



CHRISTIAN LEGAL FELLOWSHIP

— Alliance des chrétiens en droit —

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**SUBMISSION OF CHRISTIAN LEGAL FELLOWSHIP (“CLF”)
TO THE
SPECIAL JOINT COMMITTEE ON PHYSICIAN-ASSISTED DYING**

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I. WHAT IS PARLIAMENT’S ROLE?

The Supreme Court’s “declaration” in paragraph 127 of *Carter*¹, removed from its context, has been nearly the sole focus of this Committee’s deliberations. Observing the deliberations, one might think the Supreme Court of Canada had already amended the *Criminal Code* and that all it left for Parliament to do, if anything, was to define terms and procedures. The Committee has been preoccupied with questions such as: What does “grievous and irremediable” mean? How do we ensure a person who requests euthanasia or assistance in suicide is “competent” and “clearly consents”? Should Parliament answer such questions, or leave that up to the provinces or medical profession? And so on. We appreciate the inherent challenges the Committee currently faces in fulfilling its mandate, but respectfully submit that there are several problems with the narrow line of inquiry that has predominated thus far.

First, it treats the *Carter* decision as dictating the fundamental requirements of any future law on the matter of assisted suicide and euthanasia, whereas the Court clearly stated its intent to avoid usurping Parliament’s role in crafting a remedy.² Second, it treats the Court’s declaration as a free-standing statement of a newfound constitutional right—the supposed right of any and all competent, consenting adults with “grievous and irremediable” conditions to be killed by a physician or to have a physician assist them in committing suicide—which it is not. The SCC’s declaration was not made in the abstract; rather, it was wholly dependent on two key findings:

- (1) in the circumstances of Ms. Taylor (the plaintiff with ALS) and “persons in her position”, sections 14 and 241(b) of the *Criminal Code* infringed her right to life, liberty and security of the person; and
- (2) the object of sections 14 and 241(b) was to prevent vulnerable people from being pressured into committing suicide, but the means chosen (a complete prohibition) to accomplish this object was overbroad (and therefore not “in accordance with the principles of fundamental justice”) because it also prevented “non-vulnerable” people from obtaining assistance.

The question you face as you legislate in response to *Carter*, therefore, is not “will this law allow for any competent person with a grievous and irremediable condition to obtain ‘assisted dying?’”—as if any judge could demand this of Parliament. Rather, the relevant questions are:

1. Why should Canada have a law governing assisted suicide and euthanasia—what objective(s) should the law achieve?
2. What are appropriate means to accomplish the objective(s)?
3. How would the chosen means impact individuals’ *Charter* rights, particularly under section 7 of the *Charter*?³
4. If the law does interfere with the right to life, liberty, or security of the person, as most criminal law provisions do,⁴ would this law violate the principles of fundamental justice (PFJ)?⁵

¹ *Carter v Canada (Attorney General)*, 2015 SCC 5 [*Carter*].

² *Ibid*, at paras 125, 126, and 132.

³ In *Carter*, for example, the Court found that law interfered with the right to life, liberty, and security of the person because it robbed a person of bodily control in the context of end-of-life decision making. The foundation for this finding is explained further, below.

⁴ Criminal offences are often punishable by incarceration, which deprives one of liberty. Therefore any such law must comply with the principles of fundamental justice.

⁵ The PFJ involve a comparison between the means and the objective of the law. The means chosen to accomplish the objective of the law must not be arbitrary, overbroad, or grossly disproportionate.

5. If the law interferes with life, liberty, or security of the person and violates the principles of fundamental justice, would it nevertheless be justified under section 1 of the *Charter*?

The questions above appear in their logical order. We offer suggestions regarding what legislative objectives Parliamentarians ought to have in mind, how those might be achieved, and what the *Charter* implications are in Parts 4-7, below. However, because *Carter* has been widely misunderstood and its scope greatly exaggerated, we begin by explaining, in Parts 2-3, the reasoning underlying the outcome in *Carter* and the scope of the SCC's "declaration" in paragraph 127 of *Carter*.

II. AVOIDING "POLICY DISTORTION"

Political scientists use the term "policy distortion" to describe the phenomenon that occurs when lawmakers choose policies that may be less desirable or effective but which they believe will be more easily defensible against *Charter* challenges. Members of this Committee may risk foregoing the most important legislative objectives or the most effective means to achieve their objectives out of the mistaken belief that *Carter* precludes them. This is why it is so important to understand what *Carter* in fact decided and why.

Limited scope of the *Carter* ruling

Carter was a difficult case about a person suffering from ALS who sought the freedom to escape a slow death by suffocation that might eventually result from her progressive bodily deterioration and physical debilitation. The SCC applied the jurisprudential framework for section 7 of the *Charter* to these facts. It is often said that hard cases make bad law. The SCC Justices, of all people, would be acutely aware of this maxim. In such a case as this, where concerns were raised about normalizing suicide, devaluing life, putting the vulnerable at risk, overturning key principles of medical ethics, and so on, we might expect the SCC to carefully limit the scope of its ruling. The Court did, in fact, do just that.

Only by extracting one sentence of the Supreme Court's ruling and ignoring the rest can you take seriously the position that *Carter* requires Parliament to legalize assisted suicide or euthanasia for every competent, consenting adult who suffers from a subjectively grievous and irremediable condition, whether that condition be ALS, cancer, depression, bipolar disorder, or something else. Such a position makes the *Carter* judgment self-contradictory and nonsensical. Adopting this position would require you to ignore the Court's statement in paragraph 127 that its declaration is limited to the factual circumstances of the case and does not apply to other situations (situations dissimilar to Ms. Taylor's) where physician-assisted dying may be sought. It would require you to disregard the Court's statement that certain situations "would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions."⁶ In fact, in order for you to believe that *Carter* creates a right for every competent, consenting adult who suffers from a subjectively grievous and irremediable condition to receive "physician-assisted death", you must disregard basic rules for interpreting and applying jurisprudence, along with the actual construction of section 7 of the *Charter* itself⁷.

⁶ *Carter*, *supra* note 1, at para 111.

⁷ Section 7 of the Charter is often misunderstood, unique as it is among Charter provisions for containing its own "internal limits" on the rights contained therein. Section 7 does not establish rights to life, liberty, and security of the person, full stop. If that were true, every prison sentence since 1982 would have been in violation of the section 7 right to liberty, for example. Rather, section 7 affords the right to not be deprived of life, liberty, or security of the person except in accordance with the principles of fundamental justice (PFJ). This explains why section 7 falls under the heading "Legal Rights" in the Charter, not "Fundamental Freedoms" (section 2). Peter Hogg (in *Constitutional Law of Canada, 5th Edition*

The Court in *Carter* expressly limited the scope of its ruling in paragraph 127. Even if it had done so explicitly, however, the scope of the ruling would be limited anyway by the facts of the case and the specific legal reasoning that led the Court to conclude that Ms. Taylor’s rights were violated and that the violation was not justified.

“Grievous and irremediable” in context

The SCC reviewed and affirmed the trial judge’s reasons for concluding that the law deprived Ms. Taylor and persons in her position of the right to life, liberty and security of the person—reasons which depended on the facts. We get a sense of what “grievous and irremediable” means in *Carter* by examining the factual circumstances to which the Court refers. As the trial judge noted, at paragraph 1041:

The plaintiffs provide evidence that some individuals who wish to end their lives are unable to do so without assistance because of grievous and irremediable illness, and that some individuals, including Ms. Taylor, face the prospect of becoming unable, because of grievous and irremediable illness, to end their lives at the time of their choosing. The illnesses they point to include ALS, Huntington’s disease, locked-in syndrome and severe inoperable spinal stenosis.⁸

The right to life was infringed in *Carter* because the law might “force” persons with debilitating diseases to take their own lives while they are still physically capable of doing so, for fear of being incapable later. Their liberty and security were infringed because the law deprived them of control over their bodily integrity in the context of end-of-life health care decisions. In the Court’s view, the principle of patient autonomy on which Ms. Taylor relied in this context “is the same principle that is at work in the cases dealing with the right to refuse consent to medical treatment or to demand that treatment be withdrawn”. The Court also considered it contradictory that the law allows people in Ms. Taylor’s situation to request palliative sedation or to refuse life-sustaining treatment, while denying them assistance in committing suicide.

The trial judge had granted Ms. Taylor and her doctor an exemption from the law, after ruling that the law would become void in one year for violating Ms. Taylor’s Charter rights. Notably, the trial judge’s exemption for Ms. Taylor contained significant stipulations, among them that her attending physician must attest that she “is terminally ill and near death, and there is no hope of her recovering” before aiding her suicide.⁹ The SCC says nothing about the trial judge’s conditions for Ms. Taylor being unconstitutional and there is no reason to believe that they were, or that legislation with similarly strict conditions would be. Rather, the SCC was adamant that enacting conditions is Parliament’s job. The Court’s clear statement that its declaration responds to the facts of *Carter* and not to other situations gives lawmakers great latitude to restrict assisted suicide and euthanasia.

Supplemented (December 1, 2014) suggests section 7 is better understood as enacted in French, which does not repeat the word “right” (“droit”) as the English does. Or as Guy Regimbald and Dwight Newman explain it (in *The Law of the Canadian Constitution, 1st edition* (Markham: LexisNexis, 2013), at 618) life, liberty, and security of the person are “interests” protected by section 7, and section 7 is “engaged” when the state interferes with any of these—but section 7 is only violated where one of these interests is “engaged and where the state law or action violates a PFJ.

⁸ *Carter v Canada (Attorney General)*, 2012 BCSC 886 [*Carter* trial judgment]. The term “grievous and irremediable” also refers to other conditions that cause patients to experience severe physical suffering and loss of ability to care for their basic needs and to act independently. See also paras 73, 258, and 1041 of the trial judgment.

⁹ Note that it was the same trial judge, who declared the law invalid for violating the Charter, who also set out strict conditions governing Ms. Taylor’s access to assisted death. By the time the case reached the Supreme Court, Ms. Taylor had died of natural causes. Therefore, although the SCC, like the trial judge, declared the law invalid but delayed the invalidation of the law for one year, no exemption was granted in the interim period.

In short, the court’s analysis was within the context of a patient who was (a) suffering from a terminal illness and nearing end-of-life, and (b) whose illness would eventually render them physically incapable of committing suicide without assistance. Any discussion surrounding what is meant by “grievous and irremediable condition” must be understood within that context.

III. MENTAL ILLNESS

The plaintiffs in *Carter* did not suffer from mental illness. The Court did not analyse the impact of the law on persons with mental illness. Last week, Professor Downie told this Committee that *Carter* requires assisted suicide and euthanasia to be available to such people. She noted that there was evidence about persons with mental illness before the Court, and that the federal government even introduced additional evidence at the Supreme Court level about highly controversial cases of PAD occurring in Belgium.¹⁰ Professor Downie rightly noted that the new evidence did not change anything in the Court’s analysis—but the reason that evidence did not change anything is crucial. That evidence did not change the outcome of *Carter* because the Court was simply not addressing: (1) whether a ban on assisted suicide and euthanasia would infringe on the right to life, liberty, or security of the person of an individual suffering from mental illness, (2) if it did, whether that infringement would also violate the principles of fundamental justice, and (3) if it both infringed on the right to life, liberty, or security and violated the PFJ, whether the resulting violation of section 7 would be justified under section 1 of the *Charter*.

If Parliament enacted a new law prohibiting anyone from euthanizing or assisting in the suicide of a person with a mental illness or psychiatric disorder, in order for someone successfully challenge that law, he would have to succeed at each of the three stages of the *Charter* analysis above. This three-stage *Charter* analysis would of course be different in the case of a plaintiff with depression than it would be in the case of a plaintiff with ALS or other physically debilitating and terminal disease. Again, the question is not whether such a law would prevent a competent, consenting adult with a subjectively grievous and irremediable condition from being euthanized or committing suicide with a physician’s help. The SCC’s declaration is not some abstract, nebulous extrapolation of *Charter* rights. It is one part of the Court’s explanation for its ruling in this particular case.

Does a law preventing a clinically depressed person (for example) from obtaining “assisted dying” violate her right to life? If so, how? Certainly not by forcing a person to take her own life for fear of being physically incapable of doing so later, as in *Carter*. How about liberty and security of the person? These rights are not unlimited in scope. In *Carter*, the SCC found that in circumstances where a person can otherwise request palliative sedation or the removal of life-sustaining treatment, the right to liberty and security of the person included the right to make decisions about how one will die. The reasoning in this part of the decision would not apply to a plaintiff with mental illness. If, however, the law did somehow violate the clinically depressed person’s right to life, liberty, or security of the person, the next two questions would be whether such a law violates the principles of fundamental justice and, if so, whether this violation is justified under section 1 of the *Charter*. *Carter* offers no answer to any of these questions. It was not a case about mental illness.

IV. PARLIAMENT’S OBJECTIVES

Why prohibit or restrict the availability of assisted suicide or euthanasia? As we noted in Part 1, this is logically the first question that legislators need to ask and answer. Any law enacted by Parliament pursuant to its criminal law power must delineate the boundary between criminal and non-

¹⁰ Ordinarily, the evidentiary record is completed at the trial level, and the higher courts review the case based on that record, with a high degree of deference to the trial judge regarding findings of fact.

criminal participation in deliberately causing another person's death. Any law, however strict or flexible, may be subject to a *Charter* challenge. The possibility of a *Charter* challenge is no reason to shy away from taking a stricter approach. Whatever Parliament does, a scrutinizing court might one day compare the law's object and the means it uses to achieve its object. The SCC's interpretation of the objective of s. 241(b) of the *Criminal Code* in *Carter*—namely, protecting vulnerable people from being pressured to commit suicide in a moment of weakness—is binding only with respect to that provision as it is currently worded, not with respect to future amendments or enactments.

The SCC ruled in *Carter* that the objective of Canada's existing prohibition on aiding or abetting suicide (part of the Criminal Code since its inception in 1892) is not to protect life or even to prevent suicide, but merely to “protect vulnerable people from being induced to commit suicide in a moment of weakness.” On this objective rested the fate of the law. The Court itself established the principle of fundamental justice that a law cannot be “overbroad” two years after it upheld the assisted suicide prohibition in *Rodriguez* (1993). A law is overbroad if it denies the rights of some individuals in a way that bears no relation to the law's (Parliament's) objective. Since, in the Court's opinion in *Carter*, the existing law's objective was only to protect vulnerable people from being induced to commit suicide, but the law also prevented non-vulnerable people from obtaining assisted suicide, it followed that the law was overbroad and therefore invalid.

Chief Justice McLachlin once said: “Every generation faces unique moral issues. And historically, every generation has turned to the criminal law to address them.”¹¹ Criminal law is the exclusive domain and responsibility of Parliament. A criminal law enactment must have a criminal law purpose, which historically include public morality, safety, peace, order, security, or “some similar purpose.”¹² Given the importance of the law's objective to the outcome of judicial review of the law, whether that review is on the basis of the constitutional division of powers or the *Charter* or both, making the objective clear is crucially important.

V. PRINCIPLED OPPOSITION TO ASSISTED SUICIDE

In 2010, during Parliamentary debate on Bill C-384, Liberal MP Paul Szabo, who for five years sat on the ethics committee of the board of the Mississauga hospital, said he was “strongly opposed” to the Bill, explaining, “In my view, it is simply wrong to deliberately kill another human being. The miracle of life is inherently dignified and each day is a gift to be cherished.” Conservative MP David Sweet said he was “worried that Bill C-384 signals a devaluing of life” and concluded his speech by saying, “I would urge members to reject Bill C-384 and signal to all Canadians that we hold life as sacred and do not find the intentional taking of life acceptable whatsoever.” Other members made similar statements. Some opposed the bill for other reasons, and some spoke in favour. The bill was defeated soundly, 228 votes to 59.¹³

Some would have you believe that, in light of *Carter*, principled opposition to euthanasia and assisted suicide (whether such opposition is absolute in nature as articulated by Szabo and Sweet, or admitting of some exceptions) is now legally irrelevant. But that is simply not the case. In *Carter*, the SCC decided that, if Parliament was opposed to killing or assisting in the suicide of competent, non-vulnerable persons who clearly consent, its opposition was not to be found in section 14 or 241(b) of

¹¹ Reference re Assisted Human Reproduction Act, 2010 SCC 61, at para 1.

¹² *Ibid*, at para 43.

¹³ Some who have appeared before the Committee have said that *Carter* requires a legislative response that would be similar in several ways to Bill C-384. That bill would have created an exemption from criminal liability for physicians who provide “aid in dying” to persons who: are 18 years of age or older; suffer from terminal illness or continues to experience several physician or mental pain with no prospect of relief; provide two written requests expressly stating their consent, 10 days apart, while lucid.

the *Criminal Code*. The Court did not say that preventing suicide and the normalization of suicide, maintaining respect for life, affirming the equal worth of every life regardless of physical inequalities, and preserving a medical ethical culture against killing would be illegitimate objectives for Parliament to pursue—it simply found that it was not clear from the text of sections 14 and 241(b) that their purpose was any of the above. The “object” (or purpose) of these sections is not explicitly spelled out in the *Code*, so the SCC had to decipher their object from the text and the statutory context. The SCC ultimately found that Parliament’s purpose as embodied in these provisions was not to oppose euthanasia or assisted suicide in all situations, but simply to prevent vulnerable people from error or abuse that might occur if assisted suicide and euthanasia were legal.

The Attorney General of Canada (AGC) argued in *Carter*, ultimately unsuccessfully, that the object of these provisions is to affirm the equal value of every life. Deliberately bringing about the death of another person, the AGC explained, necessarily involves an affirmation of the subject’s conclusion’s that his or her life is worth living. The AGC also argued that prohibiting euthanasia and assisted suicide prevents the normalization of suicide and the denormalization of physical dependence. Our organization likewise argued that the law was tied to the principle of equality, that the deliberate taking of any life is always wrong, despite the many inequalities (in physical and mental ability, bodily health, etc.) that exist between us. Such an approach refuses to draw a dividing line between circumstances and personal wishes that merit suicide intervention and those that supposedly merit suicide assistance or euthanasia.

This is not just a personal or private issue. Maintaining respect for life, preventing suicide, preserving a medical culture against killing—these are valid concerns and valid legislative objectives. Euthanasia and assisted suicide are social acts, the practice of which shapes the ethos and culture of a society. Canadians rightly look to Members of Parliament to carefully deliberate about and decide what the law ought to say about the issue according to their informed best judgment and on the basis of fundamental moral considerations, not according to recent polling data or whatever the loudest voices say the “spirit” of the *Carter* decision requires if you wish to avoid future *Charter* challenges. Besides, the scope of *Carter* has been greatly exaggerated. If Members of this Committee, the House, or the Senate oppose euthanizing or assisting the suicide of persons who suffer from grievous and irremediable medical conditions, they should make their position known and state the reasons for it. Their reasoning may inform the objectives that Parliament pursues in enacting a new law, whether the new law be a complete ban or a set of restrictions.

VI. THE LEGAL BASIS FOR A COMPLETE BAN POST-CARTER

Nothing in *Carter* precludes Parliament from greatly restricting (or even banning) assisted suicide pursuant to other legislative objectives and Parliament ought to consider other important objectives in addition to objective of preventing the abuse of vulnerable persons.

Parliament has authority to decide what constitutes a criminal act on the basis of fundamental moral considerations. The moral and constitutional principle underlying a complete ban is the equality of persons and the inviolability of human life. A complete prohibition can be maintained by specifying in the law itself that upholding the inviolability¹⁴ of human life is the purpose of the new

¹⁴ The inviolability of life is the principle that the intentional taking of all human life is wrong without exception, no matter whose life it is, no matter what the circumstances. The inviolability principle does not create any obligation on an individual or a society to take every possible step to prolong life. It respects the right of a person where that treatment is futile or overly burdensome. It is a cornerstone of Western civilization, is evident in ancient Greek philosophy and Roman law, and was received into the common law long before it was constitutionalized as the right to life in s.7 of the Charter and held to inform the principles of fundamental justice.

law, not *merely* the protection of vulnerable people from the risk of error and abuse, as the SCC interpreted the purpose of the existing law. Parliament can choose to prohibit certain conduct both because of the wrongness of the conduct and in order to prevent accompanying harms.¹⁵ A prohibition enacted for that purpose would not be overbroad.

The protection of vulnerable people that results from a complete ban on assisted suicide may be considered a secondary objective of the law or simply a beneficial side effect. In this sense, a prohibition on assisted suicide functions in the same way as the prohibitions in *R v Sharpe*¹⁶ and *R v Butler*¹⁷. Similarly, an assisted suicide prohibition protects vulnerable groups directly through prohibition and indirectly by maintaining a cultural attitude that every life is equally valuable.¹⁸ Prohibition also supports the medical ethical culture against killing. The risk of permitting assisted suicide or voluntary euthanasia at all is that the culture against killing will erode. Again, the concern is not simply that a new law permitting assisted suicide in certain circumstances will be abused or disobeyed, it is that medical culture will shift towards favouring assisted suicide where it is a legally permissible option.

Finally, prohibition remains the best means available for protecting the vulnerable. The SCC recognized that there are risks inherent in legalizing assisted dying, risks that cannot be eliminated entirely, but only “very substantially minimized”.¹⁹ The broader social and societal concerns involved in legalizing assisted suicide do not factor into the SCC’s judgment, but must be considered by Parliament.

VII. RESTRICTING ASSISTED DYING TO CIRCUMSTANCES IN CARTER

Short of a complete ban, which remains the best legislative option, Parliament should enact a strictly limited exception to the general prohibition on assisted suicide, along with a comprehensive regime detailing safeguards, reporting, and oversight mechanisms. Parliament’s criminal law power gives it authority to establish an administrative and enforcement regime necessary to give effect to the general prohibition and the accompanying limited exception. Judicial approval must be given in every case, only where the legal conditions and procedures are met, and consent must in every case be reliably obtained and recorded.

¹⁵ Consider the law of assault as an example. Physical contact with another person is generally not assault where there is consent, but nobody is entitled to consent to the infliction of serious bodily harm. Justice Gonthier, for the majority of Supreme Court in *R v Jobidon*, [1991] SCJ No 65 (QL), explained that this rule acts as a deterrent against consensual fighting and discourages fighting in general, thus also protecting those who do not consent to a fight from physical aggression (para 114). Gonthier J. also said: “Wholly apart from deterrence, it is most unseemly from a moral point of view that the law would countenance [...] the sort of interaction displayed by the facts of this appeal. The sanctity of the human body should militate against the validity of consent to bodily harm inflicted in a fight” (para 115). The law can and does limit autonomy for moral reasons, while simultaneously promoting various policy objectives. By deterring aggression in general, the law of assault has the beneficial effect of protecting the autonomy and bodily integrity of those who would not consent to a fight. Yet the “moral point of view” is the primary basis for vitiating consent to assault causing serious bodily harm. The law of assault is about more than protecting personal autonomy. By contrast, in *Carter*, although section 241(b) says nothing about consent, the SCC decided that the existing prohibition is about protecting vulnerable persons from abuse and nothing more.

¹⁶ 2001 SCC 2.

¹⁷ [1992] 1 SCR 452. The SCC found in *Sharpe* that the prohibition against possessing child pornography protected children because “in a larger attitudinal sense [the law] asserts the value of children against the erosion of societal attitudes towards them.” In *Butler*, the prohibition on obscene materials was characterized as countering harm to women not only through direct prohibition, but also indirectly through countering harmful cultural attitudes towards women.

¹⁸ 2013 BCCA 435 (Factum of the Intervenor CLF, at paras 4-6). See also *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 SCR 519, 1993 CanLII 75 (SCC), at 595. Justice Sopinka in *Rodriguez* recognized that s. 241(b) of the *Criminal Code*, like s. 14, is grounded in the state’s interest in protecting life and not allowing human life to be depreciated.

¹⁹ *Carter*, *supra* note 1, at para 27.

a) Assisted suicide remains a criminal law matter

The *Carter* ruling does not turn assisted suicide into an ordinary health service to be regulated by the provinces. It has never been part of Canadian health care. Sections 14 and 241(b) of the *Criminal Code* were within Parliament’s criminal law power²⁰ to enact and do not interfere with the “core” of any provincial head of power.²¹ It remains a “matter” falling within Parliament’s criminal law jurisdiction. The criminal law power authorizes federal laws that punish or regulate conduct that is dangerous to health or that raises issues of public morality.²²

Parliament must not leave this matter up to the provinces. The provinces may lack jurisdiction to enact strict limits, given that assisted suicide is historically a criminal law matter.²³ Since the provinces cannot fill “gaps” in criminal law,²⁴ Parliament cannot merely put in place a simple exception to the general prohibition on assisted suicide. The SCC deliberately did not dictate the conditions and safeguards necessary to ensure legalizing assisted suicide will not result in vulnerable persons being pressured to end their lives. Parliament must do so. Provinces cannot.

Parliament’s criminal law power allows Parliament to enact a limited exception to a general criminal law prohibition, along with a comprehensive regulatory regime to give effect to such an exception. General prohibitions with limited and conditional exceptions or defences are a common feature of criminal law.²⁵ The fact that Parliament introduced an exception allowing abortion for health reasons in 1969, for example—an exception which required a certificate of approval from a panel of three doctors in provincially approved hospitals—did not mean that Parliament gave up or narrowed its jurisdiction to regulate abortion, as the SCC has affirmed repeatedly, even after the 1969 law was found to violate the *Charter*.²⁶

Parliament also has authority to create administrative and enforcement schemes under its criminal law power to give effect to an exception to a general prohibition. The creation of such a scheme may impact matters falling under provincial jurisdiction, but provided that Parliament enacts an integrated legislative scheme for a criminal law purpose, incidental impacts on matters of provincial jurisdiction are permissible.²⁷ Just because a federal law has the incidental effect of regulating provincial health institutions does not mean that it is constitutionally invalid.²⁸ Provincially regulated health professionals and health care institutions are subject to criminal law.²⁹ There is no “core” provincial jurisdiction over health such as to prevent the application of a comprehensive federal regulatory regime to medical professionals or health institutions.³⁰ Should there be a conflict between legitimately enacted federal and provincial laws, which occurs where compliance with one

²⁰ *Constitution Act, 1867*, section 91(27).

²¹ *Carter*, *supra* note 1, at paras 49-53.

²² Examples include federal laws regulating narcotics, tobacco, and other harmful products, and in the past, federal regulation of abortion. Key statutes are the *Food and Drugs Act*, the *Controlled Drugs and Substances Act* and the *Criminal Code*.

²³ *R v Morgentaler*, [1993] 3 SCR 463.

²⁴ *Ibid*, at 498.

²⁵ *RJR-Macdonald v Canada (Attorney General)*, [1995] 3 SCR 199, at para 53.

²⁶ The jurisdictional validity of the criminal law scheme permitting abortion only where approved by a therapeutic abortion committee for health reasons was upheld in *Morgentaler v The Queen* (1975), [1976] 3 SCR 616, at 627. Parliament’s jurisdiction over the matter of abortion was reaffirmed by the SCC in *R v Morgentaler*, [1993] 3 SCR 463; it was mentioned more recently by the SCC again in *Canada v PHS Community Services Society*, 2011 SCC 44, at para 68 [*PHS*].

²⁷ See *Morgentaler v The Queen* (1975), *ibid*, at 628; *Firearms Reference*, 2000 SCC 31; *PHS*, *ibid*, at paras 50-52.

²⁸ *PHS*, at para 51.

²⁹ *Ibid*, at para 72.

³⁰ *Ibid*, at para 69; *Carter*, *supra* note 1, at para 53.

law makes compliance with the other impossible or where the provincial law frustrates the purpose of the federal law, federal law is paramount.

b) Legalization requires strict limits, scrupulously monitored and enforced

As recognized by all levels of court in *Carter*, assisted suicide (and voluntary euthanasia) is a complex issue. Legalization involves significant risks to society and to individuals, especially persons with disabilities, severe illness, or mental health problems. As the trial judge noted: “This review of the evidence permits no conclusion other than that there are risks inherent in permitting physician-assisted death, and that the utmost care would be needed in designing and managing a system which would allow it, in order to avoid those risks.”³¹ The SCC acknowledged in *Carter* that Parliament faces a difficult task in addressing physician-assisted suicide because it “involves complex issues of social policy and a number of competing social values” and Parliament must therefore “weigh the risks of a permissive regime with the rights of those who seek assistance in dying.”³²

The SCC stated that “Parliament must be given the opportunity to craft an appropriate remedy”. The SCC refused to implement a remedy itself because “Complex regulatory regimes are better created by Parliament than by the courts.”³³ A complex regime is *necessary* in order to substantially minimize the risk of abuse and error if assisted suicide or voluntary euthanasia is permitted at all. Such a regime must be fully in place before assisted suicide or voluntary euthanasia is permitted at all. Short of complete prohibition, Parliament must enact all necessary measures to ensure that consent is always properly obtained and recorded and that assisted suicide only takes place in strictly limited circumstances.

Short of a complete prohibition, Parliament should make an exception only where the patient:

- is a competent, fully informed adult;³⁴
- requests “assisted dying” voluntarily, without coercion, duress or ambivalence;
- is terminally ill and in an advanced state of irreversible decline; and
- is experiencing enduring and intolerable pain caused by a grievous and irremediable medical condition (not including depression or psychiatric illness);

In order to ensure that the conditions listed above are complied with, the law must only permit the provision of “aid in dying” where:

- there is in place an audio-visual record of the informed consent that includes the diagnosis and prognosis of the patient, together with a detailed description of the palliative care alternatives available to the patient to reduce pain;
- there is in place a written medical opinion signed by two physicians (one of whom must be the personal primary care provider for the patient) declaring that physician assistance in a patient's suicide is clearly consistent with the patient's wishes and best interests and provided in order to relieve suffering;

³¹ *Carter* trial judgement, *supra* note 8, at para 854.

³² *Supra* note 1, at para 98.

³³ *Ibid*, at para 125.

³⁴ In order for consent to be informed, the patient must first have had access to fully adequate palliative care. Many patients who ask for euthanasia change their minds when given good palliative care: see M.C. Jansen-Van Der Weide, B.D. Onwuteaka-Philipsen, and G. Van Der Wal, “Requests for euthanasia and physician-assisted suicide and the availability and application of palliative options”, *Palliative and Supportive Care* (2006), 4, 399–406; see also Dr. Harvey Max Chochinov, “Dignity Therapy: Final Words for Final Days”, Oxford University Press, 2012, at pp 44, highlighting the positive impact of a form of palliative care on terminally ill patients’ will to live. Currently, approximately only 16-30% of Canadians who need palliative care have access to it, which is appalling—see the Parliamentary Committee on Palliative Care and Compassionate Care report, “Not to be Forgotten: Care of Vulnerable Canadians” at p. 22 (November 2011, online: <<http://pcpcc-cpspsc.com/wp-content/uploads/2011/11/ReportEN.pdf>>

- a judge reviews the informed consent process and issues a warrant declaring that the strict limits and scrupulous monitoring required by Parliament have been followed;
- the application to the judge is made exclusively by the patient (no power of attorney and no advance directive permitted)³⁵;
- the judicial review has allowed the judge opportunity to inquire regarding cognitive impairment, depression or other mental illness, coercion, undue influence, psychological or emotional manipulation, systemic prejudice, ambivalence and misdiagnosis of the patient;
- the judicial review has confirmed that the patient is not a minor, is not suffering from a psychiatric disorder and is not simply experiencing a minor medical condition; and
- no physician or health care facility has been required to refer a patient, or otherwise participate in providing assistance, for physician-assisted suicide against the conscience of the physician or of the facility.

Participation in assisted suicide by physicians must be entirely voluntary. And for those who choose to participate, there must be adequate oversight of their activities. This is primarily a legal issue, and so physicians who choose to participate should be subject to judicial oversight. A judge will be best able to referee the boundary between homicide or illegal assisted suicide and permissible assisted suicide.

Although it appears to be a proposal for a temporary remedy, Justice McLachlin (as she then was) once proposed, in her dissenting opinion in *Rodriguez v British Columbia (AG)*:

[The relevant *Criminal Code*] provisions may be supplemented, by way of a remedy on this appeal, by a further stipulation requiring court orders to permit the assistance of suicide in a particular case. The judge must be satisfied that the consent is freely given with a full appreciation of all the circumstances. This will ensure that only those who truly desire to bring their lives to an end obtain assistance.³⁶

The presence or absence of consent may determine whether an action is a crime. When it comes to homicide and assisted suicide, however, the law makes consent irrelevant. The rule that nobody is entitled to consent to his or her own death is stated in section 14 of the *Criminal Code*, which was partially invalidated by the SCC in *Carter*. The rule upholds the inviolability of life. It also has important evidentiary implications. Any victim of homicide, euthanasia (technically a form of homicide), or assisted suicide is, of course, dead, and thus not available to testify as to whether or not he or she consented to have death inflicted on him or her. Thankfully for the prosecutor, consent has always been irrelevant, at least until the *Carter* ruling. If Parliament is willing to permit assisted suicide in any circumstances, strict procedures for reliably obtaining and recording a patient's consent must be mandated and enforced.

All of which is respectfully submitted.

CHRISTIAN LEGAL FELLOWSHIP / Alliance des chrétiens en droit

³⁵ The prohibition on assisted suicide applies unless the person “clearly consents to the termination of life”—*Carter, supra* note 1, at para 27. Stated as it is in the present tense, this statement requires contemporaneous consent from the person seeking assisted suicide, therefore ruling out advance directives and power of attorney. This was the finding of the British Columbia Court of Appeal in *Bentley v. Maplewood Care Society*, 2015 BCCA 91, where the court concluded that a patient's decision to accept or refuse food and water at her care facility could only be made in the “here and now”, not through an advance directive:

It should come as no surprise that a court of law will be assiduous in seeking to ascertain and give effect to the wishes of the patient in the ‘here and now’, even in the face of prior directives, whether clear or not. This is consistent with the principle of patient autonomy that is also reflected in the statutes referred to earlier (see especially s. 19.8 of the HCCCFA Act), and in many judicial decisions, including *Carter v. Canada (Attorney General)* 2015 SCC 5 (CanLII), where the Court emphasized that when assisted suicide is legalized, it must be conditional on the “clear consent” of the patient. (para. 127, emphasis added).

³⁶ *Rodriguez, supra* note 18, at 627.

Appendix: About Christian Legal Fellowship

Christian Legal Fellowship (CLF) is a national charitable association representing over 600 lawyers, law students, professors, and others who support its work. CLF exists to serve the legal profession by deepening and strengthening the spiritual lives of its members. Its objectives include encouraging and facilitating among Christians in the vocation of law the integration of a Biblical faith with contemporary legal, moral, and social issues.

As Canada's largest association of Christian lawyers, CLF has members across Canada practising in all areas of law and in every size of practice. It has chapters in cities across Canada and student chapters in most Canadian law schools. While having no direct denominational affiliation, CLF's members represent more than 30 Christian denominations working in association together.

CLF is dedicated to advancing the public good by articulating legal and moral principles that are consistent with, and illuminated by, our Christian faith through court interventions and public consultations. Over nearly two decades, CLF has intervened in 19 separate proceedings involving *Charter* issues, including several before the Supreme Court of Canada, seeking to advance justice, protect the vulnerable, promote equality, and advocate for freedom of religion, conscience, and expression.

The CLF has appeared before Parliamentary committees and made representations to provincial governments on issues of conscience, religious freedom, inviolability of life, and human rights. CLF has also been granted Special Consultative Status as an NGO with the Economic and Social Council of the United Nations, and has been involved in numerous international matters.

CLF has developed considerable expertise in legal issues surrounding assisted suicide and euthanasia. In 2012, CLF was recognized by the Quebec Superior Court as "possess[ing] an important degree of expertise in the areas of philosophy, morality, and ethics which areas could be useful for the defense considering the Plaintiff's request that article 241 (b) of the *Criminal Code* be declared unconstitutional." (*Leblanc v. Attorney General of Canada et al* at p. 45).

CLF was one of the few organizations to intervene in all levels of court in *Carter*, including the post-judgment motion for a further extension of time at the Supreme Court. CLF also intervened in both levels of court in *D'Amico c. Québec (Procureure générale)* concerning the constitutionality of Quebec's assisted suicide legislation (a case which remains ongoing). CLF participated, by invitation, in the consultations of the federal External Panel on Options for a Legislative Response to *Carter v Canada* and the Provincial/ Territorial Expert Advisory Group on Physician-Assisted Dying. CLF also participated in the consultations of the medical Colleges of Saskatchewan, Manitoba, Ontario, and New Brunswick on this issue. Most recently, CLF filed a detailed legal submission to the Ontario government in response to its consultation on the issue of assisted suicide and euthanasia.