No. S112688
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

LEE CARTER, HOLLIS JOHNSON, DR. WILLIAM SHOICHET, THE BRITISH COLUMBIA CIVIL LIBERTIES ASSOCIATION and GLORIA TAYLOR

PLAINTIFFS

AND:

ATTORNEY GENERAL OF CANADA

DEFENDANT

AND:

ATTORNEY GENERAL OF BRITISH COLUMBIA

Party pursuant to the *Constitutional Question Act*, R.S.B.C. 1996, c.68

AND:

FAREWELL FOUNDATION FOR THE RIGHT TO DIE (Represented by Russel Ogden, Erling Christensen, Laurence Cattoire, John Lowman and Paul Zollman), THE CHRISTIAN LEGAL FELLOWSHIP, CANADIAN UNITARIAN COUNCIL, EUTHANASIA PREVENTION COALITION and EUTHANASIA PREVENTION COALITION – BRITISH COLUMBIA and AD HOC COALITION OF PEOPLE WITH DISABILITIES WHO ARE SUPPORTIVE OF PHYSICIAN-ASSISTED DYING (As Represented by Jeanette Andersen, Margaret Birrell, Donald Danbrook, Michelle Des Lauriers, Zofia (Zosia) Anna Ettenberg, Craig Langston, and Paul A. Spiers)

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1. The Canadian Unitarian Council ("CUC") offers these submissions in support of the plaintiffs' challenge to the impugned provisions. It is grateful for the opportunity to do so.

2. While the CUC supports the plaintiffs' arguments with respect to the division of powers and section 15 of the *Charter*, it will limit its submissions to section 7 of the *Charter*. The CUC focuses on section 7 because that section best exposes the impugned provisions' fundamental injustice: they prevent seriously and terminally ill persons from making choices of profound importance to them for reasons that are irrational and grossly heavy-handed.

An Overview of the Section 7 Challenge

3. Section 7 protects the rights to life, liberty and security of the person except in accordance with principles of fundamental justice. Three such principles are commonly cited: that laws not be arbitrary, nor overbroad, nor grossly disproportionate. The CUC respectfully submits that the impugned provisions limit all three rights to life, liberty and security of the person, and that they do so in a manner that violates all three principles of fundamental justice.

4. The right to life is limited by the impugned provisions because they restrict the timing and manner of a person's death. A life is the arc from birth through death. As Chief Justice McEachern stated in his dissent in *Rodriguez* in the Court of Appeal, "death and the way we die is a part of life itself." Of course that is so. The circumstances of a person's death are a critical part of the narrative of his life, and a restriction on the manner and timing of a person's death is a profoundly intrusive limit on that person's life.

5. It is also clear – indeed, it is beyond all serious debate – that the impugned provisions limit the rights to liberty and security of the person.

6. The liberty interest is not engaged in this case only by the threat of imprisonment. Rather, the liberty guarantee also protects an individual's autonomy "in making decisions of fundamental personal importance" without state restrictions.[1] Liberty includes "the right to an irreducible sphere of personal autonomy wherein individuals may make inherently private choices free from state interference" where those choices are "fundamentally or inherently personal such that, by their very nature, they implicate basic choices going to the core of what it means to enjoy individual dignity and independence".[2] It cannot be doubted that the choice to die – including when and how – is an inherently personal decision with the most profound implications for the dignity and independence of individuals. There probably can be no greater intrusion on personal liberty than a restriction on one's choice to die.

7. Such a restriction also limits individuals' security interests. All judges who addressed the point in *Rodriguez* found that the impugned provisions limit the right to security of the person.[3] Sopinka J., writing for the majority and dismissing the constitutional challenge to the impugned provisions, looked to the Court's judgments in *Morgentaler*[4] and concluded: "[t]here is no question, then, that personal autonomy, at least with respect to the right to make choices concerning one's own body, control over one's physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these."[5] On that basis, he found that section 241, which interfered with the appellant's wish to end her life with assistance, "deprives the appellant of autonomy

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[1] *R. v. Malmo-Levine*, 2003 SCC 74, [2003] 3 S.C.R. 571 at para 85.

[2] *Ibid*.

[3] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, per Sopinka J. for the majority at paras 136-138; McLachlin J. at 197; and Cory J., impliedly, at para 228.

[4] *R. v. Morgentaler*, [1988] 1 S.C.R. 30.

[5] *Rodriguez* at para 136.

over her person and causes her physical pain and psychological stress in a manner which impinges on the security of her person."[6]

8. That same conclusion must be reached in this case. The impugned provisions deny seriously and incurably ill persons the right to choose the timing and manner of their deaths. It condemns them to living for weeks, months or years in a state of such poor quality that they would prefer death. For some, like Gloria Taylor, the impugned provisions impose enormous anxiety as they wait for, and then experience, the degradation of their bodies. The impugned provisions plainly and obviously limit these persons' security interests.

9. The real debate in this case is whether the impugned provisions' restriction of the section 7 interests is in accordance with the principles of fundamental justice. The CUC submits they are not, in that they are arbitrary, overbroad and grossly disproportionate.

10. The submissions that follow are organized around three central points. First, the broader legal framework that governs medical decision-making and the values inherent in the *Charter* dictate that a competent, informed and uncoerced choice of physician-assisted dying deserves to be respected. Put another way, a decision to end one's life with the assistance of a physician is not incompatible with the fundamental norms of our law. Second, the various slippery slope arguments erected by the defenders of the impugned provisions are entirely addressed by a rigorous application of the ordinary legal standard for all medical decision-making: the standard of informed consent. That standard is deemed sufficient for a decision to withdraw life-sustaining medical treatment with the intended consequence of the patient's death; there is no compelling reason whatsoever not to apply the same standard in the context of physician-assisted dying, and a total ban is therefore overbroad. Third, the "active/passive" distinction that is sometimes made between physician-assisted dying and the withdrawal of life-sustaining medical treatment does not support the state's true objective and so is

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[6] *Ibid*. at para 137.

arbitrary. Worse, it imposes a terrible toll on persons like Gloria Taylor, and so is grossly disproportionate.

11. These issues are addressed in turn under the following three headings.

A Competent, Informed and Freely Made Choice of Physician-Assisted Dying Deserves Respect

12. Perhaps the most important point in this case is that – so long as a seriously and incurably ill person is competent, informed and free of coercion[7] – his or her choice to die with assistance is one that deserves respect in our free and democratic society. That choice is a potent manifestation of a person's autonomy over her own body and life and is precisely the kind of decision that section 7 and the broader values underlying the *Charter* are designed to reserve to each individual. Indeed, two fundamental and related *Charter* values – the autonomy and the inherent dignity of individuals – are *advanced* by supporting each competent and incurably ill individual's right to choose whether to die with assistance. This is so in at least two respects.

13. The first is one touched on above in relation to the life, liberty and security interests. The choice to die has profound implications – and, plainly, enormous importance – for the individual who makes it. In quite a real sense, that choice is that person's last. Some of us may not wish to exercise any choice over the timing and manner of our deaths; many of us may feel that our lives are best honoured by allowing death to come when and how it will, without our intervention. But plainly some of us believe that the dignity of our lives is best supported by acting to ensure that our deaths unfold in a manner consistent with our values. That concern is most poignant, and most understandable, where a person's health is such that, without intervention, death will be painful or will involve a profound loss of physical independence or of mental faculties. For such a person, who deeply desires to arrange for a death she considers to be more consistent with her dignity, a restriction on her ability to do so is a terrible and cruel

intrusion on her autonomy and an affront to her personhood. The simple *availability* of choice over the timing and manner of death is of fundamental personal importance.

14. So long as a person is informed, uncoerced and mentally competent, a decision over the timing and manner of death is also one that a person is uniquely qualified to make in relation to her own life. Only that person can properly determine whether death is preferable to continued life with a serious and incurable disease. Only that person can truly determine whether her dignity and sense of self are best honoured by meeting her death on her own terms or by fighting for life until the last breath. Only that person knows what death means within the narrative of her own life. No one else can know these things as well. A close family member or friend might be the best available substitute where the person is mentally incompetent, but where the person is competent no other person could ever make the decision with the same precision and certainty. A choice that is so profoundly personal will always be best made by the person herself, because it is the kind of choice that derives much of its meaning from her subjective experience.

15. For at least these two reasons, allowing each individual the choice of physician-assisted dying advances the values of autonomy and human dignity. It is by allowing individuals such choices that these values are given expression in a free and democratic society. Without actually allowing for such choices – without allowing a person to choose something on the basis of his preferences that another person would not on the basis of hers – autonomy and dignity are just empty words.

16. So it is not only that physician-assisted dying is not *contrary* to the autonomy and dignity of individuals, but rather that it is by allowing individuals to choose physician-assisted dying, or not, that these values are *actually realized* in a free and democratic society. Our society would better fulfill its aspirations to be free and just by permitting such a choice.

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[7] In this submission, the word “competent” will sometimes be used to mean all of competent, informed

17. But it is important to return to a point that was just passed over: that physician-assisted dying is not contrary to autonomy and dignity, or with any other fundamental social norm. It is important to address this point because the ban on physician-assisted dying is often defended on those terms. Some defenders of the ban argue that the choice of physician-assisted dying is not one that deserves respect in our society because, they say, it is a choice that is inconsistent with human dignity and the "sanctity of life". This general proposition may be framed in a number of ways: that a choice to end one's life is not worthy of respect because human life is sacred and inviolable and may never be intentionally ended; that a decision to die is contrary to freedom of choice because it would end that person's ability to make choices; that the inherent dignity of human life requires that human life be treated as an end in itself to be defended to the last, and not as a thing over which choices may be made.

18. Each of these statements is a reasonable principle by which an individual might guide his or her own life. However, there are many other equally reasonable perspectives that would lead to opposite conclusions. One person may view the dignity of his life as being conditioned upon some basic level of physical independence and control. Another person may feel her dignity to be compromised when some threshold of pain is reached. Still another may believe that his personhood will be eroded when he loses his mental capacity, such that he wishes to end his life before that stage is reached.

19. None of these conceptions of the dignity and sanctity of life – whether for or against assisted suicide – can claim any universal consensus within Canadian society. None of them has any moral or legal authority that justifies its imposition on anyone. The "sanctity of life" need not mean that life be preserved at all costs, or that it may not be intentionally ended, or that active steps may not be intentionally taken to end it. There are as many perspectives on how the sanctity of our lives is best honoured as there are individuals, for one way in which we "sanctify" our lives is by searching for our own view of a good life and striving to achieve it.

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and uncoerced.

20. The only principle that does have broad consensus within our society and our law is that of *informed consent*, whereby medical treatment may not be imposed upon a patient against her will. That standard of informed consent is the touchstone of medical ethics and of the law pertaining to medical decision-making. As Robins J.A. stated in *Fleming v. Reid*:[8]

> The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent.

21. The critical and incontrovertible fact that flows from the standard of informed consent is that our society *does* regard some decisions to intentionally end one's life as worthy of respect and protection, even where the assistance of a physician is required. The common law and statutes[9] firmly protect a patient's right to refuse medical treatment even where that treatment is necessary to preserving the individual's life. Indeed, the common law allows a patient to require that life-sustaining treatment be withdrawn even after it has been commenced, and the criminal law does not prevent a physician from complying with that request. As Sopinka J. stated in his majority judgment in *Rodriguez*:[10]

> Canadian courts have recognized a common law right of patients to refuse consent to medical treatment, or to demand that treatment, once commenced, be withdrawn or discontinued (*Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119). <u>This right has been specifically recognized to exist even if the withdrawal from or refusal of treatment may result in death</u> (*Nancy B. v. Hôtel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. S.C.); and *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.)). The United States Supreme Court has also recently recognized that the right to refuse life-sustaining medical treatment is an aspect of the liberty interest protected by the Fourteenth Amendment in *Cruzan v. Director, Missouri Health Department* (1990), 111 L. Ed. 2d 224. However, that Court also enunciated the view that when a patient was unconscious and

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[8] (1991), 4 O.R. (3d) 74 (C.A.), at p. 85, quoted in *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119 at para 40.

[9] For the British Columbia statute, see *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 4.

[10] *Rodriguez* at para 156; emphasis added.

> thus unable to express her own views, the state was justified in requiring compelling evidence that withdrawal of treatment was in fact what the patient would have requested had she been competent.

22. There is therefore no consensus at all within Canadian society that a competent, informed and uncoerced decision to end one's life is *not* worthy of respect. Quite to the contrary, our law accords to each of us the freedom to make such decisions. We recognize, on the basis of individual autonomy, that our bodies must remain within our own control. If we do not wish medical treatment – if we wish even to die – then that choice must be respected. Medical treatment cannot be imposed contrary to a patient's will, regardless of how beneficial or life-sustaining it may be.

23. In the CUC's respectful submission, this is a total answer to the array of arguments that suggest that the choice of assisted suicide is not one that should be respected. Those arguments are directly belied by the reality of our law: a patient has the right to refuse or have withdrawn any medical treatment, even if it is necessary to sustaining life. To put it another way, a patient has the right to demand that a physician withdraw life-sustaining medical treatment with the intention and the consequence that the patient will die. There is no principle of fundamental justice which precludes the intentional termination of one's own life, with or without assistance. There is no norm within our law that holds that the intentional termination of one's life degrades the value of life and cannot be allowed. There is no consensus that the existence of palliative care is sufficient to override a patient's decision to have life-sustaining treatment withdrawn so that she will die. Rather, a patient's decision to end her life through a physician's assistance in withdrawing life-sustaining medical care is firmly protected by the common law, by statute and by section 7 of the *Charter*. Any suggestion that the intentional ending of one's own life through the assistance of a physician is always contrary to our law and social norms is simply incorrect.

24. The fact that the law respects such decisions to intentionally end one's life is relevant in two other respects, each of which will be discussed further below. First, the most substantial defence of the impugned provisions enlists fears of misuse and abuse

of assisted suicide. The stated concern is that no system of safeguards can provide perfect assurance that physician-assisted dying will not in some cases be undertaken non-voluntarily or involuntarily, and so the total ban on physician-assisted dying is necessary to prevent misuse. While certainly the issue of safeguards is absolutely critical, the assertion that a total ban is necessary is utterly inconsistent with the fact that the law protects a patient's right to end her life by refusing or having withdrawn life-sustaining medical treatment. The impugned provisions are therefore overbroad.

25. The only true distinction between refusal or withdrawal of life-sustaining treatment and physician-assisted dying is that the former can be characterized as *passive*, and the latter as *active*, in the causal pathway by which the patient's death is intentionally achieved. But this active/passive distinction serves no legitimate state interest, and indeed is inconsistent with the law's concern to enforce the standard of informed consent in medical decision-making. The distinction drawn by the impugned provisions is therefore arbitrary. But perhaps more critically, the provisions visit an enormous cost upon incurably ill patients who seek assistance in dying, and all for a rationale that has no real moral substance and serves no serious state objective. The impugned provisions are grossly disproportionate.

26. These issues are addressed in the following two sections.

The Critical Role of Informed Consent in End of Life Decisions

27. The Attorneys General seek to justify the ban on physician-assisted dying by asserting that only a total ban can ensure that no patient dies non-voluntarily or involuntarily with the assistance of a physician. Some of the stated concerns are that a patient may be subtly coerced by family into choosing assisted dying against her will, or may be depressed when she makes the choice, or that improvements in medical treatment after the patient's death might prove her death to have been unnecessary.

For these reasons, the Attorneys General say that a total ban on physician-assisted dying is necessary.[11]

28. It is of course essential that physician-assisted dying be regulated to address the possibility of misuse. Just as Gloria Taylor and others who seek physician-assisted dying deserve to have their wishes respected in relation to this profoundly personal decision, so too is it fundamentally important that the medical and legal systems guard against physician-assisted dying being administered to individuals who do not competently, knowingly and freely choose it. Robust safeguards will have to be erected around any legalization of physician-assisted dying.

29. The question in the case at bar is simply whether adequate safeguards can be put in place at all. The heart of the governments' defence of the impugned provisions is their assertion that no possible system of safeguards can be adequate. The CUC submits that assertion is plainly wrong.

30. For one thing, the assertion is wrong on the evidence, as the plaintiffs have detailed in their written submissions.[12] The evidentiary record in this case clearly demonstrates that adequate systems of safeguards can be designed, and that such systems have in fact been implemented in other jurisdictions. The governments' assertion that adequate safeguards are impossible to achieve is wrong in fact.

31. But it is also important to step back from the particular evidence in this case and view the foundations of the governments' defence. Those foundations have three critical weaknesses, each of which fatally undermines the governments' position.

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[11] Attorney General of Canada's (AGC's) Amended Response to the Amended Notice of Civil Claim, paras 12-22; Attorney General of British Columbia's (AGBC's) Amended Response to the Amended Notice of Civil Claim, paras 16-24.

[12] See, in particular, paras 177-238.

32. The first has been touched on above. The governments' assertion that a total ban on physician-assisted dying is necessary to prevent abuse is belied by the fact that no such ban is deemed necessary in respect of the refusal or withdrawal of life-sustaining medical treatment. Every concern about misuse that arises with physician-assisted dying is just as, or more, substantial in respect of the refusal or withdrawal of such medical treatment. In this latter case, there are obvious reasons to be concerned that the patient is not competent or otherwise does not understand the implications of the decision, or that he has been subtly coerced by his family, or that he is trapped in a temporary phase of depression, or that his condition has been misdiagnosed, or that medical treatment may improve after the decision is implemented such that his condition could have been ameliorated. Yet the law recognizes that these concerns can be addressed by the medical system ensuring that life-sustaining treatment is withdrawn only with the patient's informed consent.

33. As discussed above, that standard of informed consent is the ethical and legal touchstone for medical decision-making. It is applied countless times every day in hospitals and clinics across the country and around the world. Part of the application of that standard requires an assessment that the patient is capable of providing consent, which is based on the patient's comprehension of information, his ability to weigh that information and consider alternatives, and his capacity to make and communicate a decision.[13] These criteria are applied with increasing rigour as the seriousness of the decision rises.

34. Plainly, a choice of physician-assisted dying would require the strictest application of the standard of informed consent to ensure that the choice is being made by a competent patient who is fully informed and entirely uncoerced, and who genuinely desires assistance in dying.[14] But the point is that that medical decision would require

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[13] Donnelly #1, paras 11 and 12, Record Vol. 6, Tab 52.

[14] Donnelly #1, paras 12-15, Record Vol. 6, Tab 52; Ganzini #1, para 42, Record Vol. 2, Tab 23; Donnelly #2, paras 4-7, 26, 28 and 30, Record Vol. 25, tab 105; Smith #1, paras 24-26, Record Vol. 8, Tab 62; Ganzini #2, para 44, Record Vol. 26, para 111.

no different standard, and no greater rigour in its application, than does the withdrawal of life-sustaining treatment. Both decisions will intentionally result in death; both engage the medical system in bringing about that death; and both raise the same concerns regarding capacity and voluntariness. The standard of informed consent is deemed adequate in our law for a decision to withdraw life-sustaining treatment, and so that same standard must necessarily be adequate for physician-assisted dying. The fact that the withdrawal of life-sustaining medical treatment is permitted on the basis of informed consent makes perfectly plain that the total ban on physician-assisted dying is overbroad.

35. There is also other glaring proof that the total ban is unnecessary and overbroad, which is the second weakness in the governments' slippery slope defence. That proof lies in persons like Gloria Taylor. It simply cannot be doubted by any reasonable and fair-minded person that Ms. Taylor truly desires physician-assisted dying and that she is competent and informed. Whatever standard of proof one demanded to reach this conclusion – indeed, on a standard of *beyond any doubt whatsoever* – Ms. Taylor fulfills it. It is an irrefutable fact that Ms. Taylor competently, knowingly and freely desires access to physician-assisted dying.

36. That being the case, the impugned provisions, which deny such access *even to her*, are plainly and obviously overbroad. It may well be that access to physician-assisted dying should be so narrowly restricted by safeguards as to be only available to persons whose informed consent is as irrefutable as is Ms. Taylor's. If the plaintiff's constitutional challenge succeeds, it will be up to Parliament to craft a regulatory system, and future litigation may test whether the safeguards Parliament puts in place are overbroad. But the unavoidable conclusion in the case at bar is that section 7 of the Charter requires *some* access to physician-assisted dying and that a total ban on it is necessarily overbroad.

37. There is a third fundamental weakness in the governments' slippery slope arguments. As has been discussed above, their contention that an adequate system of

safeguards is impossible is factually wrong. The weight of the evidence clearly demonstrates that *is* possible to erect a system of safeguards that ensures that only truly consenting persons may access physician-assisted dying. But leaving that point aside for now, the governments' insistence that a total ban is necessary if there is *any possibility of misuse* is unwarranted. While it is certainly the case that rigorous safeguards must be put in place to ensure that only truly consenting persons have access to physician-assisted dying, the avoidance of misuse is not the only objective the law must strive to achieve. Rather, the law must also respect the life, liberty and security of persons who genuinely and knowingly desire to access physician-assisted dying. The law must take account of and seek a balance to protect the interests *both* of individuals who might be vulnerable to coercion and of individuals who genuinely wish to die with assistance. Neither a total ban nor unregulated access is sufficient. Instead, it is incumbent upon Parliament to craft a law that strikes a reasonable balance, so as to allow reasonable access while providing reasonable protection against misuse.

38. For these reasons, the CUC respectfully submits that the impugned provisions are overbroad.

The Active/Passive Distinction Is Arbitrary and Grossly Disproportionate

39. The submissions above have referred many times to the basic fact that our law protects the right of a patient to refuse or have withdrawn medical treatment that is necessary to preserving his or her life. In broad terms, the relevance of this fact is two-fold: first, that it is <u>not</u> a fundamental principle of justice that a person cannot choose to terminate her own life, and second, that our law accepts that a standard of informed consent is adequate to ensure that physicians assist in implementing a patient's decision to end her own life only where that patient is competent, informed and uncoerced. In the CUC's respectful submission, this analogy to the withdrawal of life-sustaining medical treatment squarely undermines the bulk of the governments' defences of the total ban on physician-assisted dying.

40. There remains, however, the objection that the withdrawal of life-sustaining medical treatment involves only a *passive* role in the patient's death, because it is the patient's illness which is the immediate cause of death. Physician-assisted dying, on the other hand, involves the physician in an *active* step – that of preparing the direct cause of death in the form, usually, of a lethal mixture of drugs, which the patient then drinks. This active/passive argument suggests that merely passive involvement in the patient's death is entirely acceptable, while a more active role is morally blameworthy and deserving of criminal sanction.

41. In the CUC's respectful submission, this distinction in no way justifies a ban on physician-assisted dying.

42. For one thing, permitting the withdrawal of life-sustaining treatment while criminalizing physician-assisted dying is to create an arbitrary distinction in the law. The most recent articulation of arbitrariness from the Supreme Court of Canada is in the *Insite* case:[15]

> The jurisprudence on arbitrariness is not entirely settled. In *Chaoulli*, three justices (*per* McLachlin C.J. and Major J.) preferred an approach that asked whether a limit was "necessary" to further the state objective: paras. 131-32. Conversely, three other justices (*per* Binnie and LeBel JJ.), preferred to avoid the language of necessity and instead approved of the prior articulation of arbitrariness as where "[a] deprivation of a right . . . bears no relation to, or is inconsistent with, the state interest that lies behind the legislation": para. 232. It is unnecessary to determine which approach should prevail, because the government action at issue in this case qualifies as arbitrary under both definitions.

43. As in *Insite*, the impugned provisions are arbitrary on either approach. Both approaches look to the state objective or interest. The objective of the impugned provisions is "to protect the lives of all Canadians, particularly those in vulnerable circumstances", according to the Attorney General of Canada[16] (the Attorney General of

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[15] *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44 at para 132.

[16] AGC's Amended Response to the Amended Notice of Civil Claim at para 6.

British Columbia states the objective nearly identically[17]). But what possible relationship does the active/passive distinction have to the objective of protecting the lives of Canadians?

44. The answer is none. With both physician-assisted dying and the withdrawal of life-sustaining medical treatment the patient and the physician *intend* death to result, the physician *acts* to effect that result, and death is indeed the *consequence*. In both cases the physician and the patient have intentionally taken action that will inevitably cause the patient's death. The only difference is that the ultimate, final cause of death in one case is that the physician no longer *prevents* death, while in the other case it is that the physician assists the patient in *inducing* death.

45. This distinction drawn by the criminal law bears no relation to protecting the lives of Canadians, including those who are particularly vulnerable. The "active" component of physician-assisted dying creates no threat to a patient beyond what "passive" withdrawal of life-sustaining medical treatment entails. So long as the standard of informed consent is rigorously applied and the patient is seriously and incurably ill, the "active" involvement of a physician in a patient's death bears no risk to the lives of Canadians that is greater than the physician's more "passive" role in the withdrawal of life-sustaining care. For this reason, the impugned provisions are arbitrary by reference even to the objective as framed by the Attorneys General.

46. But this Court should not simply accept the Attorneys General's statement of the law's objective, because that statement is inconsistent with the overarching objective of the broader legal framework to which the impugned provisions are related. The legal framework that regulates medical decision-making is guided by the principle that the patient has the right to determine whether medical treatment is administered to him or

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[17] AGBC's Amended Response to the Amended Notice of Civil Claim at para 7.

her. Recall the Ontario Court of Appeal's decision in *Fleming v. Reid*, quoted and approved of by the Supreme Court of Canada in *Cialarello*:[18]

> The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent... The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination. ... It is the patient, not the doctor, who ultimately must decide if treatment -- any treatment -- is to be administered.

47. Plainly, the true objective of the law relating to medical decisions – even relating to end-of-life decisions – is *not* simply to protect the lives of Canadians, particularly the vulnerable. If that were the objective, then a physician would be entitled to apply beneficial medical treatment to a patient against her will and it would be criminal for a physician to follow a patient's request to withdraw life-sustaining treatment. That is not the effect of our law because that is not its objective. Rather, the law's true and proper objective is to protect patients' autonomy over their bodies in the context of fundamentally personal decisions, such as medical treatment. That is so both in respect of beneficial medical treatment and in respect of acts that would cause their deaths. Indeed, the law allows for decisions that involve serious risks to a patient's health – even decisions to withdraw life support and intentionally end the person's life – to be made by advance directive, and even by substitute decision-maker.[19] The law allows for such serious decisions to be made on these bases because its first concern and primary object is to protect the autonomy of the patient in respect of decisions of such fundamental importance to him. Put another way, the law embodies and enforces the standard of informed consent in respect of those decisions.

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[18] Quoted in *Cialarello* at para 40. See also *Rodriguez* at para 156.

[19] See, for instance: *Fleming v. Reid*, *supra*; *Representation Agreement Act*, R.S.B.C. 1996, c. 405, ss. 4, 7 and 9; *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, ss. 16-19.91; Trial Exhibit 67, Royal Society Report, pp. 29-31, SuppRecord Vol. 36, Tab 143/67.

48. The total ban on physician-assisted dying is obviously inconsistent with this overarching objective of protecting informed consent on matters of such fundamental personal importance. Not only is the ban unnecessary to achieving that objective, it indeed *thwarts* it for persons like Gloria Taylor. As the ban is contrary to the true governmental objective, it is arbitrary and inconsistent with the principles of fundamental justice.

49. There is also another – and perhaps more central – principle of fundamental justice breached by the impugned provisions. The impugned provisions impose on persons who knowingly and freely desire physician-assisted dying a burden that is grossly disproportionate to the benefit the law achieves.

50. As just discussed, the impugned provisions are arbitrary in that they are inconsistent with the law's broader objective of protecting physical autonomy through informed consent over medical decisions and, in any event, they do nothing to advance the objective, as stated by the Attorneys General, of protecting the lives of Canadians. But even if this Court accepts the Attorneys General's statement of the objective and finds that the impugned provisions make some real contribution to it, any such contribution is utterly dwarfed by the enormous toll on persons like Gloria Taylor. Unless she flees to some more compassionate jurisdiction like Switzerland, or unless she and some caring partner break the law and risk its sanction, the impugned provisions condemn Ms. Taylor to a life's ending filled with pain, anxiety, debilitation and, in her view, indignity. In their gross indifference to her interests – in their utter lack of concern for her preferences in this most profoundly personal and important matter – the impugned provisions are devoid of compassion and mercy toward her. The total ban on physician-assisted dying is a manifestation of cruel indifference to persons like Ms. Taylor, and it is incompatible with our society's commitment to fostering human dignity and autonomy.

51. The CUC respectfully submits that there may be no law that is more grossly disproportionate in its effects than the ban on physician-assisted dying erected by the impugned provisions. The ban constitutes a grave violation of section 7 of the *Charter*.

The Impugned Provisions Are Unconstitutional

52. For these reasons, the CUC respectfully submits that the impugned provisions breach the rights to life, liberty and security of the person, and do so in a manner that is arbitrary, overbroad and grossly disproportionate. The CUC does not advance any particular submissions on section 1, other than to say that a breach of section 7 of such magnitude could never be justified under section 1.

53. The CUC submits that, other than in respect of Gloria Taylor, the appropriate remedy in this case is a suspended declaration of invalidity, as sought by the plaintiffs. As discussed above, it is essential that an appropriate system of safeguards be erected around the legalization of physician-assisted dying. The design of those safeguards is best left to Parliament. It may be that the courts are later called upon to review the constitutionality of whatever system of safeguards Parliament constructs, but it is appropriate that Parliament craft the safeguards at first instance.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

Tim Dickson
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the Canadian Unitarian Council

List of Authorities

Cases

1. *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44
2. *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119
3. *Fleming v. Reid,* (1991), 4 O.R. (3d) 74 (C.A.)
4. *R. v. Malmo-Levine*, 2003 SCC 74, [2003] 3 S.C.R. 571
5. *R. v. Morgentaler*, [1988] 1 S.C.R. 30
6. *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519

Statutes

7. *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181
8. *Representation Agreement Act*, R.S.B.C. 1996, c. 405