No.: S 112688
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 COLUMIBIA

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 Zollmann), 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, Zofja (Zosia) Anna Ettenberg, Craig Langston, and Paul A. Spiers)

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I. INTRODUCTION

1. The Christian Legal Fellowship ("CLF") has intervened in this litigation:

   (a) to provide argument about the content and application of the legal and moral principle of the inviolability of life found in the *Canadian Charter of Rights and Freedoms* ("*Charter*"), and

   (b) to emphasize the role of the prohibition on physician-assisted suicide and euthanasia in protecting the well-being of the most vulnerable in Canadian society.

2. The impugned provisions of the *Criminal Code* (the "Impugned Provisions") are consistent with sections 7 and 15 of the *Charter*. Under section 7 of the *Charter*, Canadians have the right to life and the Impugned Provisions protect the right to life without unjustifiably limiting the *Charter* rights of the Plaintiffs.

3. The principle governing this case is set forth in these words of Justice La Forest in *Eve*:

> Here, it is well to recall Lord Eldon's admonition in *Wellesley's* case, *supra* at 2 Russ. p. 18, 38 E.R. p. 242, that "it has always been the principle of this Court not to risk the incurring of damage to children which it cannot repair, but rather to prevent the damage being done." Though this comment was addressed to children who were the subject matter of the application, it aptly describes the attitude that should always be present in exercising a right on behalf of a person who is unable to do so.[1]

In exercising the right to make a life and death decision, this Court would do well to "not risk ... damage ... it cannot repair." This is the oath every physician takes. The Supreme Court of Canada says that it applies equally to judges. In the words of Justice La Forest, "the choice is one the courts cannot safely exercise".[2]

4. To exclude the terminally ill from the protection of the Impugned Provisions, as requested by the Plaintiffs, is to discriminate against the terminally ill contrary to section 15(1) of the *Charter*.

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[1] *Re Eve*, [1986] 2 S.C.R. 388 at para. 79.

[2] *Eve* at para. 99.

II. DISCUSSION

A. *RODRIGUEZ*: *STARE DECISIS*

5. The Plaintiffs have advanced a novel conception of *stare decisis*, relying on reasons of Justice Rothstein in *Fraser* that were expressly disavowed by the majority.[3]

6. The Supreme Court of Canada in *Fraser* emphasized that overturning one of its own precedents "is a step not to be lightly undertaken" by that Court.[4] And it expressly rejected the proposition that the constitutional nature of a decision could be "a primary consideration" in deciding whether to overrule its own precedent.[5]

7. By the Plaintiffs' reasoning, nearly any development of constitutional doctrine would invalidate prior precedent. This would have a massively destabilizing effect on the rule of law.

8. No matter how much a trial court may wish for reasons of compassion or otherwise, to ignore the binding authority of higher courts, it cannot do so. To do so would wreak havoc on the rule of law. In Canada, there is no higher authority than the Supreme Court of Canada. The case of *Rodriguez* is on 'all fours' with this case and is binding on this Court.

9. Furthermore, with respect to the authority of lower courts to reject a binding precedent, the Plaintiffs primarily rely on cases in which lower courts have declined to strike pleadings on the grounds of *stare decisis*. In the only decision directly on point, *Wakeford*, Justice Swinton reviewed the intervening Supreme Court of Canada decisions and found, "nothing in the court's decisions suggest that the decision in *Rodriguez* is open to reconsideration" because of a shift in jurisprudence or new developments in public policy or new facts.[6] The Court of Appeal for Ontario[7] agreed: "the issue has been fully settled by the Supreme Court of Canada in *Rodriguez*."[8]

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[3] See Plaintiffs Written Submissions, para. 21; *Ontario (Attorney General) v. Fraser*, [2011] 2 S.C.R. 3, 2011 SCC 20 **[*Fraser*]**.

[4] *Fraser* at para. 56.

[5] *Fraser* at para. 58.

[6] *Wakeford v. Canada (A.G.)*, [2001] O.T.C. 84 QL at para. 15 **[*Wakeford*]**.

[7] *Wakeford v. Canada (A.G.)* (2001), 156 O.A.C. 385 (CA) (QL) **[*Wakeford CA*]**.

[8] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 (QL) **[*Rodriguez*]**.

Significantly, the Supreme Court of Canada refused to grant leave to appeal in *Wakeford*.[9]

B. THE PROHIBITION'S RATIONALE: THE EQUALITY OF ALL PERSONS

1. The inviolability principle: a bright line to protect the equality of all persons

10. The lives of all human beings are intrinsically and equally valuable, and, without exception, the *intentional* taking of innocent human life is always wrong. What is commonly called the 'principle of inviolability of life' (sometimes the 'sanctity of life') is a cornerstone of Western civilization, stretching back to ancient Greek philosophy, prior to its reception by the common law.

11. In contemporary contexts, the inviolability principle was posited in Article 2.1 of the *European Convention of Human Rights* (ECHR): "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally..." Further, the principle is enunciated in a more abbreviated form in Article 3 of the *Universal Declaration of Human Rights*, and section 7 of the *Canadian Charter of Rights and Freedoms*: "everyone has the right to life..."

12. All formulations of this principle emphasize the moral significance of *intention*. The various misunderstandings of medical ethics and mischaracterizations of end-of-life care on display in the Plaintiffs' written submissions can be traced back – on nearly every page – to their neglect of the concept of intention.

13. The Impugned Provisions were enacted for the benefit of all Canadians. It is intended to protect the lives of all, particularly (though not exclusively) those who are in a vulnerable or dependant condition.

14. But the protection offered by the legislation is broad, to adapt a proposition from *Sharpe*: "Over and above the specific objectives of the law ... the law in a larger attitudinal sense asserts the value [of the vulnerable, the disabled, and the elderly] against the erosion of societal attitudes towards them."[10]

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[9] *Wakeford v. Canada (Attorney General)* (2001), 156 O.A.C. 385 (CA), leave to appeal to SCC refused, [2002] S.C.C.A. 72 (QL).

[10] *R. v. Sharpe*, [2001] 1 SCR 45 para. 45 **[*Sharpe*].**

15. The autonomy-based arguments of the Plaintiffs require that the treating physicians, and society at large, endorse patients' judgments that their lives are no longer worth living, have no value, and that the continuation of their lives is a harm[11] to them. If these judgments about the worthlessness of a person's life are to be decisive in a physician's decision to take life-ending action, we must consider the implications for persons in the same condition who cannot (or do not) request the termination of their lives. If a physician agrees with a patient that his or her life has no value, that judgment is transitive; it applies to all persons in the same state, regardless of whether they have requested death.

16. What this entails is an invitation to physicians, and society at large, to assess the lives of all similarly situated persons in exactly the same way; that those who have become dependent, those who have lost their self-mastery and excellence in achievement, those who have become incontinent and create burdens on others, have lives that are of less than no value, and in fact cause harm.

17. A physician who believes that a patient's life is valueless can be expected to approach treatment differently than one who believes that a patient's life (no matter how compromised) has value. Such a result is flatly inconsistent with one of the most fundamental principles of Canadian constitutional law: that all lives are equally valuable, and equally deserving of concern, respect, and consideration.[12]

18. This invitation to abandon solidarity with the dependent is a great threat to the principle of equality and to all persons served by it. It will create subtle and not so subtle pressures on those who would otherwise not desire assisted suicide, to accept others' views of their lives as valueless.[13]

19. Members of the disabled community have shared their current experiences of systematic, pervasive and persistent discrimination. However, there is concern that without the protection of a bright line prohibition, subtle pressures from family, the medical profession, and society will influence some in the disabled community to

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[11] For example see: Affidavit #1 of Wayne Sumner (4th assumption of expert report) at page 17 of the Exhibits, AR Vol. 5, Tab 45.

[12] *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143; *Granovsky v. Canada (Minister of Employment and Immigration)*, 2000 SCC 28, [2000] 1 S.C.R. 703.

[13] Affidavit #1 of David Martin at para. 13, AR Vol. 10, Tab 71; Affidavit #1 of Rhonda Wiebe at paras. 56 & 61, AR Vol. 9, Tab 65; Affidavit #1 of Ilora Finlay para 22 & 61, AR Vol. 18, Tab 86 **[Finlay Affidavit].**

submerge their interests beneath a perceived duty to submit to physician-assisted suicide.[14]

2. The inviolability principle in the law is needed to support a powerful medico-ethical culture against killing

20. One of the great achievements of Canadian *Charter* jurisprudence is the profound insight – deployed in several different contexts – that law shapes culture and culture shapes conduct.[15]

21. The prohibition of assisted suicide and euthanasia supports a medical ethics culture in which intentional killing is never to be considered as a treatment option. The evidence is that this "bright line", internalized by medical practitioners, has been a remarkably effective bulwark against intentional killing.

22. Although many of the Plaintiffs' experts disagree with the inviolability principle (either in the abstract or in specific applications), and have expressed favour for providing physician-assisted suicide and euthanasia, none of them (despite the Plaintiffs' assertion to the contrary)[16] fail to understand where the line is currently drawn.

23. By contrast, the intimacy of the patient-physician relationship is such that in many respects it defies effective regulatory oversight. This is illustrated by the Dutch experience with life-terminating acts without explicit request ("LAWER"). The uncontroverted evidence is that the Dutch regime has not been able to ensure physician compliance with Dutch law governing physician-assisted death.[17]

24. Neither euthanasia nor assisted suicide are private acts, but rather are acts requiring the cooperation of others. It is not seriously suggested under any contemplated regime that every competent person will be entitled to euthanasia or assisted suicide on demand; others will need to be persuaded to assist. It will be these others who will have the power to decide when a patient is suffering enough, depressed enough, or sufficiently tired of life, to warrant the conclusion, "this is a person who should die". The supposed right to assisted suicide will belong not to the patient, to be exercised at the patient's

[14] Ibid.

[15] *Reference re: Section 293 of the Criminal Code of Canada*, 2011 BCSC 1588 **[*Polygamy Reference*]**; *R. v. Keegstra*, [1990] 3 S.C.R. 697; *Sharpe*.

[16] For example see Plaintiffs Supplemental Written Submissions at paras. 45-47.

[17] Affidavit #1 of Professor John Keown at paras. 16-18, AR Vol. 15, Tab 80 **[*Keown Affidavit*]**.

demand, but to persons whose lives are judged by others (by a physician) to be no longer worth living. What looks like patient autonomy is, in reality, a greatly expanded discretionary power over life and death to be given to physicians.

25. The plaintiffs argue that physicians already have the opportunity to kill patients unlawfully and escape accountability. This is not in dispute. Neither is it disputed that unlawful acts of euthanasia and assisted suicide are sometimes carried out in Canada.

26. The Parliament of Canada has chosen to deal with assisted suicide and euthanasia through the direct prohibitions contained in the Impugned Provisions. These prohibitions support the medico-ethical culture through the inviolability principle: no intentional killing. The Plaintiffs have not produced any evidence that would suggest that the law in Canada has not been remarkably effective.

27. The evidence suggests that what prevents physicians from engaging in physician-assisted suicide is both:

(a) the bright line prohibition; and

(b) the medical profession's moral conviction that the bright line of intentional killing by a medical practitioner should never be crossed.

28. What accounts for compliant behaviour among physicians and other medical personnel is not regulatory oversight, but a powerful, internalized ethic (an ethic supported by law) that killing is not treatment. What the plaintiff proposes is to dismantle that ethic and provide an illusion of accountability in its place. The evidence from the Dutch experience establishes that an "oversight commission" relying on self-reporting does not prevent abuse.[18]

29. Dismantling the current medico-ethical culture would negatively impact palliative care.[19] The medical profession currently has powerful reasons to continue to striving for improvements in palliative care. Much work continues to be done to improve palliative

[18] Expert Report of Dr. Herbert Hendin, AR Vol. 20, Tab 94, generally; *Keown* Affidavit, generally.

[19] Expert Report of Dr. Jose Pereira at para. 108, AR Vol. 20, Tab 96 [Pereira Report]; Affidavit #1 of Professor Eugene Bereza at paras. 27 & 75, AR Vol. 10, Tab 73 **[Bereza Affidavit]**; Affidavit #1 of Thomas Koch at para. 70. AR Vp;/ 15. Tab 82; Expert Report of Dr. Harvey Chochinov, AR Vol. 11, Tab 74, generally **[Chochinov Report].**

care. One example is Dr. Chochinov's dignity therapy.[20] It is often limitations that breed creativity and advancement.

30. The Plaintiffs' attack on palliative care in Canada is both misplaced and lacking in credible evidence. Before concluding that there are any constitutionally significant deficiencies in Canada's palliative care programs, a full trial with a comprehensive review of all evidence available should be required by this Court.

31. As a matter of comity, this Court should not quickly dismiss as incorrect the conclusion of the Ontario Court of Appeal in *Rasouli*:

> In most situations, life-ending decisions are worked out over time through a combination of patience, understanding, professional guidance and counselling. In this regard, the College of Physicians and Surgeons and individual hospitals deserve credit for the very sensitive protocols they have put in place to address life-ending decisions and the trauma that family and loved ones face when required to make them.[21]

32. One of the reasons for the bright line in favour of life represented by the Impugned Provisions is found in the *Rasouli* judgment. The Court of Appeal in *Rasouli* highlighted the fact that the Sunnybrook Health Sciences Centre "argued before the application judge that if the withdrawal of life support is included in the definition of treatment under the Act, individuals who have no chance of recovering would nevertheless have to be kept alive for extended periods of time if consent to end life was not forthcoming and this would impact severely on the limited resources of its intensive care unit".[22]

33. Canadians should not be put in a position of thinking it is their civic duty to die in order to allow the "limited resources" of an "intensive care unit" to be allocated to another person.

34. There is evidence in this claim that where physician-assisted suicide is an option, palliative care suffers.[23]

35. Instead, what the experts in this case have said is that we must focus and prioritize palliative care. Such focus would also be consistent with the recent report from the Parliamentary Committee on Palliative and Compassionate Care.[24]

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[20] Chochinov Report, generally.

[21] *Rasouli* v. *Sunnybrook Health Sciences Centre*, 2011 Ont. C.A. 482 at para 63 **[*Rasouli*].**

[22] *Rasouli* at para. 31.

[23] Pereira Report at para. 108; Bereza Affidavit at para. 27.

36. The *Polygamy Reference* dealt with a similar social issue. In that case, Chief Justice Bauman recognized than when dealing with such complex social issues deference was to be given to Parliament.[25] Parliament, through its elected representatives, through committees and through other means has resources that the courts could not possibly have at their disposal, particularly in the context of an expedited summary trial. Deference to Parliament is merited in these circumstances, particularly when one considers that physician-assisted suicide is a more complex social issue than polygamy.

C. THE LAW'S CONSISTENT DEPLOYMENT OF THE INVIOLABILITY PRINCIPLE

37. The CLF adopts the submissions of the Attorney General of Canada and of the Attorney General of British Columbia with respect to the *Charter* guarantees of equality and life, liberty, and security of the person. The CLF also adopts the submissions of the Attorneys General with respect to the principles of fundamental justice, and notes the following errors in the Plaintiffs' argument.

38. The Plaintiffs argue that Canadian law governing end-of-life decisions are confused and arbitrary. But these objections are themselves confused, owing to some basic misunderstandings of the inviolability principle, and its observation in common law and medical ethics.

39. The following errors pervade the Plaintiff's section 7 argument:

(a) confusing the inviolability principle with "vitalism" (i.e., the belief that life must be lengthened at all costs),

(b) mischaracterizing end-of-life care as euthanasia

(c) claiming that the decriminalization of suicide was an endorsement of suicide as a choice worthy option.

1. The inviolability principle is not "vitalism"

40. The inviolability principle should not be confused with "vitalism", or the conviction that life must be prolonged at all costs. The common law has never required this. The inviolability principle proposes no obligation on an individual or a society to take every possible step to lengthen every life, irrespective of the patient's wishes, the physical

[24] Trial Exhibit 66, "Parliamentary Committee on Palliative and Compassionate Care – Not to be Forgotten: Care of Vulnerable Canadians", SAR Vol. 35, Tab 143(66).

[25] *Polygamy Reference* at para 1302.

burdens of the treatment placed on the patient, or the efficacy of the treatment. The inviolability principle, as reflected in common law, maintains that an individual has a right to refuse medical treatment.[26]

2. Refusal of treatment is consistent with the inviolability principle

41. The inviolability principle holds that a doctor may not act with the intention of killing a patient. The principle governs both acts and omissions. The Plaintiffs are correct to argue that there is no ethically significant distinction between intended acts and intended omissions. The Plaintiffs are entirely mistaken, however, when they unjustifiably conclude that the Impugned Provisions are in any way based on such an ethical distinction.[27] Again, this error results from the Plaintiffs' failure to attend to the moral and legal significance of intention. A focus on intention isolates what is really at stake and avoids the confusion created by the unhelpful distinction between active and passive courses of action.

42. It is uncontroversial that at common law, a physician can (and indeed must) accede to a competent patient's request to withdraw medical treatment, regardless of whether the physician believes that the withdrawal of medical treatment will likely (or even certainly) lead to an earlier death. There is no obligation on a patient to accept unwanted treatment.

43. There are many reasons that a patient might have for refusing treatment, even refusing nutrition and hydration. A treatment maybe considered to be futile, or overly invasive, or painful, or burdensome, or otherwise unwelcome.[28] Or the patient could refuse a treatment, say a blood transfusion, because of religious conviction.

44. Even a patient who refuses treatment or requests withdrawal of treatment for suicidal reasons acts lawfully. Suicide is not a crime. More significantly for our purposes, a physician who withholds or withdraws treatment on a patient's request (even believing that death will likely be hastened as a result) acts ethically and lawfully. The only proviso is that the physician's intention in withholding or withdrawing treatment must not be to kill the patient. Whatever the patient's intention, it is not presumed that it is shared

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[26] Cross Examination of Professor John Keown, November 21, 2011 at pages 80 and 81, SAR Vol. 33, Tab 139 **[Keown Cross Examination]**.

[27] See Plaintiffs Supplemental Written Submissions at paras. 30-31.

[28] Cross Examination of Dr. Jose Pereira, November 22, 2011, pp. 42:38 to 44:5, SAR Vol. 34, Tab 140.

– or even known – by the physician. The physician who withholds or withdraws treatment simply out of respect for the patient's decision, acts lawfully.[29]

45. The bright line, again, is not set by a specious act or omission distinction, but by intention. Two acts can be different in kind even though everything about one's behaviour in the observable context is the same. So, (1) a physician who withdraws medical treatment in order to respect a patient's wishes, or because the treatment is judged to provide no benefit, acts lawfully, but (2) a physician who withdraws medical treatment with the *intention* to end a patient's life commits euthanasia.

46. The Plaintiffs failed to grasp Professor Keown's evidence on this point.[30] His criticism of the House of Lords' reasons in *Bland* was not that the withdrawal of artificial feeding of a 17 yr old in a persistent vegetative state could not be lawful. Professor Keown was clear that if the physicians were of the view that the treatment was futile, they could withdraw it. What he objected to in the reasons of the majority was the proposition that artificial feeding could be discontinued lawfully with the *intention* to end life.[31]

3. Palliative care is consistent with the inviolability principle

47. The evidence is that, despite common misconceptions to the contrary, effective palliative care does not necessarily hasten death.[32]

48. Sometimes, however, palliative care (and particularly terminal sedation) will have the effect of hastening death. Nevertheless, its sound administration is not inconsistent with the inviolability principle and is not, as the plaintiffs argue, "a euphemism for physician-assisted dying".[33] Once again, the Plaintiffs are only able to come to this conclusion by ignoring intention.[34] That some physicians may abuse the tools of palliative care to kill patients intentionally does not render palliative care an instance of euthanasia. That some physicians may join them in this conceptual error is irrelevant.

49. A physician can lawfully administer opioids with the intention of relieving pain, knowing, perhaps, that the drugs will (in addition to relieving pain) hasten death. Acting with the

[29] Keown Cross Examination at pages 81 and 82.

[30] See Plaintiffs Supplemental Written Argument at para. 49.

[31] See Keown Cross Examination at pages 29-30 and 80.

[32] Pereira Report at paras. 27, 38, and 76-78.

[33] See Plaintiffs Supplemental Written Argument at para. 51.

[34] See Plaintiffs Supplemental Written Argument at paras. 50-58.

foresight that one's pain-relieving prescription will also cause the patient to die more quickly than otherwise, is not acting with the intent to kill the patient. Foreknowledge of a result is not the same thing as intending that result, even if the result may be welcome.

50. If, however, drugs are administered, for example, in a dose that is far in excess of what could be necessary to relieve pain, and with the intent to hasten death, it is an act of euthanasia. The fact that terminal sedation, the use of opioids, and the withholding and withdrawal of treatment are capable of being used as means to kill, does not render the law inconsistent with the inviolability principle. Again, intention provides the bright line needed to characterize these acts.

4. The decriminalization of suicide is not a rejection of the inviolability principle

51. As characterized by Justice Sopinka in *Rodriguez*, the repeal of the offence of suicide in 1972 (S.C. 1972, c.13, s.16) is not aptly described as giving priority to suicidal autonomy: "(r)ather, the matter of suicide was seen to have its roots and its solution in sciences outside the law, and for that reason not to mandate a legal remedy."[35] A similar result was reached by the UK House of Lords in characterizing the decriminalization of suicide in *Regina (Pretty) v. Director of Public Prosecutions*, [2001] UKHL 61, 1 A.C. 800, upheld in *Pretty v. United Kingdom*, [2002] 2 FCR 97 (Eur. Ct. H.R.).

52. The repeal was not an endorsement of suicide as a valuable life choice that ought to be respected or facilitated in any way. Despite decriminalization, governments continue to expend enormous efforts on suicide prevention.[36]

53. The repeal is thus not inconsistent with the inviolability principle.

D. AUTONOMY, EQUALITY, CONSENT

54. One of the logical fallacies in the argument of the Plaintiffs is that they and other Canadians have a constitutional right to suicide. As noted by Chief Justice Bauman in the *Polygamy Reference*, the *Charter* has not created a libertarian playground. The

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[35] *Rodriguez* at para. 155.

[36] See AGC Written Submissions at paras. 85 to 95.

government remains free to act in a paternalistic manner where justified in a free and democratic society.[37]

55. Much has been made by the Plaintiffs of the principle of autonomy. It is almost as though they misread Thomas Jefferson to have written "death, liberty and pursuit of happiness" in the Declaration of Independence. Pierre Trudeau did not write "death, liberty and security of the person" in section 7 of the *Charter*. Section 7 of the *Charter* is not ambiguous. It is "life" – not death – that is secured for every Canadian under our Constitution.

56. Furthermore, the existence of consent, no matter how certain, is an unreliable legal, constitutional or social basis upon which to base the right to die with the aid of another. Under the common law and under the *Criminal Code*, it has never been permissible to consent to one's own murder. The Constitution takes the same hard line. It is never possible to waive a *Charter* right or freedom, including the right to life.

57. Chief Justice Bauman noted in the *Polygamy Reference* that consent is not always enough.[38] Sometimes society must say that consent is not enough where the choice in question degrades the person making the choice and degrades the other persons participating in the choice, once made.

58. One need not look far from home to find examples of the abuse of consent. There is a particularly dark chapter in Alberta's history in which thousands of adult women and men were sterilized with their "consent". The August 1, 2008 edition of the Canadian Review of Sociology includes excellent analysis of this phenomenon in an article titled "Sterilization in Alberta, 1928 to 1972: Gender Matters".[39] One of the disturbing findings was that "promiscuity" came to be the most often referenced reasons for sterilization.[40] Most significantly, the authors noted that women capable of making decisions on their own were persuaded to choose sterilization in the name of reproductive morality, to protect future generations by choosing sterilization. The authors asked this question in their conclusion:

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[37] *Polygamy Reference* at para. 1198.

[38] *Polygamy Reference* at para. 1320.

[39] Grekul Jana, "Sterilization in Alberta, 1928 to 1972: Gender Matters." The Canadian Review of Sociology (2008) Vol. 45, Issue 3 at page 247 **[Grekul].**

[40] Grekul at pages 257 to 261.

> How many of the women consented because mental health professionals were able to convince them that they were in fact "incapable of intelligent parenthood" and would be doing society and the race a favour by consenting? In such instances, the line between voluntary and involuntary consent is blurred...[41]

59. Unlike the plaintiffs in *Bedford,*[42] the Impugned Provisions do not result "in an increased risk of them being subjected to violence".[43] The only consequence for the Plaintiffs will be that like every other Canadian facing death, the experience will be unpleasant and beyond their control.

60. Canadians who are not disabled do not typically choose to commit suicide in the face of a terminal illness. For this reason, it strains credulity to suggest that disabled persons are treated unequally because they are not able to kill themselves unaided.

61. Furthermore, even if one were to accept the concept that the disabled facing terminal illness are a disadvantaged group because they cannot commit suicide, the right to physician-assisted suicide may only by granted by Parliament. Section 15(2) of the *Charter* permits Parliament to create certain ameliorative programs, notwithstanding section 15(1). But section 15(2) does not require a program in every case of disadvantage, nor does it give the courts the power to order ameliorative programs.

62. In any event, the prohibitions on murder and assisting in a murder are not, in concept, a burden or harm imposed on Canadians. The Impugned Provisions are a benefit of citizenship. They protect the citizen's right to life under the *Charter*. In a very real way, the exclusion of the terminally ill from the protection of the Impugned Provisions is to discriminate against the terminally ill contrary to section 15(1) of the *Charter*.

E. SECTION 1 – WHAT RISKS MUST CANADIANS ACCEPT?

63. The ultimate question is, what risks must Canadians be forced to accept for the benefit of the Plaintiffs?

64. Parliament has concluded that nothing short of an absolute prohibition of all intentional killing will be sufficient to discharge its duty to protect all persons, particularly those most

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[41] Grekul at page 265.

[42] *Bedford v. Canada (A.G.)* (2010), 327 D.L.R. (4th) 52, 2010 ONSC 4264 **[Bedford].**

[43] *Bedford* at para. 499.

vulnerable. This conclusion is based on reason and evidence drawn from many persons and many institutions over many years, and the court must defer to it.

65. When considering the evidence that nothing short of an absolute prohibition will achieve Parliament's objective, one must bear in mind Chief Justice McLachlin's observation in *Sharpe* (echoing Aristotle) that "complex human behaviour may not lend itself to precise scientific demonstration, and the courts cannot hold Parliament to a higher standard of proof than the subject matter admits of".[44]

66. Similarly, minimal impairment does not mean that Parliament must identify a single, most minimally impairing legislative option: "(a) certain measure of deference may be appropriate, where the problem Parliament is tackling is a complex social problem. There may be many ways to approach a single problem, and no certainty as to which will be the most effective...For this reason, this Court has held that on complex social issues, the minimal impairment requirement is met if Parliament has chosen one of several reasonable alternatives".[45]

67. Several governments in free and democratic societies have established commissions and forums to study these issues.[46] Each of these forums were constituted by a diverse membership, conducted investigations, and received submissions from a wide range of interested and learned parties. The evidence is that "virtually every expert body that's addressed that question [whether physician-assisted dying should be allowed] over the past 75 years, from the House of Lords in the 1930s to the House of Lords in 1994 to the House of Lords again [in] 2006 when they heard all the arguments from the Netherlands and Oregon, all these bodies, the New York task force in 1994, have come to the same conclusion. Having reviewed all the evidence exhaustively that it's not a risk that should be taken".[47]

68. Although there are a small number of jurisdictions that have concluded otherwise, it is salient that almost all jurisdictions that have freshly reconsidered the issue have reaffirmed their absolute prohibitions on intentional killing.

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[44] *Sharpe* at para. 89.
[45] *Canada (A.G.) v. JTI-Macdonald Corp.*, [2007] 2 SCR 610 at para. 43.
[46] See AGC Written Submissions at paras. 125 to 178.
[47] Keown Cross Examination at page 101.

69. What are these risks? The evidence from the Netherlands and Oregon gives no reason to believe that exceptions to the prohibition can be restricted to those who are "grievously and irremediably ill" and expressing "genuine desire".

70. In particular, in the Netherlands (the jurisdiction for which the most data is available), the evidence is that:

    (a) the Dutch have not been able to enforce the controls that they have established through the law and guidelines, and

    (b) the Dutch have not held the line on the criteria that they have established to participate in voluntary euthanasia and physician-assisted suicide.[48]

71. That is, the regulatory regime established in the Netherlands suffers from both a *practical* problem and a *legal or conceptual* problem.

72. The practical problem is evidenced by the Dutch data. It reveals that doctors have in thousands of cases illegally terminated patients' lives without request, have in thousands of cases illegally covered up deaths from euthanasia and assisted suicide as death by "natural causes", and have seldom referred patients for psychiatric evaluation.[49]

73. Similarly, in Oregon, controls have failed as the vast majority of patients have not been referred for psychiatric evaluation.[50]

74. These failures of legislative controls should not be dismissed as idiosyncratic to the Dutch or Oregon regulatory regimes. Control will be ineffective whenever a regime relies on self-reporting by a physician. The intimate nature of the patient/physician relationship is such that it defies effective oversight in this situation.

75. This court should not accept Professor Battin's assurances that statistical evidence from Oregon and the Netherlands establishes that the lives of people identified as belonging to vulnerable classes are not ended by assisted suicide more frequently than the lives of the background population. The statistics may show that vulnerable groups do not resort to physician-assisted suicide at a greater rate than the background population.

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[48] Keown Cross Examination, generally; Keown Affidavit, generally.

[49] Keown Affidavit at para. 16.

[50] Ibid.

But this does not establish that the vulnerability of those persons was not exploited in the process.[51]

76. In many cases, there is much doubt about the voluntariness of the decision to seek physician-assisted suicide. The evidence demonstrates that the decision:

(a) will be made by an ill and medicated patient and competence and voluntariness will not be certain;[52]

(b) may be affected by pressures, subtle or otherwise, on disabled person who are disenfranchised and feel that they are burdens to society and to those who support them;[53]

(c) will often be made without the patient's full knowledge of all alternatives and options or the benefit of experiencing the alternatives and options;[54] and

(d) is often not persistent as people change their minds, especially when the consequence of the decision is fatal.[55]

77. The *legal or conceptual* problem suggested by the Dutch experience (sometimes described as the "logical slippery slope") is the tendency for the posited criteria to receive increasingly expansive interpretations, thus authorizing euthanasia and assisted suicide for a class of cases much broader than originally intended.

78. In Canada, the bright line has been drawn at the inviolability principle: no acting with an intention to kill. The Netherlands drew a line at voluntary euthanasia. That line has not held.[56]

79. The Canadian constitutional order presents a further legal and conceptual difficulty with drawing the line anywhere but in support of the inviolability principle. As Justice Sopinka cautioned in *Rodriguez*, "we have no assurance that the exception can be made to limit the taking of life to those who are terminally ill and genuinely desire death".[57] Absent the

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[51] Keown Affidavit at page 180 of affidavit exhibits; Finlay Affidavit at exhibit C "Legal physician-assisted suicide in Oregon and The Neherlands: evidence concerning the impact on patients in vulnerable groups- another perspective on Oregon's data".

[52] See AGC Written Submissions at paras. 316 to 348.

[53] Cross Examination of Dr. Martha Donnelly, 9 November 211, p. 20:15-25, SAR Vol. 31, Tab 129; Dr. Gallagher Expert Report, page 11:28-32, AR Vol. 11, Tab 75.

[54] Finlay Affidavit at para. 72.

[55] Affidavit of Alison Davis, AR Vol. 10, Tab 70, generally; Affidavit of Professor Thomas Koch at para. 54, AR Vol. 15, Tab 82, Finlay Affidavit at para. 62; See also AGC Written Submissions at paras. 385 to 401.

[56] Keown Affidavit, generally; Keown Cross Examination at pages 74 to 76; Finlay Affidavit, generally.

[57] Rodriguez at para. 188.

inviolability principle, it seems unlikely that any criteria can be articulated – any line drawn – that will withstand *Charter* scrutiny under section 15(1). Once death has been accepted conceptually as a potential benefit, as the Plaintiffs urge, on what grounds could it be refused to those who seek it?

III. REMEDY

80. The Plaintiffs ask this Court to strike down the impugned sections of the *Criminal Code* and suggest that the necessary regulatory regime in its place be left to Parliament.

81. However, the Plaintiffs cannot provide any assurance that *any* legislation will follow if the current prohibitions are struck down. The Court has no power under the Constitution to order Parliament to do anything. At most, a court may:

(a) declare a law unconstitutional;

(b) read down a law;

(c) read words into a law.

82. A declaration is an equitable remedy and the following equitable considerations should lead this Court to refrain from granting a declaration of constitutional invalidity:

(a) a declaration of invalidity would leave many vulnerable individuals at risk in the event Parliament and the provincial legislatures fail to act;

(b) a declaration of invalidity will not give the Plaintiffs the remedy they desire, as the College of Physicians and Surgeons of British Columbia will discipline any physician who kills a patient or assists in killing a patient;

(c) the evidence before the Court is abbreviated and incomplete; and

(d) there are other means available in palliative care facilities to reduce and eliminate the physical pain suffered by any of the Plaintiffs.

83. In any event, it is not for the courts to craft responses to complex social problems. Chief Justice Bauman emphasized this in the *Polygamy Reference*.[58] Chief Justice Bauman concluded that Parliament was better positioned to choose among the competing approaches to the social problems associated with polygamy (human trafficking, child abuse and social disorder). He also refused to strike down the blanket ban on polygamy

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[58] *Polygamy Reference* at para. 1342.

just because there were other ways for Parliament to craft laws to address the harm identified.[59]

IV. CONCLUSION

84. The principle of inviolability of life provides a recognizable, stable, and defensible principle to guide end-of-life medical treatment. It supports a culture in which the lives of all are recognized as inherently equal. The Plaintiffs have mischaracterized the principle and its relationship to Canadian law and clinical practice, wrongly concluding that is arbitrary.

85. Furthermore, apart from the foregoing argument, this Court should be reluctant to strike down legislation in matters of complex public policy where the Court does not have the benefit of the wide-ranging consultations that are available to government.

86. The wide consultation and lengthy investigation that characterized the government-sponsored studies referenced earlier is absent in this case. Litigation, particularly when constrained by an expedited schedule as in this case, provides few opportunities for Canadians to be heard.

87. Indeed, there are many representative bodies of interested stakeholders who, for whatever reason, are notably absent from this litigation. They include:

(a) the Canadian Medical Association;

(b) provincial colleges of physicians and surgeons;

(c) hospitals and treatment centres;

(d) other health care professional groups;

(e) faith based and religious groups;

(f) institutional care givers;

(g) provincial trustees and guardianship offices; and

(h) numerous disabled and other vulnerable groups not represented in this claim.

88. This is an issue that, properly, has been debated for decades. Society must continue to pay attention to, and continually revisit, the subject of end-of-life care. If Canadian society, through its government and law, chooses to legalize assisted suicide and

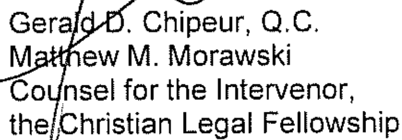
[59] *Polygamy Reference* at 1305.

euthanasia, this will be a decision that remains with the Canadian people, capable of future revision or repeal.

89. The Plaintiffs (and other euthanasia advocates) have been given a great many hearings in Canada. They have been unable to convince their fellow citizens to accept the risks entailed with what they propose. Having failed at Parliament, they now propose simply to end the debate: to use constitutional litigation to forever remove the question from democratic deliberation.

90. This is not consistent with the clear trend in the Supreme Court of Canada. Whenever asked, the Supreme Court of Canada has chosen life.[60] It is not an easy choice, but it is the only choice that the court may safely make.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.



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[60] *Rodriguez; Re Eve; R. v. Latimer, 2001 SCC 1, [2001] 1 S.C.R. 3.*

CHRISTIAN LEGAL FELLOWSHIP'S
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11. *Reference re: Section 293 of the Criminal Code of Canada*, 2011 BCSC 1588;
12. *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 (QL).
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1. Grekul Jana, "Sterilization in Alberta, 1928 to 1972: Gender Matters." The Canadian Review of Sociology (2008) Vol. 45, Issue 3 at page 247.