



**EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE IN THE CASE OF MATURE MINORS,
ADVANCE REQUESTS, AND MENTAL ILLNESS:**

LEGAL, ETHICAL, CULTURAL, AND CLINICAL CONSIDERATIONS

BACKGROUND PAPER OF THE

CHRISTIAN LEGAL FELLOWSHIP/ALLIANCE DES CHRÉTIENS EN DROIT

OCTOBER 6, 2017

WWW.CHRISTIANLEGALFELLOWSHIP.ORG

“Killing a person — in order to relieve the suffering produced by a medically manageable physical or mental condition — is not a proportionate response to the harm represented by the non-life-threatening suffering resulting from that condition.”

-Supreme Court of Canada, 2001¹

Overview

Christian Legal Fellowship (“CLF”) is Canada’s national association of Christian legal professionals. Its membership consists of over 700 lawyers, law students, professors, and retired judges nationwide, representing over 30 denominations and virtually every area of legal practice.

CLF has consistently engaged with the development of Canadian euthanasia and assisted suicide (“EAS”) policies since 2011, when the *Carter* litigation first commenced (see Appendix “A” for additional information).

While some commenters have suggested that the Supreme Court’s decision in *Carter* must extend EAS to include advance directives, mental illness and mature minors, this reading of *Carter* fundamentally misinterprets the factual context and parameters of the Court’s reasoning.²

In addition to correcting this misinterpretation, one of CLF’s overarching concerns is the adverse impact that expanding EAS will have on vulnerable populations, such as seniors, mature minors, persons with disabilities, and those who suffer from mental illness. This concern regarding adverse impact raises two key considerations for the Council of Canadian Academies: (1) no right or freedom is absolute; and (2) sections 7 and 15 *Charter* rights of vulnerable communities and individuals are increasingly engaged and violated as EAS eligibility is expanded, particularly where access to meaningful medical care aimed at alleviating suffering is lacking.

No right or freedom is absolute

Any interpretation of sections 7 and 15 of the *Charter*, and the principles of “liberty” and “autonomy” must take into account not only the interests of those patients seeking EAS, but also how the exercise of those interests impacts on the rights of others. Conduct that would potentially cause harm to or interference with the rights of others is not necessarily protected by the *Charter*.³ Justice Smith of the British Columbia Supreme Court recognized this in her *Carter* judgment noting that the existence of arguments for expansion of circumstances permitting physician-assisted suicide “does not mean that those arguments will succeed.”⁴

¹ *R v Latimer*, 2001 SCC 1 at para 41.

² See discussion below; see also John Sikkema & Derek Ross, “[Misreading Carter](#)” (January 8, 2016) *Convivium*.

³ *Syndicat Northcrest v Amselem*, 2004 SCC 47 at paras 61-62.

⁴ *Carter v Canada*, 2012 BCSC 886 at para 315 [“*Carter* (BCSC)”].

Therefore, this Council⁵ must consider the rights and interests of those who will be adversely affected by expanding EAS, including the broader societal impact and the implications of determining that certain lives are not worth living.

Charter rights of vulnerable communities and individuals

The only category of persons whose *Charter* rights have ever been considered by a Canadian court in the EAS context are those of “Ms. Taylor and of persons in her position”.⁶ No court has conducted a *Charter* analysis in the EAS context of the rights of:

- Patients who do not wish to receive EAS or to be pressured, directly or indirectly, to receive EAS;
- Persons with illnesses and/or disabilities whose sense of self-worth, hope, and dignity, and access to “equal concern, respect and consideration”, are susceptible to socially constructed conceptions regarding the value of their lives/existence;⁷
- Patients whose sole or primary underlying condition is a mental illness (“persons with psychiatric disorders” are specifically precluded from *Carter’s* parameters);⁸
- Patients who are not adults, i.e. children (“minors” are specifically precluded from *Carter’s* parameters);⁹ and
- Patients who are incapacitated/suffering from dementia/incapable of providing contemporaneous consent (only “competent adults” are included in *Carter’s* parameters).¹⁰

For reasons discussed below, it is CLF’s position that if eligibility for EAS were to be expanded beyond that currently provided for under Bill C-14, any so-called “protections” or “safeguards” would be insufficient to protect certain persons’ *Charter* rights to life, liberty and security and/or their right to the equal protection of the law without discrimination based on age or mental or physical disability, in a manner that is demonstrably justified in a free and democratic society.

Given the specific scope of study undertaken by the Council, this paper will address only mature minors, mental illness and advance directives.

Section 7

Section 7 of the *Charter* states that “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”¹¹

⁵ The Council has specifically asked for submissions on: (1) “What are the potential implications for individuals and other affected persons, including their families, care providers, and health professionals, related to MAID for the three topic areas?” and (2) “What are the potential impacts on society of permitting or prohibiting requests for MAID for the three topic areas?”.

⁶ *Carter v Canada, 2015 SCC 5*, para 56 [“*Carter* (SCC)”].

⁷ *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624, para 56; see also note 54 and discussion.

⁸ *Carter* (SCC), *supra* note 6 at para 111.

⁹ *Carter* (SCC), *supra* note 6 at para 111.

¹⁰ *Carter* (SCC), *supra* note 6 at para 147.

In broad terms, the right to life is engaged “where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly.”¹² Liberty is defined as “the right to make fundamental personal choices free from state interference”¹³ and security of the person points to “a notion of personal autonomy involving ... control over one’s bodily integrity free from state interference.”¹⁴ Security of the person protects “both the physical and the psychological integrity of the individual”¹⁵ and is infringed when state actions impose suffering on an individual,¹⁶ and where state action has a “serious and profound effect on a person’s psychological integrity” that is “greater than ordinary stress or anxiety.”¹⁷

As with all *Charter* rights there are reasonable limits¹⁸ and justifiable infringements, considering the nature of the law itself as well as competing moral claims and broad societal implications.¹⁹ However, expanding EAS to mature minors is not one of those reasonable limits or justifiable infringements, for the reasons outlined below.

Mature minors

Canadian courts have consistently recognized that children (“mature minors”) are a “[highly vulnerable](#)” group in need of protection.²⁰ On this ground, the law regularly draws distinctions based on age to protect minors, and in the criminal law context, it is a principle of fundamental justice that young people are treated differently from adults because of “reduced maturity and moral capacity”.²¹

While children are sometimes permitted to make their own health care decisions, minors with capacity are not guaranteed an unqualified right to do so, and courts have consistently intervened to **protect** minors from decisions that imperil their health and create unnecessary risk of death. All minors need protection from making “life-threatening mistakes”²² and even where they are able to exercise some measure of mature, independent judgment, “the more serious the nature of the decision and the more

¹¹ [Canadian Charter of Rights and Freedoms](#), s 7, Part I of the *Constitution Act*, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11 [*Charter*].

¹² [Carter \(SCC\)](#), *supra* note 6 at para 62.

¹³ [Blencoe v British Columbia \(Human Rights Commission\)](#), 2000 SCC 44 at para 54.

¹⁴ [Rodriguez v British Columbia \(Attorney General\)](#), [1993] 3 SCR 519 at 587-88.

¹⁵ [New Brunswick \(Minister of Health and Community Services\) v G\(J\)](#), [1999] 3 SCR 46 at para 58.

¹⁶ [Rodriguez](#), *supra* note 14 at 589.

¹⁷ [New Brunswick](#), *supra* note 15 at paras 77-78.

¹⁸ Most *Charter* rights are subject to the limitation clause in section 1, whereby infringements are permitted provided they can be “demonstrably justified in a free and democratic society”. Section 7 has an internal limitation, namely that infringements are permitted to the extent that they accord with the principles of fundamental justice. As per [Carter \(SCC\)](#), *supra* note 6 at para 95, it is “difficult” to justify section 7 infringements because these rights are “fundamental, and ‘not easily overridden by competing social interests,’” evidenced by the fact the Supreme Court has not yet upheld a section 7 violation under section 1.

¹⁹ [Carter \(SCC\)](#), *supra* note 6 at para 79.

²⁰ [AC v Manitoba, 2009 SCC 30](#), paras 104, 143 [“AC”].

²¹ [R v DB](#), 2008 SCC 25, para 47.

²² [AC](#), *supra* note 20 at para 130.

severe its potential impact on the life or health of the child, the greater the degree of scrutiny will be required”.²³

The Supreme Court has been guided by the best interests of the child in determining whether an intervention in opposition to a minor’s wishes is necessary and desirable. The Supreme Court has upheld the constitutionality of child welfare legislation that allows a child’s wishes to be overridden, even where those wishes engage a *Charter* right (i.e. freedom of religion).²⁴ In *AC v Manitoba*, the majority noted “it is dangerous to speculate on whether a judge would ever...decline to order medical treatment for a child under the age of 16 where the result would be probable death.”²⁵

Canada’s [international commitments](#)²⁶ further entrench its obligation to protect children, help ensure their *full* development, recognize the right of the child to enjoy the highest attainable standard of health, and take appropriate measure to diminish infant and child mortality.

The United Nations’ Human Right Committee (UNHRC), in its definitive interpretation of Article 6 of the *International Covenant of Civil and Political Rights* (which Canada has acceded to), emphasizes that “the expression ‘inherent right to life’ cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures”, including “all possible measures to reduce infant mortality and to increase life expectancy.”²⁷ The UNHRC has also recognized that individuals planning or attempting to commit suicide are often undergoing a momentary crisis which may affect their ability to make irreversible decisions such as to terminate their life. Therefore, the UNHRC’s draft General Comment on Article 6 urges participating states to take adequate measures “to prevent suicides, especially among individuals in particularly vulnerable situations.”²⁸

Extending assisted suicide to minors eviscerates Canada’s obligation to protect and nurture children to full development and utterly fails children in their state of vulnerability. Any such extension would result in state-imposed stress and anxiety on children by fostering uncertainty as to their inherent value, worth and dignity as human beings; children would be viewed as a category of people the state can be authorized to kill. Minors are particularly susceptible to external expectations and pressures and would be at a greater risk of accepting EAS in the face of such pressures, subtle and undetectable as they may be. Expanding access to minors would therefore impose “an increased risk of death on [them], either directly or indirectly”²⁹, and would be contrary to the *Charter* rights to life, liberty and security of children.

²³ *Ibid* at paras 21-22.

²⁴ *AC*, *supra* note 20.

²⁵ *Ibid* at para 133.

²⁶ Such as the [UN Convention on the Rights of the Child](#), signed by Canada May 28, 1990.

²⁷ UN Human Rights Committee, “[CCPR General Comment No 6: Article 6 \(Right to Life\)](#)”, (1982) at para 5.

²⁸ Human Rights Committee, “[General Comment No. 36 on Article 6 of the International Covenant on Civil and Political Rights, on the Right to Life](#)” at para 10.

²⁹ [Carter \(SCC\)](#), *supra* note 6 at para 62.

Broader Social Impact of Normalizing Suicide

As noted in the preamble to Bill C-14, suicide is a significant public health issue that has lasting and harmful effects on individuals, families and communities. There is therefore a societal interest in suicide prevention, supporting communities that are disproportionately impacted by suicide, maintaining respect for the inviolability of life, and preventing the normalization of suicide as a “solution” to suffering.

Expanding eligibility for assisted suicide undermines these important societal aims, as demonstrated by experience in other jurisdictions where there is a correlation between legalizing assisted death and increasing suicide rates.³⁰ Part of this increase is due to “continuing attitudinal and cultural shifts” where the “values of autonomy and self-determination have become more prominent” and “acceptance of euthanasia continues to increase in the population at large.”³¹

Mental illness

The impact of these attitudinal shifts is likely to be disproportionately borne by those living with mental illness. Expanding assisted suicide to non-terminally ill patients “with psychiatric conditions will put many vulnerable and stigmatized people at risk.”³² In Belgium & Netherlands, psychiatric assisted suicide has increased by 15% a year since 2006, and 1/25 deaths in Netherlands is result of psychiatric assisted suicide.³³

Many patients struggling with mental illness don’t find effective coping techniques for “long periods of their lives” and presenting assisted suicide as a “viable option” reinforces a loss of hope and “demoralization” for struggling patients.³⁴ Not only does EAS remove “a central therapeutic element in the doctor-patient relationship”³⁵ - that element being hope - it sets aside a “core clinical imperative in psychiatric treatment: compassionately and skillfully helping patients even through sustained periods of suffering during which people often lose the will to live and despair about whether things will get better.”³⁶ Furthermore, an astonishing percentage (close to 48%) of mentally ill patients change their minds regarding assisted suicide requests;³⁷ establishing further grounds to reject EAS as a “solution” to mental illness.

³⁰ Lydia S Dugdale & Daniel Callahan, “[Assisted Death and the Public Good](#)” (2017) 110 Southern Medical Journal 559 at 559-560.

³¹ Canadian Mental Health Association, [Position Paper on Medical Assistance in Dying](#) at 4 [CMHA].

³² Kim, Scott & Trudo Lemmens, “[Should Assisted Dying for Psychiatric Disorders Be Legalized in Canada?](#)” CMAJ 1016 at 5.

³³ [CMHA](#), *supra* note 31 at 4.

³⁴ [Kim, Scott & Lemmens](#), *supra* note 32; Ron Berghmans, Guy Widdershoven & Ineke Widdershoven-Heerding, “[Physician-assisted suicide in psychiatry and loss of hope](#),” (2013) 36 International Journal of Law and Psychiatry at 437.

³⁵ [Kim, Scott & Lemmens](#), *supra* note 32 at 6.

³⁶ *Ibid* at 3.

³⁷ Citing a Belgian case study, see [CMHA](#), *supra* note 31 at 4.

Instead, those living with mental illnesses should be assisted by their physicians and health-care professionals “to live and thrive”.³⁸ These patients should not face a situation in which the doctor-patient relationship is “compromised by conferring on physicians the power to adjudicate whose life is worth living.”³⁹

Implications of Determining that Some Lives are Not Worth Living

Inherent in expanding access to EAS is the necessary social conclusion that some lives are not worth living. The essence of crafting criteria for access is to conclude that lives within these particular categories are not always worth living, a statement borne out by the Oregon experience, where over 40% of EAS recipients over the past 18 years cite “being a burden” as one of the reasons for ending their lives.⁴⁰ Further statistics from Oregon and Washington indicate the main reasons motivating EAS requests are “existential”.⁴¹ This notion of human existence as being “burdensome” has a detrimental impact on societal attitudes toward those living with disabilities and their inherent dignity, and on the worth of all people regardless of limitations or physical health.⁴²

Advance directives

The notion that some lives are simply not worthy of living or deserving of protection directly impacts those who cannot give contemporaneous consent to assisted suicide or euthanasia. The Supreme Court emphatically and explicitly states that assisted suicide should only be made available where a person “clearly consents to the termination of life”, a concurrent granting of consent.⁴³ This requirement was applied by the [BC Court of Appeal](#) in deciding not to give effect to an Alzheimer’s patient’s prior directive to be deprived of “nourishments or liquids” because her present wishes suggested otherwise.⁴⁴ Courts - and legislatures - must “give effect to the wishes of the patient in the ‘here and now’, even in the face of prior directives”.⁴⁵ [Carter](#) was unambiguous on this point: assisted suicide is conditional on the clear consent of the patient.⁴⁶ Consent for irreversible decisions such as to terminate one’s life can only be meaningful where it is truly independent and informed, which is virtually impossible in this context:

³⁸ Romyne Gallagher, “[Medical assistance in dying: Living with dignity until life naturally ends](#)” (2017) 59 BCMJ 50 at 50-51.

³⁹ [Dugdale & Callahan](#), *supra* note 30 at 560.

⁴⁰ [Romyne Gallagher](#), *supra* note 38 at 50-51.

⁴¹ [Dugdale & Callahan](#), *supra* note 30 at 560.

⁴² Studies indicate that the “opinion of others is of importance to many people with dementia ... even to the extent that some of them express being worried about others finding out about their diagnosis or being afraid others won’t listen to them... due to the possibility of stigmatization” and “the way people are treated by medical personnel also influences their well being”; see M de Boer et al, “[Suffering from dementia – the patient’s perspective: A review of the literature.](#)” 19 *International Psychogeriatrics* at 1027-8.

⁴³ [Carter \(SCC\)](#), *supra* note 6 at paras 127 and 147.

⁴⁴ [Bentley v. Maplewood Seniors Care Society](#), 2015 BCCA 91.

⁴⁵ *Ibid* at para 18.

⁴⁶ [Carter \(SCC\)](#), *supra* note 6 at para 127.

To be capable of independent choice, an individual must be able to understand the important information relevant to that choice. The memory and other cognitive impairments associated with dementia reduce a person's ability to evaluate the choice for PAD. **As a result, many, perhaps most, individuals diagnosed with dementia are incapable of making that choice.**⁴⁷

When the patient is incapable of consent, one must ask whose suffering EAS is intended to alleviate. Patients with "moderate to severe dementia can reliably rate their own quality of life"⁴⁸, and studies reveal that such patients "rate their quality of life higher than do their family members who are influenced by their own distress".⁴⁹ This is likely due, in part, to the fact that the patient is able to adapt to the changing situation; a scenario that can lead to the disappearance of former advance desire for euthanasia.⁵⁰ Family - and societal - discomfort with illness, disease and physical decline ought not diminish the value and dignity of life. In fact, it ought to prompt societal efforts in the opposite direction, maintaining good contact, and ensuring patients that their lives are worthwhile and useful.⁵¹ Dignity cannot mean simply "life without misery or helplessness" because that is a natural part of all life and all lives.⁵² Furthermore, many assumptions about advance directives and dementia patients, for example, are unfounded:

Despite the fact that dementia is accompanied by a lot of negative feelings, the literature on the perspective of the patient offers no solid support to the widespread assumption that dementia is necessarily a state of dreadful suffering, or a disaster without consolation as some clinic psychologists suggest. [...] Furthermore, the adaptive processes which people with dementia go through should be carefully considered in discussions on advance directives, because there is a good chance that, in the end, **people with dementia will not act in accordance with their earlier values and anticipatory beliefs regarding a life with dementia.**⁵³

Returning to the concept of dignity, it must not import these erroneous assumptions. Rather, dignity signifies the inherent value of every single person, regardless of disease, disability, or illness and we, as a society "must reclaim" these individuals and the aging process "as part of who we are".⁵⁴ Only then will the necessary respect for life and protection for the vulnerable exist in a meaningful way.

⁴⁷ Rebecca Dresser, "[On Legalizing Physician-Assisted Death for Dementia](#)" (2017) 47 Hastings Center Report 5 at 5-6 [emphasis added].

⁴⁸ Christopher Beer et al, "[Factors Associated with Self and Informant Ratings of the Quality of Life of People with Dementia Living in Care Facilities: A Cross Sectional Study](#)" (2010) 5 PLoS ONE 1 at 1.

⁴⁹ [Romaine Gallagher](#), *supra* note 38 at 51.

⁵⁰ E Bolt et al, "[Advance Directive to Euthanasia: Stable Preference in Older People](#)" at 1629.

⁵¹ As noted in a review of literature studying patients with dementia, "a good quality of life was often generated by good contact with other people and the sense of being useful", see [M de Boer](#), *supra* note 42 at 1030.

⁵² [Dugdale & Callahan](#), *supra* note 30 at 560.

⁵³ [M de Boer](#), *supra* note 42 at 1033-4 [emphasis added].

⁵⁴ [Romaine Gallagher](#), *supra* note 38 at 51; this is particularly important in light of a study that found patients with an advance directive most likely to follow through with euthanasia were those "worried about a loss of dignity"; see also [E Bolt et al](#), *supra* note 50 at 1631. By affirming certain categories of people are eligible for assisted

Section 15 Equality

In order to understand how EAS expansion in cases of mental illness and advance requests may violate section 15 of the *Charter*, it is necessary to first understand:

- (i) the broader impact of normalizing suicide and its disproportionate impact on persons living with mental illness; and
- (ii) the implications of determining that some that lives are not worth living and its disproportionate impact on the requirement for contemporaneous consent.

Section 15(1) of the *Charter* guarantees that “every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination” based on a variety of enumerated grounds, including age or mental or physical disability.

To access section 15 protection, a claimant must demonstrate that (1) the *Charter* applies because a state actor has infringed equality guarantees through an application of law⁵⁵; (2) the law “creates a distinction on the basis of an enumerated or analogous ground”;⁵⁶ and (3) the law “fails to respond to the actual capacities and needs of the members of the group and instead imposes burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating or exacerbating their disadvantage.”⁵⁷

In this case, the proposed expansion of EAS in the criminal law creates a distinction between Canadians experiencing mental illness and those who are not, as well as between those who are able to consent to medical intervention⁵⁸ and those who are not, by virtue of what would be expanded eligibility criteria.⁵⁹

We must also consider whether such distinctions have a discriminatory impact in terms of prejudicing or stereotyping.⁶⁰ Prejudice is the “holding of pejorative attitudes based on strongly held views about the appropriate capacities or limits of individuals or the groups of which they are a member.”⁶¹ Stereotyping is a disadvantaging attitude “that attributes characteristics to members of a group regardless of their actual capacities.”⁶² The test then boils down to one question: “Does the challenged law violate the

suicide, it also (erroneously) affirms that those lives are not worth living, and the only “dignity” that remains is to die. It is a self-fulfilling prophecy.

⁵⁵ In this instance, the application of the Federal Criminal Law power through expansion of criteria contained in the [Criminal Code](#), RSC 1985, c C-46.

⁵⁶ [Kahkewistahaw First Nation v Taypotat](#), 2015 SCC 30 at para 19 [“*Taypotat*”].

⁵⁷ [Ibid](#) at para 20.

⁵⁸ Whether assisted suicide should properly be considered “medical care” is not settled.

⁵⁹ At this point, of course, it is impossible to point to the precise wording as it has not yet been recommended or developed.

⁶⁰ [Withler v Canada \(Attorney General\)](#), 2011 SCC 12 at paras 34, 37, 39 [“*Withler*”]; [Quebec \(Attorney General\) v A](#) 2013 SCC 5 at para 324 [“*Quebec v A*”].

⁶¹ [Quebec v A](#), *supra* note 61 at para 326.

⁶² [Ibid](#). See also paras 325, 333: Prejudice and stereotyping are not discrete elements of the test that the claimant is obliged to prove, but are indicia that may help answer whether substantive equality is violated. It is also the discriminatory impact, not the attitude at issue. In other words, it matters not whether the government intentionally discriminated.

norm of substantive equality”?⁶³ In this case, it could be altered to ask, ‘does the proposed expansion of the law violate the norm of substantive equality’?

As Christian Legal Fellowship has argued elsewhere:

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 be applied to *all persons* in the same state, regardless of whether they have requested death.⁶⁴

And as articulated in the context of physical disability and EAS decriminalization:

...the law perpetuates disadvantage. People are categorized according to their abilities and disabilities. Judgments of some regarding their worthlessness are projected onto others. The disadvantages are profound: people in this category lose the benefit of the *Criminal Code* assumption of non-consent;⁶⁵ physicians and society assume that individuals in this category prefer death; and health care systems develop different standards of suicide response and care depending on disability and disease.⁶⁶

The same applies to the categories of individuals being considered for EAS eligibility/expansion by the Council. It is discrimination that relates to personal characteristics of an individual or group, and that imposes burdens and disadvantages not imposed upon other individuals or groups, limiting access to opportunities, benefits and advantages available to others.⁶⁷ Indeed, it is more than an equality rights violation; it is a societal failing when patients, in the process of mourning a health loss (whether physical or mental) that may result in expressions of depression and despair,⁶⁸ are faced with the prejudice that, as a result, finds their lives are less worthy of protection and care.

Charter Rights of Health Care Professionals

Expanding access to euthanasia by advance requests also implicates the *Charter* rights and freedoms of health care professionals, who may have a conscientious/ethical/professional objection to administer lethal drugs to patients who are incapable of providing consent.⁶⁹ This has been the experience in the Netherlands, where one Dutch group describes the physician’s experience as follows:

⁶³ *Ibid* at para 325, citing *Withler*, *supra* note 58 at para 2.

⁶⁴ [Factum of Christian Legal Fellowship](#), Intervener in *Carter* (SCC) at para 30.

⁶⁵ *Criminal Code*, *supra* note 56, s 14.

⁶⁶ *Schutten*, *supra* note 55 at 176-177.

⁶⁷ *Law Society of British Columbia v Andrews*, [1989] 1 SCR 143 at 174.

⁶⁸ *M de Boer*, *supra* note 42 at 1033.

⁶⁹ See Deina Warren and Derek Ross, “[Physicians, conscience, and assisted dying](#)” (2017) *Policy Options*.

“Imagine...an incompetent but still alert and conscious patient with advanced dementia, to whom we cannot explain that in a long forgotten past this was what he wanted to happen to the demented person he has now become.”⁷⁰

To these physicians, ending the life of such a patient would entail “killing a person with dementia,” rather than respecting that person’s autonomy.⁷¹ Similar considerations apply in the context of administering euthanasia to minors and patients with mental illness, adding further and important justification for maintaining EAS limits in accordance with the Supreme Court’s parameters in *Carter*.

Lack of palliative care

The fundamental rights and freedoms of Canadian patients are further at risk where EAS is publicly funded and widely available, but medical care aimed at alleviating suffering - such as palliative care - is not.

In expanding access to the former and not the latter, the government is undermining meaningful options for patients to pursue a life of autonomy, dignity, and hope. It is troubling that so much emphasis has been placed, both in this consultation and in public policy generally, on ensuring and expanding access to medical assistance in **dying**, when many Canadians do not even have meaningful access to medical assistance in **living**.

Palliative care provides “many benefits for patients and their families, including: greater involvement in healthcare decisions about treatment and care; better quality-of-life; longer life; and fewer hospitalizations.”⁷²

In the EAS context, patients are experiencing suffering and/or stress at such a high level that they are considering ending their lives. If patients had access to palliative care that could adequately control their symptoms, they would often live over a premature death.⁷³ Patients who do not have such access and instead choose EAS suffer diminished autonomy and a premature death. The lack of access to palliative care, which has been judicially acknowledged⁷⁴, therefore exacerbates the *Charter* rights infringements discussed in this paper, and indeed, may itself constitute an unjustifiable violation of the *Charter* in some cases (a discussion of which is beyond the scope of this paper).

While the Supreme Court in *Carter* indicated that s. 7 does not require that “all human life be preserved at all costs”⁷⁵, it does not mean that death should be promoted as an appropriate solution to suffering,

⁷⁰ [Dresser](#), *supra* note 47 at 6.

⁷¹ C. Hertogh et al, “[Beyond a Dworkinian View on Autonomy and Advance Directives in Dementia](#),” (2007) 7 *American Journal of Bioethics* W4-W6 at W5.

⁷² McMaster University, “[The McMaster Health Forum](#)” (2013) at 4.

⁷³ See discussion in [Carter \(BCSC\)](#), *supra* note 4 at paras 821-831.

⁷⁴ In [Carter \(BCSC\)](#), *supra* note 4, at para 192 Justice Smith observed that “high quality palliative care is far from universally available in Canada” and cited evidence that “only 16-30% of Canadians receive palliative care as part of their life-threatening illness” and that “there are many places in Canada, particularly in rural or remote areas, where there is little or no access to palliative care specialist nurses or physicians.”

⁷⁵ [Carter \(SCC\)](#), *supra* note 6 at para 63.

and certainly not as a *more* accessible solution than life-enhancing treatment such as palliative care. As the Supreme Court affirmed in *Carter*, the sanctity of life is “one of our most fundamental societal values” and section 7 of the Charter is “rooted in a profound respect for the value of human life”.⁷⁶

Conclusion

In light of these submissions, CLF urges the Council to consider not only whether assisted suicide should be expanded (and CLF submits that it should not), but whether the reasons outlined above justify additional restrictions and protections within the current regime (and CLF submits that they do).

⁷⁶ [*ibid.*](#)

APPENDIX “A”**CHRISTIAN LEGAL FELLOWSHIP: RELEVANT KNOWLEDGE**

Christian Legal Fellowship (CLF) is a national charitable association representing over 700 lawyers, law students, professors, and others who support its work. Over nearly two decades, CLF has intervened in more than 20 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. CLF filed detailed legal submissions to the Ontario and Alberta governments in response to their consultation on the issue of assisted suicide and euthanasia. CLF also made submissions to the Special Joint Parliamentary Committee on Physician-Assisted Dying, and to both the House of Commons and the Senate’s Standing Committees on Bill C-14. Further details and links to each of CLF’s submissions are below:

* * *

CHRISTIAN LEGAL FELLOWSHIP: RELEVANT KNOWLEDGE

- April 2017: [Factum](#) filed jointly with the Evangelical Fellowship of Canada and the Assembly of Catholic Bishops in the case of *Christian Medical and Dental Society et al v. College of Physicians and Surgeons of Ontario*. The case involves a *Charter* challenge to (1) a Human Rights policy mandating effective referrals and obligatory emergency care even if it conflicts with conscience or religious beliefs; and (2) a Medical Assistance in Dying policy that specifically requires effective referrals for assisted suicide.
- March 2017: [Oral](#) and [written](#) submissions before Ontario's Standing Committee on Finance and Economics re the Medical Aid in Dying bill (Bill 84).
- August 2016: [Written submissions](#) urging the Government of Manitoba to introduce legislation protecting freedom of conscience for health care professionals and explaining why forcing health care providers to participate in facilitating the death of a patient would violate the *Canadian Charter of Rights and Freedoms*. The government subsequently introduced Bill C-34, *The Medical Assistance in Dying (Protection for Health Professionals and Others) Act*, which specifically protects the rights of those who refuse to aid in the provision of medical assistance in dying on the basis of his or her personal convictions.
- May 2016: Written [submission](#) filed with the Senate Standing Committee on Legal and Constitutional Affairs concerning Bill C-14.
- May 2016: Oral [submissions](#) before the federal House of Commons Standing Committee on Justice and Human Rights concerning Bill C-14.
- May 2016: Written [submission](#) filed with the federal House of Commons Standing Committee on Justice and Human Rights concerning the government's proposed assisted-dying legislation, Bill C-14.
- March 2016: Written [submission](#) filed with Alberta's Minister of Health, Minister of Seniors, Justice Minister, Solicitor General and Minister of Aboriginal Relations of Alberta in response to the provincial government's consultation concerning physician-assisted dying and end-of-life decisions.
- March 2016: [Open letter](#) to Jody Wilson-Raybould, Minister of Justice of Canada and the Auditor General of Canada, to "express concern about and to rectify certain misunderstandings reflected in the Special Joint Committee's Report regarding the scope of the *Carter* ruling and its implications for Parliament's legislative response."
- February 2016: Written [submission](#) filed with the federal Special Joint Parliamentary Committee on Physician-Assisted Dying.
- January 2016: Written [submission](#) to Ontario's Attorney General and Minister of Health in response to the provincial government's consultation concerning physician-assisted dying and end-of-life decisions.
- January 2016: Written [submission](#) concerning physician-assisted dying with the College of Physicians and Surgeons of Ontario, urging freedom of conscience for health care professionals.
- January 2016: Written [submission](#) concerning physician-assisted dying with the College of Physicians and Surgeons of New Brunswick, urging freedom of conscience for health care professionals.
- December 2015: [Factum](#) filed with the Supreme Court of Canada in "*Carter II*", urging the Court to extend time for Parliament to pass a euthanasia law and to maintain a national prohibition on euthanasia in the interim.

- November 2015: Written [submission](#) concerning physician-assisted dying with the College of Physicians and Surgeons of Manitoba, urging freedom of conscience for health care professionals.
- November 2015: Written [submission](#) in response to invitation, with the federal External Panel on Options for a Legislative Response to *Carter v. Canada*
- October 2015: Written [submission](#) concerning physician-assisted dying with the College of Physicians and Surgeons of Saskatchewan, urging freedom of conscience for health care professionals.
- September 2015: [Recommendations](#) concerning the Supreme Court's decision in *Carter* to the provincial/territorial Expert Advisory Group on Physician-Assisted Dying.
- August 2014: [Factum](#) filed with the Supreme Court of Canada in the second appeal for *Carter v Canada*.
- December 2012: [Factum](#) filed with the British Columbia Court of Appeal in the first appeal for *Carter v Canada*.
- December 2012: [Factum](#) filed with Superior Court for the District of Trois-Rivières in *Leblanc v Canada* (Quebec).
- July 2012: CLF [granted](#) the right to intervene, make written and oral submissions and cross-examine witnesses in *Leblanc v Canada (Attorney General) & Québec (Attorney General)*.
- December 2011: [Factum](#) filed with the Supreme Court of British Columbia in *Carter et al v Canada*.