IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *O'Neill v British Columbia (Minister of Health),* 2026 BCSC 2316

Date: 20261127
Docket: S244011
Registry: Vancouver

Between:

Gaye O'Neill, Administrator of the Estate of Sam O'Neill, Dr. Jyothi Jayaraman and Dying with Dignity Canada

Plaintiffs

And

His Majesty the King in Right of the Province of British Columbia, as represented by the Minister of Health, Vancouver Coastal Health Authority and Providence Health Care Society

Defendants

And

Canadian Civil Liberties Association, British Columbia Humanist Association, Canadian Centre for Christian Charities, Canadian Physicians for Life, Christian Legal Fellowship, Delta Hospice Society, and Evangelical Fellowship of Canada

Interveners

Before: The Honourable Chief Justice Skolrood

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Introduction

[1] In 2015, the Supreme Court of Canada released its landmark decision in *Carter v Canada (Attorney General)*, 2015 SCC 5 [*Carter*], in which the Court struck down provisions of the *Criminal Code* that prohibited assistance in dying, including assistance from physicians, on the basis that the prohibition violated s 7 of the *Canadian Charter of Rights and Freedoms*.

[2] As a result of *Carter*, what is known as Medical Assistance in Dying ("MAiD") became legal in Canada.

[3] While *Carter* opened the door to the provision of MAiD across the country, once the federal government provided a legislative scheme to govern the parameters under which MAiD could be provided, it fell to the provinces to develop implementation policies and practices given the primacy of provincial constitutional jurisdiction over healthcare. In BC, the policy development work was largely done by a Ministry of Health ("MOH") sponsored MAiD Working Group.

[4] That work resulted in the adoption of the "MOH Policy on Medical Assistance in Dying: Access to and Care Coordination" (the "MOH MAiD Policy"). The MOH MAiD Policy sets out a comprehensive set of guidelines for the provision of MAiD within BC's public healthcare system.

[5] One feature of the MOH MAiD Policy, which is central to this litigation, is the provision permitting faith-based organizations ("FBOs") to decline to provide MAiD in facilities operated by those organizations. This option is also recognized within Vancouver Coastal Health Authority's ("VCH") policy titled "Medical Assistance in Dying (Responding to Requests)", which governs the provision of MAiD within the VCH region (the "VCH MAiD Policy").

[6] One such FBO is the defendant Providence Health Care Society ("PHC"), which operates several healthcare facilities in BC, including St. Paul's Hospital ("SPH"), one of the province's largest and busiest tertiary care hospitals.

[7] PHC is a Catholic organization that provides healthcare services in accordance with Catholic teachings and values. Based on those teachings and values, PHC has exercised the option granted under the MOH MAiD Policy to opt out of providing MAiD within its facilities. PHC's position on MAiD is set out in its "Medical Assistance in Dying: Responding to Requests Policy", dated effective May 27, 2022 (the "PHC MAiD Policy").

[8] Pursuant to the PHC MAiD Policy, patients who are assessed and approved for MAiD while at a PHC facility, such as SPH, must transfer to another non-PHC facility in order to receive MAiD. The plaintiffs allege that these transfers violate various *Charter* rights of both patients and physicians. In terms of patients, the plaintiffs say that the transfer requirement impedes the patients' ability to make fundamental personal decisions about their own deaths and subjects them to unwarranted physical and psychological harm. With respect to physicians, the plaintiffs argue that physicians are prevented from practising medicine in accordance with their conscientious beliefs. At the heart of the plaintiffs' claim is the allegation that the MAiD transfers and the policies that permit them favour PHC's Catholic beliefs over the rights of patients.

[9] The plaintiffs submit that these harms could be avoided by permitting, or requiring as part of the MOH MAiD Policy, provision of MAiD at FBO-operated facilities by third-party MAiD providers. According to the plaintiffs, this would ensure that patients in those facilities have reasonable access to MAiD, while at the same time respecting the FBO's religious-based objections.

[10] The plaintiffs' constitutional challenge is largely directed at the MOH MAiD Policy because it creates the circumstances giving rise to the alleged *Charter* breaches. The plaintiffs also challenge the VCH MAiD Policy and the PHC MAiD Policy "to the extent necessary" as these policies reflect the implementation of the MOH MAiD Policy.

[11] For the purposes of these reasons, I will refer to the three policies collectively as "the impugned policies", except where it is necessary or appropriate to identify a specific policy.

[12] At the outset, it is useful to address an issue of terminology. Throughout the proceeding, the plaintiffs have used the term "forced transfers" to refer to situations in which a patient is moved from their present location for MAiD to be administered. The plaintiffs say that these transfers are "forced" because the transfers are not carried out for any proper clinical, resource, or administrative reasons but are done to accommodate an FBOs religious-based objection to MAiD.

[13] The defendants submit that the transfers are not forced but rather are undertaken to facilitate the patient's choice to access MAiD when that medical service is not available in the current facility in which the patient is being treated. In this sense, the defendants submit that the transfers for MAiD are the same as other transfers that happen routinely on a daily basis in the healthcare system.

[14] In my view, "forced transfers" is a loaded term that presupposes the outcome of the legal analysis at the heart of this case. A more appropriate term, and the term that I will use in these reasons, is "MAiD transfer" as this accurately captures the purpose for which these transfers are made.

Summary of Findings

[15] Before delving into the facts underpinning the plaintiffs' claims and the analysis of the issues that arise, it is useful to first provide a brief summary of my key findings.

[16] As set out above, the plaintiffs allege that the impugned polices violate the *Charter* rights of both physicians who include MAiD as part of their medical practice and patients who seek to avail themselves of MAiD.

[17] Specifically, the plaintiffs allege that the impugned polices, which result in MAiD transfers, infringe physicians' s 2(a) freedom of conscience rights and patients'

s 2(a) freedom of conscience and religion rights, as well as patients' s 7 rights to life, liberty and security of the person.

[18] The alleged infringements are based on what the plaintiffs again characterize as the preference given under the impugned polices to Catholic beliefs over the rights of patients and the increased risk of physical and psychological harm that patients are said to be subject to as a result of MAiD transfers.

[19] The plaintiffs rely heavily on the *Carter* decision in support of their constitutional challenge. However, the circumstances of *Carter* differ significantly from those before the Court in the present case. In *Carter*, the Court struck down provisions of the *Criminal Code* that prohibited patients from accessing MAiD on the basis that the prohibition deprived patients of the ability to make fundamental personal choices impacting their bodily integrity and subjected them to increased pain and psychological stress.

[20] The impugned polices here do not similarly prohibit patients from accessing MAiD. That is not their intention nor does the evidence establish that they have had that effect. Indeed, all of the patients whose specific circumstances were entered into evidence received MAiD within a very short time after their decision to do so.

[21] The plaintiffs submit, however, that MAiD transfers subject patients to increased pain and psychological stress, and it is these impacts that largely ground their *Charter* challenges.

[22] In terms of physicians who provide MAiD services, the plaintiffs submit that the impugned polices, specifically the PHC MAiD Policy, violate the freedom of conscience rights of practitioners by interfering with their ability to practice medicine in a manner consistent with their ethical and moral beliefs, which causes them moral distress.

[23] In my view, the plaintiffs have failed to establish this alleged breach. Physicians who practice medicine at FBOs, like PHC, do so voluntarily and with full knowledge of the particular facility's position on MAiD. There is nothing in any of the

impugned policies that compel physicians to act contrary to their conscientious beliefs.

[24] It is clear from the evidence led by all of the parties that different physicians hold different moral and ethical beliefs about MAiD. These differences are reflected in the Canadian Medical Association's MAiD policy, which acknowledges both conscientious participation in, and conscientious objection to, MAiD by physicians.

[25] A particular physician's belief in the importance and value of MAiD does not give rise to a right to provide MAiD services wherever the physician wishes to do so nor does it permit a physician to compel a facility to make MAiD available. Section 2(a) of the *Charter* is intended to protect individuals from state coercion on matters of conscience; it is not intended to empower individuals to compel the state or other institutional actors to act in a particular manner that accords with that individual's conscientious beliefs.

[26] In terms of the impacts on patients, the plaintiffs argue that the impugned policies violate both the freedom of conscience and the freedom of religion rights. I am unable to agree.

[27] With respect to conscience, while the decision to seek MAiD is undoubtedly an intensely personal decision, it is not apparent on the evidence before the Court that such choices reflect an overarching moral belief or set of beliefs that inform all aspects of a person's life, as is necessary to ground a freedom of conscience claim. Furthermore, even if the choice to seek MAiD is a matter of conscience within the meaning of s 2(a), the right does not extend to permitting the patient to choose the precise timing and location of the procedure.

[28] As for freedom of religion, the plaintiffs again submit that the impugned polices favour Catholic beliefs over the rights of patients and effectively impose Catholic doctrine on patients seeking MAiD. This allegation is similarly not made out on the evidence. Specifically, there is no evidence that any patients, including the

patients whose circumstances were in evidence, were compelled to accept or observe Catholic beliefs either generally or as a condition of receiving MAiD.

[29] The MOH MAiD Policy on its face does not manifest a preference for Catholic beliefs, or any religious beliefs or practices, to the exclusion of others. The fact that it permits different FBOs to operate in a manner consistent with their beliefs, does not amount to state sponsorship of those beliefs or make the practice of those beliefs mandatory.

[30] The plaintiffs' position that the impugned polices, and the resulting MAiD transfers, violate patients' s 7 rights largely rests on their position that those transfers subject patients to increased risk of pain and psychological stress.

[31] However, it is apparent on the evidence that transfers are a routine aspect of healthcare in BC and, to the extent that there are risks associated with those transfers, specific patient needs are addressed and the risks are managed. The fact that a transfer may occur for the purposes of MAiD, does not change that fact.

[32] The plaintiffs' position that MAiD transfers are fundamentally different from other transfers, for example for clinical purposes, essentially amounts to a claim to the right to demand access to MAiD at the time and in the location of the patient's choice. Such a claim goes well beyond the established bounds of the *Charter* rights relied on and would improperly insert the Court into the management of day to day healthcare operations.

[33] It is important to acknowledge at the outset the evidence led by the plaintiffs from family and friends of a number of patients who experienced MAiD transfers. There is no question that the family and friends were profoundly distressed by what they observed. However, without intending to dismiss or discount those personal experiences, for reasons that I will develop below, this evidence is of limited value in establishing breaches of the patients' rights.

[34] The evidence at trial demonstrated that within the medical community, and indeed society at large, there is a wide divergence of religious, moral, and ethical

beliefs concerning MAiD. In *Carter*, the Supreme Court of Canada observed that these divergent views would need to be addressed and reconciled in the legislative and regulatory response to the decision (at para 32).

[35] While the Court was ostensibly speaking about the rights of patients and individual physicians, this observation is, in my view, no less applicable to other actors in the healthcare field, including healthcare facilities that may have differing ethical or religious views about MAiD.

[36] The MOH MAiD Policy is intended to do exactly that. Its principal objective is to ensure reasonable access throughout the province to MAiD, including for patients receiving care at FBOs, while at the same time acknowledging the right of those FBOs to opt out of providing MAiD in accordance with their religious beliefs. Implicit in this acknowledgement is a recognition of the essential and long-standing role that FBOs like PHC have played in the delivery of healthcare services in BC.

[37] In my respectful view, the plaintiffs have not established any basis for the Court to interfere in that Policy.

[38] In sum, I find that the plaintiffs have not established that the impugned policies violate the *Charter* rights of physicians or patients. The action is therefore dismissed.

The Parties

[39] The plaintiff Gaye O'Neill is the administrator of the estate of Sam O'Neill, a young woman who elected MAiD while a patient at SPH and who was transferred to another non-PHC facility in order to receive MAiD. The circumstances of Sam O'Neill's case are part of the factual underpinnings of the plaintiffs' case.

[40] The plaintiff Dr. Jyothi Jayaraman is a physician who provides MAiD services. Dr. Jayaraman alleges that PHC's choice to opt-out of MAiD impacts the manner in which she practices her profession and infringes her freedom of conscience rights under s 2(a) of the *Charter*.

[41] The plaintiff Dying with Dignity is a national, charitable organization that advocates for end-of-life rights, including access to MAiD.

[42] His Majesty the King in Right of the Province of British Columbia (the "Province"), PHC and VCH are all named as defendants. All are involved in the delivery of healthcare in BC, and, as noted above, all have policies relating to MAiD that are the subject of the plaintiffs' constitutional challenge.

[43] In addition to the parties, intervenor status was granted to the Canadian Civil Liberties Association ("CCLA"), British Columbia Humanist Association ("BCHA"), Canadian Centre for Christian Charities ("CCCC"), Canadian Physicians for Life ("CPL"), Christian Legal Fellowship ("CLF"), Delta Hospice Society ("DHS"), and Evangelical Fellowship of Canada ("EFC"), all of whom provided different perspectives and useful submissions on the issues raised.

Evidentiary Issues

[44] The defendants object to portions of the plaintiffs' evidence. The objections include reliance on lay, anecdotal evidence about alleged harms associated with MAiD transfers, multi-level hearsay, evidence tainted by argument and speculation, and unqualified and unsubstantiated expert opinion evidence.

[45] For the most part, rather than deal with the objections in advance, I directed the parties to address the issues as part of their final submissions.

[46] I did, however, hear a preliminary application brought by VCH to strike portions of affidavits submitted by the plaintiffs sworn by three physician MAiD providers—Drs. Jayaraman, Henriquez, and Daws. The impugned portions of these affidavits provide the physicians' descriptions of their involvement with unidentified patients whom they assessed for MAiD, some of whom were required to undergo a transfer to another facility to receive MAiD. These descriptions were referred to as the "Anecdotes".

[47] In oral reasons for judgment given January 14, 2026 I found that the bulk of the affidavit evidence was admissible only for a limited purpose:

> [15] In my respectful view, these examples and the Anecdotes generally, constitute permissible and admissible evidence of a physician's personal observations and experiences.
>
> [16] However, consistent with the line drawn by Justice Steeves in [*Cambie Surgeries Corporation v British Columbia (Attorney General)*, 2016 BCSC 1896], this evidence is only admissible for the purpose of establishing the impact on the physicians of what they observed and the moral distress they allege as a result of not being able to treat patients in accordance with their personal and professional beliefs.
>
> [17] What is not permissible is for the three physicians to offer opinion evidence on whether the harms or patient experiences observed by the physicians were caused by what the plaintiffs refer to as the forced transfers. As Justice Steeves found in *Cambie Surgeries*, that type of causal relationship requires expert evidence and, in any event, is for the Court to decide.
>
> [18] Further, while the defendants can test the evidence of the physicians as to their personal experience and observations, through cross-examination, they would be unable to properly test the assertion that specific harms were caused to the unknown patients referred to in the Anecdotes as a result of the transfer. As VCHA submits, that is a complex issue involving a number of factors that cannot be assessed without access to a more extensive record, including the patient's medical history, course of care, and specific MAiD plan.

[48] The defendants submit that much of the lay evidence relied on by the plaintiffs going to the issue of whether MAiD transfers cause harm is similarly flawed in that it is comprised largely of vague anecdotes that are lacking in detail and that are impossible to test. While I will deal with the evidence in more detail as part of my analysis of the issues, I will say at the outset that many of the defendants' objections are well-founded.

[49] It is useful at this juncture to underscore the evidentiary standard that must be met in order to establish a *Charter* breach. Specifically, there must be a proper evidentiary record in order for the Court to find the facts necessary to adjudicate the constitutional claims.

[50] This point was made by Justice Slatter in *Allen v Alberta*, 2015 ABCA 277:

> [23] The presumption is that constitutional cases will be decided on a full evidentiary record, including, where appropriate, the evidence of expert witnesses: *Canada (A.G.) v Bedford*, 2013 SCC 72 at paras. 53-4, [2013] 3 SCR 1101. The expectation is that the parties will prove the facts on which the constitutional challenge lies, and that resort to judicial notice will be kept on a "short leash", the more so the closer one comes to the ultimate issue: *R. v Spence*, 2005 SCC 71 at paras. 58, 64, [2005] 3 SCR 458. As a general rule, evidence from unrelated cases cannot be transported into the record: *R. v Daley*, 2007 SCC 53 at para. 86, [2007] 3 SCR 523.
>
> [24] All of the leading section 7 cases, like *Bedford*, *Carter v Canada*, 2015 SCC 5, [2015] 1 SCR 331, and *R. v Smith*, 2015 SCC 34 were decided on full evidentiary records. Each had a substantial record of evidence demonstrating (a) how the claimant was deprived of the right to security of the person by specific actions of the state, (b) the relevant principles of fundamental justice, (c) whether any of those applied and to what effect and (d) whether section 1 of the *Charter* was potentially applicable.

[51] In the *Cambie Surgeries Corporation v British Columbia (Attorney General)* litigation, at the trial level, the judge was regularly called on to make evidentiary rulings in order to ensure there was a proper record on which to ground his analysis of the constitutional issues relating to waitlists in the public healthcare system and the validity of the limitations placed on private healthcare and insurance under the *Medicare Protection Act*, RSBC 1996, c 286. He said (2016 BCSC 1390):

> [39] The subject case is not a reference but adversarial litigation involving informed and resourced parties, as well as intervenors. There are critical and controversial adjudicative facts to be determined with respect to the system of health care in British Columbia, wait lists in particular. That is the who, what, where, when, how and motive of the *MPA*. I conclude that the expansive approach to admissibility of evidence in the *Polygamy Reference* decision has little application to the adjudicative facts here.

[52] The Court of Appeal endorsed the trial judge's approach to the evidence. Specifically, the majority said:

> … In our view, it is necessary that a complainant establish a proper evidentiary foundation for the claim by showing constitutionally significant ("serious") consequences of being required to wait beyond the benchmark. In our view, the judge was correct in noting that in cases such as *R. v. Morgentaler*, [1988] 1 S.C.R. 30, *Bedford*, and *Carter*, the claimants adduced concrete evidence to establish a connection between the impugned provisions and the harms they allegedly caused: at paras. 1730–1731. The judge was not wrong to require objective medical evidence to substantiate that waiting for certain types of treatment causes, contributes to, or increases the risk of serious harm to at least some patients.

> (*Cambie Surgeries Corporation v British Columbia (Attorney General)*, 2022 BCCA 245 [*Cambie Surgeries CA*] at para. 251

[53] Here, as will be seen, a central issue is whether the plaintiffs' have adduced evidence sufficient to establish the harms they allege result from MAiD transfers.

[54] In support of their respective positions, the plaintiffs and defendants also rely on extensive expert reports offering a range of perspectives on MAiD generally and on the specific issue of MAiD transfers. Much of this evidence is of little assistance to the court in determining the essential adjudicative facts necessary to resolve the plaintiffs' claims.

[55] While I will again address the expert evidence in more detail below, my view of much of that evidence is similar to that before the Court in *Ontario Health Coalition and Advocacy Centre for the Elderly v His Majesty the King in Right of Ontario*, 2025 ONSC 415 [*OHC*], which involved a constitutional challenge to legislation that authorized the movement of patients out of hospitals and into long-term care facilities, without their consent. In rejecting the challenge, the court found little assistance in much of the expert sociological and policy-focused opinion evidence relied on by the plaintiffs, noting with respect to at least one of the experts that her "opinion makes a meaningful contribution to the rich policy debate surrounding health care in Ontario but is of limited assistance to me in determining the constitutional issues raised on this application" (at para 126).

[56] That observation applies with equal force to much of the expert evidence adduced by all parties in this case.

MAiD in Canada: The *Carter* Decision

[57] As noted, it was the Supreme Court of Canada's decision in *Carter* that paved the way for the legalization of MAiD in Canada. *Carter* also provides the analytical framework underpinning the plaintiffs' claims in this case, so it is important at the outset to understand exactly what the Court decided. *Carter* originated in British Columbia. The case largely centered around an individual, Gloria Taylor, who was diagnosed with a fatal neurodegenerative disease, amyotrophic lateral sclerosis.

Other plaintiffs in the case included Lee Carter and Hollis Johnson, who had assisted Ms. Carter's mother in accessing assisted suicide in Switzerland, where it was legal.

[58] As Ms. Taylor's condition deteriorated, she formed the desire to obtain a physician-assisted death. The Supreme Court described her situation in these terms:

> [13] Ms. Taylor … 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 …. 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.

[59] A constitutional challenge to the provisions of the *Criminal Code* was therefore brought and the case was heard by way of a summary trial before Justice Lynn Smith of this Court in late 2011. In extensive reasons for judgment (indexed at 2012 BCSC 886), Justice Smith declared that the impugned provisions of the *Code* violate ss 7 and 15 of the *Charter* and are of no force and effect to the extent that they prohibit physician-assisted suicide by a medical practitioner.

[60] A majority of the Court of Appeal allowed the appeal (2013 BCCA 435) on the basis that the trial judge was bound by the Supreme Court of Canada's earlier decision in *Rodriguez v British Columbia (Attorney General)*, 1993 CanLII 75, [1993] 3 SCR 519 (SCC), where the Court upheld the constitutionality of the prohibition against physician-assisted suicide, albeit by a slim 5-4 majority.

[61] On further appeal to the Supreme Court of Canada, a unanimous Court held that the impugned provisions infringe the right to life, liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice and, as such, violate s 7 of the *Charter*. In light of that determination, the Court found it unnecessary to consider whether s 15 was also violated.

[62] The Court found that all three elements of s 7 were engaged. The right to life was engaged on the basis that the prohibition on physician-assisted death "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" (at paras 57–58). This is because 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" (at para 62).

[63] As for the rights to liberty and security of the person, the Court emphasized that underlying these rights "is a concern for the protection of individual autonomy and dignity" (at para 64). The right to liberty protects the right to make fundamental personal choices free from state interference, while security of the person encompasses a notion of personal autonomy involving control over one's bodily integrity free from state interference and is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering (at para 64).

[64] The Court agreed with the trial judge that the prohibition interfered with an individual's ability to make decisions concerning their bodily integrity and medical care, thus trenching on their liberty, and the prohibition leaves some individuals to endure intolerable suffering, thus impinging on their security of the person (at para 66). These conclusions rested on the finding that "[a]n individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy" (at para 66). The Court summarized the trial judge's key findings in this regard as follows:

> [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).

[65] The Court saw this as in line with s 7 jurisprudence generally protecting patient autonomy in medical decision-making (at para 67). The Court also recognized that the decision to seek physician-assisted death is done "out of a deeply personal and fundamental belief about how they wish to live, or cease to live" (at para 68).

[66] Turning to the principles of fundamental justice, the Court concluded that the prohibition was overbroad (at para 86). While finding it unnecessary to reach a conclusion on the issue of gross disproportionality, the Court agreed with the trial judge's finding that the impact on life, liberty, and security of the person was severe (at para 90). This is because, by imposing unnecessary suffering on affected individuals, the prohibition deprives them of the ability to determine what to do with their bodies and how their bodies will be treated and may cause them to take their own lives sooner than they would have were they able to obtain a physician-assisted death (at para 90).

[67] Consistent with the decision of the trial judge, the Court held that the impugned provisions could not be saved under s 1 of the *Charter*.

[68] It is important to note the remedy granted by the Court:

> [127] … 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 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. [emphasis added]

[69] The Court suspended the declaration of invalidity for 12 months.

[70] Also of note is the Court's discussion of a request from certain intervenors to confirm that physicians who object on moral grounds cannot be compelled to participate in MAiD. The Court said:

> [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 … that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief …. 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.

Background

[71] Many of the key background facts are set out in a comprehensive agreed statement of facts helpfully compiled by the parties (the "ASF"). I commend counsel for their efforts in this regard.

Eligibility for MAiD

[72] Following the release of the *Carter* decision, the *Criminal Code* was amended to exempt from criminal liability medical practitioners and other individuals who provide MAiD in circumstances in which prescribed eligibility criteria were met (see Bill C-14, *an Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 42nd Parl, st Sess, 2016 (assented to 17 June 2016), SC 2016 c 3.)

[73] In 2021, the *Criminal Code* was again amended to remove the "reasonably foreseeable natural death" requirement to be eligible for MAiD (Bill C-7, *An Act to amend the Criminal Code (Medical Assistance in Dying)*, 43rd Parl, 2nd Sess, 2021). This led to the development of two different sets of safeguards; the MAiD process for patients whose natural death is reasonably foreseeable is referred to as "Track 1", whereas the process for patients whose natural death is not reasonably foreseeable is referred to as "Track 2".

[74] In order to be eligible to receive MAiD, a person must meet all the following criteria:

a) be eligible for health services publicly funded by a government in Canada, such as being registered or eligible for British Columbia's Medical Services Plan;

b) be at least 18 years of age and capable of making decisions about their health;

c) have made a voluntary request for MAiD that, in particular, was not made as a result of external pressure;

d) have given informed consent to receive MAiD after being informed of the means that are available to relieve their suffering, including palliative care; and

e) have a grievous and irremediable medical condition, which means:

i. they have a serious and incurable illness, disease or disability (not including a mental illness, though this restriction is currently set to be removed by the federal government in March 2027);

ii. they are in an advanced state of decline that cannot be reversed; and that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions they consider acceptable.

[75] Two independent physicians or nurse practitioners must assess the person to confirm their eligibility. In circumstances where the patient's death is not reasonably foreseeable (i.e., Track 2 cases), one of these assessors must have expertise in the person's illness, disease or disability. In such Track 2 cases, if neither of the two assessing doctors or nurse practitioners have expertise in the illness, disease or disability causing the person's suffering, one of the assessors must consult with a doctor or nurse practitioner who does have such expertise and must share the results of that consultation with the other assessor.

[76] According to the ASF, in 2024, 6.9% of all deaths in British Columbia and 5.1% of all deaths in Canada occurred by way of MAiD. The parties also provided statistics about the number of MAiD transfers:

British Columbia

Year	MAiD Deaths	Number of Transfers	*Percentage*
2021	2,030	39	1.9
2022	2,515	52	2.1
2023	2,767	50	1.8
2024	3,000	62	2.1

Canada

Year	MAiD Deaths	Number of Transfers	*Percentage*
2021	9,950	N/A	N/A
2022	13,102	N/A	N/A
2023	15,343	429	2.8
2024	16,499	349	2.1

Delivery of Healthcare in BC and the Role of Faith-Based Organizations

[77] Considerable evidence was led at trial about the structures and processes governing the delivery of healthcare generally in BC. While it is not necessary to review that evidence in detail, it is useful to highlight certain relevant points.

[78] Since the 1990's, BC has utilized a decentralized or regional model of healthcare delivery whereby health services are delivered by a number of regional health authorities (see *Health Authorities Act*, RSBC 1996, c 180). Under this model, numerous private corporations formerly involved in delivering healthcare services

were amalgamated with the health authorities. There are currently five regional health authorities, including VCH, as well a Provincial Health Services Authority.

[79] VCH and other health authorities provide care to patients both directly and through contracted services. Direct care services are those that VCH provides at facilities it operates. Contracted services are those supplied by other operators by way of contracts between VCH and the operator.

[80] Some contracted services are provided by FBOs, like PHC. FBOs are not exclusively Catholic but include organizations from a number of religious backgrounds including Jewish, Christian, Pentecostal, Baptist and Royal Arch Masonry.

[81] Most FBOs operating withing the healthcare field are members of the Denominational Health Care Association ("DHA"). Members of the DHA were not amalgamated into the Health Authorities but rather, through the DHA, entered into a master agreement with the Province dated March 15, 1995 (the "Denominational Master Agreement") pursuant to which DHA members would work with health authorities to deliver healthcare services. Members of the DHA are from 12 religious denominations and include 24 non-profit groups or societies that own and operate 33 hospitals or residential care facilities in BC.

[82] The Denominational Master Agreement includes the following provisions:

> 1. The MINISTER acknowledges the ownership and title to the facilities set out in Schedule A and those additional facilities as may be added from time to time by the OWNERS in furtherance of their religious mission belongs to the respective OWNERS set opposite their names and they shall continue to enjoy the powers and privileges of ownership including without limiting the generality thereof the right to determine in the context of their respective values and traditions the mission and values of the OWNER so as to preserve the spiritual nature of the facility, to establish such medical staff bylaws as they deem necessary to safeguard the mission and values aforesaid and the

> right to govern the facility, appoint a chief executive officer and approve and implement a staffing plan.
>
> 3.8 ... the [health authorities] shall determine the health care programs and services it will contract from the OWNER with respect to any facility provided the OWNER is not required to provide those services which are inconsistent with the mission and values set out in paragraph 1 hereof.

[83] It is clear on the evidence that pursuant to the terms of the Denominational Master Agreement, various FBOs have long played a significant role in delivering healthcare services in the Province.

History of PHC and SPH and their role in BC's Public Healthcare System

[84] PHC evolved from healthcare facilities originally founded by five orders of Roman Catholic nuns who created centers of care in Vancouver beginning in the late 19th century. One of those orders, the Sisters of Providence, founded SPH in 1894.

[85] In 1999, the Archbishop of Vancouver consolidated five Catholic healthcare facilities, including SPH, to establish PHC as a Public Juridic Person. Generally speaking, a Public Juridic Person is a legal entity created for the purpose of carrying out certain functions in the name of the Catholic Church which is subject to Catholic canon law under the direction of the Church's leadership.

[86] In 2000, PHC was incorporated as a non-profit society under the *Society Act*, RSBC 1996 c 433. PHC's Constitution identifies the following purposes of the society:

> 1. to establish, maintain and operate on a non-profit basis, hospitals and health care facilities for the reception and care of persons suffering from illnesses, disabilities and other conditions which require health care, and residential housing facilities for community and assisted living;
>
> 2. to promote care and the advancement of wellness for the elderly and persons requiring long term care;
>
> 3. to promote, apply and evaluate scientific research related to the prevention of illness, the care of the sick and the advancement of wellness;

4. to carry on educational activities related to the prevention of illness, the care of the sick and the advancement of wellness and the delivery and management of health care services;

5. to strive continually for excellence in administration, care teaching and research;

6. to acquire and hold interests in, or rights of occupancy of, land whether by ownership in fee-simple, lease, licence or otherwise for the purposes of establishing, maintaining or operating the hospitals and health care facilities of the Society; and

7. to relieve poverty by providing modest, affordable housing, support services, and rent supplements, incidental to the Society's health care programs and facilities, primarily to people of low and modest income; and

8. to ensure that health care facilities owned or operated by the Society continue to provide services in accordance with Catholic/Christian values as demonstrated by the Religious Congregations (as defined in the Bylaws of the Society).

[87] PHC's Bylaws contain the following provisions:

2. **Mission and Values**

2.1 **Purposes Aligned with Roman Catholic Church**

The purposes of the Society are to be carried out in accordance with the teachings, canons and ethics of the Roman Catholic church.

2.2 **Society's Mission Statement**

The mission of the Society is: The Society is a Catholic health care community that respects the sacredness of all aspects of life. Inspired by the healing ministry of Jesus Christ, the staff, physicians and volunteers are dedicated to service and to the support of one another. In this environment of service, support and respect, the Society meets the physical, emotional, social and spiritual needs of those served through compassionate care, teaching and research.

2.3 **Society's Value Statement**

The values of the Society are:

Spirituality. We nurture God-given creativity, love and compassion that dwells within us all.

Integrity. We found our relationships on honesty, justice and fairness.

Stewardship. We share accountability for the well-being of our community.

Trust. We behave in ways that generate trust and build confidence.

Excellence. We achieve excellence through learning and continuous improvement.

Respect. We respect the diversity, dignity and interdependence of all persons.

> …
>
> 2.5 **Canon Law**
>
> …
>
> In all circumstances, the Board will manage the affairs of the Society and the Facilities in accordance with the Health Care Ethics Guide as may be interpreted by the Archbishop and/or the Local Roman Catholic Ordinary in those areas in which the Society operates Facilities outside of the Archdiocese of Vancouver.

[88] While PHC is a "private" entity in the sense that it is, as noted, incorporated as a society under the direction of the Catholic Church, it plays an essential role in the delivery of healthcare services within BC's public healthcare system. Further, the vast majority of PHC's funding comes from public sources. From 2020-2025, public funds made up on average 93% of PHC's total revenues versus 7% from private sources.

[89] SPH is located in the downtown core of Vancouver. It serves a large and diverse patient population and, as noted above, SPH is one of BC's largest and busiest tertiary care hospitals.

[90] PHC is currently engaged in building a new St. Paul's Hospital, to be located outside of the downtown core. The construction of the new St. Paul's Hospital will involve building a new hospital as well as other facilities including a clinical support and research centre.

[91] The new St. Paul's Hospital requires total funding in excess of $2 billion. Construction is being funded through a combination of public and private sources. Private funding sources are responsible for approximately $1 billion in contributions to the new St. Paul's Hospital. Most of the funding comes from public sources, however, including the Province, which is providing approximately $1.327.

[92] Private funding sources for the new St. Paul's Hospital include the St. Paul's Foundation and Providence's sale proceeds from the current St. Paul's Hospital, which raised approximately $850,000,000.

The MOH MAiD Policy

[93] As noted at the outset of these Reasons, following *Carter*, provincial governments across the country worked to develop policy frameworks for the provision of MAiD given that MAiD is a healthcare service and, as such, falls within provincial jurisdiction.

[94] In BC, the MAiD Working Group engaged with key participants in the healthcare system to develop the MOH MAiD Policy, including medical regulatory colleges and regional health authorities. PHC was also represented on the Working Group. According to Derrick Rains, an MOH employee involved with the Working Group, PHC's involvement reflected its "key role in the provision of health care in the province … and the need for specific consideration of faith-based organizations like [PHC] in any provincial policy framework".

[95] The MAiD Working Group was guided in its policy development work by the principles and objectives identified in a briefing note dated March 14, 2016, including to "use its collective operational, clinical and administrative expertise to develop appropriate patient access pathways that balance respect for patient access with the conscience rights of individual providers, the regional service delivery model and terms of the Agreement with the Denominational Health Care Facilities Association".

[96] That briefing note also stated that "[a] requirement that MAiD be provided at all publicly funded facilities is impractical from a resource efficiency, appropriateness and operational perspective. A facility's existing service mix and human resources, the populations served, contractual agreements, as well as regional access may be considered in determining facility-level availability".

[97] The MOH MAiD Policy went through a number of drafts. The current version of the Policy, dated effective March 4, 2022, contains the following material provisions:

Definitions

…

- **Faith-based Organization:** An organization that is a party to the Master Agreement with the Denominational Health Care Facilities Association, or otherwise in its constitution declares itself as being an organization based on religion or spirituality.

…

Policy Objective

The objective of this policy is to clarify expectations related to access to MAiD and to support a consistent approach to service delivery across the province. This will include:

1. Establishing a provincial policy framework that supports reasonable access across the province to MAiD, in a manner similar to other health care services.
2. Supporting a consistent approach to delivery of MAiD that complies with the [*Criminal Code of Canada*].
3. Recognizing that MAiD is an option available to eligible adults, whose suffering cannot be relieved through other means acceptable to them.

…

Policy

Health Authorities/hospital societies must ensure the policy direction below is followed:

Access

1. Health Authorities are responsible for ensuring that MAiD is reasonably available in a manner similar to other end-of-life health care services. This may require collaboration with community-based services and health care providers to ensure care is effectively sequenced in a patient-centered manner across settings, programs and services.
2. No individual should be denied admission or access to a program or service for which they would otherwise be eligible, due to a request or potential request for MAiD.

Health Care Provider Participation

3. MAiD must be available in a manner that is respectful of the requesting individual's personal autonomy and the conscience of individual health care providers.
4. Regulated health care providers must adhere to their professional standards of practice. Health Authorities must not establish operating procedures that put the health care provider in a direct conflict with their professional standards.
5. Health Authorities must ensure that information about how to access MAiD within each Health Authority is available to the public, individuals who may request MAiD, health care providers and staff.
6. Nothing in this policy compels an individual to provide or assist in providing MAiD.

…

Location and Availability

8. Health Authorities must make reasonable efforts to facilitate assessment and provision of MAiD in the appropriate location of the requesting individual's choosing, irrespective of whether the interdisciplinary care team in that setting is involved in the assessment or provision.

[A footnote to cl. 8 provides that the location of choice may include the individual's home, but does not include Non-participating Faith-based Organizations]

…

9. A physical transfer of an admitted patient, resident or client from one facility or setting to another, as a result of a request for MAiD, should be avoided unless:

   a. the request for transfer originates with the individual; or,

   b. the individual is receiving care at a Non-participating Faith-based Organization (see #12) or a Contracted Organization that refuses to allow provision of MAiD (see #11b).

…

Faith-Based Organizations

12. Faith-based Organizations may decide to Opt-out of the provision of MAID in the facilities operated by the organization. Health Authorities must consult with their affiliate Non-participating Faith-based Organizations to develop policies and procedures that outline how Faith-based Organizations will work with the Health Authority or with community-based health care providers (e.g. physician in private practice), to ensure that patient-centred pathways are in place to support an effective connection with another health care provider or organization willing to explore a request for information, Transfer of Care or physical transfer, as required. Health Authorities must work with Faith-based Organizations that Opt-out to ensure the following:

    a. the requesting individual has full information regarding the services and treatment options available to them;

    b. the requesting individual is aware of available information resources, including information regarding the Health Authority's role in care coordination;

    c. the Non-participating Faith-based Organization will respect and not impede the individual's request for information concerning MAID;

    d. the Non-participating Faith-based Organization will minimize harm to medically frail patients, working with the Health Authority to meet patient needs;

e. the Non-participating Faith-based Organization will continue to provide comprehensive care for the requesting individual, to ensure care needs unrelated to MAiD are met; and

f. the Health Authority is reasonably assured that the Non-participating faith-based organization meets the definition of Faith-based Organization as noted in definitions section.

VCH's MAID Policy and MAiD Provision Within the VCH Region

[98] While the VCH MAiD Policy acknowledges that faith-based organizations may decline to provide MAiD in their facilities, it does not itself confer the right to do so. Rather, the VCH MAiD Policy is an administrative policy intended to ensure that VCH acts in accordance with, and respects, the MAiD policy framework established by the MOH MAiD Policy.

[99] VCH's MAiD Policy is set out in a policy document entitled "Medical Assistance in Dying (Responding to Requests)". It contains the following relevant provisions:

> **1.1 Description**
>
> This policy sets out the expectations of Staff (which includes service providers) in sensitively addressing Patient's requests for Medical Assistance in Dying (MAID).
>
> …
>
> **2. Policy**
>
> **2.1 VCH is guided by the Ministry of Health Access to Care Policy**
>
> The Ministry of Health (Ministry) has issued a policy regarding MAID to support a consistent approach to service delivery across the Province. VCH is responsible for ensuring that the Ministry policy is adhered to within VCH Sites and VCH Affiliated Sites. Under the Ministry policy, VCH is responsible for ensuring that MAID is reasonably available in a manner similar to other end-of-life health care services.
>
> …
>
> **2.5 Location of Assessments and the Assisted Death**
>
> There is no designated location for Patients requesting MAID. Patients will have their requests addressed, assessments performed and, if eligible, receive an assisted death in the care location consistent with their care needs and wishes.

> Patients' usual care journey in a setting or between settings will not be disrupted as a result of their request for MAID, except as provided for in the Denominational Health Care Association Master Agreement….
>
> Every effort will be made by Staff to facilitate assessment and the assisted death in the appropriate location chosen by the patient, irrespective of whether the Staff in that setting are involved in the assessment and the assisted death.
>
> …
>
> VCH is responsible for providing an alternative space for a Patient to receive an assisted death for those not able to have an assisted death in the Patient's current location due to the facility being party to the Denominational Health Care Association Master Agreement. For facilities outside the Denominational Health Care Association Master Agreement, VCH will endeavor to find a space if the Patient does not want to have MAID in their current location.
>
> …
>
> **2.8 Conscientious Objection by Faith-based Organizations**
>
> In accordance with the Denominational Health Care Association Master Agreement, VCH respects that Faith-based Organizations that are parties to this Agreement may decide not to perform or allow assisted deaths on organization property. VCH expects that these Non-Participating organizations will:
>
> a) Ensure the Patient is fully informed regarding the services and care options available to them which may address the Patient's suffering, including MAID;
>
> b) Make Patients aware of available information resources and MAID care coordination support…;
>
> c) Not impede the Patient's access to MAID information, signing of MAID forms, assessments related to MAID, including waiver of final consent.
>
> d) Plan (including any payment required) and ensure Patient care is safely transferred to the location of the MAID prescriber and, where needed, provide staff or equipment to ensure a seamless transfer, including transfer where a Patient has waived final consent for MAID in advance of the scheduled MAID death;
>
> e) Continue to provide comprehensive care for the Patient other than the assisted death, and its related activities … including care for the Patient during the period of reflection before assisted death, and grief support for families following MAID; and
>
> f) Maintain a bed space for the Patient, from the time of transfer for MAID until the death is confirmed, ensure a timely and organized transfer and return to care if MAID is not provided.

[100] In order for VCH to deliver MAiD services, it has established a MAiD care coordination service known as the VCH Assisted Dying Program (the "ADP"). The

ADP, through its clinical care coordinators, supports patients and families through the process of application, assessment and planning for MAiD, including facilitating access to MAiD providers. Once a patient has been assessed and found eligible for MAiD, the ADP is almost always involved in coordinating the arrangements, including arranging for the MAiD provider and organizing the date and location of the service including, where necessary, a MAiD transfer.

The PHC MAiD Policy

[101] On July 13, 2016, Providence enacted an initial version of its MAiD policy which stated that "PHC Personnel will not provide Medical Assistance in Dying." The Providence MAiD Policy permitted patients to be assessed for MAiD at a Providence facility in "exceptional cases."

[102] As of December 14, 2018, Providence removed the "exceptional cases" requirement for third-party MAiD assessments to occur at Providence facilities.

[103] PHC's current policy, titled "Medical Assistance in Dying: Responding to Requests", dated effective May 27, 2022, includes the following relevant provisions:

> **1.1 Description**
>
> The purpose of this policy is to provide a consistent ethical and compassionate approach, reflective of the *Health Ethics Guide* and Catholic teaching, when responding to a person in care within Providence Health Care ("PHC") who requests Medical Assistance in Dying ("MAiD"), either through medically assisted suicide, where the patient is provided assistance in intentionally ending his or her own life, or voluntary euthanasia, where a physician directly administers a lethal dose of medication to end the patient's life. The procedure further outlines the steps for a safe and timely transfer of care for the patient to another facility/setting in accordance with their wishes.
>
> **1.2 Scope**
>
> This policy applies to all PHC Staff, physicians, volunteers, students and any other persons acting on behalf of PHC and caring for PHC patients (to be referred to as "Personnel").
>
> **2.0 Policy**
>
> As a Catholic health care organization, PHC is committed to the inherent dignity of every human being throughout the entire continuum of life from conception to natural death. PHC has an institutional obligation as a Catholic health care provider to uphold the principles of Catholic moral teaching as set out in the Health Ethics Guide … approved by the Canadian Conference of

> Catholic Bishops … Given the incompatibility of Catholic teaching with actions intended to terminate human life, PHC Personnel will not provide MAiD and MAiD will not occur where PHC provides medical services.
>
> …
>
> **2.1 Principles**
>
> **2.1.1** A request for MAiD from a patient in our care is received in a compassionate and respectful manner.
>
> **2.1.2** The patient is provided support in a non-judgmental way to ensure they are aware of all care options available to them, and they are provided with the wanted and appropriate physical, psychological, and spiritual supports to help address needs (suffering) that may underlie their expressed request and impact their quality of life.
>
> **2.1.3** Patients and their families' personal beliefs are respected and honoured. Inquiries or requests for MAiD are actively engaged in a timely manner and access to the lawful MAiD request process is not impacted.
>
> **2.1.4** Given the medical fragility of patients in our care and the dynamic nature of informed decision making for those experiencing suffering, formal assessments for MAiD eligibility take place at PHC sites if wanted by the patient.
>
> **2.1.5** Formal on-site assessments are carried out by external providers through Vancouver Coastal Health's Assisted Dying Program, or another Health Authority's MAiD Care Coordination Service.
>
> **2.1.6** PHC welcomes patients to remain in PHC's care until a transfer of care for MAiD is required. At PHC we are committed to a culture of compassion and social justice that honours and respects the individual in their suffering during their most difficult times of life, regardless of their end-of-life choices.

Adjacent Spaces: Shoreline

[104] On November 3, 2023, the MOH directed that Providence assign or otherwise transfer to VCH a leasehold interest over a portion of the lands on which SPH is located to allow patients to be transferred to an adjacent space operated by VCH to receive MAiD.

[105] By way of an agreement dated January 1, 2024, Providence completed the assignment to VCH with an effective date of February 1, 2024. Thereafter, VCH constructed the Shoreline Facility ("Shoreline") which opened in January 2025.

[106] Shoreline is a modular building that is located off the main corridor of SPH, next to the elevator bank. To access Shoreline, patients go through a double set of doors from SPH. Patients wishing to access MAiD at Shoreline will typically be

moved without the need for a vehicle transfer either in their hospital bed, by stretcher, or in a wheelchair. The VCH ADP is typically involved in coordinating the transfer.

[107] Since Shoreline opened, all patients who have been assessed and approved for MAiD at SPH have received MAiD at Shoreline.

[108] It is anticipated that a similar adjacent space will be constructed at or adjacent to the new St. Paul's Hospital.

Specific Patient Facts

[109] The plaintiffs led evidence about four specific patients who chose to avail themselves of MAiD:

a) Samantha (Sam) O'Neill;

b) Sheila Baxter;

c) Christina Bates; and

d) Anna Chamberlain.

[110] I will describe in a general way the circumstances of each of the four patients and then will deal with their specific facts in more detail when considering the *Charter* claims.

[111] Sam O'Neill was only 33 years old when she was diagnosed with Stage 4B cervical cancer in April 2022. Over the next year, she received a variety of treatments at SPH. It was a difficult and painful journey.

[112] In February 2023, while admitted to the SPH palliative care unit, Ms. O'Neill was assessed and approved for MAiD. She was subsequently re-admitted to SPH on March 12, 2023, with a compression fracture in her lumbar spine. She underwent a surgical procedure but it did little to alleviate her pain.

[113] On April 4, 2023, Ms. O'Neill chose to receive MAiD. For that to occur, she needed to be transferred to a VCH Provision Space at St. John's Hospice on the University of British Columbia campus. Because of the level of pain she was experiencing, Ms. O'Neill was sedated for the transfer and never regained consciousness. Ms. O'Neill's family and friends found the process, particularly the transfer, rushed and believe that it caused Ms. O'Neill significant additional pain.

[114] Sheila Baxter was a long-time resident of the west end of Vancouver. SPH was her community hospital, and she was admitted there in November 2022. Ms. Baxter was assessed and approved for MAiD on December 17, 2022, and the MAiD provision was scheduled for December 19, 2022.

[115] In order to receive MAiD, Ms. Baxter was transferred from SPH to the Doctor's Residence, a facility operated by VCH located near Vancouver General Hospital (VGH). The transfer involved moving Ms. Baxter from her hospital bed onto a gurney, transporting her by ambulance, and then moving her into a chair at the provision space. Ms. Baxter's grandson described the transfer as "upsetting and distressing to witness."

[116] Christina Bates was diagnosed with colon cancer in August 2021. She was assessed and approved for MAiD in early November 2021, and the MAiD provision was scheduled for November 7, 2021. On that day, Ms. Bates was transferred by ambulance to the Doctor's Residence at VGH for the MAiD provision. Her partner provided evidence in affidavit form that the transfer was difficult and appeared to cause Ms. Bates pain.

[117] The plaintiffs were granted leave to file evidence concerning Anna Chamberlain after the initial deadline for filing affirmative evidence had passed. Ms. Chamberlain's circumstances were different than those of the other three patients referred to above in that she was assessed and approved for MAiD after the creation of the Shoreline space.

[118] Ms. Chamberlain was diagnosed with lung cancer in February 2025. The disease advanced and on December 10, 2025, Ms. Chamberlain received her first MAiD assessment. She received her second MAiD assessment on January 3, 2026, after being admitted to SPH. At that time, she was moved to the palliative care unit.

[119] Ms. Chamberlain's MAiD provision was initially scheduled for 9:00 am on January 6, 2026, but it was cancelled because she was receiving medication by way of an infusion pump and Providence staff were not permitted to accompany her to Shoreline in order to continue that treatment. The MAiD provision was subsequently rescheduled for 3:00 pm on January 7, 2026, after an accommodation had been achieved between PHC and VCH's Assisted Dying Program (the "ADP"). I will return to the specific facts of Ms. Chamberlain's MAiD provision below.

[120] While each of these four patients received MAiD in accordance with their choice to do so, the plaintiffs led evidence from family members and friends of each who described how, in their experience, the MAiD transfers, and in Ms. Chamberlain's case, the delay, were disruptive and upsetting and further exacerbated the suffering of their loved ones.

Issues

[121] The plaintiffs challenge the impugned polices on the basis that they violate the s 2(a) freedom of conscience rights of physicians and the freedom of conscience and religion rights of patients, as well as patients' s 7 rights.

[122] PHC also asserts freedom of religion rights under s 2(a).

[123] I will address each of these issues in turn.

Analysis

The s 2(a) Claims: Freedom of Conscience and Religion

Legal Framework

[124] In *Hoogerbrug v British Columbia*, 2024 BCSC 794 [*Hoogerbrug*], Justice Coval succinctly summarized the key principles governing claims under s 2(a):

[234] Section 2(a) says: "Everyone has the… freedom of conscience and religion". Its purpose is to ensure the state does not interfere with profoundly held personal beliefs that govern a person's conception of themselves, humankind, nature, and, in some cases, a higher or different order of being. Canada's pluralistic, multicultural society depends on respect for a broad range of such beliefs and their associated practices (*R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713, 1986 CanLII 12, at paras. 97, 215).

[235] The parties agree that, to establish an infringement of s. 2(a) religious freedom, one must meet the two-part test established in *Syndicat Northcrest v. Amselem*, 2004 SCC 47, at para. 65*,* and reaffirmed in subsequent cases including *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37 at para. 32, by showing*:* sincere commitment to a belief or practice that has a nexus with religion; and, that the Orders interfered, in a non-trivial way, with the ability to act in accordance with that belief or practice.

[236] To satisfy (i), the belief or practice must have spiritual significance for the person as an individual. It may be entirely personal and not part of a more widely held belief system. It need not be obligatory, required by official religious dogma or in conformity with the position of religious officials, but only personally and sincerely held and linked to their spiritual faith or connection to the divine, so long as the practice has a nexus with religion (*Amselem*, paras. 46-56, 69).

[237] To satisfy (ii), the non-trivial, state-imposed cost or burden can be "direct or indirect, intentional or unintentional, foreseeable or unforeseeable" (*Edwards Books*, para. 96).

…

[239] Turning to freedom of conscience, this aspect of s. 2(a) has received less judicial attention than freedom of religion. In my view, the following principles emerge from the cases:

> a) freedom of religion may be viewed as a subset of freedom of conscience, in that religious belief and practice are "paradigmatic of conscientiously-held beliefs" (*R. v. Big M Drug Mart Ltd.,* [1985] 1 S.C.R. 295, 1985 CanLII 69, at para. 123);
>
> b) freedom of conscience is aimed at protecting serious matters of conscience based on strongly held moral ideas of right and wrong (*Roach v. Canada (Minister of State for Multiculturalism and Citizenship)*, [1994] 2 F.C. 406, 1994 CanLII 3453 (C.A.));
>
> c) freedom of conscience is not the mere decision to act or not act in a certain way. To warrant constitutional protection, the behaviour or practice must be based upon "a set of beliefs by which one feels bound to conduct most, if not all, of one's voluntary actions" (*R. v. Videoflicks Ltd*., 48 O.R. (2d) 395, 1984 CanLII 44 (C.A.) at 40, rev'd in part on other grounds in *Edwards Books*); and
>
> d) the commitment must have a "profound moral dimension" and be embedded in a "larger belief system of right and wrong"
> The *Amselem* test for infringement of religious freedom might be adapted and applied to an alleged infringement of freedom of

> conscience by substituting "nexus with conscience" for "nexus with religion" in the first branch of the test (*Affleck v. The Attorney General of Ontario,* 2021 ONSC 1108 at paras. 40-46, 51-52).

[125] In addition to these principles, the plaintiffs also rely on the doctrine of state neutrality as an aspect of the s 2(a) guarantee of freedom of religion. The Supreme Court of Canada described the doctrine in *Mouvement laÏque québécois v Saguenay (City)*, 2015 SCC 16 [*Saguenay*], in these terms:

a. "…freedom of conscience and religion protects the right to entertain beliefs, to declare them openly and to manifest them, while at the same time guaranteeing that no person can be compelled to adhere directly or indirectly to a particular religion or to act in a manner contrary to his or her beliefs" (at para 69);

b. "These protections are not limited to religious beliefs. The freedom not to believe, to manifest one's non-belief and to refuse to participate in religious observance is also protected … freedom of religion includes the freedom to have no religious beliefs whatsoever" (at para 70);

c. "… the evolution of Canadian society has given rise to a concept of neutrality according to which the state must not interfere in religion and beliefs. The state must instead remain neutral in this regard. This neutrality requires that the state neither favour nor hinder any particular belief, and the same holds true for non-belief …. It requires that the state abstain from taking any position and thus avoid adhering to a particular belief" (at para 72);

d. "By expressing no preference, the state ensures that it preserves a neutral public space that is free of discrimination and in which true freedom to believe or not to believe is enjoyed by everyone equally, given that everyone is valued equally. … a neutral public space does not mean the homogenization of private players in that space. Neutrality is required of institutions and the state, not individuals …. On the contrary, a neutral public space free from coercion, pressure and judgment on the part of public authorities in matters of

spirituality is intended to protect every person's freedom and dignity. The neutrality of the public space therefore helps preserve and promote the multicultural nature of Canadian society enshrined in s 27 of the *Canadian Charter*. Section 27 requires that the state's duty of neutrality be interpreted not only in a manner consistent with the protective objectives of the *Canadian Charter*, but also with a view to promoting and enhancing diversity" (at para 74); and

e. "When all is said and done, the state's duty to protect every person's freedom of conscience and religion means that it may not use its powers in such a way as to promote the participation of certain believers or non-believers in public life to the detriment of others" (at para 76).

Physicians' Freedom of Conscience Claim

[126] The plaintiffs submit that the impugned policies, particularly as reflected in the PHC MAiD Policy, infringe the freedom of conscience rights of practitioners by interfering with their ability to practice medicine in a manner consistent with their ethical and moral beliefs, which causes them moral distress.

[127] Dr. Jayaraman describes the position she finds herself in as follows:

> Moral distress, for me, arises wherever I have to act against my own principles. Central to my own principles is respect for patient autonomy. Where an eligible patient chooses to access MAiD, respecting their autonomy means they should be able to access their legal right to have MAiD with as little disruption as possible. Forced transfers arise because the beliefs of the institution override that autonomous choice. Whenever a patient is being transferred due to the policies of a faith-based institution, I am compelled to tell the patient that they have to be moved not because I cannot provide the procedure where the patient is, but because the policy requires the move. Patients are not being moved for their benefit, and there is nothing that I can do to intervene. The policy of an institution whose faith I do not believe in requires me to prevent patients from accessing care that they have autonomously chosen.
>
> My own principles also include the duty to promote patient well being (beneficence) and not cause harm to them (non-maleficence). I provide MAiD to patients (who have been assessed and found eligible) that want nothing more than for their suffering to end. These patients are only eligible because of their intolerable suffering. For me, the moral choice is to relieve the

> suffering as expeditiously as possible. Delaying MAiD for avoidable reasons prevents me from benefitting my patients in that way.
>
> …
>
> I have never experienced as much moral distress in my medical practice as I do when I provide MAiD to patients who have been forced to transfer as a result of the policies of a faith-based institution. Despite this, I continue to provide MAiD to patients who have been transferred. It is a privilege for me to be part of patients' end-of-life journey. I believe strongly that patients should be able to access MAiD, and I am aware that there are not that many MAiD providers. In addition, not infrequently, patients who have been assessed and found eligible for MAiD by me end up in faith based facilities. If I refused to provide MAiD in such cases, I would be causing serious harm to my patients and letting them down when they need me the most. So, although providing MAiD to patients who have been transferred causes me moral distress, I am willing to endure that because I believe that providing MAiD to a transferred patient is in the best interests of the patient.

[128] Dr. Boris Henriquez gave similar evidence. In his affidavit he states that MAiD transfers "stop me from fulfilling my patients' wishes in a manner that respects their autonomy, and make me complicit in a process that does not benefit them and often harms them."

[129] The plaintiffs also rely on the affidavit evidence of Dr. Tanya Daws, a physician and MAiD assessor and provider who lives on Vancouver Island. She describes difficulties encountered with MAiD transfers that took place in 2016–2017 when she had privileges at a Catholic facility that did not provide or permit MAiD.

[130] In my view, the plaintiffs have fallen short of establishing a breach of practitioners' s 2(a) freedom of conscience rights.

[131] For one thing, the impugned policies are not directed at physicians and do not purport to proscribe physician conduct. Rather, they permit healthcare facilities to determine the type and scope of services to be provided within the facility; decisions that are routinely made by such facilities.

[132] Further, there is no constitutional right to practice medicine, let alone a right to practice in the location and manner chosen by a practitioner. It is well established that state-imposed limitations on employment or the practice of a profession do not engage s 7 liberty rights (see *Tatlock v British Columbia* (*Attorney General*), 2025

BCCA 181 at para 38 [*Tatlock*], citing *Siemens v Manitoba (Attorney General),* 2003 SCC 3; *Walker v Prince Edward Island*, 1995 CanLII 92, [1995] 2 SCR 407; *Green v Law Society of Manitoba,* 2017 SCC 20; *Tanase v College of Dental Hygienists of Ontario,* 2021 ONCA 482 [*Tanase*]).

[133] While the Court in *Tatlock* was considering a claim under s 7 of the *Charter*, the plaintiffs' claim here is not strengthened by characterizing the physicians' position as a matter of conscience rather than liberty.

[134] The right to practice medicine is a statutory right subject to the requirements of the governing legislation and the rules and regulations made thereunder (*Tanase* at para 41). In BC, and elsewhere, the regulatory framework requires physicians to be granted privileges to practice medicine at a particular facility or within a specific health authority. To be granted privileges, a physician must agree to abide by the policies and rules of the granting institution, often in the form of medical staff bylaws.

[135] In the case of PHC, the PHC medical staff bylaws are clear that the provision of MAiD will not be permitted in any facility operated by PHC. Both Dr. Jayaraman and Dr. Henriquez testified that they were aware of the bylaw provisions and both agreed that they nonetheless chose to apply for and accept privileges at PHC. Both also acknowledged that, in doing so, they agreed to be bound by the terms of the bylaws.

[136] Neither Dr. Jayaraman nor Dr. Henriquez, nor any other physician, is compelled or coerced to practice medicine at a PHC facility, or at any other facility operated by an FBO. Indeed, the decision about where to practice medicine and what services to provide, including MAiD, is entirely voluntary, as both Dr. Jayaraman and Dr. Henriquez testified.

[137] In this sense, the impugned policies are fundamentally different from those at issue in *The Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*, 2018 ONSC 579 [*Christian Medical SC*], aff'd 2019 ONCA 393 [*Christian Medical CA*]. At issue there were policies of the

defendant College that required physicians who object to providing certain medical procedures, for example MAiD and abortions, on the basis of religion or conscience to provide the patient with an effective referral to another health care provider. The plaintiffs (appellants) argued that these policies infringe physicians' s 2(a) freedom of conscience and religion rights and also violate s 15 (*Christian Medical SC* at para 212; *CA* at para 187).

[138] Of note for the purposes of this case, both the Divisional Court at first instance and the Court of Appeal found an infringement of the right to freedom of religion because the referral requirements interfered with the ability of some physicians to practice medicine in accordance with their beliefs in a manner that was not trivial or insubstantial (*Christian Medical SC* at para 114). Given this finding, it was not necessary to consider whether the physicians' right to freedom of conscience was also infringed. Both levels of Court found that the infringement of the freedom of religion right was justified under s 1 of the *Charter*.

[139] The impugned polices here do not have the same coercive effect on practitioners. Indeed, as noted, they are not aimed at practitioners at all. Rather, they establish institutional policies that practitioners can voluntarily agree to or reject by way of their decision to apply, or not, for privileges.

[140] Dr. Jayaraman expressly confirmed her willingness to continue to accept MAiD patient referrals at PHC facilities in an email to various colleagues, including Ms. Plewes, the ADP Operations Director, dated July 5, 2023:

> I just want to reassure you all that I don't feel any pressure about accepting cases in PHC. I have always been treated with kindness and respect in all their facilities and I expect nothing less going forward. So, Coordinators, please feel free to continue to send me those cases.

[141] It is difficult to reconcile the sentiments expressed by Dr. Jayaraman in this email with the claim that her conscience rights have been violated by PHC's policies.

[142] The plaintiffs rely on the opinion of Dr. Holland, who suggests that institutional policies requiring a patient to be transferred from a faith-based facility in order to

receive MAiD place physicians in an "impossible ethical dilemma—participate in a process that goes against the medical ethics that guide our profession, or step away from the process, also going against the medical ethics that guide our profession". In Dr. Holland's view, the latter option violates the ethical principle of non-abandonment.

[143] Respectfully, I do not agree that Dr. Holland's opinion supports a finding that physicians' s 2(a) conscience rights are infringed by PHC's MAiD Policy.

[144] As I noted at the outset of these reasons, much of the expert evidence adduced by both parties might be useful for the purposes of the policy debate surrounding MAiD and the issue of religious or moral objections, but it is of little assistance in the legal analysis in which the Court is required to engage.

[145] This is particularly so with respect to the ethics opinions of Dr. Holland and of Dr. Genuis, whose expert report was submitted by PHC in response to Dr. Holland's report. Both Dr. Holland and Dr. Genuis are eminently qualified ethicists who, simply put, hold different opinions about the ethical implications of the PHC MAiD Policy, specifically the use of MAiD transfers to give effect to patients' choices to access MAiD.

[146] The different opinions are well-captured in the following passage from Dr. Genuis' report:

> Dr. Holland suggests institutional non-participation in MAiD necessitating transfer of care from PHC to VCH "place[s] a clinician in an impossible ethical dilemma—participate in a process that goes against the medical ethics that guide our professions, or step away from the process, also going against the medical ethics that guide our profession." In my opinion, neither participation nor non-participation in PHC's current approach is fundamentally unethical. Individual clinicians are free to choose whether or not to participate in the practices of PHC. Individual clinicians can participate, or decline to do so, without going against the medical ethics that guide physician practice.

[147] Clearly these are issues on which professional ethicists can and do disagree and it is not the role of the court—nor is the court equipped—to resolve this difference.

[148] The plaintiffs submit that the Court should prefer Dr. Holland's opinion over that of Dr. Genuis because Dr. Genuis is PHC's Physician Ethicist and, as such, is directly interested in the matters in issue in the litigation. However, it is apparent from Dr. Holland's evidence that he is equally as invested in the issues. He clearly opposes any transfer or movement of a patient for MAiD purposes; rather, he favours (and indeed advocates for) a policy of MAiD in place, i.e., at the time and location of the patient's choosing. As I will discuss below, that view, while no doubt genuinely held, does not align with the realities of how the healthcare system operates.

[149] Further, Dr. Holland's opinion about the violation of the ethical duty of non-abandonment fails to address the fact that practitioners who conduct MAiD assessments at faith-based facilities like SPH do so voluntarily and with full knowledge of PHC's MAiD Policy.

[150] It is clear from the evidence led by all of the parties that different physicians hold different moral and ethical beliefs about MAiD. There are physicians who decline to provide MAiD services. For other physicians, their support of MAiD access extends to them making it central to their practice of medicine. These differences are reflected in the Canadian Medical Association's MAiD policy, which acknowledges both conscientious participation in, and conscientious objection to, MAiD by physicians.

[151] A particular physician's belief in the importance and value of MAiD does not give rise to a right to provide MAiD services wherever the physician wishes to do so nor does it permit a physician to compel a facility to make MAiD available. Section 2(a) of the *Charter* is intended to protect individuals from state coercion on matters of conscience; it is not intended to empower individuals to compel the state or other institutional actors to act in a particular manner that accords with that individual's conscientious beliefs. Put another way, the fact that certain physicians may oppose an institutional policy on grounds of conscience does not mean that their constitutionally protected right to freedom of conscience has been violated.

[152] For these reasons, I find that the plaintiffs have not established that the impugned policies violate physicians' s 2(a) freedom of conscience rights.

Patients' Freedom of Conscience and Religion Claims

[153] The plaintiffs submit that the impugned provisions violate the s 2(a) rights of patients in two respects: (i) they offend the duty of state neutrality and the right of individuals to be free from state imposed religious doctrine, and (ii) they interfere with patients' ability to choose MAiD as a matter of conscience.

[154] Respectfully, the plaintiffs have similarly failed to establish a breach of either element of patients' s 2(a) rights.

[155] Dealing with conscience first, it is well established that decisions about medical care, including end of life care, involve fundamental, personal choices that are central to an individual's sense of autonomy and bodily integrity. As such, decisions of this nature are protected by the s 7 right to liberty and security of the person. Describing such decisions as a matter of conscience, adds little to the analysis. As the Alberta Court of Appeal put it in *Lewis v Alberta Health Services*, 2022 ABCA 359 at para 40: "a conscientious *belief* in bodily autonomy adds nothing to the *right* to bodily autonomy [the plaintiff] already enjoys under s 7 of the *Charter*."

[156] Further, while the choice of whether to access MAiD is clearly an intensely personal one, it is not apparent on the evidence before the Court that such choices reflect an overarching moral belief or are based on "a set of beliefs by which one feels bound to conduct most, if not all, of one's voluntary actions" (*Hoogerbrug* at paras 239(c), 262).

[157] In particular, the evidence concerning the four patients whose specific circumstances were put before the Court, while establishing the importance of the MAiD decision to them individually, did not establish that the choice, or any disagreement with PHC's MAiD Policy, was based upon a broader set of beliefs or overarching moral code.

[158] The plaintiffs rely on the expert opinion of Dr. Sumner in support of their argument that patients' s 2(a) conscience rights are violated. However, Dr. Sumner's opinion suffers from similar flaws as Dr. Holland's report. For example, Dr. Sumner cites, without support, the bald proposition that a patient's decision to choose MAiD is made "in accordance with their core moral beliefs" and that the refusal of faith-based institutions to "allow MAiD to be provided at the time and place requested" permits the institution to override the dictates of the patient's own conscience. Even if it is found that the choice to access MAiD falls within the protective scope of s 2(a), despite the absence of an evidentiary foundation as noted above, that protection does not extend to dictating the timing and location of the service.

[159] Simply put, the test for establishing a breach of the freedom of conscience right has not been met and, as was the case in *Carter,* the impact of the impugned policies on patients' choice to access MAiD is best analyzed under s 7 (leaving aside the religious dimension which was not an issue in that case).

[160] Turning to the freedom of religion claim, the plaintiffs submit that the impugned provisions violate the principle of state neutrality and the right to be free from religion. They argue that both the purpose and effect of the impugned policies is to prefer Catholicism and to impose Catholic doctrine on patients.

[161] I disagree.

[162] The MOH MAiD Policy does not expressly refer to Catholicism, nor does it purport to prefer Catholic doctrine. Rather, it permits FBOs to opt out of the provision of MAiD in facilities they operate, subject to certain conditions (see s 12 of the MOH MAiD Policy). While the plaintiffs' claims are directed at PHC's MAiD Policy, the evidence demonstrated that there are other FBOs that do not permit MAiD at their facilities, including Menno Home, Broadway Pentecostal Lodge, Salvation Army Hospice, Inglewood Care Centre operated by the Baptist Housing Oak Bay Care Society, Menno Hospital, Rotary House and Southview Heights (both operated by the Salvation Army), and the Louis Brier Home and Hospital (operated by the Jewish Home for the Aged of British Columbia), as contemplated by the MOH MAiD Policy.

[163] The fact that there are a number of different FBOs that opt out of providing MAiD in accordance with the MOH MAiD Policy demonstrates that the intent and effect of the policy is to accommodate a diversity of religious beliefs and values. It is not to prefer, promote, or impose a particular set of values.

[164] The circumstances of this case can be contrasted with those in *Saguenay.* There, council meetings of the defendant municipality typically opened with the mayor reciting a prayer and there were religious symbols displayed in council chambers. An individual, who was an atheist, regularly attended council meetings and was uncomfortable with these religious practices. When the mayor declined his request to stop them, he filed a complaint with the Quebec Human Rights Tribunal alleging a violation of his freedom of conscience and religion rights guaranteed under the Quebec *Charter of human rights and freedoms*, CQLR, c C-12. At one point, the municipality passed a bylaw purporting to authorize and regulate the recitation of prayers at council meetings, thus the Tribunal was called upon to consider both the religious practices and the validity of the bylaw.

[165] The Tribunal found that the prayer in issue was religious in nature and that the mayor, in reciting the prayer, demonstrated a preference for one religion to the detriment of others, thus violating the duty of neutrality. The Tribunal also found that the prayer and the exhibiting of religious symbols interfered with the complainant's freedom of conscience and religion.

[166] The Quebec Court of Appeal set aside the Tribunal decision. In their view, the prayer expressed universal values that could not be identified with any particular religion and that the religious symbols were works of art devoid of religious connotation.

[167] A further appeal to the Supreme Court of Canada was allowed and the Tribunal decision was restored. The key aspects of the Supreme Court's analysis are set out above at para 125. For present purposes, it is important to understand the Court's application of those principles to the particular facts and why the Court found a breach of the duty of state neutrality.

[168] The Court considered possible breaches resulting from both legislation and from practices engaged in by state officials. With respect to legislation, the Court noted:

> [81] A provision of a statute, of regulations or of a by-law will be inoperative if its purpose is religious and therefore cannot be reconciled with the state's duty of neutrality. The legislation, including its preamble, its structure and its evolution, as well as its context and the legislative debate, are all indicators that can be used to delineate the provision's purpose (R. Sullivan, *Sullivan on the Construction of Statutes* (6th ed. 2014), at pp. 274-87). The legislative objective cannot be to impose or favour, or to express or profess, one belief to the exclusion of all others. A typical example of a legislative breach of the duty of neutrality would be a situation in which the state enacted legislation whose purpose was to make the observance of a religious practice mandatory (see *Big M*).

[169] Where the alleged infringement is based on a practice, rather than legislation, the Court said:

> [83] … the alleged breach of the duty of neutrality must be established by proving that the state is professing, adopting or favouring one belief to the exclusion of all others (*S.L.*, at para. 32) and that the exclusion has resulted in interference with the complainant's freedom of conscience and religion (see *Boisbriand*, at para. 85; *Bergevin*, at p. 538; *Forget*, at p. 98).

[170] The key issue is whether the legislation or state action or practice favours one belief to the exclusion of all others, and whether it interferes with the freedom of conscience and religion of one or more individuals (at para 88).

[171] The Court found that the recitation of the prayer at the outset of council meetings clearly manifested an intention to prefer one set of religious beliefs over others:

> [118] … the recitation of the prayer at the council's meetings was above all else a use by the council of public powers to manifest and profess one religion to the exclusion of all others. It was much more than the simple expression of a cultural tradition. It was a practice by which the state actively, and with full knowledge of what it was doing, professed a theistic faith. What the respondents are defending is not a tradition, but the municipality's right to manifest its own faith.

[172] The Court also found that the effect of the practice interfered with the complainant's freedom of conscience and religion:

> [120] The prayer recited by the municipal council in breach of the state's duty of neutrality resulted in a distinction, exclusion and preference based on religion — that is, based on Mr. Simoneau's atheism — which, in combination with the circumstances in which the prayer was recited, turned the meetings into a preferential space for people with theistic beliefs. The latter could participate in municipal democracy in an environment favourable to the expression of their beliefs. Although non-believers could also participate, the price for doing so was isolation, exclusion and stigmatization. This impaired Mr. Simoneau's right to exercise his freedom of conscience and religion.
>
> [121] In this regard, the evidence accepted by the Tribunal shows that when Mr. Simoneau went to meetings of the municipal council, he had to choose between remaining in the chamber and conforming to the City's religious practice, excluding himself from the practice by refusing to participate in it, and physically excluding himself from the chamber for the duration of the prayer. If he chose to conform to the council's practice, he would be acting in direct contradiction with his atheistic beliefs. If he chose to exclude himself from the prayer either by refusing to participate in it or by leaving the chamber, he would be forced to reveal that he is a non-believer (para. 266). According to the Tribunal's findings, Mr. Simoneau had experienced a strong feeling of isolation and exclusion (paras. 265-66). This led the Tribunal to conclude that the interference caused by this situation was more than trivial or insubstantial (para. 262). Such interference constitutes an infringement of the complainant's freedom of conscience and religion.

[173] Unlike the prayer at issue in *Saguenay*, the MOH MAiD Policy does not manifest a preference for Catholic beliefs, or any religious beliefs or practices, to the exclusion of others. The fact that it permits different FBOs to operate in a manner consistent with their beliefs does not amount to state sponsorship of those beliefs or make the practice of those beliefs mandatory (*Saguenay* at para 81). Accommodation does not equal preference or promotion.

[174] The plaintiffs' characterization of MAiD transfers as "religious-based coercion" and the submission that the impugned polices amount to "state-sponsored imposition of … Catholic moral teachings on the patients they serve" are misplaced and not borne out by the evidence. Specifically, there is no evidence that any patients, including Ms. O'Neill, Ms. Baxter, Ms. Bates, or Ms. Chamberlain, were compelled to accept or observe Catholic beliefs either generally or as a condition of receiving MAiD.

[175] The absence of compulsion or coercion also distinguishes this case from *Hoogerbrug,* where certain plaintiffs were required to accept vaccinations contrary to their religious beliefs or lose their jobs (although the measures in issue were nonetheless upheld as reasonable in accordance with the analysis in *Dore* at paras 307–314); from *Christian Medical*, where physicians were effectively required to provide referrals for medical procedures that offended their religious beliefs; and from *Multani v Commission scolaire Marguerite-Bourgeoys*, 2006 SCC 6, where a majority of the Court held that compelling a Sikh student to choose between wearing a religious symbol (a kirpan) and attending a public school, violated his freedom of religion (at paras 38–41).

[176] In sum, the plaintiffs have not established that the impugned policies violate the principle of state neutrality or otherwise offend patients' s 2(a) rights.

PHC's s 2(a) Asserted Rights

[177] PHC submits that it is entitled to advance a s 2(a) freedom of religion right in defence of the MOH MAiD Policy and its own MAiD Policy. It notes, fairly, that if the Province sought to compel the provision of MAiD by PHC directly or by third party providers within PHC operated facilities, PHC would clearly assert its religious rights in opposition.

[178] The plaintiffs argue that PHC cannot claim freedom of religion rights under s 2(a) of the *Charter*, both because it is a legal, corporate entity incapable of holding sincere beliefs in the same manner as a human person and because its primary purpose and function is to provide healthcare services rather than promoting or teaching religious beliefs.

[179] In my view, it is unnecessary to decide whether an institution like PHC holds and can assert s 2(a) freedom of religion rights because it is not seeking to rely on those rights as a shield to protect itself from government intrusion into those beliefs.

[180] That is not to say that PHC's religious beliefs are irrelevant. Indeed, it is the accommodation of those beliefs as reflected in the PHC MAiD Policy that is at the centre of the plaintiffs' constitutional challenge.

[181] In my view, useful guidance on how to assess PHC's religious rights can be found in *Loyola High School v Quebec (Attorney General)*, 2015 SCC 12. There, the appellant was a private Catholic high school that challenged a policy issued by the Minister of Education limiting its ability to teach certain subjects, including Catholicism, from a Catholic perspective.

[182] A majority of the Supreme Court of Canada held that the Ministry directive unduly limited Loyola High School's freedom of religion more than was necessary to meet the underlying objective of teaching students to think critically about different cultures and religions orders. As such, the directive was disproportionate and therefore unreasonable under the analytical framework established in *Doré v Barreau du Québec*, 2012 SCC 12. In light of that finding, the majority found it unnecessary to decide whether Loyola High School could assert a s 2(a) right. The minority came to a similar conclusion but went further and determined that the policy infringed Loyola High School's s 2(a) freedom of religion right.

[183] Both the majority and the minority however found that Loyola High School's religious rights were engaged. Specifically, the Court acknowledged that religious beliefs and practices have both an individual and a collective or associational aspect. The majority put it this way, citing Justice Dickson's (as he then was) seminal decision in *R v Big M Drug Mart Ltd.*, 1985 CanLII 69 (SCC), [1985] 1 SCR 295:

> [59] Justice Dickson's formulation of religious freedom is founded on the idea that no one can be forced to adhere to or refrain from a particular set of religious beliefs. This includes both the individual *and* collective aspects of religious belief: *Hutterian Brethren*, at paras. 31, 130 and 182; *R. v. Edwards Books and Art Ltd*., 1986 CanLII 12 (SCC), [1986] 2 S.C.R. 713, at p. 781. In the words of Justice LeBel: "Religion is about religious beliefs, but also about religious relationships" (*Hutterian Brethren*, at para. 182).
>
> [60] Religious freedom under the *Charter* must therefore account for the socially embedded nature of religious belief, and the deep linkages between

> this belief and its manifestation through communal institutions and traditions…To fail to recognize this dimension of religious belief would be to "effectively denigrate those religions in which more emphasis is placed on communal worship or other communal religious activities"…

[184] The majority then noted that the Minister's policy effectively required Loyola High School, as a Catholic institution, to speak about Catholicism in terms defined by the state rather than its own understanding of Catholicism (at para 63). The majority went on to find that "measures which undermine the character of lawful religious institutions and disrupt the vitality of religious communities represent a profound interference with religious freedom" (at para 67).

[185] PHC submits that the plaintiffs claim, if given effect to, would similarly undermine its fundamental character as a religious healthcare institution by compelling it to act in a manner inconsistent with its Catholic beliefs.

[186] The plaintiffs reject the notion of institutional religious belief because, again, they say that PHC's primary function is concerned with healthcare not religion. In this sense, the plaintiffs say that PHC differs from *Loyola High School* which was created for the very purpose of teaching Catholicism.

[187] I am unable to accept this distinction. PHC's Constitution and Bylaws (see paras 86-87 above) make it clear that PHC was created and operates as a Catholic institution. Moreover, the uncontradicted evidence from a number of PHC witnesses was that the delivery of healthcare services, particularly to vulnerable members of the population, is an integral part of PHC's Catholic identity and mission.

[188] PHC has also been unequivocal in its position that permitting the provision of MAiD within its facilities, even by third party providers, would conflict with its well-established and sincerely held beliefs. As I will return to later in these reasons, it is not for the Court to second guess or override these beliefs. Indeed, to do so, for example by compelling PHC to permit third party MAiD assessments in its facilities, would constitute a "profound interference with religious freedom" (*Loyola High School* at para 67).

[189] So, regardless of whether PHC could successfully assert a s 2(a) right, it was appropriate, and indeed necessary, for the Province to acknowledge PHC's religious beliefs, including its objection to MAiD, when crafting the MOH MAiD Policy and determining how MAiD would be administered throughout the province.

The s 7 Life, Liberty and Security of the Person Claims

[190] The plaintiffs allege that the impugned policies violate patients' s 7 rights by erecting barriers to the patients' ability to choose and access MAiD and by subjecting those patients to unwarranted risks of harm associated with MAiD transfers.

[191] In advancing this claim, the plaintiffs say that they are not advocating for a freestanding, constitutional right to healthcare at the time and place of a patient's choosing, or at all. Rather, they argue that where, as here, the Province has implemented a scheme for the delivery of MAiD as an aspect of the public healthcare system, that scheme must respect the *Charter* rights of patients.

Legal Framework

[192] Section 7 of the *Charter* guarantees everyone 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."

[193] It is well-established that the s 7 analysis proceeds in two steps:

a) First, the claimant must establish a deprivation of one of the three protected interests.

b) Second, the claimant must establish that the deprivation is not in accordance with the principles of fundamental justice.

See: *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44 at para 84; *Canada (Attorney General) v Bedford*, 2013 SCC 72 at para 57 [*Bedford*].

[194] The requirement to establish a deprivation caused by state action is a critical element of the first step in the analysis. In order to meet that test, there must be a "sufficient causal connection" between the impugned state action or law and the harm suffered by the claimant (*Bedford* at paras 75–76).

[195] In *Council of Canadians with Disabilities v British Columbia (Attorney General)*, 2026 BCSC 1416 [*CCD*], Justice Blake recently provided a helpful and succinct summary of the constituent elements of the s 7 rights:

> [734] At the first stage of the analysis CCD bears the burden of showing a deprivation of life, liberty, or security of the person. The right to life is engaged where state action either imposes death, or an increased risk of death, on a person either directly or indirectly: *Carter SCC* at para. 62, citing *Chaoulli v. Quebec (Attorney General*), 2005 SCC 35 and *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44.
>
> [735] It is not necessary for CCD to prove that a particular identifiable individual who was involuntarily detained and treated pursuant to the Impugned Provisions and s. 8(a) of the *MHA* experienced death, or an increased risk of death. Rather, the existence of admissible expert evidence that identifies a class of persons for whom such involuntary treatment caused an increased risk of death is sufficient to make out this deprivation: *Cambie Surgeries BCCA* at para. 168.
>
> [736] If the Court is satisfied that a compelling inference arises on the factual findings, and that at least one unidentified involuntary patient faced an increased risk of death as a result of their involuntary treatment, that is sufficient: *Cambie Surgeries BCCA* at paras. 179–180. That unidentified involuntary patient need not be before the court.
>
> [737] I turn next to the rights to liberty and security of the person.
>
> [738] The right to liberty is not restricted to mere freedom from physical restraint; rather, it protects the right to make decisions of fundamental importance free from state interference: *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44 [*Blencoe*] at paras. 49–50; see also *Carter SCC* at para. 64.
>
> [739] The right to security of the person encompasses the right to personal autonomy, and to control one's own bodily integrity. The common law right to determine what shall, or shall not, be done to one's body, and to be free from non-consensual medical treatment, is deeply rooted in our common law: *Fleming* at para. 31. It underlies the doctrine of informed consent and is "so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection": *Fleming* at paras. 31 and 39. As noted by the Supreme Court of Canada in *Carter*:
>
> > [64] … 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.

[740] Decisions concerning "fundamentally important and personal medical decision-making" have been found to engage both the right to liberty and the right to security of the person: *Carter SCC* at para. 65. The common law right to determine what happens to one's own body and the constitutional right to security of the person are co-extensive: *Fleming* at para. 39.

[741] An order imposing medical treatment implicates both a right to liberty and a right to security of person: *A.C. v. Manitoba (Director of Children and Family Services)*, 2009 SCC 30 [*A.C.*] at para. 100. Underlying both rights is the concern for the protection of individual autonomy and dignity: *Carter SCC* at para. 64. The right to life and the right to security of the person protect the right of an adult to direct their own medical care, and was set out as follows in *Carter SCC*:

> [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.).

[196] In approaching the s 7 analysis, the court's task is to determine the constitutionality of legislation, not rule on the policy wisdom of the government's approach. This point was helpfully articulated by the Ontario Court of Appeal in *Cycle Toronto v Ontario (Attorney General)*, 2026 ONCA 582 [*Cycle Toronto*], a

recent decision that dealt with a policy decision to remove bike lanes to address congestion:

> [22] Now, courts learn a great deal about a matter in the course of judicial review proceedings, and judges may be tempted to comment on matters of policy. The temptation to do so may be great; judges may suppose that they have much to offer to public policy debate. But the temptation must be resisted. It is not just that courts have no expertise in policy making – no expertise in making the sorts of polycentric decisions that legislatures make routinely. It is illegitimate for courts to involve themselves in matters of legislative policy. Policy is for politics. Whether courts think legislation is wise or unwise, is irrelevant so far as its constitutionality is concerned, and constitutionality is the only question with which courts are legitimately concerned…
>
> …
>
> [26] It is important to remember that judicial independence is a two-way street: the government and legislature must obviously respect the independence of the courts, but courts must respect the roles and responsibilities of the other branches of government.

[197] Such restraint is particularly important where the government is balancing and working to accommodate conflicting *Charter* rights and values, as is the case here.

Analysis

[198] *Carter* again provides the analytical framework underpinning the plaintiffs' s 7 claim. However, the circumstances of *Carter* differ significantly from the facts of this case.

[199] As discussed above, In *Carter*, the Supreme Court of Canda struck down provisions of the *Criminal Code* that imposed a complete prohibition on physician-assisted death such that the plaintiffs there were unable to access MAiD and suffered demonstrable harm as a result. Similarly, in *R v Morgentaler*, 1988 CanLII 90, [1988] 1 SCR 30 [*Morgentaler*], still a seminal decision for the s 7 analysis, it was a criminal prohibition that was struck down.

[200] Here, the evidence does not establish that patients are being denied access to MAiD. Indeed, the four patients whose specific circumstances are before the

Court all elected MAiD and were able to access the service, either the same day or within a short time after they made their choice.

[201] However, the plaintiffs argue that the impugned policies create barriers to the exercise of that choice and subject patients who are in PHC facilities and seek MAiD to increased physical and psychological harm arising out of the requirement for MAiD transfers to access the service. In this sense, the plaintiffs say that both the liberty and security of the person interests protected by s 7 are engaged. The plaintiffs also allege a breach of the right to life protected by s 7, but did not strenuously advance this argument and, in any event, the right to life argument adds little to the analysis.

[202] The decision in *OHC* is instructive in considering the plaintiffs' claim. As noted above, the case involved a constitutional challenge to legislation that authorized the movement of patients out of hospitals and into long-term care facilities without their consent. Patients who refused to be transferred were required to pay a fee of $400 per day to remain in hospital. The Court held that the impugned legislation did not violate either s 7 or s 15 of the *Charter*. Alternatively, the Court found that if there was a deprivation of the right to life, liberty or security of the person under s 7, such deprivation would be in accordance with the principles of fundamental justice and could otherwise be justified under s 1.

[203] The court began its s 7 analysis by identifying a central flaw in the applicant's argument:

> [209] In my view, the Advocacy Centre's submissions on s. 7 fail to account for the fact that there is no *Charter* right to publicly funded health care, much less for a person to remain in hospital once the most responsible physician has determined that the person does not require the intensity of resources or services provided by a hospital. Section 7 of the *Charter* is not a tool authorizing the courts to second-guess how the Legislature allocates scarce resources.

[204] As in the present case, the applicant in *OHC* relied on leading s 7 cases from the Supreme Court of Canada including *Bedford, Carter*, *Chaoulli v Quebec*

(Attorney General), 2005 SCC 35 [*Chaoulli*], and *Morgentaler*. However, the Court found those cases distinguishable:

> [210] The Advocacy Centre relies on a string of the Supreme Court of Canada's most important s. 7 cases: *Bedford*, *Carter*, *Chaoulli*, and *Morgentaler*. The issues raised in those cases are nothing like the issues in this case. Ontario correctly points out that in each of those cases, Parliament or a legislature had enacted a penal prohibition, coupled with a fine or imprisonment for persons violating statutory prohibitions. Bill 7 does none of those things.

[205] The Court went on to say that, while s 7 restricts the ability of government to deprive people of their enumerated rights, it "does not place a positive obligation on the state to ensure that each person enjoys a particular standard of life, liberty, or security of the person" (at para 213). Nor does it oblige government to provide a certain level of funding for healthcare or other social services (at para 213).

[206] Numerous arguments were advanced by the plaintiffs in *OHC* in support of their position that the impugned legislation violated s 7. While the Court addressed each of the arguments in detail, the overarching response is well reflected in the following passages:

> [226] The right to liberty protects the right to make fundamental personal choices free from state interference. Security of the person encompasses a notion of personal autonomy, that involves control over one's bodily integrity free from state interference, 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.
>
> [227] Persons have the right to direct their health care and the concept of informed consent is protected by the guarantees of liberty and security of the person. In *Carter*, the Supreme Court of Canada put it this way:
>
> > The law has long protected patient autonomy in medical decision-making. In M*anitoba (Director of Child & Family Services) v. C. (A.)*, 2009 SCC 30, [2009] 2 S.C.R. 181 (S.C.C.), 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 (Ont. C.A.)). As noted in *Fleming v. Reid* (1991), 4 O.R.

> (3d) 74 (Ont. 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 (S.C.C.); *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (Ont. C.A.); and *B. (N.) c. Hôtel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (C.S. Que.).
>
> [228] The Advocacy Centre submits that Bill 7 violates the right to liberty and security of the person "by depriving them of personal autonomy in their medical treatment and health care." I disagree. I will address the Advocacy Centre's submissions one at a time, but as an overarching comment, all of the Advocacy Centre's submissions fail to reflect that there is no *Charter* right to health care, much less to health care spending at a particular level or in a particular setting.

[207] The same fundamental flaw runs through the plaintiffs' position. Despite their submissions to the contrary, their position effectively amounts to a claim that patients have a *Charter* right to MAiD at the time and place of their choosing and that, based on that right, health care facilities can be compelled to provide that service. I note again the opinions of Dr. Holland and Dr. Sumner that effectively advocate for that position. In my view, that stretches s 7 well beyond its established scope.

[208] That is not the end of the analysis however, because while s 7 does not guarantee the right to health care services, including MAiD, where, when and how requested by a patient, it does protect patients from state action that interferes with an individual's physical or psychological integrity in a manner that is "serious" (*Cambie Surgeries CA* at para 207; *Chaoulli* at para 123).

[209] In *Cambie Surgeries CA*, the majority said:

> [207] … The threshold set in [the *Chaoulli*] analysis is "seriousness". In the healthcare context, this means a serious impact on "a condition that is clinically significant to their current and future health". That is not to say that the judge's analysis here is totally undermined. It is not. The appellants must still demonstrate a serious physical or psychological impact to engage the rights to life and security of the person.
>
> [208] In the context of a systemic claim of constitutional invalidity of the impugned provisions, the provisions fall only if they cause or increase the risk

> of serious harm to persons in British Columbia in respect of their asserted s. 7 rights (and further, only if contrary to the principles of fundamental justice) ...

[210] The plaintiffs submit that MAiD transfers do exactly that—they subject patients to increased and unnecessary risks of harm.

[211] Much of the evidence led by the plaintiffs was directed at proving these harms. In considering that evidence, it is important to keep in mind the evidentiary standard that must be met in order to establish a breach of s 7. As noted above, there must be a proper evidentiary record in order for the Court to find the facts necessary to adjudicate the constitutional claims. I have previously alluded to the fact that there are significant flaws in the evidence relied on by the plaintiffs to establish the alleged harms. I will consider some of that evidence now in more detail before turning to the analysis of the s 7 claim.

[212] The circumstances of Ms. O'Neill, Ms. Baxter, Ms. Bates and Ms. Chamberlain are outlined briefly above (see paras 109-120). The plaintiffs rely on the experience of these patients, along with a number of expert reports, in support of their position that MAiD transfers cause harm and therefore violate patients' s 7 rights.

[213] With respect to Ms. O'Neill, there is evidence from her parents and two friends who provided their perceptions of the circumstances surrounding Ms. O'Neill's MAiD provision, including her transfer from SPH to St. John's hospice. Unquestionably, Ms. O'Neill's family and friends found the process upsetting, particularly the fact that there was limited time to say goodbye to Ms. O'Neill.

[214] Ms. O'Neill's mother, Gaye O'Neill, deposed:

> When it was our turn to say goodbye, Sam was sitting on a commode, in the middle of her hospital room, lightly sedated and covered with only a bedsheet for privacy. I was overwhelmed by this disregard for her dignity. We then only had about a minute each to say our goodbye before nursing staff prepared her for the transfer.
>
> …

> Sam was an independent person who greatly valued her autonomy. Sam's cancer diagnosis robbed her of so much control over her life. I expected that MAiD would allow Sam to die in a dignified, peaceful manner with those she loved present. It was devastating to helplessly witness our daughter being denied this autonomy in her final moments and it was horrible to hear Sam's father recount the pain of her transfer.

[215] Ms. O'Neill's father, James O'Neill, offered a number of observations about Ms. O'Neill's circumstances, as well as his views on PHC's policies:

> … The record states Sam indicated that it was not important for her to be awake for the provision and that they agreed Sam would say her goodbyes in her room and then St. Paul's would sedate her for transfer. Sam understood that she was denied access to MAiD in St. Paul's, so she had to agree to be transferred out of St. Paul's to another facility to access MAiD. Sam also understood the transfer would be very painful, so she agreed to be fully sedated at St. Paul's with the understanding she would never regain consciousness, which is why she agreed to say final goodbyes in her St. Paul's room. In other words, I do not believe Sam "chose" to be transferred or to be sedated for that transfer.
>
> I accompanied Sam during the transfer to the VCH Space …
>
> Although Sam was fully sedated during the approximately 25-minute journey from the palliative care unit to the VCH Space, she seemed to feel the bumps in the road as she was jostled as we drove. After driving for about ten minutes or so, Sam was writhing and moaning in pain and it was getting progressively worse. The nurse asked for my assistance to move the IV bag so she could inject Sam with more pain medication intravenously. The medical records indicate Sam received Sufentanil and Midazolam at 7:40 pm. Witnessing this was excruciating for me and continues to be very disturbing.
>
> …
>
> The transfer was not only painful, but it disrupted Sam's close friends and family's ability to have a meaningful connection with her in her final moments. The whole day felt rushed and stressful, and our ability to express our love and say goodbye to Sam was swallowed up by the logistics of her physical transfer. I feel furious when I think about how the only reasons Sam had to experience so much pain and indignity in those last few hours, was for someone else's religious views.
>
> … I am offended by what I see as the insincerity of stated beliefs, values and traditions and the hypocrisy of how PHC acted. I cannot understand why Sam was transferred when St. Paul's knew the transfer would hurt her, which ignores their own stated value … that their exercise of conscientious objection must not put Sam at risk of harm. I cannot understand how St. Paul's could take action to knowingly cause Sam such serious harm by transferring her to a PHC operated hospice, when the alternative should have been to let Dr. … provide MAiD in the PHC operated hospital. The distinction they make to justify this seems to me to be arbitrary, hypocritical and insincere. Sam was in a private room at St. Paul's that could easily have

> allowed Dr. … to administer MAiD without the need for a transfer at all. The hypocrisy and arbitrariness of PHC's actions on April 4, 2023, and the ongoing harm caused by other Catholic hospitals across the country have destroyed any respect of faith I might have left for the Catholic Church.
>
> I am also deeply disappointed in the federal government and the BC provincial government for their failure to recognize that hurting people before they are allowed access to medical care, in fact, impedes their access to health care. From my perspective, the MAiD policies of PHC and the Province of BC act as if the spiritual beliefs of medically fragile, terminally ill patients are inferior and unequal to the beliefs of PHC.

[216] Two friends of Ms. O'Neill also deposed that the MAiD experience was rushed and deprived both Ms. O'Neill and her family and friends of a meaningful opportunity to say goodbye.

[217] Similar, although less extensive, evidence was adduced in respect of, Ms. Baxter, Ms. Bates, and Ms. Chamberlain.

[218] As noted, Ms. Baxter was assessed and approved for MAiD on December 17, 2022, and the MAiD provision was scheduled for December 19, 2022, at a VCH facility, which necessitated a transfer from SPH. Ms. Baxter's grandson, Robert Chavarie, described his observations of the transfer. Specifically, he said that the process of getting Ms. Baxter from her hospital bed onto a transfer gurney appeared to cause Ms. Baxter pain and that she appeared to be in pain throughout the transfer.

[219] Mr. Chavarie also provided his views on the impact of PHC's policy:

> Sheila [Baxter] had strong relationships with her health care team at St. Paul's. It was her West End community hospital. The fact that she had to undergo a painful and unnecessary transfer from a hospital where she had a bedside view of her community, to an impersonal and sterile space in a basement, all on the basis of an institution's religious beliefs, frustrates me to this day.
>
> … She had a strong belief in her access to MAiD and did not want to be transferred. Subjecting her to this transfer in the final hours of her life violated her dignity and autonomy. I am still left bewildered about why this unnecessary forced transfer was deemed socially acceptable by our health care system.

[220] Ms. Bates' partner, Mr. Harrison, gave evidence about the circumstances surrounding her transfer from SPH to a provision space at VGH. He believes that Ms. Bates' MAiD transfer deprived her of the "opportunity to have peaceful and meaningful final moments with her loved ones, and that [this] was replaced with additional pain and suffering".

[221] Mr. Harrison described his observations of Ms. Bates' transfer:

> It was very painful for Christina to move and get on the stretcher. The 15-minute drive was filled with bumps and turns that caused Christina considerable pain and suffering. She was a tough, strong woman, but I could see the pain this drive was causing her.

[222] He also offered his opinion on PHC and its MAiD policy:

> I believe, and Chistina also believed, that the Catholic Church should not be allowed to continue to deliver public health care services to Canadians, due to the harms caused from the operation of residential schools, protection of church leaders who harm children, failures to provide women's health services and avoidance of paying settlement funds to residential school survivors. Christna's experience with the forced transfer has only further affirmed my belief.
>
> …
>
> A policy of prohibiting access to a public healthcare service such as MAiD on the basis of Catholic values makes no sense to me. It is my view that forced transfers cost BC taxpayers money and are a waste of valuable healthcare resources. It upsets me to see that this policy continues and that other families may have a similar experience to the one that I had with Christina.

[223] Ms. Chamberlain's circumstances were different from the other three patients described above in that she was provided MAiD at the Shoreline space. As described above, Ms. Chamberlain's MAiD provision was delayed from the scheduled time of 9:00 am on January 6, 2026, to approximately 3:00 pm on January 7, 2026. The delay resulted from the fact that, initially, it appeared that Ms. Chamberlain could not in fact be transferred to the Shoreline space because PHC staff and the equipment required for her medication infusion pump were not permitted to accompany her to Shoreline. That issue was resolved and the transfer proceeded on January 7th.

[224] Ms. Chamberlain's daughter, Ms. Rivera, described the impact of the delay:

> While my mom was eventually able to get MAiD, it was a very difficult, confusing and frustrating process to get there. Those almost 48 hours of uncertainty and bureaucratic wrangling were filled with watching my mom suffer and deteriorate. It was filled with fear that her wishes would not be honoured, with anger that her interests and well-being seemed to take a backseat to their rules that I did not understand, and with overwhelming sadness and distress that my mom was suffering so much longer than she should have. It was shocking to find out, during a moment of crisis, that my mom's care options were constrained for reasons that no one could even clearly articulate.

[225] I note that Ms. Chamberlain was in fact sedated for the entire period during which her MAiD provision was delayed.

[226] As I indicated at the outset, the defendants take issue with much of this evidence. As I also indicated, those objections are largely well-founded, although the issue is less about technical admissibility and more about the fact that the evidence is incapable of establishing the facts that the plaintiffs seek to prove, specifically the alleged harms to patients associated with MAiD transfers.

[227] Without intending to diminish the legitimacy of the concerns and the profound sense of distress experienced by family members and friends, there are limitations on the utility of this evidence in analyzing the alleged breaches of the patients' individual rights.

[228] As is apparent from the references set out above, much of the lay evidence from family and friends of the patients describes their own personal experiences and their impressions of what the patients were experiencing. Such evidence does not meet the standard of objective medical evidence necessary to establish actual harms to the patients or a causal relationship between the impugned policies and those alleged harms.

[229] Moreover, the weight to be attached to this evidence is further undermined by the opinions, argument and advocacy directed at PHC's policy that figure prominently in the lay evidence. Again, while no doubt reflecting the honestly held

beliefs of the various witnesses, this type of evidence is of no assistance in establishing the necessary facts to determine the plaintiffs' claims (*Field v GlaxoSmithKline Inc*., 2011 SKQB 16 at para 36, *L.M.U v R.L.U.*, 2004 BCSC 95 at para 40, *Cambie Surgeries Corporation v British Columbia (Attorney General)*, 2018 BCSC 514 at para 73).

[230] I will also highlight portions of the expert evidence adduced by the parties on the issue of whether MAiD transfers cause harm.

[231] Dr. Susan MacDonald is an experienced and highly qualified palliative care physician who provided an expert opinion report on behalf of the plaintiffs, as well as a responsive report to Dr. Herx, a palliative care expert retained by PHC (see below). In her report, Dr. MacDonald talks at some length about the potential physical harm and psychological distress that can occur when patients are required to move, whether to receive MAiD or other forms of medical care. She suggests that those concerns are not ameliorated when the transfer is to an adjacent space like Shoreline:

> Just the fact that a patient is required to move, can cause distress. If the patient does not want to be moved to another location, even within a facility, if they are forced or required to do so, it may cause stress and anxiety. Taking a patient out of a room where they have stayed for some time, away from the staff they have developed a rapport with and isolating them at the last moments of their lives, is not in keeping with the goals of palliative care. Patients who are forced out of their room, even to travel a short distance in order to be outside of the care facility, can feel that they have been banished, or are unworthy. This is not something we want our patients to experience at the end of their lives.

[232] Dr. MacDonald concludes her report by saying:

> Transfers, whether they be to another bed in the same room or across town all have risks for a palliative patient. There are times when it is not advisable to move a patient at all. If and when a patient decides to go to another location, or the institution requires a move, several issues must be addressed. These include the pain and other significant physical symptoms that will be exacerbated or caused by movement. While there are medications and treatments that may reduce the physical stresses of movement and can be helpful in mitigating physical suffering, they are not always effective and can have significant side effects. It is always preferable

> to prevent increased pain and other symptoms by limiting those situations that cause harm. When a transfer is absolutely mandatory, all efforts to reduce the physical impact must be top of mind.
>
> Physical suffering is not the only negative consequence of a transfer. When a patient is forced or coerced to move location, the emotional and psychological suffering can be amplified. This is also true of those who love and care for the patient. There can be lasting impacts on the family's ability to grieve in a healthy manner in such situations.

[233] Dr. Leonie Herx is also an eminently qualified and experienced palliative care physician. Dr. Herx was retained by PHC to provide an initial assertive expert report as well as a responsive report to Dr. MacDonald and a further responsive report to a report authored by Dr. Catherine Perron (see below), relied on by the plaintiffs.

[234] One of the points made by Dr. Herx, in both her assertive report and in her response to Dr. MacDonald, is that patient transfers are a routine part of healthcare, including palliative care. In her response to Dr. MacDonald, she states:

> Patients receiving palliative care are routinely transferred within facilities and between facilities to receive various therapies, investigations, or specific types of care, such as hospice care at the end of life. Patients are also routinely moved within their room, for example to toilet or bathe, such as transferring to a commode, toilet or tub, or to relocate rooms within a ward or be moved to another ward, for example if the room they are in is required for another patient with specific needs (e.g. one who requires isolation) or their care is transferred to another team located in a different setting (e.g. transfer from medicine to palliative care unit).
>
> Transferring is a normal part of providing healthcare (including palliative care) and when any transfer is undertaken, consideration is given to the care needs and comfort of the patient, including any pre-medication or counselling needed for pain or anxiety. …
>
> There are not any specific types of cases in palliative care where transfer is not possible or advisable, even at the very end of life.

[235] As noted, both Dr. MacDonald and Dr. Herx are highly qualified palliative care physicians and their respected expert opinions align in many respects, particularly on the fundamental principles governing palliative care medicine. They have in fact co-authored or co-edited a number of publications.

[236] However, one of the key points of disagreement is the role of MAiD in palliative care. Dr. MacDonald's view is that MAiD is an end-of-life option and thus part of palliative care work. Dr. Herx takes a different view:

> Dr. MacDonald's point of view that MAiD should be part of palliative care work … is contrary to the accepted standards of the discipline—by definition, palliative care does not hasten death and fundamentally differs from MAiD in its philosophy, intention and approach. National …and international palliative care associations have all clearly stated that palliative care is a practice distinct from MAiD … the Canadian Medical Association has also recognized that palliative care and MAiD are distinct. Palliative care includes care for people at the end of life, but it does not end life.
>
> Like other areas of medicine, physicians from any specialty, including palliative medicine, can choose to practice MAiD, but that does not make it fundamentally part of that discipline.

[237] It would be unfair, and an oversimplification, to characterize Dr. MacDonald as "pro-MAiD" and Dr. Herx as "anti-MAiD", but they clearly have different professional and philosophical opinions about MAiD. This difference is reflected throughout their reports, particularly in their respective opinions about MAiD transfers. In her responsive report, Dr. MacDonald suggests that in saying that transfers can be properly managed, Dr. Herx focussed on the wrong question. According to Dr. MacDonald, "the focus should not be whether a physician <u>can</u> transfer a patient but whether they <u>should</u>, particularly when such a transfer does not align with the patient's goals of care" (emphasis added).

[238] The differences of opinion between Drs. MacDonald and Herx are similar to the differences between Dr. Holland and Dr. Genuis discussed above. They reflect good faith views held by different physicians about their professional and ethical obligations that are not capable of resolution by the Court.

[239] The plaintiffs also rely on the expert opinions of Dr. Eliana Close and Dr. Catherine Perron.

[240] Dr. Close is a Canadian-Australian academic at the Australian Centre for Health Law Research at Queensland University of Technology in Brisbane Australia. The principal focus of Dr. Close's report is the issue of what if any harms result from

MAiD transfers to patients, family members and clinicians. Specifically, Dr. Close was asked to address three questions:

1. How do patient transfers based on institutional religious objections to providing MAiD impact patients, family members, clinicians and other stakeholders in the public health care system? What, if any, are the harms resulting from a patient transfer based on institutional religious objections?

2. What regimes are in place in other jurisdictions where faith-based facilities have refused to provide MAiD on their premises based on institutional objections? How do those regimes address the issue of patient transfers?

3. What impact do those regimes have on patients, family members, clinicians and other stakeholders in the public health care system?

[241] Dr. Close summarizes the key points of her opinion as follows:

> Patient transfers based on institutional religious objections to MAiD can result in a range of harms to patients, family members, and clinicians. Some of these harms are direct and obvious, such as pain and suffering due to a transfer. Other harms, including emotional and psychological suffering and stigma, can be more insidious, but are also detrimental. Institutional objections cause emotional distress, place stress and logistical burdens on patients, family members, support person, and clinicians. Institutional objections can also interfere with patients' ability to have control and autonomy over their end-of-life options, including the timing and place of death, and the integration of MAiD and palliative care. In some instances, institutional objections cause patients to lose access to MAiD.
>
> The harms that result from institutional religious objections to MAiD interfere with a person experiencing a "good death". The concept of a "good death" is widely discussed and debated in fields including medicine, bioethics, sociology, and law. Institutional objections can displace many of the conditions for a "good death". They can cause physical and emotional harms, they interfere with patients' ability to die in a preferred place, and they delay or block access to MAiD.

[242] Dr. Perron is a professor in the School of Social Work at the Université de Sherbrooke and a clinical and organizational ethicist at the Laval Integrated Health and Social Services Centre. She was retained by the plaintiffs to provide an expert opinion in which she was asked to address the following questions:

1. What considerations are relevant to the provision of ethical end-of-life care generally, and when a patient has elected to receive MAiD?

2. Please discuss any ethical concerns or dilemmas that may arise in respect of a transfer of a patient at the end-of-life for the purposes of accessing MAiD based on the conscientious objection of a faith-based health care facility. Please consider potential impacts on actors across the health care system including patients, family members, clinicians, the facilities themselves and other stakeholders.

3. What, if any, particular ethical concerns or dilemmas may arise if a patient must be fully sedated for a transfer to access MAiD, and is unlikely to regain consciousness before MAiD is provided?

4. Please describe the current regime with respect to the provision of MAiD by publicly-funded faith-based healthcare facilities in Quebec.

5. How, if at all, has the regime in Quebec responded to or mitigated any of the ethical concerns or dilemmas referred to above?

[243] Without going into detail on each of the answers provided by Dr. Perron, key portions of her opinion include the following:

> The relevant considerations for the ethical provision of end-of-life care are interconnected and encompass a wide range of values, both individual and collective, which are embodied in practice and shape the quality of support provided. An integrative ethical approach seeks to bring these values together. This involves recognizing and respecting each person's right to self-determination, while also preserving solidarity and justice within the health care system.
>
> In short, a patient-centered approach in end-of-life care allows for personalized support that takes into account each patient's dignity, preferences, beliefs, values, and specific needs. Such an approach is essential to guarantee ethical and human care, particularly in contexts where patients may be vulnerable or marginalized.
>
> In Canada, the literature demonstrates a convergence around these pragmatic reference points, while also highlighting persistent challenges, notably those related to inequalities of access, trust in the health care system, coherence, and the availability of services. The ethical provision of end-of-life care therefore requires constant vigilance regarding proportionality and

> accessibility of care, social and geographic inequalities, and power imbalances between parties. It is in the articulation of these values, and in the respect for cultural plurality, that a truly ethical practice—one centered on the person at the end of life—can be grounded.
>
> …
>
> In situations where a patient must be transferred solely due to the faith-based refusal of the facility—while professionals could exercise their individual right to conscientious objection—the institutional accommodation can no longer be considered reasonable. Its cost then falls on the patient, who suffers disproportionate harm relative to the symbolic benefit granted to the institution. Ethical practice suggests that protecting and relieving an individual's suffering should take precedence over institutional preferences.
>
> …
>
> Transfers, even between floors of the same facility, expose patients to service disruptions and information loss with tangible consequences. We frequently—and continue to—receive MAiD requests several days or weeks after the form has been signed, due to staff and unit changes. We often observe situations in which new professionals responsible for the patient are unaware of the ongoing MAiD process, generating discomfort and dissatisfaction among patients and their loved ones, who must repeat and sometimes justify the chosen care path.
>
> These situations vividly illustrate how the multiplication of actors and steps in a sensitive procedure like MAiD can generate significant risks, both for patient safety and dignity, and for the emotional burden on families and professionals. They highlight the crucial importance of clear, uniform, and widely known protocols to ensure relational continuity and quality of care. They also show that risks inherent to practice can only be mitigated by minimizing transitions, changes, and interfaces among teams, services, or care settings. Each additional step multiplies opportunities for service disruption and information loss.
>
> …
>
> … it is necessary to reaffirm a principle of ethical balance: while freedom of belief must be respected, this respect must not result in serious infringement on patients' autonomy, dignity and equality. Ethical practice must also ensure that loved ones and caregivers are not subjected to disproportionate emotional and moral burdens. The paradox is striking: in protecting the institutional conscience of an establishment, we end up undermining the actual conscience of the patient, who loses their voice, autonomy, and role as the main actor in their own end of life. The collective challenge is therefore to design mechanisms that accommodate the beliefs promoted by institutions without sacrificing the lived conscience of patients.

[244] The observation emanating from *OHC* concerning the use that might be made of this type of evidence applies with particular force to the opinions of Dr. Close and Dr. Perron. The very nature of the questions asked of the two experts, and the scope

of the opinions given, illustrate the point that while the reports may be useful in the context of policy discussions surrounding MAiD, they fall well short of providing evidence capable of establishing adjudicative facts necessary to ground the plaintiffs' constitutional challenge to the impugned MAiD policies.

[245] With respect to Dr. Perron's report, I agree with the Province's assertion that there are numerous problems that render it inadmissible for its intended purpose, including:

a) The report is largely based on a literature review in which she paraphrases or summarizes various other commentaries and studies that have considered ethical issues relating to MAiD;

b) The report contains multi-levels of hearsay including quotations from unnamed or anonymized individuals from unknown jurisdictions which are impossible to test by way of cross-examination; and

c) The report relies on a variety of other reports and studies prepared for different purposes, which again are immune from challenge by way of cross-examination.

[246] Simply put, Dr. Perron's report lacks a sufficient degree of reliability to permit the Court to attach any weight to the opinions about the alleged harms relating to MAiD transfers.

[247] The same can be said for Dr. Close's report. The fundamental problems with the report are well summarized in the Province's notice of application seeking to strike the report:

> Part A of Dr. Close's report consists primarily of italicized quotations from unidentified respondents who were interviewed as "case studies" which "explore[d] the regulation of voluntary assisted dying" and "examine[d] the experiences of people involved in the MAiD system". This included a limited number of family caregivers, and a single patient, who "did not experience

> institutional objection but described engaging in advocacy to combat it". The work was funded by the Australian Research Council Future Fellowship Scheme, and was "aimed to explore the regulation of voluntary assisted dying" in that jurisdiction.
>
> The italicized quotes are, by their nature, anonymous, commonly attributed only to "a MAiD provider", or less frequently, "a family caregiver", etc. The quotes originate from survey participants in Canada (with the Province unspecified), as well as Australia and New Zealand. The underlying survey's main method of recruitment was through the plaintiff, Dying with Dignity Canda's mailing list, supplemented by other sources as the research continued.
>
> Part A of the Close report is inadmissible for at least five reasons—a) it is improper to tender this type of anecdotal evidence through an expert; b) Part A's evidentiary value is so low as to render it irrelevant and unnecessary; c) it constitutes multi-level hearsay disguised as opinion evidence; d) it is prejudicial to the defendants; and e) it is outside of Dr. Close's asserted expertise and constitutes advocacy.

[248] Similar problems run through the balance of the report.

[249] In its written submission, VCH also provides a succinct summary of the flaws in the plaintiffs' evidence led in support of their claim that MAiD transfers cause patients harm (at para 434):

> The plaintiffs have largely chosen to rely on the subjective perception of family members in support of their claims of harm, along with qualitative sociological and organizational ethics research, rather than objective or expert medical evidence, whether from their treating physicians or otherwise.

[250] The rejection of these reports for their intended purpose should not be interpreted as criticism of Dr. Perron or Dr. Close's credentials or the validity of their work, for example from an academic perspective. The point again is simply that

these reports do not provide an evidentiary foundation for the adjudicative facts the plaintiffs seek to establish.

[251] In addition to physical harms, the plaintiffs allege that patients who are transferred to receive MAiD are subjected to unnecessary increased psychological harms, including the message that their choice to access MAiD is morally wrong. They say that this stigmatization and rejection profoundly impacts the patients' psychological integrity.

[252] Respectfully, the plaintiffs' argument on this point is highly speculative and untethered from the evidence led at trial.

[253] For example, the evidence does not establish that any of Ms. O'Neill, Ms. Baxter, Ms. Bates, or Ms. Chamberlain felt rejected or morally judged because of their decision to access MAiD or because they required a transfer in order to do so. Indeed, the evidence from family and friends of the patients is that the patients' caregivers treated them with kindness and respect.

[254] The speculative nature of the plaintiffs' claim on this point is well illustrated in the assertive report of Dr. MacDonald where she states:

> One must always remember when having a patient transferred to another facility at the request of the facility rather than the patient's request is how this request or order will be perceived by the patient.
>
> Many people in Canada have had a personal or an ancestral experience of colonialism which has resulted in a high level of suspicion and a lack of trust with institutional care. For our marginalized patients who have had their lives dictated by organizations that have not focussed on the patient's best interest, there is long-standing distrust and negativity. Certainly, there is a long history with our Indigenous population that institutions and organizations have dictated negative experiences that the patient was not permitted to refuse. For those patients and all persons who have had negative experiences with the healthcare system or with another organization such as a church or government agency, there will naturally be a level of distrust and a sense of being marginalized and dictated to. In palliative care, we look beyond the physical state of the patient but also care for their emotional psychosocial and cultural safety. These types of issues are very important to keep in mind. Extra care must be taken with these patients to ensure that they feel control of their destiny as much as possible, and their wishes and concerns are respected. Patients can feel shame, that they have been

> stigmatized, or disconnected from the health care team they had grown to trust. None of these are in the patient's best interest.

[255] While the concerns identified by Dr. MacDonald should not be discounted, they are stated in very general terms and are not grounded in the evidence led at trial. Again, while perhaps useful in the policy discussion surrounding MAiD, Dr. MacDonald's opinion again does little to assist the Court in finding the facts relevant to determining the plaintiffs' claims.

[256] In my view, the plaintiffs have not established that MAiD transfers cause patients "serious and profound" psychological distress so as to infringe their right to security of the person (*New Brunswick (Minister of Health and Community Services) v G (J),* 1999 CanLII 653 (SCC), [1999] 3 SCR 46 at para 60).

[257] What the evidence did establish is that patient transfers are a common feature of the healthcare system in BC and Canada and that any risks associated with such transfers can be managed.

[258] Cindy Loo is the Operations Director for patient flow at VGH. She oversees the access and flow department at VGH which coordinates the movement and placement of patients between various VCH facilities to facilitate access to care. The movement or transfer of patients can be within the same facility or between different facilities. These transfers happen for a variety of reasons including patient care needs and resource or capacity issues.

[259] The complexity of this process is described by Ms. Loo in her affidavit:

> On a day-to-day basis, the work of the access and flow department involves matching our capacity with demand, ensuring we have sufficient inpatient capacity for the admitted patients in ED, patients who are scheduled for surgery and patients waiting to be transferred from other facilities for higher level of care, as well as facilitating transfers of patients within the hospital to higher/lower levels of care. The access and flow team also works with our community partners to facilitate patient discharges home and to other acute care sites for transfer back to their community hospitals.
>
> …
>
> Access and flow collects information including how many patients are on each unit, how many patients are waiting in the ER, how many patients are

> awaiting surgery/operative room space, how many discharges are expected and from what units, among other information, including patient specific data, to plan around allocations for patient placement.
>
> As an example of patient specific information, the access and flow department will consider whether the patient requires access to a post-operative surgical bed, requires the specialized care of a program (e.g. bone marrow transplants or spine) or can be moved our of the specialized unit for another patient who requires it, whether the patient is being moved to a higher or lower level of care, whether the patient requires a private room, possibly due to psychosocial factors (mental health, risks of self-harm) or management of communicable diseases … among other things.
>
> Access and flow also considers staffing resources, including whether a particular unit is short-staffed and how that would impact access to care. If staffing challenges cannot be mitigated such that it impacts capacity, the access and flow team would look at strategies such as moving patients to other units that are adequately staffed or delaying transfer of patients from other hospitals if possible.

[260] Ms. Loo also makes the point that "a patient could be moved several times during their stay at VGH." This is true for patients at any major hospital, including SPH.

[261] Dr. Erik Vu is an Emergency and Critical Care Physician with a subspecialty in Prehospital and Transport Medicine. He was retained by the Province to provide an expert report addressing the role, frequency and management of inter-facility patient transports in BC's healthcare system.

[262] In his report, Dr. Vu describes in some detail the extensive patient transfer and transport system in BC coordinated through the BC Emergency Health Services Agency ("BCEHS").

[263] It was Dr. Vu's evidence that patient transfers reflect the fact that the healthcare system operates on a regional hub basis with different facilities offering different types and level of care. This often requires transfer between facilities to ensure patient access to care. Dr. Vu noted that from 2020–2024, BCEHS completed over 350,000 inter-facility transfers.

[264] Dr. Vu also testified that there is no specific category of transfers particular to MAiD patients. He said in cross-examination:

> We don't have a MAiD transfer category. As I said, every…interfacility transfer [IFT], is one patient at a time patient-centric. So, whether it's MAiD, a spinal fracture, a heart attack, it is patient-focussed, symptom-based, and in that regard we match the scope of practice that we've just been alluding to the patient's actual and anticipated needs.

[265] In his report, Dr. Vu discussed the steps taken to preserve patient dignity during transfer:

> Patient dignity and comfort remain central in patient-centered care, which are core tenants in BCEHS paramedic training. In keeping with guiding principles or patient autonomy, consent and providing patient-centered care that includes comfort, paramedics will perform a systems-based review of each patient, develop a problem-based treatment plan, and in the context of IFT, take measures to mitigate any predictable environmental change (e.g. transit outdoors) or stimulus (e.g. moving from hospital bed to transport stretcher) to ensure that, throughout this process, patient dignity and comfort are maintained.

[266] To be clear, the evidence does not establish that there are no risks associated with MAiD transfers. Rather, it is apparent that while there are risks that may arise on any transfer, whether intra or inter-facility, specific patient needs are accounted for and the risks are generally managed. I note that Dr. MacDonald, in her responsive report, acknowledged that palliative care physicians have the "capability, knowledge and skills" to manage patient transfers, even when the patients are unwell and close to death (although she again objects to MAiD transfers which she characterizes as being against the patient's will).

[267] The fact that transfers occur routinely and often in the healthcare system reveals another flaw in the plaintiffs' argument. A number of the plaintiffs' experts opine that <u>any</u> transfer of a grievously ill person creates risks. For example, Dr. MacDonald opines that "for some patients, even moving from one bed to another in the same room can cause significant pain and distress".

[268] Yet, the plaintiffs do not argue that routine transfers, for example transfers between rooms, from a bed to a bathroom, or to an operating room for a surgical procedure, engage patients' s 7 rights. Rather, it is only when the transfer is made because of the institution's religious objection that a violation of s 7 is said to occur.

[269] However, the reason or motivation for an action is irrelevant at the initial stage of determining whether a violation has occurred. Further, the evidence does not establish that there are different or heightened risks associated with MAiD transfers in comparison to other transfers. That is particularly so at facility like SPH where the MAiD transfer is to the Shoreline space, which is effectively part of the SPH campus, albeit it is administered by VCH.

[270] It will be apparent from the above that I am not satisfied that the plaintiffs have established a breach of patients' s 7 rights. Specifically, in terms of the alleged breach of the right to liberty, the impugned polices do not deny patients access to MAiD. Rather, they are intended to facilitate that access, albeit with some limitations on where the medical procedure occur. As discussed above, *OHC* is instructive in explaining why such limitations do not violate the liberty right. So too are the majority's observations in *Cambie Surgeries (CA)* at para 240:

> The liberty right is a right to make fundamental personal choices on the basis of autonomy and human dignity: *Carter* at para. 64; *R. v. Clay*, 2003 SCC 75 at para. 31. Unlike in *Carter*, where the provision served to restrict access to an entire class of treatment, the provisions at hand restrain patients from choosing the means by which the (identical) treatment is received, with the only distinctions being the financing and potential wait. We think it stretches the definition of "liberty" too far to suggest the choice of private or public medical care is a fundamental choice related to autonomy and human dignity.

[271] The plaintiffs have also failed to establish a breach of patients' right to security of the person. As discussed above, patients who are transferred for the purpose of receiving MAiD are not subjected to different or heightened risks of physical or psychological harm beyond what is involved in routine transfers that again happen on a daily basis within the healthcare system.

[272] It is the role and responsibility of the medical professionals to determine how those risks are best managed. The plaintiffs' position seeks to improperly insert the court into that determination and to elevate patient choice about the location of a treatment into a constitutional imperative. Respectfully, that is well beyond the established scope of s 7 of the *Charter*.

Principles of Fundamental Justice

[273] Given my finding that MAiD transfers do not violate patients' s 7 rights to liberty or security of the person, it is not strictly necessary to consider the principles of fundamental justice. However, in the event that I am wrong in my analysis of the alleged breaches, I will turn briefly to those principles.

Legal Framework

[274] Once it has been established that s 7 is engaged, a claimant must demonstrate that the deprivation at issue is not in accordance with the principles of fundamental justice (*Carter* at para 55).

[275] These principles "set out the minimum requirements that a law that negatively impacts on a person's life, liberty, or security of the person must meet" (*Bedford* at para 94). This analysis helps to capture "inherently bad laws" that infringe the right to life, liberty, or security of the person "in a way that runs afoul of our basic values" (*Bedford* at para 96).

[276] The plaintiffs argue that the impugned provisions violate the principles of arbitrariness, overbreadth, and gross disproportionality. These principles have emerged as "central in the recent s 7 jurisprudence" (*Carter* at para 72).

[277] The plaintiffs also argue that the provisions violate the principle of state neutrality, a principle not yet recognized as a principle of fundamental justice, by depriving patients of their fundamental rights on the basis of religious dogma. As I have already found that the doctrine of state neutrality as an element of the s 2(a) right to freedom of religion has not been breached, principally because the impugned policies do not have the intent or effect of imposing Catholic values on patients or preferring those values, it is unnecessary to consider this argument.

[278] Regardless of the principle at issue, the analysis at this stage is distinct from the analysis under s 1: "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*" (*Carter* at para 79).

[279] In considering the plaintiffs' arguments on arbitrariness, overbreadth, and gross disproportionality, the first step is to identify the object of the impugned provisions (*Carter* at para 73). In doing so, the object of the law at issue must be defined precisely (*Carter* at para 78).

[280] The Court articulated the approach to articulating a law's purpose in *R. v Sharma*, 2022 SCC 3:

> [87] As the law's purpose is the principal reference point, its proper identification is crucial to the s. 7 analysis (*R. v. Safarzadeh-Markhali*, 2016 SCC 14, [2016] 1 S.C.R. 180, at para. 24; *R. v. Moriarity*, 2015 SCC 55, [2015] 3 S.C.R. 485, at para. 24). Indeed, identifying a law's purpose may be determinative of its constitutionality (R. J. Sharpe and K. Roach, *The Charter of Rights and Freedoms* (7th ed. 2021), at p. 279). It is important to characterize the purpose of a law at the appropriate level of generality (*Safarzadeh-Markhali*, at para. 27; *Moriarity*, at para. 28). At one end of the spectrum lies an abstract purpose akin to the animating social value. At the other extreme is a "virtual repetition of the challenged provision, divorced from its context" (*Safarzadeh-Markhali*, at para. 27). A proper framing of purpose lies somewhere between these two poles, and is precise and succinct (*Moriarity*, at para. 29).
>
> [88] The most significant and reliable indicator of legislative purpose would, of course, be a statement of purpose within the subject law. Beyond that, generally, courts seeking to identify legislative purpose look to the text, context, and scheme of the legislation and extrinsic evidence, which can (subject to the caution we offer below) include Hansard, legislative history, government publications and the evolution of the impugned provisions (*Safarzadeh-Markhali*, at para. 31; *Moriarity*, at para. 31; *Application under s. 83.28 of the Criminal Code (Re)*, 2004 SCC 42, [2004] 2 S.C.R. 248, at para. 37).
>
> …
>
> [91] Having reviewed whatever sources are available, courts should strive to arrive at a precise and succinct statement that faithfully represents the legislative purpose of the impugned provision (*Safarzadeh-Markhali*, at para. 28; *Moriarity*, at para. 29). Overly broad, multifactorial statements of purpose can artificially make impugned provisions unassailable to arguments of overbreadth or arbitrariness.

[281] This purpose becomes crucial to the analysis under arbitrariness, overbreadth, and gross disproportionality.

[282] Arbitrariness "asks whether there is a direct connection between the purpose of the law and the impugned effect on the individual, in the sense that the effect on the individual bears some relation to the law's purpose" (*Bedford* at para 111). A law will fail at this stage where it is not *capable* of fulfilling its objectives (*Carter* at para 83). The evidence must establish that the law has no connection between its effect and purpose (*Bedford* at para 119).

[283] In contrast, overbreadth considers 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" (*Carter* at para 85). The court is not to consider whether legislatures have 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" (*Carter* at para 85). As such, it essentially considers whether the law is arbitrary in part because the scope of the law is so broad that it includes some conduct that bears no relation to its purpose (*Bedford* at para 112).

[284] The test for gross disproportionality was succinctly described by the Court in *Carter*:

> [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).

[285] In considering gross disproportionality, the Ontario Court of Appeal in *Cycle Toronto* stressed that this is a high threshold, with lesser disproportionality being properly left to the realm of public and legislative debate:

> [69] The rule against gross disproportionality is not the same as a rule against mere disproportionality: *R. v. Safarzadeh-Markhali*, 2016 SCC 14, [2016] 1 S.C.R. 180, at paras. 67-73. The decision to recognize the rule against gross disproportionality as a principle of fundamental justice reflects an intention to 2026 ONCA 582 (CanLII) elevate the standard considerably – well beyond the possibility of reasonable disagreement inherent in questions of mere disproportionality – in order to preserve "'broad latitude … for legislative action'": *Bedford*, at para. 103, quoting *Malmo-Levine*, at para. 175. Purported disproportionality short of that high threshold is a matter for public and legislative debate rather than judicial intervention, even where the law's effects are serious: *Malmo-Levine*, at para. 175. This reinforces the idea that the principles of fundamental justice are basic legal principles inherent in the Canadian constitutional order – not instruments authorizing courts to declare winners and losers in public policy debates.

Analysis

[286] The plaintiffs characterize the purpose of the impugned MAiD policies as permitting faith-based organizations, including PHC, to provide healthcare to the public in a manner consistent with their religious missions. The plaintiffs submit that this purpose is evident on the face of s 12 of the MOH MAiD Policy, which confers the right on FBOs to opt out of providing MAiD in their facilities.

[287] The defendants submit that the plaintiffs define the purpose too narrowly by focussing only on the exemption portion rather than the text of the s 12 as a whole. In its written submission, the Province describes the purpose of the impugned provisions as two-fold:

a) Ensuring reasonable access to, and effective coordination of, care for MAiD in religious healthcare facilities in a manner that balances the rights and interests of patients, healthcare provider, and faith-based healthcare organizations.

b) Preserving and ensuring the sustainability of health care delivery across British Columbia through continued participation by, collaboration with, and access to the resources provided by faith-based health care organizations.

[288] In my view, the purpose as defined by the Province aligns more closely with the specific terms of s 12 of the MOH MAiD Policy, which requires FBOs who wish to opt out of providing MAiD to work with the relevant Health Authority to develop policies and procedures to ensure that:

a) The requesting individual has full information regarding the services and treatment options available to them;

b) The requesting individual is aware of available information resources, including information regarding the Health Authority's role in care coordination;

c) The FBO will respect and not impede the individual's request for information concerning MAiD;

d) The FBO will minimize harm to medically frail patients, working with the Health Authority to meet patient needs;

e) The FBO will continue to provide comprehensive care for the requesting individual, to ensure care needs unrelated to MAiD are met.

[289] These specific requirements must be read in conjunction with the broader objectives of the MOH MAiD Policy as a whole, which include:

a) Establishing a provincial policy framework that supports reasonable access across the province for MAiD, in a manner similar to other health care services.

b) Supporting a consistent approach to delivery of MAiD that complies with the [*Criminal Code*].

c) Recognizing that MAiD is an option available to eligible adults, whose suffering cannot be relieved through other means acceptable to them.

[290] While these broader objectives reflect an overarching purpose of providing fair and reasonable access to MAiD throughout the Province, s 12 is concerned with ensuring that this purpose is extended to patients in FBOs. As the Province submits: "Reasonable access to MAiD for patients in objecting facilities is the *raison d'etre* of this provision".

[291] Before turning to the specific principles of fundamental justice set out in s 7, it is necessary to address one key proposition advanced by the plaintiffs, that being that the Court can and should look behind PHC's asserted religious beliefs or at least the manner in which those beliefs are manifested in PHC's MAiD Policy. This proposition is reflected in the plaintiffs' submission that the Court, when considering whether the impugned polices offend the principles of fundamental justice, is required to look into the application of religious dogma and second-guess the Church's interpretation of its own laws. The plaintiffs in fact invite the Court to find that the degree of cooperation and facilitation provided for in the PHC MAiD Policy already violates Catholic canon law and that permitting third party provision of MAiD in PHC facilities would in fact be consistent with Catholic doctrine, particularly if directed to do so by the MOH.

[292] The plaintiffs rely largely on Dr. Sumner's opinion in support of this position. His view is that PHC would not be harmed by a rule that would prevent PHC from prohibiting third-party provision:

> The rule would also impose no harms on Providence itself, or any of its facilities, since (a) it is at least arguable that the rule would not require them to contravene their Catholic ethical principles; (b) it would not prevent either Providence or the facilities from carrying out their principal mission, which is the delivery of health care; and (c) in any case, institutions as such cannot suffer the harm of contravening their principles; only natural persons can.

[293] I do not accept Dr. Sumner's opinion on this point. As seen in the above quote, he purports to separate PHC's adherence to Catholic teachings from its "principal mission" of delivering healthcare. However, the evidence at trial very clearly established that such a separation does not exist and that providing healthcare services is an integral aspect of PHC's Catholic mission.

[294] Dr. Sumner in fact acknowledged this in cross-examination:

> Q. I put it to you that this entire section you quoted makes it clear that, from the Catholic perspective, the charitable work of healthcare is an integral part of the mission of the church.
>
> A. Yes, seemingly so.

[295] Dr. Sumner further acknowledged that he is not an expert in Catholic bioethics or theology.

[296] Dr. Sumner notes in his report that there is not uniform agreement within Catholic spheres about whether permitting third party MAiD provision in Catholic facilities would in fact violate Catholic teachings. He refers in particular to a report authored by Dr. Peter Cataldo, a Catholic bioethicist, who concluded that it would not, particularly if done pursuant to government direction. Dr. Cataldo's report was referred to at trial but never entered into evidence.

[297] Dr. Sumner also notes that other Catholic ethicists take a different view. He cites the report of Dr. Moira McQueen prepared at the request of PHC, who opines:

> In light of the teachings of the Catholic Church…, PHC could never at any time support, whether intentionally or not, the provision of euthanasia (MAiD) in its healthcare facilities since these procedures are considered intrinsically evil and are practices that should never be allowed. On the same basis, third party providers may not use Catholic facilities to provide euthanasia (MAiD).

[298] Dr. Sumner quite fairly says this about the difference in opinion between Drs. Cataldo and McQueen:

> The issues at stake between Cataldo and McQueen are complex and deeply embedded in a Thomistic ethical tradition that distinguishes different forms of cooperation in (supposed) evil: formal v. material, immediate v. mediate, and proximate v. remote. While they agree that allowing third-party provision of MAiD in Providence facilities would constitute material cooperation in the act, they disagree over whether that cooperation is mediate (Cataldo) or immediate (McQueen). Because I have no facility with, and no expertise in, that particular tradition, I will offer not verdict on wo has made the more convincing case in its terms. Instead, I will suggest that this is a question on which reasonable people who share a common ethical tradition can disagree.

[299] As with other ethical disagreements referred to in these reasons, the Court is no better situated to resolve the divide between Drs. Cataldo and McQueen. Nor is

the Court well-positioned to challenge the determination made by Archbishop Michael Miller, the former Archbishop of the Vancouver Archdiocese, who made the ultimate determination that third party provision of MAiD at PHC facilities was impermissible.

[300] In his affidavit, filed in evidence, he stated:

> Catholic doctrine is unambiguous that euthanasia and MAiD are not permissible. As such, the decision on Third-Party Provision at PHC was ultimately a clear no.

[301] Archbishop Miller in his affidavit also referred to a statement issued by the Canadian Conference of Catholic Bishops dated November 30, 2023, in which the bishops "unanimously and unequivocally oppose the performance of either euthanasia or assisted suicide (MAiD) within health organizations with a Catholic identity."

[302] Not only is the Court unqualified to review or second-guess determinations of religious dogma, the Supreme Court of Canada has held that it is not the court's role to do so. In *Syndicat Northcrest v Amselem*, 2004 SCC 47, Justice Iacobucci for the majority said:

> 50 In my view, the State is in no position to be, nor should it become, the arbiter of religious dogma. Accordingly, courts should avoid judicially interpreting and thus determining, either explicitly or implicitly, the content of a subjective understanding of religious requirement, "obligation", precept, "commandment", custom or ritual. Secular judicial determinations of theological or religious disputes, or of contentious matters of religious doctrine, unjustifiably entangle the court in the affairs of religion.

[303] Justice Iacobucci went on to find that a court may inquire into the sincerity of a party's professed belief, where sincerity is in fact in issue (at para 51). Here, on the evidence, there is no issue as to the sincerity of the Catholic beliefs underpinning the PHC MAiD Policy and, indeed, the plaintiffs do not argue otherwise.

[304] Turning to the principles of fundamental justice, the plaintiffs argue that the impugned polices are arbitrary because there is no real connection between the purpose of the policies and their impact on patients.

[305] However, as I have found, the plaintiffs define the purpose of the policies too narrowly and overstate the impact on patients. When the two-fold purpose of the provisions (see para 287 above) is considered, the direct connection between those purposes and the impact on patients is readily apparent. Specifically, the MOH MAiD Policy is intended to facilitate reasonable access to MAiD while respecting the ability of FBOs to continue to provide healthcare services in a manner consistent with their religious beliefs.

[306] The plaintiffs argue that the impugned policies are overbroad because they grant PHC a "building management right" which goes beyond what is necessary to ensure that FBOs can deliver healthcare services in accordance with their religious mission.

[307] This argument suggests that the use that an FBO such as PHC makes of its facilities can be separated from its core religious function. The plaintiffs' position however fails to acknowledge that the Denominational Master Agreement expressly grants participant FBOs the right to manage and govern their facilities in order to preserve the spiritual nature of the facility. It also ignores the uncontradicted evidence of PHC that the use of its facilities is directly tied to its religious mission. To suggest that PHC is simply given a "building management right" under the MOH MAiD Policy again improperly invites the Court to second guess the sincerity of this aspect of PHC's Catholic beliefs.

[308] Finally, the plaintiffs argue that the impugned policies are grossly disproportionate because they impose "egregious, medically unnecessary suffering to vulnerable patients" in pursuit of the objective of permitting FBOs to provide health care in a manner consistent with their religious missions. Once again, however, the plaintiffs' position is based on an overly narrow statement of purpose, which I have rejected, and findings of harm that have not been established.

[309] In sum, on s 7, the plaintiffs have not established that the impugned policies violate patients' rights to life, liberty, or security of the person nor have they proven that, if there is a breach, it fails to accord with the principles of fundamental justice.

[310] Given my findings on the alleged s 7 breach, as well as the alleged s 2(a) breach, it is not necessary to consider PHC's alternative argument that the PHC MAiD Policy is not subject to scrutiny under the *Charter.*

Summary and Conclusion

[311] In summary, for the reasons set out above, I find that the impugned policies do not violate the s 2(a) rights of physicians wishing to provide MAiD nor the s 2(a) and s 7 rights of patients seeking to avail themselves of MAiD.

[312] The plaintiffs' action is therefore dismissed.

[313] If the parties are unable to agree on costs, they may make arrangements to speak to the issue. If the parties wish to do so, they should contact Supreme Court Scheduling within 60 days to schedule a conference at which the process and timing for dealing with costs will be addressed.

[314] I am indebted to counsel for all of the parties and intervenors for their professionalism throughout this matter and for their helpful and thorough submissions.

"Chief Justice Skolrood"