change" to the s. 1 analysis (para. 995). The trial judge concluded that these changes in the law, combined with the changes in the social and factual landscape over the past 20 years, permitted her to reconsider the constitutionality on the prohibition on physician-assisted dying.

[29] The trial judge then turned to the *Charter* analysis. She first asked whether the prohibition violated the s. 15 equality guarantee. She found that the provisions imposed a disproportionate burden on persons with physical disabilities, as only they are restricted to self-imposed starvation and dehydration in order to take their own lives (para. 1076). This distinction, she found, is discriminatory, and not justified under s. 1. While the objective of the prohibition — the protection of vulnerable persons from being induced to commit suicide at a time of weakness — is pressing and substantial and the means are rationally connected to that purpose, the prohibition is not minimally impairing. A "stringently limited, carefully monitored system of exceptions" would achieve Parliament's objective:

> Permission for physician-assisted death for grievously ill and irremediably suffering people who are competent, fully informed, non-ambivalent, and free from coercion or duress, with stringent and well-enforced safeguards, could achieve that objective in a real and substantial way. [para. 1243]

[30] Turning to s. 7 of the *Charter*, which protects life, liberty and security of the person, the trial judge found that the prohibition impacted all three interests. The prohibition on seeking physician-assisted dying deprived individuals of liberty, which

encompasses "the right to non-interference by the state with fundamentally important and personal medical decision-making" (para. 1302). In addition, it also impinged on Ms. Taylor's security of the person by restricting her control over her bodily integrity. While the trial judge rejected a "qualitative" approach to the right to life, concluding that the right to life is only engaged by a threat of death, she concluded that Ms. Taylor's right to life was engaged insofar as the prohibition might force her to take her life earlier than she otherwise would if she had access to a physician-assisted death.

[31] The trial judge concluded that the deprivation of the claimants' s. 7 rights was not in accordance with the principles of fundamental justice, particularly the principles against overbreadth and gross disproportionality. The prohibition was broader than necessary, as the evidence showed that a system with properly designed and administered safeguards offered a less restrictive means of reaching the government's objective. Moreover, the "very severe" effects of the absolute prohibition in relation to its salutary effects rendered it grossly disproportionate (para. 1378). As with the s. 15 infringement, the trial judge found the s. 7 infringement was not justified under s. 1.

[32] In the result, the trial judge declared the prohibition unconstitutional, granted a one-year suspension of invalidity, and provided Ms. Taylor with a constitutional exemption for use during the one-year period of the suspension.

Ms. Taylor passed away prior to the appeal of this matter, without accessing the exemption.

[33] In a separate decision on costs (2012 BCSC 1587, 271 C.R.R. (2d) 224), the trial judge ordered an award of special costs in favour of the plaintiffs. The issues in the case were "complex and momentous" (para. 87) and the plaintiffs could not have prosecuted the case without assistance from pro bono counsel; an award of special costs would therefore promote the public interest in encouraging experienced counsel to take on *Charter* litigation on a pro bono basis. The trial judge ordered the Attorney General of British Columbia to pay 10 percent of the costs, noting that she had taken a full and active role in the proceedings. Canada was ordered to pay the remaining 90 percent of the award.

B. *British Columbia Court of Appeal, 2013 BCCA 435, 51 B.C.L.R. (5th) 213*

[34] The majority of the Court of Appeal, per Newbury and Saunders JJ.A., allowed Canada's appeal on the ground that the trial judge was bound to follow this Court's decision in *Rodriguez*. The majority concluded that neither the change in legislative and social facts nor the new legal issues relied on by the trial judge permitted a departure from *Rodriguez*.

[35] The majority read *Rodriguez* as implicitly rejecting the proposition that the prohibition infringes the right to life under s. 7 of the *Charter*. It concluded that the post-*Rodriguez* principles of fundamental justice — namely overbreadth and gross

disproportionality — did not impose a new legal framework under s. 7. While acknowledging that the reasons in *Rodriguez* did not follow the analytical methodology that now applies under s. 7, the majority held that this would not have changed the result.

[36] The majority also noted that *Rodriguez* disposed of the s. 15 equality argument (which only two judges in that case expressly considered) by holding that any rights violation worked by the prohibition was justified as a reasonable limit under s. 1 of the *Charter*. The decision in *Hutterian Brethren* did not represent a change in the law under s. 1. Had it been necessary to consider s. 1 in relation to s. 7, the majority opined, the s. 1 analysis carried out under s. 15 likely would have led to the same conclusion — the "blanket prohibition" under s. 241 of the *Criminal Code* was justified (para. 323). Accordingly, the majority concluded that "the trial judge was bound to find that the plaintiffs' case had been authoritatively decided by *Rodriguez*" (para. 324).

[37] Commenting on remedy in the alternative, the majority of the Court of Appeal suggested the reinstatement of the free-standing constitutional exemption eliminated in *R. v. Ferguson*, 2008 SCC 6, [2008] 1 S.C.R. 96, instead of a declaration of invalidity, as a suspended declaration presented the spectre of a legislative vacuum.

[38] The majority denied the appellants their costs, given the outcome, but otherwise would have approved the trial judge's award of special costs. In addition, the majority held that costs should not have been awarded against British Columbia.

[39] Finch C.J.B.C., dissenting, found no errors in the trial judge's assessment of *stare decisis*, her application of s. 7, or the corresponding analysis under s. 1. However, he concluded that the trial judge was bound by Sopinka J.'s conclusion that any s. 15 infringement was saved by s. 1. While he essentially agreed with her s. 7 analysis, he would have accepted a broader, qualitative scope for the right to life. He agreed with the trial judge that the prohibition was not minimally impairing, and concluded that a "carefully regulated scheme" could meet Parliament's objectives (para. 177); therefore, the breach of s. 7 could not be justified under s. 1. He would have upheld the trial judge's order on costs.

V. Issues on Appeal

[40] The main issue in this case is whether the prohibition on physician-assisted dying found in s. 241(*b*) of the *Criminal Code* violates the claimants' rights under ss. 7 and 15 of the *Charter*. For the purposes of their claim, the appellants use "physician-assisted death" and "physician-assisted dying" to describe the situation where a physician provides or administers medication that intentionally brings about the patient's death, at the request of the patient. The appellants advance two claims: (1) that the prohibition on physician-assisted dying deprives competent adults, who suffer a grievous and irremediable medical condition that causes the person to endure

physical or psychological suffering that is intolerable to that person, of their right to life, liberty and security of the person under s. 7 of the *Charter*; and (2) that the prohibition deprives adults who are physically disabled of their right to equal treatment under s. 15 of the *Charter*.

[41] Before turning to the *Charter* claims, two preliminary issues arise: (1) whether this Court's decision in *Rodriguez* can be revisited; and (2) whether the prohibition is beyond Parliament's power because physician-assisted dying lies at the core of the provincial jurisdiction over health.

VI. Was the Trial Judge Bound by *Rodriguez*?

[42] The adjudicative facts in *Rodriguez* were very similar to the facts before the trial judge. Ms. Rodriguez, like Ms. Taylor, was dying of ALS. She, like Ms. Taylor, wanted the right to seek a physician's assistance in dying when her suffering became intolerable. The majority of the Court, per Sopinka J., held that the prohibition deprived Ms. Rodriguez of her security of the person, but found that it did so in a manner that was in accordance with the principles of fundamental justice. The majority also assumed that the provision violated the claimant's s. 15 rights, but held that the limit was justified under s. 1 of the *Charter*.

[43] Canada and Ontario argue that the trial judge was bound by *Rodriguez* and not entitled to revisit the constitutionality of the legislation prohibiting assisted suicide. Ontario goes so far as to argue that "vertical *stare decisis*" is a *constitutional*

principle that requires all lower courts to rigidly follow this Court's *Charter* precedents unless and until this Court sets them aside.

[44] The doctrine that lower courts must follow the decisions of higher courts is fundamental to our legal system. It provides certainty while permitting the orderly development of the law in incremental steps. However, *stare decisis* is not a straitjacket that condemns the law to stasis. Trial courts may reconsider settled rulings of higher courts in two situations: (1) where a new legal issue is raised; and (2) where there is a change in the circumstances or evidence that "fundamentally shifts the parameters of the debate" (*Canada (Attorney General) v. Bedford*, 2013 SCC 72, [2013] 3 S.C.R. 1101, at para. 42).

[45] Both conditions were met in this case. The trial judge explained her decision to revisit *Rodriguez* by noting the changes in both the legal framework for s. 7 and the evidence on controlling the risk of abuse associated with assisted suicide.

[46] The argument before the trial judge involved a different legal conception of s. 7 than that prevailing when *Rodriguez* was decided. In particular, the law relating to the principles of overbreadth and gross disproportionality had materially advanced since *Rodriguez*. The majority of this Court in *Rodriguez* acknowledged the argument that the impugned laws were "over-inclusive" when discussing the principles of fundamental justice (see p. 590). However, it did not apply the principle of overbreadth as it is currently understood, but instead asked whether the prohibition was "arbitrary or unfair in that it is unrelated to the state's interest in protecting the

vulnerable, and that it lacks a foundation in the legal tradition and societal beliefs which are said to be represented by the prohibition" (p. 595). By contrast, the law on overbreadth, now explicitly recognized as a principle of fundamental justice, asks whether the law interferes with some conduct that has no connection to the law's objectives (*Bedford*, at para. 101). This different question may lead to a different answer. The majority's consideration of overbreadth under s. 1 suffers from the same defect: see *Rodriguez*, at p. 614. Finally, the majority in *Rodriguez* did not consider whether the prohibition was grossly disproportionate.

[47] The matrix of legislative and social facts in this case also differed from the evidence before the Court in *Rodriguez*. The majority in *Rodriguez* relied on evidence of (1) the widespread acceptance of a moral or ethical distinction between passive and active euthanasia (pp. 605-7); (2) the lack of any "halfway measure" that could protect the vulnerable (pp. 613-14); and (3) the "substantial consensus" in Western countries that a blanket prohibition is necessary to protect against the slippery slope (pp. 601-6 and 613). The record before the trial judge in this case contained evidence that, if accepted, was capable of undermining each of these conclusions (see *Ontario (Attorney General) v. Fraser*, 2011 SCC 20, [2011] 2 S.C.R. 3, at para. 136, per Rothstein J.).

[48] While we do not agree with the trial judge that the comments in *Hutterian Brethren* on the s. 1 proportionality doctrine suffice to justify reconsideration of the

s. 15 equality claim, we conclude it was open to the trial judge to reconsider the s. 15 claim as well, given the fundamental change in the facts.

VII. Does the Prohibition Interfere With the "Core" of the Provincial Jurisdiction Over Health?

[49] The appellants accept that the prohibition on assisted suicide is, in general, a valid exercise of the federal criminal law power under s. 91(27) of the *Constitution Act, 1867*. However, they say that the doctrine of interjurisdictional immunity means that the prohibition cannot constitutionally apply to physician-assisted dying, because it lies at the core of the provincial jurisdiction over health care under s. 92(7), (13) and (16) of the *Constitution Act, 1867*, and is therefore beyond the legislative competence of the federal Parliament.

[50] The doctrine of interjurisdictional immunity is premised on the idea that the heads of power in ss. 91 and 92 are "exclusive", and therefore each have a "minimum and unassailable" core of content that is immune from the application of legislation enacted by the other level of government (*Canadian Western Bank v. Alberta*, 2007 SCC 22, [2007] 2 S.C.R. 3, at paras. 33-34). To succeed in their argument on this point, the appellants must show that the prohibition, in so far as it extends to physician-assisted dying, impairs the "protected core" of the provincial jurisdiction over health: *Tsilhqot'in Nation v. British Columbia*, 2014 SCC 44, [2014] 2 S.C.R. 256, at para. 131.

[51] This Court rejected a similar argument in *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, [2011] 3 S.C.R. 134. The issue in that case was "whether the delivery of health care services constitutes a protected core of the provincial power over health care in s. 92(7), (13) and (16) . . . and is therefore immune from federal interference" (para. 66). The Court concluded that it did not (per McLachlin C.J.):

> Parliament has power to legislate with respect to federal matters, notably criminal law, that touch on health. For instance, it has historic jurisdiction to prohibit medical treatments that are dangerous, or that it perceives as "socially undesirable" behaviour: *R. v. Morgentaler*, [1988] 1 S.C.R. 30; *Morgentaler v. The Queen*, [1976] 1 S.C.R. 616; *R. v. Morgentaler*, [1993] 3 S.C.R. 463. The federal role in the domain of health makes it impossible to precisely define what falls in or out of the proposed provincial "core". Overlapping federal jurisdiction and the sheer size and diversity of provincial health power render daunting the task of drawing a bright line around a protected provincial core of health where federal legislation may not tread. [para. 68]

[52] The appellants and the Attorney General of Quebec (who intervened on this point) say that it is possible to describe a precise core for the power over health, and thereby to distinguish *PHS*. The appellants' proposed core is described as a power to deliver necessary medical treatment for which there is no alternative treatment capable of meeting a patient's needs (A.F., at para. 43). Quebec takes a slightly different approach, defining the core as the power to establish the kind of health care offered to patients and supervise the process of consent required for that care (I.F., at para. 7).

[53] We are not persuaded by the submissions that *PHS* is distinguishable, given the vague terms in which the proposed definitions of the "core" of the provincial health power are couched. In our view, the appellants have not established that the prohibition on physician-assisted dying impairs the core of the provincial jurisdiction. Health is an area of concurrent jurisdiction; both Parliament and the provinces may validly legislate on the topic: *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199, at para. 32; *Schneider v. The Queen*, [1982] 2 S.C.R. 112, at p. 142. This suggests that aspects of physician-assisted dying may be the subject of valid legislation by both levels of government, depending on the circumstances and focus of the legislation. We are not satisfied on the record before us that the provincial power over health excludes the power of the federal Parliament to legislate on physician-assisted dying. It follows that the interjurisdictional immunity claim cannot succeed.

VIII. Section 7

[54] Section 7 of the *Charter* states that "[e]veryone 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."

[55] In order to demonstrate a violation of s. 7, the claimants must first show that the law interferes with, or deprives them of, their life, liberty or security of the person. Once they have established that s. 7 is engaged, they must then show that the

deprivation in question is not in accordance with the principles of fundamental justice.

[56] For the reasons below, we conclude that the prohibition on physician-assisted dying infringes the right to life, liberty and security of Ms. Taylor and of persons in her position, and that it does so in a manner that is overbroad and thus is not in accordance with the principles of fundamental justice. It therefore violates s. 7.

A. *Does the Law Infringe the Right to Life, Liberty and Security of the Person?*

(1) Life

[57] The trial judge found that the prohibition on physician-assisted dying had the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable. On that basis, she found that the right to life was engaged.

[58] We see no basis for interfering with the trial judge's conclusion on this point. The evidence of premature death was not challenged before this Court. It is therefore established that the prohibition deprives some individuals of life.

[59] The appellants and a number of the interveners urge us to adopt a broader, qualitative approach to the right to life. Some argue that the right to life is

not restricted to the preservation of life, but protects quality of life and therefore a right to die with dignity. Others argue that the right to life protects personal autonomy and fundamental notions of self-determination and dignity, and therefore includes the right to determine whether to take one's own life.

[60] In dissent at the Court of Appeal, Finch C.J.B.C. accepted the argument that the right to life protects more than physical existence (paras. 84-89). In his view, the life interest is "intimately connected to the way a person values his or her lived experience. The point at which the meaning of life is lost, when life's positive attributes are so diminished as to render life valueless, . . . is an intensely personal decision which 'everyone' has the right to make for him or herself" (para. 86). Similarly, in his dissent in *Rodriguez*, Cory J. accepted that the right to life included a right to die with dignity, on the ground that "dying is an integral part of living" (p. 630).

[61] The trial judge, on the other hand, rejected the "qualitative" approach to the right to life. She concluded that the right to life is only engaged when there is a threat of death as a result of government action or laws. In her words, the right to life is limited to a "right not to die" (para. 1322 (emphasis in original)).

[62] This Court has most recently invoked the right to life in *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791, where evidence showed that the lack of timely health care could result in death (paras. 38 and 50, per Deschamps J.; para. 123, per McLachlin C.J. and Major J.; and paras. 191 and 200,

per Binnie and LeBel JJ.), and in *PHS*, where the clients of Insite were deprived of potentially lifesaving medical care (para. 91). In each case, the right was only engaged by the threat of death. In short, the case law suggests that the right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly. Conversely, concerns about autonomy and quality of life have traditionally been treated as liberty and security rights. We see no reason to alter that approach in this case.

[63] This said, we do not agree that the existential formulation of the right to life *requires* an absolute prohibition on assistance in dying, or that individuals cannot "waive" their right to life. This would create a "duty to live", rather than a "right to life", and would call into question the legality of any consent to the withdrawal or refusal of lifesaving or life-sustaining treatment. The sanctity of life is one of our most fundamental societal values. Section 7 is rooted in a profound respect for the value of human life. But s. 7 also encompasses life, liberty and security of the person during the passage to death. It is for this reason that the sanctity of life "is no longer seen to require that all human life be preserved at all costs" (*Rodriguez*, at p. 595, per Sopinka J.). And it is for this reason that the law has come to recognize that, in certain circumstances, an individual's choice about the end of her life is entitled to respect. It is to this fundamental choice that we now turn.

(2) Liberty and Security of the Person

[64] Underlying both of these rights is a concern for the protection of individual autonomy and dignity. Liberty protects "the right to make fundamental personal choices free from state interference": *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 S.C.R. 307, at para. 54. Security of the person encompasses "a notion of personal autonomy involving . . . control over one's bodily integrity free from state interference" (*Rodriguez*, at pp. 587-88 per Sopinka J., referring to *R. v. Morgentaler*, [1988] 1 S.C.R. 30) and it is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering (*New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46, at para. 58; *Blencoe*, at paras. 55-57; *Chaoulli*, at para. 43, per Deschamps J.; para. 119, per McLachlin C.J. and Major J.; and paras. 191 and 200, per Binnie and LeBel JJ.). While liberty and security of the person are distinct interests, for the purpose of this appeal they may be considered together.

[65] The trial judge concluded that the prohibition on assisted dying limited Ms. Taylor's s. 7 right to liberty and security of the person, by interfering with "fundamentally important and personal medical decision-making" (para. 1302), imposing pain and psychological stress and depriving her of control over her bodily integrity (paras. 1293-94). She found that the prohibition left people like Ms. Taylor to suffer physical or psychological pain and imposed stress due to the unavailability of physician-assisted dying, impinging on her security of the person. She further noted that seriously and irremediably ill persons were "denied the opportunity to

make a choice that may be very important to their sense of dignity and personal integrity" and that is "consistent with their lifelong values and that reflects their life's experience" (para. 1326).

[66] We agree with the trial judge. 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.

[67] The law has long protected patient autonomy in medical decision-making. In *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181, a majority of this Court, per Abella J. (the dissent not disagreeing on this point), endorsed the "tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity" (para. 39). This right to "decide one's own fate" entitles adults to direct the course of their own medical care (para. 40): it is this principle that underlies the concept of "informed consent" and is protected by s. 7's guarantee of liberty and security of the person (para. 100; see also *R. v. Parker* (2000), 49 O.R. (3d) 481 (C.A.)). As noted in *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.), the right

of medical self-determination is not vitiated by the fact that serious risks or consequences, including death, may flow from the patient's decision. It is this same principle that is at work in the cases dealing with the right to refuse consent to medical treatment, or to demand that treatment be withdrawn or discontinued: see, e.g., *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119; *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.); and *Nancy B. v. Hôtel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. Sup. Ct.).

[68] In *Blencoe*, a majority of the Court held that the s. 7 liberty interest is engaged "where state compulsions or prohibitions affect important and fundamental life choices": para. 49. In *A.C.*, where the claimant sought to refuse a potentially lifesaving blood transfusion on religious grounds, Binnie J. noted that we may "instinctively recoil" from the decision to seek death because of our belief in the sanctity of human life (para. 219). But his response is equally relevant here: it is clear that anyone who seeks physician-assisted dying because they are suffering intolerably as a result of a grievous and irremediable medical condition "does so out of a deeply personal and fundamental belief about how they wish to live, or cease to live" (*ibid.*). The trial judge, too, described this as a decision that, for some people, is "very important to their sense of dignity and personal integrity, that is consistent with their lifelong values and that reflects their life's experience" (para. 1326). This is a decision that is rooted in their control over their bodily integrity; it represents their deeply personal response to serious pain and suffering. By denying them the opportunity to make that choice, the prohibition impinges on their liberty and security

of the person. As noted above, s. 7 recognizes the value of life, but it also honours the role that autonomy and dignity play at the end of that life. We therefore conclude that ss. 241(*b*) and 14 of the *Criminal Code*, insofar as they prohibit physician-assisted dying for competent adults who seek such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering, infringe the rights to liberty and security of the person.

[69] We note, as the trial judge did, that Lee Carter and Hollis Johnson's interest in liberty may be engaged by the threat of criminal sanction for their role in Kay Carter's death in Switzerland. However, this potential deprivation was not the focus of the arguments raised at trial, and neither Ms. Carter nor Mr. Johnson sought a personal remedy before this Court. Accordingly, we have confined ourselves to the rights of those who seek assistance in dying, rather than of those who might provide such assistance.

(3) Summary on Section 7: Life, Liberty and Security of the Person

[70] For the foregoing reasons, we conclude that the prohibition on physician-assisted dying deprived Ms. Taylor and others suffering from grievous and irremediable medical conditions of the right to life, liberty and security of the person. The remaining question under s. 7 is whether this deprivation was in accordance with the principles of fundamental justice.

B. *The Principles of Fundamental Justice*

[71] Section 7 does not promise that the state will never interfere with a person's life, liberty or security of the person — laws do this all the time — but rather that the state will not do so in a way that violates the principles of fundamental justice.

[72] Section 7 does not catalogue the principles of fundamental justice to which it refers. Over the course of 32 years of *Charter* adjudication, this Court has worked to define the minimum constitutional requirements that a law that trenches on life, liberty, or security of the person must meet (*Bedford*, at para. 94). While the Court has recognized a number of principles of fundamental justice, three have emerged as central in the recent s. 7 jurisprudence: laws that impinge on life, liberty or security of the person must not be arbitrary, overbroad, or have consequences that are grossly disproportionate to their object.

[73] Each of these potential vices involves comparison with the object of the law that is challenged (*Bedford*, at para. 123). The first step is therefore to identify the object of the prohibition on assisted dying.

[74] The trial judge, relying on *Rodriguez*, concluded that the object of the prohibition was to protect vulnerable persons from being induced to commit suicide at a time of weakness (para. 1190). All the parties except Canada accept this formulation of the object.

[75] Canada agrees that the prohibition is intended to protect the vulnerable, but argues that the object of the prohibition should also be defined more broadly as simply "the preservation of life" (R.F., at paras 66, 108 and 109). We cannot accept this submission.

[76] First, it is incorrect to say that the majority in *Rodriguez* adopted "the preservation of life" as the object of the prohibition on assisted dying. Justice Sopinka refers to the preservation of life when discussing the objectives of s. 241(*b*) (pp. 590, 614). However, he later clarifies this comment, stating that "[s]ection 241(*b*) has as its purpose the protection of the vulnerable who might be induced in moments of weakness to commit suicide" (p. 595). Sopinka J. then goes on to note that this purpose is "grounded in the state interest in protecting life and reflects the policy of the state that human life should not be depreciated by allowing life to be taken" (*ibid.*). His remarks about the "preservation of life" in *Rodriguez* are best understood as a reference to an animating social value rather than as a description of the specific object of the prohibition.

[77] Second, defining the object of the prohibition on physician-assisted dying as the preservation of life has the potential to short-circuit the analysis. In *RJR-MacDonald*, this Court warned against stating the object of a law "too broadly" in the s. 1 analysis, lest the resulting objective immunize the law from challenge under the *Charter* (para. 144). The same applies to assessing whether the principles of fundamental justice are breached under s. 7. If the object of the prohibition is

stated broadly as "the preservation of life", it becomes difficult to say that the means used to further it are overbroad or grossly disproportionate. The outcome is to this extent foreordained.

[78] Finally, the jurisprudence requires the object of the impugned law to be defined precisely for the purposes of s. 7. In *Bedford*, Canada argued that bawdy-house prohibition in s. 210 of the *Code* should be defined broadly as to "deter prostitution" for the purposes of s. 7 (para. 131). This Court rejected this argument, holding that the object of the prohibition should be confined to measures directly targeted by the law (para. 132). That reasoning applies with equal force in this case. Section 241(*b*) is not directed at preserving life, or even at preventing suicide — attempted suicide is no longer a crime. Yet Canada asks us to posit that the object of the prohibition is to preserve life, whatever the circumstances. This formulation goes beyond the ambit of the provision itself. The direct target of the measure is the narrow goal of preventing vulnerable persons from being induced to commit suicide at a time of weakness.

[79] Before turning to the principles of fundamental justice at play, a general comment is in order. In determining whether the deprivation of life, liberty and security of the person is in accordance with the principles of fundamental justice under s. 7, courts are not concerned with competing social interests or public benefits conferred by the impugned law. These competing moral claims and broad societal

benefits are more appropriately considered at the stage of justification under s. 1 of the *Charter* (*Bedford*, at paras. 123 and 125).

[80] In *Bedford*, the Court noted that requiring s. 7 claimants "to establish the efficacy of the law versus its deleterious consequences on members of society as a whole, would impose the government's s. 1 burden on claimants under s. 7" (para. 127; see also *Charkaoui v. Canada (Citizenship and Immigration)*, 2007 SCC 9, [2007] 1 S.C.R. 350, at paras. 21-22). A claimant under s. 7 must show that the state has deprived them of their life, liberty or security of the person and that the deprivation is not in accordance with the principles of fundamental justice. They should not be tasked with also showing that these principles are "not overridden by a valid state or communal interest in these circumstances": T.J. Singleton, "The Principles of Fundamental Justice, Societal Interests and Section 1 of the Charter" (1995), 74 *Can. Bar Rev*. 446, at p. 449. As this Court stated in *R. v. Swain*, [1991] 1 S.C.R. 933, at p. 977:

> It is not appropriate for the state to thwart the exercise of the accused's right by attempting to bring societal interests into the principles of fundamental justice and to thereby limit the accused's s. 7 rights. Societal interests are to be dealt with under s. 1 of the *Charter*.

[81] In *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486 (the "*Motor Vehicle Reference*"), Lamer J. (as he then was) explained that the principles of fundamental justice are derived from the essential elements of our system of justice, which is itself founded on a belief in the dignity and worth of every human person. To deprive a

person of constitutional rights arbitrarily or in a way that is overbroad or grossly disproportionate diminishes that worth and dignity. If a law operates in this way, it asks the right claimant to "serve as a scapegoat" (*Rodriguez*, at p. 621, per McLachlin J.). It imposes a deprivation via a process that is "fundamentally unfair" to the rights claimant (*Charkaoui*, at para. 22).

[82] This is not to say that such a deprivation cannot be *justified* under s. 1 of the *Charter*. In some cases the government, for practical reasons, may only be able to meet an important objective by means of a law that has some fundamental flaw. But this does not concern us when considering whether s. 7 of the *Charter* has been breached.

(1) Arbitrariness

[83] The principle of fundamental justice that forbids arbitrariness targets the situation where there is no rational connection between the object of the law and the limit it imposes on life, liberty or security of the person: *Bedford*, at para. 111. An arbitrary law is one that is not capable of fulfilling its objectives. It exacts a constitutional price in terms of rights, without furthering the public good that is said to be the object of the law.

[84] The object of the prohibition on physician-assisted dying is to protect the vulnerable from ending their life in times of weakness. A total ban on assisted

suicide clearly helps achieve this object. Therefore, individuals' rights are not limited arbitrarily.

(2) Overbreadth

[85] The overbreadth inquiry asks whether a law that takes away rights in a way that generally supports the object of the law, goes too far by denying the rights of some individuals in a way that bears no relation to the object: *Bedford*, at paras. 101 and 112-13. Like the other principles of fundamental justice under s. 7, overbreadth is not concerned with competing social interests or ancillary benefits to the general population. A law that is drawn broadly to target conduct that bears no relation to its purpose "in order to make enforcement more practical" may therefore be overbroad (see *Bedford*, at para. 113). The question is not whether Parliament has chosen the least restrictive means, but whether the chosen means infringe life, liberty or security of the person in a way that has no connection with the mischief contemplated by the legislature. The focus is not on broad social impacts, but on the impact of the measure on the individuals whose life, liberty or security of the person is trammelled.

[86] Applying this approach, we conclude that the prohibition on assisted dying is overbroad. The object of the law, as discussed, is to protect vulnerable persons from being induced to commit suicide at a moment of weakness. Canada conceded at trial that the law catches people outside this class: "It is recognized that not every person who wishes to commit suicide is vulnerable, and that there may be people with disabilities who have a considered, rational and persistent wish to end

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

[87] Canada argues that it is difficult to conclusively identify the "vulnerable", and that therefore it cannot be said that the prohibition is overbroad. Indeed, Canada asserts, "every person is *potentially* vulnerable" from a legislative perspective (R.F., at para. 115 (emphasis in original)).

[88] We do not agree. The situation is analogous to that in *Bedford*, where this Court concluded that the prohibition on living on the avails of prostitution in s. 212(1)(*j*) of the *Criminal Code* was overbroad. The law in that case punished everyone who earned a living through a relationship with a prostitute, without distinguishing between those who would assist and protect them and those who would be at least potentially exploitive of them. Canada there as here argued that the line between exploitative and non-exploitative relationships was blurry, and that, as a result, the provision had to be drawn broadly to capture its targets. The Court concluded that that argument is more appropriately addressed under s. 1 (paras. 143-44).

(3) Gross Disproportionality

[89] This principle is infringed if the impact of the restriction on the individual's life, liberty or security of the person is grossly disproportionate to the object of the measure. As with overbreadth, the focus is not on the impact of the measure on society or the public, which are matters for s. 1, but on its impact on the rights of the claimant. The inquiry into gross disproportionality compares the law's purpose, "taken at face value", with its negative effects on the rights of the claimant, and asks if this impact is completely out of sync with the object of the law (*Bedford*, at para. 125). The standard is high: the law's object and its impact may be incommensurate without reaching the standard for *gross* disproportionality (*Bedford*, at para. 120; *Suresh v. Canada (Minister of Citizenship and Immigration)*, 2002 SCC 1, [2002] 1 S.C.R. 3, at para. 47).

[90] The trial judge concluded that the prohibition's negative impact on life, liberty and security of the person was "very severe" and therefore grossly disproportionate to its objective (para. 1378). We agree that the impact of the prohibition is severe: it imposes unnecessary suffering on affected individuals, deprives them of the ability to determine what to do with their bodies and how those bodies will be treated, and may cause those affected to take their own lives sooner than they would were they able to obtain a physician's assistance in dying. Against this it is argued that the object of the prohibition — to protect vulnerable persons from being induced to commit suicide at a time of weakness — is also of high importance. We find it unnecessary to decide whether the prohibition also violates

the principle against gross disproportionality, in light of our conclusion that it is overbroad.

(4) Parity

[91] The appellants ask the Court to recognize a new principle of fundamental justice, the principle of parity, which would require that offenders committing acts of comparable blameworthiness receive sanctions of like severity. They say the prohibition violates this principle because it punishes the provision of physician assistance in dying with the highest possible criminal sanction (for culpable homicide), while exempting other comparable end-of-life practices from any criminal sanction.

[92] Parity in the sense invoked by the appellants has not been recognized as a principle of fundamental justice in this Court's jurisprudence to date. Given our conclusion that the deprivation of Ms. Taylor's s. 7 rights is not in accordance with the principle against overbreadth, it is unnecessary to consider this argument and we decline to do so.

IX. Does the Prohibition on Assisted Suicide Violate Section 15 of the *Charter*?

[93] Having concluded that the prohibition violates s. 7, it is unnecessary to consider this question.

X. Section 1

[94] In order to justify the infringement of the appellants' s. 7 rights under s. 1 of the *Charter*, Canada must show that the law has a pressing and substantial object and that the means chosen are proportional to that object. A law is proportionate if (1) the means adopted are rationally connected to that objective; (2) it is minimally impairing of the right in question; and (3) there is proportionality between the deleterious and salutary effects of the law: *R. v. Oakes*, [1986] 1 S.C.R. 103.

[95] It is difficult to justify a s. 7 violation: see *Motor Vehicle Reference*, at p. 518; *G. (J.)*, at para. 99. The rights protected by s. 7 are fundamental, and "not easily overridden by competing social interests" (*Charkaoui*, at para. 66). And it is hard to justify a law that runs afoul of the principles of fundamental justice and is thus inherently flawed (*Bedford*, at para. 96). However, in some situations the state may be able to show that the public good — a matter not considered under s. 7, which looks only at the impact on the rights claimants — justifies depriving an individual of life, liberty or security of the person under s. 1 of the *Charter*. More particularly, in cases such as this where the competing societal interests are themselves protected under the *Charter*, a restriction on s. 7 rights may in the end be found to be proportionate to its objective.

[96] Here, the limit is prescribed by law, and the appellant concedes that the law has a pressing and substantial objective. The question is whether the government has demonstrated that the prohibition is proportionate.

[97] At this stage of the analysis, the courts must accord the legislature a measure of deference. Proportionality does not require perfection: *Saskatchewan (Human Rights Commission) v. Whatcott*, 2013 SCC 11, [2013] 1 S.C.R. 467, at para. 78. Section 1 only requires that the limits be "reasonable". This Court has emphasized that there may be a number of possible solutions to a particular social problem, and suggested that a "complex regulatory response" to a social ill will garner a high degree of deference (*Hutterian Brethren*, at para. 37).

[98] On the one hand, as the trial judge noted, physician-assisted death involves complex issues of social policy and a number of competing societal values. Parliament faces a difficult task in addressing this issue; it must weigh and balance the perspective of those who might be at risk in a permissive regime against that of those who seek assistance in dying. It follows that a high degree of deference is owed to Parliament's decision to impose an absolute prohibition on assisted death. On the other hand, the trial judge also found — and we agree — that the absolute prohibition could not be described as a "complex regulatory response" (para. 1180). The degree of deference owed to Parliament, while high, is accordingly reduced.

(1) Rational Connection

[99] The government must show that the absolute prohibition on physician-assisted dying is rationally connected to the goal of protecting the vulnerable from being induced to take their own lives in times of weakness. The question is whether the means the law adopts are a rational way for the legislature to

pursue its objective. If not, rights are limited for no good reason. To establish a rational connection, the government need only show that there is a causal connection between the infringement and the benefit sought "on the basis of reason or logic": *RJR-MacDonald*, at para. 153.

[100] We agree with Finch C.J.B.C. in the Court of Appeal that, where an activity poses certain risks, prohibition of the activity in question is a rational method of curtailing the risks (para. 175). We therefore conclude that there is a rational connection between the prohibition and its objective.

[101] The appellants argue that the *absolute* nature of the prohibition is not logically connected to the object of the provision. This is another way of saying that the prohibition goes too far. In our view, this argument is better dealt with in the inquiry into minimal impairment. It is clearly rational to conclude that a law that bars all persons from accessing assistance in suicide will protect the vulnerable from being induced to commit suicide at a time of weakness. The means here are logically connected with the objective.

(2) Minimal Impairment

[102] At this stage of the analysis, the question is whether the limit on the right is reasonably tailored to the objective. The inquiry into minimal impairment asks "whether there are less harmful means of achieving the legislative goal" (*Hutterian Brethren*, at para. 53). The burden is on the government to show the absence of less

drastic means of achieving the objective "in a real and substantial manner" (*ibid.*, at para. 55). The analysis at this stage is meant to ensure that the deprivation of *Charter* rights is confined to what is reasonably necessary to achieve the state's object.

[103] The question in this case comes down to whether the absolute prohibition on physician-assisted dying, with its heavy impact on the claimants' s. 7 rights to life, liberty and security of the person, is the least drastic means of achieving the legislative objective. It was the task of the trial judge to determine whether a regime less restrictive of life, liberty and security of the person could address the risks associated with physician-assisted dying, or whether Canada was right to say that the risks could not adequately be addressed through the use of safeguards.

[104] This question lies at the heart of this case and was the focus of much of the evidence at trial. In assessing minimal impairment, the trial judge heard evidence from scientists, medical practitioners, and others who were familiar with end-of-life decision-making in Canada and abroad. She also heard extensive evidence from each of the jurisdictions where physician-assisted dying is legal or regulated. In the trial judge's view, an absolute prohibition would have been necessary if the evidence showed that physicians were unable to reliably assess competence, voluntariness, and non-ambivalence in patients; that physicians fail to understand or apply the informed consent requirement for medical treatment; or if the evidence from permissive jurisdictions showed abuse of patients, carelessness, callousness, or a slippery slope, leading to the casual termination of life (paras. 1365-66).

[105] The trial judge, however, expressly rejected these possibilities. After reviewing the evidence, she concluded that a permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error. While there are risks, to be sure, a carefully designed and managed system is capable of adequately addressing them:

> My review of the evidence in this section, and in the preceding section on the experience in permissive jurisdictions, leads me to conclude that the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced. [para. 883]

[106] The trial judge found that it was feasible for properly qualified and experienced physicians to reliably assess patient competence and voluntariness, and that coercion, undue influence, and ambivalence could all be reliably assessed as part of that process (paras. 795-98, 815, 837 and 843). In reaching this conclusion, she particularly relied on the evidence on the application of the informed consent standard in other medical decision-making in Canada, including end-of-life decision-making (para. 1368). She concluded that it would be possible for physicians to apply the informed consent standard to patients who seek assistance in dying, adding the caution that physicians should ensure that patients are properly informed of their diagnosis and prognosis and the range of available options for medical care, including palliative care interventions aimed at reducing pain and avoiding the loss of personal dignity (para. 831).

[107] As to the risk to vulnerable populations (such as the elderly and disabled), the trial judge found that there was no evidence from permissive jurisdictions that people with disabilities are at heightened risk of accessing physician-assisted dying (paras. 852 and 1242). She thus rejected the contention that unconscious bias by physicians would undermine the assessment process (para. 1129). The trial judge found there was no evidence of inordinate impact on socially vulnerable populations in the permissive jurisdictions, and that in some cases palliative care actually improved post-legalization (para. 731). She also found that while the evidence suggested that the law had both negative and positive impacts on physicians, it did support the conclusion that physicians were better able to provide overall end-of-life treatment once assisted death was legalized: para. 1271. Finally, she found no compelling evidence that a permissive regime in Canada would result in a "practical slippery slope" (para. 1241).

(a) *Canada's Challenge to the Facts*

[108] Canada says that the trial judge made a palpable and overriding error in concluding that safeguards would minimize the risk associated with assisted dying. Canada argues that the trial judge's conclusion that the level of risk was acceptable flies in the face of her acknowledgment that some of the evidence on safeguards was weak, and that there was evidence of a lack of compliance with safeguards in permissive jurisdictions. Canada also says the trial judge erred by relying on cultural

differences between Canada and other countries in finding that problems experienced elsewhere were not likely to occur in Canada.

[109] We cannot accede to Canada's submission. In *Bedford*, this Court affirmed that a trial judge's findings on social and legislative facts are entitled to the same degree of deference as any other factual findings (para. 48). In our view, Canada has not established that the trial judge's conclusion on this point is unsupported, arbitrary, insufficiently precise or otherwise in error. At most, Canada's criticisms amount to "pointing out conflicting evidence", which is not sufficient to establish a palpable and overriding error (*Tsilhqot'in Nation*, at para. 60). We see no reason to reject the conclusions drawn by the trial judge. They were reasonable and open to her on the record.

(b) *The Fresh Evidence*

[110] Rothstein J. granted Canada leave to file fresh evidence on developments in Belgium since the time of the trial. This evidence took the form of an affidavit from Professor Etienne Montero, a professor in bioethics and an expert on the practice of euthanasia in Belgium. Canada says that Professor Montero's evidence demonstrates that issues with compliance and with the expansion of the criteria granting access to assisted suicide inevitably arise, even in a system of ostensibly strict limits and safeguards. It argues that this "should give pause to those who feel very strict safeguards will provide adequate protection: paper safeguards are only as strong as the human hands that carry them out" (R.F., at para. 97).

[111] Professor Montero's affidavit reviews a number of recent, controversial and high-profile cases of assistance in dying in Belgium which would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions. Professor Montero suggests that these cases demonstrate that a slippery slope is at work in Belgium. In his view, "[o]nce euthanasia is allowed, it becomes very difficult to maintain a strict interpretation of the statutory conditions."

[112] We are not convinced that Professor Montero's evidence undermines the trial judge's findings of fact. First, the trial judge (rightly, in our view) noted that the permissive regime in Belgium is the product of a very different medico-legal culture. Practices of assisted death were "already prevalent and embedded in the medical culture" prior to legalization (para. 660). The regime simply regulates a common pre-existing practice. In the absence of a comparable history in Canada, the trial judge concluded that it was problematic to draw inferences about the level of physician compliance with legislated safeguards based on the Belgian evidence (para. 680). This distinction is relevant both in assessing the degree of physician compliance and in considering evidence with regards to the potential for a slippery slope.

[113] Second, the cases described by Professor Montero were the result of an oversight body exercising discretion in the interpretation of the safeguards and restrictions in the Belgian legislative regime — a discretion the Belgian Parliament

has not moved to restrict. These cases offer little insight into how a Canadian regime might operate.

(c) *The Feasibility of Safeguards and the Possibility of a "Slippery Slope"*

[114] At trial Canada went into some detail about the risks associated with the legalization of physician-assisted dying. In its view, there are many possible sources of error and many factors that can render a patient "decisionally vulnerable" and thereby give rise to the risk that persons without a rational and considered desire for death will in fact end up dead. It points to cognitive impairment, depression or other mental illness, coercion, undue influence, psychological or emotional manipulation, systemic prejudice (against the elderly or people with disabilities), and the possibility of ambivalence or misdiagnosis as factors that may escape detection or give rise to errors in capacity assessment. Essentially, Canada argues that, given the breadth of this list, there is no reliable way to identify those who are vulnerable and those who are not. As a result, it says, a blanket prohibition is necessary.

[115] The evidence accepted by the trial judge does not support Canada's argument. Based on the evidence regarding assessment processes in comparable end-of-life medical decision-making in Canada, the trial judge concluded that vulnerability can be assessed on an individual basis, using the procedures that physicians apply in their assessment of informed consent and decisional capacity in the context of medical decision-making more generally. Concerns about decisional capacity and vulnerability arise in all end-of-life medical decision-making. Logically

speaking, there is no reason to think that the injured, ill and disabled who have the option to refuse or to request withdrawal of lifesaving or life-sustaining treatment, or who seek palliative sedation, are less vulnerable or less susceptible to biased decision-making than those who might seek more active assistance in dying. The risks that Canada describes are already part and parcel of our medical system.

[116] As the trial judge noted, the individual assessment of vulnerability (whatever its source) is implicitly condoned for life-and-death decision-making in Canada. In some cases, these decisions are governed by advance directives, or made by a substitute decision-maker. Canada does not argue that the risk in those circumstances requires an absolute prohibition (indeed, there is currently no federal regulation of such practices). In *A.C.*, Abella J. adverted to the potential vulnerability of adolescents who are faced with life-and-death decisions about medical treatment (paras. 72-78). Yet, this Court implicitly accepted the viability of an individual assessment of decisional capacity in the context of that case. We accept the trial judge's conclusion that it is possible for physicians, with due care and attention to the seriousness of the decision involved, to adequately assess decisional capacity.

[117] The trial judge, on the basis of her consideration of various regimes and how they operate, found that it is possible to establish a regime that addresses the risks associated with physician-assisted death. We agree with the trial judge that the risks associated with physician-assisted death can be limited through a carefully designed and monitored system of safeguards.

[118] Canada also argues that the permissive regulatory regime accepted by the trial judge "accepts too much risk", and that its effectiveness is "speculative" (R.F., at para. 154). In effect, Canada argues that a blanket prohibition should be upheld unless the appellants can demonstrate that an alternative approach eliminates all risk. This effectively reverses the onus under s. 1, requiring the claimant whose rights are infringed to prove less invasive ways of achieving the prohibition's object. The burden of establishing minimal impairment is on the government.

[119] The trial judge found that Canada had not discharged this burden. The evidence, she concluded, did not support the contention that a blanket prohibition was necessary in order to substantially meet the government's objectives. We agree. A theoretical or speculative fear cannot justify an absolute prohibition. As Deschamps J. stated in *Chaoulli*, at para. 68, the claimant "d[oes] not have the burden of disproving every fear or every threat", nor can the government meet its burden simply by asserting an adverse impact on the public. Justification under s. 1 is a process of demonstration, not intuition or automatic deference to the government's assertion of risk (*RJR-MacDonald*, at para. 128).

[120] Finally, it is argued that without an absolute prohibition on assisted dying, Canada will descend the slippery slope into euthanasia and condoned murder. Anecdotal examples of controversial cases abroad were cited in support of this argument, only to be countered by anecdotal examples of systems that work well. The resolution of the issue before us falls to be resolved not by competing anecdotes,

but by the evidence. The trial judge, after an exhaustive review of the evidence, rejected the argument that adoption of a regulatory regime would initiate a descent down a slippery slope into homicide. We should not lightly assume that the regulatory regime will function defectively, nor should we assume that other criminal sanctions against the taking of lives will prove impotent against abuse.

[121] We find no error in the trial judge's analysis of minimal impairment. We therefore conclude that the absolute prohibition is not minimally impairing.

(3) Deleterious Effects and Salutary Benefits

[122] This stage of the *Oakes* analysis weighs the impact of the law on protected rights against the beneficial effect of the law in terms of the greater public good. Given our conclusion that the law is not minimally impairing, it is not necessary to go on to this step.

[123] We conclude that s. 241 (*b*) and s. 14 of the *Criminal Code* are not saved by s. 1 of the *Charter*.

XI. Remedy

A. *The Court of Appeal's Proposed Constitutional Exemption*

[124] The majority at the Court of Appeal suggested that this Court consider issuing a free-standing constitutional exemption, rather than a declaration of invalidity, should it choose to reconsider *Rodriguez*. The majority noted that the law does not currently provide an avenue for relief from a "generally sound law" that has an extraordinary effect on a small number of individuals (para. 326). It also expressed concern that it might not be possible for Parliament to create a fully rounded, well-balanced alternative policy within the time frame of any suspension of a declaration of invalidity (para. 334).

[125] In our view, this is not a proper case for a constitutional exemption. We have found that the prohibition infringes the claimants' s. 7 rights. Parliament must be given the opportunity to craft an appropriate remedy. The concerns raised in *Ferguson* about stand-alone constitutional exemptions are equally applicable here: issuing such an exemption would create uncertainty, undermine the rule of law, and usurp Parliament's role. Complex regulatory regimes are better created by Parliament than by the courts.

B. *Declaration of Invalidity*

[126] We have concluded that the laws prohibiting a physician's assistance in terminating life (*Criminal Code*, s. 241(*b*) and s. 14) infringe Ms. Taylor's s. 7 rights to life, liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice, and that the infringement is not justified under s. 1 of the *Charter*. To the extent that the impugned laws deny the s. 7 rights of people

like Ms. Taylor they are void by operation of s. 52 of the *Constitution Act, 1982*. It is for Parliament and the provincial legislatures to respond, should they so choose, by enacting legislation consistent with the constitutional parameters set out in these reasons.

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

[128] We would suspend the declaration of invalidity for 12 months.

[129] We would not accede to the appellants' request to create a mechanism for exemptions during the period of suspended validity. In view of the fact that Ms. Taylor has now passed away and that none of the remaining litigants seeks a personal exemption, this is not a proper case for creating such an exemption mechanism.

[130] A number of the interveners asked the Court to account for physicians' freedom of conscience and religion when crafting the remedy in this case. The Catholic Civil Rights League, the Faith and Freedom Alliance, the Protection of Conscience Project and the Catholic Health Alliance of Canada all expressed concern that physicians who object to medical assistance in dying on moral grounds may be obligated, based on a duty to act in their patients' best interests, to participate in physician-assisted dying. They ask us to confirm that physicians and other health-care workers cannot be compelled to provide medical aid in dying. They would have the Court direct the legislature to provide robust protection for those who decline to support or participate in physician-assisted dying for reasons of conscience or religion.

[131] The Canadian Medical Association reports that its membership is divided on the issue of assisted suicide. The Association's current policy states that it supports the right of all physicians, within the bounds of the law, to follow their conscience in deciding whether or not to provide aid in dying. It seeks to see that policy reflected in any legislative scheme that may be put forward. While acknowledging that the Court cannot itself set out a comprehensive regime, the Association asks us to indicate that any legislative scheme must legally protect both those physicians who choose to provide this new intervention to their patients, along with those who do not.

[132] In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures. However, we note — as did Beetz J. in addressing the topic of physician participation in abortion in *R. v. Morgentaler* — that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the *Charter* rights of patients and physicians will need to be reconciled.

XII. Costs

[133] The appellants ask for special costs on a full indemnity basis to cover the entire expense of bringing this case before the courts.

[134] The trial judge awarded the appellants special costs exceeding $1,000,000, on the ground that this was justified by the public interest in resolving the legal issues raised by the case. (Costs awarded on the usual party-and-party basis would not have exceeded about $150,000.) In doing so, the trial judge relied on *Victoria (City) v. Adams*, 2009 BCCA 563, 100 B.C.L.R. (4th) 28, at para. 188, which set out four factors for determining whether to award special costs to a successful public interest litigant: (1) the case concerns matters of public importance that transcend the immediate interests of the parties, and which have not been previously

resolved; (2) the plaintiffs have no personal, proprietary or pecuniary interest in the litigation that would justify the proceeding on economic grounds; (3) the unsuccessful parties have a superior capacity to bear the cost of the proceedings; and (4) the plaintiffs did not conduct the litigation in an abusive, vexatious or frivolous manner. The trial judge found that all four criteria were met in this case.

[135] The Court of Appeal saw no error in the trial judge's reasoning on special costs, given her judgment on the merits. However, as the majority overturned the trial judge's decision on the merits, it varied her costs order accordingly. The majority ordered each party to bear its own costs.

[136] The appellants argue that special costs, while exceptional, are appropriate in a case such as this, where the litigation raises a constitutional issue of high public interest, is beyond the plaintiffs' means, and was not conducted in an abusive or vexatious manner. Without such awards, they argue, plaintiffs will not be able to bring vital issues of importance to all Canadians before the courts, to the detriment of justice and other affected Canadians.

[137] Against this, we must weigh the caution that "[c]ourts should not seek on their own to bring an alternative and extensive legal aid system into being": *Little Sisters Book and Art Emporium v. Canada (Commissioner of Customs and Revenue)*, 2007 SCC 2, [2007] 1 S.C.R. 38, at para. 44. With this concern in mind, we are of the view that *Adams* sets the threshold for an award of special costs too low. This Court has previously emphasized that special costs are only available in "exceptional"

circumstances: *Finney v. Barreau du Québec*, 2004 SCC 36, [2004] 2 S.C.R. 17, at para. 48. The test set out in *Adams* would permit an award of special costs in cases that do not fit that description. Almost all constitutional litigation concerns "matters of public importance". Further, the criterion that asks whether the unsuccessful party has a superior capacity to bear the cost of the proceedings will always favour an award against the government. Without more, special costs awards may become routine in public interest litigation.

[138] Some reference to this Court's jurisprudence on advance costs may be helpful in refining the criteria for special costs on a full indemnity basis. This Court set the test for an award of advance costs in *British Columbia (Minister of Forests) v. Okanagan Indian Band*, 2003 SCC 71, [2003] 3 S.C.R. 371. LeBel J. identified three criteria necessary to justify that departure from the usual rule of costs:

> 1. The party seeking interim costs genuinely cannot afford to pay for the litigation, and no other realistic option exists for bringing the issues to trial — in short, the litigation would be unable to proceed if the order were not made.
>
> 2. The claim to be adjudicated is *prima facie* meritorious; that is, the claim is at least of sufficient merit that it is contrary to the interests of justice for the opportunity to pursue the case to be forfeited just because the litigant lacks financial means.
>
> 3. The issues raised transcend the individual interests of the particular litigant, are of public importance, and have not been resolved in previous cases. [para. 40]

[139] The Court elaborated on this test in *Little Sisters*, emphasizing that issues of public importance will not in themselves "automatically entitle a litigant to

preferential treatment with respect to costs" (para. 35). The standard is a high one: only "rare and exceptional" cases will warrant such treatment (para. 38).

[140] In our view, with appropriate modifications, this test serves as a useful guide to the exercise of a judge's discretion on a motion for special costs in a case involving public interest litigants. First, the case must involve matters of public interest that are truly exceptional. It is not enough that the issues raised have not previously been resolved or that they transcend the individual interests of the successful litigant: they must also have a significant and widespread societal impact. Second, in addition to showing that they have no personal, proprietary or pecuniary interest in the litigation that would justify the proceedings on economic grounds, the plaintiffs must show that it would not have been possible to effectively pursue the litigation in question with private funding. In those rare cases, it will be contrary to the interests of justice to ask the individual litigants (or, more likely, pro bono counsel) to bear the majority of the financial burden associated with pursuing the claim.

[141] Where these criteria are met, a court will have the discretion to depart from the usual rule on costs and award special costs.

[142] Finally, we note that an award of special costs does not give the successful litigant the right to burden the defendant with any and all expenses accrued during the course of the litigation. As costs awards are meant to "encourage the reasonable and efficient conduct of litigation" (*Okanagan Indian Band*, at para. 41),

only those costs that are shown to be reasonable and prudent will be covered by the award.

[143] Having regard to these criteria, we are not persuaded the trial judge erred in awarding special costs to the appellants in the truly exceptional circumstances of this case. We would order the same with respect to the proceedings in this Court and in the Court of Appeal.

[144] The final question is whether the trial judge erred in awarding 10 percent of the costs against the Attorney General of British Columbia. The trial judge acknowledged that it is unusual for courts to award costs against an Attorney General who intervenes in constitutional litigation as of right. However, as the jurisprudence reveals, there is no firm rule against it: see, e.g., *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315; *Hegeman v. Carter*, 2008 NWTSC 48, 74 C.P.C. (6th) 112; and *Polglase v. Polglase* (1979), 18 B.C.L.R. 294 (S.C.).

[145] In her reasons on costs, the trial judge explained that counsel for British Columbia led evidence, cross-examined the appellants' witnesses, and made written and oral submissions on most of the issues during the course of the trial. She also noted that British Columbia took an active role in pre-trial proceedings. She held that an Attorney General's responsibility for costs when involved in constitutional litigation as of right varies with the role the Attorney General assumes in the litigation. Where the Attorney General assumes the role of a party, the court may find the Attorney General liable for costs in the same manner as a party: para. 96.

She concluded that the Attorney General of British Columbia had taken a full and active role in the proceedings and should therefore be liable for costs in proportion to the time British Columbia took during the proceedings.

[146] We stress, as did the trial judge, that it will be unusual for a court to award costs against Attorneys General appearing before the court as of right. However, we see no reason to interfere with the trial judge's decision to do so in this case or with her apportionment of responsibility between the Attorney General of British Columbia and the Attorney General of Canada. The trial judge was best positioned to determine the role taken by British Columbia and the extent to which it shared carriage of the case.

XIII. Conclusion

[147] The appeal is allowed. We would issue the following declaration, which is suspended for 12 months:

> Section 241(*b*) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect to the extent that 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.

[148] Special costs on a full indemnity basis are awarded against Canada throughout. The Attorney General of British Columbia will bear responsibility for 10 percent of the costs at trial on a full indemnity basis and will pay the costs associated with its presence at the appellate levels on a party and party basis.

Appeal allowed with costs.

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Solicitor for the respondent the Attorney General of British Columbia: Attorney General of British Columbia, Victoria.

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Solicitor for the intervener the Attorney General of Quebec: Attorney General of Quebec, Québec.

Solicitors for the interveners the Council of Canadians with Disabilities and the Canadian Association for Community Living: Bakerlaw, Toronto.

Solicitors for the intervener the Christian Legal Fellowship: Miller Thomson, Calgary.

Solicitors for the interveners the Canadian HIV/AIDS Legal Network and the HIV & AIDS Legal Clinic Ontario: Paliare Roland Rosenberg Rothstein, Toronto; Canadian HIV/AIDS Legal Network, Toronto; HIV & AIDS Legal Clinic Ontario, Toronto.

Solicitor for the intervener the Association for Reformed Political Action Canada: Association for Reformed Political Action Canada, Ottawa.

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Solicitors for the intervener the Evangelical Fellowship of Canada: Geoffrey Trotter Law Corporation, Vancouver.

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Solicitors for the intervener the Canadian Medical Association: Polley Faith, Toronto.

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Solicitors for the intervener the Canadian Civil Liberties Association: Borden Ladner Gervais, Toronto.

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