NOVA SCOTIA COURT OF APPEAL

Citation: *Y. v. Swinemar*, 2020 NSCA 56

Date: 20200904
Docket: CA 499817
Registry: Halifax

Between:

Y

Appellant

v.

Schelene Swinemar, X, and Nova Scotia Health Authority

Respondents

Judge:	Van den Eynden, J.A.
Motion Heard:	August 26, 2020, in Halifax, Nova Scotia in Chambers
Held:	Motion for stay dismissed
Counsel:	Hugh Scher, John Campion, and Kate Naugler, for the appellant Philip Romney, for the respondent X Karen Bennett-Clayton, for the respondents Ms. Swinemar and Nova Scotia Health Authority Mary Ann Persaud, for the respondent Nova Scotia Health Authority (in-house counsel)

Overview

[1] The appellant's husband, Mr. X, sought medical assistance in dying (MAiD) to alleviate his pain and suffering. To be eligible, Mr. X had to meet specific criteria set out in the *Criminal Code*, which included findings from medical professionals that he has a grievous and irremediable medical condition, his death was reasonably foreseeable, and he had the capacity to provide informed consent.

[2] The governing legislative framework has built-in safeguards. Before MAiD can be administered, two qualified and independent medical professionals must assess the individual and opine that all the eligibility criteria have been met.

[3] In this case, the appellant's husband was found to have met the eligibility criteria. All the necessary plans were in place for him to receive MAiD on a date certain. However, the appellant commenced legal proceedings in the court below in order to block her husband from accessing MAiD. Ultimately, the appellant seeks a declaration that her husband does not meet the eligibility criteria and wants a permanent injunction preventing his access to assisted dying.

[4] On August 7, 2020, the appellant's request for an interlocutory (temporary) injunction to halt the administration of MAiD was heard before the Honourable Justice Peter P. Rosinski. The application in the court below has yet to be heard on the merits.

[5] Rosinski, J. rendered his decision on August 14, 2020 (2020 NSSC 225). He declined to order an injunction and vacated an earlier emergency interim injunction the appellant obtained *ex parte* (*ex parte* meaning without notice to either her husband or the other named respondents). Thus, there was nothing legally preventing Mr. X from obtaining MAiD.

[6] On the same day that Rosinski, J. released his decision and issued the resulting order, the appellant filed a Notice of Appeal and requested a stay of the lower court order pending the determination of her appeal.

[7] When a party appeals a lower court order, the order remains operative pending the appeal outcome unless a stay is granted. A panel of judges hears and determines the appeal. A single judge sitting in chambers determines a stay motion. A stay is not automatic, and there are principles that guide the exercise of this discretionary remedy.

[8] My colleague, Justice Anne S. Derrick, sitting in chambers, first addressed this stay motion on a preliminary and emergency basis. She set the motion down for hearing, directed filing dates for materials and ordered that the provision of MAiD to Mr. X not proceed until this stay motion was determined.

[9] I heard the motion on August 26, 2020. Having reviewed the record and materials before me, and having considered the submissions of the parties and the guiding legal principles, I decline to grant a stay. The appellant has failed to establish a stay is warranted.

[10] Before turning to my reasons, I mention the use of initials when referring to the appellant and her respondent husband. In his written decision, Rosinski, J. referred to the applicant (appellant) as "Y" and her respondent husband as "X". There is no publication ban in place. Rather, the judge exercised his discretion to anonymize their identity given the deeply personal issues at stake and a desire to be sensitive to privacy interests without compromising the open courts principle. Their identity may be garnered from the publicly accessible court file. I see no reason not to follow this naming choice; in the body of my decision I refer to the appellant as Mrs. Y and her husband as Mr. X.

Guiding legal principles

[11] As noted, the filing of a Notice of Appeal does not operate as a stay of execution of the judgment being appealed. That is because a successful party is entitled to the benefit of the judgment obtained. This is in keeping with the companion proposition that an order, although under appeal, is presumed correct unless and until it is set aside. These principles are well-established in Canadian law. They were reiterated by Prowse, J.A. of the British Columbia Court of Appeal, sitting in chambers, when she denied a stay motion aimed at preventing access to assisted death (*Carter v. Canada (Attorney General)*, 2012 BCCA 336 at ¶8).

[12] The power to grant a stay is discretionary. For context of what follows, it is helpful to understand the basic legal framework for a stay early in my decision. I will return to the application of these principles in my analysis.

[13] Nova Scotia *Civil Procedure Rule* 90.41(2) provides:

> 90.41 (2) A judge of the Court of Appeal on application of a party to an appeal may, pending disposition of the appeal, order stayed the execution and

> enforcement of any judgment appealed from or grant such other relief against such a judgment or order, on such terms as may be just.

[14] To succeed on her stay motion, Mrs. Y must establish on a balance of probabilities:

1. There is an arguable issue raised by her appeal;
2. If a stay is not granted and the appeal is successful, she will have suffered irreparable harm; and
3. She will suffer greater harm if the stay is not granted than her husband Mr. X will suffer if the stay is granted.

[15] If all three criteria are not met, there remains discretionary power to grant a stay providing there are exceptional circumstances that would make it fit and just to grant a stay (see: *Purdy v. Fulton Insurance Agencies Ltd.* (1990), 100 N.S.R. (2d) 341, per Hallett, J.A.). This latter branch of the test is akin to a safety valve, catching cases that warrant a stay but fall outside the primary three step test (*La Ferme D'Acadie v. Atlantic Canada Opportunities Agency*, 2009 NSCA 5 at ¶22).

[16] Mrs. Y points out that if a stay is not granted, Mr. X may choose to avail himself of MAiD before her appeal is heard and determined. Should he elect to exercise his right to do so, Mrs. Y views this as effectively rendering her appeal moot.

[17] Mootness is considered at the irreparable harm stage in the above-noted *Fulton* test, which I will address in my analysis. For now, I note there is ample authority, including in the MAiD context, that mootness does not automatically constitute irreparable harm. It is but one factor to consider. Furthermore, the issues Mrs. Y raises on appeal appear broader in effect, regardless of whether Mr. X dies before her appeal is determined.

Background

[18] To better understand my decision to decline a stay in such an important and serious matter, it is helpful to review: the statutory MAiD eligibility criteria and safeguards; Mr. X's medical conditions; the assessment process he underwent; Mrs. Y's allegations of defective assessment; and, her assertions of how the judge erred in rejecting her request for an interlocutory injunction halting Mr. X's right to pursue MAiD.

MAiD eligibility criteria and safeguards

[19] The criteria for medical assistance in dying is set out in the *Criminal Code* at s. 241.2:

> **Eligibility for medical assistance in dying**
>
> **241.2 (1)** A person may receive medical assistance in dying only if they meet all of the following criteria:
>
> > **(a)** they are eligible - or, but for any applicable minimum period of residence or waiting period, would be eligible - for health services funded by a government in Canada;
> >
> > **(b)** they are at least 18 years of age and capable of making decisions with respect to their health;
> >
> > **(c)** they have a grievous and irremediable medical condition;
> >
> > **(d)** they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
> >
> > **(e)** they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.
>
> **Grievous and irremediable medical condition**
>
> **(2)** A person has a grievous and irremediable medical condition only if they meet all of the following criteria:
>
> > **(a)** they have a serious and incurable illness, disease or disability;
> >
> > **(b)** they are in an advanced state of irreversible decline in capability;
> >
> > **(c)** that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
> >
> > **(d)** their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

[20] The *Criminal Code* also mandates safeguards for MAiD. Section 241.2(3) provides:

> **Safeguards**
>
> **(3)** Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must

(a) be of the opinion that the person meets all of the criteria set out in subsection (1);

(b) ensure that the person's request for medical assistance in dying was

(i) made in writing and signed and dated by the person or by another person under subsection (4), and

(ii) signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;

(c) be satisfied that the request was signed and dated by the person -or by another person under subsection (4) - before two independent witnesses who then also signed and dated the request;

(d) ensure that the person has been informed that they may, at any time and in any manner, withdraw their request;

(e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);

(f) be satisfied that they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are independent;

(g) ensure that there are at least 10 clear days between the day on which the request was signed by or on behalf of the person and the day on which the medical assistance in dying is provided or - if they and the other medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent - any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;

(h) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying; and

(i) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision.

[21] Also of note is s. 241.2(7) which provides:

Reasonable knowledge, care and skill

(7) Medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards.

[22] All three professionals involved in the facilitation of MAiD—medical practitioners, nurse practitioners and pharmacists—are self-regulated. Their adherence to law and policy relevant to the provision of clinical services is overseen by their respective self-governing bodies.

[23] The principal role of all three colleges is to protect the interests of the public by establishing and maintaining standards of practice, including proper practices related to the provision of MAiD, and assessments of capacity and consent in general. Assessments of capacity and eligibility for MAiD are exercises of clinical judgment. The Nova Scotia Government has delegated the oversight role to these professions through the enactment of the *Medical Act,* S.N.S. 2011, c. 38, the *Nursing Act,* S.N.S. 2019, c. 8 and the *Pharmacy Act,* S.N.S. 2011, c. 11.

[24] In addition to regulatory and oversight mandates from the various professional regulatory bodies, the respondent Nova Scotia Health Authority (NSHA) developed and implemented a detailed Interdisciplinary Clinical Policy to guide the MAiD process.

[25] The Policy forms part of the record and there is no need to summarize it other than to say it sets out clear roles, expectations, and responsibilities for the medical professionals involved. The Policy also establishes overarching principles and values and the process should a second assessor determine the patient does not meet the eligibility criteria.

[26] The principles and values are:

1. Accountability:

    1.1. The Act recognizes the need for processes to ensure accountability and oversight. NSHA, through this policy, monitors the implementation of MAiD.

    1.2. NSHA adheres to legislative regulatory requirements in relation to oversight of MAiD processes.

2. Respect for Persons:

    2.1. Respecting persons involves both respecting individuals' rights to make choices and respecting the range of values that are relevant to choices.

        2.1.1. NSHA:

            2.1.1.1. Promotes care that respects personal autonomy and fosters the person's sense of self-determination.

2.1.1.2. Recognizes and respects that decision making may take place in the sphere of Relational Autonomy in that both the content and process of decision making may be shaped and informed in the context of relationships with others, such as family.

2.1.1.3. Ensures that a person's decision making is supported and that the person is not coerced or subject to undue influence.

3. Freedom from Stigma

3.1. Stigma refers to prejudice and discrimination towards certain groups of people or patient populations. Patients who inquire about or request MAiD should be free from experiencing negative attitudes and responses that leave them feeling unwanted or shamed, and negatively affect their relationships with others or the health system.

[27] The process in the event of disagreement is:

3.1.4.3. If the first assessor determines the patient does not meet the eligibility criteria:

3.1.4.3.1. Promptly communicate findings directly to the patient and explain the reasons for the determination.

3.1.4.3.2. Advise the patient that they can request assessment from another physician/NP. If they request assistance, contact the VP Medicine/delegate or the Medical Affairs Advisor to inform of the second request for MAiD and seek guidance, as necessary.

[28] It is clear from the various MAiD assessment reports which form part of the record that at least two qualified medical professionals determined: (1) Mr. X met all the eligibility criteria; and, (2) he was afforded all the required statutory safeguards.

[29] I turn to Mr. X's medical conditions and the assessment process.

Mr. X's medical conditions

[30] Mr. X is 83 years old and suffers from end-stage chronic obstructive pulmonary disease (COPD). He was diagnosed in 2003 (approximately).

[31] In addition to COPD, Mr. X suffers from general frailty, due to his age and overall medical condition. He had a bad fall in 2016, resulting in a bone fracture. He was assessed and found to be at risk of further falls and potential injury. His attending medical professionals advised him to reduce his activity. Unfortunately, Mr. X recently had another fall.

[32] Over the past nine-to-ten months, Mr. X reported that his shortness of breath has become significantly worse, he has experienced increased fatigue, difficulty moving around, an increased sense of instability and increased difficulty concentrating. Mr. X has had a significant reduction in function and has been experiencing considerable physical and mental suffering. Further details of Mr. X's medical condition and related suffering will be expanded upon in my summary of the following assessment process.

Mr. X's MAiD assessment process

[33] It is important to keep in mind Parliament delegated the assessment of MAiD eligibility criteria to medical professionals–not to the courts. This is demonstrated in the *Criminal Code*, which states a medical practitioner or nurse practitioner must be satisfied that the person seeking MAiD meets the eligibility criteria (s. 241.2(3)). This interpretation is well-supported by the Hansard transcripts, which reveal that members of Parliament turned their minds to the question of whether eligibility assessments should be made by physicians and nurse practitioners or by the courts. Parliament decided that the assessments were properly within the purview of medical professionals.

[34] Before summarizing Mr. X's specific MAiD assessments, I will review the legislative framework in some detail because it relates to important aspects of Mrs. Y's stay motion. Mrs. Y argues that when there is a discrepancy between medical opinions in the MAiD assessment process, the individual patient's case should be adjudicated by a court to determine eligibility prior to the provision of MAiD. She also contends the pursuit of a second medical opinion, or what she refers to as "doctor shopping", is not what Parliament intended. However, there are significant problems with these assertions as the following will demonstrate.

[35] In *A.B. v. Canada (Attorney General)*, 2017 ONSC 3759, a patient, AB, was assessed to be eligible for MAiD by one physician, ineligible by the next, and eligible by a third. Therefore, AB met the criteria for MAiD; two physicians concluded she was eligible. However, upon learning that another physician had disagreed with his opinion, the first physician declined to assist AB (despite his continued opinion that AB was eligible and despite knowing that another physician agreed with him) because he feared legal repercussions. AB applied to the court for a declaration that she was eligible for MAiD.

[36] Perell, J. provided a summary of the legislative history of s. 242.2 of the *Criminal Code*. For context, it is helpful to quote at length:

[38] On July 17, 2015, in response to *Carter 2015*, the federal Ministers of Health and Justice appointed an External Panel on Options for a Legislative Response to *Carter v. Canada*.

[39] The External Panel held discussions with the interveners in *Carter 2015* and with relevant medical authorities. It also conducted a consultation open to all Canadians. On December 15, 2015, the External Panel submitted its Final Report. The report identified four categories of how requests for medically assistance in dying might be authorized; namely: (1) prior judicial authorization; (2) prior authorization by administrative tribunal; (3) prior authorization by a panel of physicians; or (4) a decision between individuals and their physicians.

[40] On December 11, 2015, the Senate and House of Commons struck a Special Joint Committee on Physician-Assisted Dying to review the External Panel's Final Report and to consult with Canadians, experts, and stakeholders, and to make recommendations on the framework of a federal response on physician-assisted dying.

[41] The Special Joint Committee determined that requiring a review by either a panel or a judge would create an unnecessary barrier or impediment to individuals requesting medical assistance in dying and recommended that the Government of Canada work with the provinces and territories, and their medical regulatory bodies to ensure that the process to regulate medical assistance in dying does not include a prior review and approval process.

[42] The federal government introduced Bill C-14. The Bill did not include any requirement for prior judicial or other review before a physician or nurse practitioner could provide medical assistance in dying. Instead, the criteria for providing medical assistance in dying, including the criteria that death has become reasonably foreseeable, were to be applied by physicians and nurse practitioners using their professional judgment.

[43] In introducing Bill C-14, in the House of Commons Debates, Hon. Jody Wilson-Raybould (Minister of Justice and Attorney General of Canada, Lib.) stated:

> To be clear, the bill does not require that people be dying from a fatal illness or disease or be terminally ill. Rather, it uses more flexible wording; namely, that "their natural death has become reasonably foreseeable, taking into account all of their medical circumstances". This language was deliberately chosen to ensure that people who are on a trajectory toward death in a wide range of circumstances can choose a peaceful death instead of having to endure a long or painful one.
>
> ...
>
> It makes sense to limit medical assistance in dying to situations where death is reasonably foreseeable, where our physicians, nurse practitioners,

> and others, can draw on existing ethical and practical knowledge, training and expertise in addressing those challenging circumstances.
>
> ...
>
> The question was specifically around reasonable foreseeability. In terms of the legislation, reasonable foreseeability and the elements of eligibility in terms of being able to seek medical assistance in dying, all must be read together. We purposefully provided flexibility to medical practitioners to use their expertise, to take into account all of the circumstances of a person's medical condition and what they deem most appropriate or define as reasonably foreseeable.

[...]

[46] In Parliamentary Committee, Mr. Ted Falk, a Conservative MP, made motions to amend the Bill to allow medical assistance in dying provided: (1) only if a judge of the superior court makes an order stating that the court is satisfied that the person meets all of the *Criminal Code's* criteria; or (2) only with the written consent of the Minister of Health; or (3) only with a prior review of a competent legal authority appointed by the province or the federal Minister of Health and Justice if a province failed to do so. Department of Justice officials, government members, and NDP members of the Committee objected to these proposals, and the amendments were defeated.

[47] Notwithstanding that these proposed amendments were defeated in Committee, when the Bill went [*sic*] the whole House, the Speaker of the House of Commons allowed a vote on the proposal that there by [sic] a prior review by a competent legal authority before there could be medical assistance in dying. The proposed preapproval requirement was again rejected.

[48] In the Senate, the Leader of the Opposition moved an amendment to require a person who is not at end of life to receive medical assistance in dying only with the authorization of a judge of a superior court. That amendment was also defeated.

[49] In responding to a Senate amendment that would have removed Bill C-14's definition of grievous and irremediable harm (including the requirement that death has become reasonably foreseeable), both the Attorney General and the Minister of Health reiterated the government's intention was to have physicians and nurse practitioners determine when patients' deaths had become reasonably foreseeable. The Attorney General stated:

> Reasonable foreseeability is something that has been used quite regularly in the *Criminal Code*. We placed it in the legislation to inject what we feel is a necessary flexibility to provide medical practitioners with the ability, based on their direct relationship with their patient, to determine when that patient would be eligible for medical assistance in dying. In other words,

> they would determine when their patient's death has become reasonably foreseeable.
>
> [50] The House rejected a Senate amendment and restored the requirement that physicians or nurse practitioners providing medical assistance in dying determine whether a patient's death had become reasonably foreseeable.
>
> [51] Bill C-14 was enacted and came into force on June 17, 2016. The Department of Justice published a Glossary to Bill C-14, which explained that:
>
>> Natural death has become "reasonably foreseeable" means that there is a real possibility of the patient's death within a period of time that is not too remote. In other words, the patient would need to experience a change in the state of their medical condition so that it has become fairly clear that they are on an irreversible path toward death, even if there is no clear or specific prognosis. Each person's circumstances are unique, and life expectancy depends on a number of factors, such as the nature of the illness, and the impacts of other medical conditions or health related factors such as age or frailty. Physicians and nurse practitioners have the necessary expertise to evaluate each person's unique circumstances and can effectively judge when a person is on a trajectory toward death. While medical professionals do not need to be able to clearly predict exactly how or when a person will die, the person's death would need to be foreseeable in the not too distant future.

[37] Parliament considered the issue of prior adjudicative approval at every stage of debate and decided against it. As Perell, J. stated of eligibility assessments in *A.B.*, *supra*, "With the enactment of Bill C-14 that job is for the medical profession, and it is not for the court to give confirming comforting orders" (¶59). Perell, J. continues:

> [62] I agree with Ontario and Canada that Bill C-14's legislative history (and its language) demonstrates Parliament's intention that the physicians and nurse practitioners who have been asked to provide medical assistance in dying are exclusively responsible for deciding whether the Code's criteria are satisfied without any pre-authorization from the courts.
>
> [63] I also agree with Ontario and Canada that AB cannot ask the court to preempt the medical practitioners and make the decision for them. The legislation requires the physician or nurse practitioner providing medical assistance in dying to "<u>personally</u>" form an opinion and to ensure that another independent physician or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria before providing a person with medical assistance in dying. The court cannot assume the responsibility of forming somebody else's opinion, and the court obviously does not provide medical assistance in dying or

> at all. The court is a legal practitioner not a medical practitioner. [original emphasis]

[38] The idea of "doctor shopping", as Mrs. Y calls it, was also aired in Parliament. Garrett Genuis, MP for Sherwood Park–Fort Saskatchewan argued that a "system of advance legal review by competent authority would eliminate doctor shopping" (2 May 2016). He argued the "requirement that two doctors sign off merely encourages doctor shopping". He addressed Parliament as follows:

> There are multiple options here, some better than others. The criteria are not worth the paper they are written on if someone with competent legal authority is not making a determination in advance to ensure the legal criteria are met.
>
> The government, though, wants to force doctors into this role. However, doctors do not constitute competent legal authority. Doctors do not make these types of decisions in other parts of their work, given how aberrant the taking of life is from the normal medical process of protecting life, and the proposed legislation's allowance for doctor shopping does not actually mean that the doctor providing the prior care would provide advance review, since the patient, or worse, someone else, could simply go on the Internet to find a doctor with a more liberal interpretation of the criteria.

[39] Parliament understood these "doctor shopping" concerns but chose not to amend the Bill to prohibit it. Parliament also chose not to require unanimity among the opinions of all medical assessors. Instead, it required only two independent medical assessors approve a person for MAiD. As noted in ¶21 above, Parliament included s. 241.2(7) in the *Criminal Code* mandating MAiD "must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial law, rules or standards". The Nova Scotia Health Authority's Interdisciplinary Clinical Policy and Procedure on MAiD clearly sets out the process for medical assessors to follow where there is disagreement, reproduced at ¶27 above. It states that an assessor who decides a patient is ineligible must advise that patient that they can request another assessment from a different assessor.

[40] The issue of advance legal review was thoroughly debated in Parliament. The following exchange, which occurred during Second Reading of the Bill on April 22, 2016, provides a useful example:

> **Mr. Garnett Genuis (Sherwood Park–Fort Saskatchewan, CPC):**
>
> [...]
>
> We have seen significant studies from Belgium and other Benelux countries that show that without an effective system of advance legal review, which need not be

> onerous, and one suggestion has been to use consent and capacity boards which already exist at the provincial level, a simple system of not onerous advance review could be added to this legislation which would ensure that we do not go down the road that many of the studies have shown us going down in the Benelux countries. What is wrong with adding that basic protection?
>
> **Mr. Murray Rankin:**
>
> Mr. Speaker, I appreciate the opportunity to be more specific.
>
> Advance legal review would be an absolute barrier for many people, particularly in remote communities. I have confidence in doctors. Doctors do these things every day. They look after us in life, and I trust them to look after us in the last days of our life as well. To talk about a consent and capacity board which one province has and others do not is not helpful. We need to figure out how we can do this. We are absolutely required to address the needs of the vulnerable, but we cannot provide an untenable barrier to people whose constitutional rights are affected. That would not work, and we would oppose such an amendment.

[41] *A.B. v. Canada (Attorney General), supra*, is not binding; however, these comments respecting the role of the courts in the MAiD scheme are insightful and worthy of note:

> [73] The regime for medical assistance in dying is in early days, and given the extreme gravity of the issues involved and the enormous public interest in how the Canadian regime operates, there is utility in removing doubts about the interpretation and operation of the statute creating the regime. **This exercise, however, is not to do anything more than that, and it certainly is not an exercise that can in advance remove or alter the role of the medical practitioners in this regime, and it is not an exercise that will create barriers by requiring or offering the alternative of judicial approvals of requests for medical assistance in dying**.
>
> [Emphasis added]

[42] *Truchon c. Procureur général du Canada,* 2019 QCCS 3792, a case in which two plaintiffs challenged the constitutionality of the requirement that death be “reasonably foreseeable”, is to a similar effect:

> [259] The assessment of the patient’s capacity is part of common medical practice in this country. It is performed in accordance with generally-accepted criteria in which physicians in Canada are well trained. [...] [N]o other medical procedure, even irreversible, is subject to such a consistent, rigorous and thorough assessment of competence as medical assistance in dying.
>
> […]

> [264] The fact that the law requires two separate medical capacity assessments is a standard that goes far beyond all those required for other types of decisions, even irreversible ones. Every patient is different and must be assessed on the basis of his or her specific characteristics, regardless of the nature of the illness or its stage.
>
> [...]
>
> [273] The Court finds that Canadian physicians are perfectly able to assess the capacity of patients who request medical assistance in dying and that there is currently no other medical procedure that is as strictly regulated in this regard, given that two formal assessments are required and the treatment team must ensure that the patient remains competent throughout the process and until the very end. Because physicians are able to assess an individual's decision-making ability, they can therefore determine whether they are dealing with a vulnerable person or not.

[43] Parliament's choice to delegate eligibility assessments to physicians and nurse practitioners is consistent with *Carter v. Canada (Attorney General)*, 2015 SCC 5 in which the Supreme Court of Canada explained:

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

[44] Turning to the specifics of Mr. X's MAiD assessment, the record contains an affidavit filed by the NSHA wherein the MAiD process steps were explained, and Mr. X's assessment reports were appended as exhibits. In total, he had five formal assessments. In addition, he had two auxiliary assessments related to the MAiD process—one with a geriatric psychiatrist to assess capacity and another from a respirologist to assess whether his death was reasonably foreseeable.

[45] What follows is a summary of the assessment reports:

Schelene Swinemar, Nurse Practitioner

Schelene Swinemar is a Nurse Practitioner and Mr. X's regular primary care provider. In April of 2020, she assessed Mr. X at his request. She determined that Mr. X met all of the eligibility criteria for MAiD.

Lorri Giffin, Nurse Practitioner

Mr. X's second assessment was performed in April 2020 by NP Lorri Giffin. Mrs. Y was present during the assessment. NP Giffin noted Mr. X became angry when challenged on the specifics of his illness and noted extreme emotional lability. Her assessment of Mr. X's physical state was based in part on statements provided by Mrs. Y. NP Giffin reported she did not feel Mr. X was capable of making decisions regarding MAiD due to dementia. In addition, while she determined that Mr. X had a "grievous, progressive and incurable illness", she reported she did not "feel" that his death was "foreseeable."

Drs. Terry Chisholm and Kathleen Singh

Given the discrepancy between the first and second assessments, Dr. Terry Chisholm, geriatric psychiatrist, and her resident, Dr. Kathleen Singh, assessed Mr. X on May 8, 2020.

They opined that while Mr. X likely has mild cognitive impairment, he does not have dementia. They determined that his cognitive status does not impair his ability to consent to MAiD. There was no evidence of a major disorder such as dementia. Moreover, Dr. Chisholm did not feel that Mr. X suffered from a psychiatric illness or delusional thoughts—rather, she opined that his idiosyncratic thoughts about illness were consistent with a lifelong pattern of belief. In short, they concluded Mr. X has the capacity to make decisions related to medical assistance in dying. They further opined that Mr. X has a grievous and irremediable medical condition.

They asked NP Swinemar to arrange an urgent reassessment from Mr. X's respirologist to confirm that a natural death had become reasonably foreseeable, given Mr. X's decline and worsening of symptoms over the few months prior.

Dr. Du Toit, Respirologist

Dr. Du Toit, Respirologist, conducted an auxiliary assessment on May 14, 2020. He had seen Mr. X previously for his lung condition. Dr. Du Toit noted that Dr. Chisholm had found Mr. X to be capable of making decisions and did not make any contrary finding with respect to Mr. X's capacity.

With respect to the reasonable foreseeability of Mr. X's natural death, Dr. Du Toit explained that he had "no idea" what the term reasonably foreseeable means, but did not "see" that Mr. X would die "from his lungs in the next year". He noted additionally, "That however is never sure with the COVID 19 and other respiratory tract infections".

> Finally, he noted that he was willing to reassess lung function and perform additional tests to be able to provide some more accurate information regarding Mr. X's lung condition.
>
> ***Dr. David Martell***
>
> Mr. X was assessed for MAiD by Dr. David Martell on July 11, 2020. Before meeting with Mr. X, Dr. Martell reviewed all of Mr. X's prior MAiD assessments.
>
> Dr. Martell performed an in-depth assessment of Mr. X's lifestyle, history, and beliefs. He noted that differences in religious belief between Mr. X and Mrs. Y created "a lot of conflict in their home."
>
> Dr. Martell reviewed the MAiD criteria and process with Mr. X in detail.
>
> Following his assessment, Dr. Martell concluded Mr. X met all of the eligibility criteria for MAiD, including decision-making capacity and that Mr. X's death is reasonably foreseeable.
>
> Dr. Martell specifically noted that he asked NP Swinemar, Mr. X's primary care provider, the "surprise" question commonly used by MAiD assessors—whether she would be surprised to learn Mr. X had passed away naturally within the next six months. NP Swinemar reported to Dr. Martell that her answer was no, she would not be surprised.
>
> Dr. Martell noted that the respirologist opined that Mr. X's pulmonary condition alone did not create a reasonably foreseeable death. However, Dr. Martell's report focuses on cerebrovascular disease as the foremost condition resulting in Mr. X's grievous and irremediable illness for which death is reasonably foreseeable.
>
> Dr. Martell concluded that cerebrovascular disease is what is underpinning Mr. X's rapid decline and distressing symptoms. He also noted that further investigation would provide more specific information about the cause of Mr. X's condition, but that further testing and investigation was inconsistent with Mr. X's goals of care and clearly-stated wishes.

[46] Based on the agreement between NP Swinemar and Dr. Martell's assessments, Mr. X's MAiD procedure had been planned for July 20, 2020 and NP Swinemar was to perform the procedure. The record indicates that the procedure did not move forward as planned because Mrs. Y expressed her intention to pursue legal action against Ms. Swinemar if she proceeded with the MAiD procedure.

[47] On July 21, 2020, Mr. X was assessed for MAiD by Dr. Ashley Miller. She is a general internist with experience in chronic lung disease, cerebrovascular disease and progressive frailty, and has experience as a medical assistance in dying assessor and provider. The following is a summary of her assessment report:

> Mr. X informed Dr. Miller he did not want his wife present during the assessment "as he felt that she was 'interfering with' his ability to access medical assistance in dying".

Mr. X was able to provide a detailed history of Mrs. Y's involvement with the process. He specifically outlined what he described as "harassment" from members of Mrs. Y's church community, including frequent phone calls from individuals who urge him to reconsider his decision to undergo MAiD.

Dr. Miller confirmed with Mr. X that he had received and reviewed the College of Physicians and Surgeons of Nova Scotia's Professional Standard Regarding Medical Assistance in Dying.

Dr. Miller reported Mr. X was clearly able to recount the history of assessments he had undergone and was able to explain the reason for delay in his ability to access the procedure.

As other assessors noted, Dr. Miller reported Mr. X has an "odd belief" related to the relationship between his lung disease and his past history of stroke; however, she concluded that his thought process was logical and rational and his cognitive function was intact, and his belief was "grounded in layperson logic" and consistent over interactions with several healthcare providers.

Dr. Miller reported witnessing a significant change in Mr. X's behaviour and communication style when she saw him alone relative to when he was with Mrs. Y. She reported that he had a better capacity to express his ideas in an organized fashion without her present.

Dr. Miller determined Mr. X had the capacity to consent to MAiD.

With respect to the reasonable foreseeability of Mr. X's death, Dr. Miller provided a detailed analysis of Mr. X's shortness of breath, its increasing prevalence and its impact on his life and function. She also reported that Mr. X is frail, having lost a significant amount of weight over recent years.

Mr. X explained to Dr. Miller that he was so distressed by the delay in accessing MAiD arising from Mrs. Y's actions he has contemplated suicide as an alternative. Dr. Miller noted that Mr. X was clear that his reasoning was to end his suffering related to his physical symptoms, rather than a desire to end his life.

Dr. Miller was of the opinion that while Mr. X's cerebrovascular disease contributes to his overall status, it was not the major driver of his symptom burden or functional decline.

Dr. Miller concluded Mr. X's death was reasonably foreseeable as a result of progressive frailty driven by end-stage COPD and associated dyspnea. She also asked herself the "surprise question" and reported she would not be surprised if Mr. X died naturally in the coming year if he did not have access to MAiD.

Finally, at the end of the assessment Dr. Miller invited Mrs. Y to join her and Mr. X in the assessment room. Dr. Miller reported that Mrs. Y was angry from the outset of the interaction; she used the word "murder" in describing the reason for Dr. Miller's assessment, and repeatedly stated that NP Swinemar is "trying to put [Mr. X] down."

> Dr. Miller reported that when Mr. X attempted to speak, Mrs. Y immediately responded with negative comments or rebuttals refuting his descriptions of his own experience.
>
> Dr. Miller explained Mr. X's condition and his legal rights to Mrs. Y in detail. Dr. Miller stated that Mrs. Y concluded by saying "we will see" and later "I have options to fight this". When Dr. Miller explained to Mrs. Y that it was her obligation to protect Mr. X's legal right to access care in a manner of his choosing, Mrs. Y responded by saying that she is "protecting his soul".
>
> Finally, Dr. Miller noted Mr. X was very disappointed by the ongoing delay in his ability to access MAiD and expressed concern that Mrs. Y would sue his treating physicians and nurse practitioner after he has died.

[48] On August 1, 2020, Mr. X underwent his fifth and final assessment to date with Dr. Holland. He reviewed Mr. X's medical record, all previous MAiD assessments, two auxiliary assessments, and personally interviewed Mr. X for three hours. Dr. Holland provided a very detailed report explaining his findings. He opined that Mr. X meets all the requirements and is therefore eligible.

[49] Dr. Holland explained that while the case is complicated by several factors, that does not mean that Mr. X's eligibility is questionable or "borderline." The following is a summary of his assessment findings:

> Like Dr. Miller, Dr. Holland noted Mr. X has beliefs about his own medical condition are perhaps not scientifically sound but are grounded in layperson logic and form part of a long-term pattern of belief. Dr. Holland notes: "Human beings will naturally look for explanations-especially so with their health". Dr. Holland sets out a detailed chronology of Mr. X's health concerns in his own words, which demonstrate the patterns Mr. X has identified and provide very helpful context in understanding Mr. X's thought process.
>
> Dr. Holland outlined Mr. X's recent history with falling and loss of function. Dr. Holland also described Mr. X's shortness of breath as marked, and notes that it contributes to his fatigue, which has been a major contributor to his suffering. Dr. Holland explained that while Mr. X still has the capacity for medical decision-making, he cannot engage in the high-level scholarly activity that defined much of his life. Dr. Holland reports that Mr. X has lost the ability to take part in simple pleasures he previously enjoyed in his life.
>
> Dr. Holland points out that the criteria of intolerable suffering is "intolerable to them"; it is a subjective criterion.
>
> Dr. Holland also posed the "surprise" question to himself and concluded that he would not be surprised if Mr. X died in the next month. He provided extensive detail leading to that conclusion. Dr. Holland determined that Mr. X's death is reasonably foreseeable.
>
> With respect to Mr. X's capacity to consent to MAiD, Dr. Holland explains that although NP Giffin found Mr. X was not able to consent due to dementia, she does not provide any further information related to that assessment. Dementia is a spectrum of illness—

> someone with mild dementia, Dr. Holland points out, is likely still capable of making medical decisions.
>
> However, Dr. Holland relies on the conclusion of geriatric psychiatrist Dr. Chisholm, as well as his own assessment of Mr. X, in determining that Mr. X does not have dementia.
>
> Dr. Holland went on to conduct a detailed assessment of Mr. X's appreciation of the consequences of the procedure, his reasoning behind his decision, his clear and consistent expression of his decision, and his mental status, including consideration of potential mental illness including "hypochondriasis with severe anxiety." He determined that Mr. X did not suffer from such a condition, but noted that even if he did, that would not render him ineligible for MAiD.
>
> Dr. Holland concluded that Mr. X is eligible for MAiD. He pointed out that Mr. X had five formal assessments for MAiD, and the four assessments in which he was approved for MAiD were all performed by experienced MAiD assessors. Dr. Holland diagnosed Mr. X with end-stage COPD in the setting of frailty and other co-morbidities, and assessed him eligible for MAiD as of August 1, 2020.

[50] Before turning to Mrs. Y's concerns about the MAiD assessment process, I pause to briefly explain what is meant by a "reasonably foreseeable" death. I do not know of any appellate-level consideration of the meaning of "reasonably foreseeable" in the context of MAiD. However, I find the comments of Perell, J. in *A.B. v. Canada*, *supra* helpful.[1] Perell, J. interpreted the meaning of "reasonably foreseeable" as follows:

> [80] [...] Physicians, of course, have considerable experience in making a prognosis, but the legislation makes it clear that in formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime.
>
> [81] In referring to a "natural death" the language denotes that the death is one arising from causes associated with natural causes; i.e., the language reveals that the foreseeability of the death must be connected to natural causes, which is to say about causes associated with the functioning or malfunctioning of the human body. These are matters at the core if not the whole corpus of medical knowledge and better known to doctors than to judges. The language reveals that the natural death need not be connected to a particular terminal disease or condition and rather is connected to all of a particular person's medical circumstances.
>
> [...]

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[1] I also note that the definition as set out in that case is cited in College of Physicians & Surgeons of Nova Scotia's "Professional Standard Regarding Medical Assistance in Dying" at footnote 9, which guides the provision of MAiD by physicians in our province (Exhibit "B" to the Affidavit of Cheryl Tschupruk sworn on August 6, 2020, filed by the respondent Nova Scotia Health Authority).

> [83] As the Attorney General said [when introducing the Bill], the language of s. 241.2(2)(d) encompasses, on a case-by-case basis, a person who is on a trajectory toward death because he or she: (a) has a serious and incurable illness, disease or disability; (b) is in an advanced state of irreversible decline in capability; and (c) is enduring physical or psychological suffering that is intolerable and that cannot be relieved under conditions that they consider acceptable.

Mrs. Y's allegations of a defective assessment process and assertions of how the judge erred

[51] To begin I will summarize the proceedings below.

[52] Mrs. Y filed her application in the court below on July 31, 2020. She understood her husband's MAiD procedure was rescheduled for August 4, 2020. She applied for a permanent and interlocutory injunction to block his access to MAiD and a declaration he did not meet MAiD requirements. She also sought an order compelling production of a litany of medical records pertaining to her husband and directions on various procedural matters.

[53] The Honourable Justice Jamie S. Campbell of the Nova Scotia Supreme Court dealt with the matter on an urgent basis on the same day the application was filed. He expressed concern regarding the status of the materials filed and referred to the matter as "a bit of a procedural mess, quite frankly".

[54] Campbell, J. noted there was no motion before him for an *ex parte* (emergency) interim injunction, although that is what Mrs. Y was seeking. The only two named respondents, NSHA and Ms. Swinemar, were not provided with notice. More shockingly, Mr. X was not provided notice, nor even named as a party. Mr. Scher, (counsel for Mrs. Y), swore an affidavit in support of Mrs. Y's application stating: "I am not aware of other persons beyond the parties [Mrs. Y, NSHA and Ms. Swinemar] with an interest in this matter."

[55] It is clear from the record Campbell, J. did not see it that way. He directed Mr. X be provided proper notice going forward, as well as the other parties. There is no question Mr. X has a significant vested interest in the application. He and his constitutionally-protected rights are front and centre. That should have been blatantly obvious to Mrs. Y and her counsel.

[56] On July 31, 2020, apart from Mrs. Y's counsel (Mr. Scher and Ms. Naugler), the only other participant in the proceeding was NSHA in-house counsel, Ms. Persaud. Her participation was arranged at the judge's direction, and she had only

15 minutes' notice of the matter and no opportunity to obtain instructions from her client.

[57] Campbell, J. granted an *ex parte* interim injunction, mindful of the impact of his order in these less than ideal circumstances. He insisted the matter be brought back in short order, and it was adjourned to the following Friday (August 7).

[58] Rosinski, J. presided over the matter on August 7, 2020. At this point, Mr. X had finally received notice, and had retained counsel to defend the relief sought by his spouse. The judge discussed various procedural issues with counsel, and it was agreed that the interlocutory injunction hearing would proceed based on the materials filed at the time—the affidavit filed by the NSHA, as well as the affidavits filed by and on behalf of Mrs. Y.

[59] NSHA counsel took no position with regard to the injunction application. The NSHA filed materials solely "to provide the court with the background structure of the MAiD procedure as it relates to the policy of the Health Authority and also the evidentiary record of what has occurred with regard to [Mr. X]."

[60] There was express agreement waiving cross-examination of the affiants at this interlocutory stage of the proceeding (without prejudice to the right of full cross-examination at the merit hearing), plus acknowledgement that Mrs. Y's request for production orders and any resulting requests for cross-examination would be dealt with as part of the merit hearing. Yet, as I will address later, Mrs. Y now alleges as a ground of appeal that she was denied the right to cross-examination.

[61] After hearing oral submissions from counsel, Rosinski, J. reserved his decision and maintained the interim injunction ordered by Campbell, J. until he rendered his decision on August 14, 2020.

[62] Rosinski, J. found there were no grounds to continue an interim interlocutory injunction. He ordered the *ex parte* interim injunction to be of no force and effect.

[63] A summary of his reasons is captured in these paragraphs:

> [11] In order to obtain an interlocutory injunction, Y must satisfy the court of each of the following, namely that:
>
> > 1. there exists a serious question/issue(s) to be considered: is the approval of the MAID-process regarding X lawful?

> [I am so satisfied]
>
> 2. Y, who seeks the injunction, will suffer irreparable harm (refers to the nature of the harm suffered rather than its magnitude – which either cannot be quantified in monetary terms or which cannot be cured, if the injunction is not granted);
>
> [In her written brief at para. 47, Y puts her position as: "if the injunction is denied, [Y] will lose her husband of 48 years unduly and this application will become moot as [he] will be dead. This is the ultimate irreparable harm and mitigates strongly in favour of granting this injunction." While arguably Y could sue for wrongful death and, if successful, receive damages for her loss of X-given that X is otherwise presently constitutionally entitled to exercise his choice and schedule his MAID almost immediately, if this court concludes that the injunction should not be continued, then the dispute at issue here would become qualitatively moot, and so I am satisfied Y would suffer irreparable harm.]
>
> 3. that Y would suffer the greater harm, if the injunction is not granted, as compared with the harm X will suffer if the injunction is granted (the so-called "balance of convenience").
>
> [I am NOT so satisfied – I conclude that there is significant compelling evidence that X has reasonably been determined to have "a grievous and irremediable medical condition" as defined in section 241.2 (2) of the Criminal Code of Canada, and that the other eligibility conditions have been met. X is constitutionally entitled to take this course of action, and given that he has some level of ongoing dementia, which could, by itself or in addition to other phenomena such as cerebrovascular disease, render him incapable, and therefore no longer qualified to consent to his presently chosen MAID process, there is a real risk here that he will be deprived of his present choice. He has also been found by MAID assessors to be presently enduring "a grievous and irremediable medical condition and his natural death has become reasonably foreseeable, taking into account all of his medical circumstances". Further delay entails further suffering for X. I conclude he would suffer irreparable harm if the injunction is granted. On balance, the harm he would suffer is significantly greater than what his wife would suffer.]

[64] Mrs. Y contends the eligibility criteria of Mr. X's MAiD assessments missed the mark and the medical professionals did not scrutinize all the considerations that they should have. She gives examples such as Mr. X being vulnerable to money scams, being a hypochondriac and/or suffering from depression or delusional or disordered thinking. She questions his capacity to consent.

[65] Mrs. Y has attempted to identify what she believes to be material inconsistencies within the MAiD assessments; however, the medical professionals appear to confront at least her main concerns and explain why they do not disqualify Mr. X from exercising his right to choose MAiD. In my view, material inconsistencies do not appear to be borne out on any fair reading of the record.

Analysis

Has Mrs. Y raised an arguable issue?

[66] An arguable issue must be a realistic ground of appeal available to Mrs. Y. One which, if established, appears of adequate substance to persuade a panel of this Court to allow the appeal. An arguable issue must be reasonably specific as to the error it alleges on the part of the judge; a general allegation of error may not suffice. *Nova Scotia (Attorney General) v. Morrison Estate,* 2009 NSCA 116 explains:

> [45] [...] Once the grounds of appeal are shown to contain an arguable issue, the working assumption of the Chambers judge is that the outcome of the appeal is in doubt: either side could be successful.

[67] Although no Appeal Book has been filed in this matter, I have the benefit of essentially a complete record—all the documents filed in the court below, the parties' written submissions, and the transcripts of the proceedings. In addition, I received extensive written and oral submissions on the stay motion.

[68] The interests at stake call for a careful analysis of whether Mrs. Y has raised an arguable issue within the confines of the stay test. Given the completeness of the record, I am well-positioned to examine whether an arguable issue has been raised for the purpose of a stay motion. That acknowledged, ultimately it is for the panel to decide the issue of leave to appeal this interlocutory order and, if granted, whether the grounds have merit.

[69] The Notice of Appeal (which was subsequently amended) sets out 25 purported grounds of appeal spanning some five pages. As an aside, Mrs. Y filed a Notice of Appeal (General). She was advised by a Deputy Registrar of this Court that leave is required as this is an appeal of an interlocutory order. The form of appeal should be a Notice of Application for Leave to Appeal and Notice of Appeal (Interlocutory). I advised the parties to be prepared to address the issue of leave during the hearing, in the event the panel calls for leave submissions.

[70] Returning to the Notice of Appeal, most of the 25 grounds read as arguments/submissions and do not articulate any specific alleged error. The more specific complaints are as follows:

> (1) The court erred in applying the criteria to determine a request for an interim injunction and particularly erred by finding that the balance of convenience did not favour granting the injunction in the circumstances of this life and death determination.
>
> (2) The court's decision disregards the only direct affidavit and non-hearsay evidence including medical evidence in support of the request for an injunction.
>
> (3) The court relies on hearsay medical opinion evidence as a business document as the foundation for its determination which is impermissible, particularly in the circumstances.
>
> [...]
>
> (7) The Court erred by failing to permit the cross-examination of the medical assessors who authored the medical reports relied on by the Court.
>
> (8) The Court erred by relying on possible delay in the hearing process without providing parties the opportunity to make submissions on the question of possible delay.

[71] The remaining "grounds" offer general complaints about the MAiD assessment process and allege Mr. X does not meet the eligibility criteria.

[72] Mr. X takes the position there is no arguable issue raised on appeal. He met the MAiD criteria prior to the last two assessments of Drs. Miller and Holland; however, their recent and very thorough assessments unequivocally confirm he meets the criteria set out in s. 241.2 of the *Criminal Code*. Mr. X argues the stay motion should be dismissed on that basis.

[73] Mr. X points out it is the responsibility of the medical professionals to conduct his assessments—not the courts as Mrs. Y invites. That said, he notes Rosinski, J. carefully reviewed the MAiD assessments and considered the arguments and evidence advanced by Mrs. Y to the effect he either lacked capacity and/or was not suffering from a grievous and irremediable medical condition and/or his death was reasonably foreseeable. On the evidence before him, the judge found no basis to continue the *ex parte* interim injunction that had been granted earlier and declined to impose any further injunctive relief.

[74] As an aside, I note that Rosinski, J. flagged the issue of standing in his third footnote:

> While it was not raised as a preliminary issue herein, and I conclude that in these circumstances Y likely has standing to request the sought after relief, the question of "who has standing?" may well be a significant consideration in other circumstances.

[75] Apart from any standing considerations being raised, Mr. X points out that the decision to pursue MAiD is his constitutionally-protected right. It is his decision to make—not his spouse's.

[76] The remaining respondents (NSHA and Ms. Swinemar) did not take a position on the stay other than to provide information to the Court that formed part of the record below and to make limited submissions on the hearsay complaint. As to Mrs. Y's claims of reviewable error, the respondents astutely point out that although Mrs. Y complains about the judge's admission and use of the MAiD assessment reports, Mrs. Y herself relied heavily upon them in the court below and in support of her stay motion.

[77] Returning to the specific complaints of error set out in ¶70 above, they disclose no arguable issue. I deal with them in turn.

[78] First, Mrs. Y complains that the judge erred in his application of the interim injunction principles and he should have tipped the balance of convenience in her favour and granted the interim injunction. Apart from declaring this general allegation of error, I am not satisfied Mrs. Y has pointed to anything of adequate substance to support these complaints.

[79] The judge correctly identified the legal principles he had to apply. His reasons demonstrate both an application of these principles and a clear explanation of why he exercised his discretion to decline to grant the requested interim injunction. No error is apparent to me. Nor do I see any patent injustice arising from the exercise of his discretion. Mrs. Y would have preferred him to exercise his discretion differently, but not doing so does not automatically equate to error.

[80] Next, I will deal with the various complaints respecting the judge's use of evidence. Mrs. Y alleges the judge ignored and misused evidence. However, it is evident from the record and the judge's thorough written decision he did not ignore any evidence, rather the evidence Mrs. Y urged him to accept was not afforded the weight she had hoped for. A key example is how the judge afforded little weight to

the affidavit a doctor in Florida (Christian G. Bachman) filed in support of Mrs. Y's pursuit of an injunction. The judge explained:

> [23] X's counsel also objects to the affidavit of Dr. CB.
>
> [24] Insofar as he purports to give expert opinion, his curriculum vitae notes that he graduated from Dalhousie Medical School in Halifax, Nova Scotia and received his MD in June 1993 and that he was certified in Family Medicine as of June 8, 1995 in Canada, but it does not show him having any license to practice medicine in Canada since that time. He also questioned how much opportunity Dr. CB has had to interact with X in person, particularly recently, other than a July 29, 2020 telephone conversation.
>
> [25] Moreover, he is not qualified to assert that "[X] has suffered from a lifelong psychiatric disorder... He is now suffering from a powerful delusional thought process as it applies to an age-appropriate disease burden... None of these processes are likely to cause death in the reasonably foreseeable future. [X] is suffering. His desire for urgent euthanasia stems not from the above medical conditions but from a treatable psychiatric condition – hypochondriasis with severe anxiety."
>
> [26] I accept these arguments – Dr. B is not a licensed psychiatrist, even in the United States. He is not a licensed doctor in Canada. He has very limited recent contact with X. It is entirely unclear when he last saw X in person. I give no weight to the purported expert opinion evidence contained in his affidavit. I will consider his factual evidence therein, but find it of minimal weight, particularly when contrasted with the very recent medical opinions and observations of X made by doctors licensed to practice medicine in Nova Scotia. Moreover, he has not had access to all the records regarding X that they have.

[81] As to the complaints of the misuse of hearsay, I again refer to the judge's reasoning:

> [27] NSHA has filed an extensive affidavit from the Interim Director for MAiD in Nova Scotia. Therein she chronicles the MAiD process which X has engaged since April 15, 2020, and attaches the NSHA's MAiD Policy, effective August 7, 2019.[10]
>
> [28] Y's counsel objects to this affidavit on the basis that it contains only hearsay factual documentation in relation to X's circumstances as he progressed through the MAiD process. On the other hand, Y's counsel was quite prepared to rely on evidence therein that buttressed his client's case – he pointed to the evidence of NP Giffin and that of Dr. du Toit.
>
> [29] I conclude that the NSHA affidavit in its entirety is admissible either as "business records" pursuant to section 23 of the Evidence Act, c. 154 RSNS 1989, as amended, and pursuant to the common law "business records" exception,

> articulated by the Supreme Court of Canada in Ares v Venner, or as an exception to the hearsay rule (as being necessary and reliable), captured in the recent canvas of the law articulated by Justice Beveridge in R v Keats, 2016 NSCA 94 at paras. 108-131.

[82] There was no evidence the MAiD assessments were performed by unqualified medical professionals nor offside the statutory requirements. Respectfully, the use of evidence complaints fall short of adequate substance.

[83] I turn to Mrs. Y's alleged ground that the judge failed to permit cross-examination. This ground lacks merit. The assertion is troubling as I see no support for it in the record. Rather the contrary. The record reveals the parties expressly agreed to argue the interim injunction based on the materials filed. Mr. X waived cross-examination of Mrs. Y and deponents who filed supporting affidavits. Counsel for Mrs. Y did not elect to cross-examine the Interim Director of MAiD, who filed an affidavit setting forth the MAiD process.

[84] Mrs. Y claims she was denied the opportunity to cross-examine the medical professionals who authored the MAiD assessments upon which the judge relied. However, the record is clear Mrs. Y did not ask for that to occur during the hearing of the interim injunction.

[85] Next, Mrs. Y's delay complaint. Mrs. Y asserts the judge erred by relying on possible delay in the hearing process without providing parties the opportunity to make submissions on this consideration. In my view, that is an overstatement of what transpired below.

[86] The parties discussed setting the mater down during the hearing of the interim injunction. There were varying views of the length of time needed; however, it was clear that there were many steps outstanding such as the motion for production, the motion to secure the cross-examination of non-parties, plus the merit hearing itself, estimated to occupy some number of days. All of this occurring against the backdrop of a global pandemic which has disrupted court processes. Rosinski, J. said:

> [10] This proceeding has not yet been set down for a full hearing on the merits. However, based on the present positions of the parties, and the continuing implications of Covid 19's disruption to court operations which have created great backlogs of matters (particularly time sensitive criminal proceedings) requiring hearings in the near future, I agree with counsel for NSHA that for a full hearing, (an optimistic estimate is) the earliest dates for hearing will be in the late fall of

> 2020, and I conclude it could be as late as early Spring of 2021 before the hearing is concluded. Certainly, all of the procedural steps proposed by Y's counsel will extend when the earliest date that the hearing can take place. [footnote omitted]

[87] It is clear the judge was concerned about the impact a delay might have on Mr. X. He was cognizant of Mr. X's ongoing suffering and his right to choose MAiD—and the risk of him missing that right should he lose capacity over time. The issue of delay was—or ought to have been—on everyone's mind. There is no indication Mrs. Y was limited to making any submissions on the impact of delay.

[88] Also, while the issue of delay is not determinative, it nevertheless is a relevant consideration by the judge (*Nova Scotia (Community Services) v. B.F.*, 2003 NSCA 125). This is particularly true in the context of this case, coupled with the reality of court operations in the COVID-19 era.

[89] As to Mrs. Y's general complaints, dispersed through the some remaining twenty alleged grounds, about the MAiD assessment process and her allegation Mr. X does not meet the eligibility criteria—she has failed to satisfy me they meet the threshold of an issue that, if established, could persuade a panel of this Court to allow the appeal.

[90] I note that in the stay decision of *Carter v. Canada (Attorney General)*, *supra*, Prowse, J.A. accepted the appeal raised arguable issues related to the trial judge's declaration that the then-*Criminal Code* prohibition on medically assisted death was invalid, as well as the legality of the exemption. However, that case has distinguishing features. It was decided prior to the Supreme Court of Canada ruling that medical assistance in dying is a constitutionally protected right, and prior to Parliament's subsequent passage of the MAiD scheme into Canadian law.

[91] Mrs. Y has made clear that she welcomes, if not views as mandatory, an oversight role for courts in the assessment of MAiD eligibility, particularly in the face of conflicting medical assessments. I am not suggesting there is no role for courts; rather, not the usurping assessment function or confirming comfort orders which, in effect, is what Mrs. Y seeks. Thus, none of her complaints in this regard give rise to an arguable issue.

[92] Having determined there is no arguable issue on appeal, I could end my analysis here. Mrs. Y's stay motion fails the first step of the *Fulton* test (no arguable issue on appeal). However, in these circumstances, it is important to explain why I would also decline a stay under the remaining considerations.

If a stay is not granted and the appeal is successful, will Mrs. Y suffer irreparable harm?

[93] The interests of Mrs. Y are considered at this “irreparable harm” stage of the stay analysis (*Municipal Association of Police Personnel v. McNeil*, 2009 NSCA 45 at ¶17). Mrs. Y argues she will suffer irreparable harm as a result of the loss of her husband. I do not dispute this is an unquantifiable and permanent loss. However, Mr. X is a very frail and elderly man. He has end-stage COPD as well as other co-morbidities. Several experienced and qualified MAiD professionals, including, most recently, Drs. Miller and Holland have assessed, according to their statutory responsibility, whether Mr. X meets all the eligibility criteria for MAiD. They have concluded he does—including finding that his death is reasonably foreseeable.

[94] With respect, and with no intent to be insensitive, given Mr. X’s medical condition, he is on a trajectory of death. At some point he will die, regardless of the outcome of this appeal and the application in the court below (which, to my knowledge has not been yet set down for a determination on its merits). In these circumstances, it raises the question whether the loss of her husband alone can constitute irreparable harm to Mrs. Y.

[95] I return to Mrs. Y’s concern that to refuse a stay pending appeal might, in effect, render her appeal moot. That, in part, depends on whether Mr. X elects to end his life in advance of the date this Court hears her appeal and renders its decision.

[96] In some cases, mootness may indeed cause irreparable harm to an appellant. However, as noted earlier, a determination of irreparable harm does not automatically follow where the refusal to order a stay renders an appeal moot or nugatory. Potential mootness of an appeal is but one factor to be considered at the irreparable harm stage of the *Fulton* analysis (*Canglobe Financial Group v. Johnson*, 2010 NSCA 46 at ¶13; *Colpitts v. Nova Scotia Barristers’ Society*, 2019 NSCA 45).

[97] For example, I again reference *Carter v. Canada (Attorney General)* in which Prowse, J.A. considered the government’s motion for a stay, which would have had the effect of precluding Ms. Taylor from exercising her right to die via a medically assisted death.

[98] While the legal issues at the heart of the matter before Prowse, J.A. are different, there are similarities. Prowse, J.A. concluded irreparable harm to the appellant was not made out, even if Ms. Taylor were to exercise her right to die prior to the hearing of the appeal because the appellant was still able to pursue its broader challenges to the lower court's declaration that the *Criminal Code* prohibition of medically-assisted death was invalid, as well as the exemption scheme. I reference her reasoning:

> [31] While the irreparable harm to be considered at this stage of the test is irreparable harm to the appellant only, I note that counsel for Ms. Taylor submits it is Ms. Taylor who is more likely to suffer irreparable harm if the stay is granted, since she will be precluded from exercising her rights under the exemption and she will lose the peace of mind and solace which the exemption provides to her in the interim. Under the authorities, however, this point is more appropriately dealt with in discussing the balance of convenience.
>
> [...]
>
> [34] There is no doubt that Parliament is charged with the duty of promoting and protecting the public interest and that the assisted suicide provisions of the *Code* were designed to protect the public. For that reason, if the question were whether AG Canada would suffer irreparable harm if the declarations of invalidity were not stayed, I would be more inclined to answer "yes", at least if the declaration took effect immediately and there were no safeguards in place. The reasoning in paras. 71 and 72 of *RJR* would appear to apply. **In this case, however, I am unable to see that AG Canada is entitled to a presumption of irreparable harm if its application for a stay of the exemption only is dismissed**.
>
> [...]
>
> [36] But can it reasonably be said that permitting the exemption to stand pending the resolution of this appeal would result in irreparable harm to AG Canada as representative of the public interest? In my view, it cannot. **I do not consider that reasonable members of the public, fully apprised of the circumstances of this case, and having read the reasons of the trial judge, would conclude that the public interest would suffer irreparable harm if the exemption were permitted to continue, even knowing that Ms. Taylor may find it necessary to exercise her rights under the exemption before the appeal is concluded. I do not consider that those members of the public would find it necessary that Ms. Taylor, who has fought so courageously and in such difficult circumstances to assert this right, should be required to sacrifice her right to a concept of the "greater good" if it should come to that.** Nor do I consider it a likely consequence of allowing the exemption to stand pending the resolution of this appeal that the value of life would seen to be diminished either

> by the state, which has pursued this relief with a view to the public good, or by the judiciary, which is required to tackle these difficult issues.
>
> [37] I accept that the exercise by Ms. Taylor of her rights under the exemption would give rise to some harm to the public interest, which is concerned with the value of all life, but I am not persuaded that the level of harm reaches the level of irreparable harm alleged by AG Canada. In coming to that conclusion, I place some weight on the distinction between the stay of the declarations of invalidity, the refusal of which is more likely to result in irreparable harm for the reasons set out at paras. 71-72 of RJR, and the stay of the exemption.
>
> [38] If I am wrong, however, and irreparable harm to AG Canada would flow from the very fact of the exemption in these circumstances, that would not end the analysis. I would then have to go on to consider the balance of convenience. This is so because it is only irreparable harm to the appellant which is considered at the second stage of the test for a stay, whereas the balance of convenience requires the Court to consider the degree of harm to Ms. Taylor in the event the stay is granted.
>
> [Bold emphasis added]

[99] Also, I repeat that Mrs. Y's appeal purports to raise issues of broader import to the overall MAiD regime.

[100] In conclusion, and with respect, in these circumstances there may be some question whether Mrs. Y will suffer irreparable harm. However, even accepting she would, there is no doubt in my mind that, on balance, Mr. X would suffer greater harm if a stay were granted. I will briefly explain why.

Will Mrs. Y suffer greater harm if the stay is not granted than her husband Mr. X will suffer if the stay is granted?

[101] The third branch of the stay analysis is the balance of convenience. The question is whether Mrs. Y would suffer greater harm from the denial of a stay than Mr. X would suffer from the granting of a stay. To grant a stay in this case would be to further—at least temporarily—deny Mr. X's ability to access MAiD.

[102] For the reasons set out by the Supreme Court of Canada in *Carter*, I am of the view that the balance of convenience favours Mr. X. To find otherwise would be to remove his right of medical self-determination—a right that is grounded in s. 7 of the *Charter* (*Carter v. Canada*, 2015 SCC 5 at ¶67).

[103] In *A.B v. C.D. and E.F.*, 2019 BCSC 254, the British Columbia Supreme Court considered an application for injunctive relief from a father who sought to

enjoin gender transition treatments for his teenage transgender son. The BCSC held that delaying life-altering medical treatment for the patient was "not a neutral option" because the child's suffering was ongoing. In that case, the child's suffering was such that there was evidence that he was at risk of suicide. Similarly in this case, Dr. Miller reports that Mr. X is so troubled by his delay in accessing MAiD that he has contemplated dying by suicide.

[104] In the above BCSC case, the balance of convenience clearly favoured A.B. In light of the established law regarding the right of a mature minor to consent, the assessments of multiple physicians, and the evidence that the proposed treatment was in the son's best interests, the BCSC determined that there was no serious issue to be tried.

[105] Returning to *Carter*, the Supreme Court of Canada described a patient's medical autonomy rights in detail:

> [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 (CanLII), [2009] 2 S.C.R. 181, a majority […] 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), 2000 CanLII 5762 (ON CA), 49 O.R. (3d) 481 (C.A.)). As noted in *Fleming v. Reid* (1991), 1991 CanLII 2728 (ON CA), 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 the 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 […]
>
> [Emphasis added]

[106] The balance of convenience clearly lies with Mr. X. To hold otherwise would not be in keeping with *Carter* and Mr. X's right to medical self-determination, which is grounded in s. 7 of the *Charter*. The Supreme Court of Canada further explained:

> [68] In *Blencoe*, a majority of the Court held that the s. 7 liberty interest is engaged "where state compulsions or prohibitions affect important and fundamental life choices" (para. 49). In *A.C.*, where the claimant sought to refuse a potentially lifesaving blood transfusion on religious grounds, Binnie J. noted

> that we may "instinctively recoil" from the decision to seek death because of our belief in the sanctity of human life (para. 219). But his response is equally relevant here: it is clear that anyone who seeks physician-assisted dying because they are suffering intolerably as a result of a grievous and irremediable medical condition "does so out of a deeply personal and fundamental belief about how they wish to live, or cease to live" (*ibid.*). The trial judge, too, described this as a decision that, for some people, is "very important to their sense of dignity and personal integrity, that is consistent with their lifelong values and that reflects their life's experience" (para. 1326). **This is a decision that is rooted in their control over their bodily integrity; it represents their deeply personal response to serious pain and suffering. By denying them the opportunity to make that choice, the prohibition impinges on their liberty and security of the person. As noted above, s. 7 recognizes the value of life, but it also honours the role that autonomy and dignity play at the end of that life.** We therefore conclude that ss. 241(b) and 14 of the Criminal Code, insofar as they prohibit physician-assisted dying for competent adults who seek such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering, infringe the rights to liberty and security of the person.
>
> [Emphasis added]

[107] Having explained why Mrs. Y has not satisfied me on a balance of probabilities that she has satisfied the three parts of the primary *Fulton* test, I will now address the final consideration of whether a stay should nevertheless be granted due to exceptional circumstances.

Are there exceptional circumstances that otherwise warrant the granting of a stay?

[108] I see no exceptional circumstances warranting a stay.

[109] The Supreme Court of Canada decided that medical assistance in dying is a constitutionally-protected right. Parliament debated and passed the MAiD scheme into Canadian law. It seems Mrs. Y wants to relitigate issues that have been considered and decided by both the SCC and Parliament.

[110] While I am not aware of any other case in which a third party sought an injunction to prevent an individual from dying via medical assistance, such applications are not new in the context of medical decision-making generally.

[111] For example, in *Tremblay v. Daigle*, [1989] 2 SCR 530, the Supreme Court of Canada overturned a lower court decision granting a woman's former partner an injunction to stop her from obtaining an abortion. The Supreme Court held that a

potential father had no right to veto the personal health care decisions of a woman in respect of the foetus she is carrying.

[112] *Tremblay* and *A.B. v. C.D. and E.F.* are representative of a long line of jurisprudence emphasizing the right of an individual to make his or her own medical decisions. As described in *Carter*, Canadian "law has long protected patient autonomy in medical decision-making" (¶67). Competent individuals have the right to make decisions regarding their own bodily integrity and to direct the course of their own medical care, even where serious risks or consequences, including death, flow from that decision (¶67).

Conclusion

[113] Motion to stay dismissed.

Van den Eynden, J.A.