Case Name:

W.V. v. Canada (Attorney General)

Between
W.V., Applicant, and
Attorney General of Canada, Respondent, and
Attorney General of Ontario, Respondent, and
Dr. C. Doe, Respondent

[2016] O.J. No. 1739

2016 ONSC 2302

Court File No.: 787-16

Ontario Superior Court of Justice
London, Ontario

R.M. Raikes J.

Heard: March 23, 2016.
Judgment: April 5, 2016.

(42 paras.)

Criminal law -- Constitutional issues -- Application by WV for constitutional exemption to ss. 241(b) and 14 of Criminal Code allowed -- WV had aggressive cancer that did not respond well to treatment -- WV's life expectancy was measured in months -- WV was in constant pain which was increasing -- WV requested authorization for physician-assisted suicide -- WV suffered from grievous irremedial medical condition that caused enduring suffering that was intolerable to her and resulted in dramatic reduction in quality of life -- Evidence established that WV clearly consented to termination of life and had capacity to give that consent -- Criminal Code, ss. 14, 251(b).

Criminal law -- Criminal Code offences -- Offences against person and reputation -- Suicide -- Application by WV for constitutional exemption to ss. 241(b) and 14 of Criminal Code allowed -- WV had aggressive cancer that did not respond well to treatment -- WV's life expectancy was measured in months -- WV was in constant pain which was increasing -- WV requested authorization for physician-assisted suicide -- WV suffered from grievous irremedial medical condition that caused enduring suffering that was intolerable to her and resulted in dramatic reduction in quality of life --

Evidence established that WV clearly consented to termination of life and had capacity to give that consent -- Criminal Code, ss. 14, 251(b).

Application by WV for a constitutional exemption to ss. 241(b) and 14 of the Criminal Code. WV had clear cell ovarian cancer, which was an aggressive cancer that did not respond well to treatment. WV's prognosis was poor, and her life expectancy was measured in months. WV was in constant pain that was increasing. WV's palliative care doctor advised that WV requested an authorization for a physician-assisted suicide. A psychiatrist advised that WV had the mental capacity to make a clear, free, and informed decision about a physician-assisted death.

HELD: Application allowed. WV suffered from a grievous irremedial medical condition that caused enduring suffering that was intolerable to her in the circumstances of her condition and resulted in a dramatic reduction in quality of life. The evidence established that WV clearly consented to the termination of life and had the capacity to give that consent. She commenced the current application aware of its implication and desirous of its outcome. The evidence clearly supported a keen awareness of her medical condition, its prognosis, treatment options, palliative care options, and the risks and implications of a physician-assisted death. Her doctors and a psychiatrist assessed her capacity and unequivocally confirmed that she was fully informed, competent and capable of making the decision. Her consent was without coercion, undue influence or ambivalence.

Statutes, Regulations and Rules Cited:

Canadian Charter of Rights and Freedoms, 1982, s. 7

Coroners Act, s. 10

Criminal Code, s. 14, s. 251(b)

Health Care Consent Act,

Counsel:

David Williams and C. Campbell, Counsel for the Applicant, W.V.

No one appearing, for the Respondent, Attorney General of Canada.

Rochelle S. Fox and Padraic Ryan, for the Respondent, Attorney General of Ontario.

Erica J. Baron, for the Respondent, Dr. C. Doe.

R.M. RAIKES J.:--

Overview

1 On March 23, 2016, I heard an application brought by the Applicant, W.V. [not her real initials], seeking a constitutional exemption to sections 241(b) and 14 of the Criminal Code pursuant to the decision in Carter v. Canada (Atty. Gen.), 2016 SCC 4 authorizing a physician-assisted death.

2 I granted the order requested by the Applicant on March 24, 2016 with Reasons to follow. There was then a very real prospect that any delay that would result from my penning these Reasons could deprive her of the relief which she sought. It was my view that the order should issue with reasons to follow soon after to avoid even the slightest chance that her constitutional rights could be pre-empted and her suffering unnecessarily prolonged.

Applicable Law

3 Section 241(b) of the Criminal Code, R.S.C. 1985, c. C-46 states:

> "Every one who,
>
> (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."

4 Section 14 of the *Criminal Code* states:

> "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."

5 By these provisions and until June 6, 2016, it remains a crime in Canada to assist another person in ending his/her life. The above sections apply to a physician who provides or administers medication that intentionally brings about a patient's death at the patient's request in the absence of a court ordered exemption.

6 On February 6, 2015, the Supreme Court of Canada released its decision in *Carter v. Canada (Atty. Gen.), 2015 SCC 5*. In that decision, the Supreme Court decided that the above sections of the Criminal Code, which effectively prohibit physician-assisted death, violate an individual's right to life, liberty and security of the person contrary to section 7 of the *Canadian Charter of Rights and Freedoms, 1982*. The Court found that the provisions, as drafted, were overbroad to the extent they prohibited physician-assisted death for those persons who were suffering intolerably from a grievous irremediable medical condition.

7 The Supreme Court declared void those sections of the Criminal Code insofar as they prohibited physician-assisted death but suspended the operation of its order for a period of one year to permit the federal government to enact new legislation that would not offend section 7 of the Charter. The federal government was unable to meet that deadline and sought an extension.

8 In *Carter v. Canada (Atty. Gen.), 2016 SCC 4*, the Supreme Court extended the time for the federal government to enact new legislation to June 6, 2016. However, in the interim, the Supreme Court ordered that applications could be made to the Superior Courts in each province and territory for an exemption from the application of existing provisions of the *Criminal Code*.

9 The criteria which must be satisfied on such an application are found in paragraph 127 of the 2015 decision in *Carter v. Canada (Atty. Gen.), supra*, as follows:

> "The appropriate remedy is therefore a declaration that s. 241(b) and s. 14 of the Criminal Code are void in so far as they prohibited physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremedial 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. "Irremedial", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual..."

10 In *A.B. v. Canada (Atty. Gen.), 2016 ONSC 1912*, Perell J. considered and explained the requirements derived from paragraph 127 in Carter (2015). He wrote:

> "[22] I extract five criteria from para 127 of *Carter-2015*; namely: (1) the person is a competent adult person; (2) the person has a grievous and irremedial medical condition including an illness, disease or disability; (3) the person's condition is causing him or her to endure intolerable suffering; (4) his or her suffering cannot be alleviated by any treatment available that he or she finds acceptable; and, (5) the person clearly consents to the termination of life.
>
> [23] For the superior courts to properly carry out their role after *Carter-2016*, each of the five criteria require some elucidation or explanation.
>
> [24] With respect to the first criterion, the common law definition of capacity in the context of making decisions about medical treatment is the ability to understand the nature, the purpose and the consequences of the proposed treatment: *Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre, 2013 SCC 53*. Under the *Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A*, a patient is presumed to be competent. However, for the first criterion to be satisfied, the matter of capacity must be proven, not assumed.
>
> [25] With respect to the second criterion, a grievous medical condition connotes that the person's medical condition greatly or enormously interferes with the quality of that person's life and is in the range of critical, life-threatening, or terminal. An irremedial medical condition connotes that the medical condition is permanent and irreversible. Like the first criterion, this criterion must be proven to the satisfaction of the court.
>
> [26] With respect to the third criterion, there must be a causal connection between the person's medical condition and the persons suffering from enduring, intolerable pain. There are two elements here, the first being that the person is suffering grievous pain and the second element being that the medical condition is the predominant source of that suffering. Because pain is influenced by subjective or idiosyncratic features, the evidence to satisfy this third criterion will be a mixture of subjective and objective medical evidence.
>
> [27] With respect to the fourth criterion, it is the pain and suffering, not the medical condition that cannot be alleviated by any treatment acceptable to the person.

> Once again, there is both an objective and subjective element to this criterion. Objectively, there may or may not be effective treatments to alleviate and manage the person's pain but, if there are treatments, they must be subjectively acceptable to the person.
>
> [28] With respect to the fifth criterion, under s.11(1) of the *Health Care Consent Act, 1996*, consented to treatment requires the following: (1) the consent must relate to the treatment; (2) the consent must be informed; (3) the consent must be given voluntarily; and (4) the consent must not be obtained through misrepresentation or fraud."

11 I agree with and adopt Justice Perell's analysis as it relates to criteria 1, 2, 4 and 5 above. With respect to the third criterion in Justice Perell's analysis, I note the following:

1. Paragraph 127 in *Carter (2015)* does not confine "suffering" to "pain";

2. The Supreme Court of Canada did not expressly require that the medical condition be the "predominant source" of the suffering.

12 I respectfully disagree with Justice Perell's analysis of the third criterion to the extent he confines suffering to pain and requires that the medical condition be the predominant source of that pain. A grievous irremedial condition may well compromise a person's ability to tolerate enduring suffering. That suffering may have multiple causes and not be limited to the irremedial medical condition itself. For example, an individual may have significant pain which they have tolerated or learned to live with but then they become ill with a terminal disease. The terminal disease may add to the pain the person is suffering and carry it past the point that he or she can tolerate. Alone, the pain from the terminal disease may be manageable but when taken with the person's underlying condition, may simply be too much.

13 In my view, the court should not parse the source of the suffering to assess whether the terminal disease is the predominant cause of pain; rather, the court should consider whether the irremedial medical condition results in enduring suffering which is intolerable to the individual having regard to their individual circumstances.

14 Further, one might well imagine a terminal illness for which the pain can be managed within reasonable limits, but the manner and timing of death is so horrifying that the individual's ability to carry that burden to that end is intolerable. The suffering in that case carries with it not only a measure of pain or discomfort but significant psychological suffering. The psychological component informs the intolerable nature of the enduring suffering.

15 I turn now to the circumstances of the applicant, W.V..

The Applicant

16 The Applicant is 66 years old. She was injured in a very serious motor vehicle accident several years ago. The accident left her significantly disabled and suffering from chronic pain. She had multiple surgeries including skin grafts that harvested most of the skin on her back. She tried various medical alternatives to deal with the pain which provided minimal relief. Her mobility was dramatically less than before the accident. Nevertheless, she persevered. She bore the pain and adapted as best she could for many years.

17 In 2014, the Applicant noticed a lump in her abdomen. She had surgery to remove the mass from her abdomen. During the surgery, the mass ruptured. Soon after the surgery, she was diagnosed with clear cell ovarian cancer. Because the mass ruptured during surgery, her oncologist deemed the cancer to be stage IC. Had the mass not ruptured during surgery, there was a prospect that the progression of the disease could be slowed with radiation.

18 Clear cell ovarian cancer is an aggressive cancer that does not respond well to treatment. The Applicant was advised by doctors that it was considered to be "platinum resistant" ovarian cancer.

19 Because the cancerous mass ruptured during surgery, it needed to be treated aggressively with chemotherapy and radiation. The Applicant started chemotherapy in December, 2014. She was able to complete five of the six cycles recommended by her doctors. There were many complications and she visited hospital Emergency approximately six times during her chemotherapy. Her many complications included dangerously reduced white blood cell counts, fevers, urinary tract infections, problems with blood pressure, hemoglobin and heart palpitations.

20 The Applicant was generally bedridden throughout this course of treatment. She experienced both nausea and vomiting. In general, she tolerated the therapy very poorly. A number of sessions had to be cancelled or delayed because she was too sick to tolerate treatment. Her physicians reduced the dosage enough to get her through the treatments but eventually, it became too dangerous to continue chemotherapy.

21 In April, 2015, a CT scan showed that her cancer had continued to spread aggressively despite chemotherapy and her prognosis was poor. The Applicant was advised that she was no longer eligible for chemotherapy due to her poor health and the fact that her cancer was chemo-refractory. She was advised that she was also no longer a candidate for radiation treatment. In February, 2015, she sought a further opinion on her diagnosis from an internationally recognized expert in ovarian cancer in Toronto. She saw this doctor again in April and May, 2015. He agreed that it was worth trying a clinical trial that her oncologist suggested as a treatment of last resort to slow the progression of the disease, and advised her that there were no other treatment options available.

22 The clinical trial involved a very toxic drug which would not cure her cancer but, if successful, might slow the progression of the cancer to extend her life. She did not meet the minimum platelet requirements for the trial and had to receive a platelet transfusion in order to be enrolled.

23 Upon starting the new drug, the Applicant became ill almost immediately. She was forced to go off the drug. She tried again several times without success and was eventually advised that it was too dangerous to continue. She experienced side effects that included severe dizziness, constipation, diarrhea, drowsiness, brain fog, blurred vision, double vision, extremely painful cramping in her hands and feet and an episode of excruciating bone pain in her legs.

24 The Applicant was repeatedly advised by physicians that her cancer does not respond well to therapy. When she dropped out of the clinical trial, she was advised that she had a life expectancy measured in months. Her tumors had continued to grow notwithstanding the treatment that she undertook. Her treating doctors supported her decision to abandon any treatment other than symptom management and palliative care.

25 The Applicant suffers pain from the cancer mainly confined to her abdomen. She has shortness of breath and experiences an uncomfortable pain and fullness in her lower rib cage area. She is now experiencing pain from both the cancer and the chronic pain from her motor vehicle accident.

26 CT scans completed in April and August 2015 showed that her cancer was actively spreading throughout her abdomen. There was also evidence of cancer in her thoracic area. A large tumor presses upon her bowel increasing the risk of bowel obstruction, which could cause death.

27 The Applicant recently had a peritoneal port laparoscopically implanted into her abdomen to relieve the buildup of fluid. She was in hospital for seven days for that procedure. She found that experience terrifying. While there, she learned the various ways in which she might ultimately die from her disease.

28 W.V. has been advised by her palliative care doctor that she will not survive more than a few more months. She has been fighting this cancer for over 15 months and there is no further treatment that bears any prospect of curing or slowing the progress of this insidious disease. In the meantime, she remains in constant pain which is increasing.

29 To make matters worse, the Applicant is unable to tolerate pain medication at sufficient dosage to provide relief from or otherwise make tolerable the pain that she suffers on a daily basis. Her body simply rejects the pain medication with attendant side-effects. As a result, conventional palliative care to make her more comfortable provides little relief.

30 The Applicant was able to accept and adjust to the chronic pain from the motor vehicle accident but the cancer has weakened her body's ability to fight through that pain and has added to it by the pain caused by the cancer.

31 The quality of her life has also diminished significantly. She survives, getting through each day as best she can in constant pain and with the knowledge that her life will soon end from the cancer that is aggressively attacking her body. Her energy level has fallen dramatically, a sign her doctors advise signals that her death is imminent. She barely eats and does so with the fear that it may cause a fatal bowel obstruction. She has already lived longer than was projected for this disease.

32 The Applicant's family respect and support her decision.

33 W.V.'s palliative care physician provided the following evidence on the application:

1. W.V. has "metastatic clear cell carcinoma of the ovaries with peritoneal or carcinomatosis (spread of her cancer)";

2. It is incurable;

3. W.V. also suffers from a pulmonary embolus;

4. W.V. has a "grievous irremedial medical condition that causes suffering";

5. W.V. is "suffering enduring pain that cannot be and has not been alleviated by any treatment acceptable to her";

6. The doctor believes that W.V. understands that she has a grievous irremedial medical condition, the prognosis, treatment options, palliative care options and the risks associated with a physician-assisted death;

7. W.V. presently makes her own medical decisions pursuant to the Health Care Consent Act. The doctor has not observed anything that calls into question the Applicant's mental capacity to make a clear, free and informed decision about physician-assisted death;

8. The doctor has advised W.V. that her request for an authorization for a physician-assisted death may be withdrawn at any time. W.V. advised this doctor that she understood that advice and the doctor believes the Applicant;

9. The doctor believes W.V. is requesting an authorization for a physician-assisted death freely and voluntarily. The doctor has observed no undue influence, coercion or ambivalence; and,

10. The doctor advised W.V. that if the authorization is granted, the decision to use or not use the authorization is entirely the Applicant's decision to make. W.V. advised her that she understood that advice.

34 W.V. was also assessed by a psychiatrist who reviewed her health records including consultation notes from other psychiatrists. He assessed W.V. on February 19, 2006 in the presence of W.V.'s daughter and a social worker. The psychiatrist opined that:

1. W.V. has a grievous irremedial condition that causes suffering;

2. W.V. makes her own medical decisions pursuant to the Health Care Consent Act;

3. In his opinion, W.V. has the mental capacity to make a clear, free, and informed decision about a physician-assisted death;

4. W.V. advised him that she wishes and consents to physician-assisted death. In his opinion, W.V. has consented without any coercion, undue influence or ambivalence;

5. He advised W.V. that her request for an authorization for physician-assisted death may be withdrawn at any time. The Applicant advised him that she understood that advice and he believed her;

6. He asked whether she is making the request for authorization for physician-assisted death freely and voluntarily, and she confirmed that she does. He believes her;

7. He advised W.V. and he believes that she understood that if the authorization is granted, the decision to use or not use the authorization is entirely her decision to make.

35 Finally, a further affidavit was provided by a physician who is prepared to assist the Applicant if she makes the decision for a physician-assisted death and if she has capacity/competence at the time that she so decides. The physician swore an affidavit in which he deposed:

1. He reviewed the College of Physicians and Surgeons of Ontario's Interim Guidance on physician-assisted death and believes that W.V. meets the criteria elaborated upon in section IV. A of that Guidance;

2. In the event Court approval is given and W.V. chooses to seek a physician-assisted death, he will follow the Interim Guidelines for physician's assistance in dying at a hospital with any appropriate or necessary modifications agreed to by the Applicant. The timing of death will depend on W.V.'s wishes and the availability of the necessary resources;

3. He is willing to provide assistance to the Applicant in dying if that act is authorized by court order;

4. He believes that providing assistance to W.V. would be clearly consistent with her wishes; and,

5. He understands that if the authorization is granted, the decision to use the authorization rests entirely with W.V. as is the manner and timing of physician-assisted death.

36 The Guidance appended as Exhibit "C" to the latter physician's affidavit sets out the manner in which a physician-assisted death will be performed. It contemplates the administration of very carefully controlled medications in dosages that will painlessly achieve the Applicant's death. I need not set out or explain that methodology herein. It was canvassed fully during oral submissions. The Applicant is well-aware of the procedure that will be followed and accepts it.

Findings

37 I am satisfied on the evidence before me that the Applicant, W.V., suffers from a grievous irremedial medical condition that causes enduring suffering that is intolerable to her in the circumstances of her condition. She is in considerable pain from which she can get little respite given her intolerance to and inability to take therapeutic doses of pain medication. Her terminal illness when overlaid on her underlying chronic pain results in suffering including a dramatic reduction in quality of life. I note that even if one applies Justice Perell's analysis of the third criterion, it is satisfied on the evidence before me.

38 The evidence also satisfies me that she clearly consents to the termination of life and has the capacity to give that consent. She has brought this application aware of its implications and desirous of its outcome. The evidence clearly supports a keen awareness of her medical condition, its prognosis, treatment options, palliative care options, and the risks and implications of a physician-assisted death. She is aware that even if the court grants the order that she seeks, she need not pursue physician-assisted death. Her doctors and a psychiatrist have assessed her capacity and unequivocally confirm that she is fully informed, competent and capable of making this decision. Her consent is without coercion, undue influence or ambivalence.

39 In my Endorsement of March 24, 2016, I specifically included a provision which requires that her capacity be further assessed when and if she decides to invoke the exemption so as to have a physician-assisted death. That further assessment is a prerequisite to any steps by the physician to assist her. It will ensure that her death, although physician-assisted, is the result of her competent decision.

40 In my Endorsement, I also granted relief with respect to section 10 of the *Coroners Act* for essentially the same reasons expressed by Perell J. in *A.B. v. Canada (Atty. Gen.), supra,* at paras. 53-71. I adopt the rationale at paragraph 71 in that decision.

41 I have already set out in my Endorsement of March 24, 2016 the terms of the Order granted. For ease of reference, I append a copy of that Endorsement as Schedule "A" to these Reasons.

Conclusion

42 For the reasons above, I grant the order set out in Schedule "A" hereto.

R.M. RAIKES J.