Court of Appeal File No: CA040079

COURT OF APPEAL

ON APPEAL FROM: THE ORDER OF THE HONOURABLE MADAM JUSTICE SMITH OF THE SUPREME COURT OF BRITISH COLUMBIA PRONOUNCED JUNE 15, 2012

BETWEEN:

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

RESPONDENTS
APPELLANTS ON CROSS APPEAL
(Plaintiffs)

AND:

ATTORNEY GENERAL OF CANADA

APPELLANT
RESPONDENT ON CROSS APPEAL
(Defendant)

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CHRONOLOGY OF RELEVANT DATES IN THE APPEAL

DATE	EVENT
March 27, 1991	Private Member's Bill C-351, An *Act to amend the Criminal Code (terminally ill persons)*, was introduced in the House of Commons. The bill died with the prorogation of Parliament.
February 18, 1992	Private Member's Bill C-203, An *Act to amend the Criminal Code (terminally ill persons)*, was introduced in the House of Commons in May, 1991. On September 24, 1991, Bill C-203 was referred to the Legislative Committee H for consideration. The Committee commenced hearings and heard from 21 non-governmental witnesses as well as officials from the Department of Justice and the Law Reform Commission of Canada. The Committee on Bill C-203 adjourned without reporting back to the House of Commons on Bill C-203.
October 24, 1991	Private Member's Bill C-261, *An act to legalize the administration of euthanasia under certain conditions*, was introduced in the House of Commons in June, 1991. Bill C-261 was debated at second reading but never proceeded to a vote.
December 9, 1992	Private Member's Bill C-385, *An Act to amend the Criminal Code (aiding suicide)*, was introduced in the House of Commons. The Bill died with the prorogation of Parliament.
May 20, 1993	The SCC in *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, rejected the claim that a terminally ill person has a constitutionally protected right to have the assistance of a doctor to commit suicide even when the person is suffering and cannot commit suicide without assistance.
September 21, 1994	Private Member's Bill C-215, *An Act to amend the Criminal Code (aiding suicide)*, was introduced in the House of Commons on February 16, 1994. The Bill was debated on September 21, 1994 but never proceeded to a vote.
June, 1995	In February, 1994, a Special Senate Committee was established to examine and report on the legal, social and ethical issues relating to euthanasia and assisted suicide. In June, 1995, the Committee issued its report entitled *Of Life and Death*.

DATE	EVENT
March 6, 1997	On June 12, 1996, Bill C-215 was re-introduced as Private Member's Bill C-304, *An Act to amend the Criminal Code (aiding suicide*) On March 6, 1997, the Bill received second reading but never proceeded to a vote.
November, 2005	On June 15, 2005, Private Member's Bill C-407, *An Act to Amend the Criminal Code (right to die with dignity)*, was introduced in the House of Commons. On October 31, 2005, Bill C-407 was debated at second reading and referred to committee but was never debated by a committee. Bill C-407 died on the *Order Paper* in November, 2005 with the dissolution of Parliament.
September, 2008	On June 12, 2008, Private Member's Bill C-562, *An Act to amend the Criminal Code (right to die with dignity*), was introduced in the House of Commons. In September, 2008, Bill C-562 died on the *Order Paper* with the dissolution of Parliament.
November 18, 2009	On May 26, 2009, M388, a Private Member's motion to reaffirm that assisted suicide by any means, including via the internet or other telecommunications, remains a crime in Canada, was brought in the House of Commons. M388 was debated on September 30, 2009 and November 5, 2009. The House of Commons passed the motion unanimously by a vote of 230 to 0 on November 18, 2009.
December 9, 2009	Gloria Taylor was diagnosed with amyotrophic lateral sclerosis (ALS).
January 26, 2010	On or about January 26, 2010, Dr. Hannah Briemberg, Neurologist gave the prognosis that Gloria Taylor was likely to be paralyzed in six months and likely to die within one year.
April 21, 2010	On May 13, 2009, Private Member's Bill C-384, *An Act to amend the Criminal Code (right to die with dignity)*, was introduced in the House of Commons. Bill C-384 was identical to Bill C-562 (2008). On April 21, 2010, Bill C-384 was defeated at second reading by a vote of 228-59.
April 26, 2011	The respondents, with the exception of Gloria Taylor, filed their Notice of Civil Claim and Notice of Application under the *Constitutional Question Act*

DATE	EVENT
August 3, 2011	At the respondent's request, the Honourable Madam Justice Smith set the matter down for hearing commencing November 14, 2011 for four weeks and set the following deadlines for the matter to proceed by way of summary trial: (1) The respondents must file and serve their materials by August 30, 2011; (2) Canada and British Columbia must file and serve their materials by September 30, 2011; (3) Intervention applications must be filed by October 7, 2011; (4) the respondents must file their reply materials by October 30, 2011; (5) all cross-examinations must be completed by October 31, 2011.
August 12, 2011	The respondents filed a consent order adding Gloria Taylor as a plaintiff.
August 15, 2011	The respondents filed an Amended Notice of Civil Claim, as a result of the addition of Gloria Taylor.
September 2, 2011	At a Case Planning Conference, Canada and British Columbia made submissions to the Court and sought an extension to the deadlines set by the Court and a delay to the commencement of the hearing. The Honourable Madam Justice Smith denied the requests.
August 26 - September 2, 2011	The respondents delivered their evidence.
September 19 - October 17, 2011	Canada delivered its evidence.
September 19 - October 20, 2011	British Columbia delivered its evidence.
October 25, 2011 - November 2, 2011	The respondents delivered their reply evidence.
November 2-11, 2011	Cross-examinations of some witnesses took place.
November 2, 2011	Canada brought an application to dismiss this matter from proceeding by way of summary trial. Canada's application was supported by British Columbia.

DATE	EVENT
November 8, 2011	The Court dismissed Canada's application and concluded that this matter should proceed by way of summary trial, commencing on November 14, 2011, with modifications to the ordinary summary trial process.
November 14 – December 16, 2011	The hearing of the summary trial. Cross-examinations took place before the Court between November 14 -25, 2011. On November 25 and 28, 2011, the Court heard submissions from the parties with respect to evidentiary objections. On December 1-16, 2011 the Court heard oral argument from the parties.
June 15, 2012	Reasons for Judgment of the Honourable Madam Justice Smith of the Supreme Court of British Columbia (*Carter v. Canada (Attorney General)*, 2012 BCSC 886).
July 25, 2012	The Court heard submissions on costs.
July 30, 2012	The respondents advised that Gloria Taylor has been given the prognosis that her life expectancy is now six months.
October 4, 2012	Gloria Taylor passed away suddenly without accessing her constitutional exemption.

OPENING STATEMENT

The trial judge was understandably moved to find a solution for the individuals who recounted a bleak picture of their existence and asked the Court to permit them assistance to die. However, in doing so the trial judge erroneously strayed beyond the constitutional question of whether Parliament is required to permit physician-assisted dying and into the policy question of whether Parliament should do so. The Supreme Court of Canada has cautioned against conflating such policy questions with constitutional questions when considering whether or not an impugned provision passes *Charter* scrutiny.

The decision below focuses on the plight of those who wish to access assisted suicide. However, on the other side of the story are individuals who, given the opportunity, struggle through incredible adversity to live fulfilling lives as a result of not having access to assisted suicide. There are also individuals who would, were assisted suicide available, be faced with the prospect of having to justify their continued existence to well meaning people who do not wish to see them suffer. The *Charter* does not require Parliament to accept the risk of their deaths, against their true wishes, in order to reduce the suffering of others.

Nor does the *Charter* require Parliament to condone suicide for a particular class of individuals - those with a serious illness, disease or disability - while trying to prevent suicide in the rest of society. Doing so sends the message that there is no dignity or value in such lives and that it is rational that such individuals should want to commit suicide.

The trial judge effectively substituted the values and preferences of the respondents over those of Parliament, which represents the will and values of Canadian society. In doing so, the trial judge committed an error of law. Parliament has made a policy choice to prohibit assisted suicide for the greater good of individuals and all of society, and it is within the Constitution for Parliament to make that choice.

PART I – STATEMENT OF FACTS

1. The respondents brought a civil claim challenging the constitutionality of the *Criminal Code* prohibitions against assisted suicide and euthanasia, specifically: s.14 - the prohibition against an individual consenting to having death inflicted upon them; ss.21(1)(b) and 21(2) - the prohibitions against aiding an offence and carrying out an offence with a common intention; s.22 - the prohibition against counselling an offence; ss.222(1) to 222(5) - the prohibition against homicide; and s.241 - the prohibitions against counselling suicide and assisting another person to commit suicide.[1]

2. By decision dated June 15, 2012, the trial judge made a declaratory order, suspended for one year, that, in specified circumstances, the impugned provisions unjustifiably infringe ss.7 and 15 of the *Charter* to the extent that they prohibit physician-assisted suicide by a physician and, in the case of s.7, consensual physician-assisted suicide or euthanasia by a physician. During the period of suspension, Ms. Taylor was granted a constitutional exemption to access physician-assisted suicide or euthanasia provided she met certain enumerated conditions. Ms. Taylor passed away suddenly on October 4, 2012 without accessing her constitutional exemption.[2]

3. In reaching her decision, the trial judge had before her expert and lay evidence which generally fell into one of several categories.

The Nature of the Desire for Hastened Death

4. The trial judge had before her expert evidence demonstrating that the desire for death is most often ambivalent and transitory[3] and that in the vast majority of cases, an

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[1] Notice of Civil Claim (Appeal Record ("Record"), Vol. 1, pp. 1-20); Notice of Application under section 8(2)(a) of the *Constitutional Questions Act* (Record, Vol. 3, pp. 512-533).
[2] Reasons for Judgment of the Honourable Madam Justice Smith pronounced June 15, 2012 ("Reasons") (Record, Vol. 2, pp. 109-320 and Vol. 3, pp. 321-503).
[3] Dr. Chochinov Report, Exhibit F at pp. 97-98 (Joint Appeal Book ("Appeal Book"), Vol. 19 at pp. 6471-6472); Baroness Finlay Affidavit #1 at paras. 81-92 and Exhibit K at pp. 123-125 (Appeal Book, Vol. 28, pp. 9672- 9675 and Ex. K: 9774- 9776); Dr. Gallagher Report at p. 13:3-6 (Appeal Book, Vol. 36, p. 12390:3-6); Dr. Mishara Report at paras.

expressed desire for a hastened death can be successfully addressed with good treatment, including palliative care, dignity therapy, and other therapeutic interventions.[4]

5. The trial judge found that these concerns could be addressed by assessing capacity and requiring "some time" to pass between the decision and its implementation.[5] She rejected concern over implementing such an irreversible decision when future circumstances, such as an individual's reassessment of the value of their own life, or mistakes as to prognosis, are not known as she was of the view that it was hypothetical that individuals who lose their lives might regret the decision "if regret is possible after death".[6]

The Ability to Assess the Authenticity of the Desire for Hastened Death

6. Both parties filed evidence addressing the ability of physicians to determine if a patient's desire for hastened death was influenced by cognitive impairment, depression, outside influence, or lack of understanding of options such as palliative care. The evidence showed that determining, for example, the role of depression in decision-making is difficult, even by expert assessment.[7]

22, 27-29, 31-32 and 43-46 (Appeal Book, Vol. 37, pp. 12730-12731, 12733-12737 and 12742-12745); Dr. Downing Cross-examination, November 9, 2011 (Appeal Book, Vol. 40, pp. 13578:2 to 13579:7).

[4] Dr. Chochinov Report at paras. 39-42, 44-45, Exhibits C, K and N (Appeal Book, Vol. 19, pp. 6387-6389, Ex. C: 6442- 6450, Ex. K: 6507-6510 and Ex. N: 6527); Baroness Finlay Affidavit #1 at paras. 16-18 (Appeal Book, Vol. 28, pp. 9656-9657); Dr. Pereira Report at paras. 15-42 and 82 (Appeal Book, Vol. 29, pp. 9783-9795 and 9813-9814); Dr. Gallagher Report at pp. 10:8-23 and 11:9-16 (Appeal Book, Vol. 36, pp. 12387:8-23 and 12388:9-16); Dr. Mishara Report at paras. 39-41 (Appeal Book, Vol. 37, pp. 12474-12475); Dr. Rodin Report at pp. 5-9 (Appeal Book, Vol. 38, pp. 12854-12858); Dr. Meckling Cross-examination, November 4, 2011 (Appeal Book, Vol. 39, pp. 13341:7 to 13342:47).

[5] Reasons at para. 843 (Record, Vol. 3, p. 342).

[6] Reasons at paras. 757, 843 and 1268 (Record, Vol. 3, pp. 322-323, 342 and 463).

[7] See for example, Reasons at paras. 431, 766, 768, 771, 774, 785 and 788-792 (Record, Vol. 2, p. 240 and Vol. 3, pp. 325-327 and 329-331).

7. Notwithstanding this, the trial judge concluded that the authenticity of a patient's desire for hastened death can be assessed so long as such assessments are conducted by properly qualified and experienced physicians, who: describe all reasonable palliative care interventions, including those aimed at loss of personal dignity; apply a very high level of scrutiny; proceed with great care; and are aware of the risks, including the risks of subtle influence and unconscious biases.[8]

Personal Accounts of Individuals in Difficult Circumstances

8. The respondents filed numerous affidavits from individuals with various diseases who want the choice of assisted suicide. These individuals described their difficulty in coping with the impacts of their conditions and their fears in relation to the future.

9. Canada filed evidence of individuals with the opposite perspective. These individuals also described their initial fears and difficulty in coping, but went on to describe how, given the opportunity, they adapted to their circumstances and led meaningful lives.[9] For example, Ms. Davis has multiple significant disabilities and suffered through many years in her life when she would have chosen assisted suicide had it been available. However, as that choice was not available to her, and her suicide attempts were unsuccessful, she went on to have what is now a very fulfilling life - a life she would have been denied had assisted suicide been available.

Impact on Individuals with Disabilities and Elderly Individuals

10. Canada filed both expert and lay evidence regarding the experiences of people with disabilities in dealing with a society that assigns them inferior value and pities them (commonly referred to as an "ableist" society). This evidence also addressed the impact of this ableist attitude within the medical profession and demonstrated that individuals with disabilities face prejudice and stereotyping and consistent assumptions that their

[8] Reasons at paras. 798, 815 and 831 (Record, Vol. 3, pp. 332, 336 and 339).
[9] Davis Affidavit #1 (Appeal Book, Vol. 19, pp. 6809-6814); Wiebe Affidavit #1 at paras. 45-49 (Appeal Book, Vol. 23, pp. 7825-7827); Baroness Finlay Affidavit #1 at paras. 81-92 and Exhibit K at pp. 123-125 (Appeal Book, Vol. 28, pp. 9672- 9675 and Ex. K: 9774-9776).

quality of life is much lower than they themselves perceive.[10] The respondents did not challenge this evidence and it was accepted by the trial judge.

11. Although the evidence showed that in Oregon and the Netherlands it is not possible to draw conclusions regarding the impact of assisted suicide and euthanasia on disabled individuals as data is not collected on whether an individual is disabled prior to becoming terminally ill and accessing assisted death,[11] the trial judge found that there was no evidence that persons with disability are at heightened risk.[12]

12. Despite the uncontradicted evidence of prevalent bias and the lack of data from permissive jurisdictions on the impact on disabled individuals, the trial judge found that risk to persons with disabilities can be avoided through "careful and well-informed capacity assessments" by qualified physicians alert to the risks to disabled individuals.[13]

13. Canada also filed evidence on the potential impact of assisted suicide and euthanasia on elderly individuals in the context of the elder abuse which unfortunately already exists in Canadian society.[14] However, due to the time limits imposed by the trial judge, Canada was unable to put a full record on this issue before the Court.[15]

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[10] Reasons at paras. 194 and 848-853 (Record, Vol. 2, p. 168 and Vol. 3, pp. 343-345); Martin Affidavit #1 at paras. 10-14 (Appeal Book, Vol. 19, pp. 6817-6818); Wiebe Affidavit #1 at paras. 17-38 (Appeal Book, Vol. 23, pp. 7817-7823); Professor Frazee Report at paras. 28-40, Exhibits B-C, H, I, J and K (Appeal Book, Vol. 36, pp. 12107-12110, Ex. B-C: 12131-12140, Ex. H: 12770-12288, Ex. I: 12289-12290, Ex. J: 12291-12295 and Ex. K: 12296-12297).

[11] Reasons at para. 628 (Record, Vol. 2, p. 292); Dr. Ganzini, November 14, 2011 (Transcript Book ("Transcripts"), Vol. 1, p. 63:27-42); Professor Battin Affidavit #1, Exhibit C at pp. 63-64 (Appeal Book, Vol. 3, pp. 988-989); Professor Deliens Affidavit #1, Exhibit L at pp. 133-134 (Appeal Book, Vol. 13, pp. 4433-4434); Professor Deliens, November 23, 2011 (Transcripts, Vol. 3, pp. 489:47 to 490:4); Professor Bernheim Cross-examination, November 11, 2011 (Appeal Book, Vol. 40, pp. 13860:23 to 13861:19).

[12] Reasons at para. 852 (Record, Vol. 3, p. 345).

[13] Reasons at para. 853 (Record, Vol. 3, p. 345).

[14] Canada's Notice to Admit #1, Appendix T at pp. 391-392 and 400 (Appeal Book, Vol. 12, pp. 4247-4248 and 4256); Canada's Notice to Admit #2, Appendix L at pp. 1043-1044 (Appeal Book, Vol. 17, pp. 5846-5847); Dr. Heisel Report at paras. 46-49, 59-64,

Experience in Permissive Jurisdictions

14. Both parties filed evidence in relation to the experience in the few jurisdictions which permit assisted suicide or euthanasia.[16] The evidence largely focused on the nature and efficacy of the safeguards in place in those jurisdictions.

15. The evidence showed that difficulties exist with respect to obtaining reliable data on euthanasia and physician-assisted suicide in these jurisdictions.[17]

16. The trial judge also identified various problems in compliance with the safeguards in other jurisdictions[18] but came to the conclusion that: 1) in Canada physicians would comply, despite noting that there are some doctors who do not currently comply with the absolute prohibition; and 2) weaknesses could be addressed through "stringent limits that are scrupulously monitored and enforced".[19]

Ethics

17. Both parties filed evidence regarding the ongoing ethical debate over assisted suicide. The trial judge found that "thoughtful and well-motivated people can and have come to different conclusions about whether physician-assisted death can be ethically

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and 77-78 (Appeal Book, Vol. 37, pp. 12477-12479, 12484-12486 and 12492-12493); Dr. Donnelly Cross-examination, November 9, 2011 (Appeal Book, Vol. 39, pp. 13501:2-13504:23); Dr. Donnelly Cross Exhibit 1 and 2 at pp. 40-41 (Appeal Book, Vol. 39, Ex. 1: 13523-13538 and Ex. 2: 13562-13563); Trial Exhibit 66 at pp. 94-101 (Appeal Book, Vol. 42, pp. 14591-14598).

[15] Case Planning Conference, September 2, 2011 (Appeal Book, Vol. 3, p. 718:33-40) and November 8, 2011 (Appeal Book, Vol. 39, pp. 13428:21-41 and 13452:17-37).

[16] For a list of permissive western jurisdictions, see Reasons at para. 9 (Record, Vol. 2, p. 117).

[17] Reasons at paras. 406, 524, 649 and 655-657 (Record, Vol. 2, pp. 232-233, 266 and 297-299).

[18] See for example, Reasons at paras. 9, 431, 433, 435, 483, 541, 554, 560, 562-563, 568, 576-577, 635, 649, 653, 655- 656, 671-672, 785, 789, 793 and 818 (Record, Vol. 2, pp. 117, 240-241, 254, 269, 272, 274-277, 279, 294, 297-299 and 302-303 and Vol. 3, pp. 329-331 and 336-337).

[19] Reasons at paras. 204, 854, 883, 1240, 1282 and 1284 (Record, Vol. 2, p. 171 and Vol. 3, pp. 345, 357, 457 and 468).

justifiable"[20]and that there is not a clear societal consensus either way.[21] She also found that within the medical and bioethical community the question remains open on whether an ethical distinction exists between physician-assisted death and other end of life treatments.[22] The trial judge found that physician-assisted death is not "clearly inconsistent" with medical ethics.[23]

PART 2 – ERRORS IN JUDGMENT

18. Canada submits that the trial judge erred in:

(a) finding that she was not fully bound by the SCC's decision in *Rodriguez*[24];

(b) finding that the prohibition violated the respondents' right to life under s.7 of the *Charter* and that any violations of life, liberty, and security of the person were not in accordance with the principles of fundamental justice;

(c) finding that the prohibition violated s.15 of the *Charter*;

(d) finding that neither the s.7 nor s.15 violations could be justified under s.1 of the *Charter*;

(e) granting Ms. Taylor a constitutional exemption from the suspension of the declarations of invalidity, however, this issue is now moot, and;

(f) compressing the timelines of the trial and receiving improper reply submissions from the respondents.

PART 3 – ARGUMENT

I. ***STARE DECISIS***

19. In issuing declarations of invalidity, the trial judge failed to properly apply the principle of *stare decisis* and improperly purported to overrule the SCC decision in

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[20] Reasons at para. 343 (Record, Vol. 2, p. 215).
[21] Reasons at para. 358 (Record, Vol. 2, pp. 218-219).
[22] Reasons at para. 334 (Record, Vol. 2, p. 213).
[23] Reasons at para. 1369 (Record, Vol. 3, p. 487).
[24] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 (QL) [***Rodriguez***].

Rodriguez. The trial judge erred in applying principles enunciated in *Henry*[25] to narrow the precedential effect of *Rodriguez.*[26]

20. Contrary to the trial judge's approach, in *Henry* the SCC did not instruct courts to use the test, "what a case actually decides on its facts", to narrow what is binding on lower courts to something less than the conclusions reached by the Court.[27] Rather, *Henry* made the point that what the SCC has 'decided' in a previous case, and is therefore binding on lower courts, should not be limited to the *ratio decidendi,* but is expanded to include some of what would generally be considered *obiter.*[28]

21. The adjudicative facts in *Rodriguez* are indistinguishable in any meaningful way from those in this case.[29] The Court in *Rodriguez* decided that although the *Criminal Code* prohibition on assisted suicide infringed the liberty and security of the person interests of Ms Rodriguez, it did so no more than necessary to achieve the government's objectives of preserving life, upholding respect for life and protecting the vulnerable. It further held that the prohibition was proportionate to these same objectives. As a result, the SCC decided that the prohibition against assisted suicide did not violate s.7 of the *Charter,* and assuming, but not deciding, that there was a violation of s.15, any such violation was saved under s.1.[30]

22. As the adjudicative facts are the same in the two cases, the conclusions in *Rodriguez* are complete answers to the respondents' claims. The trial judge erred in defining too narrowly what *Rodriguez* decided when she concluded that the overbreadth and gross disproportionality claims under s.7 were not covered by *stare decisis*.[31] She further erred in determining that she was free to come to a different conclusion on s.1

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[25] *R. v. Henry,* [2005] 3 S.C.R. 609, 2005 SCC 76 (QL) [***Henry***].
[26] Reasons at para. 901 (Record, Vol. 3, pp. 362-363).
[27] Reasons at para. 901 (Record, Vol. 3, pp. 362-363).
[28] *Henry*, *supra* note 25 at paras. 54-57.
[29] Reasons at para. 941 (Record, Vol. 3, p. 373).
[30] *Rodriguez, supra* note 24 at paras. 122, 140, 149, 174, 185, 188 and 190.
[31] Reasons at para. 936 (Record, Vol. 3, p. 372).

because the SCC had addressed the s.1 analysis "only very summarily",[32] and that the *Hutterian Brethren*[33] case marked a "substantive change" in the s.1 jurisprudence and "put life into the final balancing step in the analysis" under s.1.[34]

23. It was not open to the trial judge to purport to overrule the SCC's decision on s.1 because she was not satisfied with the Court's s.1 analysis. According to the trial judge, this, along with different legislative facts, was sufficient to warrant a fresh s.1 inquiry.[35] It is an error for a lower court to override, overrule or sidestep an SCC decision simply because the lower court believes that the SCC's approach in subsequent cases would lead that Court to come to a different conclusion. In *Canada v. Craig*, the SCC made it clear that in such circumstances a trial judge ought only to write reasons as to why the SCC's decision is problematic.[36] A robust approach to *stare decisis* is particularly important in *Charter* cases.[37]

24. Although it was open to the trial judge to set out her views on the development of the law since *Rodriguez,* it was not open to her to issue declarations of invalidity that are contrary to *Rodriguez*.

A. *RODRIGUEZ* CONSIDERED OVERBREADTH AND GROSS DISPROPORTIONALITY

25. The trial judge erred in disregarding the fact that the SCC in *Rodriguez* effectively applied the tests for overbreadth and gross disproportionality as those principles are understood today. To conclude that *stare decisis* did not cover these aspects of the claim on the basis that these principles were not named or applied as independent

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[32] Reasons at para. 936 (Record, Vol. 3, p. 372).
[33] *Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 S.C.R. 567, 2009 SCC 37 (QL) [[34] Reasons at paras. 994-995 (Record, Vol. 3, p. 388).
[34] Reasons at paras. 994-995 (Record, Vol. 3, p. 388).
[35] Reasons at para. 998 (Record, Vol. 3, pp. 388-389).
[36] *Canada v. Craig*, 2012 SCC 43 (QL) at para. 21.
[37] *Air Canada Pilots Association v. Kelly*, 2012 FCA 209, 100 C.C.E.L. (3d) 1 (QL) at paras. 43-44 [***Air Canada Pilots***].

principles of fundamental justice until after *Rodriguez* was to privilege form over substance and to disregard what the Court actually decided in *Rodriguez*.

26. The trial judge recognised that over-inclusiveness was referenced in *Rodriguez*, but concluded that she could revisit the s.7 issue because overbreadth was not recognised as an independent principle of fundamental justice until 1994 in *R. v. Heywood*.[38] However, in explaining that legislation will be overbroad where it uses means that are broader than necessary to achieve the state objective, *Heywood* was not creating new law.[39] This is evidenced by the Court's discussion of overbreadth, which begins with the observation that "[t]his Court considered the issue of overbreadth as a principle of fundamental justice in *R. v. Nova Scotia Pharmaceutical Society*"[40] – a case that *pre*-dates *Rodriguez*.

27. In *Rodriguez*, the substance of the challenge was precisely that the absolute prohibition on assisted suicide was overly broad. [41] In the course of Sopinka J.'s analysis of the principles of fundamental justice, he observed that there was no certainty that abuses can be prevented by anything less than a complete prohibition and that creating an exception might frustrate the purpose of protecting the vulnerable.[42] He also concluded in his s.1 analysis that "[t]here is no halfway measure that could be relied upon with assurance to fully achieve the legislation's purpose."[43]

28. The fact that this second statement appears in the context of his s.1 analysis is immaterial in light of the fact that an analysis under s.7 overbreadth replicates the concerns that underpin the minimal impairment analysis under s.1.[44]

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[38] *R. v. Heywood*, [1994] 3 S.C.R. 761 (QL) [***Heywood***].
[39] *Heywood*, *supra* note 38 at para. 49.
[40] *Heywood, supra* note 38 at paras. 47-52.
[41] *Rodriguez, supra* note 24 at para. 140.
[42] *Rodriguez, supra* note 24 at para. 162.
[43] *Rodriguez, supra* note 24 at para. 188.
[44] *R. v. Sharpe*, [2001] 1 S.C.R. 45, 2001 SCC 2 (QL) at para. 18 [***Sharpe***].

29. With respect to gross disproportionality, the relevant question is whether the prohibition on assisted suicide is grossly disproportionate to the state interest in preserving life, upholding respect for life, and protecting the vulnerable.[45] As with overbreadth, this is an issue relevant to both ss.7 and 1.

30. The Court in *Rodriguez* was clearly alive to the impacts of the prohibition as well as the government objectives sought to be achieved through the prohibition and came to the conclusion that the prohibition is proportionate to the objectives.[46]

31. However, as with her overbreadth analysis, the trial judge found she could revisit the issue because gross disproportionality was not specifically named as a principle of fundamental justice until *Malmo-Levine*[47]*.* This, despite recognising that gross disproportionality was inherent in some sense in the reasoning in *Rodriguez*. [48]

B. *RODRIGUEZ* DECIDED THE S.7 ISSUES IN RELATION TO THE RIGHT TO LIFE

32. Before the trial judge, the respondents argued that the prohibition had the effect of shortening the lives of persons who commit suicide at a given point because they fear they will be unable to do so later.[49] Although this particular argument was not raised in *Rodriguez*, any such effect is so closely intertwined with, and closely analogous to, the effects that *were* considered in *Rodriguez* that the Court's conclusions are equally applicable to this aspect of s.7 and this additional argument cannot justify purporting to overrule an SCC decision.

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[45] *Canada (Attorney General) v. PHS Community Services Society*, [2011] 3 S.C.R. 134, 2011 SCC 44 (QL) at para. 133 [***PHS***].
[46] *Rodriguez, supra* note 24 at paras. 137, 140, 167 and 190.
[47] *R. v. Malmo-Levine; R. v. Caine*, [2003] 3 S.C.R. 571, 2003 SCC 74 (QL) [***Malmo Levine***].
[48] Reasons at para. 983 (Record, Vol. 3, p. 384); *Malmo Levine, supra* note 47 at paras. 143-144.
[49] Reasons at para. 1322 (Record, Vol. 3, p. 476).

33. In *Rodriguez,* in considering s.7, the Court described Ms. Rodriguez's fears that the prohibition would result in her being "required to live until the deterioration from her disease is such that she will die as a result of choking, suffocation or pneumonia caused by aspiration of food or secretions" and "totally dependent upon machines to perform her bodily functions and completely dependent upon others" while remaining "mentally competent and able to appreciate all that is happening to her."[50]

34. The concern over shortening of life is properly understood as the response of an individual to the effects outlined above. The choice to take one's life pre-emptively, as one of several choices available to an individual in these circumstances, is inextricable from the effects that were considered in *Rodriguez* and does not alter the analysis under the principles of fundamental justice. The addition of the shortening of life argument does not take this case beyond what the Court in *Rodriguez* actually decided and does not allow for the principle of *stare decisis* to be avoided.

C. *HUTTERIAN BRETHREN* DID NOT CHANGE THE S.1 PROPORTIONALITY TEST

35. The trial judge also erred in finding that the SCC's s.1 analysis in *Hutterian Brethren*, combined with the allegedly different legislative facts in this case, permitted her to revisit the s.1 analysis undertaken in *Rodriguez*. [51]

36. Contrary to the trial judge's finding, *Hutterian Brethren* did not change the s.1 proportionality test itself, which was developed prior to *Rodriguez* in *Oakes*, nor did it change the SCC's approach to that test.[52] *Hutterian Brethren* simply corrected academic commentary and confirmed for lower courts that the test should be applied as it had been articulated in *Oakes.* The SCC gave absolutely no indication that any of its

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[50] *Rodriguez, supra* note 24 at para. 137.
[51] Reasons at para. 998 (Record, Vol. 3, pp. 388-389).
[52] *R. v. Oakes*, [1986] 1 S.C.R. 103 (QL) at paras. 69-71 [***Oakes***].

own jurisprudence had inappropriately applied the *Oakes* test or needed to be revisited.[53]

37. The trial judge further explained her departure from *Rodriguez* on the basis that the legislative facts in this case are "significantly and materially" different from those in *Rodriguez*.[54] The reliance on different legislative facts was misplaced for two reasons. First, if *Hutterian Brethren* changed the law in a manner which allowed a lower court to come to a different conclusion than the SCC in *Rodriguez*, which it did not, then different legislative facts add nothing to the analysis of whether the trial judge was bound by *stare decisis.* On the other hand, if *Hutterian Brethren* did not change the law in a manner which permitted the trial judge to avoid *stare decisis,* then different legislative facts could not provide the necessary justification to do so.[55]

38. If correct, the trial judge's finding that *Hutterian Brethren* significantly changed the s.1 test would undermine much of SCC *Charter* jurisprudence. All issues decided under s.1 before *Hutterian Brethren* would be open for re-consideration by lower courts.

II. ERRORS IN THE *CHARTER* ANALYSIS

39. Even if the trial judge was not bound by *stare decisis*, she erred in concluding that the prohibition violates ss.7 and 15 and that the prohibition cannot be justified by s.1.

40. Two problematic assumptions emerge from the trial judge's *Charter* analysis and impact on all aspects of her reasoning. First, the trial judge's analysis reveals an inappropriately high tolerance for the risk of harm that she finds is "inherent" in the practice of assisted suicide.[56] Second, the trial judge speculated that all of the risks that she noted with respect to the safeguards in other jurisdictions will simply not arise in a Canadian-specific regulatory regime. She hypothesised that the safeguards will work in

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[53] *Hutterian Brethren*, *supra* note 33 at paras. 72-78.
[54] Reasons at paras. 942 and 998 (Record, Vol. 3, pp. 373 and 388-389).
[55] *Air Canada Pilots, supra* note 37 at para. 47; *Bedford v. Canada (Attorney General),* 2012 ONCA 186, 346 D.L.R. (4th) 385 (QL) at paras. 83-84.
[56] Reasons at paras. 671 and 883 (Record, Vol. 2, p. 302 and Vol. 3, p. 357).

Canada if there are "stringent limits" that are "scrupulously monitored and enforced" and applied with the "utmost care".[57] These assumptions imbue the trial judge's erroneous findings that ss.7 and 15 are violated as well as her justification analysis under s.1.

A. PURPOSE OF THE PROHIBITION

41. The purpose of the prohibition, as identified by Sopinka J. in *Rodriguez*, has several elements. It is to protect the vulnerable, who might be induced in moments of weakness to commit suicide, and is a reflection of the state's policy that the inherent value of all human life should not be depreciated by allowing one person to take another's life. However, it is also to discourage everyone, even the terminally ill, from choosing death over life, and to guard against the negative social messaging that would result from a system which signals that there are circumstances in which the state condones suicide.[58] In this regard, the prohibition prevents sending the message that the lives of some are less valuable, and less worthy of protection, than others.

42. The broader purposes articulated in *Rodriguez* have since been affirmed as Parliament has repeatedly stressed the profound and serious harms that the prohibition prevents. Most recently in 2010, during the debate on Bill C-384, *An Act to amend the Criminal Code (Right to Die with Dignity)*, parliamentarians discussed the rationales for the prohibition of assisted suicide including the interest of Parliament in protecting human life. This interest includes protecting the vulnerable and preventing negative messaging concerning the value of human life, particularly the lives of those who have to cope with various forms of illness and disability.[59]

43. The trial judge accepted the purpose set out by Sopinka J. in *Rodriguez,* but erred in focusing on its narrowest articulation of protecting the vulnerable from being induced

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[57] Reasons at paras. 670, 795, 798, 815, 853-854, 883 and 1233 (Record, Vol. 2, p. 302 and Vol. 3, pp. 331-332, 336, 345, 357 and 455).
[58] *Rodriguez, supra* note 24 at paras. 149, 174 and 188.
[59] Canada's Notice to Admit #1, Appendix Q at pp. 177-202 (Appeal Book, Vol. 12, pp. 4033-4058).

to commit suicide in moments of weakness.[60] This impacted on the remainder of her analysis.

B. SECTION 7

1. The Trial Judge Failed to Properly Apply the Reasonable Apprehension of Harm Standard in Applying the Principles of Fundamental Justice

44. The trial judge's analysis of overbreadth in s.7 and minimal impairment in s.1 failed to properly apply the reasonable apprehension of harm standard. Where Parliament has a reasonable apprehension that harm will result from anything less than a blanket prohibition on assisted suicide and euthanasia, then the prohibition cannot be said to be overbroad.[61] In the present case, not only did the government adduce extensive evidence that established a reasonable apprehension of harm, the respondents' own witnesses provided evidence of the inherent risks associated with permitting physician-assisted suicide and euthanasia.[62]

45. On the proper application of the reasonable apprehension of harm standard, the question is not whether it is more likely than not that there are intractable risks associated with physician-assisted dying. Although the evidence amply meets this standard, the proper question is the more circumspect one of whether it is reasonable for Parliament to consider that the risks cannot be effectively addressed by a system of safeguards. The trial judge's apparent conclusion that the risks associated with

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[60] Reasons at paras. 1190, 1243 and 1348 (Record, Vol. 3, pp. 446, 458 and 482).
[61] *R. v. Butler*, [1992] 1 S.C.R. 452 (QL) at para. 107 [***Butler***]; *Sharpe, supra* note 44 at paras. 85 and 198; *Malmo-Levine, supra* note 47 at para. 136.
[62] Dr. Ganzini Affidavit #1 at para. 42 (Appeal Book, Vol. 7, pp. 2130-2131); Dr. Ganzini, November 14, 2011 (Transcripts, Vol. 1, pp. 72:14 to 74:42); Professor Van Delden Affidavit #1 at paras. 14, 23 and 26 (Appeal Book, Vol. 10, pp. 3514, 3518-3520); Professor Deliens Affidavit #1 at paras. 23-25, 29-30 and Exhibits F-J (Appeal Book, Vol. 13, pp. 4291-4293, Ex. F: 4374-4377, Ex. G: 4383-4387, Ex. H: 4390, 4393, 4395-4396, Ex. I: 4402, Ex. J: 4420); Professor Deliens, November 23, 2011 (Transcripts, Vol. 3, pp. 485:17 to 486:32, 487:7-26, 496:7-15 and 503:2-41; Trial Exhibits 43 and 72 (Appeal Book, Ex. 43: Vol. 42, pp. 14357-14362 and Ex. 72: Vol. 43, pp. 14842-14848); Professor Battin Affidavit #2, Exhibit A (Appeal Book, Vol. 39, pp. 13278-13286); Trial Exhibit 21 (Appeal Book, Vol. 41, pp. 14139-14170); Professor Starks, November 17, 2011 (Transcripts, Vol. 2, p. 212:11-15).

physician-assisted dying and euthanasia can more likely than not be managed does not render Parliament's apprehension of harm unreasonable.

46. While the most extensive discussion of the reasonable apprehension of harm standard has occurred in the context of the SCC's s.1 jurisprudence, the principles articulated in this context are equally applicable to the analysis of the principles of fundamental justice under s.7.[63]

47. In *Sharpe*, the Court emphasised that in demonstrating the harm that a criminal prohibition targets, the government is not required to proceed on the basis of scientific proof based on concrete evidence. Nor did the Court require that the evidence be tested against a balance of probabilities standard. Rather, the government is entitled to proceed based on a reasonable apprehension of harm.[64]

48. In its earlier decision in *Butler*, the SCC noted that the social science evidence on the causal relationship between obscenity and the risk of harm to society at large was subject to controversy. The Court concluded that Parliament was entitled to have a reasoned apprehension of harm notwithstanding that some of the research indicated that there was *no* causal relationship between pornography and violence.[65]

49. In *Irwin Toy*, the majority explained that in the face of competing social science evidence, the question is whether Parliament had a reasonable basis for concluding that the impugned provision impairs the right as little as possible in view of the pressing and substantial objective.[66] Contrary to this approach, in this case the trial judge simply weighed the expert evidence to decide which perspective was, in her view, more persuasive. Had she applied the proper test, she would have asked herself whether, notwithstanding that she found the respondents' position more compelling, the evidence

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[63] *Sharpe, supra* note 44 at para. 18.
[64] *Sharpe, supra* note 44 at para. 85.
[65] *Butler, supra* note 61 at paras. 101-107.
[66] *Irwin Toy Ltd. v. Quebec (Attorney General)*, [1989] 1 S.C.R. 927 (QL) at para. 81 [***Irwin Toy***].

Canada relied on constituted a reasonable basis for Canada's apprehension of harm in respect of anything less than an absolute prohibition.

50. Additionally, in the context of its s.7 overbreadth analysis in *Clay*, the SCC found that a complete prohibition on the possession of marihuana was not overly broad because a narrower prohibition would not meet the state's "interest in avoiding harm to users and others caused by marihuana consumption" as "the members of at least some of the vulnerable groups and chronic users could not be identified in advance."[67]

51. Similarly, in this case, the transitory nature of both the wish to die and the circumstances which may make a given individual vulnerable make it difficult, if not impossible, to identify in advance who requires protection and when they require it. States of depression may come and go and a person's susceptibility to pressure from family members and society may also be subject to change. Thus, the need for protection can vary not just from one person to the next, but from one time to the next in relation to any particular individual. Sopinka J. recognised in *Rodriguez* that the prohibition may discourage from suicide some individuals who, at a particular moment, consider life to be unbearable, or consider themselves to be a burden on others.[68]

52. The trial judge identified five areas of risk associated with physician-assisted suicide and euthanasia: competence; voluntariness; informed consent; ambivalence, and socially vulnerable individuals. She concluded that these risks could be "greatly minimized" with the use of safeguards that are "scrupulously monitored and enforced."[69]

53. The trial judge provided an overview of various recommendations for systems of safeguards, none of which have been tested and proven effective, and also examined the safeguards in permissive jurisdictions, to illustrate the ways in which she believed

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[67] *R. v. Clay*, [2003] 3 S.C.R. 735, 2003 SCC 75 (QL) at paras. 37-40 [***Clay***].
[68] *Rodriguez, supra* note 24 at para. 174.
[69] Reasons at paras. 883 and 1240 (Record, Vol. 3, pp. 357 and 457).

that risks may be minimised. Yet, upon closer examination, the evidence in relation to safeguards in these jurisdictions supports Canada's reasonable apprehension of harm.

54. Not only did the trial judge have before her numerous expert opinions from Canada and British Columbia that clearly demonstrated the significant harms associated with physician-assisted suicide,[70] the respondents' own experts also conceded that the existing research does not conclusively settle the matter of whether or not the risks can be avoided. The trial judge noted, for example, that the evidence of the respondents' expert, Professor Battin, includes a 2007 study of Oregon and the Netherlands and expressly states that "[t]he evidence available cannot provide conclusive proof about the impact on vulnerable patients" nor does it "show that people in vulnerable groups could not be disproportionately affected in the future or in other jurisdictions."[71]

55. If the trial judge had applied the proper standard, she would have found that the conclusions of Battin's study are not sufficient to displace a reasonable apprehension of harm in relation to the impact of legalised physician-assisted dying on vulnerable individuals. In fact, Battin's conclusions strongly support Canada's argument that the existing research has not conclusively settled the matter of whether or not the risks associated with physician-assisted death can be avoided.

56. In addition to the evidence of Professor Battin, the trial judge enumerated, and ultimately accepted, a number of risks associated with physician-assisted dying and

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[70] Canada's Notice to Admit #1, Appendix T at pp. 376-397 (Appeal Book, Vol. 12, pp. 4232-4253); Dr. Bereza Affidavit #1 at paras. 42-44 and 61-62 (Appeal Book, Vol. 23, pp. 7844-7845 and 7850); Dr. Bereza Affidavit #2 at paras. 21 and 34-37 (Appeal Book, Vol. 28, pp. 9563-9564 and 9567-9568); Dr. Hendin Report (Appeal Book, Vol. 27, pp. 9296-9370); Baroness Finlay Affidavit #1 (Appeal Book, Vol. 28, pp. 9652-9776); Professor Frazee Report (Appeal Book, Vol. 36, pp. 12101-12376); Dr. Gallagher Report at pp. 8-9 and 11-12 (Appeal Book, Vol. 36, pp. 12385-12386 and 12388-12389); Dr. Heisel Report at paras. 49-54, 56-64 and 72-83 (Appeal Book, Vol. 37, pp. 12478-12481, 12483-12486, 12490-12495); Dr. Mishara Report at paras. 31-32, 41, 43-51 and 54 (Appeal Book, Vol.37, pp. 12735-12737, 12741-12749 and 12751).

[71] Reasons at para. 635 (Record, Vol. 2, pp. 294).

euthanasia, including the risks associated with lack of compliance with the safeguards in permissive jurisdictions. Many of these risks were expressly acknowledged by the respondents' experts:

Generally

- It is impossible to know from the statistics how often patients have accessed physician-assisted suicide after facing subtle or overt pressure from caregivers.[72]

Oregon

- Dr. Ganzini acknowledged that despite the extensive safeguards in the Oregon *Dying With Dignity* Act ("ODDA"), it is impossible to say that there is no risk that a psychologically influenced or depressed person will slip through the safeguards.[73] In fact, her study showed that three people with major depressive disorder accessed lethal prescriptions.[74]

- Dr. Ganzini's study also notes that determining the influence of depression on decision-making is difficult, even by experts[75] and concluded that, even with its safeguards, the ODDA may fail to protect patients with mental illness.[76]

- In Oregon, "doubts exist about full compliance with the requirement for referral to a mental health professional of patients suffering from a psychological or psychiatric disorder or depression causing impaired judgment."[77]

- The Oregon system is "working fairly well" but needs improvements.[78]

[72] Reasons at para. 671 (Record, Vol. 2, p. 302).
[73] Reasons at para. 435 (Record, Vol. 2, p. 241).
[74] Reasons at para. 435 (Record, Vol. 2, p. 241).
[75] Reasons at para. 431 (Record, Vol. 2, p. 240).
[76] Reasons at paras. 433 and 450 (Record, Vol. 2, pp. 241 and 245).
[77] Reasons at para. 649 (Record, Vol. 2, p. 297).
[78] Reasons at para. 653 (Record, Vol. 2, p. 298).

The Netherlands

- Dr. Van Delden's studies revealed many cases of LAWER (life-ending acts without explicit request) in the Netherlands.[79]

- Compliance with safeguards is "continually improving" but is "not yet at an ideal level" even after 10 years of legalisation.[80]

Belgium

- Dr. Deliens acknowledged that patients who do not have a psychiatric disorder but who have some level of depression as well as patients with cognitive impairments, such as dementia, might be vulnerable to being euthanised.[81]

- One Belgian study showed that in 34% of cases where euthanasia had been requested there was no consultation with a second physician, but euthanasia was nevertheless performed in 17 % of those cases. The recommendation of an independent second physician is required under Belgian law. [82]

- Another Belgian study of nine cases of euthanasia showed three cases in which a second physician was not consulted. In two cases, the second physician was not independent, and only five of the nine cases were reported as required.[83]

- Only 52.8% of cases of euthanasia are reported as required in Belgium and unreported cases are generally dealt with less carefully than reported cases. There was also a significant relationship between reporting and the patient's age – euthanasia of older individuals was reported less. Dr. Deliens acknowledged that these older individuals were vulnerable.[84]

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[79] Reasons at para. 483 (Record, Vol. 2, p. 254).
[80] Reasons at paras. 455 and 656 (Record, Vol. 2, pp. 247 and 299).
[81] Reasons at para. 672 (Record, Vol. 2, pp. 302-303).
[82] Reasons at paras. 510 and 543 (Record, Vol. 2, pp. 261-262 and 270).
[83] Reasons at paras. 510 and 554-556 (Record, Vol. 2, pp. 261-262 and 272-273).
[84] Reasons at paras. 560, 562-563 and 576 (Record, Vol. 2, pp. 274-275 and 279).

- In LAWER cases, the decision was never even discussed with the patient in 77.9% of the cases.[85] In Belgium there are still low rates of reporting and high rates of LAWER, despite 10 years of legalisation.[86]

57. In large measure, the trial judge considered very similar evidence to that considered by Parliament on the many occasions that it has looked at assisted suicide and euthanasia. On each of those occasions, Parliament concluded that the risks inherent in physician-assisted suicide and euthanasia are too great.[87] The legal status of assisted suicide and euthanasia has been one of the most extensively debated and studied issues in Canadian Parliamentary history. Since *Rodriguez*, there have been nine private members bills introduced into the House of Commons seeking to amend the *Criminal Code* to decriminalise assisted suicide or to legalise euthanasia. Parliament has comprehensively debated six of those bills. The most recent rejection of physician-assisted suicide occurred on April 21, 2010 when, after full debate on second reading, Bill C-384 was defeated 228 – 59 on a free vote in the House of Commons.[88]

58. Since 1994, the Senate has produced four reports on end of life issues which have also been subject to rigorous analysis and debate.[89] The Senate's 1995 Report, *On Life and Death*, was a comprehensive examination of the legal, social and ethical issues related to physician-assisted suicide and euthanasia. The committee responsible for the Report heard from over 130 non-governmental witnesses, including: 29 witnesses from the Netherlands; Ministers of Justice and Health; and the Office of the Crown Attorney and Coroner for Ontario. The committee held 30 days of hearings across the country

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[85] Reasons at para. 568 (Record, Vol. 2, pp. 276-277).
[86] Reasons at paras. 505 and 657 (Record, Vol. 2, pp. 260 and 299).
[87] Canada's Notice to Admit #1 at paras. 15-38 and Appendices H-U (Appeal Book, Vol. 12, pp. 3859-3862 and 3909-4283).
[88] Canada's Notice to Admit #1 at paras. 29-31 and Appendix Q (Appeal Book, Vol. 12, p. 3861 and pp. 4025-4058).
[89] Canada's Notice to Admit #1 at paras. 35-38 and Appendices S-U (Appeal Book, Vol. 12, pp. 3861-3862 and pp. 4082-4283); Canada's Notice to Admit #2 at paras. 11-12 and Appendices I-J (Appeal Book, Vol. 15, p. 4806 and Vol. 17, pp. 5616-5723).

and received hundreds of additional letters and briefs. A majority of the committee recommended that no changes be made to the prohibition and that any permissive legislation could result in abuses, especially with respect to the most vulnerable members of society.[90]

59. Furthermore, Canada is joined by many other countries in concluding that the risks associated with physician-assisted suicide and euthanasia are too great. There was evidence of the fact that throughout the common law world, the prohibition on physician-assisted suicide and euthanasia remains the norm.[91] After extensive and rigorous study of these issues, the overwhelming majority of comparable western democracies have sought to avoid the same harms and have come to the same conclusion as Canada – the risks associated with physician-assisted suicide and euthanasia require a continued blanket prohibition.[92] Comparable practice in similar jurisdictions has been relied on by the SCC as evidence that the impugned measure relates to a reasonable apprehension of harm and falls within a range of reasonable alternatives.[93]

60. The trial judge also had before her international jurisprudence upholding the prohibition on physician-assisted suicide and euthanasia as a reasonable measure to protect individuals from harm. For instance, the United States Supreme Court has held that the prohibition on physician-assisted suicide is rationally related to legitimate government interests such as: preserving human life; preventing suicide; and protecting

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[90] Canada's Notice to Admit #1, para. 36 and Appendix T at pp. 396-398 (Appeal Book, Vol. 12, p. 3862 and pp. 4252-4254).
[91] Professor Shariff Report at paras. 22-23 and 33-44 (Appeal Book, Vol. 20, pp. 6831, 6834-6835).
[92] Canada's Notice to Admit #2 at paras. 2-5 and 7-10, Appendices B-D and F-H (Appeal Book, Vol. 15, pp. 4805-4806, Ex. B-D: 4870-5139 and Ex. F-H: Vol. 16, pp. 5149-5615); Professor Shariff Report at paras. 50-52, 135, 161-173, 177, 186-193, 197, 206, 216-217, 219, 226-235, and 237-239 (Appeal Book, Vol. 20, pp. 6836-6837, 6853, 6859-6867, 6869, 6871-6872 and 6874-6877).
[93] *Canada (Attorney General) v. JTI-Macdonald Corp.,* [2007] 2 S.C.R. 610, 2007 SCC 30 (QL) at paras. 10 and 138 [***JTI-Macdonald***].

vulnerable groups from prejudice, indifference and psychological and financial pressure to end their lives.[94]

61. In a case such as this, which involves complex human behaviour, and where Parliament must consider the competing interests of different groups, the question is not, as the trial judge appears to have believed, whether the evidence establishes that harm would occur in any system of legalised physician-assisted dying. Rather, the correct question is: does the government have a reasonable basis for concluding that an absolute prohibition is necessary to achieve the government's objectives.[95]

62. The majority in *Rodriguez* correctly apprehended the nature and scope of the constitutional issue, concluding that "[i]n light of the significant support for the type of legislation under attack in this case and the contentious and complex nature of the issues, I find that the government had a reasonable basis for concluding that it had complied with the requirement of minimal impairment."[96]

63. Having established a reasonable apprehension of harm in respect of any system of legislated exceptions to the blanket prohibition on assisted suicide, the decision as to how to reconcile the competing interests and the choice of whether or not Canadian society should assume the risks associated with physician-assisted dying is a policy choice for Parliament and not a constitutional imperative.

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[94] *Washington v. Glucksberg,* 117 S Ct. 2258 (1997) at 2262-2263, 2267, 2269 and 2271-2275 cited in Professor Shariff Report at para. 56 (Appeal Book, Vol. 20, p. 6838); see also *Vacco v. Quill*, 1997 U.S. LEXIS 4038 (QL), cited in Shariff Report at para. 58 (Appeal Book, Vol. 20, p. 6838); see also *Case of Pretty v. The United Kingdom*, No 2346/02, [2002] III ECHR 1 (BAILII) cited in Professor Shariff Report at para. 143 (Appeal Book, Vol. 20, p. 6855); see also *Nicklinson v. Ministry of Justice*, [2012] EWHC 2381 (Admin) at para. 150.
[95] *Irwin Toy, supra* note 66 at paras. 79-81.
[96] *Rodriguez, supra* note 24 at para. 189.

2. The Trial Judge Erred in Finding that a Complex Regulatory Regime is a Reasonable Alternative

64. In the context of both her s.7 overbreadth and s.1 minimal impairment analyses, the trial judge erred in her approach to the availability of less rights-infringing alternatives that would accomplish the government's objective in a real and substantial manner.

65. Although the trial judge correctly stated the test in this way in various places in the judgment, in applying the test she erroneously asked whether the absolute prohibition is "the least restrictive means of preventing the inducement to suicide of vulnerable persons".[97] The jurisprudence has clearly indicated that the test is not that the government prove that the absolute prohibition is the "least restrictive means" of achieving its ends,[98] but whether the prohibition falls within a range of reasonable alternatives.[99]

66. The trial judge found that in order for the inherent risks of physician-assisted suicide and euthanasia to be "greatly minimized", a "stringently limited, carefully monitored system of exceptions"[100] was necessary. The trial judge's ruling implicitly requires Parliament to create a complex comprehensive regulatory regime, and to allocate resources to its monitoring and enforcement in order to mitigate the risks to vulnerable individuals created by the removal of the blanket prohibition. This is an inappropriate expansion of the principle against overbreadth and misunderstands the scope of "reasonable alternatives".

67. The effectiveness of the required regulatory regime is dependent upon a number of variables beyond the ability of any level of government to regulate. For example, the trial judge concluded that the effectiveness depends, in large part, on the ability of

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[97] Reasons at paras. 1361 and 1363 (Record, Vol. 3, pp. 485-486).
[98] *Sharpe, supra* note 44 at para. 96.
[99] *Hutterian Brethren, supra* note 33 at paras. 37 and 62; *JTI-Macdonald, supra* note 93 at paras. 66 and 137.
[100] Reasons at paras. 883, 1240 and 1243 (Record, Vol. 3, pp. 357 and 457-458).

physicians to a) properly assess competency through the application of “a rigorous standard of scrutiny”, and b) overcome unconscious biases about the quality of life of a person with a disability by being “alert” to that risk.[101] Setting aside the logical impossibility of overcoming unconscious bias through a conscious activity, the trial judge’s heavy reliance on what might be termed the ‘perfect’ doctor, is simply not realistic and speaks to the high degree of speculation that underlies her conclusion that a regulatory regime will protect the vulnerable.

68. A finding of overbreadth may require some nature of legislative or judicial remedy to appropriately narrow the ambit of the impugned provision. However, that remedy cannot properly involve the necessary creation of an extensive regulatory regime in order to avoid the risk that individuals may die while in a state of vulnerability - a risk that arises as a direct result of the removal or modification of the impugned provision.

69. In addition, it is the very regulatory regime which the trial judge proposed that, by defining which kinds of lives may be taken in this way, sends the message which is antithetical to Parliament’s objective of confirming the value of every life. As such, the alternative proposed by the trial judge does not achieve, but directly undermines, an important aspect of Parliament’s objective.

3. The Trial Judge Erred in Concluding that the Blanket Prohibition is Grossly Disproportionate

70. Gross disproportionality describes legislative responses to a problem that are so extreme that they are *per se* disproportionate to any legitimate government interest.[102]

71. It is not disputed that the effects of the blanket prohibition on some individuals are potentially serious. However, on the other side of the scale is the risk of death not genuinely desired for other individuals not before the court – many of whom are likely to be more disadvantaged and more vulnerable than those who claim a right to assisted

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[101] Reasons at paras. 795 and 853 (Record, Vol. 3, pp. 331-332 and 345).
[102] *PHS, supra* note 45 at para. 133; *Malmo-Levine, supra* note 47 at para. 143.

suicide. In view of the nature and severity of the risks inherent in any system of physician-assisted dying, it cannot be said that the blanket prohibition is so extreme that it is *per se* disproportionate to the government interest in preserving live, upholding respect for life and protecting the vulnerable from death.

4. The Trial Judge Erred in Her Consideration of the Ethical Debate

72. Although the trial judge correctly concluded she was bound by *Rodriguez* on the issues of arbitrariness under s.7 and rational connection under s.1, she engaged in a lengthy discussion of the ethical distinctions between the withdrawal of life-sustaining treatment and physician-assisted dying as she was of the view that it would be relevant to the issue of arbitrariness for later consideration by the SCC.[103]

73. The trial judge's analysis of this evidence was misplaced for three reasons. First, even if the practices are not ethically distinguishable, or even if society tolerates similar risks in relation to end of life practices, this is not relevant to the question of arbitrariness. The SCC has recognised that the concept of arbitrariness does not compel Parliament to deploy the criminal law equally against all conduct that may arguably warrant comparable treatment.[104]

74. Second, even if it was necessary for there to be a distinction between assisted suicide and euthanasia and other end of life practices in order for the prohibition not to be arbitrary, there is, as the majority in *Rodriguez* found, a persuasive and defensible legal distinction between withdrawal of treatment and physician-assisted suicide and euthanasia, based on the fact that treatment, absent consent, constitutes battery and that a physician has no choice but to comply with a valid request to cease treatment.[105]

75. Third, in any event, Canada disputes the trial judge's finding that there are no ethical distinctions between physician-assisted suicide or euthanasia and other end of

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[103] Reasons at paras. 161-358 and 1336, (Record, Vol. 2, pp. 161-219 and Vol. 3, p. 479).
[104] *Malmo-Levine, supra* note 47 at paras.138-140.
[105] *Rodriguez, supra* note 24 at para. 171.

life practices. The trial judge had before her evidence of Parliament's consistent conclusion, reached after rigorous analysis and discussion of the ethical debates, that there is an ethical distinction between these practices.[106] Similarly, she had evidence before her that almost every national medical association, including the Canadian Medical Association, opposes euthanasia and physician-assisted suicide and that many of these organizations expressly cite an ethical distinction between physician-assisted suicide or euthanasia and other end of life practices, as well as a legal distinction.[107]

76. Causation of death is a fundamental component of Canada's homicide laws. Physician-assisted suicide and euthanasia involve third parties that directly cause or directly participate in causing death, whereas withdrawal or refusal of treatment involve physicians respecting the wishes of an individual not to be touched and witnessing that individual's possible death from an underlying medical condition. This is not only the basis for the legal distinction, but is also the basis for a valid and important ethical distinction.

5. The Trial Judge Erred in Finding that the Right to Life Interest is Engaged

77. The trial judge agreed with Canada that the right to life protected under s.7 is engaged only when there is a threat of death. She properly rejected the respondents' claim that the right to life includes a right to die.[108] However, the trial judge went on to find that the *Criminal Code* prohibition on assisted suicide had the effect of "forcing an earlier decision and possibly an earlier death on persons in Ms. Taylor's situation."[109]

78. Although s.7 may apply when a deprivation occurs at the hands of a non-state actor, it can only do so where there is a sufficient causal connection between the

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[106] Canada's Notice to Admit #1 at paras. 31 and 36, Appendices Q and T (Appeal Book, Vol. 12, pp. 3861-3862, App. Q: 4025-4058 and App. T: 4228-4260).
[107] Canada's Notice to Admit #1, Appendix Q at p.181 (Appeal Book, Vol. 12, p. 4037); Affidavit of Nancy Reimer #1 (Appeal Book, Vol. 18, pp. 5948-6106).
[108] Reasons at para. 1320 (Record, Vol. 3, p. 476).
[109] Reasons at para. 1322 (Record, Vol. 3, p. 476).

impugned state action and the deprivation in question.[110] A significant causal connection is required. [111]

79. Properly understood, the shortening of lives to which the trial judge referred is one possible response to *anticipated* suffering that *may* result from the prohibition on assisted suicide. The proper focus of the s.7 analysis is limited to the actual consequences of the prohibition, and does not extend to an individual's free and voluntary choice to respond to anticipated consequences in a particular way. The actual consequences were fully canvassed in *Rodriguez* and found to accord with the principles of fundamental justice.

80. Furthermore, the trial judge erred in not considering the government's approach to suicide as a whole. When that is done, it cannot be said that suicide is ever a direct consequence of the prohibition against assisted suicide and euthanasia. The trial judge did not analyse the legislative scheme in its full context and overlooked the fact that Parliament does what it effectively can, within its constitutional authority, to prevent and discourage all suicides.

81. For example, federal organisations, including Health Canada, the Public Health Agency of Canada, the Canadian Institute of Health Research, Veterans Affairs, Aboriginal Affairs and Northern Development Canada, and the Canadian Forces, are working to address suicide and other mental health issues.[112] Parliament's repeal of the attempted suicide offence does not detract from these efforts. It merely reflects a recognition that the criminal law is an ineffectual and inappropriate tool for dealing with an individual who is so distressed that they attempt suicide.[113]

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[110] *Suresh v. Canada (Minister of Citizenship and Immigration)*, [2002] 1 S.C.R. 3, 2002 SCC 1 (QL) at paras. 54-55.
[111] *Blencoe v. British Columbia (Human Rights Commission)*, [2002] 2 S.C.R 307, 2000 SCC 44 (QL) at paras. 69-70.
[112] *Mental Health Act*, R.S.B.C. 1996, c. 288, ss. 22-24, Appendix "B"; Canada's Notice to Admit #2, Appendix K at p. 925 (Appeal Book, Vol. 17, p. 5728); Fairey Affidavit #1 (Appeal Book, Vol. 26, pp. 8864-8948).
[113] *Rodriguez, supra* note 24 at para. 155.

82. The decision to commit suicide while one is still physically able to do so is but one of several choices available to an individual. Although it may arise in part as a response to the consequences of the prohibition on assisted suicide, it is nevertheless a free and voluntary choice – one that Parliament does what it can to discourage and prevent. As such, it cannot be swept into the net of consequences that can fairly be said to have been "caused" by the prohibition on physician-assisted suicide.

C. SECTION 15

83. The trial judge erred in finding that the prohibition infringes s.15(1). In particular, the trial judge erred in: a) finding that the distinction related to a benefit or burden *of the law;* and b) finding the prohibition was discriminatory.

1. The s.15(1) Claim Does Not Relate to a Benefit or Burden of the Law

84. Although s.15(1) encompasses both the denial of benefits and the imposition of burdens, as the SCC explained in *Auton,*[114] a s.15(1) claim must always relate to something, be it a benefit or the absence of a burden, that is conferred *by law* in the sense of having been intentionally granted to some groups but withheld from others.

85. There is no law or government policy which provides the right to commit suicide. The lack of a criminal prohibition against suicide does not constitute a benefit provided by law. As a result, the inability of persons with severe disabilities to have assistance in suicide does not relate to a benefit or absence of a burden emanating from the law.

86. The trial judge rejected the benefit of the law argument on the erroneous assumption that Canada was arguing that s.15(1) is limited to cases where a benefit "in the sense of access to a government benefit program, has been denied", noting that

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[114] *Auton (Guardian ad litem of) v. British Columbia (Attorney General),* [2004] 3 S.C.R. 657, 2004 SCC 78 (QL) at paras. 29 and 42 [***Auton***]. See also *Canadian Blood Services v. Freeman*, 2010 ONSC 4885, 217 C.R.R. (2d) 153 (QL).

s.15(1) equally encompasses "claims for the removal of burdens imposed by the law" where those burdens are based on enumerated or analogous characteristics.[115]

87. Canada does not dispute that s.15(1) encompasses claims for the removal of burdens imposed by the law. When government confers a benefit, it must take into account the unique needs and circumstances of persons with disabilities and accommodate them. A facially neutral law that fails to make such reasonable accommodations will give rise to a distinction for s.15(1) purposes.[116] However, *Auton* makes it clear that the legislative scheme at issue must be examined with a view to determining whether the advantage sought (be it a positive benefit or the absence of a burden) is conferred *by law* on anyone. The trial judge's analysis erroneously held that s.15(1) encompasses the removal of burdens to access perceived benefits that are not provided by law to anyone.

88. Unlike this case, in *Turpin,* a case on which the trial judge relied in this connection, the advantage sought, namely the right to choose a trial by judge alone, was expressly conferred by law on some individuals while being withheld from others.[117]

89. By contrast, Canada's argument is that the alleged right or freedom to commit suicide is one that falls entirely outside, and is antithetical to, the general legislative scheme which is intended to discourage and make difficult access to suicide for everyone. As the claim does not relate to a benefit of the law, it cannot succeed.

90. Furthermore, the effect of the trial judge's decision with respect to s.15(1) is to require Parliament to create a complex regulatory scheme in order to provide a perceived benefit, a preferred method of suicide, to one group of people. The requirement to take steps to provide this perceived benefit to one group on the basis of s.15(1) is at odds with *Auton,* in which the SCC stated that "the legislature is under no

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[115] Reasons at para. 1064 (Record, Vol. 3, pp. 408-409).
[116] *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 (QL) [***Eldridge***].
[117] Reasons at paras. 1059-1060 (Record, Vol. 3, pp. 406-407).

obligation to create a particular benefit. It is free to target the social programs it wishes to fund as a matter of public policy, provided the benefit itself is not conferred in a discriminatory manner."[118]

2. The Prohibition is Not Discriminatory

91. In looking at the contextual factors which are used to determine if a given distinction is discriminatory, the trial judge erred in three ways. First, the trial judge erred in characterising the nature of the interest affected too broadly as the autonomy to relieve oneself of suffering. What is at issue in the present case is not the relief of suffering *simpliciter*, but rather the autonomy to relieve suffering by ending one's life. This cannot fairly be said to be a basic aspect of membership in Canadian society. Second, she erred in finding that the prohibition does not correspond to the claimant's circumstances. The prohibition takes into account the prevalent and often unconscious biases that devalue the lives of people with disabilities and can put them at risk in a system which allows for assisted suicide and euthanasia. Finally, in finding that the ameliorative effects factor is not relevant, the trial judge overlooked the question of whether the prohibition has an ameliorative effect on some other more disadvantaged group.[119]

(a) The ability to choose the time and manner of one's death is not a basic aspect of full membership in Canadian society

92. The trial judge erred in determining that the value of autonomy with respect to physical integrity includes the autonomy to relieve oneself of suffering by dying at a time and in the place and manner of one's own choosing.[120] The ability to relieve oneself of suffering in this way is not a basic aspect of full membership in Canadian society.[121]

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[118] *Auton, supra* note 114 at paras. 41 and 47.
[119] Reasons at paras. 1079-1162 (Record, Vol. 3, pp. 413-437).
[120] Reasons at paras. 15 and 1156 (Record, Vol. 2. pp. 118-119 and Vol. 3, p. 436).
[121] *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 (QL) at para. 74 [***Law***].

93. In *Law*, the SCC explained that in determining whether or not differential treatment is discriminatory, courts must evaluate the economic, constitutional and societal significance attributed to the interest or interests adversely affected by the legislation in question. Moreover, the Court found it is relevant to consider whether the distinction restricts access to a fundamental social institution, or affects a "basic aspect of full membership in Canadian society" .[122]

94. The trial judge's s.15(1) analysis is grounded in the fact that suicide is not criminally prohibited.[123] Suicide, however, is not a fundamental social institution. Certainly the absence of a criminal prohibition on suicide is not indicative of any such status, but simply reflects Parliament's considered view that the person who wishes to end his or her own life is properly the subject of health law, rather than the criminal law.[124]

95. Furthermore, short of suicide, no one has control over the time and manner of their death and having that control cannot be considered a basic aspect of full membership in Canadian society.

(b) <u>The prohibition corresponds to the circumstances of persons with disabilities</u>

96. The trial judge erred in finding that the prohibition does not correspond to the circumstances of those who have limited means of committing suicide as a result of being physically disabled. The prohibition takes into account the actual needs, capacities, or circumstances of the respondents and others with similar traits in a manner that respects their value as human beings and members of Canadian society.[125]

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[122] *Law, supra* note 121 at para. 74.
[123] Reasons at paras. 15 and 1158 (Record, Vol. 2, pp. 118-119 and Vol. 3, p. 436).
[124] *Rodriguez, supra* note 24 at para.155.
[125] *Law, supra* note 121 at paras. 69-71.

97. As noted above, the purpose of the prohibition is, in part, the protection of individuals who might be induced in moments of weakness to commit suicide. This purpose is grounded in the state interest in protecting life.[126] All people with or without physical disability, who are considering suicide, are potentially vulnerable and in need of protection from the interventions of others to avoid, amongst other things, abuses, coercion, unconscious bias and subtle pressures.

98. The trial judge accepted that "persons with disabilities face prejudice and stereotyping and that there is a risk of unconscious bias about the quality of life of a person with a disability."[127] She concluded, however, that the prohibition fails to correspond with the needs and circumstances of persons with disabilities because it is based on the assumption that an autonomous, "independent-minded" and clear-thinking person with physical disabilities needs protection from this prejudice and stereotyping.[128]

99. The trial judge failed to address Canada's argument that every person who is contemplating suicide is potentially vulnerable and that it is impossible to reliably differentiate individuals who may be vulnerable at a particular time from those who may not.

100. The heightened risk for individuals with disabilities relates not to their capacity to make autonomous decisions but to the way in which requests for physician-assisted dying made by persons with disabilities are perceived in an ableist society. The risk is that a request made by a person whose quality of life is perceived as unacceptable within an ableist society will be more readily accepted as reasonable and be less likely

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[126] *Rodriguez, supra* note 24 at para. 149.
[127] Reasons at para. 853 (Record, Vol. 3, p. 345).
[128] Reasons at para. 1129 (Record, Vol. 3, p. 429).

to receive the full benefit of intervention *against* self-destructive impulses that would be afforded to an able-bodied patient making the same request.[129]

101. In stating that there was little evidence before the Court that physicians would, even unconsciously, respond differently to requests for assisted death from individuals with physical disabilities as opposed to others, the trial judge contradicted herself and overlooked the evidence that was adduced on this point, which she accepted.[130]

102. The trial judge held that the prejudices and stereotypes of an ableist society could be avoided through careful and well-informed capacity assessments by physicians alert to these risks.[131] The trial judge erred in making this finding by not taking into account the impact of physicians' subconscious biases. Expecting physicians to control their unconscious biases in order to protect individuals who request physician-assisted death is an unrealistic premise which does not correspond to the circumstances and experiences of persons with disabilities in dealing with the medical profession or society in general.

103. The trial judge accepted that the effectiveness of any safeguards depends on various factors, including the "the cultural context in which they are situate" and "the skills and commitment of the physicians who are responsible for working within them".[132] The reality is, as the trial judge acknowledged, that our cultural context is one in which the lives of persons with disabilities are devalued, even within the medical profession, and that not all physicians have the necessary skills and commitment to ensure that this context does not detrimentally impact persons with disabilities.

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[129] Reasons at paras. 848-851 and 853 (Record, Vol. 3, pp. 343-345); Wiebe Affidavit #1 at paras. 27-38 (Appeal Book, Vol. 23, pp. 7820-7823); Professor Frazee Report (Appeal Book, Vol. 36, pp. 12101-12376).
[130] Reasons at paras.194, 811, 815, 848-851, 853 and 1129 (Record, Vol. 2, p. 168 and Vol. 3, pp. 335-336, 343-345 and 429); Martin Affidavit #1 at paras. 12-14 (Appeal Book, Vol. 19, p. 6818); Wiebe Affidavit #1 at paras. 27-38 (Appeal Book, Vol. 23, pp. 7820-7823); Professor Frazee Report (Appeal Book, Vol. 36, pp. 12101-12376).
[131] Reasons at para. 853 (Record, Vol. 3, p. 345).
[132] Reasons at para. 1239 (Record, Vol. 3, p. 457).

104. The prohibition also corresponds to the needs and capacities of persons with disabilities because, absent a reliable mechanism for identifying in advance the non-vulnerable, the blanket prohibition protects the vulnerable members within that group.

105. The complete prohibition also takes into account that the wish to die may be transitory. The trial judge failed to recognise Parliament's legitimate interest in discouraging the suicide of such individuals, like Ms. Davis, whose wish to die may satisfy the requirements of any legalised regime for physician-assisted suicide or euthanasia but may nevertheless be transitory.[133]

106. Finally, the disability rights community is divided on the issue of assisted dying, with some disability groups in support of the prohibition on the basis that it protects persons with disabilities, and others against.[134] Given that s.15(1) does not require perfect correspondence,[135] this supports Canada's position that the prohibition corresponds with the actual needs and circumstances of people with disabilities.

107. The prohibition does not represent a failure to accommodate disability resulting in the exclusion of individuals with material disabilities from an aspect of mainstream society.[136] The prohibition corresponds with the needs and capacities of persons with disabilities in the same way as it corresponds with the needs and capacities of the able-bodied – by protecting vulnerable members of each of those respective groups who might be induced in moments of weakness to commit suicide. That protection is even more important to many persons with disabilities given the bias and prejudice that they face in our society.

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[133] Reasons at para. 757 (Record, Vol. 3, pp. 322-323); Davis Affidavit #1 at paras. 13-29 (Appeal Book, Vol. 19, pp. 6811-6814).
[134] Reasons at paras.1120 and 1125 (Record, Vol. 3, pp. 427-428).
[135] *Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429, 2002 SCC 84 (QL) at paras. 55-56; *Law, supra* note 121 at para. 106; *Withler v. Canada (Attorney General)*, [2011] 1 S.C.R. 396, 2011 SCC 12 (QL) at para. 67 [***Withler***].
[136] *Eldridge, supra* note 116 at para. 65.

(c) The prohibition has an ameliorative effect

108. Although programs with an ameliorative purpose should be analysed under s.15(2), ameliorative effect may be relevant in the s.15(1) analysis.[137]

109. In concluding that the ameliorative effects factor is not relevant in this case, the trial judge found that individuals with material physical disabilities who are affected by the prohibition are less advantaged, in a relative sense, than able-bodied Canadians.[138] In doing so, she erred in limiting her comparison to the physically disabled and the able-bodied and failed to consider whether the prohibition has an ameliorative effect on "some other, more disadvantaged group."[139]

110. Even if not every individual with disabilities who wishes to commit suicide is vulnerable to the impacts of societal biases, there are individuals who are. The blanket prohibition reflects the difficulty of realistically and reliably identifying and protecting those vulnerable persons who may be at greater risk if some form of assisted suicide or euthanasia was allowed.

111. The trial judge relied upon statistical studies in concluding that individuals with disabilities do not access physician-assisted suicide and euthanasia in disproportionate numbers.[140] However, the statistical evidence she relied upon does not contain data on whether individuals who accessed physician-assisted suicide had pre-existing physical disabilities. In any event, measuring the rate at which members of certain disadvantaged groups access physician-assisted dying as compared to members of the background population does not answer concerns about the inherent risks associated with physician-assisted suicide and euthanasia that are enumerated in the s.7 analysis

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[137] *R. v. Kapp*, [2008] 2 S.C.R. 483, 2008 SCC 41 (QL) at para. 23; *Withler, supra* note 135 at para. 38.
[138] Reasons at paras. 1140-1141 (Record, Vol. 3, p. 432).
[139] *Nova Scotia (Workers' Compensation Board) v. Martin; Nova Scotia (Workers' Compensation Board) v. Laseur*, [2003] 2 S.C.R. 504, 2003 SCC 54 (QL) at para. 102.
[140] Reasons at paras. 852 and 1113 (Record, Vol. 3, pp. 345 and 425).

above, nor does it answer concerns about risks that transcend discrete categories of vulnerability.

112. The prohibition particularly has an ameliorative effect on those individuals with disabilities who *are* vulnerable to the prejudices and biases within our society regarding the value of their lives.

3. Conclusions on s.15(1)

113. The prohibition against assisted suicide and euthanasia supports the fundamental purpose of s.15. It affirms that every life, including the lives of the severely disabled, should be valued by society and is worthy of protection.

114. In contrast, in finding a violation of s.15(1), the trial judge determined that equality rights require the government to provide lesser protection to those with physical disabilities.

115. In particular, in the context of her s.15(1) analysis, the trial judge's conclusion suggests that although the government may protect the vulnerable from the inherent risks of physician-assisted suicide and euthanasia, it may only do so if the vulnerable are not individuals with physical disabilities. For individuals with physical disabilities, the protection is removed in the name of providing equality. Justice Sopinka acknowledged this potential inequality in *Rodriguez*: "[s]. 241(b) protects all individuals against the control of others over their lives. To introduce an exception to this blanket protection for certain groups would create an inequality."[141]

[141] *Rodriguez, supra* note 24 at para. 187.

116. The trial judge's s.15(1) analysis was premised on the fact that suicide is not criminally prohibited for everyone. An approach to equality analysis which is grounded in the absence of an ineffective law stands on weak footing that does nothing to advance the purposes of s.15. This is reflected in the comments of McLachlin, J. (as she then was) in *Rodriguez*:

> I am of the view that this is not at base a case about discrimination under s. 15 of the Canadian Charter of Rights and Freedoms, and that to treat it as such may deflect the equality jurisprudence from the true focus of s. 15 -- "to remedy or prevent discrimination against groups subject to stereotyping, historical disadvantage and political and social prejudice in Canadian society"[142]

D. SECTION 1

1. The Prohibition is Rationally Connected to a Pressing and Substantial Objective

117. The trial judge accepted that the purpose of the prohibition represents a pressing and substantial legislative objective.[143] She further concluded that the prohibition is rationally connected to the legislative objective, observing that she was bound by *Rodriguez* on this point.[144]

2. The Trial Judge Erred in Finding that the Prohibition is Not Minimally Impairing

118. Canada's arguments with respect to the errors in the trial judge's s.7 analysis of the principles of fundamental justice are equally applicable to Canada's argument with respect to s.1.

119. As in her approach to s.7, the trial judge erroneously asked whether the absolute prohibition is "the least restrictive means of preventing the inducement to suicide of vulnerable persons"[145] The trial judge ought to have assessed whether the prohibition fell within a range of reasonable alternatives, bearing in mind the fact that the

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[142] *Rodriguez, supra* note 24 at para. 196.
[143] Reasons at paras. 1204-1205 (Record, Vol. 3, p. 449).
[144] Reasons at paras.1208-1209 (Record, Vol. 3, p. 450).
[145] Reasons at para. 1363 (Record, Vol. 3, p. 486) [emphasis added].

government had demonstrated a reasonable apprehension of harm in respect of any legislated exception to the blanket prohibition.

120. The trial judge's proposed alternative means do not meet the prohibition's objective in a real and substantial manner. Instead, they require the government to significantly compromise its objective. The effectiveness of the alternative means is purely speculative, which is underscored by the trial judge's statement that "the evidence suggests it is extremely unlikely that physicians in Canada would be other than rigorously compliant with legislation"[146] despite the fact that she had just stated that physician-assisted suicide is currently occurring in Canada.[147]

121. Furthermore, it is the very regulatory scheme proposed by the trial judge that, by defining which kinds of lives may be taken, sends the message which is antithetical to Parliament's objective of confirming the value of every life. Legalising assisted suicide or euthanasia means that some people who say that they want to die will receive suicide intervention, while others will receive suicide assistance. The difference between these two groups of people will be their health or disability status.

122. As a result, the blanket prohibition falls within a reasonable range of alternatives in addressing Canada's reasonable apprehension of harm.

3. The Trial Judge Erred in Finding that the Deleterious Effects of the Prohibition Outweigh the Salutary Effects

123. The trial judge held the government to an inappropriately high standard of proof in establishing the basis for and benefits of the blanket prohibition on assisted suicide and in discounting the severity of the harms at which the prohibition is directed as being "generalized and, in some instances, ambivalent", apparently, at least in part, because they relate to "unknown persons".[148]

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[146] Reasons at para. 1284 (Record, Vol. 3, p. 468).
[147] Reasons at paras.1282 and 1370 (Record, Vol. 3, pp. 468 and 487).
[148] Reasons at paras. 1275 and 1283 (Record, Vol. 3, pp. 465 and 468).

124. In considering the deleterious effects of the prohibition, the trial judge stated that given that assisted death occurs in Canada, contrary to the law, the positive effect of bringing under regulation what has previously been unregulated must be taken into account.[149]

125. In making this statement, the trial judge erred and overlooked the fact that assisted death in Canada *is* regulated – it is prohibited. The fact that some people choose not to comply with the prohibition does not undermine the legitimacy of Parliament's considered decision that the blanket prohibition is the best way to attain its legislative objective. In this connection, the SCC has counselled deference to Parliament in assessing the utility of its chosen responses to social problems.[150]

126. The trial judge's conclusion on proportionality is also irreconcilable with her own finding that the prohibition acts as a deterrent to assisted death, including physician-assisted death, and therefore probably results in some patients continuing to live longer than they otherwise would. The trial judge ignored the evidence before her in saying that it is "unknown whether those patients are grateful for that further time." [151]

127. The trial judge further agreed that the blanket prohibition promotes a positive message about the value of all human life and that it sends "an anti-suicide message."[152] However, she did not agree with Canada's submissions that the prevention of negative social messaging outweighs a particular individual's desire for physician-assisted suicide or euthanasia.[153]

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[149] Reasons at paras.1282-1283 (Record, Vol. 3, p. 468).
[150] *Malmo-Levine, supra* note 47 at paras. 177-178.
[151] Reasons at para. 1268 (Record, Vol. 3, p. 463); Davis Affidavit #1 at para. 24 (Appeal Book, Vol. 19, p. 6813); Finlay Affidavit #1 at paras. 81-92 and Exhibit K (Appeal Book, Vol. 28, pp. 9672-9675 and Ex. K: 9774-9776).
[152] Reasons at para. 1265 (Record, Vol. 3, p. 463).
[153] Reasons at para. 1266 (Record, Vol. 3, p. 463).

128. Negative social messaging as to the value of the lives of individuals with physical disabilities is the basis for significant and widespread harm to individuals with disabilities and should not be minimised. Furthermore, it should not be weighed alone against the impacts on those seeking access to physician-assisted suicide or euthanasia. Rather, all the benefits of the prohibition, including the avoidance of the unwarranted deaths of vulnerable individuals, must be weighed together against those impacts.

129. Throughout her *Charter* analysis, the trial judge failed to give adequate weight to the fact that a harm the prohibition seeks to prevent is the death of individuals who may not have a genuine and non-transitory wish to die. The fact that those individuals may be "unknown"[154] or that they will be unable to voice their regret once they are dead, does not make their protection any less important.

130. Although the suffering of individuals seeking physician-assisted suicide or euthanasia must also be recognised, as difficult as their situations are, their suffering can never be said to outweigh the unwarranted death of others.

III. PROCEDURAL ERRORS

131. The following procedural errors are sufficient to warrant sending this matter back to the trial court.[155]

A. TIMELINES WERE INAPPROPRIATELY COMPRESSED

132. As a result of the expedited timelines in which the trial proceeded, Canada was unable to put its full evidentiary case before the Court.

133. At the respondents' request, and over the objections of Canada, the matter proceeded by way of summary trial on expedited timelines. [156] In support of their claim,

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[154] Reasons at para. 1275 (Record, Vol. 3, p. 465).
[155] *Hixon (Guardian ad litem of) v. Roberts,* 2004 BCCA 335, 131 A.C.W.S. (3d) 981 (QL); *Houston v. Kine,* 2011 BCCA 358, 340 D.L.R. (4th) 717 (QL).
[156] Reasons at para. 139 (Record, Vol. 2, pp. 146-147).

the respondents filed more than 80 affidavits, approximately 37 of which were from experts. Canada was given 30 days to obtain and file evidence in response to the respondents. Canada was unable to meet that timeline, and was permitted to file some evidence after the deadline. Canada was still not able, within the time restrictions imposed, to obtain all of the evidence that it wished to present to the trial judge but was denied further extensions of time.[157]

134. The trial judge's statement in her reasons that Canada did not point to any evidence that it would have provided to the Court but for the timelines, is simply not accurate.[158] At a case management conference on September 2, 2011, Canada expressed its desire to put forward evidence of the prevalence of elder abuse and the prejudices faced by persons with disabilities, not only in society at large, but also in the medical community. However, Canada informed the trial judge that given the timelines imposed and the volume of material received from the respondents, it would not be in a position to put the full evidentiary record before the Court, and requested an extension of the timelines.[159] The Court refused the extension.

135. The fact that, from Canada's perspective, there remained holes in the evidentiary record as a result of the compressed timelines was reiterated at a case management conference on November 8, 2012 when Canada requested a change to the trial schedule, including the ability to file additional evidence. At that time the additional evidence was identified as evidence on elder abuse and evidence from an expert who had already filed a report but had not had an opportunity to review and specifically respond to the evidence filed by the respondents.[160] The request was denied by the trial judge.

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[157] Case Planning Conference, November 8, 2011 (Appeal Book, Vol. 39, pp. 13428:21-41; 13452:17 to 13453:5, 13488:10 to 13489:22 and 13493:8 to 13494:34).
[158] Reasons at para. 145 (Record, Vol. 2, p. 148).
[159] Case Planning Conference, September 2, 2011 (Appeal Book, Vol. 3, p. 718:33-40).
[160] Case Planning Conference, November 8, 2011 (Appeal Book, Vol. 39, pp. 13428:21-41 and 13452:17 to 13453:5).

136. It is impossible to speculate how this additional evidence on these important issues would have impacted the trial judge's conclusions, particularly in respect of the efficacy of safeguards. The difficulty of putting a complete record before the trial judge highlights the fact that the trial process is not equipped to deal with such a complex social issue.

B. ACCEPTANCE OF IMPROPER REPLY SUBMISSIONS

137. At the commencement of oral argument, on day 12 of the hearing, the respondents provided their initial written argument of 86 pages. Subsequently, supplemental submissions of 26, 1 and 11 pages were provided on days 14, 14 and 17 respectively. Canada provided its written argument of 198 pages at the commencement of its oral submission on day 17 of the hearing.

138. The trial judge improperly accepted the respondents' written reply submissions at trial, which were provided to Canada only on the last day of the trial and totalled 163 pages. In her reasons, the trial judge determined that the respondents' reply was proper, and received it without providing Canada with an opportunity for sur-reply.[161]

139. Canada objected to the propriety of the reply submissions and requested that if they were accepted by the trial judge, Canada be provided with an opportunity for sur-reply. The respondents made new arguments and references to the evidence in their reply, which ought to properly have been made in their submissions in chief, and to which Canada did not have an opportunity to respond.[162]

140. For example, in the respondents' reply submissions, they argued that the evidence of a number of Canada's witnesses should be given less weight, including the evidence of Dr. Keown, Dr. Pereira, Dr. Chochinov, Dr. Rodin, Dr. Heisel, Dr. Mishara, and

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[161] Reasons at paras.148-159 (Record, Vol. 2, pp. 148-150).
[162] *Allcock Laight & Westwood Ltd. v. Patten, Bernard and Dynamic Displays Ltd.; Patten and L.A. Corney Commercial Deliveries Ltd. v. Bernard and Dynamic Displays Ltd.*, [1967] 1 O.R. 18 (QL) at 3-4 (CA); *Clausen v. Canada Timber and Lands Ltd.* (1925), 35 B.C.R. 461 (QL) at 3 (CA).

Baroness Finlay. Canada was not provided with an opportunity to respond to these submissions. In her reasons, the trial judge stated that she had assessed the weight to be given to the expert opinion evidence, taking into account various factors.[163] As, with one exception, the trial judge did not further articulate the factors considered for any particular expert or the weight that she gave to their evidence, it cannot be known what impact the respondents' submissions had on the trial judge's weighing of the evidence, or the outcome of the trial.

141. The one exception was the trial judge's treatment of the evidence of Dr. Hendin. In the respondents' reply submissions, they argued that the cross-examination of Dr. Hendin, one of Canada's expert witnesses, revealed that Dr. Hendin was neither impartial nor particularly learned, and requested that the Court disregard Dr. Hendin's evidence in its entirety, with two exceptions. In her reasons, the trial judge found that Dr. Hendin was not impartial, and that he lacked expertise in certain areas.[164] The trial judge should not have discounted Dr. Hendin's testimony without affording Canada the opportunity to make submissions in that respect.

142. The inappropriate reply and inability to put a full record before the Court prejudiced Canada and it is not possible to address this prejudice within the limitations of an appeal. It is impossible to know how these serious procedural defects may have impacted the result of the trial.

PART 4 – NATURE OF ORDER SOUGHT

143. Canada requests that the appeal be allowed, with costs to Canada in this Court and in the trial court.

144. Canada further requests that the trial judgment be set aside and that the declarations and constitutional exemption be set aside.

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[163] Reasons at para. 116 (Record, Vol. 2, p. 143).
[164] Reasons at paras. 504, 664 and 796 (Record, Vol. 2, pp. 260 and 300-301 and Vol. 3, pp. 332).

145. In the alternative, Canada requests that the matter be sent back to the trial court.

146. In the further alternative, Canada requests that any declaration of constitutional invalidity be suspended until the later of the final disposition of any appeal or one year from the date of this Court's decision. In the event there is no appeal, Canada requests leave during the period of suspension to apply for extensions of suspension if necessary.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

Dated: October 22, 2012

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Counsel for the Appellant,
Attorney General of Canada

Dated: October 22, 2012

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Dated: October 22, 2012

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APPENDIX “A”

Criminal Code, R.S.C. 1985, c. C-46

Consent to Death

14. No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

14. Nul n’a le droit de consentir à ce que la mort lui soit infligée, et un tel consentement n’atteint pas la responsabilité pénale d’une personne par qui la mort peut être infligée à celui qui a donné ce consentement.

Parties to Offences

21. (1) Every one is a party to an offence who

(a) actually commits it;

(b) does or omits to do anything for the purpose of aiding any person to commit it; or

(c) abets any person in committing it.

(2) Where two or more persons form an intention in common to carry out an unlawful purpose and to assist each other therein and any one of them, in carrying out the common purpose, commits an offence, each of them who knew or ought to have known that the commission of the offence would be a probable consequence of carrying out the common purpose is a party to that offence.

21. (1) Participent à une infraction :

(a) quiconque la commet réellement;

(b) quiconque accomplit ou omet d’accomplir quelque chose en vue d’aider quelqu’un à la commettre;

(c) quiconque encourage quelqu’un à la commettre.

(2) Quand deux ou plusieurs personnes forment ensemble le projet de poursuivre une fin illégale et de s’y entraider et que l’une d’entre elles commet une infraction en réalisant cette fin commune, chacune d’elles qui savait ou devait savoir que la réalisation de l’intention commune aurait pour conséquence probable la perpétration de l’infraction, participe à cette infraction.

Person Counselling Offence

22. (1) Where a person counsels another person to be a party to an offence and that other person is afterwards a party to that offence, the person who counselled is a party to that offence, notwithstanding that the offence was committed in a way different from that which was counselled.

(2) Every one who counsels another person to be a party to an offence is a party to every offence that the other commits in consequence of the counselling that the person who counselled knew or ought to have known was likely to be committed in consequence of the counselling.

(3) For the purposes of this Act, "counsel" includes procure, solicit or incite.

22. (1) Lorsqu'une personne conseille à une autre personne de participer à une infraction et que cette dernière y participe subséquemment, la personne qui a conseillé participe à cette infraction, même si l'infraction a été commise d'une manière différente de celle qui avait été conseillée.

(2) Quiconque conseille à une autre personne de participer à une infraction participe à chaque infraction que l'autre commet en conséquence du conseil et qui, d'après ce que savait ou aurait dû savoir celui qui a conseillé, était susceptible d'être commise en conséquence du conseil.

(3) Pour l'application de la présente loi, « conseiller » s'entend d'amener et d'inciter, et « conseil » s'entend de l'encouragement visant à amener ou à inciter.

Homicide

222. (1) A person commits homicide when, directly or indirectly, by any means, he causes the death of a human being.

(2) Homicide is culpable or not culpable.

(3) Homicide that is not culpable is not an offence.

(4) Culpable homicide is murder or manslaughter or infanticide.

(5) A person commits culpable homicide when he causes the death of a human being,

(a) by means of an unlawful act,

222. (1) Commet un homicide quiconque, directement ou indirectement, par quelque moyen, cause la mort d'un être humain.

(2) L'homicide est coupable ou non coupable.

(3) L'homicide non coupable ne constitue pas une infraction.

(4) L'homicide coupable est le meurtre, l'homicide involontaire coupable ou l'infanticide.

(5) Une personne commet un homicide coupable lorsqu'elle cause la mort

(b) by criminal negligence,

(c) by causing that human being, by threats or fear of violence or by deception, to do anything that causes his death, or

(d) by wilfully frightening that human being, in the case of a child or sick person.

(6) Notwithstanding anything in this section, a person does not commit homicide within the meaning of this Act by reason only that he causes the death of a human being by procuring, by false evidence, the conviction and death of that human being by sentence of the law.

d'un être humain:

(a) soit au moyen d'un acte illégal;

(b) soit par négligence criminelle;

(c) soit en portant cet être humain, par des menaces ou la crainte de quelque violence, ou par la supercherie, à faire quelque chose qui cause sa mort;

(d) soit en effrayant volontairement cet être humain, dans le cas d'un enfant ou d'une personne malade.

(6) Nonobstant les autres dispositions du présent article, une personne ne commet pas un homicide au sens de la présente loi, du seul fait qu'elle cause la mort d'un être humain en amenant, par de faux témoignages, la condamnation et la mort de cet être humain par sentence de la loi.

Counselling or Aiding Suicide

241. Every one who

(a) counsels a person to commit suicide, or

(b) aids or abets a person to commit suicide,

whether suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.

241. Est coupable d'un acte criminel et passible d'un emprisonnement maximal de quatorze ans quiconque, selon le cas :

(a) conseille à une personne de se donner la mort;

(b) *aide* ou encourage quelqu'un à se donner la mort,

que le suicide s'ensuive ou non.

APPENDIX “B”

Mental Health Act, R.S.B.C. 1996, c. 288

Involuntary admissions

22 (1) The director of a designated facility may admit a person to the designated facility and detain the person for up to 48 hours for examination and treatment on receiving one medical certificate respecting the person completed by a physician in accordance with subsections (3) and (4).

(2) On receipt by the director of a second medical certificate completed by another physician in accordance with subsections (3) and (5) respecting the patient admitted under subsection (1), the detention and treatment of that patient may be continued beyond the 48 hour period referred to in subsection (1).

(3) Each medical certificate under this section must be completed by a physician who has examined the person to be admitted, or the patient admitted, under subsection (1) and must set out

(a) a statement by the physician that the physician

(i) has examined the person or patient on the date or dates set out, and

(ii) is of the opinion that the person or patient is a person with a mental disorder,

(b) the reasons in summary form for the opinion, and

(c) a statement, separate from that under paragraph (a), by the physician that the physician is of the opinion that the person to be admitted, or the patient admitted, under subsection (1)

(i) requires treatment in or through a designated facility,

(ii) requires care, supervision and control in or through a designated facility to prevent the person's or patient's substantial mental or physical deterioration or for the protection of the person or patient or the protection of others, and

(iii) cannot suitably be admitted as a voluntary patient.

(4) A medical certificate referred to in subsection (1) is not valid unless both it and the examination it describes are completed not more than 14 days before the date of admission.

(5) A second medical certificate referred to in subsection (2) is not valid unless both it and the examination it describes are completed within the 48 hour period following the time of admission.

(6) A medical certificate completed under subsection (1) in accordance with subsections (3) and (4) is authority for anyone to apprehend the person to be admitted, and for the transportation, admission and detention for treatment of that person in or through a designated facility.

(7) A patient admitted under subsection (1) to an observation unit must be transferred to a Provincial mental health facility or psychiatric unit within the prescribed period after a second medical certificate is received under subsection (2) by the director of the observation unit unless the patient is

(a) discharged, or

(b) released on leave or transferred to an approved home under section 37 or 38.

Duration of detention

23 A patient admitted under section 22 may be detained for one month after the date of the admission, and the patient must be discharged at the end of that month unless the authority for the detention is renewed in accordance with section 24.

Review of detention

24 (1) Unless the patient has previously been discharged, authority for the detention of a patient may be renewed under this section as follows:

(a) from the end of the period referred to in section 23 for a further period of one month;

(b) from the end of any period of renewal under paragraph (a) for a further period of 3 months;

(c) from the end of any period of renewal under paragraph (b) for a further period, or further successive periods, of 6 months.

(2) During

(a) every one month period referred to in section 23,

(b) every further one month period referred to in subsection (1) (a), and

(c) the last month of every 3 month or 6 month period referred to in subsection (1) (b) or (c),

the director or a physician authorized by the director must examine the patient and either discharge the patient or record a written report of the examination and include in it the reasons of the director or physician for concluding that section 22 (3) (a) (ii) and (c) continues to describe the condition of the patient.

(2.1) An examination under subsection (2) must include

(a) consideration of all reasonably available evidence concerning the patient's history of mental disorder including

(i) hospitalization for treatment, and

(ii) compliance with treatment plans following hospitalization, and

(b) an assessment of whether there is a significant risk that the patient, if discharged, will as a result of mental disorder fail to follow the treatment plan the director or physician considers necessary to minimize the possibility that the patient will again be detained under section 22.

(2.2) If an examination under subsection (2) concludes that section 22 (3) (a) (ii) and (c) continues to describe the condition of the patient, the director or physician must renew under subsection (2) the authority for the detention of that patient.

(3) The written report referred to in subsection (2) is a renewal of the authority for the detention of the patient referred to in that subsection.

PART 5 – LIST OF AUTHORITIES

No.	Caselaw	Paragraphs
1.	*Air Canada Pilots Association v. Kelly*, 2012 FCA 209, 100 C.C.E.L. (3d) 1 (QL).	23 and 37
2.	*Alberta v. Hutterian Brethren of Wilson Colony*, [2009] 2 S.C.R. 567, 2009 SCC 37 (QL).	22, 36 and 65
3.	*Allcock Laight & Westwood Ltd. v. Patten, Bernard and Dynamic Displays Ltd.; Patten and L.A. Corney Commercial Deliveries Ltd. v. Bernard and Dynamic Displays Ltd.*, [1967] 1 O.R. 18 (QL) (CA).	139
4.	*Auton (Guardian ad litem of) v. British Columbia (Attorney General),* [2004] 3 S.C.R. 657, 2004 SCC 78 (QL).	84 and 90
5.	*Bedford v. Canada (Attorney General),* 2012 ONCA 186, 346 D.L.R. (4th) 385 (QL).	37
6.	*Blencoe v. British Columbia (Human Rights Commission)*, [2002] 2 S.C.R 307, 2000 SCC 44 (QL).	78
7.	*Canada (Attorney General) v. JTI-Macdonald Corp.,* [2007] 2 S.C.R. 610, 2007 SCC 30 (QL).	59 and 65
8.	*Canada (Attorney General) v. PHS Community Services Society*, [2011] 3 S.C.R.134, 2011 SCC 44 (QL).	29 and 70
9.	*Canada v. Craig*, 2012 SCC 43 (QL).	23
10.	*Canadian Blood Services v. Freeman*, 2010 ONSC 4885, 217 C.R.R. (2d) 153 (QL).	84
11.	*Case of Pretty v. The United Kingdom*, No 2346/02, [2002] III ECHR 1 (BAILII).	60
12.	*Clausen v. Canada Timber and Lands Ltd.* (1925), 35 B.C.R. 461 (QL) (CA).	139
13.	*Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 (QL).	87 and 107
14.	*Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429, 2002 SCC 84 (QL).	106

33.	*Withler v. Canada (Attorney General)*, [2011] 1 S.C.R. 396, 2011 SCC 12 (QL).	106 and 108
No.	**Legislation**	**Paragraphs**
34.	*Criminal Code*, R.S.C. 1985, c. C-46, ss. 14, 21, 22, 222, 241.	1
35.	*Mental Health Act*, R.S.B.C. 1996, c. 288, ss. 22-24.	81