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)

AND

ALLIANCE OF PEOPLE WITH DISABILITIES WHO ARE SUPPORTIVE OF LEGAL ASSISTED DYING SOCIETY, CANADIAN UNITARIAN COUNCIL, FAREWELL FOUNDATION FOR THE RIGHT TO DIE (Represented by Russel Ogden, Erling Christensen, Laurence Cattoire, John Lowman and Paul Zollmann), THE CHRISTIAN LEGAL FELLOWSHIP, THE EVANGELICAL FELLOWSHIP OF CANADA, EUTHANASIA PREVENTION COALITION and EUTHANASIA PREVENTION COALITION – BRITISH COLUMBIA, and COUNCIL OF CANADIANS WITH DISABILITIES AND THE CANADIAN ASSOCIATION FOR COMMUNITY LIVING

INTERVENORS

FACTUM OF THE INTERVENOR, THE CHRISTIAN LEGAL FELLOWSHIP

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PART 1 – OPENING STATEMENT and STATEMENT OF FACTS

1. The Christian Legal Fellowship ("CLF") adopts Canada's Statement of Facts and intervenes in this appeal to address the inviolability of life ethic and the risks to Canadians that would be occasioned by the loss of its expression in criminal and constitutional law.

PART 2 – ERRORS IN JUDGEMENT

2. CLF submits the trial judge erred in (a) characterizing the nature of the prohibition, (b) legal reasoning and ethical analysis, (c) misapprehending the risks of rejecting the principle of inviolability and (d) misapprehending the risks in assessing consent.

PART 3 – ARGUMENT

I. PURPOSE OF PROHIBITION

A. The bright-line prohibition is intended to protect the equality of all persons

3. Although one of the purposes of the prohibition is, as stated by the trial judge, to protect the vulnerable from being induced to commit suicide in moments of weakness,[1] the trial judge erred in overlooking the broader purpose that was articulated by Sopinka J. in *Rodriguez*: the prohibition is part of a larger network of laws and governmental action that assert the equal value of all human life.

4. Negatively, the prohibition asserts the equal value of all human life by discouraging the social acceptance of suicide as a choice-worthy option. The *Criminal Code* prohibition contributes to the de-normalization of suicide. Health Canada and First Nations communities in Canada have recognized the importance of this approach to preventing suicide. The work of psychologist David Masecar argues against "(c)ommunity normalization of 'suicide as a solution' to problems" and warns that normalization may lead "children and youth" to "see suicide as [an] acceptable way of problem solving."[2]

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[1] Reasons for Judgment of the Honourable Madam Justice Smith pronounced June 15, 2012 ("**Reasons**") at paras. 1190, 1243 & 1348 (Appeal Record ("**AR**"), Vol. 2, pp. 109-320 and Vol. 3, pp. 321-503).

[2] David Masecar, *What is Working, What is Hopeful: Supporting Community-Based Suicide Prevention Strategies Within Indigenous Communities (and any other community that is interested)* (Ottawa: First Nations Inuit Health Branch, Health Canada, 2007) at 34-35 [**Masecar**]; See: Health Canada, *Linking Communities and Research: First Nations and Inuit Suicide Prevention – Report from a Gathering on Improving Collaboration* 2006; Health Canada, *Acting on What We Know: Preventing Youth Suicide in First Nations – The Report of the Advisory Group on Suicide Prevention* 2003 at 33 & 37; Laurence Kirmayer, *Aboriginal Suicide Among Aboriginal People in Canada* (Ottawa: AHF, 2007) at 30, 47-48 & 53.

5. Positively, the prohibition asserts the value of the disabled and the dependent elderly.[3] It contributes to a culture of life that resists the message that some lives are not as valuable as others, and that some persons' continued existence is not only not valuable, but is a source of harm to them. To adapt a proposition from *R. v. Sharpe*: "Over and above the specific objectives of the law ... the law in a larger attitudinal sense asserts the value [of the vulnerable, the disabled, the elderly] against the erosion of societal attitudes towards them."[4]

6. The prohibition functions in the same way as in *R. v. Butler*, where legislation was characterized as countering harm to women not only directly through prohibition, but indirectly through countering cultural attitudes towards women. The prohibition against intentional killing protects persons directly by prohibiting conduct, and indirectly by countering negative cultural attitudes towards the disabled and dependent elderly. [5]

B. The prohibition protects and respects the equality of all persons

7. The prohibition was enacted for the benefit of all Canadians, and is part of a web of law that asserts the value of all persons impartially. This egalitarian ethos benefits all persons, not only those who are currently in a vulnerable or dependant condition, or those who are experiencing moments of weakness.

8. The legal, moral, and constitutional principle behind the legislative purpose is the equality of persons. It means that the lives of all persons are equally valuable, despite the many inequalities (in physical ability, in bodily health, in ability) that exist among persons.[6] In recognition of the radical equality of persons, the state (through its laws and the actions of its governments) guards the lives of all persons impartially. Accordingly, Canadian law (criminal and constitutional) understands the *intentional* taking of all human life to be exceptionlessly wrong, no matter whose life it is.[7]

9. This specification of the equality principle is known in law and in ethics as the principle of the inviolability of life (sometimes termed the "sanctity of life"). It is a cornerstone of Western civilization, is evident in ancient Greek philosophy and Roman law,

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[3] *Rodriguez v. British Columbia (Attorney General),* [1993] 3 S.C.R. 519, 1993 CarswellBC 228 (WL Can) at paras. 34, 59 & 75 [***Rodriguez***].

[4] *R. v. Sharpe*, [2001] 1 S.C.R. 45, 2001 SCC 2 at para.82 [***Sharpe***]. Text replaced "children".

[5] *R. v. Butler*, [1992] 1 S.C.R. 452.

[6] *Andrews v. Law Society of* British Columbia, [1989] 1 S.C.R. 143 [***Andrews***].

[7] *Rodriguez; United States v. Burns,* [2001] 1 S.C.R. 283, 2001 SCC 7.

and was received into the common law long before it was constitutionalized in contemporary bills of rights such as the *Charter of Rights and Freedoms* (*Charter*). [8]

10. The inviolability principle has been posited in Article 2.1 of the *European Convention of Human Rights* ("Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally") and in Article 3 of the *Universal Declaration of Human Rights* and s. 7 of the *Charter* ("everyone has the right to life").

C. The prohibition supports the medical ethical culture against killing

11. One of the great achievements of Canadian *Charter* jurisprudence is the profound insight – deployed in several different contexts – that law shapes culture and culture shapes conduct.[9] The prohibition of assisted suicide and euthanasia supports a medical ethics culture in which intentional killing is never to be considered as a treatment option.

12. The Parliament of Canada has chosen to deal with assisted suicide and euthanasia through the direct prohibitions contained in the challenged legislation. These prohibitions support the medical ethical culture through the bright line inviolability principle: no intentional killing. The trial judge accepted that the legal prohibition is clear[10] and effective in restraining those who disagree with the inviolability principle.[11]

13. It is not seriously suggested under any contemplated regime, including the one established by the trial judge,[12] that every competent person will be entitled to euthanasia or assisted suicide on demand; others will need to be persuaded to assist. It will be these others who will have the power to decide when a patient's physical or psychological suffering is serious enough, or when the illness, disease, or disability is serious enough, to warrant the conclusion "it is right that this person should die." The supposed right to assisted death will belong not to the patient, to be exercised at the patient's demand, but to a third person (such as physician). It will be the third party, not the patient, who will ultimately decide whether the patient's life is worth living. What looks like patient autonomy is, in reality, a greatly expanded discretionary power over life and death to be given to physicians and judges.

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[8] *Airedale N.H.S. Trust v. Bland*, [1993] A.C. 789 at 863-864.

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

[10] Reasons at para 231 (AR, Vol.3).

[11] Reasons at para. 204 (AR, Vol.3).

[12] Reasons at paras. 1384-93 (AR, Vol 3).

14. Although physicians comply with the current law, what accounts for their compliance is not regulatory oversight, but a powerful, internalized ethic (an ethic supported by law) that killing is not treatment. If the law that supports the ethic is struck down, the ethic will collapse as well. The evidence from the Dutch experience establishes that an "oversight commission" relying on self-reporting does not prevent abuse.[13]

II. ERRORS IN ETHICAL ANALYSIS

15. The trial judge correctly noted that although law and ethics are distinct analytical domains,[14] principles of ethics influence the development of the law and, in particular, constitutional law.[15] However, the trial judge erred in converting ethical reasoning into a search for consensus or the "preponderance" of scholarly or medical opinion.

A. Overarching errors in reasoning

16. One of the overarching errors in the reasons for judgment is the trial judge's subordination of "rational inquiry" to a search for a "consensus" of "societal values" (about, for example whether there is a non-arbitrary distinction between legal treatment of suicide and assisted suicide).[16] A subordination of judicial reasoning to a search for a consensus (whether measured by opinion polls or "the preponderance of evidence" of ethicists who happened to give evidence)[17] is a manifestation of the majoritarianism that judicial review is meant to correct, and an abdication of the judicial role.

17. The trial judge acknowledged that she was bound by *Rodriguez*, but wrongly limited its application by claiming that *Rodriguez* settled only *legal* questions (of whether there is a distinction between lawful end-of-life treatment and assisted suicide) and not the identical ethical questions.[18] The clear implication is that, in the opinion of the trial judge, although *Rodriguez* may have the force of law, it is ethically unprincipled. But the fact that a subset of ethicists – those who provided evidence for the Respondents – dissent does not limit the holding in *Rodriguez* in the way that the trial judge suggested.

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[13] Reasons at paras. 481 – 86 and 655–66 (AR, Vol 3); Professor John Keown Affidavit #1 at paras. 16-18 (Joint Appeal Book ("**AB**"), Vol. 27) ("**Keown Affidavit**").
[14] Reasons at para. 173 (AR, Vol. 3).
[15] Reasons at para. 165 (AR, Vol. 3).
[16] Reasons at paras. 317 & 357-358 (AR, Vol. 3).
[17] Reasons at para. 335 & 1336 (AR, Vol. 3).
[18] Reasons at para. 334 (AR, Vol. 3).

18. Furthermore, the trial judge mischaracterized the record in finding a consensus on the proposition that "if it is ever ethical in an individual case for a physician to assist in death, it would be only in limited and exceptional circumstances."[19] This statement is highly misleading, suggesting that there is consensus on certain circumstances that could justify physician-assisted death. The consensus, however, is on a very different proposition: the circumstances under which all agree that physician-assisted death is wrong. There is no consensus that physician-assisted death can be justified under any circumstances.[20]

B. Specific errors

i. Confusing the inviolability principle with "vitalism"

19. The trial judge erred to the extent she confused the principle of the inviolability of life with "vitalism", or the conviction that "life must always be preserved at all costs."[21]

20. No formulation of the inviolability principle in law, and no competent formulation of it in ethics, has ever equated inviolability of life and "vitalism". Nor was any evidence presented to the contrary. The inviolability principle creates no obligation on an individual or a society to take every possible step to lengthen every life, irrespective of the patient's wishes, the physical burdens of the treatment on the patient, or the treatment's efficacy. The inviolability principle maintains that an individual has a right to refuse medical treatment[22] and accept palliative care that may, as a side-effect, hasten death.

ii. Finding refusal of care and assisted suicide indistinguishable

21. The trial judge accepted the legal distinction between refusal of care and assisted suicide.[23] Where the trial judge erred was in concluding that there is no *ethical* distinction between refusal of care and assisted suicide, and that the legal distinction in *Rodriguez* is therefore 'elusive' and unprincipled.[24]

22. A refusal of treatment need not be, and typically is not, an intentional taking of one's own life, even in circumstances where death is a foreseen result. Even the most extreme cases of refusing necessary blood transfusions on religious grounds are not misunderstood

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[19] Reasons at para. 342 (AR. Vol. 3).
[20] Reasons at para. 358 (AR, Vol. 3).
[21] Reasons at para. 355, the question was misframed as whether 'life must always be preserved at all costs' (AR, Vol. 3).
[22] *Rodriguez* at para. 41.
[23] Reasons at para. 334 (AR, Vol. 3).
[24] Reasons at paras. 334–38 (AR, Vol. 3).

as suicide. There are many reasons that a patient might have for refusing treatment, even refusing nutrition and hydration: the treatment is believed to be futile, or overly invasive, or painful, or burdensome, or otherwise unwelcome.[25] Or the patient could refuse a treatment, say a blood transfusion, because of religious conviction.

23. Such refusal of treatment would be consistent with both the legal principle and the ethical principle of inviolability even if the person foresaw that the result of the refusal of treatment would be death.[26]

24. The trial judge also erred in mischaracterizing the "factual distinction" raised by Sopinka J. in *Rodriguez*.[27] His conclusion was that there is a legal distinction between assisted suicide and refusal of care and palliative care, and that the distinction is sound.[28] Where he observed that "factually the distinction may, at times, be difficult to draw", he was not suggesting that there is anything conceptually unclear, unstable, or imprecise about the distinction. His comment was purely evidential (and uncontroversial): that it can sometimes be difficult to determine, as a question of fact, what a person's intentions were.

iii. Finding palliative care and euthanasia indistinguishable

25. The evidence at trial was that, despite common misconceptions, effective palliative care does not necessarily, or even typically, hasten death.[29] The trial judge erred in refusing to make a finding of fact on this point,[30] stating that it did not undermine her conclusion that there is no ethical distinction between palliative care and assisted suicide.[31]

26. The logic of *Rodriguez*,[32]supported by expert evidence at trial, is that a physician can lawfully and ethically administer opioids with the intention of relieving pain. The fact that terminal sedation, the use of opioids, and the withholding and withdrawal of treatment are capable of being used as means to kill, does not render the law unprincipled. Again, intention provides the bright line needed to characterize these acts.

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[25] Dr. Jose Pereira cross-examination, November 22, 2011, pp. 42:38 to 44:5, BCSC Supplemental Application Record, Vol. 34, Tab 140.

[26] Professor Keown cross-examination, November 21, 2011, pp. 80 and 81, BCSC Supplemental Application Record, Vol. 33, Tab 139 ("**Keown Cross**").

[27] Reasons at para. 329 (AR, Vol. 3).

[28] *Rodriguez*, at para. 58.

[29] Dr. Jose Pereira Expert Report at paras. 27, 38, 76-78 (AB, Vol. 29).

[30] Reasons at para. 332 (AR, Vol. 3).

[31] Reasons at paras. 333-35.(AR, Vol. 3).

[32] *Rodriguez* at para 57-58.

27. Although the trial judge accepted the distinction as a matter of law,[33] she denied it as a matter of ethics.[34] The trial judge provided no explanation, beyond bare citation, for why she rejected the distinction between "physician-assisted death and other end-of-life practices whose outcome is highly likely to be death."[35]

iv. Finding assisted suicide and suicide indistinguishable

28. The trial judge also erred in adopting the conclusions of Professor Sumner that there can be no ethical distinction between suicide and assisted suicide, such that if one is lawful, then so should be the other.[36] Suicide, though not illegal, is not condoned at law, much less can it be articulated to be a matter of legal right. The circumstances of the decriminalization of suicide have not been canvassed in this appeal. It is not safe to conclude that the considerations that bear on societal treatment of suicide are the same as those that bear on the provision of assistance in suicide.

III. WHAT RISKS MUST CANADIANS ACCEPT?

29. The autonomy-based arguments of the Respondents require that the treating physicians, and society at large, endorse the judgments of autonomous patients that their lives are no longer worth living and that the continuation of life is a harm to them. If these judgments about the worthlessness of a person's life are to be decisive, we must remember that when a physician agrees with a patient that his or her life has no value, that judgment is transitive; it must logically apply to all persons in the same state, regardless of whether they have requested death.

30. A physician who believes that a patient's life is valueless can be expected to approach treatment differently than one who believes that a patient's life (no matter how compromised) has value. Such a result is flatly inconsistent with one of the most fundamental principles of Canadian constitutional law: that all lives are equally valuable and equally deserving of concern, respect, and consideration.[37]

31. The Canadian constitutional order presents a further legal and conceptual difficulty with courts drawing the line anywhere outside the inviolability principle. As Sopinka J.

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[33] Reasons at paras. 324, 330 (AR, Vol. 3).
[34] Reasons at paras. 334-35 (AR, Vol. 3).
[35] Reasons at para. 335 (AR, Vol. 3).
[36] Reasons at para. 339 (AR, Vol. 3).
[37] *Andrews; Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703.

cautioned in *Rodriguez*, "we have no assurance that the exception can be made to limit the taking of life to those who are terminally ill and genuinely desire death."[38] Absent the inviolability principle, it seems unlikely that any criteria can be articulated – any lines drawn – that will withstand *Charter* scrutiny under s. 15(1). Once death has been accepted conceptually as a potential benefit, as the respondents urge, on what grounds could it be refused to those who seek it?

32. When considering the evidence that nothing short of an absolute prohibition will achieve Parliament's objective, one must bear in mind McLachlin C.J.'s observation in *Sharpe* (taken from Aristotle) that "complex human behaviour may not lend itself to precise scientific demonstration, and the courts cannot hold Parliament to a higher standard of proof than the subject matter admits of."[39]

33. Similarly, minimal impairment does not mean that Parliament must identify a single, most minimally impairing legislative option; on complex social issues, the requirement is met if Parliament chooses one of several reasonable alternatives.[40] In Canada, the bright line has been drawn at the inviolability principle: no acting with intent to kill. The Netherlands drew a line at voluntary euthanasia. That line has not held.[41]

IV. COURTS SHOULD NOT AUTHORIZE THE TAKING OF LIFE

34. Unless a judge is present at the time of the life-ending act, the judge will be in no position to determine whether at the time of death the patient was giving a free and informed consent. Furthermore, in light of the nature of death, no judge or appellate body will be in a position to sit in judgment on the question after the fact.

35. In addition, in many cases, there is much doubt about the voluntariness of decisions to seek physician assisted suicide. The decisions:

(a) will be made by an ill and medicated patient where competence and voluntariness will not be certain;[42]

(b) may be affected by pressures, subtle or otherwise, on disabled persons who feel that they are burdens to society and to family;[43]

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[38] *Rodriguez* at para. 75.

[39] *Sharpe* at para. 89.

[40] *Canada (AG) v JTI-Macdonald Corp.*, [2007] 2 S.C.R 610 at para. 43; *Polygamy Reference* at para. 1342.

[41] Reasons at paras. 481-86 & 655-66; Keown Cross at pp. 74-76; Keown Affidavit generally and at paras. 16-18; Baroness Finlay Affidavit #1 generally (AB, Vol. 28).

[42] Reasons at paras. 762-784 (AR, Vol. 3).

(c) will often be made without the patient's full knowledge of all alternatives and options or the benefit of experiencing the alternatives and options;[44]

(d) are often not persistent, as people change their mind, especially when the consequence of the decision is fatal.[45]

36. To act upon the decision of patients under these circumstances in service of the principle of autonomy would be, to borrow phrasing from McLachlin C.J., "a particularly impoverished understanding of their rights and civil liberties."[46]

37. From 1928 to 1971, the Government of Alberta authorized the consensual sterilization of "feeble-minded" individuals institutionalized in mental health facilities in Alberta. Subsequent studies concluded that the so-called "consents" to sterilization obtained by mental health professionals were not free and informed. One study of that era concludes with this observation:

> How many of the women consented because mental health professionals were able to convince them that they were in fact "incapable of intelligent parenthood" and would be doing society and the race a favour by consenting? In such instances, the line between voluntary and involuntary consent is blurred, as is the line between sterilization and eugenics. [47]

38. Finally, one must ask whether it is wise for the courts to tamper with a health system that is addressing end of life issues effectively:

> In most situations, life-ending decisions are worked out over time through a combination of patience, understanding, professional guidance and counselling. In this regard, the College of Physicians and Surgeons and individual hospitals deserve credit for the very sensitive protocols they have put in place to address life-ending decisions and the trauma that family and loved ones face when required to make them. [48]

39. One of the reasons for the bright line in favour of life is found in *Rasouli*, where the Court of Appeal of Ontario noted that Sunnybrook Health Sciences Centre "argued before the application judge that if the withdrawal of life support is included in the definition of treatment under the Act, individuals who have no chance of recovering would nevertheless

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[43] Reasons at paras. 799-815 (AR, Vol. 3).

[44] Reasons at paras. 816-831 (AR, Vol. 3).

[45] Reasons at paras. 832-843 (AR, Vol. 3).

[46] The Right Honourable Beverly McLachlin, P.C., "Medicine and the Law: the Challenges of Mental Illness", Remarks, (17 and 18 February 2005), online: Supreme Court of Canada <http://www.scc-csc.gc.ca/court-cour/ju/spe-dis/bm05-02-17-eng.asp>.

[47] Jana Grekul, "Sterilization in Alberta, 1928 to 1972: Gender Matters" (2008) 45:3 Can. Rev. of Sociology at 247.

[48] *Rasouli* v. *Sunnybrook Health Sciences Centre*, 2011 ONCA 482 at para. 63 [***Rasouli***].

have to be kept alive for extended periods of time if consent to end life was not forthcoming and this would impact severely on the limited resources of its intensive care unit."[49] Canadians should not be put in a position of thinking it is their civic duty to die to allow the "limited resources" of an "intensive care unit" to be allocated to another person.

V. CONCLUSION

40. Death is not a medical procedure to which one may consent and in which the courts may safely intervene. One may no more consent to a contract of death authorized by government, than consent to a contract of slavery authorized by government. Both authorizations offend every value found within s. 7 of the *Charter*. For this reason, the courts should resist the invitation to authorize a lethal injection administered or sanctioned by governments.

41. The principle governing requests that the courts take responsibility for and authorize death is best summarized by LaForest J. in *Re Eve*:

> Here, it is well to recall Lord Eldon's admonition ... that "it has always been the principle of this Court not to risk the incurring of damage to children which it cannot repair, but rather to prevent the damage being done." Though this comment was addressed to children who were the subject matter of the application, it aptly describes the attitude that should always be present in exercising a right on behalf of a person who is unable to do so.[50]

42. In exercising the power to make a life and death decision, a court would do well to "not risk ... damage ... it cannot repair." This is the oath every physician takes. The Supreme Court of Canada says that it applies equally to judges. In the words of Justice La Forest, "the choice is one the courts cannot safely exercise."[51]

ALL OF WHICH IS RESPECTFULLY SUBMITTED DECEMBER 20, 2012

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Counsel for the Christian Legal Fellowship

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[49] *Rasouli* at para. 31.
[50] *Re Eve*, [1986] 2 S.C.R. 388 at para. 79 [***Eve***].
[51] *Eve* at para. 99.

LIST OF AUTHORITIES

CASELAW	
No.	**Cases**
1.	*Airedale N.H.S. Trust v. Bland*, [1993] A.C. 789.
2.	*Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143.
3.	*Canada (AG) v. JTI-Macdonald Corp.*, [2007] 2 S.C.R. 610, 2007 SCC 30.
4.	*Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703.
5.	*R. v. Butler*, [1992] 1 S.C.R. 452.
6.	*R. v. Keegstra*, [1990] 3 S.C.R. 697.
7.	*R. v. Sharpe*, [2001] 1 S.C.R. 45, 2001 SCC 2.
8.	*Re Eve*, [1986] 2 S.C.R. 388.
9.	*Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONCA 482.
10.	*Reference re: Section 293 of the Criminal Code of Canada*, 2011 BCSC 1588.
11.	*Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, 1993 CarswellBC 228 (WL Can).
12.	*United States v. Burns*, [2001] 1 S.C.R. 283, 2001 SCC 7.

OTHER	
No.	**Other**
1.	David Masecar, *What is Working, What is Hopeful: Supporting Community-Based Suicide Prevention Strategies Within Indigenous Communities (and any other community that is interested)* (Ottawa: First Nations Inuit Health Branch, Health Canada, 2007).
2.	Health Canada, *Acting on What We Know: Preventing Youth Suicide in First Nations – The Report for the Advisory Group on Suicide Prevention* (Ottawa: Health Canada, 2003).
3.	Health Canada, *Linking Communities and Research: First Nations and Inuit Suicide Prevention – Report from a Gathering on Improving Collaboration* (Report from a Gathering on Improving Collaboration, Montreal, 21-23 March 2005)([Ottawa]: Health Canada, 2006).
4.	Jana Grekul, "Sterilization in Alberta, 1928 to 1972: Gender Matters" (2008) 45:3 Can. Rev. of Sociology.
5.	Laurence Kirmayer, *Suicide Among Aboriginal People in Canada* (Ottawa: Aboriginal Healing Foundation, 2007).
6.	The Right Honourable Beverly McLachlin, P.C., "Medicine and the Law: the Challenges of Mental Illness", Remarks, (17 and 18 February 2005), online: Supreme Court of Canada <http://www.scc-csc.gc.ca/court-cour/ju/spe-dis/bm05-02-17-eng.asp>.