File Number: 35591

**IN THE SUPREME COURT OF CANADA**
(ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA)

BETWEEN:

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

Appellants
(Respondents/Cross-Appellants)

– and –

**ATTORNEY GENERAL OF CANADA**

Respondent
(Appellant/Cross-Appellant)

– and –

**ATTORNEY GENERAL OF BRITISH COLUMBIA**

Respondent
(Appellant)

– and –

**ATTORNEY GENERAL OF ONTARIO, ATTORNEY GENERAL OF QUÉBEC, ATTORNEY GENERAL OF BRITISH COLUMBIA, COUNCIL OF CANADIANS WITH DISABILITIES, THE CANADIAN ASSOCIATION FOR COMMUNITY LIVING, CHRISTIAN LEGAL FELLOWSHIP, CANADIAN HIV/AIDS LEGAL NETWORK, THE HIV & AIDS LEGAL CLINIC ONTARIO, ASSOCIATION FOR REFORMED POLITICAL ACTION CANADA, PHYSICIANS' ALLIANCE AGAINST EUTHANASIA, EVANGELICAL FELLOWSHIP OF CANADA, CHRISTIAN MEDICAL AND DENTAL SOCIETY OF CANADA, CANADIAN FEDERATION OF CATHOLIC PHYSICIANS' SOCIETIES, DYING WITH DIGNITY, CANADIAN MEDICAL ASSOCIATION, CATHOLIC HEALTH ALLIANCE OF CANADA, CRIMINAL LAWYERS' ASSOCIATION (ONTARIO), FAREWELL FOUNDATION FOR THE RIGHT TO DIE, ASSOCIATION QUÉBÉCOISE POUR LE DROIT DE MOURIR DANS LA DIGNITÉ, CANADIAN CIVIL LIBERTIES ASSOCIATION, CATHOLIC CIVIL RIGHTS LEAGUE, FAITH AND FREEDOM ALLIANCE, PROTECTION OF CONSCIENCE PROJECT, ALLIANCE OF PEOPLE WITH DISABILITIES WHO ARE SUPPORTIVE OF LEGAL ASSISTED DYING SOCIETY, CANADIAN UNITARIAN COUNCIL and EUTHANASIA PREVENTION COALITION AND EUTHANASIA PREVENTION COALITION – BRITISH COLUMBIA**

Interveners

**FACTUM OF THE INTERVENERS**
**CATHOLIC CIVIL RIGHTS LEAGUE, FAITH AND FREEDOM ALLIANCE and PROTECTION OF CONSCIENCE PROJECT**

(Pursuant to Rule 42 of the *Rules of the Supreme Court of Canada*)


**BENNETT JONES LLP**
3400 One First Canadian Place
P.O. Box 130
Toronto, ON M5X 1A4

**Robert W. Staley**
**Ranjan K. Agarwal**
**Jack R. Maslen**

Telephone: 416-777-4857
Facsimile: 416-863-1716
Email: staleyr@bennettjones.com

Counsel to the Interveners,
Catholic Civil Rights League, the Faith and Freedom Alliance and the Protection of Conscience Project

**BENNETT JONES LLP**
World Exchange Plaza
1900 - 45 O'Connor Street
Ottawa, ON K1P 1A4

**Sheridan Scott**

Telephone: 613-683-2302
Facsimile: 613-683-2323
Email: scotts@bennettjones.com

Agent to the Interveners, the Catholic Civil Rights League, the Faith and Freedom Alliance and the Protection of Conscience Project


ORIGINAL TO: THE REGISTRAR
SUPREME COURT OF CANADA

COPIES TO:

FARRIS, VAUGHAN, WILLS & MURPHY LLP
25th Floor, 700 West Georgia Street
Vancouver, BC V7Y 1B3

**Joseph J. Arvay, Q.C.**
**Alison M. Latimer**
**Sheila M. Tucker**

Telephone: 604-684-9151
Facsimile: 604-661-9349
Email: jarvay@farris.com

Counsel to the Appellants, Lee Carter, Hollis Johnson, Dr. William Shoichet, The British Columbia Civil Liberties Association and Gloria Taylor

GOWLING LAFLEUR HENDERSON LLP
160 Elgin Street, Suite 2600
Ottawa, ON K1P 1C3

**Jeffrey W. Beedell**

Telephone: 613-786-0171
Facsimile: 613-788-3587
Email: jeff.beedell@gowlings.com

Agent to the Appellants, Lee Carter, Hollis Johnson, Dr. William Shoichet, The British Columbia Civil Liberties Association and Gloria Taylor

ATTORNEY GENERAL OF CANADA
50 O'Connor Street, Suite 500, Room 556
Ottawa, ON K1P 6L2

**Robert J. Frater**
**Melissa Nicolls**
**BJ Wray**
**Donnaree Nygard**

Telephone: 613-670-6289
Facsimile: 613-954-1920
Email: robert.frater@justice.gc.ca

Counsel to the Respondent, Attorney General of Canada

ATTORNEY GENERAL OF BRITISH COLUMBIA
P.O. Box 9280
Stn Prov. Govt.
Victoria, BC V8W 9J7

**Bryant Mackey**
**Christina Drake**

Telephone: 250-356-8890
Facsimile: 250-356-9154

Counsel to the Respondent, Attorney General of British Columbia

BURKE-ROBERTSON
441 MacLaren Street, Suite 200
Ottawa, ON K2P 2H3

**Robert E. Houston, Q.C.**

Telephone: 613-236-9665
Facsimile: 613-235-4430
E-mail: rhouston@burkerobertson.com

Agent to the Respondent, Attorney General of British Columbia

ATTORNEY GENERAL OF ONTARIO
720 Bay Street, 4th Floor
Toronto, ON M5G 2K1

**Zachary Green**

Telephone: 416-326-4460
Facsimile: 416-326-4015
Email: zachary.green@ontario.ca

Counsel to the Intervener, Attorney General of Ontario

BURKE-ROBERTSON
441 MacLaren Street, Suite 200
Ottawa, ON K2P 2H3

**Robert E. Houston, Q.C.**

Telephone: 613-236-9665
Facsimile: 613-235-4430
E-mail: rhouston@burkerobertson.com

Agent to the Respondent, Attorney General of Ontario

ATTORNEY GENERAL OF QUÉBEC
1200, Route de l'Église, 2 étage
Québéc, QC G1V 4M1

**Sylvain Leboeuf**
**Syltiane Goulet**

Telephone: 418-643-1477 Ext: 21010
Facsimile: 418-644-7030
Email: sylvain.leboeuf@justice.gouv.qc.ca

Counsel to the Intervener, Attorney General of Québec

NOËL & ASSOCIÉS
111, rue Champlain
Gatineau, QC J8X 3R1

**Pierre Landry**

Telephone: 819-771-7393
Facsimile: 819-771-5397
Email: p.landry@noelassocies.com

Agent to the Intervener, Attorney General of Québec

BAKERLAW
4711 Yonge Street, Suite 509
Toronto, ON M2N 6K8

**David Baker**
**Sarah Mohamed**

Telephone: 416-533-0040
Facsimile: 416-533-0050
Email: dbaker@bakerlaw.ca

Counsel to the Intervener, Council of Canadians with Disabilities and the Canadian Association for Community Living

SUPREME ADVOCACY LLP
100 - 340 Gilmour Street
Ottawa, ON K2P 0R3

**Marie-France Major**

Telephone: 613-695-8855 Ext: 102
Facsimile: 613-695-8580
Email: mfmajor@supremeadvocacy.ca

Agent to the Intervener, Council of Canadians with Disabilities and the Canadian Association for Community Living

MILLER THOMSON LLP
3000, 700-9th Avenue SW
Calgary, AB T2P 3V4

**Gerald D. Chipeur, Q.C.**

Telephone: 403-298-2425
Facsimile: 403-262-0007

Counsel to the Intervener, Christian Legal Fellowship

SUPREME ADVOCACY LLP
100 - 340 Gilmour Street
Ottawa, ON K2P 0R3

**Marie-France Major**

Telephone: 613-695-8855 Ext: 102
Facsimile: 613-695-8580
Email: mfmajor@supremeadvocacy.ca

Agent to the Intervener, Christian Legal Fellowship

PALIARE, ROLAND, ROSENBERG, ROTHSTEIN, LLP
155 Wellington Street West
35th Floor
Toronto, ON M5V 3H1

**Gordon Capern**
**Michael Fenrick**

Telephone: 416-646-4311
Facsimile: 416-646-4301
Email: gordon.capern@paliareroland.com

Counsel to the Intervener, Canadian HIV/AIDS Legal Network (the "Legal Network") and the HIV & AIDS Legal Clinic Ontario ("HALCO")

SUPREME ADVOCACY LLP
100 - 340 Gilmour Street
Ottawa, ON K2P 0R3

**Marie-France Major**

Telephone: 613-695-8855 Ext: 102
Facsimile: 613-695-8580
Email: mfmajor@supremeadvocacy.ca

Agent to the Intervener, Canadian HIV/AIDS Legal Network (the "Legal Network") and the HIV & AIDS Legal Clinic Ontario ("HALCO")

ASSOCIATION FOR REFORMED POLITICAL ACTION (ARPA) CANADA
1 Rideau Street, Suite 700
Ottawa, ON K1N 8S7

**Andre Schutten**

Telephone: 613-297-5172
Facsimile: 613-670-5701
Email: andre@arpacanada.ca

Counsel to the Intervener, Association for Reformed Political Action Canada

NORTON ROSE FULBRIGHT CANADA LLP

1 Place Ville Marie
Bureau 2500
Montréal, QC H3B 1R1

**Pierre Bienvenu**
**Andres C. Garin**
**Vincent Rochette**

Telephone: 514-847-4452
Facsimile: 514-286-5474
E-mail: pierre.bienvenu@nortonrose.com

Counsel to the Intervener, Physicians' Alliance Against Euthanasia

NORTON ROSE FULBRIGHT CANADA LLP
1500 - 45 O'Connor Street
Ottawa, ON K1P 1A4

**Sally Gomery**

Telephone: 613-780-8604
Facsimile: 613-230-5459
Email: sally.gomery@nortonrose.com

Agent to the Intervener, Physicians' Alliance Against Euthanasia

GEOFFREY TROTTER LAW CORPORATION
Suite 1700 - 1185 West Georgia Street
Vancouver, BC V6E 4E6

**Geoffrey Trotter**

Telephone: 604-678-9190
Facsimile: 604-259-2459
Email: gt@gtlawcorp.com

Counsel to the Intervener, Evangelical Fellowship of Canada

VINCENT DAGENAIS GIBSON LLP
260 Dalhousie Street, Suite 400
Ottawa, ON K1N 7E4

**Albertos Polizogopoulos**

Telephone: 613-241-2701
Facsimile: 613-241-2599
Email: albertos@vdg.ca

Agent to the Intervener, Evangelical Fellowship of Canada

VINCENT DAGENAIS GIBSON LLP
Suite 400 - 260 Dalhousie Street
Ottawa, ON K1N 7E4

**Albertos Polizogopoulos**

Telephone: 613-241-2701
Facsimile: 613-241-2599
Email: albertos@vdg.ca

Counsel to the Interveners, Christian Medical and Dental Society of Canada and Canadian Federation of Catholic Physicians' Societies

SACK GOLDBLATT MITCHELL LLP
1100 – 20 Dundas Street West
Box 180
Toronto, ON M5G 2G8

**Cynthia Petersen**
**Kelly Doctor**

Telephone: 416-977-6070
Facsimile: 416-591-7333
Email: cpetersen@sgmlaw.com

Counsel to the Intervener, Dying with Dignity

SACK GOLDBLATT MITCHELL LLP
500 - 30 Metcalfe Street
Ottawa, ON K1P 5L4

**Raija Pulkkinen**

Telephone: 613-235-5327
Facsimile: 613-235-3041
Email: rpulkkinen@sgmlaw.com

Agent to the Intervener, Dying with Dignity

POLLEY FAITH LLP
80 Richmond Street West, Suite 1300
Toronto, ON M5H 2A4

**Harry Underwood**

Telephone: 416-365-6446
Facsimile: 416-365-1601
Email: hunderwood@polleyfaith.com

Counsel to the Intervener, Canadian Medical Association

GOWLING LAFLEUR HENDERSON LLP
160 Elgin Street, Suite 2600
Ottawa, ON K1P 1C3

**D. Lynne Watt**

Telephone: 613-786-8695
Facsimile: 613-788-3509
Email: lynne.watt@gowlings.com

Agent to the Intervener, Canadian Medical Association

VINCENT DAGENAIS GIBSON LLP
Suite 400 - 260 Dalhousie Street
Ottawa, ON K1N 7E4

**Russell G. Gibson**
**Albertos Polizogopoulos**

Telephone: 613-241-2701 Ext: 229
Facsimile: 613-241-2599
Email: russell.gibson@vdg.ca

Counsel to the Intervener, Catholic Health Alliance of Canada.

SACK GOLDBLATT MITCHELL LLP
1100 - 20 Dundas Street West
Toronto, ON M5G 2G8

**Marlys A. Edwardh**
**Daniel Sheppard**

Telephone: 416-979-4380
Facsimile: 416-979-4430
Email: medwardh@sgmlaw.com

Counsel to the Intervener, Criminal Lawyers' Association (Ontario)

GOWLING LAFLEUR HENDERSON LLP
160 Elgin Street, Suite 2600
Ottawa, ON K1P 1C3

**D. Lynne Watt**

Telephone: 613-786-8695
Facsimile: 613-788-3509
Email: lynne.watt@gowlings.com

Agent to the Intervener, Criminal Lawyers' Association (Ontario)

GRATI & COMPANY
302 - 560 Beatty Street
Vancouver, BC V6B 2L3

**Jason B. Grati**

Telephone: 604-694-1919
Facsimile: 604-608-1919

Counsel to the Interveners, Farewell Foundation for the Right to Die and Association québécoise pour le droit de mourir dans la dignité

GOWLING LAFLEUR HENDERSON LLP
160 Elgin Street
26th Floor
Ottawa, ON K1P 1C3

**Guy Régimbald**

Telephone: 613-786-0197
Facsimile: 613-563-9869
Email: guy.regimbald@gowlings.com

Agent to the Interveners, Farewell Foundation for the Right to Die and Association québécoise pour le droit de mourir dans la dignité

BORDEN LADNER GERVAIS LLP
Scotia Plaza, 40 King Street West
Toronto, ON M5H 3Y4

**Christopher D. Bredt**
**Ewa Krajewska**
**Margot Finley**

Telephone: 416-367-6165
Facsimile: 416-361-7063
Email: cbredt@blg.com

Counsel to the Intervener, Canadian Civil Liberties Association

BORDEN LADNER GERVAIS LLP
World Exchange Plaza
100 Queen Street, Suite 1300
Ottawa, ON K1P 1J9

**Nadia Effendi**

Telephone: 613-237-5160
Facsimile: 613-230-8842
Email: neffendi@blg.com

Agent to the Intervener, Canadian Civil Liberties Association

BORDEN LADNER GERDAIS LLP
1200 - 200 Burrard Street
Vancouver, BC V7X 1T2

**Angus M. Gunn, Q.C.**

Telephone: 604-687-5744
Facsimile: 604-687-1415

Counsel to the Intervener, Alliance Of People With Disabilities Who Are Supportive Of Legal Assisted Dying Society

BORDEN LADNER GERVAIS LLP
World Exchange Plaza
100 Queen Street, Suite 1300
Ottawa, ON K1P 1J9

**Nadia Effendi**

Telephone: 613-237-5160
Facsimile: 613-230-8842

Agent to the Intervener, Alliance Of People With Disabilities Who Are Supportive Of Legal Assisted Dying Society

FARRIS, VAUGHAN, WILLS & MURPHY LLP
Box 10026, Pacific Cre. S. TD Bank Tower
25th Floor - 700 Georgia Street West
Vancouver, BC V7Y 1B3

**Tim A. Dickson**
**R.J.M. Androsoff**

Telephone: 604-661-9341
Facsimile: 604-661-9349
Email: tdickson@farris.com

Counsel to the Intervener, Canadian Unitarian Council

BORDEN LADNER GERVAIS LLP
World Exchange Plaza
100 Queen Street, Suite 1300
Ottawa, ON K1P 1J9

**Nadia Effendi**

Telephone: 613-237-5160
Facsimile: 613-230-8842

Agent to the Intervener, Canadian Unitarian Council

SCHER LAW PROFESSIONAL CORPORATION
69 Bloor Street East, Suite 210
Toronto, ON M4W 1A9

**Hugh R. Scher**
**Geoff Cowper, Q.C.**

Telephone: 416-515-9686
Facsimile: 416-969-1815
Email: hugh@sdlaw.ca

Counsel to the Intervener, Euthanasia Prevention Coalition and Euthanasia Prevention Coalition – British Columbia

FASKEN MARTINEAU DUMOULIN LLP
55 Metcalfe Street, Suite 1300
Ottawa, ON K1P 6L5

**Yael Wexler**

Telephone: 613-236-3882
Facsimile: 613-230-6423
Email: ywexler@fasken.com

Agent to the Intervener, Euthanasia Prevention Coalition and Euthanasia Prevention Coalition – British Columbia

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## PART I: OVERVIEW AND STATEMENT OF FACTS

1. This appeal is about whether seriously ill or disabled Canadians have a constitutional right to physician-assisted death.[1]

2. But it is *also* about whether healthcare providers should be obligated to participate in or support in such acts. Even though the focus of section 241 of the *Criminal Code*[2] is on the person who assists in a suicide, the jeopardy faced by healthcare providers who object to killing patients or assisting patients kill themselves is absent from this appeal.

3. The Catholic Civil Rights League, the Faith and Freedom Alliance and the Protection of Conscience Project (the **Interveners**) submit as follows:

(a) An indeterminate number of Canadian healthcare providers consider physician-assisted death immoral or unethical for reasons of conscience or religion. Their views are consistent with the current Canadian legal framework, which would be fundamentally changed if physician-assisted death were decriminalized. If this change were implemented, these healthcare providers would be confronted by demands that they directly or indirectly participate in what they consider to be immoral activities.

(b) If the objective of the impugned legislation is to prevent vulnerable people from succumbing to pressure to commit suicide, it is fully consistent with the objective of the law to provide an additional safeguard by ensuring that those who object to physician-assisted death for reasons of conscience or religion cannot be compelled to participate in or support the procedures, or be discriminated against for refusing to do so.

(c) To the extent that this Court might find the impugned legislation to be of no force and effect, it should direct legislatures to ensure that replacement legislation provides robust protection for the freedoms and equality of those who decline to support or participate in physician-assisted death for reasons of conscience or religion.

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[1] As defined by the trial judge and appellants, physician-assisted death includes both physician-assisted suicide and consensual physician-assisted death or voluntary euthanasia.
[2] RSC 1985, C-46.

4. The Interveners accept the facts as stated in the factum of the Attorney General of Canada (**AGC**).

## PART II: STATEMENT OF POSITION

5. The Interveners support the AGC's position that if the impugned legislation is declared invalid, any such declaration should be suspended to allow the legislature to implement constitutional legislation. The Interveners submit that any such legislation should robustly protect the freedom of conscience of healthcare providers who object to directly or indirectly participating in physician-assisted death.

6. The Catholic Civil Rights League and the Faith and Freedom Alliance support the AGC's position that the impugned legislation does not infringe sections 7 or 15 of the *Canadian Charter of Rights and Freedoms* (***Charter***)[3] or that such an infringement is demonstrably justified under section 1 of the *Charter*. The Interveners do not take a position on the other questions at issue in this appeal.

## PART III: STATEMENT OF ARGUMENT

### A. Overview

7. In this case, the trial judge concludes that there are "experienced and reputable Canadian physicians" who would "in some circumstances" assist patients to die.[4] Though she acknowledges an ethical debate about a physician's right to refuse to perform physician-assisted death, she does not discuss the issue further because the appellants did not assert that healthcare providers "should be compelled to assist in suicide or perform euthanasia".[5]

8. In doing so, the trial judge ignores the fact that physicians and other healthcare providers[6] have no legal duty to kill patients or assist patients in killing themselves, nor ought there be. The trial judge in *Rodriguez v British Columbia (AG)* correctly found:

> In the case at bar, dealing with the subject of physician-assisted suicide, in my view, there could be no corresponding duty at law on a

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[3] Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act (1982)* (UK), 1982, c 11.
[4] Reasons for Judgment of Smith J, Supreme Court of British Columbia (**Trial Reasons**), ¶319, Joint Record, Vol I, 102.
[5] *Ibid*, ¶311, Joint Record, Vol I, 96.
[6] The appellants' definition of physician-assisted death seeks to limit the involvement of healthcare providers to physicians and surgeons, *i.e.*, medical practitioners as defined in section 29 of the *Interpretation Act*, RSBC 1996, c 238. However, physician-assisted death may require the involvement of many other providers, including nurses, pharmacists, and psychologists, who provide either direct health-related services or work in the support and delivery of those services.

> physician to assist the petitioner in achieving her goal. Consequently, if s. 241 were struck on the basis that it violated s. 7 *Charter* rights, she would have the right to request assistance but the person requested to so perform would have no duty at law (with or without s. 241) to comply with the petitioner's wishes. If it were otherwise and such a duty existed which would be enforceable at the instance of the petitioner, it would ultimately mean that the petitioner could apply for a court order to compel another to assist her in carrying out her wishes. When the petitioner's position is taken to that extreme it demonstrates, in my view, that there is no right as there is no corresponding duty. Insofar as s. 241 may be alleged to interfere with her life, liberty or security of person, that only does so on the basis that it interferes with the rights of others who may wish to assist the petitioner in achieving her goal.[7]

9. The appellants, on this appeal, do, in fact, assert that physicians (and, presumably all healthcare providers) have an ethical requirement to "act in their patients' best interests",[8] which implies that healthcare providers may be obligated to participate in physician-assisted death.

10. In deciding this case, this Court must consider how to protect the freedom of conscience of healthcare providers who morally object to directly or indirectly killing patients or assisting patients kill themselves.

## B. The Freedom of Conscience and Religion

11. Everyone has the freedom of conscience and religion.[9]

12. The freedom of conscience, unlike the freedom of religion, has only been defined once by this Court. In *R v Morgentaler*,[10] Justice Wilson, in her concurring opinion, said that the freedom of conscience is "personal morality which is not founded in religion" and "conscientious beliefs which are not religiously motivated".[11]

13. Other sources of interpretation are consistent with this view. The European Court of Human Rights has similarly defined the freedom of conscience: "a weighty and substantial aspect of human

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[7] *Rodriguez v British Columbia (AG)*, [1992] BCJ no 2738 (WL Can) ¶15, Interveners' Book of Authorities (**Interveners' Authorities**), Tab 1, aff'd [1993] 3 SCR 519 [***Rodriguez SCC***], Attorney General of Canada's Book of Authorities (**AGC Authorities**), Vol II, Tab 44.
[8] Appellants' Factum, pages 3-4, ¶9 and fn 11.
[9] *Charter, supra* note 3, s 2(a).
[10] [1988] 1 SCR 30 at 161, Interveners' Authorities, Tab 2.
[11] *Ibid* at 177-178, Interveners' Authorities, Tab 2.

life and behaviour" that rises above a mere opinion.[12] The *Canadian Oxford English Dictionary* defines "conscience" as "a person's moral sense of right and wrong".[13]

14. This Court has never found a law or government action to infringe the freedom of conscience. As such, it has never discussed the legal test for finding a breach of the section 2(a) freedom of conscience.

15. The test for triggering a conscience freedom claim is or should be the same as a religious freedom claim: (a) does the claimant have a moral practice or belief that calls for a particular line of conduct; and (b) is he or she sincere in his or her belief?[14]

16. The Interveners use the term "conscience" in this factum, though a healthcare provider's objection to participating in physician-assisted death may equally arise from his or her religious beliefs.

## C. The Obligation to Assist in Intentionally Killing a Patient

17. The appellants' position that section 241 of the *Criminal Code* should be declared unconstitutional necessarily implies that, in some circumstances, healthcare providers should have a legal or professional obligation to kill patients or assist patients kill themselves.

18. If healthcare providers were required to kill a patient, either morally or legally, this obligation would be an extraordinary departure from modern Canadian law. There is no obligation in Canadian law to kill an individual. Although the historic laws of England (and, therefore, Canada) imposed such an obligation on public executioners,[15] in modern Canada there is no obligation to kill, not even in military combat.

19. The trial judge's reasons and the appellants' position seem to suggest that this issue is irrelevant because the appellants "do not assert that a physician should be compelled to assist in suicide or perform euthanasia."[16]

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[12] *Campbell v The United Kingdom*, no 7511/76; 7743/76, [1982] ECHR 1 ¶36, Interveners' Authorities, Tab 3.
[13] 11th ed, *sub verbo* "conscience", Interveners' Authorities, Tab 4.
[14] *Syndicat Northcrest v Amselem*, 2004 SCC 47, [2004] 2 SCR 551 ¶56, Interveners' Authorities, Tab 5.
[15] William Blackstone, *Commentaries on the Laws of England*, 12th ed, vol 4 (London, UK: Strahan & Woodfall, 1795) at 403-404, Interveners' Authorities, Tab 6.
[16] Trial Reasons, *supra* note 4, ¶311, Joint Record, Vol I, 96.

20. This conclusion misses the mark. Even if a healthcare provider objects to directly participating in physician-assisted death, they may be called upon to refer the patient to a non-objecting healthcare provider, which may equally infringe the objecting provider's freedom of conscience by compelling him or her to become a party to what they believe is morally wrong.

21. Further, it is not clear from the trial judge's reasons in this case whether a healthcare provider *may justifiably* object to assist a patient in killing themselves:

(a) In *Rodriguez*, this Court made clear that patients—not doctors—have the right to decide if any treatment is to be administered.[17]

(b) The evidence at trial goes further: Professor Margaret Batin testified that physicians should be "obliged" to offer "assistance in dying".[18]

(c) The Royal Society of Canada Expert Panel's Report, *End-of-Life Decision Making*, admitted into evidence by the trial judge,[19] states that objecting physicians "are obligated to pass the person requesting [physician-assisted death] on to a professional who will provide such assistance."[20]

22. In the absence of clear direction from this Court about the protection of the freedom of conscience of objecting healthcare providers, there is likely to be conflict between patients and doctors, or amongst healthcare providers should physician-assisted death be decriminalized.

23. This conflict is occurring with respect to abortion. At present, physicians are not required to perform abortions. However, some pro-abortion advocates argue that physicians who refuse to provide or otherwise facilitate abortions violate the Canadian Medical Association's *Code of Ethics* and policies on abortions. Abortion advocates argue: "Even if not willing to provide abortion services themselves, physicians should ensure that patients receive the referrals they require, and in a timely fashion."[21]

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[17] *Rodriguez SCC*, *supra* note 7 at 598, AGC Authorities, Vol II, Tab 44.
[18] Trial Reasons, *supra* note 4, ¶240, Joint Record, Vol I, 73.
[19] *Ibid*, ¶129, Joint Record, Vol I, 37.
[20] Udo Schuklenk, *The Royal Society of Canada Expert Panel: End-of-Life Decision Making* (Ottawa: The Royal Society of Canada, November 2011) at 101, Joint Record, Vol LII, at 14795.
[21] Sanda Rogers & Jocelyn Downie, "Abortion: ensuring access" 175:1 CMAJ (4 July 2006) 9, Interveners' Authorities, Tab 7.

24. If this Court decriminalizes physician-assisted death without considering the freedom of conscience of objecting healthcare providers, those providers may find themselves subject to discrimination and unfair treatment, such as being barred from working in palliative care units or denied hospital privileges. Such discrimination or unfair treatment may result from conflicts amongst healthcare providers, conflicts between healthcare providers and institutions (such as hospitals) or from conflicts with professional bodies.

25. Further, in the absence of direction from this Court, the decision in *Trinity Western University v British Columbia College of Teachers*[22] may lead regulators and other state actors to believe that, in fact, healthcare providers *must* set aside the personal beliefs and take action against objecting providers.

26. In *Trinity Western*, this Court said: "The freedom to hold beliefs is broader than the freedom to act on them".[23] Though the Interveners do not dispute this proposition in general, it is not responsive to all of the complex questions that arise from the freedom of conscience and religion in a pluralistic democracy. It fails to respond to the nature of the "weighty and substantial" moral belief protected by the freedom of conscience. The Ontario Human Rights Commission's position, with respect to the Ontario *Human Rights Code,*[24] is that doctors must "check their personal views at the door" when providing medical care even if those views are sincerely-held moral convictions.[25]

27. The Province of Québec has seemingly enshrined this view in its legislation. The recent *An Act respecting end-of-life care* states: "This Act does not limit the right of health professionals to refuse, in accordance with their code of ethics, to provide or take part in providing end-of-life care for reasons of conscience".[26] But the *Code of Ethics of Physicians* requires conscientious objectors to "offer to help the patient find another physician".[27] As such, if a physician in Québec objects to assisting a patient kill themselves and, sincerely believes that referring the patient to another physician is "assisting", Québec's law *requires* the physician to act against their beliefs. The appellants cite the Québec end-of-life legislation as one possible remedial model if the impugned

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[22] 2001 SCC 31, [2001] 1 SCR 772, Interveners' Authorities, Tab 8.
[23] *Ibid* ¶36, Interveners' Authorities, Tab 8.
[24] RSO 1990, c H.19.
[25] Ontario Human Rights Commission, Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy "Physicians and the Ontario Human Rights Code", online: <http://www.ohrc.on.ca/en/submission-ontario-human-rights-commission-college-physicians-and-surgeons-ontario-regarding-draft-0>, Interveners' Authorities, Tab 9; cited in Sean Murphy and Stephen J Genius, "Freedom of Conscience in Health Care: Distinctions and Limits" 10:3 Journal of Bioethical Inquiry (October 2013) 347 at 347, Interveners' Authorities, Tab 10.
[26] RSQ c S-32.0001, s 44.
[27] CQLR c M-9, r 17, s 24.

legislation is struck down,[28] and despite asserting there is no issue on this appeal of compelling healthcare providers to participate in killing.

28. If the views of the Royal Society of Canada Expert Panel, the Ontario Human Rights Commission, the Province of Québec or other advocates were adopted, it would mean that healthcare providers have a freedom to *hold* beliefs but can be compelled to act *against* beliefs, whether directly or indirectly. Though the state can *limit* the exercise of freedom of conscience by preventing individuals from doing what they believe is *good*, because it is objectively harmful or the limitation serves the common good, it does not follow that the state may *force* individuals to do what they believe is *wrong*.

29. It is simply unjust to require, either as a matter of express law or by omission, that healthcare providers who have a moral objection to killing patients or assisting patients kill themselves "park" that belief at the risk of discriminatory or unfair treatment.

## D. The Freedom of Conscience is a Social Interest

30. The principles of fundamental justice engaged by section 7 of the *Charter* must be "basic tenets and principles, not only of our judicial process, but also of other components of our legal system".[29] These principles must also be guided by a balance between individual and societal interests.[30] Though the Interveners acknowledge that there is no freestanding "balancing" of interests under section 7, at the same time, this Court cannot ignore social interests either in its section 7 or section 1 analysis. In this case, this Court should consider two important social interests: (a) the autonomy of patients *and* healthcare providers; and (b) the promotion of interdependency.

### 1. The Clash of Autonomies

31. The appellants emphasize the importance of autonomy. But their characterization of autonomy is one-sided—they focus exclusively on patients.

32. The appellants fail to consider the autonomy of healthcare providers, who have the freedom of choice not to assist a patient in killing themselves because it violates that provider's conscience. This choice is protected by the "basic theory" underlying the *Charter*: "The state will respect choices

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[28] Appellants' Factum, page 52, ¶156, fn 312.
[29] *Rodriguez SCC*, *supra* note 7 at 591, AGC Authorities, Vol II, Tab 44.
[30] *R v Malmo-Levine; R v Caine*, 2003 SCC 74, [2003] 3 SCR 571 ¶96, Interveners' Authorities, Tab 11.

made by individuals and, to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life."[31]

33. The appellants argue that the patient's autonomy interest requires physicians to provide services required by a patient, even if that means killing the patient. In doing so, the appellants characterize conflicts between the patient and the healthcare provider as a conflict between the patient's *autonomy or self-determination* and that of the physician. The freedom of conscience and religion becomes, in this view, nothing more than an expression of personal autonomy or self-determination. It empties the section 2(a) freedom of its moral, ethical or religious content, reducing the sincerely-held belief to a mere opinion.

34. This subordination, though masked as "balancing", is inappropriate when dealing with an individual's deeply held beliefs and suggests that some are superior to others or may be compromised. The possibility of this subordination ought to be properly considered in this Court's section 7 and section 1 analysis.

### 2. Promoting Interdependency

35. Autonomy and choice are not the only societal interests at issue in this case. Indeed, our society is fundamentally interdependent—we rely on each other to make it function. In *Lavigne v OPSEU*, Justice La Forest poignantly observed: "As a matter of metaphysical and sociological reality, 'no man is an island', and the *Charter* must be taken to recognize this. ... In Justice Holmes' phrase, the state is 'the one club to which we all belong' and its activities will inevitably associate us with policies and groups...."[32]

36. This interdependency, association and relationship with others, is at the root of our collective compassion and our legal and moral duties to each other. It also forms the basis of our democratic processes, our social programs, our "multicultural heritage"[33] and diversity, and social fabric. Interdependency, indeed, is the root of legitimate autonomy—many of our choices in our day-to-day lives can only be made with the assistance of others. Decriminalizing physician-assisted death without protecting the freedom of conscience of healthcare providers "on the front line" disregards interdependency in favour of "one conception of the good life".

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[31] *Morgentaler*, *supra* note 10 at 166, Interveners' Authorities, Tab 2.
[32] [1991] 2 SCR 211 at 320-21, Interveners' Authorities, Tab 12.
[33] *Charter*, *supra* note 3, s 27.

## E. Protecting Conscientious Objectors

37. The legislative purpose of section 241 is to protect "persons who may be vulnerable to the influence of others in deciding whether, when and how to terminate their lives."[34] There seems to be no dispute between the parties that this objective is, in and of itself, valid and legitimate. The issue in dispute is whether the means chosen by Parliament is consistent with this objective.

38. The appellants in this case seek a declaration that the impugned laws are of no force and effect either entirely or to the extent they prohibit physician-assisted death. They expressly argue against a suspension of invalidity, suggesting that Parliament need not do anything in response. The AGC and other respondents seek that the laws be upheld.

39. "In the absence of legislation, it is open to this Court to suggest guidelines"[35] or directions to the legislature. In the event this Court grants the appeal, the Interveners submit it must give direction to the legislature that, in enacting a regulatory scheme to deal with end-of-life decisions, the legislature must provide robust freedom of conscience to healthcare providers. Such direction is wholly consistent with the purpose of the impugned laws.

40. Finally, it is not enough for legislatures to permit healthcare providers to refuse to provide or take part in physician-assisted death. Rather, the applicable schemes should prevent healthcare providers from being intimidated (either directly or indirectly) into consulting or planning the death, pronouncing death, or providing a professional opinion or rendering medical assistance to killing patients or assisting patients kill themselves.

## F. Conclusion

41. Though the focus of section 241 of the *Criminal Code* is on the person counseling, aiding or abetting in the suicide and though the appellants seek a declaration that would necessarily engage healthcare providers in this act, there is little or no discussion about the impact this appeal will have on healthcare providers who object to killing patients or assisting patients kill themselves on a moral or conscientious basis.

42. There should be no dispute that healthcare providers with a sincere belief that assisting suicide is wrong are protected under the *Charter*, from being coerced into violating this belief.

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[34] *Rodriguez SCC*, *supra* note 7 at 558, AGC Authorities, Vol II, Tab 44.
[35] *R v Seaboyer*, [1991] 2 SCR 577 at 633, Interveners' Authorities, Tab 13.

Nonetheless, there is a seemingly influential view that physicians and other healthcare providers are "duty-bound" to kill patients or assist patients kill themselves, based on the "the patient's best interest" and regardless of the provider's moral beliefs.

43. The views of healthcare providers opposed to killing patients or assisting patients kill themselves form part of the social framework that this Court should consider when determining if section 241 of the *Criminal Code* manifests the legitimate objective of protecting vulnerable persons from being influenced into suicide.

44. If this Court strikes down section 241 of the *Criminal Code* as it relates to physician-assisted death, this Court should make clear to the legislature that any legislation in this area must protect the freedom of conscience of healthcare providers. That protection cannot be limited to a right of refusal. The protection must be broader. It must ensure that healthcare providers are not directly or indirectly coerced into becoming parties to killing patients or assisting patients kill themselves.

45. "The conscience of each is a personal matter and the concern of nobody else."[36] Just as it would be "distressing" for the majority to impose its religious views on a minority, it would be a "shocking error" to expose conscientious objectors to compulsion or, worse, discrimination because they refuse to cause a patient's death.

## PART IV: SUBMISSIONS CONCERNING COSTS

46. The Interveners do not seek their costs of this appeal. The Interveners should not be ordered to the pay the whole or any part of the costs of this appeal.

## PART V: ORDER REQUESTED

47. The Interveners respectfully request permission to present oral argument at the hearing of this appeal.

**ALL OF WHICH IS RESPECTFULLY SUBMITTED THIS 29th DAY OF AUGUST 2014.**

**BENNETT JONES LLP**
Counsel to the Interveners

[36] *Chaput v Romain*, 1955 SCR 834, (1955) 1 DLR (2d) 241 at 840 (translated), Interveners' Authorities, Tab 14.

## PART VI: TABLE OF AUTHORITIES

| JURISPRUDENCE | CITED AT: |
|---|---|
| *Campbell and Cosans v The United Kingdom,* no 7511/76; 7743/76, [1982] ECHR 1 | ¶13 |
| *Chaput v Romain,* [1955] SCR 834, (1955) 1 DLR (2d) 241 | ¶45 |
| *Lavigine v OPSEU,* [1991] 2 SCR 211 | ¶35 |
| *R v Malmo-Levine; R v Caine,* 2003 SCC 74, [2003] 3 SCR 571 | ¶30 |
| *R v Morgentaler,* [1988] 1 SCR 30 | ¶12, ¶32 |
| *R v Seaboyer,* [1991] 2 SCR 577 | ¶39 |
| *Rodriguez v British Columbia (Attorney General),* [1992] BCJ no 2738 (WL Can) | ¶8 |
| *Rodriguez v British Columbia (Attorney General,* [1993] 3 SCR 519 | ¶21, ¶30, ¶37 |
| *Syndicat Northcrest v Amselem,* 2004 SCC 47, [2004] 2 SCR 551 | ¶15 |
| *Trinity Western University v British Columbia College of Teachers,* 2001 SCC 31, [2001] 1 SCR 772 | ¶25, ¶26 |
| **SCHOLARLY LITERATURE** | **CITED AT:** |
| Blackstone, William, *Commentaries on the Laws of England,* 12th ed Vol 4 (London, UK: Straham & Woodfall, 1795) | ¶18 |
| *Concise Oxford English Dictionary,* 11th ed, *sub verbo* "conscience" | ¶13 |
| Murphy, Sean & Stephen J Genius, "Freedom of Conscience in Health Care: Distinctions and Limits" (2013) 10:3 J Bioeth Inq 347 | ¶26 |
| Ontario Human Rights Commission, Submission of the Ontario Human Rights Commission to the College of Physicians and Surgeons of Ontario Regarding the draft policy, "Physicians and the Ontario Human Rights Code", online: <http://www.ohrc.on.ca/en/submission-ontario-human-rights-commission-college-physicians-and-surgeons-ontario-regarding-draft-0> | ¶26 |
| Rogers, Sanda & Jocelyn Downie, "Abortion: Ensuring Access" (2006) 175:1 CMAJ 9 | ¶23 |

## PART VII: CONSTITUTION AND STATUTES

**Constitution**

| ***Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11** | ***Charte canadienne des droits et libertés*, partie I de la *Loi constitutionelle de 1982*, constituent l'annexe B de la *Loi de 1982 sur le Canada* (R-U), 1982 c 11** |
|---|---|
| Rights and freedoms in Canada<br><br>1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society. | Droits et libertés au Canada<br><br>1. La *Charte canadienne des droits et libertés* garantit les droits et libertés qui y sont énoncés. Ils ne peuvent être restreints que par une règle de droit, dans des limites qui soient raisonnables et dont la justification puisse se démontrer dans le cadre d'une société libre et démocratique. |
| Life, liberty and security of person<br><br>7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. | Vie, liberté et sécurité<br><br>7. Chacun a droit à la vie, à la liberté et à la sécurité de sa personne; il ne peut être porté atteinte à ce droit qu'en conformité avec les principes de justice fondamentale. |
| Equality before and under law and equal protection and benefit of law<br><br>15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.<br><br>Affirmative action programs<br><br>(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. | Égalité devant la loi, égalité de bénéfice et protection égale de la loi<br><br>15. (1) La loi ne fait acception de personne et s'applique également à tous, et tous ont droit à la même protection et au même bénéfice de la loi, indépendamment de toute discrimination, notamment des discriminations fondées sur la race, l'origine nationale ou ethnique, la couleur, la religion, le sexe, l'âge ou les déficiences mentales ou physiques.<br><br>Programmes de promotion sociale<br><br>(2) Le paragraphe (1) n'a pas pour effet d'interdire les lois, programmes ou activités destinés à améliorer la situation d'individus ou de groupes défavorisés, notamment du fait de leur race, de leur origine nationale ou ethnique, de leur couleur, de leur religion, de leur sexe, de leur âge ou de leurs déficiences mentales ou physiques. |

| ***Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11** | ***Charte canadienne des droits et libertés*, partie I de la *Loi constitutionelle de 1982*, constituent l'annexe B de la *Loi de 1982 sur le Canada* (R-U), 1982 c 11** |
|---|---|
| Multicultural Heritage<br><br>27. This Charter shall be interpreted in a manner consistent with the preservation and enhancement of the multicultural heritage of Canadians. | Maintien du patrimoine culturel<br><br>27. Toute interprétation de la présente charte doit concorder avec l'objectif de promouvoir le maintien et la valorisation du patrimoine multiculturel des Canadiens. |

**Federal**

| ***Criminal Code*, RSC 1985, C-46** | ***Code criminel*, LRC (1985), ch C-46** |
|---|---|
| Counseling or aiding suicide<br><br>241. Every one who<br><br>(a) counsels a person to commit suicide, or<br><br>(b) aids or abets a person to commit suicide,<br><br>whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years. | Fait de conseiller le suicide ou d'y aider<br><br>241. Est coupable d'un acte criminel et passible d'un emprisonnement maximal de quatorze ans quiconque, selon le cas :<br><br>*a*) conseille à une personne de se donner la mort;<br>*b*) aide ou encourage quelqu'un à se donner la mort,<br><br>que le suicide s'ensuive ou non. |

**Québec**

| ***An Act respecting end-of-life care*, RSQ c S-32.0001** | ***Loi concernant les soins de fin de vie*, LRQ c S-32.0001** |
|---|---|
| Mandate of the Commission<br><br>44. In exercising its functions under the first paragraph of section 42, the Commission may, as an exception, take such measures as<br><br>(1) soliciting the opinion of individuals or groups on any end-of-life care issue;<br><br>(2) conducting or commissioning studies and research it deems necessary; and<br><br>(3) calling on outside experts to report to it on one or more specific points. | Mandat de la Commission<br><br>44. Dans l'exercice des fonctions qui lui sont dévolues par le premier alinéa de l'article 42, la Commission peut notamment, de façon exceptionnelle:<br><br>1° solliciter l'opinion de personnes et de groupes sur toute question relative aux soins de fin de vie;<br><br>2° effectuer ou faire effectuer les études et les recherches qu'elle juge nécessaires;<br><br>3° avoir recours à des experts externes afin de lui faire rapport sur un ou plusieurs points précis qu'elle détermine. |

| ***Code of Ethics of Physicians*, CQLR c M-9, r 17** | ***Code de déontologie des médecins*, RLRQ c M-9, r 17** |
|---|---|
| 24. A physician must, where his personal convictions prevent him from prescribing or providing professional services that may be appropriate, acquaint his patient with such convictions; he must also advise him of the possible consequences of not receiving such professional services.<br><br>The physician must then offer to help the patient find another physician. | 24. Le médecin doit informer son patient de ses convictions personnelles qui peuvent l'empêcher de lui recommander ou de lui fournir des services professionnels qui pourraient être appropriés, et l'aviser des conséquences possibles de l'absence de tels services professionnels.<br><br>Le médecin doit alors offrir au patient de l'aider dans la recherche d'un autre médecin. |

**British Columbia**

| ***Interpretation Act*, RSBC 1996, c 238** |
|---|
| Expressions defined<br><br>29. In an enactment:<br><br>[...]<br><br>"medical practitioner" means a registrant of the College of Physicians and Surgeons of British Columbia entitled under the Health Professions Act to practise medicine and to use the title "medical practitioner";<br><br>[...] |

File Number: 35591

**IN THE SUPREME COURT OF CANADA**
(ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA)

BETWEEN:

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

Appellants
(Respondents/Cross-Appellants)

– and –

**ATTORNEY GENERAL OF CANADA**

Respondent
(Appellant/Cross-Respondent)

– and –

**ATTORNEY GENERAL OF BRITISH COLUMBIA**

Respondent
(Appellant)

– and –

**ATTORNEY GENERAL OF ONTARIO, ATTORNEY GENERAL OF QUEBEC, ATTORNEY GENERAL OF BRITISH COLUMBIA, COUNCIL OF CANADIANS WITH DISABILITIES, THE CANADIAN ASSOCIATION FOR COMMUNITY LIVING, CHRISTIAN LEGAL FELLOWSHIP, CANADIAN HIV/AIDS LEGAL NETWORK, THE HIV & AIDS LEGAL CLINIC ONTARIO, ASSOCIATION FOR REFORMED POLITICAL ACTION CANADA, PHYSICIANS' ALLIANCE AGAINST EUTHANASIA, EVANGELICAL FELLOWSHIP OF CANADA, CHRISTIAN MEDICAL AND DENTAL SOCIETY OF CANADA, CANADIAN FEDERATION OF CATHOLIC PHYSICIANS' SOCIETIES, DYING WITH DIGNITY, CANADIAN MEDICAL ASSOCIATION, CATHOLIC HEALTH ALLIANCE OF CANADA, CRIMINAL LAWYERS' ASSOCIATION (ONTARIO), FAREWELL FOUNDATION FOR THE RIGHT TO DIE, ASSOCIATION QUÉBÉCOISE POUR LE DROIT DE MOURIR DANS LA DIGNITÉ, CANADIAN CIVIL LIBERTIES ASSOCIATION, CATHOLIC CIVIL RIGHTS LEAGUE, FAITH AND FREEDOM ALLIANCE, PROTECTION OF CONSCIENCE PROJECT, ALLIANCE OF PEOPLE WITH DISABILITIES WHO ARE SUPPORTIVE OF LEGAL ASSISTED DYING SOCIETY, CANADIAN UNITARIAN COUNCIL and EUTHANASIA PREVENTION COALITION AND EUTHANASIA PREVENTION COALITION – BRITISH COLUMBIA**

Interveners

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# FACTUM OF THE INTERVENERS CATHOLIC CIVIL RIGHTS LEAGUE, FAITH AND FREEDOM ALLIANCE and PROTECTION OF CONSCIENCE PROJECT

(Rule 42 of the *Rules of the Supreme Court of Canada*)

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**BENNETT JONES LLP**
3400 One First Canadian Place
P.O. Box 130
Toronto, ON M5X 1A4

**Robert W. Staley**
**Ranjan K. Agarwal**
**Jack R. Maslen**
Telephone: 416-777-4857
Facsimile: 416-863-1716
Email: staleyr@bennettjones.com

Counsel to the Interveners, the Catholic Civil Rights League, the Faith and Freedom Alliance and the Protection of Conscience Project

**BENNETT JONES LLP**
World Exchange Plaza
1900-45 O'Connor Street
Ottawa, ON K1P 1A4

**Sheridan Scott**
Telephone: 613-683-2302
Facsimile: 613-683-2323
Email: scotts@bennettjones.com

Agent to the Interveners, the Catholic Civil Rights League, the Faith and Freedom Alliance and the Protection of Conscience Project