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Chair

Mr. Anthony Housefather

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● (1605)

[*English*]

The Chair (Mr. Anthony Housefather (Mount Royal, Lib.)): Ladies and gentlemen, welcome to this first meeting of the Standing Committee on Justice and Human Rights related to our study of Bill C-14.

[*Translation*]

It is a great pleasure to welcome all of you here.

[*English*]

Today's subject matter is difficult. It's subject matter on which we have to reconcile autonomous rights, rights that have been set out in the charter, and rights set out in the Carter decision with the protection of the vulnerable.

The most important thing for me is that we do all of this with great respect. I know that our committee is capable of that, and I'm pleased today to welcome our first witnesses.

We have the Minister of Justice, the Honourable Jody Wilson-Raybould, and the Minister of Health, the Honourable Jane Philpott. With them, from the Department of Justice, we have William Pentney, the deputy minister and deputy attorney general; and from the Department of Health, Simon Kennedy, the deputy minister.

I'm going to turn it over to you, ministers. I'm not sure which one of you is going to speak first, but you're very welcome here.

Hon. Jody Wilson-Raybould (Minister of Justice and Attorney General of Canada): Thank you, Mr. Chair.

I will present first, and then my colleague will present after me.

First of all, I want to acknowledge you, Mr. Chair, and the members of the committee. Thank you for providing us with this important opportunity to be here to speak about Bill C-14, which responds to last year's unanimous decision of the Supreme Court of Canada in Carter v. Canada and introduces a federal framework around medical assistance in dying.

Medical assistance in dying, as you said, Mr. Chair, is a complex and deeply personal issue. Every jurisdiction in the world that permits it or has debated it has carefully considered the wide range of interests at stake. In Canada, we work within a distinct legal and constitutional framework, which includes a division of powers between provincial, territorial, and federal governments, and the Charter of Rights and Freedoms, all of which inform the government's choices as reflected in this bill.

Bill C-14 would establish criminal law rules regarding medical assistance in dying that address eligibility, procedural safeguards, and the framework for a monitoring system. The proposed legislation would re-enact sections 14 and section 241, paragraph (b), of the Criminal Code, so that it would continue to be a crime to assist another person to die or to cause another person's death with their consent, except if either of these actions were done in accordance with the rules for medical assistance in dying as set out in this bill.

Bill C-14 would exempt physicians and authorized nurse practitioners from criminal liability if they provide medical assistance in dying to an eligible person in accordance with the procedural safeguards in the legislation. It would also exempt others who might be involved in this process, such as pharmacists who fill the prescription for medication.

Importantly, the bill includes a parliamentary review five years after coming into force. The government is also committed to further studying the complex issues of medical assistance in dying in the context of advance requests, mature minors, and where a mental illness is the sole underlying medical condition, none of which were before the court in Carter.

The government chose this approach after thoroughly considering the full range of potential options for a medical-assistance-in-dying regime. As noted in our legislative background paper, which I tabled at second reading, this included analyzing and comparing regimes in other jurisdictions, including Quebec's legislation, certain American states, several European countries, the country of Colombia, and others.

The government also relied on consultations conducted in this country, including the work of the special joint committee, the external panel, the provincial-territorial expert advisory group, and Quebec's multi-year study that informed the development of that province's own legislation. We also engaged and consulted with a wide array of stakeholders.

With the benefit of all this evidence and knowledge, which exceeds even the detailed record that was before the Supreme Court of Canada in the Carter case, the government has thoughtfully addressed this issue. Bill C-14 would allow for greater flexibility than the laws that exist in the United States, which are limited to terminally ill patients. At the same time, it does not go as far as some of the more permissive regimes in European countries. As the court noted in its Carter decision, “Complex regulatory regimes”—such as this—“are better created by Parliament than by the courts.”

Bill C-14 is fair and practical, and presents a balanced approach.

In terms of eligibility. I'm aware the requirement that a person's natural death be “reasonably foreseeable” has received some attention, including in terms of how it relates to the Carter decision. I would like to address these concerns.

The bill was deliberately drafted to respond to the circumstances that were the focus of the Carter case, where the court only heard evidence about people with late-stage incurable illnesses who were in physical decline and whose natural deaths were approaching. The court said the complete prohibition on assisted dying was a violation of charter rights for persons in these circumstances. In this way, the eligibility criteria in Bill C-14 comply with the Carter decision. They focus on the entirety of the person's medical circumstances and not on the specific list of approved conditions or illnesses.

● (1610)

By defining the term “grievous and irremediable medical condition”, the bill would ensure that all competent adults who are in an irreversible decline while on a path toward their death would be able to choose a peaceful, medically assisted death, whether or not they suffer from a fatal or terminal condition.

A person can be approaching a natural death based on medical circumstances that are not directly related to a serious, incurable illness, for example. As well, eligibility does not depend on a person's having a given amount of time remaining, such as a certain number of weeks or months to live, as in the United States. Reasonable foreseeability of death is ultimately a medical decision, and not a legal one, to be made by taking into account all of the person's medical circumstances, including the types and number of medical conditions, frailty, age, etc.

The vice-president of the Canadian Medical Association has confirmed that reasonable foreseeability of death is a standard that provides sufficient guidance to physicians and nurse practitioners by taking out a lot of the subjectivity that was left by the court's undefined concept of a grievous condition, while allowing those with the necessary medical knowledge and expertise to make the decisions based on the individual circumstances of each case.

There are other compelling reasons for there to be a requirement that the person's natural death be reasonably foreseeable. First, it provides a fair way to restrict eligibility without making assisted dying available to almost everyone. Second, restricting eligibility in this way is necessary to protect the vulnerable.

Other approaches to eligibility that were proposed and suggested would be arbitrary. For example, it would be arbitrary to permit people with degenerative but non-fatal conditions to have access to medical assistance in dying before their deaths have become reasonably foreseeable, while excluding individuals with mental illness alone, or those born with a physical disability, or those suffering physically or psychologically for any other reason. These are not viable options, in our opinion, as they discriminate on the basis of a person's medical condition from the outset rather than allowing the medical practitioner to consider all of the person's circumstances.

Others have suggested that the government should grant access liberally, based on the subjective experience of suffering of each individual and the right to choose when life ceases to have meaning, with little in the way of objective parameters related to their condition or safeguards. Our government firmly believes that medical assistance in dying should not be available for any and all types of suffering. If that were the case, the risk to vulnerable people would be greatly increased and, frankly, would be unacceptable. Such an approach could contribute to the stigmatization of persons with disabilities; it could undermine suicide prevention; and it could lead marginalized or lonely individuals to seek medical assistance to end their lives prematurely.

As the court noted in Carter, when crafting legislation, Parliament must balance and weigh the perspective of those who might be at risk in a permissive regime. Our government respects the Supreme Court of Canada, and believes that in legislating in this incredibly complex and personal area, we must be concerned with protecting the dignity of these Canadians' lives.

This is why the criteria in the bill address the full range of medical circumstances that can make a person's death reasonably foreseeable. In doing so, the law sends a clear message about the intended purpose of medical assistance in dying: to give competent adults who are in a path toward their natural death the choice of a peaceful passing. It also provides maximum flexibility for medical assessment to health care providers, both in terms of the circumstances that led a person to be on a trajectory toward death and in terms of the time during which they can seek medically assisted death.

I want to emphasize the importance of having a legislative response in place before June 6, 2016, when the court's declaration of invalidity expires. Without a new law, on June 6 the parameters of the Carter decision would come into effect.

● (1615)

The scope of the decision is uncertain in several respects and, as a result, there would be uncertainty as to how it would be applied in practice. Assuming for a moment that the Carter decision read down in section 14 and section 241, paragraph (b), of the Criminal Code so that except for medical assistance in dying these criminal laws would be in force, sufficient uncertainty would still remain.

First, given that in the medical community there is no common understanding of a “grievous and irremediable” condition, it would become difficult for a patient who would be eligible under Bill C-14 to gain access to medical assistance in dying. Without a clear law in place, some physicians who may otherwise be willing to provide it could refuse to do so because they are not clear on who properly qualifies.

As well, failing to define the Carter parameters with federal legislation could lead to a wide variation on how eligibility is applied, not only between provinces or regions, but within them. Access in remote and rural areas would be negatively affected, not only because physicians may be unwilling to provide medical assistance in dying in such an uncertain legal environment, but also because, under the Carter decision, nurse practitioners are not able to provide assistance.

Second, the current interim court approval process will end on June 6. Therefore, outside of Quebec, there would be no legally binding framework to govern medical assistance in dying in Canada. In other words, there would be no mandatory procedural safeguards to prevent abuses and protect vulnerable persons.

Guidelines published by medical regulators are not binding, nor are they uniform, which further risks creating a patchwork across Canada. This can pose very serious public safety risks. For instance, a patient could both request and receive medical assistance in dying on the same day. Without going through an exhaustive list of risks, needless to say, it would be irresponsible to let June 6 come and go without a federal law in place.

As the court made clear in paragraph 117 of Carter, “the risks associated with physician-assisted death can be limited through a carefully designed and monitored system of safeguards”. Bill C-14 provides a responsible and balanced framework that limits those risks and puts in place those safeguards.

I certainly welcome the opportunity to discuss this bill and contribute to your study of the proposed legislation. The approach in Bill C-14 responds to the Carter decision with what I believe is sensitivity in all of the issues that were before the court in this case and creates a responsible and fair legal framework to permit medical assistance in dying in Canada for the first time in our country's history.

Now, with your permission, Mr. Chair, I would like to turn it over to Minister Philpott.

● (1620)

The Chair: Thank you very much, Minister Wilson-Raybould.

[*Translation*]

Madam Minister of Health, you have the floor.

Hon. Jane Philpott (Minister of Health): Thank you, Mr. Chair.

I will be making a few comments in French as well, for those who need the earphones.

[*English*]

Mr. Chair and honourable committee members, thank you for the opportunity to appear before you this afternoon. I am very pleased to be here with my colleague to discuss this important subject of medical assistance in dying.

I think that each of us around this table would not deny the monumental nature of the piece of legislation with which we are involved. This speaks to the profound and solemn nature of our responsibility as representatives of the people of Canada to make wise decisions, and I thank you for sharing with us in this process and look forward to your comments and questions.

Conversations about the end of life can be incredibly challenging. I can say that from personal experience, and I know that all of you have had similar experiences and have your own personal stories about end-of-life conversations, yet it's a vital conversation that we need to participate in as individuals, as members of Parliament, and as a society.

They are difficult conversations for health care providers as well. Health care providers may not have had an education that has adequately prepared them for discussing this, let alone providing the supports that patients need at the end of life. As we strive to meet the needs of Canadians at the end of life, we also encounter a system that can often frustrate the attempts of people to live out their personal autonomy.

[*Translation*]

We all want a system where respect for personal autonomy is a cornerstone of all policies. We also want a system where the rights of the most vulnerable are respected and protected. This legislation is one important piece of the puzzle when it comes to ensuring that Canadians have access to not only a good life, but also a good death.

[*English*]

It's about empowering patients to take control of their own narrative and ensuring that Canadians can receive compassionate care as they approach the end of life.

As you well know, we listened to what Canadians and stakeholders had to say before we developed this legislation. We reviewed it closely to ensure consistency with the charter. We looked closely at the Carter decision to ensure that individuals in similar circumstances would have access to care that would alleviate suffering, including the option for medical assistance in dying.

In the course of this debate and since the introduction of this bill, we have heard from several parliamentarians and many stakeholders. Some have had concerns that the legislation goes too far, and we acknowledge that for many the new reality in the post-Carter era is an unfamiliar one and will heighten anxieties about how we protect the most vulnerable in society.

[*Translation*]

I want to assure those Canadians that we acknowledge their concerns, and we believe that the safeguards in place in this bill will ensure that we protect the rights of those most at risk.

[*English*]

We've also heard from others who feel that the proposed legislation does not go far enough and who would like to see expanded eligibility in certain areas, and we would also like to thank these Canadians for speaking up on behalf of those who are suffering.

Our commitment as a government was to respond to the Carter decision. This necessitates changes to the Criminal Code that will protect health care professionals as they support patients in their decision-making. At the same time, we are committed to taking time to address additional questions that are more complex and where more time and study are needed.

[*Translation*]

For instance, the proposed legislation sets the minimum eligible age for decision-making at 18—the age of majority in most provinces and territories. We believe this is appropriate, given the unique and irreversible nature of this decision. We know that the capacity to make health care decisions is not tied strictly to age and that depending on the province, children as young as 14 have had the right to refuse or consent to medical treatment.

● (1625)

[*English*]

Given the divergence of opinion on this issue among Canadians and stakeholders, the special joint committee, as you know, called for further study and broad-based consultations on the issue surrounding the concept of mature minors. Our proposed legislation reflects that guidance and the need to tread carefully; however, we acknowledge the difficult situations that mature minors and their families face at the end of life, and we commit to taking the necessary time to study this matter in the months to come.

We faced similar challenges in considering the issue of advance directives. The Supreme Court did not deal with this issue in Carter, and the views of Canadians and stakeholders, as you know, are divided. I understand the hardship for those Canadians who fear that after being diagnosed with a disease such as dementia they may experience a decline that could compromise their dignity. This has led to pleas to allow people to make requests for medical assistance in dying well in advance of the time when the person is no longer competent to make or reaffirm a desire to accelerate their own death.

I had the opportunity to meet with a group called Dying With Dignity recently to understand their perspective and the thoughtfulness with which they presented their case.

[*Translation*]

After 30 years of practising medicine, I am well aware of the concerns of Canadians who endure suffering at the end of life, and understand why some would contemplate using advance requests to seek medical assistance in dying. However, we must consider the complex policy and medical practice issues raised by advance requests.

[*English*]

By their very nature, advance requests are made before they're needed. Even if reviewed regularly, they would be an enacted only when a person has lost competence or is no longer able to communicate. This means that the final consent, a key requirement in most assisted-dying regimes around the world, could not be verified by a health care provider or anyone else.

[*Translation*]

Health care stakeholder groups have cautioned that advance directives for other forms of medical treatment can be very difficult to respect in practice, and the implications would be more significant in the case of assisted dying.

[*English*]

As June 6 approaches, we have limited time to better understand how advance directives would work in practice. Determining how they would be carried out would require extensive consultations with Canadians, stakeholders, medical professionals, regulatory bodies, provinces, and territories. In light of these circumstances, we are proposing to explore this issue with further study.

The proposed legislation also does not permit eligibility solely on the basis of suffering from mental illness. There's no denying that mental illness can cause profound suffering, but illnesses such as chronic depression, cognitive disorders, and schizophrenia raise particular concerns with respect to informed decision making.

We've consulted with numerous stakeholders on this issue and have concluded that the nuances are not sufficiently understood at this time to allow safe and appropriate legislation to be crafted.

To that end, the government is making a commitment to mandate one or more independent studies on the questions of requests by mature minors, advance requests, or requests for mental illness as the sole underlying medical condition.

Bill C-14 also includes a clause that requires Parliament to conduct a review of the legislation five years after royal assent. This will allow for a parliamentary review of the complex issues, as well as the evolving experience of Canadians in implementing medical assistance in dying.

Finally, one cannot discuss this legislation without a reaffirmation of the importance of improving access to high-quality palliative care for all Canadians. Our government is firmly committed to investing in this area, and I look forward to working with provinces and territories to ensure equitable access to all options for care at the end of life.

[*Translation*]

In closing, we believe this proposed legislation values the personal autonomy of Canadians, in line with the Supreme Court's decision in Carter, while ensuring the protection of vulnerable Canadians and the conscience rights of providers.

[*English*]

I want to thank all of you and others who have engaged thoughtfully and respectfully on this challenging issue. I know this committee is going to hear a range of views and opinions in the coming days and weeks.

I thank you for your consideration. I look forward to your responses.

● (1630)

[*Translation*]

I welcome any questions you may have.

[*English*]

The Chair: Thank you very much, Madam Minister. We very much appreciate both of you agreeing to come here today and be our first witnesses. As you mentioned, we're going to be hearing from over 40 witnesses in the course of this week. We also understand the importance of getting this done quickly, and we're trying to fulfill that by meeting the extra hours that we are.

Now we're going to have our panels of questioners. There are going to be 50 minutes of questions, and in the first round you're going to get six minutes from the Conservatives, six from the Liberals, six from the NDP, and six from the Liberals.

I'm going to turn it over to Mr. Cooper, who will be the first questioner.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you, honourable ministers, for your presentations this afternoon. I know that all honourable members appreciate your attendance.

The legislation, in my opinion, contains some very good provisions, but there are some areas I do have some concerns about.

One of the areas I have some concern about is the safeguards for persons with underlying mental health challenges. As the legislation currently stands, two nurse practitioners or two physicians could determine whether or not a patient meets the criteria for access to physician-assisted dying.

One of the issues we heard about at the special joint committee was that physicians may be able to diagnose underlying mental health challenges. To take the next step of determining capacity to consent for persons with underlying mental health challenges, there was some evidence that someone more specialized, such as a psychiatrist, might be involved.

I was wondering why a safeguard along those lines was not included in the legislation and what your comments are.

Hon. Jane Philpott: Thank you for that question. It's an important one.

The legislation makes it clear that it needs to be an adult who is capable of giving consent and informed consent at that. You are right that in some cases, such as in the case of mental illness, the illness may be such that it compromises a person's capacity. This decision will rely on the good judgment of professionals who are in the business of establishing capacity.

As you have indicated, there are a number of specialists who sometimes need to be called in and consulted on a case-by-case basis if the clarity of a person's capacity is not there. Certainly one would assume the medical professional in this case would determine that the person is capable. If there were any doubt and question, this would not stop them. There would be nothing in the legislation that would prevent someone from making a determination by an extra step to confirm a person's capacity.

Hon. Jody Wilson-Raybould: As the minister indicated in her remarks, if we're speaking about a person with mental illness alone, this is the subject for further study that we're proposing in the legislation, taking into account those considerations.

Mr. Michael Cooper: The legislation doesn't preclude someone with an underlying mental health challenge from access to physician-assisted dying if they have a physical condition—and I think that's absolutely right. But why not include a safeguard along the lines of saying that if a physician identifies that a patient has an underlying mental health condition, they be referred to a psychiatrist? The psychiatrist would undertake an evaluation and provide a report verifying that the person does have the capacity to consent.

That would seem to be a pretty simple safeguard that would go a long way to protecting vulnerable persons.

Hon. Jody Wilson-Raybould: Maybe I can speak to that, and then Minister Philpott may want to add something.

For the elements in terms of eligibility, as you've rightly indicated, one condition could be a person who's suffering from mental illness, but the elements need to be considered in the totality of the symptoms and the suffering of the individual patient.

In terms of consent, there is the requirement for clearly consenting to a medical practitioner in being able to access medical assistance in dying. If there were questions with respect to the ability of that person to consent, again, we would leave it up to the competence of medical practitioners to be able to make that determination.

Mr. Michael Cooper: I'll move on to another area of concern, which is the need to balance on the one hand the charter rights of patients, but also the charter rights of physicians and allied health professionals. The need for that balance was expressly recognized by the Supreme Court in paragraph 132 of the Carter decision.

I guess I'm a little bit concerned that the legislation doesn't contain conscience protections. Instead, this has been left to the provinces, to colleges, to professional regulating bodies. I'm wondering if you might be able to comment on why you've chosen to effectively pass the buck on to the provinces on something as important as protecting what are fundamental freedoms under the section 2 charter rights.

● (1635)

Hon. Jody Wilson-Raybould: I know that the question of conscience rights of medical practitioners is one that has been raised in many forums. Certainly it was raised at the special joint committee.

Nothing in our legislation would compel a medical practitioner to perform medical assistance in dying. As you point out, the regulatory jurisdiction falls to the provinces and territories. Having said that, I know that my colleague, Minister Philpott, will continue to work extremely collaboratively, as she has been, with the provinces and territories to assist them where possible in ensuring that there is that comprehensive regulatory framework put in place.

Hon. Jane Philpott: I would just underline—this is not within the legislation, but you've probably heard us talking about this around the topic of conscience rights—that recognizing both the fact that we are committed to upholding the conscience rights of health care providers and at the same time making sure that Canadians will have access to options for care, we have made it clear to the provinces and territories, and are in fact already working with them on developing a care coordination system for end-of-life care, that we'll ensure that if a person is in a situation where their particular provider does not feel, for reasons of conscience, that they want to participate, we would put a mechanism in place. This has been greeted with great enthusiasm by medical associations and by provinces and territories. I look forward to giving you more details as that develops.

The Chair: We'll move to Mr. Hussen.

Mr. Ahmed Hussen (York South—Weston, Lib.): Minister Wilson-Raybould, under proposed subsection 241(5) in the Criminal Code, any person who aids another person to self-administer a substance prescribed as part of medical assistance in dying is excluded from liability.

In your opinion, does allowing non-medical personnel to assist with medical assistance in dying increase the risk that a vulnerable person may be coerced to end his or her life?

Hon. Jody Wilson-Raybould: In terms of the overall safeguards put into the proposed legislation, the compliance with the eligibility criteria and with the safeguards would be left up to medical practitioners to determine. There are specific exemptions for pharmacists, for example, or persons who assist in the self-administration of any form of medication, but the requirements and the strict compliance with the safeguards would be determined by a medical practitioner.

Mr. Ahmed Hussen: In your opinion, does Bill C-14 adequately balance the principles of autonomy and the protection of vulnerable individuals? Please explain why or why not, and describe any improvements that could be made to the bill in this respect.

Hon. Jody Wilson-Raybould: We're confident this proposed legislation strikes the right balance and presents the best solution for Canada in recognizing individual autonomy and the protection of the vulnerable.

The Supreme Court said two things. One was that an absolute prohibition on medical assistance in dying is unconstitutional. The second thing they said was to Parliament, that we put a solution in place to provide for medical assistance in dying.

I have to say, and I think every person member around this table would agree, that this is an extremely complex and difficult issue. We have been careful to ensure that we adhere to the Supreme Court's decision in Carter, as well as to ensure that we balance the rights of individuals who could be more vulnerable.

We believe we have put forward the best solution for this country right now. It is really a paradigm shift in talking about death. It's a necessary conversation that isn't going to stop with the potential passage of this legislation, but will continue.

● (1640)

Hon. Jane Philpott: I will add to that, because I think it's helpful to understand how we came to the decision you see before you in Bill C-14.

The request for personal autonomy was heard loud and clear. We heard it from the folks who were involved in the Carter case, and we are obviously very sensitive to their desires and the desires of others like them who want to have that personal autonomy.

Where Minister Wilson-Raybould and I felt particularly burdened was how we could make sure that we provided for that personal autonomy, while very much feeling the weight of the life and death decisions that were also on our shoulders in terms of the protection of not simply individuals, but society as a whole. I think you'll see that reflected in the legislation.

We are fundamentally committed to making sure people can, in a sense, write their own stories and write the final chapter of their lives as much as possible, but we felt a real weight with the fact this would be the end of people's lives. We need to make sure that appropriate safeguards are in place so that nobody comes to the end of their life without adequate protection. We as a government, and we as parliamentarians, have a responsibility to uphold that solemn responsibility.

If we had more time, I'd love to tell you a bit more about that. We undertook this with a deep sense of obligation to protect not only individuals and their rights, but also society as a whole and the challenges there.

The Chair: You have about 40 seconds left. Do you have a short question?

Mr. Ahmed Hussen: Quickly, under the framework established by Bill C-14, a provincial health care facility could choose not to provide medical assistance in dying. I'd like to know what your views are on that.

Hon. Jane Philpott: For a province?

Mr. Ahmed Hussen: Yes, a provincial health care facility could choose not to provide medical assistance in dying.

Hon. Jane Philpott: As you know, the delivery of health care is in the domain of the provinces and territories. In introducing this bill, we've made it clear that the federal government acknowledges that medical assistance in dying is to be considered a medically necessary service. With any other medically necessary service, we expect provinces to act within the Canada Health Act and to be sure that all Canadians have access to these particular options for care. We will work with the provinces and territories to make sure Canadians have the access they require.

The Chair: Mr. Rankin.

Mr. Murray Rankin (Victoria, NDP): I would like to start by acknowledging the leadership of both ministers in this very sensitive area.

I want to talk about a particular issue, and that is people who have a major physical disability, but who otherwise are in good health and who will not be able to avail themselves of medical aid in dying. Maybe I could ground this in a particular example. This was a story before Madam Justice Smith of the B.C. Supreme Court. It's the tragic story of a gentleman named Tony Nicklinson, who suffered a massive stroke in the prime of his life and was left with what's called “locked-in syndrome”. The only muscles in his body that he could move were his eyelids, and he managed to type out his affidavit by blinking. He was a person who otherwise was in good physical condition and would live a long time. In other words, he would not be the kind of person who under the law as drafted would be able to say that his natural death had become reasonably foreseeable at all. Sadly, Mr. Nicklinson starved himself to death because he was unable to use the services of physician-assisted dying.

Would you be open to amending the bill to allow people like Mr. Nicklinson to avail themselves of this service? The claim I make is that the Supreme Court of Canada did not require there to be a terminal illness as a condition for this service. This particular bill, as drafted, would not allow that service for people who were physically disabled, but otherwise in good health. If you accept that, and if you agree that the situation is really quite disturbing for people like Mr. Nicklinson, would you be willing to amend the bill to address that?

● (1645)

Hon. Jody Wilson-Raybould: Maybe I can start to answer your question. I'll start by saying that, without question, we acknowledge that there are people who suffer in many different ways. After hearing from many stakeholders, reviewing reports, and benefiting from the work of the special joint committee, our government presented the best option we could. We look forward to the substantive debate and discussion that will happen at this committee.

What we sought to do in providing eligibility criteria and further defining what the Supreme Court of Canada didn't do in terms of “grievous and irremediable” was to put elements around what that means. Those elements in this proposed legislation would need to be taken into account as part of the broad medical circumstances of a particular individual. The aim or the object of our legislation is to draw a balance between personal autonomy and the protection of the vulnerable. That's why we put these criteria in place.

Mr. Murray Rankin: Do you accept that the addition of the phrase “reasonably foreseeable natural death”, which is found nowhere in the Carter decision, really goes at cross-purposes to what the Supreme Court would have permitted people like Mr. Nicklinson to do? Do you accept that this is inconsistent with the Supreme Court's decision, which did not require terminality, or do you see this as in fact what the Supreme Court intended?

Hon. Jody Wilson-Raybould: In terms of the proposed legislation, we're responding to the decision of the Supreme Court of Canada in Carter, and I want to acknowledge Gloria Taylor and Kay Carter for their efforts to bring this discussion before us. Both of those women were at the end of their lives or suffering grievous and irremediable medical conditions. With this proposed legislation, we have responded to those specific circumstances in that case and have had the benefit of engaging with Canadian stakeholders, medical practitioners, and others to find the right balance between personal autonomy and protection of the vulnerable.

Mr. Murray Rankin: Because the time is so limited, let me ask a question on another topic.

Today's *Globe and Mail* has an article by UBC professor of medicine Dr. Jesse Pewarchuk, who talks about the issue that I also wanted to raise, that of advance requests, or so-called advance directives, which, as you know, is something that was recommended by the Senate-House committee. Dr. Pewarchuk writes as follows:

> Bill C-14’s biggest flaw is that it forces the hand of those who have a progressive disease that relentlessly and predictably results in lost mental capacity to consent. Alzheimer’s patients can expect, with virtual certainty, to lose the capacity to make medical decisions over time.

He claims that “the wording of the proposed law introduces... doubt as to whether an Alzheimer’s patient who has yet to lose capacity (yet is certain to) would even be eligible, since death can take years...”. He says that “foreseeable death” and “advanced state of decline in capability”, the phrases in the definition in the bill, “are loaded, ambiguous clauses that seem to eliminate the Charter rights of dementia patients to be eligible...”.

Would you consider advance directives to address that problem?

● (1650)

Hon. Jane Philpott: As you know, we've identified the matter of advance directives as being one of the most contentious issues related to this legislation. We've also acknowledged the fact that there isn't a broad international consensus on the basis of countries where advance directives have been put in place; there are still some challenges around that. We wanted to make a decision that was based on solid evidence that adequate protection could be put in place. As I indicated in my comments, I recognize people's concerns around this and why it is desirable.

Even in the matter of advance directives other than those associated with medical assistance in dying, we hear from medical practitioners and families the real challenges around implementing directives in the case of someone who has reached the point where they no longer have capacity to reaffirm their desires at that particular point in time. I'll simply acknowledge that it is challenging.

I think that on the matter of things like dementia, for instance, one of the real challenges—and you've heard me speak to this repeatedly—is that people fear the loss of dignity that happens. They fear that they will get into a position where they will be a burden on their families or where they won't be able to care for themselves. To me, one of the things, in addition to the fact that we're going to study this in an ongoing way and we're absolutely committed to that, is that we need to do better at caring for people with dementia, for example. We need to make sure that all Canadians are able to live a dignified life and that they are cared for in a place where people respect them as human beings.

Those are some of the things that I think will happen in addition to further study of this matter.

Mr. Murray Rankin: Can I ask a further quick question, Mr. Chair?

The Chair: Yes, a quick one.

Mr. Murray Rankin: Recommendation 12 of the joint special committee was that physician-assisted dying be carried out by two physicians. It contemplated nurse practitioners playing a role, but by my reading the bill establishes that two independent nurse practitioners could fulfill all the steps.

In other words, if I'm correct, Canada would be, if this bill passes, the first jurisdiction where physician-assisted dying could occur without the involvement of a physician at any stage. If that is an accurate understanding, is that the intention of this bill?

Hon. Jane Philpott: As you know, the regulations of health care providers are determined by provincial and territorial regulatory bodies. To a certain extent, we're treading into provincial and territorial territory here.

One of the reasons we made it clear in the legislation that nurse practitioners could be the providers who would institute this—if it were deemed by their provinces to be an appropriate part of their scope of practice—was the concern about access, that is, that there are many places in this country where it's impossible to find a physician.

We will again work with the provinces and territories, and they will have to make decisions as whether that will in fact fall within the scope of practice of their nurses and nurse practitioners, but it is foreseeable. There are many, many similar kinds of acts that have been delegated safely to nurse practitioners. It's certainly something that physicians recognize: that for a nurse practitioner who is appropriately trained, this can fall within their scope.

The Chair: I have a quick clean-up question on one of Mr. Rankin's questions.

Minister Wilson-Raybould, Mr. Rankin asked if you felt that the requirement for death to be reasonably foreseeable was consistent with the Carter decision. In previous statements that you've made and in your speech in the House last week, I think you do feel that it's consistent. Can you clarify that?

Hon. Jody Wilson-Raybould: Sure. I'm happy to have further discussions with respect to reasonable foreseeability.

We were seeking to further define grievous and irremediable. When speaking about reasonable foreseeability, it must be read in light of the other elements that are contained within the definition. A patient must be on a trajectory towards death. We purposely drafted the proposed legislation this way to provide a degree of flexibility in the legislation that would enable medical practitioners, doctors or nurse practitioners, to be able to determine, based on the closeness of their relationship, on a case-by-case basis, with their patients, based on their medical expertise, their ethics, and their closeness in terms of the individual patient's circumstances, to be able to make that determination in terms of reasonably foreseeable.

We specifically did not put a time frame around reasonable foreseeability, as they have in other jurisdictions, as I mentioned, but left it to medical professionals to determine based on the individual circumstances, as I've mentioned.

● (1655)

The Chair: Mr. Bittle.

Mr. Chris Bittle (St. Catharines, Lib.): Minister Wilson-Raybould, I wanted to commend you and your department for releasing the legislative background behind Bill C-14. I appreciate the commitment to openness and transparency. I think we can all agree that it's contributed to a significant debate across Canada, and will contribute to an intense discussion around this table.

Could you highlight to the committee the importance of this review, and address any of the possible concerns raised in it?

Hon. Jody Wilson-Raybould: Is that in terms of the explanatory paper we put out?

Mr. Chris Bittle: Yes.

Hon. Jody Wilson-Raybould: As my colleague Minister Philpott indicated, this was a substantive dialogue she and I had, that we engage with stakeholders. We took into account all of the reports that are out there and reviewed practices in other jurisdictions.

I felt, as Minister of Justice, that it's important, in terms of being open and transparent, as you say, to put out all of the considerations that we undertook and considered to put together the proposed legislation, including looking at the charter and charter considerations. We feel and trust that Canadians can engage in these fundamental discussions around an issue that is so complex and personal, and it's incredibly important to be able to put out as much information as we can to enable that discussion, to enable an understanding of the depth of the information that was considered with respect to how we came up with the proposed legislation that we did, and the balance that we've sought to draw in terms of our responsibilities as parliamentarians in responding to the Supreme Court decision as well.

Mr. Chris Bittle: I'd like to open up my next question to both ministers. Perhaps you can provide some clarification with regard to the safeguards section of the bill and the 15-day waiting period. In the bill it's marked as “15 clear days”, which may in fact become 16 or 17 days, depending on how you look at it from a legal standpoint.

I'm concerned that forcing someone to wait 15 days, 16 days, 17 days in a typical case, while they're suffering and in pain, may be arbitrary and have issues under section 7, and may even be cruel and unusual.

Can you elaborate on the importance of this section and your interpretation of it?

Hon. Jody Wilson-Raybould: Sure. I'll speak to it briefly and then turn it over to Minister Philpott.

We put in place the 15-day waiting period as essentially a period of reflection, so a patient who wants to access medical assistance in dying will be able to do so, but there would be that period of time where they can reflect on their decision. We did put into the proposed legislation the ability for a medical practitioner, taking into account the circumstances of their patient, to abridge that to a shorter period of time, depending on the health at the time of the individual.

Hon. Jane Philpott: I think the only other thing I would add is that it's my understanding that there is no other legislation in the world on the matter of assistance in dying that does not have a mandatory waiting period. I believe 15 days is roughly the standard.

As Minister Wilson-Raybould has said, it makes it very clear in here that if medical practitioners feel that for some reason the person is about to lose capacity, or death is imminent, it can be abbreviated.

Mr. Chris Bittle: Would you say the inclusion of a mandatory five-year review in the legislation allows for this bill to be a first step, and that future amendments could further eliminate any concerns parliamentarians and Canadians may have?

Hon. Jody Wilson-Raybould: As I said earlier, this is a paradigm shift. This is a transformation in the discussions that we Canadians are having around death and medical assistance in dying. The provision of the five-year review that is clearly laid out and the preamble indicate that we're going to study other issues with respect to medical assistance in dying. This conversation is going to continue. Canadians will not let us not continue to have this conversation, to ensure we continue to address issues like advance directives, mature minors, or mental illness alone.

● (1700)

Hon. Jane Philpott: My only other comment would be that I would not want to give any indication that we are presupposing any decision of those committees. Our commitment to move forward with one or more committees on this is not any kind of indication on our part of making an assumption as to what the conclusions of those committees would be. If we felt that we knew what the conclusions would be, then we would have done things differently in the legislation. These really are open-ended questions.

The other thing I would say is that one thing I'd look forward to, and I suspect you do as well, is that we have made a commitment to a pan-Canadian data and surveillance monitoring plan. I will work with my department on this from the very beginning. I think there will be some extremely interesting information in that. I'd be happy to hear your suggestions as to the kinds of things that should be in that. I want it to be a robust process to include enough information so we'll know, for instance, how many 17-year olds made requests that we weren't able to meet, or how many people would have liked to see a different variation on what the process was like. I think that will be extremely valuable in the review process.

[*Translation*]

The Chair: Thank you.

We will now start our second round of questions, starting with Mr. Fraser.

Mr. Colin Fraser (West Nova, Lib.): Thank you, Mr. Chair.

I also want to thank ministers Wilson-Raybould and Philpott for having come to meet with us today, and for their presentations.

[*English*]

I'd also like to thank you very much for your thoughtful comments and work on this difficult issue. I know that we, as parliamentarians, have heard from many Canadians on all sides of this difficult issue. We want to do our best to make sure we have a law that Canadians have confidence in and that will see us move forward on this important decision by the Supreme Court of Canada. Thank you for your thoughtfulness and your assistance in that regard.

I'd like to begin by asking a question regarding section 7 of the Charter of Rights. That argument, and we heard it in the Carter decision, is that some would be forced to choose between ending life prematurely by committing suicide or continuing to suffer until natural death once they loose capacity to do it themselves or capacity to consent to receiving medical assistance and dying.

I'd like to hear your thoughts on whether this section 7 problem still exists with the lack of advance directives in the current bill.

Hon. Jody Wilson-Raybould: As we spoke about earlier, we sought to provide explanations in what we included and didn't include in the legislation, as well as looking at charter considerations around reasonable foreseeability, advance directives, and other issues.

It is my view that we are going to further study these issues and that this proposed piece of legislation directly responds to the factual circumstances with respect to the Carter decision. The object of this bill is to provide a peaceful passage to death. We recognize that there are other considerations and other views. It is for those reasons, and the reasons that Minister Philpott indicated, that we need to do further studies to look at advance directives. We need to understand the risks and the benefits that come from advance directives in terms of people's ability to make informed consent.

This proposed piece of legislation is about approaching the end of life and providing the vehicle and the mechanisms to enable people to have that peaceful passage.

Hon. Jane Philpott: With all respect for the decision, I think it's most unfortunate if someone's in a situation where there really are only two choices, and one is to continue suffering, and the second is to seek assistance in dying. In fact, as much as possible, while recognizing that there will always be suffering in life, I think we also need to find a way of making sure there are provisions to alleviate suffering that may not include assistance in dying.

I think you will be tired of hearing me talk about this, but palliation is a term that needs to be applied not only in the sense of palliation at the end of life, but applied more generally. We must find a way to do a better job so that people don't find themselves in a situation where their only choices are either to end their life or to continue to exist in suffering. I believe we can do much better on that.

● (1705)

Mr. Colin Fraser: Moving on to the terminology of “reasonably foreseeable death” in the bill, that would be for someone who perhaps does not have a terminal illness, but their death is reasonably foreseeable on their current trajectory. Can you help me understand how a medical practitioner would be able to know if that person qualifies under the current bill? Is there any concern that if, for example, a lawyer were going to give advice to a medical practitioner regarding the current state of the bill, they may be very reluctant to say that it's okay and that a medical practitioner was on safe ground here? My worry would be that you would see a lack of access because there may be medical practitioners who might be unclear on the state of the law without our specifying more clearly what “reasonably foreseeable death” means. Could you comment on that, please?

Hon. Jane Philpott: I know you will have other witnesses you will be able to ask about this as well.

Certainly I can speak for the medical practitioners that I've talked to, including medical associations that represent large bodies of physicians, for instance, who have responded very positively to the concept of reasonable foreseeability, and have felt that it's a good choice of terms. Practitioners are comfortable with this for the most part.

We had three choices. We could have said nothing about the proximity of death. We could have specified a specific amount of time—six months or 12 months. However, the concept of reasonable foreseeability is a concept that respects the professional judgment of a health care provider. I'm glancing at some of my notes from when I spoke to representatives of the Canadian Medical Association, who felt that one of the things they liked about it was the fact that we can't cover all eventualities. It's very difficult in legislation to speak to all of those individual cases that might exist. As Minister Wilson-Raybould talked about, it was a way of defining just how grievous a condition is to ensure that we didn't include, for instance, a benign or an episodic type of condition, but a condition that put the person on a trajectory toward death.

As I said, we've had very positive responses to that. I have not had any requests from medical associations that this be removed for some reason. It was felt to be very respectful.

Mr. Colin Fraser: Paragraph 127 in Carter v. Canada expressly provides that a patient not be required to undertake treatments that are not acceptable to that individual. In the bill, an irremediable medical condition includes the term “incurable” as one of the ways of defining it, but it doesn't go on to say that the patient not be required to undertake treatment not acceptable to the individual. I'm wondering why that's not in the bill, and if thought was given to that.

Hon. Jody Wilson-Raybould: Thought was given to that, and “incurable” has the same connotations as “irremediable”. In that same proposed section, paragraph (c) does refer to “enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable”. I think that speaks to the point that you've raised, so it's contained there.

The Chair: Mr. Falk.

Mr. Ted Falk (Provencher, CPC): I want to thank Minister Raybould and Minister Philpott for coming to committee and for the work they've done on this file to date.

This whole issue of physician-assisted suicide is an issue of ethics and an issue of morality in addition to being a health issue. I think when we take ethics and morality out of it, it becomes much easier to deal with, but the fact is we can't do that. We cannot take ethics and morality out of the issue.

We've seen a decline in our country over some of our moral values. We've seen an obliteration of the value of life from conception to birth, and now we're seeing a diminishing value of life in sickness and at the end of life during sickness and for the elderly.

I think we're on a slippery slope, and I think we need to recognize that. I think parts of your bill are an attempt to do that, although I think the bill could be strengthened.

One of the things that caught me right away, which I know was a term used by the Supreme Court in the decision it made, was the term “grievous”. Was any consideration at all given to using the term “terminal” in substitution for “grievous”? Either minister can respond.

Minister Raybould.

● (1710)

Hon. Jody Wilson-Raybould: Thank you for the question and certainly for the reflections about this being an ethical and a moral issue. We recognize that everyone we've spoken to has their own perspectives and their own beliefs and values. Certainly, as you know, we sought to respond to the Supreme Court of Canada's decision. The question wasn't whether but how we were going to put in place medical assistance in dying in this country.

The eligibility criteria were thought about at great length to recognize that there are different circumstances under which individuals seek medical assistance in dying. What we sought, and the objective of the bill, was to provide a peaceful passage to death. We are responding to the Carter decision on that, which is what the provisions in the legislation speak to. Nine jurisdictions in the world have medical assistance in dying. Six of them, including the one in Quebec and this one, provide end-of-life legislative frameworks.

Mr. Ted Falk: Thank you for that.

Proposed section 241.21 indicates that all of the conditions must be met, and yet proposed subsection 241.2(2) lists four points, (a) to (d), in the definition of a grievous and irremediable medical condition. It doesn't say if they all need to be met or if some of them need to be met or one of them needs to be met. Can you provide a little bit more explanation on that?

Hon. Jody Wilson-Raybould: Thanks for the question, and I'm glad to be able to provide that clarity. All four elements need to be read together; hence, the “and” at the end of the third element.

Mr. Ted Falk: So really there should be an “and” after (a) and (b) as well?

Hon. Jody Wilson-Raybould: Well, it's how it's drafted. It's a string. The “and” at the end reflects that.

Mr. Ted Falk: Okay. I think that's important, but thank you for that clarification.

Hon. Jody Wilson-Raybould: I appreciate that.

Mr. Ted Falk: Minister Philpott, you indicated that the bill provides protection for health care professionals, and I'm thinking by that you're suggesting it does from a liability perspective, but what about protecting health care professionals' conscience rights? Why are those not included right away? Why is liability so important? Actually, really, I want to know why conscience rights aren't in there, and what area they could be put in.

Hon. Jane Philpott: As you know, this is a piece of legislation that is an amendment to the Criminal Code. It's not a piece of legislation that describes the working medical practice, for instance. It's not a health bill. It's a piece of amendment to the Criminal Code, and therefore it was deemed not to be appropriate to specify that. We have made very clear that nothing in here compels a medical practitioner to participate in medical assistance in dying. The actual oversight of medical practitioners is done at the provincial and territorial level. We have indicated to them that it is our expectation that the conscience rights of providers would be protected.

I don't know whether you want to elaborate more on why it wasn't included.

Mr. Ted Falk: Another comment you made in your intervention was that a decision could never be made solely on mental suffering, but in proposed paragraph 241.2(2)(c), it says that “psychological suffering” could be the indicator that actually pushes it over the hump.

Therefore, it needn't be physical suffering at all; it could be a psychological issue.

Hon. Jane Philpott: I think that speaks to your previous comments about the fact that all four parts need to be taken into consideration, and that death is reasonably foreseeable.

If it's a medical condition alone and there's no otherwise expectation that a person is going to die.... As we've said before, people may have a medical condition and at the same time be suffering from cancer, for instance. If it's expected that they will die in a reasonably foreseeable period from their cancer, and at the same time they're suffering from depression, they would not be excluded. But a psychological condition alone, that is not otherwise terminal, would not make a person eligible.

● (1715)

The Chair: Mr. Falk, you have time for one more short question.

Mr. Ted Falk: Under the independence part of the bill, it talks about medical professionals and nurses who do not know or believe that they are a beneficiary. What happens if they are a beneficiary?

Hon. Jody Wilson-Raybould: It depends on the circumstances. There are penalties for not complying with the safeguards. If it comes to light that a connection was unknown, then there might be a defence for not having known the relationship. But within the proposed legislation there are penalties for not complying with the standards, and that is in terms of independence.

Mr. Ted Falk: Except that the person is dead, right?

Hon. Jody Wilson-Raybould: I thought you were referencing the person who was not independent in terms of providing witnessing, for example.

Mr. Ted Falk: Correct—

The Chair: Okay. Thank you very much.

We'll now go to Ms. Khalid.

Ms. Iqra Khalid (Mississauga—Erin Mills, Lib.): Ministers, thank you for coming in and giving us this presentation. It's very much appreciated.

I have a couple of questions. First, it's my understanding that it was the Department of Justice that was on the opposite side against Kay Carter in the Supreme Court. It's also my understanding that it is the same Department of Justice that has helped with the drafting of the bill. Have we sought outside counsel to ensure charter compliance of this bill?

Hon. Jody Wilson-Raybould: I'm happy to speak to that question.

In terms of the legislation, what was put forward was the result of, as we talked about, substantive discussions with stakeholders, reports, special committees. This was a decision of our government that we put forward. I'm incredibly honoured to be the Minister of Justice, and as the Minister of Justice I provide direction to my departmental officials. That direction was, as I said, provided by me and the direction of our government. I have confidence, as the minister, that our legislation is compliant with the charter.

Ms. Iqra Khalid: Another area that a number of people have raised concerns about relates to physician-assisted or the medical assistance in dying part that is self-administered by the patient.

Minister Philpott, could you please walk us though how that would work? What safeguards are proposed in the legislation that would prevent abuse, specifically with regard to the self-administration of death?

Hon. Jane Philpott: You'll see that there are a number of safeguards that need to be met whether a medical practitioner actually provides the medication, or whether it's self-ingested, for example. All of those safeguards need to be met along the way.

You'll see that proposed subsection 241.2(8) talks about the fact that there needs to be a final opportunity given to a person to reaffirm before any prescription, for instance, is given to a person, that it is what the person wants to do if that medication is handed over. That would be the time of the final opportunity for the patient to say yes or no. This is essentially providing an opportunity for people who may, for instance, want to die at home. They may want to die in the privacy of their own bedroom surrounded by their family and not want a medical practitioner to be there.

I could go through the whole list. I can give you the entire list of safeguards, but I think they're laid out quite nicely in the legislation. Whether or not the doctor is actually giving the person the pills in the same room, or whether the person is taking those pills or that injectable home to be administered by someone else, they would have to meet all of the same safeguards.

● (1720)

Ms. Iqra Khalid: What if the person, after having received the prescription, decides not to take the medication? Would that medication then just sit in their medicine cabinet?

Hon. Jane Philpott: That's an excellent question and one that I've asked myself. It's something that we will work very closely on with pharmacists, for instance, and with appropriate regulatory bodies.

That said, every single day in every single city in this country, people walk home with a bottle of pills, and if they were to take that whole bottle of pills they could potentially kill themselves, so it's not a territory with which we're unfamiliar. A tremendous amount of education of patients, providers, and pharmacists needs to be undertaken to make sure these pills are adequately cared for and that they in fact would have probably far better oversight than many other bottles of medications that are sitting in people's cupboards at home.

Ms. Iqra Khalid: With respect to the rights of conscience for medical practitioners, it's my understanding, and what you have indicated today as well, and based on the questions of our colleagues here.... Is there no way to codify the rights of conscience, as in, for example, saying that somebody cannot be forced to administer medical assistance in dying as part of the Criminal Code, or making it a penalty to coerce somebody into administering death under this legislation? Or would that not be in the federal jurisdiction at all? Would that be dealt with at the provincial level?

Hon. Jody Wilson-Raybould: Thank you for the question.

There is nothing in Bill C-14, our proposed legislation, that would compel a medical practitioner to engage in medical assistance in dying. As you quite rightly point out, this is within the jurisdiction of the provinces and territories, and Minister Philpott will continue to work with her counterparts to assist in putting together the regulatory framework, to assist the provinces.

The Chair: Although Mr. Nicholson couldn't attend today, we're delighted that we have Mr. Brassard here replacing him.

Welcome to our committee, Mr. Brassard, and over to you.

Mr. John Brassard (Barrie—Innisfil, CPC): Thank you, Mr. Chair.

By way of comment, I want to say that this issue has obviously been very difficult for many people to deal with. I think the government has put forward legislation that is somewhat reasonable at this point. I want to commend the members of the joint committee for the work they've done and commend this committee for the work that you are doing to get a better handle on the legislation.

I have only one question and it's for both ministers. You've mentioned that there have been ongoing discussions with the territories and the provinces with respect to Bill C-14.

Mr. Chair, through you, have any of the provinces or territories raised any concerns whatsoever about this bill and, if so, could the ministers please explain some of those concerns to the committee?

Hon. Jody Wilson-Raybould: Perhaps I'll just speak to my ongoing discussions and relationships with my provincial and territorial counterparts, the attorneys general from across the country.

I had the opportunity to meet face-to-face with the attorneys general in Quebec City. I had spoken with them before the legislation was introduced and with many of them after the legislation was introduced. It's fair to say in my view that the provinces and territories were looking for federal leadership with respect to medical assistance in dying. They were looking to us to put parameters around medical assistance in dying, while respecting the complex regulatory framework that would be put in place with the provinces and territories, and that we would continue to work in a collaborative manner with them and ensure that we can share best practices coming from, for example, the Province of Quebec, which has engaged in this discussion and this debate for over six years. That relationship will continue.

● (1725)

Hon. Jane Philpott: The overwhelming response from the provinces and territories has been positive. They have been thankful for a framework that will allow some of them to proceed by simply using this framework and working with their local regulatory bodies. We have had conversations with Quebec with respect to the fact that there are some distinctions between this legislation and their own. It was not an expression that was negative in any way, but it was simply an acknowledgement of the fact that they will be going back to look at whether or not they will choose to make any adjustments to their own legislation to address these inconsistencies.

Mr. John Brassard: Thank you, Mr. Chair. That's the only question I had.

The Chair: Thank you very much, Mr. Brassard.

Mr. Rankin.

Mr. Murray Rankin: I'll go to your last safeguard that is listed, that a patient reconfirm his or her expressed consent immediately before medical assistance in dying is provided. I want to ask you about two or three situations.

First, isn't it likely that many people will be incapacitated at that point because of a morphine drip? If they're not on a morphine drip, they may have very excruciating pain at the end of life that might vitiate their ability to provide consent at that time.

What if you're at home? How do you do that if you are taking the pills all by yourself or surrounded by family? How, in practical terms, can that safeguard be implemented?

Hon. Jody Wilson-Raybould: I guess on both counts, I'm going to look to Minister Philpott to speak as well.

In terms of reconfirming consent, whether a patient is on a morphine drip or passing into sedation, this is where we would leave it up to the medical practitioners to determine, based on the conditions of the patient, whether or not the 15 days are required, or if there's a shorter period of time that is necessary, given all the circumstances of the patient's condition, whether that be on a morphine drip, or whether that be organ failure, for example. In situations like that, potentially, it depends on the circumstances of each case where the physician would determine that a shorter period of time would be required to confirm the consent.

In terms of the handing over of the medication, in the case of self-administration, the consent would be confirmed upon the handing over of the medication.

Mr. Murray Rankin: If I'm alone or I'm surrounded by family, and there's no medical practitioner for miles around, would it be when I receive the medication from the pharmacist?

Is that how it would be done? How can that possibly be immediately before providing medical assistance?

Hon. Jane Philpott: The interpretation is that before providing medical assistance in dying, the moment the prescription is handed over is the provision of the medical assistance—

Mr. Murray Rankin: Which could be weeks.

Hon. Jane Philpott: Again, as with any other prescription that a health care provider gives to a person, they have a responsibility to be sure that it is fully explained, that the person understands how it's to be used. The pharmacist has the same professional obligation and an obligation to follow-up to be sure that it's used appropriately.

Mr. Murray Rankin: We spent a lot of time in committee—the Senate special committee that I was proud to be part of—talking about palliative care. I heard you say, Minister, that you heard more about that than probably any other topic.

Yet, there's nothing but a word in the preamble here, and nothing accompanying the bill with any specific money. There's no commitment to a palliative care strategy or end-of-life secretariat, or anything.

Can you speak a little bit more about what your concrete commitment is to palliative care?

Hon. Jane Philpott: Thank you for bringing that up and for your continued advocacy around palliative care.

I think you'll hear me talk about it repeatedly because I feel extremely strongly about it. As a society, apart from the fact that I think this is ground-breaking legislation that we should be proud of as Canadians, we've taken this mature step in this matter. If the other phenomenal result of this conversation can be that for the first time we are determined as a country to say that the status quo is completely unacceptable, that only 15% to 30% of Canadians have access to high-quality palliative care, we are determined to make that right. We are in negotiation with the provinces and territories.

I fundamentally believe that every Canadian should have access to high-quality palliative care at the end of life, recognizing maybe 5% or 6% of Canadians don't want it. You'll hear Senator Carstairs talk about the 94%. She's obviously done some amazing work on this. We will be working with her and others. This will very much be a part of the health accord. You know that we've made a commitment to that. I would ask you to continue to ask for it. Please ask me every single day in the House of Commons if you can, so we can raise the bar on palliative care. It makes sense. It's what people need and what they want. It's financially far better. People actually live longer if they have good palliative care than if it's not offered to them. It's absolutely the right thing to do. I can offer you $3 billion now as part of my firm commitment and part of our health accord, which will include home care and palliative care. Stay tuned for more details on that.

● (1730)

The Chair: Thanks, I'm really glad we got to talk a little about palliative care.

Mr. Rankin, I hope you'll get time during question period every day to ask Minister Philpott about it.

The Conservatives had not exhausted all their time in the previous rounds, so Mr. Cooper is going to take the remaining time if that's okay, ministers.

Mr. Cooper.

Mr. Michael Cooper: I just have one question for Minister Wilson-Raybould. Just to follow up on the question posed by Ms. Khalid, if I heard you correctly, Minister, you had said that conscience protections fell within provincial jurisdiction. We are legislating in part under Parliament's criminal law power. In paragraph 53 of the Carter decision, the Supreme Court expressly said that “Health care is an area of concurrent jurisdiction”.

Having regard for those facts as well as section 3.1 of the Civil Marriage Act, which states that religious officials don't have to perform civil marriages in an area where provincial and federal jurisdiction overlap, I just want to be clear, are you saying that Parliament cannot legislate on conscience protections in the face of the foregoing?

Hon. Jody Wilson-Raybould: I know that the Civil Marriage Act has been brought up a number of times. That provided that religious officials would not have to serve a specific community in marriages. We're talking about doctors serving the public at large. It's the jurisdiction of the provinces and territories to ensure the regulation of the conscience rights of medical practitioners. Nothing in our legislation as you know would compel a medical practitioner to perform medical assistance in dying.

The Chair: If I could wrap up by asking a question, Ms. Khalid suggested with regard to the question by Mr. Cooper that the Criminal Code could be amended to prohibit anyone from coercing a medical professional to perform physician-assisted suicide. I presume that you would agree that this prohibition could exist in the Criminal Code. The regulations may be provincial and territorial, but could that theoretically exist?

Hon. Jody Wilson-Raybould: Renovation of the Criminal Code is something that we are addressing in a comprehensive way. I'm not sure that the question is raising a particular issue that couldn't already be addressed in the discussions we're having with the provinces and territories. Certainly with the questions that have been raised here, we'll take a look.

The Chair: To wrap up on the issue of reasonably foreseeable death, as you know all the U.S. states that have that concept require the medical probability of death to occur within a certain time frame. The States uses six months. Minister Philpott mentioned that you could have thought about one year.

Would it seem to you to be congruent with the the court's decision in Carter and be compliant with section 7 should the committee in its wisdom decide to propose an amendment to the legislation to put in a time frame in which death could reasonably be foreseen?

Hon. Jane Philpott: I would encourage you to ask that question of health care providers as they come before your committee. My sense from to what I've been hearing from people is that they prefer the language of “reasonably foreseeable” death, that it actually speaks to professional judgment better than, “Is this person going to die within six months?” It's actually a harder question for people to be able to ask if they have to put a time frame around it.

I would encourage you to continue to ask that, and if you hear differently, please let me know.

● (1735)

The Chair: Thank you so much.

On behalf of all members of the committee, I'd like to thank both ministers for having spent so much time with us. It is incredibly appreciated. The dialogue about how you came to this proposed legislation and all the efforts you made to get there has been tremendously appreciated. Thank you so much.

We'll now take a few minutes to get our next panel set up.

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(Pause)

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● (1740)

The Chair: I am now more than delighted to welcome a panel from the Department of Health and the Department of Justice. We have a large number of very distinguished colleagues, including Mr. Pentney and Mr. Kennedy, who were on our last panel. From the Department of Health, we are joined by Abby Hoffman, assistant deputy minister, strategic policy branch; Helen McElroy, director general, health care programs and policy directorate, strategic policy branch; and Sharon Harper, manager of the chronic and continuing care division. From the Department of Justice, I see Joanne Klineberg, the senior counsel, criminal law policy section; Laurie Wright, the assistant deputy minister, public law sector; and Jeanette Ettel, senior counsel, human rights law section.

Welcome, all of you. I'm wondering if anyone has any statements before we move to questions. No.

We're therefore going to move straight to questions. This is our first round and we will go to the Conservatives first. Who's going first from the Conservatives?

We have Mr. Falk, and then we'll go to Mr. McKinnon.

Mr. Ted Falk: Mr. Pentney, I'm going to start with you, because you were here for the presentations, and I want to follow up a little bit more on the whole issue of conscience rights protection.

I think it's an issue that's important to a lot of folks right across Canada and to members of this committee, and we want to see if we can somehow address that. I'd like your comments and feedback on what is possible, from a legal perspective. If we were to draft something like that into the bill, what would it look like? Where would it belong? How can we do it?

● (1745)

Mr. William F. Pentney (Deputy Minister of Justice and Deputy Attorney General of Canada, Department of Justice): First, I would say, as the two ministers indicated, that the government has very much acknowledged that protection of conscience rights is an important consideration in moving forward with this. Also the Supreme Court of Canada obviously acknowledged that among the various rights and interests to be balanced, the conscience rights of physicians and medical practitioners are an important consideration. As the two ministers indicated previously, nothing in the bill compels or in that sense coerces a medical practitioner to be involved in this. The government has announced, and Minister Philpott confirmed today, the intention to continue discussions with provinces and territories about ways in which access to care can be facilitated and information can be provided, and that will be one element of a discussion around the ways in which conscience rights can be protected. Mr. Kennedy and others can speak to this if you wish

Although the Supreme Court has acknowledged that health care is a concurrent jurisdiction, what's under discussion is an exercise of the criminal law power by the federal Parliament. This bill is not about regulating medical or health professionals or institutions. This is about an exemption that is being created in the criminal law, which has been a focus of attention in response to the way the case was framed in the Carter decision and the way the case has been brought before Canadians, going back to the Rodriguez case. In all of that, the consideration was the focus of the bill. The way in which the bill is constructed, it's designed not to require or compel any medical practitioner, doctor, or nurse practitioner to be involved in this, and as Minister Philpott indicated previously, the government's commitment is to continue those discussions with provinces and territories to try to “find pathways to care.” I think that's the expression.

I hope that responds to the question.

Mr. Ted Falk: Well, it responds but it wasn't really the answer I was looking for. I was hoping to hear you say that we should draft something into the legislation that would provide protection for health care individuals so they're not coerced into assisting, and so there's a protection for them as well, because there's a fear among health care professionals that they're not going to have a choice. Not just at the physician level, but downwards from there as well, there is a fear that individuals who are currently tremendous and wonderful individuals who are providing excellent health and palliative care are going to be forced to participate in a physician-assisted suicide procedure.

Mr. William F. Pentney: Thank you for the question. I fully understand, and we have observed the debate as it has unfolded and continues to unfold in provinces and territories with medical regulators, with physicians, and with others across the country.

The bill does not compel or require anyone to provide the assistance. It opens an exemption in the criminal law to protect those who are providing medical assistance to individuals who fit within the criteria as established in the bill from what would otherwise be criminal liability. That's the nature and scope of the bill and the intention of the government.

There are a variety of other regulatory matters, medical professionalism and other issues, associated with this. We know from discussions on our side and certainly from the Health Canada discussions with provinces and territories that medical regulators, provinces, and territories are actively engaged in looking at their dimensions of this issue, and we've no doubt that examination will continue.

Mr. Ted Falk: I'm going to keep on that. I don't want to let it go just yet, because I think we could be preemptive. While we have the debate going, and while the discussion is open, I think we could be preemptive. Rather than leaving it to the territories and the provinces to come up with their own regulations and maybe create a problem for health care officials, why don't we address that issue right now, up front, with the legislation we're looking at?

Mr. William F. Pentney: I think in respect of the exercise of the criminal law power in defining the nature and scope of eligibility and safeguards, the law is clear. I think the government's commitment to complementary and additional measures and discussions is also clear. I think from the perspective of the way in which the law is constructed, it is constructed explicitly not to compel or require anyone to provide assistance in dying.

● (1750)

Mr. Ted Falk: Minister Philpott talked a lot about palliative care. Studies show that when there's a gold standard of palliative care available for individuals in end-of-life situations, and also in terminal illness situations where there's extreme discomfort, if it's mitigated by a good palliative care system, the need and the desire for physician-assisted suicide is just about non-existent. Could you comment further on that and what we can do from a palliative care perspective?

Mr. Simon Kennedy (Deputy Minister, Department of Health): I think what I would do, Mr. Chair, is just reiterate the minister's commitment to pursue this. The government's committed to negotiating a new health accord with the provinces and territories. One element of the conversations we're having with the provinces and territories right now is about how we can work to expand the palliative care services that are available. The minister has certainly given us direction as a department to make this a real priority. This is something we'll hopefully be able to get agreement on with the other governments to make an investment in this area. It is a big priority for us, and hopefully we'll be able to have more news in the months to come on that.

The Chair: Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): I believe that my questions will mainly be addressed to Ms. Klineberg. I'm not playing favourites, but it seems to me that criminal law policy is what this is about.

I'm talking about proposed subsection 241(1). The original act specified in paragraph (b) that it was an offence to aid or abet a person to die by suicide. In this new act, the provision for abetting has been moved into paragraph (a), and aiding a person can be allowed under the framework established for medical assistance in dying.

But to me, looking at the word “abet”, it implies assistance as well. I'm wondering, in the case where a charge under proposed paragraph 241(1)(b) would not be sustainable because it's a medical assistance in dying situation, what's to prevent a charge from being laid under (a), for abetting a suicide?

Ms. Joanne Klineberg (Senior Counsel, Criminal Law Policy Section, Department of Justice): There is jurisprudence under the Criminal Code that has interpreted the concept of abetting an offence to take place. Though in the dictionary definition “abetting” can mean “aiding” and also “encouraging”, the interpretation that the courts have most consistently given to the word “abetting” is that it means “encouraging” in the criminal law context. Otherwise, it would simply be replicating “aiding”, for instance. It's interpreted to have a different meaning.

This is consistent throughout the criminal law, not just in the context of this particular offence. The idea was that because abetting a person to die by suicide would actually be interpreted as encouraging them, which is much more consistent or analogous to the concept of counselling, which is also inciting and promoting and that sort of thing, abetting a person to die by suicide was relocated into paragraph (a), where it's situated next to the concept of counselling. As I mentioned, these two things are more similarly associated with each other, and it also allows for the exemptions to be cleanly applicable to “aiding”, which is in the provision of the substance that the person would use, without leaving the impression that it could be exempted from criminal liability to encourage a person to die by suicide.

So by moving “abetting” into paragraph (a), and making the exemptions applicable only to (b), which now is limited to “aiding”, the legislation is distinguishing between moral support and moral encouragement from the physical assistance.

Mr. Ron McKinnon: Fair enough, but it seems to me that the Criminal Code also holds “counselling” as encouraging or inciting. Is it not redundant to also include abetting in there?

Ms. Joanne Klineberg: They're definitely quite similar concepts. There is a definition of “counselling” in section 22 of the Criminal Code, I believe, which contains some more verbs and concepts that are quite similar to “counselling”. Counselling might require something a little more pointed than encouraging. They're definitely similar concepts. In criminal law, sometimes there are similar concepts and we use different words for them to ensure that the full range of conduct is conveyed.

There's a similarity and perhaps some overlap between “encouraging” and “counselling”, but they wouldn't be exactly the same thing.

● (1755)

Mr. Ron McKinnon: I've also been hearing representations from people such as social workers who are concerned about giving information, advice, and whatnot around grief counselling and the options that are available to a patient in a circumstance where they're enduring suffering. Their concern is that this kind of advice would constitute counselling.

I'm wondering if you or any other members of the panel would suggest that there should be a provision in the Criminal Code to exempt advice that does not rise to the level of recommendations or urging as being excluded from counselling.

Mr. Donald Piragoff (Senior Assistant Deputy Minister, Policy Sector, Department of Justice): When the legislation is passed, providing medical assistance in dying will become a legal activity. Providing information to a person to engage in a legal activity is legal, so there's no need to basically put in law that it is legal to provide information to tell someone to do something that is legal.

If you provide information as to how to undertake a legal activity, as to how to find out how to obtain the medical services of medical assistance in dying, that is legal. It's self-evident, so you don't have to say it.

Mr. Ron McKinnon: Okay, fair enough.

The Chair: You have 20 more seconds.

Mr. Ron McKinnon: Thanks to all of you.

The Chair: By the way, Mr. Piragoff, I'm sorry that I didn't notice you there before. Welcome to you as well.

Mr. Donald Piragoff: I'm hiding in the corner.

Voices: Oh, oh!

The Chair: Now we move to Mr. Rankin.

Mr. Murray Rankin: I want start with where I ended in conversation with Minister Philpott on the safeguard that requires one to "immediately before providing the medical assistance in dying" give the person an opportunity to withdraw their consent. A person who is at home with medication that might have been prescribed months or perhaps years ago can hardly be immediately provided that opportunity to reconfirm their expressed consent. I fail to understand how that section can be given any meaning in practical terms in the context where there's no medical practitioner around and the medication was provided perhaps months ago.

Mr. Donald Piragoff: I think Minister Philpott answered that question by saying that in terms of the provision of medical assistance in the situation of the provision of a medication, the assistance is provided at the time that the medication is provided to the patient. That is the time when the assistance is provided.

If the person takes it the next day, or if they don't take it until two months later or they never take it, at that point in time the assistance has been provided by giving the individual the means to take their own life, to self-administer the medication. At that point, the time when the doctor or the physician or the pharmacist provides the medication, is the person competent? Do they understand what the effect is of the medication? They may not take it.

In the United States, for example, some people don't take the medication for months after. Actually, some people don't even take the medication at all—

Mr. Murray Rankin: That's precisely the problem. I simply don't understand how in that context one could say you're "immediately" providing that opportunity, when it may well be months, if not years, before the patient opens the bottle at home.

Ms. Joanne Klineberg: I think we have to read the provisions of the legislation consistently with each other. If we look at the definition provided of "medical assistance in dying" in proposed section 241.1, it's actually a defined term in the legislation. It makes it a lot easier to draft the rest of the provisions, and the paragraph (b) part of "medical assistance in dying" talks about the prescribing or providing by a medical practitioner or a nurse practitioner of the substance to the person. It's immediately before that action that the consent of the person is to be obtained. There's also a criminal law reason for that, which is that the criminal law is not concerned with private acts by an individual who might chose to die by suicide.

The criminal law is concerned with the participation of third parties in that decision. The exemptions and the whole regime are set up to provide for a criminal exemption for physicians when they're participating in the action by a person to self-administer a substance. The physician or the nurse practitioner's involvement is at the time they either write the prescription or give the substance over. Beyond that point, the action of a person who might privately self-administer the substance in their own home is simply not a question of concern to the criminal law; there's no crime being committed in that circumstance. The criminal law runs out. However, it may be a matter that the provinces and territories or medical colleges might have an interest in addressing more fully.

● (1800)

Mr. William F. Pentney: Just to respond very quickly to the honourable member, Canada is a big and complicated country. There is no federation in the world that has taken on medical assistance in dying from a federal perspective in the way that Canada has. One of the choices that the government has made is not to require that it only be available through a doctor administering it. That was a choice in which Quebec, after long debate, decided the government was entering into a more complex area by allowing both, admittedly —but it is respecting the autonomous choices of Canadians. One of the choices that has not been made in the legislation is to require a doctor or a nurse practitioner, just before the person administers the substance, to be available. As has been explained, the "immediately" must be read in the totality of the context. However, it's also in recognition that this is to respect people's autonomy in making choices. I think it's fair to expect, based on other countries' experiences, that some people who seek medical assistance from a doctor and others who would like to self-administer, at the end of the day, will decide not to go ahead. In both circumstances, respecting their autonomy is something that the legislative framework is trying to achieve.

Mr. Murray Rankin: In the context of someone who is physically disabled but whose natural death is not reasonably foreseeable and is therefore required to starve themselves if they are not able to avail themselves of medical assistance in dying, would that potentially constitute in those circumstances a violation of section 7, consequent cruel and unusual punishment or otherwise inconsistent with the security of the person? If so, was that taken into account?

Mr. William F. Pentney: Maybe I'll start, and others can add to it.

The law is designed to respond to the overall circumstance of someone who is on the passage towards death. It is not designed to respond to a situation that changed someone's life circumstance after an accident, or where they get a diagnosis of some sort that changes their life circumstance. It's the totality of the four elements together. It may be the case that someone with a condition that is not otherwise going to end their life is suffering for other reasons and has another condition that is impairing them and has, therefore, put them on the path towards death. It's not an a) or a b) or a c). It's all of them together in the totality of the circumstances. An individual, whether or not they have a condition that is labelled as "terminal" but is dying of another condition and suffering from a third completely separate condition, in the totality of their circumstances, could be found to be in a situation where their death, to quote the bill, "has become reasonably foreseeable", and qualify for medical assistance in dying.

Therefore, in that sense, it isn't meant to be categorical, but meant to be the totality of the circumstances involving all of those considerations.

The Chair: Sorry, I think Mr. Rankin understood that. I think he was asking whether or not, given the way the legislation is drafted, a decision not to provide medical assistance in dying in the example he provided—a gentleman who had had a stroke, who couldn't do anything but move his eyebrows and was incapacitated and wanted to die and had to starve himself to death—would be consistent with the Carter decision. He's asking whether or not you believe that the law as drafted is compliant with the Carter decision in that regard.

Mr. Donald Piragoff: If a person embarks on a hunger strike or just stops eating for whatever reason, either a medical reason or because they decide to exercise their right to withdraw treatment, they have that right. A person has the right to say, “I do not want any food or liquid from this point on. I do want any medication.” They have the legal right to do that.

At some point after they make that decision, a doctor can say that this person's death is reasonably foreseeable. They don't have to die of starvation, because at that point in time a A doctor can say that this person is going to die a natural death as a result of malnourishment, and that they therefore may qualify. Of course, that's not the only condition they must have; they have to meet all the other four or five conditions.

● (1805)

Mr. Murray Rankin: But it's only if they starve themselves to death.

Mr. Donald Piragoff: No, they don't have to starve themselves to death.

Mr. Murray Rankin: Well, they get to that point with no assistance from this bill at all, and it's contrary to the Supreme Court's decision, I say with great respect.

Mr. Donald Piragoff: A person can be put into that position by natural causes. It may happen that they can no longer take nourishment because they have had a stroke, for instance.

The Chair: I'm going to let Mr. Kennedy speak, and then we're going to move to Mr. Bittle.

Mr. Simon Kennedy: I'll maybe draw the committee's attention to Minister Philpott's intervention on this matter, because I think this was a guiding consideration for the government. In looking at this there were effectively three choices: to have a fixed timeline under which death could take place, which is within six months or a year; to have no timeline whatsoever; or to have what the bill has—to provide some latitude for medical practitioners, in each individual case, to make that kind of judgment. I think the government's decision was to go for that option because six months or twelve months would be somewhat arbitrary. I think the committee's going to hear from a lot of experts.

The alternative, really, would be to have no constraints whatsoever on this notion of reasonably foreseeable death. As the ministers noted, I think that's where there were a lot of concerns about safeguards for the vulnerable, about how it becomes a much more complex undertaking to figure out how you strike the right balance among all the competing interests if you don't have that kind of limitation. It was a choice, and admittedly there may be unique individual circumstances that present themselves. However, I think the idea was to give some latitude to medical practitioners to look at the totality of evidence and make the decision. I reiterate what the minister said.

Mr. William F. Pentney: We should confirm that it is our analysis and the government's belief that this does comply with both the Carter decision and section 7 of the charter. We should confirm, as has been previously confirmed by ministers, that we believe the complex regulatory regime, which is what Carter called for Parliament to enact, and which is before the House today, represents an approach that is compliant with the charter.

The Chair: Thank you very much. We really appreciate it.

Mr. Bittle.

Mr. Chris Bittle: I'd like to focus on the definition of “grievous and irremediable”, and I'll start with proposed paragraph 241.2(2)(a). What is the difference between “irremediable” and “incurable”? When you say the word “incurable”, what comes to mind is that there could be a cure—for example, if someone had cancer and was required to go through several rounds of chemotherapy—but that the treatment in and of itself might cause enduring physical and psychological suffering. Can you explain that definition, and whether it meets the criteria set forth in the Carter decision?

Mr. William F. Pentney: First of all, the term “grievous and irremediable” is not a term that is littered throughout either the criminal law or medical practice. It's not generally been defined, and it's not defined by the Supreme Court of Canada decision.

Nonetheless, it's clearly not meant to apply to transient conditions. As the court notes, and as was noted by ministers earlier, individuals through this bill still have the right to refuse treatment they find unacceptable. It's meant to distinguish between conditions that are transient and conditions that are not. It is not meant to signify that an individual has to take treatment that they find unacceptable to themselves. As was said earlier, the bill must be read as a totality.

Mr. Chris Bittle: Is there something in the bill itself that speaks to that particular point or is that just a legal interpretation of what's here?

● (1810)

Mr. William F. Pentney: In particular, you referred to paragraph (a) and the wording “serious and incurable”. Paragraph (c) makes it clear that the suffering is intolerable and cannot be relieved under conditions that they consider acceptable, which is a slightly different formulation than the one used by the Supreme Court.

However, it actually tracks quite closely with the formulation of the court that an individual may have, as you say, a condition that is otherwise medically curable. Some people may choose to have treatment that's almost unimaginable in the grief and suffering it causes them, but will continue with that treatment. Others may find that the treatment that is available to them causes them suffering that is intolerable, and by paragraph (c), it's clear that it's their choice and the law does not in any way impair or affect that choice.

Mr. Chris Bittle: Perhaps the department is open to some level of clarification, because paragraphs (a) and (c) have to be read together, and if something is curable.... I understand what you're explaining in terms of the interpretation, but reading the plain language definition of it, it doesn't necessarily meet your interpretation of the bill.

Is the department open to a clarification in the legislation to be more explicit in your interpretation?

Mr. William F. Pentney: I think that government would be open to all carefully considered opportunities to improve the bill and would look forward to carefully study any amendments that would be proposed. I would suggest, based on all of my experience on legislative drafting, that trying to cover-off every eventuality through forms of wording will remain a challenge. If the word “incurable” were presumably to be replaced by “irremediable”, if that's a suggestion, then the question would be, would it provide greater clarity?

I'll leave that to others to consider.

Mr. Chris Bittle: In terms of paragraph (b) referring to “an advanced state of irreversible decline in capability”, there have been critics who have said that if this paragraph were read, then Kay Carter would not have met this particular definition because she was not in a state of decline, that her particular condition was stable but was enduring suffering.

Is that at odds with the Carter decision?

Ms. Joanne Klineberg: Our understanding based on the court ruling of the circumstances of Kay Carter was that she was in a wheelchair and needed assistance for most of her daily functions, so her mobility was quite limited.

It's not really a provision of paragraph (b) that speaks to there being a change over time. It can be a state of advanced and irreversible decline and capability that occurred all at once, for instance. It isn't part of the requirement that there be continuing decrease in capability; it's only required that the person be in an advanced state of decline.

It might also be helpful to note that with all of these criteria, including what is an incurable illness, the decision-making on these elements has been left in the hands of medical and nurse practitioners. What is or is not an incurable condition may depend on a variety of factors, not just necessarily the name of the disease, for instance. There might be implications relating to the accessibility of treatments

However, if we come back to the “advanced state of irreversible decline”, it's also something that can take into account a whole host of considerations. A person might be in an advanced state of decline due to exhaustion, due to fatigue, due to frailty. Again, it's designed to be flexible in order for the medical and nurse practitioners to take everything into account.

Mr. Chris Bittle: Could it be more accurate then if we put “or” into that paragraph, that “they're in an advanced state of their illness or a state of irreversible decline”?

Would that be more accurate in the interpretation of the department?

Mr. William F. Pentney: We can look at it. It's illness, disease, or disability, and it covers a very wide range of circumstances, some of which will have happened in a heartbeat and some of which will have evolved over many years. We could look at whether that would make it clearer.

It presumably would also introduce other uncertainties or other issues around what is an advanced state or advanced progression of an illness. However, we can certainly look at it, and, again, we look forward to the work of the committee and the recommendations coming forward from the committee.

● (1815)

The Chair: Thank you very much.

I know we're running out of time, but Mr. Warawa had asked for two minutes. I'm going to let each party have one last question, a short question, if they want one.

Mr. Warawa.

Mr. Mark Warawa (Langley—Aldergrove, CPC): Thank you, Chair.

On conscience protection, you said that the bill does not compel or require. You said that the Supreme Court said that we're to create a complex regulatory system. There has been a major focus, and rightly so, on vulnerable Canadians, but probably the number one issue we hear about as parliamentarians is to make sure that conscience rights are being protected. The legislation is silent on that. It does not compel or require, but it also does not protect.

It is possible, then, as we amend the Criminal Code of Canada to permit this, that we could also make it a criminal offence to coerce, intimidate, or force a physician against their will to participate. Is that not correct?

Mr. William F. Pentney: We would have to look at it. I'm not aware of the circumstances in which that is a concern. We'd have to look at it. I would say that in respect of the scope of federal jurisdiction under the criminal law, we would also be focusing on the extent to which provisions that are inserted would have practical legal effect, given the division of powers.

Mr. Mark Warawa: Examination by the provincial regulator, as you said, will continue, but we're talking about exemptions to the Criminal Code of Canada that under certain strict criteria will permit this.

Before, and even currently, it's legal to take your own life, but a person walking down the street cannot assist somebody to kill themselves. That's illegal. We're creating this strict regime, but you should also, then, not force somebody by intimidation, by coercion, or in any way to participate in the death of that individual against that person's will. My understanding is that such a restriction could be included in the Criminal Code; otherwise, we would hand it over to the provincial colleges of physicians, and the approach would not be pan-Canadian. It could be a totally different approach if we allowed each province to protect conscience rights.

I believe we do have the power and the authority to put within the Criminal Code the stipulation that you cannot coerce or force anybody to participate in the death of another person, to commit assisted suicide, against their will.

Mr. William F. Pentney: If it's the committee's wish, in terms of the completion of the study, we can certainly look at that.

The Chair: Thank you very much. We appreciate that.

The issue of conscience rights has been raised by a number of people. I think Mr. Falk, through his original question, was trying to ask you, if protection of conscience rights is important to the committee, what solution you would propose to make that fall within the law in the best possible way. One way suggested by Ms. Khalid was to make a criminal prohibition, and if there are others, we'd be delighted to hear about them before we move to our clause-by-clause deliberation.

Mr. Rankin, did you have a last question?

Mr. Murray Rankin: This is just a drafting question, I believe.

I mentioned to the ministers that our recommendation at this special joint committee was that there always be one medical practitioner and perhaps a nurse practitioner. We're very sensitive to the need for access in remote parts of Canada, but as I read Bill C-14, it in every stage refers to “medical practitioner or nurse practitioner”. It would appear that this will be the only jurisdiction in Canada—and I'm not saying this is wrong, but I want clarification from officials—where a physician-assisted death could occur without the involvement of a physician. Am I reading the bill correctly?

Mr. Simon Kennedy: I think, Mr. Chair, as the ministers explained, in the various jurisdictions the provinces delineate in certain cases certain functions that are delegated to nurse practitioners that would normally be performed by a doctor. I think the thinking here was that it will really be up to the provincial medical regulatory authorities to determine whether they wish, with the appropriate kind of guidelines and parameters, to delegate those responsibilities to nurse practitioners.

Mr. Murray Rankin: Mr. Kennedy, just to be clear, you're saying to us that a province could choose to make this service available with two nurse practitioners and the intervention of not a single physician. Is that correct?

Mr. Simon Kennedy: To the extent that a province would delegate this function to a nurse practitioner, it would only be within the scopes of practice that are available to nurse practitioners. In other words, it's not that all nurse practitioners and all nurses get to do this by virtue of the federal legislation; it is only where a province has chosen to delegate physician-like powers to nurse practitioners. That's a specific provincial decision. Provinces do that in some circumstances.

● (1820)

Mr. William F. Pentney: You are correct that it is conceivable. Where a nurse practitioner has been the one providing ongoing care in remote communities that we know exist from coast to coast to coast, where that's been delegated and authorized by a province, it is conceivable that under the law, if it's passed as it stands, that it could be two nurse practitioners. It could be that there wouldn't be a requirement for one nurse practitioner and a physician.

Mr. Murray Rankin: It was our recommendation at the committee that there always be at least one physician, no matter how remote, but you're opening the door to.... Is this the only jurisdiction in the world that would have two nurse practitioners able to provide this service?

Mr. William F. Pentney: Yes, I believe we would be the only jurisdiction in the world, and I believe that the scope of what nurse practitioners do is not commonly shared throughout the world either.

The Chair: Then would it be within the realm of possibility, if this committee decided to amend the bill, that it would be perfectly possible to say that if the first person providing medically assisted dying is a nurse practitioner, the second opinion must come from a medical practitioner? Could we do that?

Mr. William F. Pentney: If that's the committee's recommendation, that would be considered by the government and it would ultimately be determined. As you hear from other witnesses trying to consider the implications, practical access, continuity of care, and familiarity with the individuals and their circumstances would all be elements worthy of consideration.

The Chair: That's understood.

Mr. Fraser has the last question.

Mr. Colin Fraser: Thank you very much, Mr. Chair.

Paragraph 127 of the Carter decision includes the remedy provisions. It states “a competent adult person who clearly consents...”. In your opinion, when an individual clearly consents to medical assistance in dying in order to have access to this procedure, could an individual clearly consent in advance, or is the idea of advance directives incompatible with “clearly consents” in paragraph 127 of Carter?

Mr. William F. Pentney: It's not prescribed or detailed by paragraph 127. The issue and the considerations that certainly have manifested themselves in the studies of the provincial-territorial advisory committee, the external panel of the special joint committee, went beyond what was before the court in Carter. It is our understanding it was not any of the individuals who had dealt with it. In that sense, Carter didn't address it.

The Chair: I would like to take this opportunity to thank all the people from the Department of Justice and the Department of Health who joined us here today. It was most helpful to have you here. We really appreciate it. We look forward to continuing the dialogue.

We're going to take a five-minute break, a health break, so people can get some food, and we will resume with the next panel in five minutes—oh, we've been asked for 10 minutes, so we'll start the next panel in 10 minutes, since we can finish at any time. We'll start the next panel a little later.

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(Pause)

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● (1835)

The Chair: We're reconvening.

I want to thank the members of our distinguished panel for coming to join us. I would like to introduce, from the Canadian Psychological Association, Dr. Karen Cohen, who is the chief executive officer; Dr. Francine Lemire, who is the executive director and chief executive officer of the College of Family Physicians of Canada; and Mr. Philip Emberley, who is the director of professional affairs for the Canadian Pharmacists Association.

Welcome to all of you.

[*Translation*]

I want to say that I deeply appreciate your having come to testify before the committee.

We are going to begin with Ms. Cohen, who will have eight minutes. The other witnesses will also have eight minutes.

[*English*]

Dr. Cohen, thank you so much for coming. Please go ahead.

Dr. Karen R. Cohen (Chief Executive Officer, Canadian Psychological Association): Thank you.

Good evening. Thank you, honourable members of the committee, for giving the Canadian Psychological Association the opportunity to speak to you this evening about Bill C-14.

The CPA has two specific concerns with the bill.

The first concerns the role of health providers in end-of-life decision-making. The second concerns the assessment of a person's capacity to give consent to end his or her life, particularly when a psychological or cognitive disorder is concomitant with a grievous and irremediable physical one. Accordingly, we have three recommendations that we're asking you to consider.

Proposed subsection 241(1) notes that it is an offence to counsel a person to die by suicide and to aid a person to die by suicide. Proposed subsections 241(2) and 241(3) appear to exempt practitioners from the provisions of proposed subsection 241(1) if they provide medical assistance in dying or aid a practitioner in providing medical assistance in dying.

The CPA's concern is that the exemptions articulated in proposed subsections 241(2) and 241(3) appear relevant to aiding a person in dying but not to counselling a person about an end-of-life decision. While proposed subsections 241(2) and 241(3) appear to exempt practitioners for involvement in the act of dying itself, regulated health providers will reasonably be involved in decision-making before any end-of-life act is carried out. Psychologists would be among the health providers who might assess a person's capacity to give consent to medically assisted death. Psychologists would also be among the providers to whom persons with irremediable conditions might bring their end-of-life concerns.

It is important that persons who are considering hastening death have the opportunity to bring their concerns to a trusted regulated health provider if they so wish. It is equally important that a regulated health provider who enters into an end-of-life discussion or consultation with a patient also be exempt from proposed subsection 241(1).

Our first recommendation is for an additional exemption that stipulates that no regulated health practitioner commits an offence if they assess a person's capacity to give consent to an end-of-life decision and/or provide counselling regarding end-of-life decision-making issues at the request of a person with a grievous and irremediable condition, or if they aid a health practitioner in the assessment of a person's capacity to give consent to an end-of-life decision and/or in the discussion of an end-of-life decision for a person with a grievous and irremediable condition.

We also want to note that the word “counsel” in English, as used in proposed paragraph 241(1)(a), has both legal and profession-specific meaning. Mental health providers such as psychologists can be said to regularly provide counselling to their patients. In this sense, “counsel” has a very different meaning than the one intended by proposed paragraph 241(1)(a).

Our second recommendation is that proposed paragraph 241(1)(a) be revised such that “counsels” is replaced by “persuades or encourages”. It would then read “persuades or encourages a person to die by suicide or abets a person in dying by suicide”.

Finally, the CPA was also concerned that the bill is silent on how capacity to give consent should be assessed. While in many instances it may be straightforward to ascertain that informed consent can and has been given, there may be times when it may not be. Examples might be when a patient has a cognitive or psychological disorder concomitant with a grievous and irremediable physical one. The concomitance of a cognitive or psychological disorder with a physical one occurs commonly.

The CPA's submission to the expert panel that reported to the parliamentary panel made the following point, which I quote:

> ...the global experience of suffering, including suffering due to physical symptoms, is much more pervasive among terminally ill patients who are depressed than among those who are not depressed.... In the Netherlands, Dees [and his colleagues] have reported that only patients with a comorbid diagnosis of a mental disorder suffer unbearably all the time. Hence, it is likely to be a common scenario for depressed terminally ill patients to make requests for assistance in ending their lives. To prepare for this, legislation should be informed by certain clinical realities.... A mere diagnosis of a depressive disorder does not necessarily mean that someone is incompetent to make critical health decisions. Especially severe depression, however, may result in negative attitudinal biases that distort rational decision making around medical aid in dying....

The assessment of a person's capacity to give informed consent, particularly when that person has a concomitant psychological or cognitive disorder, must be left to those regulated health providers with the training and expertise to undertake these kinds of complex assessments.

● (1840)

It is CPA's view that psychologists, along with physician specialists such as psychiatrists and neurologists, have the necessary training and expertise.

Our third and final recommendation is that a new provision be added under “Safeguards” as subparagraph 241.2(3)(i), as follows:

> ensure that when a person presents with a grievous and irremediable medical condition concomitant with a cognitive and/or psychological one, the person's capacity to give consent be assessed by a regulated health provider whose scope of practice includes the assessment of cognitive and/or psychological conditions.

On behalf of the CPA, I thank you for your important work in the interests of the Canadian public. I'd be glad to answer any questions about our submission.

● (1845)

The Chair: Thank you very much for your presentation, Dr. Cohen.

[*Translation*]

I now yield the floor to Dr. Lemire.

[*English*]

Dr. Francine Lemire (Executive Director and Chief Executive Officer, College of Family Physicians of Canada): Thank you very much.

The College of Family Physicians of Canada is the national body responsible for establishing the standards for the training, certification, and lifelong education of family physicians. In this regard, we do welcome Bill C-14, an act to amend the Criminal Code and to make related amendments to other acts.

We're pleased that the bill represents a prudent first step. We believe that the medical community is being given a reasonable opportunity to familiarize itself with the new changes and accommodate accordingly. It has been noted that medical assistance in dying has not been a reality for nearly every physician currently practising in our country, but will be a feature of our health care system starting in June.

As family practice is frequently the point of first contact with the public in our health care system, family doctors are often the first to witness how medical decisions that have legal implications can affect patient care decisions. Further clarification is required regarding the eligibility criteria for accessing assisted death, particularly the requirements for eligible patients who are facing a natural death that is reasonably foreseeable. For example, a progressive multiple sclerosis patient might fit the criteria of having an incurable disease and being in a state of irreversible decline and suffering, but the timing of foreseeable death might be difficult to determine. Some specificity around this criterion is needed.

There are also questions regarding the subjective interpretation of what could be considered physical or psychological suffering that is intolerable. As family doctors we witness every day in our practices that there are varying degrees of what is considered intolerable pain or suffering. Depending on the patient's threshold, tolerance can vary greatly.

Complex health issues such as physician-assisted dying and abortion require a level of protection for the privacy of not only the patient but also the health professionals providing these procedures. To ensure a level of security for the provider, names or information about those assisting in the procedures should not be released to the public or the media. Physicians and other care providers, such as nurse practitioners, should feel safe and secure when they care for patients.

In providing medical aid in dying to a patient with a long-standing relationship, a provider should not feel under pressure to do so for other patients under the same or other circumstances. Every case should be considered on its own merits.

The CFPC would also like to see further clarifications regarding the criteria for consent. What occurs if a patient provides a voluntary request for medical aid in dying, and during the defined waiting period of at least 15 clear days, their mental capacity deteriorates unexpectedly to a point where they're no longer able to reaffirm the request for assistance? Clearer guidelines on how to assist a patient without abandoning their needs should be outlined.

Clarity of process and resource availability will be crucial for physicians and their patients, as well as an understanding of criteria, when providing physician-assisted dying. There need to be assurances that a physician's conscientious objection will be considered and balanced with both the rights of the provider and the necessity of ensuring that patients are not abandoned when they are most vulnerable.

Regardless of any legislation created, physicians must be cognizant of the scope of their responsibility in providing care to a patient. The CFPC maintains that family physicians should, above all, remain committed to their relationships with patients and their patients' loved ones during this last chapter of their lives. Recognizing that those who have serious illness or disabilities and those who are dying are among their most vulnerable patients, family doctors are health advocates on behalf of such patients.

We also place great value on palliative care. The college will continue its work in fostering high-quality palliative care within the scope of comprehensive continuous care provided by family doctors, including those with enhanced skills in this area. We believe that Bill C-14 would benefit from having the support of a national palliative care strategy. Although a small percentage of Canadians may request medical aid in dying , everyone in Canada will likely need to access palliative care. No matter where one lives in the country, one should have access to high-quality palliative care towards the end of life.

● (1850)

My colleagues who helped me prepare this brief suggested that at this point I provide a real-life story.

I'm often asked whether any of my patients have asked me for medical aid in dying. The reality is that no one, to this point, has asked. I believe part of the reason is that they did not know it was going to become a reality.

The only person who asked me is my own mother, in May of 2013. She was a “super senior”, to quote Mr. Housefather. She was 94 years of age, with terrible mixed arterial and venous insufficiency in her legs, ulcers, and terrible pain, which morphine treated by making her a zombie and for which anything less did not do the job. At that time my mother asked me whether she could get medical aid in dying, and at that time she would have met the criteria for medical aid in dying.

We fast-forward three years, and this diagnostic test that she had, an arteriogram, in fact was therapeutic. Her ulcers are now healed, but she has declined cognitively. She's quite limited. She really is a frail elderly person, and I'm not sure that today she could articulate those kinds of wishes, although it could be said that she has a degree of existential suffering.

If we were to ask her today, she probably would accept that Mother Nature should run its course. I think that as we move forward with this legislation, we need to accept that three years ago we might have done assisted dying based on the conditions my mother had at that time and she might have died, even though we know that she is now alive. I think we need to feel comfortable with that. In the same way, we need to feel comfortable thinking of my mother today at 97 as a frail elderly person who's prepared to wait for Mother Nature to run its course without necessarily making the same request. Even though the quality of her life, by some standards, could be viewed as not the best, by her own standards it's probably okay. We need to think about all these things as we think about this legislation.

We look forward to continuing to offer our advice and perspective as the legislation takes shape.

Thank you very much.

The Chair: Thank you very much for offering your own personal story. It draws a lot of us to conclusions that we otherwise may not have reached.

Now we're going to move to Mr. Emberley.

The floor is yours.

Mr. Philip Emberley (Director, Professional Affairs, Canadian Pharmacists Association): Thank you very much, Mr. Chair, and also the committee, for inviting us to speak today.

First I'd like to acknowledge the difficult task you have before you. The final legislation must strike a balance between the needs of patients, the right to access, and ensuring that health care providers are fully equipped to deliver quality care regardless of the setting.

This is a very complicated and emotional issue for many, and one that has dominated much of the profession's discussions over the last year. Very early on in our discussions within the profession, it was clear there was an important role for pharmacists as the dispensers of the lethal dose of medication for assisted dying. Over the past year, we've worked with our members to understand the impact of the court's ruling and their views on the issue. We did this through an extensive survey of pharmacists and through the development of guiding principles, which we released in February.

Pharmacists are keenly aware of their role as a primary health care provider. They are consistently rated as one of the most trusted professions and they are often the first point of contact within our health care system.

We're already hearing stories of community pharmacists being asked questions about assisted dying. As a profession, we've been very encouraged to see the conversation around assisted dying expand from what was solely seen as physician-assisted dying to what is now called medical assistance in dying. This acknowledges that, like any other health care service or procedure, assisted dying involves a much larger team of health care professionals.

However, we must also appreciate that Bill C-14 is only one component of Canada's legislative response to the Supreme Court's decision and that many important practical considerations will be left up to the provinces and territories to address. This will require additional practice guidelines and regulations.

Generally speaking, as it is drafted now, we believe that Bill C-14 appropriately recognizes the role of pharmacists and protects those pharmacists who choose to participate from any criminal liability that could result from dispensing a lethal dose of medication.

I'd like to make some comments on some of the specific provisions in the bill.

First, it is important to note that under proposed section 241.1, medical assistance in dying is permitted in two instances: it can be administered directly by a physician or nurse, or it can be self-administered. This has significant implications for the role that pharmacists might have to play in assisted dying. In particular, in the case of self-administration, we see a far greater role for pharmacists, who may have to dispense the drugs directly to the patients. It's conceivable that this could be the last interaction between the patient and a health care professional prior to death, so we are pleased to see that proposed subsection 241(4) of Bill C-14 specifically exempts pharmacists from criminal liability if they dispense a substance to a person other than a medical practitioner or nurse practitioner.

We are also very supportive of proposed subsection 241.2(8), which requires that the medical practitioner or nurse practitioner who prescribes the substance inform the pharmacist that the substance is intended for that purpose. This is something we specifically called for, and we are pleased to see it reflected in legislation.

In addition to the specific provisions we've highlighted, we also want to draw your attention to two key elements that are not provided for in legislation but that we feel are equally important. Although we are not proposing any amendments to the legislation, we are hopeful that the federal government will work with its provincial and territorial counterparts, as well as stakeholders, to address these issues in the coming months.

On the issue of conscience, we strongly believe that pharmacists and other health care professionals should not be compelled to participate in assisted dying if it is counter to their personal beliefs. The legislation does not set out whether or how health care professionals can refuse a request. This leaves protection of conscience for health care professionals, including pharmacists, up to the provinces and to professional regulators. In addition, and to ensure that freedom of conscience is respected, pharmacists should not be compelled to refer the patient directly to another pharmacist who will fulfill the patient's request. This is an important consideration for pharmacists who view referral as morally equivalent to personally assisting a patient to die.

To provide equal protection of a pharmacist's right to conscientious objection and a patient's right to access, CPhA recommends the creation of an independent information body with the capacity to refer to a participating pharmacist, and we urge the federal government to work with the provinces and territories to create and implement such a system.

The second issue that is particularly relevant to pharmacists in their day-to-day practice is the question of drug access.

● (1855)

There is no single medication or drug that exists to end someone's life. Rather, it can be a cocktail of medications that could be administered by someone or self-administered. Depending on how it's administered, different drugs could be used.

Of great concern to pharmacists, who are all too familiar with issues of drug availability and accessibility, is that the drugs in question are in some cases not readily available in Canada. There is still some work to be done to understand which drugs might be most effective in assisted dying. Evidence shows that high doses of barbiturates are usually effective for death when self-administered, while a combination of barbiturates and a neuromuscular blocking agent is more appropriate for physician- or nurse-administered injection.

To give you an example, in Oregon, where drugs for assisted dying are solely self-administered, one of two barbiturates is used, neither of which is currently available in Canada. It is critical for Health Canada, as the regulator of drugs, to ensure that whatever drugs are recommended be available and accessible to patients and their health teams. We welcome the opportunity to work with them to address this issue.

In conclusion, we urge that this legislation be passed quickly in order to ensure that there is a framework in place by the June 6 deadline and to allow the provinces and territories an opportunity to develop appropriate practice guidelines and regulations. Over the coming months, our provincial pharmacy associations will continue to work with their respective regulators to ensure that appropriate practice guidelines are in place.

We thank you again for the opportunity to appear and we look forward to answering your questions.

Thank you.

● (1900)

The Chair: Thank you very much, Mr. Emberley.

We very much appreciate all the different interventions, and now we're going to go to questions from the members.

We'll start with Mr. Cooper.

Mr. Michael Cooper: Thank you, Mr. Chair.

I will direct my first question to Dr. Cohen.

You talked a little bit about issues related to the capacity to consent of persons with underlying mental health challenges. As a starting point, the legislation says that any physician or any nurse practitioner can decide whether a patient meets the criteria of the legislation. Would you agree that any physician or nurse practitioner would be able to at least determine that a patient has an underlying mental health issue—not whether they have the capacity to consent—or is a specialization required to make that kind of a call?

Dr. Karen R. Cohen: Exactly. The point of our recommendation was that any regulated health provider should be able to assess whether in fact the condition is present. I think the more complex assessment is going to be whether that condition would impact the person's capacity to give consent. There may certainly be instances, in the case of mental disorders or cognitive deterioration, in which you might need more specialized training to make that determination.

Mr. Michael Cooper: Would it be your opinion, just so I fully understand you, that upon determining that a patient has an underlying mental health challenge, a family physician, say, would not be in the position to determine capacity to consent, and that it would be appropriate at that point for the family physician to refer the patient to a psychiatrist, psychologist, or neurologist to determine the issue of capacity to consent, which would require a more complex analysis? Do I understand you correctly?

Dr. Karen R. Cohen: I certainly can't speak for the practice of every regulated health provider, and it certainly would be the case, as I'm sure Dr. Lemire could confirm, that even different family physicians would have different sub-expertise or capacity. This is why we recommended that the assessment of these complex concomitants involving cognitive or psychological disorders should fall within someone's scope. Much of the time when they are complex, that might involve a psychiatrist, psychologist, or neurologist, but that would not necessarily be the case if a family doctor or other practitioner has that capacity within their scope.

Mr. Michael Cooper: Would it be your opinion that a psychologist, psychiatrist, or neurologist would have it within the scope of their practice to determine that type of assessment?

Dr. Karen R. Cohen: By and large I would say yes, although in the case of a senior with dementia, for example, it would more likely be a clinical neuropsychologist who would make that kind of determination. If the assessment was that depression was present, it would more likely involve a clinical psychologist.

Mr. Michael Cooper: Okay, that's fair enough.

My next question is to Dr. Lemire.

In your testimony, if I heard you correctly, you talked about the need for special training for medical assistance in dying. Could you maybe elaborate on what you meant by that?

Dr. Francine Lemire: I am not aware that I spoke to that directly in this presentation. We do recognize that the medical providers who will be involved in this procedure certainly will need to have appropriate training. We're working very hard in a collaborative manner with the Canadian Medical Association and the Royal College of Physicians and Surgeons of Canada to develop professional development that will enable those who chose to get involved in this procedure to do so.

The procedure itself is the last thing. What counts is really a caring relationship between a physician and a patient, and a journey of accompaniment with the patient during this phase of their life. A lot of conversations need to happen within the scope of the medical profession regarding the assessment of capacity and the obtaining of consent. Family doctors will be well placed to accompany patients in that journey when those elements of those competencies are already there.

Mr. Michael Cooper: I have one final question to Mr. Emberley.

On the issue of conscience protections for pharmacists, you spoke about an independent body that could be set up. I want to ensure I understand what you're recommending.

Are you suggesting that, for example, if a pharmacist had a conscientious objection to physician-assisted dying, they would then get in touch with that independent body, and the independent body would then get in touch with the patient and get the patient to a pharmacist who could provide the services that the patient needs? Such a body, I believe, exists in the province of Quebec in terms of what they provided as an alternative to an effective referral regime in Bill 52.

● (1905)

Mr. Philip Emberley: Yes, that's the kind of structure that we had anticipated. It would be an independent third party agency that could be engaged in such a way. Exactly.

The Chair: Mr. Hussen is next.

Mr. Ahmed Hussen: Thank you very much, Chair.

My question is for Ms. Lemire. Do you have any concerns with respect to whether patients will have any difficulties accessing medical assistance in dying as it is provided under Bill C-14?

Dr. Francine Lemire: The concerns relate to geographic limitations, rural environments, remote environments where such access could be more of an issue. At the same time, we need to accept the reality that there is support currently available to providers and patients in remote environments through Telehealth and other mechanisms of this nature, but there is no doubt that access in rural and remote areas of our country is a concern for us.

Mr. Ahmed Hussen: The other question I have is with respect to capacity. If the doctor or the nurse practitioner prescribes a substance for an individual to take on their own, how will that person be able to assess capacity at the time the substance is taken, if that is required?

Dr. Francine Lemire: That is a good question that's been discussed earlier today.

On the one hand, it's important for us to respect the principle of autonomy. At the same time, assisted suicide will differ from euthanasia in that once the prescription is given, the respect for autonomy has been given, the caring relationship of a provider and a patient may be altered in that the responsibility to proceed in this regard is left entirely to the patient. I hope that if this happens, the caring relationship will carry on and may enable this question to be considered, but it certainly is not a guarantee.

Mr. Ahmed Hussen: With respect to the request for medical assistance in dying, other jurisdictions require more than one request. Bill C-14 requires one request.

How is the medical practitioner supposed to determine if the request is only of a passing nature, if it's only one request? Do you have any views on that?

Dr. Francine Lemire: I believe crafting the legislation to require two independent medical opinions is important. It would hopefully help to mitigate this and provide greater...“comfort” is not the right term, but it would give us some parameters of reassurance to operate under.

As I mentioned, what happens if during the two weeks after the patient makes a request, the patient's condition deteriorates? What is the responsibility of the providers if the condition deteriorates and one is not able to assess that decision? I think obtaining greater clarity in this regard would be important.

Mr. Ahmed Hussen: This question is for Mr. Emberley.

The Special Joint Committee on Physician-Assisted Dying heard that there was a need to ensure that the drugs to be used in medical assistance in dying were available and were not subject to back order, etc.

Do you have any concerns with respect to the availability of drugs to be used in medical assistance in dying?

● (1910)

Mr. Philip Emberley: Thank you for the question.

There are concerns. These medications have not been used therapeutically for quite some time. We're talking about barbiturate drugs that in the past were used in therapeutic doses to help people sleep. We understand that the companies that used to make these medications are no longer doing so.

In doing a search for the drugs that are used in other jurisdictions, such as Oregon and in the Netherlands, namely secobarbital and pentobarbital, we found that they are no longer available in Canada. They are being made in limited quantities in the U.S., but to our knowledge they're not available in Canada as of this time. We're very concerned, as pharmacists would be, that the drugs that were to be used would be available and not shorted or lacking.

Mr. Ahmed Hussen: Have you any ideas on how that could be addressed?

Mr. Philip Emberley: Well, I think it's important that Health Canada would make the necessary provisions to allow manufacturers to import these drugs from other countries where they are being produced.

Mr. Ahmed Hussen: Thank you.

The Chair: Thank you very much, Mr. Hussen.

Mr. Rankin is next.

Mr. Murray Rankin: Thank you to all of the witnesses for coming this evening.

My first question will be to you, Mr. Emberley.

We've heard today in testimony that in the case of self-administration, the moment of prescription of a medication that a patient may take at home is when the medical assistance in dying is provided.

The question I have for you is whether you think pharmacists are capable of making the capacity assessment required to accept that the patient's consent at that moment is valid. The witnesses said today that it could be a pharmacist who gives some medication months and months earlier to a patient, who might have it in her closet for a long time and then finally take it, but the last person who has to assess whether she's in fact giving express consent would, of course, be the pharmacist.

Are your members trained to make that kind of capacity judgment?

Mr. Philip Emberley: Well, first, we feel that there are a number of unanswered questions that the pharmacy profession needs to address. What we will say, though, is that we do not believe it's within the scope of practice for pharmacists to make a judgment on capacity. We feel it's important for pharmacists to know that a patient has met the criteria for assisted death, but we do not feel that pharmacists are in a position to make that determination of capacity.

Mr. Murray Rankin: But we heard that that's precisely what they may have to do. That's one of the safeguards that's specifically listed in new paragraph 241.2(3)(h) of the list of safeguards in the bill. I'm putting to you that this might be a deficiency in the bill, if that's what the government is expecting.

Mr. Philip Emberley: It would be a concern, and we're definitely working with the pharmacy regulators in Canada to take this discussion further. If that were indeed the case, there would be much conversation that would definitely be necessary.

Mr. Murray Rankin: That's because of the huge civil liability issues, wrongful death issues. Presumably you've talked about being satisfied that there's criminal liability protection, and I think they've done a good job on that, but civil liability in that circumstance would be horrendous.

Mr. Philip Emberley: Absolutely.

Mr. Murray Rankin: Yes.

This is a question to both Dr. Cohen and Dr. Lemire.

Dr. Lemire, in your testimony you mentioned the problem of an unexpected loss of capacity during the 15-day waiting period.

To both of you, how commonly might this be expected to occur for patients whose natural death is reasonably foreseeable? From the perspective, then, of both the psychologist and a family doctor, will this unexpected loss of capacity be a rare event, or is it actually quite common for those nearing the end of life, and therefore a serious flaw in this bill?

Dr. Francine Lemire: We need to have an understanding about natural death being reasonably foreseeable. Are we talking two weeks, a month, three months, six months, a year? Greater clarity around that would be important.

If we're talking about a six- to 12-month window, there is lots of room there, and that deterioration may be much less predictable. If we're talking about a shorter interval of time, the deterioration would certainly be more likely and riskier from that assessment perspective.

● (1915)

Mr. Murray Rankin: Dr. Cohen.

Dr. Karen R. Cohen: It's going to vary a fair bit on the conditions. Dr. Lemire used the example of multiple sclerosis. I worked as a rehab psychologist for many years with people who have acquired conditions affecting the brain and spinal cord, like MS. One of its hallmarks is its course can be very unpredictable, so it may be very difficult to say when someone who has motor problems primarily as a result of their MS then acquires cognitive ones.

Mr. Murray Rankin: The words you used, Dr. Lemire, were “seek greater clarity”. Then in your testimony, when you gave the example of MS and reasonably foreseeable natural death you said, “Some specificity around this criterion is needed.” Are you suggesting there needs to be an amendment to clarify that for the purposes of this law?

Dr. Francine Lemire: We believe that statement does require clarification. We appreciate wanting to be comprehensive and allowing the latitude to the relationship between provider and patient to have the conversation and be able to do this, yet at the same time, providers will want to have an estimate of time.

The Chair: You have 25 seconds.

Mr. Murray Rankin: Thank you. I can't ask my question in 25 seconds, Mr. Chair.

The Chair: I appreciate that.

Mr. Ron McKinnon: Can I have his 25 seconds?

The Chair: Right now it's Ms. Khalid.

Ms. Iqra Khalid: Thank you very much for this presentation. You have transmitted very insightful words to us today.

Mr. Emberley, you referred to a third party or an independent body with respect to pharmacists providing the drug. Do you see a problem in remote geographical locations where there is only one pharmacy, say, servicing a rural community? How do you think such a body would affect both instances?

Mr. Philip Emberley: We think that is a very important question. The provincial regulatory bodies are in the process of drafting guidelines for their members, and this is a very important consideration. They have to drill down on some of these specifics because they need to take the need of their populations into consideration. This is an area they will need to home in on quickly to ensure that accessibility is optimized.

Ms. Iqra Khalid: Thank you.

To all the panellists if possible, we've heard a lot of questions and concerns from all our honourable members with respect to conscience rights, capacity, the administration of the bill, and the big underlying question is whether the bill's administration is going to be consistent throughout the country.

What are your thoughts on the provincial approaches and whether the provinces will be able to come together with a consistent approach to the administration of death?

The Chair: Either of you can respond.

Dr. Karen R. Cohen: Health care delivery across the country is not always consistent, so it might be hard to imagine the challenges in having this consistent as well.

Dr. Francine Lemire: Quebec is already ahead in terms of having implemented their bill. It's unlikely that they will change things in a major way. They will likely be beating their own drum. We will already have some differences there.

At the same time, I think that the federal government standing up and being counted will have an impact across the country and provide a measure of equity, although there may be differences. We should not minimize the importance of what's before us today in terms of getting us to a level of equity, realizing that there may be provincial differences.

I realize I'm skating like a good politician, but that is nevertheless what I think.

● (1920)

Ms. Iqra Khalid: Are there any specific amendments that you would propose to ensure consistency amongst the provinces?

Dr. Francine Lemire: I'm not a legal....

Mr. Philip Emberley: I would like to reply to your previous question.

We are a volunteer association of pharmacists. While we do not have any kind of regulatory enforcement over the profession of pharmacy, we feel that there's a role for CPhA to build consensus as to how guidelines are put in place so that there is a certain degree of harmonization among pharmacy practices across the country.

Ms. Iqra Khalid: I hope I have enough time for my last question.

To all the panellists, I'm assuming that you have read the bill and understand how it will be administered. I'm wondering if you've taken a hypothetical patient through both physician-administered and self-administered death, through the whole process that is outlined in the bill, and if you would care to share.

The Chair: Dr. Lemire.

Dr. Francine Lemire: I have not done that in a systematic manner for the bill.

In the example that I gave in my presentation, I certainly walked through the elements of the bill. If we went back to 2013 and took into account that situation around euthanasia, I feel that it certainly would have been possible.

I recognize the principle of autonomy around assisted suicide. I am concerned about some of the elements that have been discussed here today in terms of the potential alteration of the caring relationship between the provider and the patient once that prescription is given.

The relationship will be altered. The caring element of it will be altered. Ensuring that the right person fills the prescription and that the patient has the capacity to self-administer is another aspect. All this raises questions in relation to assisted suicide, yet the principle of autonomy, I believe, needs to be respected.

I will say that the level of comfort as a provider in that caring relationship is something that creates a little bit more uncertainty for me, certainly.

Dr. Karen R. Cohen: We haven't systematically taken a patient through it either.

Our role as psychologists is probably going to be a lot more circumscribed than the role of our colleagues who are physicians and pharmacists. I think our recommendations really embody our concern that considerable time and attention can and should be expended, way before any kind of decision is enacted. Our concern is that the bill as proposed may not sufficiently address that.

Ms. Iqra Khalid: I have a very short question, if you don't mind.

The Chair: Very short.

Ms. Iqra Khalid: With respect to self-administration, what exactly is a pharmacist giving to the patient? Is it just one pill? Is it an injection? How does it happen?

Mr. Philip Emberley: I can only comment on what was done in the state of Oregon, where they have assisted death. There the patient is given two euthanasia kits in case one of the kits is found to be defective. The kit is an inclusive kit that contains two different medications. One is designed to prevent vomiting, and the second one is the barbiturate, which brings upon death. That's my understanding of what is used there.

The Chair: Thank you.

I have one last question that relates to something the Department of Justice challenged me to do. I had raised the issue of “reasonably foreseeable” not being sufficiently clear. I had suggested, hypothetically, that a doctor should establish that it is more probable than not, medically speaking, that death was reasonably foreseeable within a certain time—say, one year. They said that medical associations would generally prefer the flexibility of not having it tied to a time period.

Based on your testimony, Dr. Lemire, do I understand that you would prefer having a time period tied to it?

● (1925)

Dr. Francine Lemire: Yes.

The Chair: That was clear.

What about you, Dr. Cohen?

Dr. Karen R. Cohen: I'm not sure. I'm not sure how to advise on that, because we would not be involved in making that determination.

The Chair: That's true.

I have one last tie-up question. Would you agree that one of the two professionals associated with this should be the primary care physician, as long as this physician does not have a conscientious objection to medically assisted dying?

Dr. Francine Lemire: So the circumstance you've given is that the physician does not—

The Chair: The physician is not a conscientious objector. He or she is a person who would dispense this. Should the primary care physician be one of the two?

Dr. Francine Lemire: I would suggest that the family physician, who has a longitudinal relationship with the patient under those circumstances, is well placed to be one of the providers involved in that caring relationship with the patient. Yes.

The Chair: Thank you for taking my question and the questions of the panel. I know it was much appreciated, as was your testimony. Thank you for coming.

We'll give two minutes to get to the next panel, and I'll ask the people in the next panel to come forward.

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(Pause)

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● (1930)

The Chair: We are going to resume.

[*Translation*]

I want to welcome our new group of witnesses. We are delighted to welcome the members of the Quebec Bar. We have with us Mr. Giuseppe Battista,

[*English*]

who is the president of the committee on criminal law.

[*Translation*]

We also have with us Mr. Jean-Pierre Ménard, who is a member of the Working Group on End-of-Life Care, and Mr. Marc Sauvé, Director of Research and Legislation Services.

[*English*]

We also have with us Dr. Will Johnston, who is with the Euthanasia Prevention Coalition of British Columbia. Then we have Ms. Françoise Hébert, who is the chair of End of Life Planning Canada. She is accompanied by Mr. Nino Sekopet, who is the client services manager.

It's a great pleasure to have all of you here with us. We're going to start with your statements.

[*Translation*]

We will begin with the representatives of the Barreau du Québec.

Mr. Sauvé, you have the floor.

Mr. Marc Sauvé (Director, Research and Legislation Services, Barreau du Québec): Thank you very much, Mr. Chair.

Ladies and gentlemen members of this august assembly, let me introduce myself: I am Marc Sauvé, Director of Research and Legislation Services for the Barreau du Québec. For this presentation I am accompanied by Mr. Giuseppe Battista, who is the President of our Committee on Criminal Law, and by Mr. Jean-Pierre Ménard, who is a member of the Working Group on End-of-Life Care.

The Barreau du Québec, as you would expect, is a professional association of lawyers whose mission is to protect the public. This is done through monitoring the exercise of the profession, but also, from a societal point of view, by promoting the rule of law.

Without further ado, I am going to yield the floor to Mr. Battista, who will discuss certain aspects of criminal law that are raised in our brief. Afterwards, Mr. Ménard will discuss other aspects, particularly the interrelations with provincial legislation.

Mr. Giuseppe Battista (President, Committee on Criminal Law, Barreau du Québec): I thank the committee for inviting us.

At the outset, I want to say that we welcome this legislative initiative, which responds to the requirements of the Supreme Court in the Carter ruling. Generally speaking, we feel that this is positive. However, I would like to share some of the reservations we have about the bill with committee members. I will highlight four points, and Mr. Ménard will provide more detail on them; then we will answer your questions.

The first reservation we have concerns the offence of counselling someone to cause their own death. There is an exemption in the bill for helping someone to die, but providing advice in that regard is not exempted. We think the bill should explicitly say that when a doctor explains all of the care available to a patient, including medical assistance in dying, that does not constitute an offence. In short, the bill should specify that for a physician to counsel a person on assistance in dying is not an offence. This has to be made very clear. Physicians or other health care professionals should not be charged with an offence if they provide information that could be interpreted as advice.

The second element is that in the bill the definition of medical assistance in dying also includes, for physicians, prescribing or providing a substance that will cause death, although the person will himself ingest the substance in question. This concerns us. One can easily imagine a situation that could arise if the health professional is not present at the time the person ingests the substance that will cause death. How can we know that that is really what caused the person's death? Moreover, there are ethical and legislative issues which may place health professionals in dilemmas or conflicts with their own standards and their own regulations. We think that the legislation should prepare for and include those situations. One cannot simply give someone a substance that can cause death without some kind of follow-up. We are concerned about that.

Also, with regard to the principle in the Carter ruling, the bill is somewhat too restrictive in our opinion. In order to obtain medical assistance in dying, it has to be shown that the medical condition of the person who is asking for this is one of advanced and irreversible decline in capacity, and that the natural death of that person has become reasonably foreseeable, in light of his overall medical condition, without necessarily having a prognosis on life expectancy. We feel that those criteria are not in the Carter ruling, and we think that the legislation has to be based on principles and statements that are in the Carter decision, and that they should frame this exercise. There is a clear risk that the bill will be challenged. Mr. Ménard will in fact go into this aspect more in depth.

The last point, which I will address quickly, concerns the new requirements regarding the documents physicians will have to complete. They must fill out forms. Even though the bill states that this must be done deliberately for an offence to be committed, it is somewhat excessive, in our opinion, to criminalize the fact of not having filled out a form properly. The provincial laws and regulations that regulate the medical profession should normally suffice for this type of information.

I will now yield the floor to Mr. Ménard.

● (1935)

Mr. Jean-Pierre Ménard (Member, Working Group on the End-of-Life Care, Barreau du Québec): Ladies and gentlemen, members of the committee, good evening.

The Barreau du Québec is the first intervenor from a province where legislation already exists on medical assistance in dying. The law has been in effect since December 10, 2015. There have already been dozens of cases, and certain issues have begun to arise in applying the law in some situations. To contribute to your debate, we are going to share some of the difficulties we have observed here and there, so that you may avoid encountering the same issues with the federal act. They are not major ones, but we have to be aware of them.

As Mr. Battista said, our first comment concerns the issue of assisting someone to commit suicide. The Quebec legislation does not provide for assisting suicide. We must not forget that the Quebec law is very comprehensive. It covers all of the medical assistance in dying practices that are under provincial jurisdiction. We decided not to include assisting suicide because at the time it was seen as an aspect that was essentially criminal, and the province had no jurisdiction in the matter. The provincial act is an act on care, it is not criminal legislation. Consequently, assisting suicide was not included. However, this will now be made accessible through medical assistance in dying.

We think it is important to think about measures to regulate this that are not contained in the Quebec legislation or any other provincial law. As Mr. Battista pointed out, one of the difficulties comes from the fact that the physician has no control over what happens once he has provided the medication to the patient. He cannot even certify that the patient really did pass away because of that process, nor can he determine when the death occurred. To the extent that the federal law permits assisting suicide, we think it should contain more obligations, such as requiring from those who assist the person that they immediately notify authorities, either the physician or a public authority, that the person has passed away in this manner, so that the proper management of the process may be monitored.

As Mr. Battista pointed out, there is an issue regarding physicians' ethical obligations. There is, for instance, the obligation of following one's patient and not abandoning him. For some physicians, giving a patient a pill and allowing him or her to take it himself is seen as a kind of abandonment. It can also be difficult for a physician to get involved in such a process.

Let's talk about compatibility with the Carter ruling. We should be aware that the impact of the law will in future be measured in light of section 7 of the Canadian Charter of Rights and Freedoms, which is broader in scope than what the bill is proposing. If we adopt more restrictive criteria than what is now allowed under section 7 of the Canadian Charter of Rights and Freedoms, clearly we will be opening the door to legal challenges. The Barreau du Québec feels that it is not desirable that people who could have access to medical assistance in dying under the criteria in the Carter decision, no longer have this access because of Bill C-14. We have seen what happens in Quebec when a more restrictive standard is applied. For instance, some people have stopped eating in order to become eligible under the law. This type of situation, which occurs because of a more restrictive criterion, is not a desirable development. This is important and that is why we made that recommendation.

Moreover, we think that the criterion of reasonably foreseeable death is too vague, too uncertain. It is important for the Barreau du Québec that citizens be able to count on a legal standard that is as clear as possible. The fact that this is highly subject to interpretation, because of the wording, may deprive certain Canadians of the constitutional right to obtain assistance in dying. If we want such a criterion to be present, it is important to develop it more. However, since this criterion does not exist in the Carter ruling, we think that leaving it in the bill will open the door to legal debates. That is why we recommend the pure and simple elimination of paragraph 241.2 (2)(d) proposed in the bill.

I'd like to discuss a few more technical situations regarding the safeguards, among others the characteristics of the witnesses. The standards being imposed are so strict that it will be difficult even for the person concerned to find a witness to sign the form. Members of the family and many other people are excluded. We should remember that the witness only attests the signature, nothing more. In any case, the physician is going to have to verify that the patient gave his or her consent freely. I think that too much is being imposed on the witnesses. These criteria would be more appropriate if we were asking for consent on behalf of someone else. But in the case of a simple witness, we think that these measures are far too rigid.

Let's move on to the declaration. Our brief was written from the perspective that a very detailed provincial law exists, and we are adding a federal law. In order to avoid a multiplication of forms and reports, I think it would be important that there be an exception in the bill; when the government is satisfied with the provincial declarations that are required, there should be an exemption in the bill so that physicians do not have to make a host of declarations. An overabundance of paperwork will also discourage a certain number of physicians from doing these things.

● (1940)

In Quebec, the reporting process is already very elaborate. Why should there be an additional report? I think that this will only make the process more cumbersome, unnecessarily. However, nothing prevents federal authorities from requiring that the province provide the information collected through its own monitoring measures. In Quebec, the province monitors medical assistance in dying. We have created an organization specifically for that purpose, the Commission sur les soins de fin de vie, the end of life care board, in addition to the monitoring done by the Collège des médecins and the Conseil des médecins, dentistes et pharmaciens. And so the creation of a new level of monitoring seems superfluous to us. We think you should consider less onerous monitoring measures in the provinces where a law already exists.

Thank you.

The Chair: Thank you very much for your presentation.

[*English*]

We're going to End of Life Planning Canada next.

Please go ahead, Madame Hébert.

[*Translation*]

Ms. Françoise Hébert (Chair, End of Life Planning Canada): Thank you very much.

[*English*]

Thank you, Mr. Chair, for the privilege of appearing before the committee this evening.

I'm Françoise Hébert, chair of End of Life Planning Canada. Before retiring four years ago to become a full-time volunteer, I was the CEO of the Alzheimer Society of Toronto. We actually trained Chief Blair's staff on how to find the poor lost souls who got lost all the time.

My colleague, Nino Sekopet, is a psychotherapist. He is our client services manager. You may recognize him from the current issue of *Maclean's* magazine, which profiles him as Canada's leading assisted-death counsellor. Nino is the one to call if you want a safe and confidential place to talk about how to achieve a good death, and he is being swarmed by the media these days—his 15 minutes of fame.

End of Life Planning Canada regrets that Bill C-14 is creating certain limitations and conditions that will shut the door to the option of assisted dying for many Canadians who might otherwise meet the criteria set out in the Carter decision.

The Special Joint Committee on Physician-Assisted Dying got it largely right, in our view, and we hope that this committee will agree that strength and gumption are called for when regulating a Charter of Rights and Freedoms issue, even if this means going further than other jurisdictions have in dealing with such a fraught and deeply personal decision as to request assistance to die. Therefore, we beg each of you around this table, as the Supreme Court justices did so well, to imagine yourself with a grievous and irremediable medical condition that's causing you enduring suffering that is intolerable to you. That is the perspective that you need to legislate from.

I'm going to turn it over for three minutes to my colleague, the famous Nino Sekopet.

● (1945)

Mr. Nino Sekopet (Client Services Manager, End of Life Planning Canada): Thank you, Françoise.

Thank you for having me here. My name is Nino Sekopet, and I am a psychotherapist retained by End of Life Planning Canada to support people who want a safe place to talk about dying. For four years before this, I played the same role with Dying With Dignity Canada.

I deal every day with the complex and profound topic of the end of life. I see it as a continuum that, unfortunately, consists of two emotionally charged and polarized extremes. We have people who support physician-assisted dying and we have people who oppose it. There is also a vast space in between. Looking through a purely psychological lens, I believe that when we as individuals or as a society stand in either one of those polarizing extremes, deserting the vast in-between space, we miss something very important. We miss the very thing that gives the charge to those polarizing extremes. We fail to recognize the impact on the end of life. We fail to recognize the impact of the fear and insecurity that drives the emotional charge at both extremes.

I believe that if we are able to correctly address the impact of fear and insecurity, and if we do it to the degree that is necessary, those polarizing extremes will lose some of their charge. We will become less polarized. As individuals and as a society, we will become healthier and more willing to consider and accept our differences. We will become more inclusive rather than exclusive. We will become more tolerant.

What I've learned through my work with people approaching death is that clarity is the best way to contain fear and create a space where these patients can feel more secure. Clarity provides a psychological frame within which individuals can rest safely, knowing that they are secure, recognized, and validated. This applies to everyone at the end of life, to all of us. It applies equally to health care professionals, to patients, and to their families.

In my professional opinion, the reasonably foreseeable natural death criterion proposed in Bill C-14 provides little security, little frame of reference. Because of its openness to interpretation, it encourages fear and insecurity, rather than creating space for safety. Removing that criterion from the proposed legislation will restore clarity in line with the Supreme Court's Carter decision. It will benefit everyone engaged in the end-of-life territory, patients as well as health care professionals. It will ultimately benefit all of us as individuals and as a society.

I would like to invite you to step into the vast in-between space and contain the fear of all individuals engaged in end-of-life territory by removing the reasonably foreseeable natural death criterion from the proposed legislation. I invite you to trust the individual who is suffering terribly, and that person's physician, to know when their time has come. By doing that, you will make us all feel safer, regardless of our place on the end-of-life spectrum.

Thank you.

● (1950)

Ms. Françoise Hébert: I want to step in now and address the second point in our brief, which is advance requests for medical aid to die.

Bill C-14 ignores recommendation 7 of the special joint committee, which would permit advance requests for someone diagnosed with a condition likely to cause loss of competence—for example, Alzheimer's disease. The government is proposing instead an independent study of advance requests, and it may revisit the issue in five years when the bill is reviewed.

Here is our view.

Dementing diseases such as Alzheimer's are terminal. They kill vital brain cells slowly and cruelly. The course of the disease can last up to 20 years after a diagnosis. In the late stages of dementing diseases, the body is alive but the brain is compromised beyond repair. The person has become a shell, living in an advanced state of irreversible decline in capability. It is a pitiable state to be in.

The idea of being demented deeply scares me. I would rather be dead than live the final stages of dementia. We've all heard someone say “Just shoot me” as they imagine themselves severely demented. We foresee the loss of quality in their future life. They foresee the quality of life in their future life, and they beg to be allowed to receive assistance to die if they have by then lost the capacity to make the request. We believe that a valid advance request that includes a specific, independently verifiable description of a future state so devoid of quality that life itself would be intolerable to the individual should survive its author's loss of capacity to request assistance to die.

Some will say this can't work because that person might change their mind, but we posit that when you lose the capacity to make an informed choice about your own body, then you also lose the capacity to change your mind, and your advance request should stand as the last expressed wishes of your competent self.

If my validly written and witnessed advance request describes a state of being so lacking in quality that it would be intolerable to me, and if my description of that state is sufficiently clear that my legal substitute decision-maker and two independent medical professionals can verify that my debilitation has reached the point that I so clearly described, then my advance request should satisfy legal requirements to allow me to receive assistance to die.

Our overall view comes down to this. Bill C-14 must put forward clear rules about who is eligible for assistance to die, but it must do this in a way that respects the autonomy of the individual, in consultation with medical professionals, to decide when suffering has become so intolerable that death is preferable. This can be done in real time, or it can be done in advance through a clear and valid advance request. We beg you not to abandon to a pitiable fate those Canadians who would take the time to draft an advance request for assistance to die should they at some point in the future lose the capacity to make an advance contemporaneous request.

Trust the people who elected you to represent them, and trust the medical profession.

Thank you.

The Chair: Thank you very much.

Now we move to Dr. Johnston.

Dr. Will Johnston (Chair, Euthanasia Prevention Coalition of British Columbia, As an Individual): Thank you very much, Chair and members of the committee. It's an honour to be here today.

I am a family physician with 35 years of experience. I deliver babies. I look after people who are at the palliative end of life. I look after people with disabilities who are nowhere near dying. I am perhaps the only person at this table who has conducted capability assessments—about a hundred of them, in fact—with a lot riding on a legal medical assessment of whether the person was capable.

It was with some great relief that I saw that Bill C-14 at first reading, as drafted, took a very careful approach. Far from trying to be groundbreaking or in the van of the entire world in its daring nature, it took a very responsible approach to the many issues in front of us.

I'd like to take a minute to tell you a story about Uncle Matt.

Uncle Matt was a strong older man who was on a hunting trip in northern B.C. He spent two weeks traipsing through the bush, but on the way home, near Chilliwack, he began to suffer weakness on one side of his body. He was having a stroke. He eventually was transferred to Surrey Memorial Hospital and came to my attention 10 days after a feeding tube had been pulled out. His niece contacted me because she was able to discern that he wanted to live. He was able to say “hungry“, “thirsty“, and the niece asked Uncle Matt's daughter, “Why are you not putting that tube back down? We think he wants to live.” Her reply, in part, was “I've been tallying things up, and he wasn't a very nice man.”

The niece and another nephew kidnapped him from Surrey Memorial Hospital and took him to Vancouver General Hospital. The nurse there, although he was able to croak out the word “thirsty“, was aware they did not hold powers of attorney and put him in an ambulance and sent him back to Surrey Memorial. He died.

He died during an emergency hearing that I helped arrange, during which a judge actually issued an order that the feeding tube be put back down, that he be rehydrated, and that his true wishes discerned.

Now, this is not to say that the people who've come to Nino or who have come in front of Françoise are like Uncle Matt, because the people who have self-selected to approach people who are involved with end-of-life planning and that organization have already self-selected to be highly motivated. This is to simply demonstrate that the medical system, as it now stands, consisted for Uncle Matt of doctors who would not listen to the possibility that he wanted to live and was being intentionally dehydrated to death—he had several million dollars' worth of real estate—and that the hospital risk management, such as it was, was more concerned about the hospital not being sued than it was about Uncle Matt's wishes being respected.

This takes me to the point that this bill, although it might be assumed, nowhere specifies that doctors must actually examine the patient, the extent to which they must do so, or the extent that doctors must inquire into the internal and external factors that create vulnerability for the patient. I refer you here to the vulnerable person standard, which is being published now and which contains four key elements that should be reflected in this legislation.

This lack of requirement for the two doctors—and I use doctors to mean doctors and nurse practitioners—to deeply engage with the patient begins with the acceptance by the doctors of a written request, which can be created before two witnesses by someone representing the patient who purports to understand the nature of the request. The doctors do not have to meet, nor do they have to assess the motives of the representative. The patient representative and two witnesses must be physically together at some point in time, but a doctor does not have to be present at that time.

The two witnesses are not required to have any understanding of the situation, other than that a request is being signed and dated. The witnesses are not expected to have any knowledge of the patient's decision-making capability or the representatives' motives. Under the draft act, any number of physicians may be canvassed by anyone to find two who approve of death in any given situation.

The factors that are enumerated in the safeguard section of the bill in proposed section 241.2 are in many ways moot. Therefore, I would propose the first amendment of four that I'm interested in proposing, and it is that there needs to be some form of prior review by a third party, such as an independent, objective judge, or some sort of process in which the facts that brought this person to the point of being proposed for assisted suicide or euthanasia could be reviewed.

● (1955)

I can tell you that it is extremely difficult to make these determinations, and I have done it many times. I think that to expect that any two doctors in the medical system could do that is to invite wrongful death. I am sure that in 20 years, as the members of this committee must understand, many deaths will have occurred under the auspices of Bill C-14. I'm sure the members of the committee will want to think that if there are wrongful deaths emanating from this legislation, you did your best to plug the gaps, to fill in the holes, and to make sure that vulnerable people were truly protected. As it stands, the two-doctor standard for assessing consent and capacity, I would suggest, is insufficient, and I think I've been echoed in that concern by others.

My second point is that it seems that Mr. Rankin has the deepest understanding of the fact that a long period of time may happen between the dispensing of the medication and the death of the patient. In that period of time, there is room for abuse, sadly. In Oregon, once the dose is dispensed from a pharmacy, it goes out into the wild blue yonder and is never accounted for again. If the patient struggled and was actually given the dose by someone else, one would never know.

Although Mr. Rankin's insistent questioning on this matter may be designed to lay the groundwork for advance consent to be put in place, I think there's another interpretation that could be taken from his acute observation, and that is on the wording of proposed paragraph 241.2(3)(h), under safeguards, that the physician must

> immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request

I would suggest that this wording really should be “at the time of”. Furthermore, why is it not possible for the lethal dose to be dispensed not from a pharmacist to the patient but from a pharmacist to the doctor, so that the doctor could ensure that at the time the lethal dose was used, the elements of consent were there and the capacity was there? This would address the concerns of Mr. Emberley from the pharmaceutical association as well as some of Francine Lemire's concerns.

We have heard four times, I think, from Minister Wilson-Raybould that nothing in this act compels anyone to become involved in assisted suicide and euthanasia. That, I think, suggests that the time may be right for those words to actually appear in this bill: “nothing in this act compels”. That could appear in the preamble. That could appear in another section. I think it would go a long way toward giving that central direction to conscience protection and the protection of professional judgment that is so desirable.

There is another question, of course, and that is the issue of whether we could actually make a simple wording change in the eligibility section of this bill, which would in some ways answer three of the four areas that I've talked about so far. We could actually.... I'm sorry. It's in proposed section 227, a proposed new section of the Criminal Code that deals with exemptions from criminal prosecution for doctors and others who provide assistance in dying to someone who qualifies under the eligibility criteria.

Under proposed subsection 241(2), it is stated that:

> No medical practitioner or nurse practitioner commits an offence

There, we could easily say “no specially licensed medical practitioner or nurse practitioner”. This would address several concerns at once. One is that in the eligibility criteria, it is nowhere specified that the person has to have received the services or an offer of services of a multidisciplinary team that could try to address the symptoms that gave rise to the request for death. A specially licensed physician or specially licensed nurse practitioner could be charged with making sure that this had happened.

● (2000)

I think that's worth commenting on further. I've heard it said several times that it was unconscionable that this be left to two physicians who are not charged with making sure that alternatives have been offered, and that could easily be fitted into the eligibility criteria.

I look forward to your questions.

The Chair: Thank you very much.

I'd like to thank each of the members of the panel for their presentations.

We'll begin questions with the Conservatives.

Go ahead, Mr. Warawa.

Mr. Mark Warawa: Thank you, Chair.

Thank you to the witnesses for being here.

I'm sure most of us in this room have experienced saying goodbye to a loved one or a friend. In my 66 years, I've said goodbye to my parents and my in-laws. Whether it's at a young age like my mother, at 47, suddenly in her sleep, or most recently my mother-in-law, it hurts.

My mother-in-law had dementia. She was never in a pitiful state. She lived a very wonderful life of love. We loved her. She was dignified. She was dignified because we gave her that dignity. She was never in a pitiful state. I heard in testimony today that it could be defined as a pitiful state, and in special committee I heard that it's not sensible for somebody to be in an adult diaper in the last year of their life in bed with dementia, but we loved her and we miss her.

We went to say goodbye to her. We were told by her family physician that she had two to five days to live. We asked what sense there was in giving her her meds, her glaucoma drops, her dementia medicine, and whatnot. As a family we said to just stop the medicine and let her go. After three days of staying with her—she was in California—my wife said goodbye. It was a wonderful experience. When we came back, we phoned the rest home: Is she gone? No. The next day: Is she gone? No. When we called the third day, they said somebody wanted to talk to us.

She came back. We had another wonderful year. It was one of the best years we had.

I tell you, we don't know what we're playing with here. We don't know if somebody's going. She missed Dad and she wanted to go. She would have qualified. But she came back, and we had that wonderful year.

Dr. Johnston, regarding putting “nothing compels a physician to” in the preamble, preambles are not usually seen by the court as the guiding principles as they would be if they were actually in the bill. I think all of us have heard from witnesses that the number one issue —and we're hearing it over and over again—is to protect the conscience rights of physicians, nurses, pharmacists, medical practitioners. We need to get it right when we protect vulnerable Canadians and we need to protect conscience rights. The Supreme Court in the Carter decision highlighted that.

The legislation that's proposed in Bill C-14 at this point is silent on that. It's been explained by the minister and the department that it does not say that anyone is forced to participate in this, but it is silent on it. Would it help, instead of having it in a preamble, to actually state in the bill that it would be a criminal offence to force, intimidate, or coerce a physician or health care practitioner, nurse practitioner, or pharmacist to participate against their will?

What we have in the Carter decision is that it was legal to commit suicide, but it was illegal to assist somebody. Carter has said that under certain criteria, you can assist somebody. The pendulum has swung to where the special committee has said you must refer, but the Canadians that I'm hearing from want conscience protected.

My question to you is this: if Bill C-14 were amended to make it a criminal offence to coerce, intimidate, or force a physician, do you think that would deal with the issue as far as conscience protection is concerned?

● (2005)

Dr. Will Johnston: Thank you very much for what are in effect two excellent questions. I would like to take your first one up first.

Your poignant story about your mother-in-law reminds us that the fatal weakness of the whole concept of advance consent is the unsupported assumption that the loss of a legal capacity and perhaps the loss of verbal abilities must necessarily be accompanied by the loss of the ability to change your mind. In fact, the fatal flaw of the advance consent argument is that what you're in essence doing is telling the person who's becoming increasingly incapable—and this is often a gradual process—when you are no longer to communicate in a way that we are going to recognize, we're going to take away your right to change your mind. I think that this is the last thing that the drafters of this law would have intended. I think that it's extremely prudent that they have stayed away from enabling the decisions you make in one physical state and under one set of circumstances to rule tyrannically over you, potentially resulting in your wrongful death, but a wrongful death that cannot be discerned externally.

Taking you up on the next point, it is true that the strongest possible statement of conscience rights would be contained in a section of the Criminal Code that actually provided not just a ringing endorsement of the section 2 charter right to conscience—which has never been properly supported in jurisprudence that I'm aware of— but also actual penalties for discrimination against a person who was contemplating entering a health care profession, was in a health care profession, or was in any way involved in the care of a patient, where that person was being coerced to either renounce their determination not to participate in assisted suicide and euthanasia or to in any other way disadvantage that person. I would, of course, heartily endorse such a thing. As a balance for this amazing innovation in Canadian law about a statement of exemption from criminal prosecution, which is as groundbreaking as the rewrite of section 241, I think that it would be appropriate for it to be accompanied by an equally groundbreaking assertion of conscience rights.

I would challenge the committee to take this up as a special issue, because this is not the last contentious thing that's going to come before us. Medical science and genetics will deliver so many more contentious questions to us in the future. Are the conscience rights of the relevant professionals or involved practitioners to be thrown under the bus every time a new access right is declared by a court or by Parliament? The time has come to decouple conscience rights from access rights. This could most effectively be begun by a ringing endorsement of conscience rights and the protection of them in the Criminal Code.

● (2010)

The Chair: Thank you very much. We've exhausted that time.

We're going to go to Mr. Fraser.

Mr. Colin Fraser: Thank you very much, Mr. Chair, and thank you very much, everybody, for attending the committee and for your thoughtful presentations. It certainly helps us in the job that we have to do to make sure we get this bill as right as we can.

[*Translation*]

My first question is for the representatives of the Barreau du Québec.

You stated that a physician or nurse practitioner who provides medical assistance in dying is not under this bill guilty of any offence, but that the fact of advising someone in this regard remains criminal.

Do you think we should amend the bill? If so, what would that amendment look like?

Mr. Giuseppe Battista: Thank you for the question.

The idea is to protect physicians so that they do not find themselves in ambiguous situations. I think Dr. Johnston explained the awkwardness of the matter. Since the subject is very delicate, we are concerned. If we do not have explicit immunity in the bill for a physician who counsels a patient about assistance in dying, we have to consider this in a broader way. Counselling someone who wants to commit suicide when one is not a recognized practitioner or licensed professional is something else. Our concern is about the interpretation that could be given to the fact of “counselling someone” or the scope that could be given to that.

Obviously, the relationship between physicians and patients is very close and confidential. Doctors have to be able to provide information freely to patients about all of the options that are open to them. We have to avoid placing physicians who counsel their patients in ambiguous situations. That is why we are proposing an amendment to protect physicians and other qualified professionals.

● (2015)

Mr. Colin Fraser: Thank you very much.

[*English*]

In the interests of time, I'm going to move to End of Life Planning Canada.

You talked about advance directives in your presentation. Paragraph 127 in Carter talks about clear consent being required. Does Carter not limit that ability, because it clearly says consent?

Ms. Françoise Hébert: I don't know that Carter used the words “contemporaneous consent”; the consent has to be clear.

If you have a clear and detailed advance directive about a future state that you know would be unacceptable to you when you consider that future state, would cause you intolerable pain, it's like the option of time shifting forward. That's what I'm talking about.

By not allowing advance consent, you're shutting the door to the possibility of somebody who would suffer terribly knowing they were in that state, but you're not allowing them the option of assistance to die. You're shutting the door entirely to them. I'm saying leave that door open for them.

Advance directives as they're administered in the provinces and territories right now are a bit of a mess. They're all different. Some are legally binding and some are not.

I see a fairly straightforward national form specifically for people who in advance imagine a state that is unacceptable to them. All the other criteria would have to be met, but their description of the state that would be unacceptable to them would have to be clearly described in that advance directive. I would want that advance directive to survive the person's lapse into an incapacitated state in which they can no longer make an informed decision.

I do not believe that many people would change their mind when they imagine themselves in a vegetative state, in a fetal position, having to be spoon-fed, with somebody cleaning their poopy diapers every day. To some that lack of quality of life would be intolerable. I don't want the law to prevent that.

Mr. Colin Fraser: Are you saying, then, that advance directives go beyond Carter or not?

Ms. Françoise Hébert: Carter didn't deal with advance directives at all. It said there had to be clear consent.

Mr. Colin Fraser: It said physician-assisted death for a competent adult person.

Ms. Françoise Hébert: That's right. When you write an advance directive and you write it when you are competent, and then you lose competence, this advance directive should remain the last statement you made while you were competent.

Mr. Colin Fraser: Thank you for your help with that.

Mr. Johnston, you also clearly said you would support advance directives and a person can change their consent. How do we know they're not going to do that?

Belgium and Luxembourg have allowed advance directives in cases where somebody is in an irreversible state of consciousness. Would an irreversible state of consciousness satisfy your concern?

Dr. Will Johnston: My concern about advance directives stems, I suppose, partly from my experience as a family physician.

I have a lot of young patients in my practice who, in the course of a physical exam, show me pretty amazing tattoos in pretty amazing places. At the time they were applied, they were competent and gave consent and thought that's what they wanted. My problem with advanced consent in this situation is that I have this visualization of advanced consent being like a bad tattoo that follows you on through life. It's pretty hard to get rid of, because by the time you wish you could get rid of it, nobody knows you wish you could get rid of it.

All of those tramp stamps, or whatever you want to call them on people, are like advanced directives. I think that's a pretty close analogy: you're in one frame of mind and you make a decision, and who knows what's going to happen when you pass to another frame of mind?

I don't think it's a stretch to refer to cases of complete locked-in syndrome and coma, in which people have woken up and have reported that they were hearing not only every word that was said but were able to recount even such shocking things as abuse on their persons while they were supposedly unresponsive.

As hard as it may be, I think we must always stop ourselves from projecting our own disgust, real and human as it is, to disability onto others. There is no human being who deserves to be called at any time in their earthly existence a shell. There is no human being who deserves to be at any time in their earthly existence described as someone who should raise your disgust by the nature of the personal care that they have to receive.

Very kindly and good people, like Françoise and Nino, are involved in trying to give people what they want. I just want to caution the committee that it is very wise of the existing legislation to shy away from advance directives.

● (2020)

The Chair: Thank you very much.

We're going to go to Mr. Rankin.

Mr. Murray Rankin: Thank you, Chair.

I want to start with the Barreau du Québec, and particularly with Mr. Ménard, and to thank you very much, sir, for the very helpful testimony that you provided to the Senate-House committee, where you were one of our first witnesses. You were very valuable in explaining the Quebec experience and you've helped a great deal today.

I listened, I confess, in English to your remarks, and I took a few notes that I want to get your comments on.

You spoke about Bill C-14 being too restrictive. You said that the law is not based on the Carter principles, that it can be constitutionally challenged, that it's more restrictive than section 7, and you alluded again to a constitutional challenge. Then you spoke about “reasonably foreseeable” death, the expression in proposed paragraph 241.2(2)(d) that you said should be eliminated from the list of criteria. You indicated that it was too nebulous and that clarity needed to be provided in a definition that was so unclear.

What you've done is given us the same testimony we've heard from Professor Downie, from the east coast, and we'll be hearing on Thursday from the lawyer, Mr. Arvay, who argued the case from the west coast. You've talked to us from French Canada and English Canada.

There seems to be, among a lot of legal experts such as yourself, an acknowledgement that this is simply inconsistent with Carter. I'd like you to elaborate.

[*Translation*]

Mr. Jean-Pierre Ménard: There may actually be all sorts of reasons, moral or other, to think otherwise, but from a strictly legal standpoint, the bill as it is worded creates a very real problem. I am a practising lawyer and I have clients, including groups of disabled individuals. Some of those groups have asked us to consider this scenario. In such a fundamental bill, it is important to generate some legal certainty for Canadians. The standards and the rules of the game must be clear for everyone.

This bill proposes a standard to enable access to medical assistance in dying, but the issue, with all due respect, is that this is not the standard from section 7 of the Canadian Charter of Rights and Freedoms as set out by the Supreme Court in the Carter decision. When a more narrow standard is adopted to cover end of life and similar issues, the problem lies in the fact that a void is being created. In fact, those individuals who do not meet the end-of-life conditions included in Bill C-14, but who do meet the conditions related to grievous and irremediable illness from the Carter decision, want to have the right to access medical assistance in dying. The Supreme Court decision truly applied to those individuals.

The Supreme Court did base its decision on end-of-life criteria. It did not wonder whether the individuals were really at the end of their life. That is not a factor the court considered. It talks about people suffering from grievous and irremediable conditions, some of which may lead to a sooner end of life. When the court gave section 7 all its scope, it did so consciously, I believe, in order to ensure a broader reach than that ensured by the bill.

The problem is that, by setting limits as has been done in this case, there is a risk of overlooking some of the people who have the constitutional right to access medical assistance in dying. This bill will take away that right or force those who want to exercise it to start from scratch again before the courts, so that the Supreme Court would once again fill that void. Two, three or four years down the road, the House of Commons—Parliament—will have to amend its legislation again.

The Barreau du Québec does not feel that this is desirable, especially when it comes to individuals with a grievous and irremediable medical condition who would have to engage in a legal battle again. That is not what we should aim for as a society.

We can agree or disagree. The Supreme Court may have gone too far, but we are talking about the Supreme Court and the law of the land. We cannot ignore this for the sake of other principles.

As for the criterion whereby death must be reasonably foreseeable, we have a similar problem in Quebec, as well. In fact, the criterion whereby the individual must be at the end of their life is also being debated. We are in the process of applying the legislation, and there are issues with this. As the criterion can sometimes be too nebulous, the position may vary from one physician to the next. Some are saying that, to be considered at the end of life, people have to be dying, terminally ill, while others are talking about three or six months. It is clear that reasonably foreseeable death is an excessively vague criterion. For Canadians, it is important that legal standards be clear, applicable and easy to understand for everyone.

We have held a long debate in Quebec to decide whether it was desirable to establish a time frame—such as six months or three months. The issue is that medical science is unable to predict whether the time frame will be three months or six months, depending on the individual. Therefore, we have decided that it would be preferable to give physicians an opportunity to use their discretion.

However, the problem is that, with nebulous criteria, Canadians' rights become more or less elastic, and that leads to problems. Taking into account those problems, as well as the scope of the Carter decision, we have recommended that this criterion simply be removed from the legislation.

● (2025)

[*English*]

Mr. Murray Rankin: I'd like to ask you another question that didn't come up in your remarks, but it is one that my colleagues have asked about: the conscience rights of physicians. I believe that when you were on television in Quebec—I heard this second-hand, so I may have it wrong—you indicated that it would be a purely provincial jurisdiction.

Would you elaborate on that if I've got it right?

[*Translation*]

Mr. Jean-Pierre Ménard: This issue seems extremely relevant to me. Conscience rights do not fall under criminal law. In medical practice and in professional practice, conscience rights are primarily a matter of medical ethics. The medical community determines how physicians should interact with patients and behave. In my opinion, it's a mistake to consider conscience rights part of criminal law. Those rights fall under medical ethics and provincial laws that also govern medical practice. The bill does not cover this, and I think that is a wise constitutional decision.

In Quebec, the Act respecting end-of-life care provides for very clear conscience rights. The physicians' code of ethics also sets out very clear rights. Those rights are similar from one province to another. However, a federal conscience right could be different from provincial conscience rights, and that would cause issues in terms of which standard the physician should follow. To my mind, it would be preferable to let each province's college of physicians define the standards of behaviour for physicians. So I invite you, with all due respect for Dr. Johnston, to keep the door closed to this kind of a situation.

In its initial proposal, the Barreau du Québec had written a comment about this, but since this issue was not part of the bill, we have removed it. However, I want to reiterate our point of view. We invite you to leave the regulation-making authority to the provinces and to colleges of physicians. The provinces are already regulating medical practice. I think we already have our hands full with the rules of criminal law, so let's not go any further.

The Chair: I now give the floor to Mr. McKinnon.

Mr. McKinnon will have the floor for four minutes, and will give up his last two minutes to Mr. Thériault, who will have an opportunity to ask you questions.

[*English*]

Mr. Ron McKinnon: Thank you, Chair. There are many questions to ask and a lot of excellent witnesses.

I'm going to focus on Barreau du Québec because you are the first legal organization we've spoken with outside of the justice department.

The Department of Justice and the ministers are quite certain and quite confident that Bill C-14 is charter compliant and fully fulfills Carter. I take it that you are not in agreement with either of those assertions.

You talked about some of this already, so I'll focus on one small aspect in particular.

The definition of a grievous and irremediable condition includes a requirement for the patient to be in an advanced state of irreversible decline. Do you think that this is mandated by Carter and do you think it's an appropriate condition?

● (2030)

[*Translation*]

Mr. Jean-Pierre Ménard: That was not a criterion established in the Carter decision. That criterion was added on. The Carter ruling provided no definition, and the Supreme Court's decision not to go too far on that issue was probably deliberate.

The notion of irreversible decline is a new criterion, and it is more limiting than what is set out in the Carter ruling. That being said, this criterion could be more easily managed than the criteria proposed in paragraph 241.2(2)(d), which talks about reasonably foreseeable death. When we decide that the grievous and irremediable illness must cause a certain decline before physician-assisted dying becomes accessible, let's just say that we are walking on a tightrope. Ultimately, without wanting to be too strict, we could let this criterion slide, but I don't think it is a criterion from the Carter decision. To strictly apply the Carter ruling, we should limit ourselves to paragraph (1) and forget the entire paragraph (2) of provision 241.2. Initially, we considered removing the entire paragraph (2). That paragraph introduces a number of criteria that are not part of the Carter decision, but the criterion of reasonably foreseeable death feels like the most important aspect to me. As for the irreversible decline criterion, I must admit that we are walking on a tightrope. In addition, that criterion does not come from the Carter decision.

[*English*]

Mr. Ron McKinnon: Regarding reasonably foreseeable death, you indicated there should be a much clearer legal standard for what that means. The minister indicated that it was really a medical decision, not a legal question.

Would you care to comment on that?

[*Translation*]

Mr. Jean-Pierre Ménard: It is clear that the issue lies in the fact that physicians expect the law to define all the situations in detail. However, the more law defines situations, the more it limits them. We have to be careful about that, as well. Given the extreme variety of situations, it is difficult to have a definition that would apply to each and every case.

It is important to give patients a certain margin of discretion in their relationship with their doctor. Key parameters and a framework to assess situations will be established. In Canada, we have to trust medical practice. We especially have to trust patients' discretion and autonomy. This piece of legislation is first and foremost about patients' rights. This entire process is an extension of patients' rights—their right to control their life and especially to control when they want to die and how. This piece of legislation does not really give physicians or health establishments powers or rights. It is made for patients.

As long as patients are conscious and competent, as long as they can make decisions, are well informed about their situation and are taking action based on that, the definition of all the medical conditions and variables need not go too far. The more details are provided, the more situations are excluded.

This is exactly what is happening here. The proposed subsection 241.2(1) talks about the Carter criteria, but by defining them in the proposed subsection 241.2(2), many people are already being excluded. We have to be extremely careful and not try to take things too far. We have to trust Canadian citizens, patients and physicians. By implementing appropriate control and oversight measures, we can reassure ourselves as a society.

The Chair: Thank you.

With Mr. McKinnon's permission, we will move on to Mr. Thériault.

Mr. Luc Thériault (Montcalm, BQ): Thank you.

Do I have two minutes?

The Chair: Yes, you have two minutes.

Mr. Luc Thériault: Thank you.

Ultimately, the Quebec legislation is based on two premises.

Here is the first one. Don't we all want to cross the threshold of death calmly, to let go without fear of suffering, without suffering? Is that not what we would wish for others?

The other premise is the following. We harm an individual's dignity by harming their self-determination; it's not a matter of diapers. The other principle is self-determination. The law considers this principle during our life, while we are healthy. So why would that self-determination principle be taken away in a moment as intimate as our own death? My neighbour won't be dying in my place or wanting to do so.

Those two principles give rise to the Quebec piece of legislation titled An Act respecting end-of-life care, which did not cover assisted suicide. The reason I am stressing that fact this afternoon is that there is a problem with conceptual confusion between euthanasia and physician-assisted death during the final stage of life. Whether we are talking about six months or a year, the fact remains that the process toward death is irreversible. We are then no longer talking about healing, but rather about the right to die and about palliative care. The request to die always emerges during palliative care, and rarely before.

The court is now asking us to provide a framework for assisted suicide. The criterion in question is that of natural death. There has been a lot of talk today about reasonably foreseeable death, but there is an even more nebulous term—reasonably foreseeable natural death. But is death in palliative care natural? To my knowledge, a patient in palliative care dies from whatever they are given to manage the pain. One last dose, even if it is not lethal, will end up stopping the heart. In that case, can we talk about natural death?

I could talk about this for a long time, but I want to ask some questions.

The Quebec legislation does not provide a time frame. In this case, we have talked about a time frame of 15 days. For all sorts of reasons, I feel like this is a dubiously drafted version of the Quebec legislation. Would you be open to adding an equivalency clause, as Professor Hogg was suggesting?

If this piece of legislation was adopted as is, it would lead to peculiar situations for Quebec. For example, the Quebec legislation does not talk about nurse practitioners or other health professionals. Would you agree with adding an equivalency clause to the legislation? That way, if the federal minister was convinced that a province or a territory has implemented the necessary guarantees equivalent in substance to the federal guarantees, the federal legislation would not apply. Would it not make more sense to do that?

● (2035)

Mr. Jean-Pierre Ménard: First of all, you have to understand the meaning of the Quebec legislation. I was very closely involved in that process. The objective of that piece of legislation is to regulate all of end-of-life care. That legislation does not come under criminal law, but under health. It covers all end-of-life care practices, including palliative care, physician-assisted death, advance medical directives, and so on. The legislation's objective is slightly different from that of the bill we are debating.

Before us is a bill that aims to amend the Criminal Code in the context of physician-assisted death, which was more broadly defined by the Supreme Court than by the Quebec legislation. In terms of equivalence, this bill is not the federal counterpart to the Quebec legislation—that much is clear. The Quebec act has a more restrictive objective.

Furthermore—and I'm saying this with all due respect for the federal legislator—many measures found in Bill C-14 are cut and pasted from the Quebec legislation in certain aspects. That's adequate, as that piece of legislation was not misguided, either. However, the issue you are raising seems relevant to me. To the extent possible, we have to avoid regime duality and Quebec citizens having to deal with two legal standards regulating their decisions once the legislation has been adopted.

If someone wants to have access to assisted suicide, it's impossible under the provincial standard, but it could be possible under the federal legislation. The procedure is slightly different. It is probably important to hold back a bit by stating that the Government of Canada can exempt a province from certain formalities or give it some flexibility when it comes to specific aspects of the legislation. However, in terms of the substance, it cannot go too far, as the intention must be compatible with the Supreme Court's decision, as well as with section 7 of the Canadian Charter of Rights and Freedoms and the rules we are currently establishing in committee.

The Chair: Mr. Thériault, you have enough time to ask a quick question.

● (2040)

Mr. Luc Thériault: In the Carter decision, the Supreme Court claims that the right to life is affected, in the sense that this would force people with a degenerative condition to precipitate their death through suicide, although they are not at a point where they would need help. However, it is important to note that people with a degenerative condition are not suicidal. They want to live as long as possible, until they can no longer handle the state they are in, and their state can decline quickly from evening to morning. They want parliamentary legislators to assure them that, at that point in their life, someone will take care of them properly.

Mr. Jean-Pierre Ménard: Those are significant problems. In the Carter decision, the Supreme Court was targeting that kind of a situation, while the bill under consideration seems to exclude it. This is a considerable limitation, and that is why we invite you to reconsider the issue. Of course, this kind of a decision is up to the legislator. We will apply whatever you decide. We will live with it and make sure that it is accessible to Canadians as much as possible.

The Chair: Thank you very much for your testimony.

[*English*]

We really appreciate all your presentations. We learned a lot.

We have an in camera session of the committee right now, so I would kindly ask everyone to quietly leave the room in the next minute or two so that we can proceed with our in camera session.

[*Proceedings continue in camera*]

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