S.C.C. FILE NO. 35591

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

BETWEEN:

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

APPELLANTS
(Respondents/Cross-Appellants)

- and -

ATTORNEY GENERAL OF CANADA

RESPONDENT
(Appellant/Cross-Respondent)

- and -

ATTORNEY GENERAL OF BRITISH COLUMBIA

RESPONDENT
(Appellant)

[style of cause continued on inside cover]

APPELLANTS' REPLY FACTUM RE INTERVENER FACTUMS
(LEE CARTER et al., APPELLANTS)
(Pursuant to Order of Justice LeBel dated July 4, 2014)

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APPELLANTS' REPLY FACTUM RE INTERVENER FACTUMS

A. Improper Attempts to Supplement the Record[1]

1. LeBel J. ordered "**[t]he interveners are not entitled to raise new issues or to adduce further evidence *or otherwise to supplement the record* of the parties**" [bold emphasis in original]. Notwithstanding that direction, interveners have done just that. Those portions of the intervener factums, and the related references and materials, should be struck or disregarded (Appendix A).

2. Some interveners reference and include as "authorities" research articles intended to counter or augment materials entered by the parties as expert evidence by attachment to an expert affidavit explaining the study or opinion and its import. The parties could and did elect to cross-examine many of the experts. It is untenable for the interveners to dump in further evidence as "authorities" in an attempt to undermine the factual findings. Some improperly include as authority an article in which an AGC expert witness, John Keown, critiques Smith J.'s findings and reasoning.[2] This amounts to giving Prof. Keown a post-trial right to defend his own earlier testimony. AGC itself quite properly did *not* attempt to place Prof. Keown's "sour grapes" article ("Keown Article") before this Court, either as evidence or authority. It should be struck.

3. Some interveners incorporate AGC's version of the "facts."[3] EPC,[4] like AGC itself, sets out its *argument* as to what *should* be found on the evidence. Others assert "facts" without evidentiary support,[5] and challenge findings the parties accept.[6] Interveners traditionally have no role in determining factual findings, nor should they here. These assertions (whether by incorporation or made individually) should be struck or disregarded. We can only briefly

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[1] This reply factum is filed pursuant to the July 4, 2014 Order of Mr. Justice LeBel.

[2] Council of Canadians with Disabilities and Canadian Association for Community Living ("CCD/CACL") and Christian Legal Fellowship ("CLF") both cite John Keown, "*A Right to Voluntary Euthanasia? Confusion in Canada in Carter*", 28:1 (2014) Notre Dame J.L. Ethics and Public Policy. His critique relates to subject matters addressed by him in evidence. Such as empirical studies of the Netherlands and Oregon, whether PAD in those jurisdictions was expanding, and regarding the ethics of assisted dying, including the role of intent. Smith J. was not persuaded by his evidence.

[3] Association for Reformed Political Action Canada ("ARPA"), ¶1; Catholic Civil Rights League, Faith and Freedom Alliance and Protection of Conscience Project ("CCRL/FFA/PCP"), ¶4; Catholic Health Alliance of Canada ("CHA"), ¶1; Christian Medical and Dental Society of Canada and Canadian Federation of Catholic Physicians' Societies ("CMDS/CFCPS"), ¶2; Council of Canadians with Disabilities and Canadian Association for Community Living ("CCD/CACL"), ¶5

[4] Euthanasia Prevention Coalition and Euthanasia Prevention Coalition – BC ("EPC")

[5] See e.g. ARPA, ¶¶30 and *fn* 27; Canadian Medical Association ("CMA"), ¶¶24-25

[6] See e.g. CLF, ¶¶21, 25, 29

illustrate the problematic nature of these assertions. Some interveners make assertions with ostensible citations, but the cited evidentiary material does not support the stated propositions.[7]

B. Points in Reply

4. ***Compliance with Safeguards in Other Jurisdictions (Reporting and LAWER)*:** Contrary to Smith J.'s findings and the evidence, some interveners allege a lack of compliance with safeguards in other jurisdictions.[8] For example, issue is taken with Smith J's treatment of foreign jurisdiction evidence.[9] Smith J. properly considered the evidence before her *as a whole*: e.g., regarding Oregon, she held that "*[o]n their own*, the data collected by OHD do not support very strong conclusions about compliance with some of the safeguards in Oregon,"[10] but then noted there was a body of evidence *supplementing* this publically collected data,[11] including evidence given by "impressive, respected researchers,"[12] and she accepted it.[13] Evidence cited by some interveners regarding Belgium and the Netherlands relates to reporting *and LAWER*;[14] it is improper to conflate LAWER with PAD.[15] EPC's evidentiary assertions at ¶¶34-35 and AGC's selective citation from evidence at ¶51 are taken out of context and should be disregarded.

5. ***Use of Palliative Care*:** CLF says it is problematic to choose PAD without *experiencing* the options, and CHA claims palliative care is a panacea.[16] Smith J. acknowledged AGC's evidence on these points.[17] She noted the evidence that palliative interventions bear their own risks and discomfort and can take time to work,[18] and appellants' position that requiring a patient to undertake medical treatment the patient would otherwise decline in order to qualify for PAD would be inconsistent with the rights to liberty and security of the person as well as the common law.[19] She agreed that the right to make decisions of fundamental personal importance was a

[7] See e.g. EPC ¶33, *fn* 19, ¶36, *fn* 22, ¶39, *fn* 25, ¶40, *fn* 27; CCRL/FFA/PCP, ¶21, *fn* 18; CCD/CACL, *fn* 51
[8] See e.g. CCD/CACL, ¶¶14, 32-35; EPC, ¶¶5, 8, 29-40, ARPA, ¶29; CLF, ¶18; and AGC Factum, ¶¶47-52, 96
[9] See, e.g., EPC, ¶¶29-30 and AGC ¶96
[10] TJ Reasons, ¶649 [emphasis added], JR v I, A.R. 189
[11] TJ Reasons, ¶650 [emphasis added], JR v I, A.R. 189
[12] TJ Reasons, ¶651, JR v I, A.R. 189
[13] TJ Reasons, ¶652, JR v I, A.R. 190
[14] See, e.g., EPC ¶¶34-36 and AGC ¶51
[15] Appellants' Factum in Chief, *fn* 282
[16] CLF, ¶36(c); CHA, ¶¶7-12
[17] See e.g. TJ Reasons, ¶385, JR v I, A.R. 116
[18] TJ Reasons, ¶826, JR v II, A.R. 32
[19] TJ Reasons, ¶878, JR v II, A.R. 50-51

constitutional one and extended to choice of medical treatment.[20] Smith J. concluded patients must be *informed* of palliative options, as with informed consent in other life-ending decisions.

6. Smith J. held there are valid reasons palliative care options, including terminal sedation, may be unacceptable to some patients.[21] With regard to terminal sedation in particular, there was evidence[22] that: some consider it inconsistent with their values and conception of a good death; there are reasonable concerns regarding its ability to effectively address the experience of suffering; and evidence that it is generally only available in the days or maybe a week before death (and yet sometimes available long before death, which is just PAD by another name.[23])

7. ***The Nature of Desire for PAD (Not Ambivalent)*:** Some interveners say the desire for death is ambivalent and transitory.[24] This is not what Smith J. found.[25] The evidence demonstrated the vast majority of people actually seeking PAD do so with "single-minded determination"[26] and do so over months or years.[27] Assuming the intended point is that the desire for death *amongst those who seek PAD* in permissive jurisdictions is ambivalent and transitory (the only relevant point), no evidence cited supports that. CCD/CACL[28] refers to the Chochinov and Rodin Reports - studies in which terminally ill patients, in jurisdictions where PAD is *against* the law, were *surveyed* as to their interest in hastened death. This evidence does not permit any conclusions about the characteristics of persons actively *seeking* PAD in a *legalized* context or the nature of their requests (the "epidemiological distinction"). Smith J. preferred appellants' evidence on this point.[29] Dr. Chochinov *himself* (AGC's witness) agreed the epidemiological distinction was a valid one.[30] CCD/CACL[31] refers to the evidence of Prof. Heisel about "traditional" suicide (i.e., involving people who are, in very high proportion,

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[20] TJ Reasons, ¶¶1295-1303, JR v II, A.R. 165-67. See also, *R. v. Parker* (2000), 49 O.R. (3d) 481 (Ont. C.A.), ¶¶86-87, 92, 102-04, Appellants' Supplemental Book of Authorities ("ASBoA") Tab 6
[21] TJ Reasons, ¶1328, JR v II, A.R. 171
[22] Appellants' Factum in Chief, *fn* 106
[23] Affidavit #1 of Rodney Syme, made 19 Aug 2011, ¶17, JR v X, 356-57; Affidavit #1 of Anne Bruce, made 25 Aug 2011, ¶12, Ex C, p. 53, JR v XIII, 1432, 1486; Affidavit #1 of Marcel Boisvert, made 26 Aug 2011, ¶13, JR v XII, 1240; Affidavit #1 of G. Michael Downing, made 3 Oct 2011, ¶54, JR v XXVI, 6123
[24] See CHA, ¶9; CCD/CACL, ¶¶11, 27, 29; CLF, ¶36(d); EPC, ¶33 and AGC Factum, ¶¶31-33
[25] TJ Reasons, ¶¶832-43, JR v II, A.R. 34-36
[26] Ganzini, TJ Reasons, ¶438, JR v I, A.R. 134
[27] Starks, TJ Reasons, ¶442, JR v I, A.R. 135
[28] CCD/CACL, ¶11
[29] TJ Reasons, ¶¶827-29, JR v II, A.R. 32-33 and see ¶¶651-52, JR v I, A.R. 189-90
[30] TJ Reasons, ¶827, JR v II, A.R. 32; Cross-examination of Harvey Chochinov Cross held 25 Nov 2011, 708:11-40, JR v VIII, 708
[31] CCD/CACL, ¶11

mentally ill, irrational and impulsive). The evidence is irrelevant given the findings that different decision-making processes are involved in "traditional" suicide and PAD requests.[32] The traditionally suicidal are not an appropriate analogue.[33] AGC has not challenged this finding.

8. ***Ability to Assess Authenticity of Request to Die***:[34] CMA and others, without reference to any evidence or facts, assert Smith J. "understated" concerns regarding outside pressures on patients, the "difficulties" in assessing the role of depression, and the challenges posed when a patient-physician relationship is not long term.[35] This, at best equivocal, assertion cannot undermine Smith J.'s factual findings based on expert evidence. Significantly, CMA's comments relate to end-of-life decisions in general – the same concerns arise with, e.g., withdrawal of life-saving treatment - yet the medical profession assesses capacity for consent in those situations. CMA asserts assessments for PAD "warrant comprehensive study by and with physicians."[36] Such study has occurred in other jurisdictions, including Oregon, and these studies were considered by Smith J. Further studies will no doubt take place, but CMA's position under "remedy" *clearly* indicates that, challenges notwithstanding, Canadian physicians currently can and do assess consent for medical decisions that hasten death, and could do so immediately (subject to court approval during the period of suspension) for purposes of PAD.[37]

9. ***Pressure*****:** Contrary to Smith J.'s findings,[38] some interveners raise the spectre of *subtle* pressures that are difficult to discern and undermine the reliability of consent assessments.[39] Drs. Donnelly and Ganzini - practising geriatric psychiatrists who regularly conduct informed consent assessments for medical decision-making - both testified that *undue* influence can be detected in a high scrutiny capacity assessment. This was accepted by Smith J.[40] Both Drs. Donnelly and Ganzini testified that influence too subtle to be detected should <u>not</u> disqualify

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[32] TJ Reasons, ¶¶813-14 and 832-33, JR v II, A.R. 29-30, 34
[33] See e.g. ARPA, ¶¶14, 16, 33 *fn* 22; CLF, ¶14, 29; CCD/CCLA, ¶¶19-21, 38 and AGC Factum, ¶¶132-33
[34] See e.g. CMA, ¶¶24-25; CLF, ¶¶36 CCD/CACL, ¶36; EPC, ¶¶37, 39
[35] CMA, ¶25; see also CCD/CACL, ¶35; EPC, ¶39
[36] CMA, ¶25
[37] CMA, ¶29
[38] TJ Reasons, ¶¶671, 806, 815, JR v I, A.R. 194 and v II, A.R. 28, 30
[39] CLF, ¶36(b); CMA, ¶25; see also AGC Factum, ¶¶15, 38 and see ¶¶135-36. Smith J.'s findings are consistent with the observations of some of the law lords in *R (Nicklinson) v Ministry of Justice*, [2014] UKSC 38 [*Nicklinson*], RA v II, Tab 34, discussed more below. E.g. Lord Wilson rejected the suggestion that courts could not distinguish between "expression of an intention which genuinely reflects the speaker's wish [to die] and one which does not do so." A former judge of the Family Division, he set out factors a court would want to consider in determining whether a person's request for assistance was voluntary: *Nicklinson*, ¶205. See also *Nicklinson*, ¶¶301-16, 349-62.
[40] TJ Reasons, ¶803, 815, JR v II, A.R. 27, 30

a patient from PAD.[41] Per Dr. Ganzini, medicine is an evidence-based endeavor and "at some point a concern has to be verifiable, otherwise it is simply not evidence-based."[42] The adoption of another standard would be a dramatic shift towards paternalism in modern medicine; society currently accepts the ability to detect influence *at a level material to voluntariness* in the context of all other medical decision-making.[43]

10. ***Depression*:** Some interveners assert determining the role of depression in decision-making is "difficult" – implying, contrary to Smith J.'s finding,[44] there can be no adequate, reliable screening for depression.[45] The *ODDA*[46] does not *exclude* persons suffering from a depression disorder. It directs assessing doctors to consider whether the person is capable and whether the person is suffering from "depression *causing impaired judgment*."[47] Thus, the fact that one of Dr. Ganzini's studies indicated that three people with Major Depressive Disorder ("MDD") obtained prescriptions does <u>not</u> mean the *ODDA* was not followed.[48] It is consistent with the medical profession to address concerns about better screening for mental health referrals with "best practices," not an absolute prohibition, and this was how Oregon responded to Dr. Ganzini's study about the three MDD people who accessed PAD.[49] Dr. Ganzini, who conducts assessments under *ODDA*, testified that (a) the personal views of a psychiatrist would not impact the ability to diagnose MDD,[50] (b) while the diagnostic process can be challenging, MDD can be reliably diagnosed even in the terminally ill,[51] and (c) the risk to decision-making posed by MDD warrants excluding outright those diagnosed as having MDD.[52]

11. The Dutch scheme also screens for depression based on whether depression is *impairing judgment*. When Smith J. found competence could be safeguarded by limiting access to those

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[41] TJ Reasons, ¶806 JR v II, A.R. 28
[42] Affidavit #2 of Linda Ganzini made 2 Nov 2011, ¶44, JR v XLVII, 13327
[43] Cross-examination of Martha Donnelly held 9 Nov 2011 ("Donnelly Cross"), p. 23, JR v XLVII, 13519
[44] TJ Reasons, ¶¶786, 798 JR v II, A.R. 23, 26
[45] CMA, ¶25(d) (whose claim is made entirely without even any *asserted* evidentiary support); CCD/CACL, ¶35; EPC, ¶39; see also AGC Factum, ¶35
[46] Oregon's *Death With Dignity Act*, Oregon Rev. Stat. §70.245 (1994) ("*ODDA*"), JR v XVI, 2816-29
[47] TJ Reasons, ¶394(c) [emphasis added], JR v I, A.R. 120
[48] TJ Reasons, ¶431, JR v I, A.R. 132
[49] Cross-examination of Linda Ganzini held 14 Nov 2011, 13:29-43 and 40:8-47, JR v V, 13, 40
[50] TJ Reasons, ¶792, JR v II, A.R. 25
[51] TJ Reasons, ¶¶788-89, JR v II, A.R. 24. Dr. Donnelly testified it is possible to diagnose MDD in terminal patients: TJ Reasons, ¶790, JR v II, A.R. 24. Canada's own expert psychologist witnesses - Drs. Heisel and Mishara – agreed that MDD could be accurately diagnosed even in the terminally ill, provided the assessor was qualified: TJ Reasons, ¶¶791-92, JR v II, A.R. 24-25
[52] TJ Reasons, ¶¶437, 789, JR v I, A.R. 134; JR v II, A.R. 24

"not clinically depressed,"[53] she adopted Dr. Ganzini's recommended approach and set the bar well *above* the standard set in any foreign jurisdiction (Washington is the same as Oregon; and Belgium and Luxembourg the same as the Netherlands), protecting decision-making by reference to a feasible point (i.e., MDD diagnosis).

12. ***Physician Relationship / Physician Qualification*:**[54] Some interveners raise concerns that Canadian patients may not have an established physician-patient relationship, making capacity assessment more difficult.[55] The degree of scrutiny to be applied in an informed consent assessment escalates in relation to the seriousness of the consequences of the medical decision at hand.[56] Thus, general medical practice obliges a physician to perform a PAD assessment at the highest possible degree of scrutiny.[57] These are the same medical practices our society relies upon (unregulated) in all other life and death medical decision-making contexts. While a pre-existing relationship of trust is a *benefit* in doing an assessment, it is *not* a *requirement.*[58] It is also unlikely that any patient with "intolerable suffering" would not be significantly involved in the medical system. On the expert evidence before her, Smith J. was entitled to find not only that Canadian physicians could and would perform PAD assessments competently and in accordance with existing medical practice, but that such assessments would be very carefully performed.[59]

13. CMDS/CMC assert PAD is contrary to the Hippocratic Oath.[60] This is inconsistent with the evidence led in this case about the Hippocratic Oaths sworn by Canadian physicians[61] and

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[53] TJ Reasons, ¶¶786-89, 1393, JR v II, A.R. 23-24, 186-87. Appellants understand "clinically depressed" in the context of the entire judgment to mean "MDD": see esp. Affidavit #1 of Linda Ganzini made 24 Aug 2011, ¶38, JR v XV, 2129. To this extent appellants and Dying with Dignity are actually *ad idem* on who should be automatically disqualified from receiving PAD – only those patients with MDD not those patients with milder forms of depression that may not affect competence.

[54] CMA, ¶25(c) and (e) (made without even any asserted evidentiary support); AGC Factum, ¶¶37, 39

[55] CMA, ¶25(d); see also AGC Factum, ¶37

[56] TJ Reasons, ¶¶762-63, JR v II, A.R. 17-18

[57] TJ Reasons, ¶¶1239-40, JR v II, A.R. 151

[58] Donnelly Cross, pp. 10-11, JR v XLVII, 13506-07. In the absence of a pre-existing relationship of trust, the assessor should seek collateral information regarding the patient from third party sources and conduct further interviews if needed.

[59] Affidavit #2 of Martha Donnelly made 31 Oct 2011 ("Donnelly #2), ¶¶14, 26, JR v XLVI, 13023, 10325; Affidavit #1 of Gerrit Kimsma made 1 Sep 2011, ¶27, JR v XVIII, 3410-11

[60] CMDS/CMC, ¶¶8-16

[61] See e.g. Affidavit #1 of Thomas Marrie made 31 Oct 2011, Ex B, D, E, G-I, K, JR v XLVI, 13055, 13057-58, 13060-62, 13064. CMA is clear that the 2014 version of the CMA Policy on "Euthanasia and Assisted Suicide" will shortly be amended to accord with the CMA's Resolution of August 18-20, 2014: CMA, ¶¶1-3. The Resolution indicates that the upcoming amendments will indicate that the CMA considers PAD consistent with medical ethics. To the extent that other Interveners cite and rely on the 2014 version of the CMA Policy, it is notable that they are citing a policy which is to be amended shortly.

with CMA's position.[62] **Notably, CMA's August Resolution**[63] **marks a very significant departure from its position presented to this Court in *Rodriguez*.**[64] Provided it is legal, nothing in PAD is contrary to the Hippocratic Oath.

14. ***Bias*:**[65] EPC asserts physicians would be unable to overcome bias, implying safeguards will be disregarded and expressed wishes to die made by the disabled too readily accepted.[66] Dr. Tom Shakespeare[67] calls this remarkable proposition implausible and refers specifically to a claim by AGC's witness Ms. Davies. Smith J. held "there is little evidence before the Court that physicians and other caregivers would, even unconsciously, respond differently to requests from for assisted death from the physically disabled persons as opposed to others."[68] Smith J. did not overlook AGC's evidence; she referenced it. Much of the evidence was anecdotal and much of that was hearsay - where hearsay was admitted, Smith J. considered it in assigning weight.

15. Smith J. was not obliged, having accepted the proposition that physicians may make assumptions about the quality of life of disabled persons, to reach the separate conclusion that physicians therefore cannot accurately assess voluntariness of disabled patients for PAD. There is no interplay between assumptions about quality of life and a high scrutiny PAD assessment (which involves measuring the decision against the patient's *own* values).[69] AGC's own expert witness on voluntariness, Prof. Mishara, deposed that voluntariness could be assessed for PAD provided a complete assessment was done by a qualified and experienced professional and a complete assessment was done.[70]

16. The thrust of EPC's complaint is that Smith J.'s faith in the medical profession was merely an assumption, not an evidentiary inference that was open to her.[71] The evidence from other jurisdictions cannot displace Smith J's findings of fact about how *Canadian physicians* are able to address such issues and therefore such assertions should be rejected as not supported by

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[62] CMA, ¶1
[63] Resolutions adopted at 147th Annual Meeting of the CMA (August 2014), CMA BoA, Tab 3
[64] *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 [*Rodriguez*], p. 608, RA v II, Tab 44
[65] EPC, ¶30; see also AGC Factum, ¶¶43-46
[66] EPC, ¶30; see also AGC Factum, ¶130
[67] Affidavit #1 of Sheila McLean made 3 Nov 2011, Ex B, p. 53, JR v XLVII, 13411T. Dr. Shakespeare is a leading scholar in the area of disability theory relied upon by AGC's witness Prof. Frazee.
[68] TJ Reasons, ¶1129, JR v II, A.R. 123
[69] Described by Smith J: TJ Reasons, ¶¶763, 784, 795 and 804, JR v II, A.R. 18, 23, 25-27, and by Affidavit #1 of Martha Donnelly made 29 Aug 2011 ("Donnelly #1"), ¶¶12-15, JR v XIV, 1984
[70] TJ Reasons, ¶800, JR v II, A.R. 27
[71] EPC, ¶30; see also AGC Factum, ¶154

the evidence. Moreover, EPC's assertions about the risks of diagnostic error,[72] the difficulty in overcoming bias,[73] and other interveners' assumptions about not experiencing palliation,[74] all ignore Smith J.'s findings of fact without actually challenging those findings.[75]

17. Smith J. noted unconscious biases could be overcome through practices of careful and well-informed capacity assessments by qualified physicians alert to those risks.[76] There is no reason to assume members of the medical profession are uniquely impervious to insight and self-awareness. There was a solid evidentiary basis for the finding that self-awareness can displace assumptions in the context of informed consent assessment and that this is an issue that the medical profession is capable of addressing in a concrete manner.[77] Smith J.'s findings were grounded in common sense (i.e., that a bias can be dislodged) and in expert evidence (i.e., professional development and self-awareness in the medical profession).

18. CCD/CACL speculates there may be inordinate impact on the socially vulnerable, but that there was inadequate evidence to establish it.[78] CCD/CACL argues AGC "challenged the fairness of the evidentiary constraints imposed upon it at trial" but has "decided it cannot correct its error before this Court."[79] AGC has never asserted evidence was improperly excluded by or refused admission by Smith J.,[80] nor did it ever, prior to the Montero Affidavit, seek to file further evidence. It has never produced any evidence it would have sought to file had it been successful in its application to move the timelines back.[81] Given its constitutional role and its unlimited resources, if AGC thought there was a point to be made in this regard on this appeal, it

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[72] EPC, ¶38
[73] EPC, ¶30; see also AGC Factum, ¶154
[74] See e.g. CHA, ¶¶6-11; CCD/CACL, *fn* 51
[75] Risk of diagnostic error: TJ Reasons, ¶¶817-18, JR v II, A.R. 30-31; Overcoming bias: TJ Reasons, ¶853, JR v II, A.R. 39, and TJ Reasons, ¶1129, JR v II, A.R. 123; see also Donnelly #1, ¶¶10-16, JR v XIV, 1983-85, Donnelly #2, ¶¶4-10, 26, 29, 31, JR v XLVI, 13020-22, 13024-26. Palliative care is not universally available in Canada and even the best palliative care cannot alleviate all suffering: TJ Reasons, ¶¶4, 188, 190, 192, 309, 823, JR v I, A.R. 8, 59-60, 96; v II, A.R. 31-32. CMA raises a concern about the availability of palliative care but rightly notes that it "seems wrong to deny grievously ill patients the option of medical aid in dying simply because of systemic inadequacies in the delivery of palliative care": CMA Factum, ¶20.
[76] TJ Decision, ¶853, JR v II, A.R. 39
[77] Donnelly #2, ¶¶28-29, JR v XLVI, 13026
[78] CCD/CACL, ¶¶7, 11, 14
[79] CCD/CACL, ¶6. In *Nicklinson* Lord Sumption wrongly accused Smith J. of excluding "a substantial body of apparently relevant material": *Nicklinson*, ¶224, RA v II, Tab 34. It is unclear to what Lord Sumption refers. There can be no suggestion Smith J. inappropriately excluded admissible evidence and AGC has not so argued.
[80] At the BCCA, AGC asserted it was prejudiced by the expedited timelines - a different assertion than that it was prevented from introducing evidence.
[81] CA Reasons, ¶196, JR v III, A.R. 92-93

certainly would have made it.[82] Further, it is not for an intervener to impose its view that the record is "incomplete" or "unbalanced" on certain issues when the record is accepted by the parties.[83] It is unacceptable for an intervener to "back seat drive" the record. Moreover, AGC *did* adduce new evidence in this Court; none of it related to the issues identified by CCD/CACL.[84] CCD/CACL's ¶¶6-8 should be struck as raising new issues contrary to LeBel J.'s order.

19. ***Life / Dignity*:** Some interveners argue that objective "life" provides a "bright line;"[85] one need look no further than the abortion debate to ascertain that it does not. Nor does inviolability of life mark a bright line between PAD and other end-of-life care: so long as there is a point at which life may cease to be worth living, there is no bright line between acceptable and unacceptable means to hasten death.[86] The secular conception of sanctity of life does not entail forcing people to live lives they abhor.[87] "Dignity" must be defined to have substantive content:[88] i.e., what value(s) is "dignity" being invoked in substitution for? Asserting that life is inviolable because it has inherent worth (i.e., because it is inviolable), merely uses "dignity" for rhetorical flourish.[89] The appellants' version of dignity captures patients' desire to maintain self-esteem and reflects their actual experience of conditions they find debasing or degrading; this "dignity" is grounded in the voices and experiences of the suffering and resonates with s. 7 interests. It is also consonant with contemporary palliative care ethos and the fact that palliative care may acceptably hasten death (i.e., give primacy to quality of life over existence of life).[90]

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[82] As Finch CJ noted, in dissent, even when challenging procedural aspects of this case before the BCCA, AGC led "no affidavit evidence before us as to what the nature of that other evidence might have been. And, when pressed in oral argument, counsel could not tell us even in general terms what difference, if any, that other evidence might have made to Smith J.'s decision": CA Reasons, ¶196, JR v III, A.R. 92-93.

[83] While it would not lie in the mouth of an intervener to raise the issue in any event, it is noteworthy CCD/CACL's assertion is not that there was *no* evidence on these issues, but rather merely CCD/CACL's *opinion* that the evidence was *incomplete* and *unbalanced*.

[84] CCD/CACL, ¶7

[85] See, e.g., ARPA, ¶¶8,11 and 20

[86] An existential conception of life entails keeping people alive as long as possible; as life is a defined good, *any* hastening is unacceptable.

[87] The *Rodriguez* majority invoked secular "sanctity", citing Dworkin. However, the fuller context of Prof. Dworkin's analysis, as noted by Lamer CJ in dissent, included the observation that "[m]aking someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny": *Rodriguez*, p. 560, RA v II, Tab 44. This understanding is also consistent with the dissent in *Cuthbertson v. Rasouli*, 2013 SCC 53 [*Rasouli*], ¶197; see also ¶169, ASBoA Tab 2

[88] Dignity was rightly rejected as a legal test under s. 15: *R. v. Kapp*, 2008 SCC 41 [*Kapp*], ¶22, ASBoA Tab 5.

[89] See, for example, ARPA ¶27 and EFC ¶22

[90] It is consonant with the dissent in *Rasouli*; and the statements in *Kapp* regarding the *subjective* nature of dignity.

20. ***Section 15***: Appellants' claim is not a right to die but a freedom from state interference.[91] For disabled people, exercise of the freedom to commit suicide may necessitate third party assistance; the law thus imposes a disproportionate burden. EPC says recently disabled people are not historically disadvantaged.[92] Smith J. properly rejected this: s. 15 is "aimed not only at groups but also at individuals," and the recently disabled are as entitled to s. 15 protection as those with lifelong experience.[93] EPC's emphasis on the group[94] is fundamentally flawed: (1) it makes stereotypical assumptions about the group and their needs; and (2) it fails to recognize that s. 15 protects *individuals*.[95] EPC says the law is protective and thus ameliorative under s. 15(1). As under s. 15(2), this factor should relate to amelioration for groups characterized by an enumerated or analogous ground,[96] and the distinction must be *necessary* for the ameliorative effect.[97] The protective effect of the impugned laws could not meet these requirements.

21. ***Remedy***: In response to FF's submission on remedy, FF attempts to dictate Parliament's response.[98] Appellants have properly challenged all provisions potentially engaged by the exercise of the constitutional right posited. It is for Parliament to determine whether a declaration of unconstitutionality should be addressed by deleting from or adding to existing provisions and/or by adding new provisions. It is also notable that FF's remedial submission is directed at permitting assisted dying, not *physician*-assisted dying.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.

Dated: September 11, 2014

Joseph J. Arvay, Q.C., Sheila M. Tucker and Alison M. Latimer
Solicitors for the Appellants

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[91] To similar effect see CMDS/CFCPS, ¶¶37-40
[92] EPC, ¶¶21, 23
[93] TJ Reasons, ¶1102, JR v II, A.R. 114-15
[94] EPC, ¶¶16-17 relies to some extent on *Withler v. Canada (Attorney General)*, 2011 SCC 12 [***Withler***], ASBoA Tab 7, in support of their "group theory." In *Withler*, this Court addressed a statutory "benefit package" designed to benefit a number of different groups with different needs at different times of life: *Withler*, ¶76. Unsurprisingly, this Court did not require "[p]erfect correspondence." This case is very different.
[95] See *Moore v. British Columbia (Education)*, 2012 SCC 61, ¶60, ASBoA Tab 3; *Quebec (Attorney General) v. A*, 2013 SCC 5, ¶¶354-55, ASBoA Tab 4, Abella J. and 430 McLachlin C.J. Abella J.'s s. 15 analysis was a majority judgment: see ¶¶385 Deschamps J. and 416 McLachlin C.J. Appellants' Factum in Chief, ¶¶105-18
[96] *Alberta (Aboriginal Affairs and Northern Development) v. Cunningham*, 2011 SCC 37 [*Cunningham*], ¶¶41-46, ASBoA Tab 1; *Kapp*, ¶23, ASBoA Tab 5
[97] *Cunningham*, ¶45, ASBoA Tab 1
[98] Farewell Foundation for the Right to Die and Association Québecoise pour le Droit de Mourir dans la Dignité ("FF") appears to also wrongly assume that striking of the *Criminal Code*, s. 14 would make consent a positive defence to murder.

TABLE OF AUTHORITIES

APPENDIX A

Paragraph / Footnote	Content	Objection
ASSOCIATION FOR REFORMED POLITICAL ACTION		
FN 25	Tinne Smets et al, "Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases" *BMJ* 2010;341:c5174 **[ARPA BoA Tab 9]**	Refers to a study which is not included in the record; improper attempt to supplement the record with additional evidence (not a proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial.
¶30, last sentence and FN 27	In Canada, with the ink not yet dry on Bill 52, the secretary of Québec's College of Physicians was already publically contemplating the need to extend the law to include far more people, calling Bill 52 "only a step." FN 27: Graeme Hamilton "As Quebec set to legalize euthanasia, doctors already looking to expand who qualifies for lethal injections" *National Post* (13 February 2014), online: http://news.nationalpost.com/2014/02/13/as-quebec-set-to-legalize-euthanasia-doctors-already-looking-to-expand-who-qualifies-for-lethal-injections/ **[ARPA BoA Tab 4]**	Asserts as "fact" matters not in evidence on the record; cites a newspaper article in support of the assertion, which article does not form part of the record; improper attempts to supplement the record with additional evidence.
CATHOLIC HEALTH ALLIANCE OF CANADA		
FN 4-5	Harvey Max Chochinov, OM, MD, PhD, FRCPC, *"Dying, Dignity, and New Horizons in Palliative End-of-Life Care"*, CA: A Cancer Journal for Clinicians, Volume 56: Number 2, March/April 2006, online: http://onlinelibrary.wiley.com/doi/10.3322/canjclin.56.2.84/pdf/, at pp. 90, 96-97, **[CHAC BoA, Tab 9]**	Refers to an article which is not included in the record; improper attempt to supplement the record with additional evidence (not a proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial; improper attempt to enter additional expert opinion evidence of an actual AGC witness.

Paragraph / Footnote	Content	Objection
FN 6	Richard M. Doerflinger and Carlos F. Gomez, M.D., Ph.D., "*Killing the Pain Not the Patient: Palliative Care vs Assisted Suicide*", United States Conference of Catholic Bishops, undated: http://www.usccb.org/issues-and-action/human-life-and-dignity/assisted suicide/killing-the-pain.cfm, **[CHAC BoA, Tab 12]**	Refers to an article which is not included in the record; improper attempt to supplement the record with additional evidence (not a proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial.
FN 7-8	Mervyn M. Dean et al., "*Framework for Continuous Palliative Sedation Therapy in Canada*", Journal of Palliative Medicine, Volume 15, Number 8, 2012, at pp. 870-71, **[CHAC BoA, Tab 11]**	Refers to an article which is not included in the record; improper attempt to supplement the record with additional evidence (not a proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial.
CHRISTIAN LEGAL FELLOWSHIP		
FN 3 and 24 FN 5	John Keown, 'A Right to Voluntary Euthanasia? Confusion in Canada in *Carter*', 28 Notre Dame Journal of Law, Ethics & Public Policy (2014) 1-45 at pp. 4–17, **[CLFA Tab 11]** John Keown, *The Law and Ethics of Medicine: essays on the inviolability of human life* (OUP 2012) at 3-8, **[CLFA, Tab 12]**	Reference to articles which are not included in the record; improper attempt to supplement the record with additional evidence (not proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial; improper attempt to enter additional expert opinion evidence of an actual AGC witness.
CHRISTIAN MEDICAL AND DENTAL SOCIETY and CANADIAN FEDERATION OF CATHOLIC PHYSICIANS' SOCIETIES		
FN 3, 4, 5	Leon R. Kass, "*Neither for love nor money: why doctors must not kill"*, The Public Interest, 94 (1989: Winter), at p. 39 **[CMDS BoA, Tab 7]**	Reference to an article which is not included in the record; improper attempt to supplement the record with additional evidence (not proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial (namely the Hippocratic Oath, its continuing role in medicine and core ethical dictates of

Paragraph / Footnote	Content	Objection
		medicine).
¶9	9. Along these lines, renowned bioethicist and first Chairman of the President's Council on Bioethics Leon Kass defines medicine as follows: "Healing is thus the central core of medicine: to heal, to make whole, is the doctor's primary business. The sick, the ill, the unwell present themselves to the physician in the hope that he can help them become well - or, rather, as well as they can become, some degree of well-ness being possible always, this side of death. The physician shares that goal; his training has been devoted to making it possible for him to serve it. Despite enormous changes in medical technique and institutional practice, despite enormous changes in nosology and therapeutics, the center of medicine has not changed: it is as true today as it was in the days of Hippocrates that the ill desire to be whole; that wholeness means a certain well-working of the enlivened body and its unimpaired powers to sense, think, feel, desire, move, and maintain itself; and that the relationship between the healer and the ill is constituted, essentially even if only tacitly, around the desire of both to promote the wholeness of the one who is ailing."	*Ibid.*
¶¶12, 13 and 16 and	12. Many medical ethicists have argued that the *Hippocratic Oath*	Reference to articles and documents which are not included in the record;

Paragraph / Footnote	Content	Objection
FN 6-7	should be abandoned, however, even those who argue against the *Hippocratic Oath* recognize the danger in having health-care practitioners end a patient's life. 13. For example, the late Edmund D. Pellegrino, bioethicist, former director of Georgetown University's Kennedy Institute of Ethics and past Chairman of the President's Council on Bioethics, has argued against maintaining the *Hippocratic Oath* and has proposed an alternate approach to medical morality. In his *Precepts as a Suggested Replacement for the Hippocratic Oath,* Pellegrino recognized that medical ethics must forbid the notion of ending a patient's life. He concluded physicians should vow: "Never to participate in direct, active, conscious killing of a patient, even for the reasons of mercy, of at the request of the state, or for any other reason." 16. The CMDS and the CFCPS submit that the overwhelming global consensus in the field of medicine and medical ethics is that ending a patient's life is not medical care. FN 6-7: Emily Woodbury, "*The Fall of the Hippocratic Oath: Why the Hippocratic Oath should be Discarded in Favor of a Modified Version of Pellegrino's Precepts*", Georgetown University Journal of Health Sciences, 2012 July; Vol. 6, No. 2: 9-17, https://blogs.commons.georgetown.edu/journal-of-health-sciences/issues-2/vol-6-no-2-july-2012/the-fall-of-the-hippocratic-oath-why-the-hippocratic-oath-should-be-discarded-in-favor-of	improper attempt to supplement the record with additional evidence (not proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial.

Paragraph / Footnote	Content	Objection
	-a-modified-version-of-pellegrino%E2%80%99s-precepts/ **[CMDS BoA, Tab 8]**	
COUNCIL OF CANADIANS WITH DISABILITIES and CANADIAN ASSOCIATION FOR COMMUNITY LIVING		
¶¶8 and 36	8. CCD/CACL request that the Court be cognizant of legislative facts …in order to correct deficiencies in the trial record. 36. While CCD/CACL has no desire to disparage the vast majority of families who are loving and supportive of their dying family members, this Court is entitled to take judicial notice of the fact that persons with disabilities and the elderly are subject to far higher than average levels of exploitation and abuse, and they are never so vulnerable as when they are dying….	Improper attempt to supplement the record by asserting facts neither in the record nor qualifying for judicial notice. (The Court can only be "cognizant" of legislative facts established in accordance with the rules of evidence.) The emphasized statement in paragraph 36 is a controversial statement and not a "notorious" matter for purposes of judicial notice.
FN 12, 48, 51	Patricia S. Mann, "Meanings of Death" in Margaret P. Battin, Rosamond Rhodes, and Anita Silvers, eds., *Physician Assisted Suicide: Expanding the Debate* (New York: Routledge, 1998) at pp. 11-27 **[CCD/CACL BoA Tab 11]**	Reference to an article which is not included in the record; improper attempt to supplement the record with additional evidence (not proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial.
FN 28, 56, 58	Professor Mary Shariff, "Assisted death and the slippery slope - finding clarity amid advocacy, convergence and complexity," (2012) 19:3 Current Oncology Daily Mail **[CCD/CACL BoA Tab 12]** Steve Doughty, "Don't Make Our Mistake," Daily Mail, July 9, 2014 **[CCD/CACL BoA Tab 14]**	Reference to articles and press reports which are not included in the record; improper attempt to supplement the record with additional evidence (not proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial; improper attempt to enter additional expert opinion evidence of an actual AGC witness (Shariff).
FN 30	In the United States, where plebiscites have occurred, and in the	Assertion of fact with no evidentiary support in the record; improper attempt to

Paragraph / Footnote	Content	Objection
	United Kingdom, where Parliament is reviewing the issue, the organized voice of the disability rights movement is actively opposing AS/E.	supplement the record.
FN 34	Leighton and Hughes, "Notes on Eskimo Patterns of Suicide," (1955) 11:4 Southwestern Journal of Anthropology II 327 at 327-328 **[CCD/CACL BoA Tab 10]** Robert Jay Lifton, The Nazi Doctors: Medical Killing and the Psychology of Genocide, (USA: Basic Books, 1986) c. 2, "Euthanasia: Direct Medical Killing" p. 45 **[CCD/CACL BoA Tab 13]**	Reference to article and book chapter not included in the record; improper attempt to supplement the record with additional evidence (not proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial.
FN 41	Donald Boudreau and Margaret Somerville, "Euthanasia is not Medical Treatment," (2013) 106 British Medical Bulletin 45 **[CCD/CACL BoA Tab 6]**	Reference to article not included in the record; improper attempt to supplement the record with additional evidence (not proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial.
FN 44, 50	John Keown, "A Right to Voluntary Euthanasia? Confusion in Canada in *Carter*" (2014) 28:1 Notre Dame J.L. Ethics and Public Policy 1 at pp. 4-17 **[CCD/CACL BoA Tab 9]**	Refers to an article which is not included in the record; improper attempt to supplement the record with additional evidence (not a proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial; <u>improper attempt to enter additional expert opinion evidence of an actual AGC witness</u>.
FN 46	Carol Gill, "Suicide Intervention for People with Disabilities: A lesson in inequality," (1992) 8:1 Issues in Law and Medicine 37 **[CCD/CACL BoA Tab 5]**	Reference to article not included in the record; improper attempt to supplement the record with additional evidence (not proper authority); undermines the record given that evidence of the same general kind was properly entered into evidence at trial.