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Chair

Mr. Anthony Housefather

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● (0850)

[*English*]

The Chair (Mr. Anthony Housefather (Mount Royal, Lib.)): I hereby convene the meeting.

Thank you for coming to this meeting of the Standing Committee on Justice and Human Rights. It's a great pleasure to have everyone here as we continue our discussions of Bill C-14.

[*Translation*]

We have four witnesses today, Dr. Georges L'Espérance, President of the Quebec Association for the Right to Die with Dignity, who is accompanied by Dr. Nacia Faure.

[*English*]

We also have with us Sally Guy, who is with the Canadian Association of Social Workers. Thank you very much for being here.

As an individual, we have with us Dr. Theo Boer, who is a professor of ethics and has experience with this in Holland. Welcome, Dr. Boer.

Prof. Theo Boer (Professor, Ethics, As an Individual): Thank you.

The Chair: The way this will work, as I've explained, is that each of you will have eight minutes to speak to the committee. I would very much ask that you speak to the legislation in front of us, not your general views of the subject. We're not trying to replicate the work of the special committee; we want to hear your views on proposed amendments or your thoughts about the legislation before us. I very much appreciate your coming here.

[*Translation*]

We will begin with Dr. L'Espérance and Dr. Faure

Welcome. You have eight minutes for your presentation.

[*English*]

Dr. Georges L'Espérance (President, Quebec Association for the Right to Die with Dignity): *Merci beaucoup*.

On behalf of Dr. Faure, myself, and the Association québécois pour le droit de mourier dans la dignité, we are very pleased to be here and thank you very much for this opportunity to discuss this very important bill.

[*Translation*]

My name is Georges L'Espérance. I am a neurosurgeon and president of the Quebec Association for the Right to Die with Dignity.

Like all neurosurgeons, I have treated patients with brain tumours, brain hemorrhages, and major brain trauma during my career. Some of them do very well while others decline slowly, sometimes over many years. These are all human beings with a name and a life.

Other patients are still young, like my younger sister who died a year ago, at the age of 49, of ovarian cancer with brain metastases. She died while in palliative care, in deplorable suffering. This is also typical of a number of other neurological diseases, such as amyotrophic lateral sclerosis and dementia.

With me today is Dr. Nacia Faure, an endocrinologist by training who devoted the final years of her career to providing palliative care with compassion. She is perfectly placed to defend the idea that medical assistance in dying should be part of palliative care for the few people who request it.

We proudly represent the Quebec Association for the Right to Die with Dignity, founded in 2007 by Hélène Bolduc, who has since fought tirelessly for the right of each person to die in dignity and freedom, and in accordance with their values. We will be addressing the purely medical aspects and will leave the legal arguments to others.

The Association understands that Bill C-14 would amend specific provisions of the Criminal Code and is not specifically a bill on medical assistance in dying. As such, Bill C-14 does not have to reiterate the protection of the physician, nurse practitioner or pharmacist who conscientiously objects. These essential considerations on such a sensitive matter must be part of any provincial laws that provide a framework for medical assistance in dying.

Conscientious objection is a well recognized concept, founded in an individual's convictions, but it does not apply to institutions. Further to the Supreme Court's unanimous decision, two specific aspects of Bill C-14 should in our opinion be expanded upon: medical assistance in dying for persons with chronic, debilitating pathologies that are not terminal in the short or medium term, and the provisions on advance medical directives.

Regarding persons with chronic, debilitating pathologies that are not terminal in the short or medium term, the most striking cases and the ones of the greatest concern to the public are patients with neurodegenerative or traumatic pathologies. Informed consent is possible when cognitive abilities are intact. The same applies to patients with chronic, debilitating pathologies, such as respiratory or cardiac insufficiency, and so forth.

The way it stands, any competent person may refuse any test or treatment even if it endangers their life. Multiple supreme court decisions in Canada and the United States have consistently upheld the right of such patients to cease any treatment, even if death is the inevitable, immediate or short-term consequence.

Any adult with an incurable illness or enduring suffering that is intolerable should have the right to medical assistance in dying at the time and in the way they wish instead of having to put themselves through unnecessary suffering just to comply with overly restrictive legislation. This of course includes patients who decide to starve themselves to death, something that can take several weeks.

It would be quite the paradox for the patient to have the right to refuse treatment, with its accompanying suffering and often constant agony, while the caregiver would not have the right to administer a final compassionate act to help the patient. Despite its many benefits, palliative care does not solve everything.

There comes a time when medical options run out and when the patient, for the sake of their dignity, no longer wishes to endure the daily nightmare of their physical existence. It is incumbent on medicine to help the patient assert their dignity if that is their considered and repeated request.

The alternative for these patients—despite the best palliative care—is to kill themselves or to attempt to do so, often under appalling circumstances. It should be up to the patient, the main party concerned, to decide whether to request medical assistance in dying.

This is a very real clinical problem that should be included in subsection 241.2(2) of Bill C-14, as stated in the second recommendation of the report by the Special Joint Committee on Physician-Assisted Dying:

> That medical assistance in dying be available to individuals with terminal and non-terminal grievous and irremediable medical conditions that cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

As others have pointed out, the time limits set out in Bill C-14 open the door to legal challenges that would be very distressing to patients with chronic pathologies who wish to exercise their rights under the Canadian Charter of Rights and Freedoms.

Dr. Nacia Faure (Former Endocrinologist and Palliative Care Doctor, Quebec Association for the Right to Die with Dignity): The second major problem is that of advance medical directives.

The Association wholeheartedly supports the spirit of the seventh recommendation made by the Special Joint Committee on Medical Assistance in Dying, to allow for advance requests for medical assistance in dying for persons having received a diagnosis of a neurodegenerative disease that is reasonably likely to lead to a loss of competence, in order to enable the person or their representative to exercise this option when they wish. The alternative to terminal decline, inevitable in the short or long term, is the possibility but not the obligation to end one's life peacefully, in accordance with one's own beliefs, and not anyone else's, whatever they might be.

The Association therefore requests that subsection 241.2(1) include the following:

> That the permission to use advance requests for medical assistance in dying be allowed after a person has been diagnosed with a grievous or irremediable condition that is reasonably likely to cause loss of competence. The same protections would apply for advance requests as for requests for immediate medical assistance.

I would like to say a few words about patients who are not competent, about minors, and about the issues relating to mental health.

As things stand, the Association is completely in favour of maintaining the prohibition pertaining to persons who are not competent and who did not make advance medical assistance requests, and to all persons born with a cognitive deficit or who have lost their cognitive abilities before clearly and explicitly stating their wishes. There must be no room for public confusion between medical assistance in dying and eugenics. As to minors and persons with primary psychiatric pathologies, further consideration is needed, as well as dialogue with countries grappling with the same issues. We could all benefit from joint reflection with several countries.

● (0855)

Dr. Georges L'Espérance: Finally, I have one more thought on assisted suicide.

The Association is concerned about section 241.1*b)* of BillC-14, which in our opinion opens the door to a type of assisted suicide. In our view, it must be very clear that medical assistance in dying is and must remain a strictly medical act, administered by a physician, nurse clinician or pharmacist, according to the legislative provisions of each province.

There are four reasons for this.

First, current medical science makes it possible for persons with serious and grave medical conditions to live very comfortably for a period of time. It is incumbent on medicine to help patients until the end and to respect their independence and dignity when they can endure no more, either physically and psychologically.

Second, the immediate and compassionate presence of a physician or nurse clinician is necessary to address any problem that might arise during the administration of medical assistance in dying.

Third, a very strict framework must be established as regards professional, ethical and moral conduct and responsibility.

Fourth, any confusion must be prevented between medical assistance in dying and an unexpected suicide, which is always a terrible tragedy.

We understand the objective of not making it a crime for someone to help another person choose assisted suicide, whether in Switzerland or elsewhere. Yet the possibility of obtaining medical assistance in dying in Canada should eliminate this alternative, and fairly, regardless of the physical, financial or psychosocial capacities of the person with the terminal condition.

Thank you for your attention.

The Chair: Thank you very much for your presentation.

[*English*]

Ms. Sally Guy (Social Worker and Policy Analyst, Canadian Association of Social Workers): Thank you and good morning.

On behalf of the board of the Canadian Association of Social Workers and our provincial and territorial partner organizations, I'd like to thank this committee for choosing to hear the perspective of social work on Bill C-14.

Our organization was founded in 1926. We're the national association voice for the social work profession. We have a dual mandate to promote the profession as well as to advance issues of social justice.

I will get right to the point on Bill C-14. Although social workers will not be administering or providing a substance to cause death, it's reasonable that they would be involved in the lead-up or the consultative process leading to the decision to undergo medical assistance in dying. Social workers may also be among the care providers to whom a client would bring their end of life concerns, and may actually be the first point of contact in this regard.

As key members of interdisciplinary teams, and quite often as the only health, mental health, or helping professional in certain rural, remote, or northern contexts, social workers must be able to provide therapeutic counselling services; support to clients, their families, and even their networks; and referrals to service on the subject of medical assistance in dying. They must be able to do all of that without fear of criminal consequence.

It is very important that clients who are considering medical assistance in dying are able to bring these end of life concerns to their preferred care provider. It's equally important that care providers who are entering into these end of life discussions, or even consultations, can do so without worrying that they are going to be party to an offence.

To this end, CASW is concerned about the lack of clarity around the exemption for persons aiding a practitioner and persons aiding a patient under paragraph 241(b) of the Criminal Code, specifically as this might apply to social workers. Furthermore, Bill C-14 focuses very much on the provision—the actual act of providing or administering the substance to cause death in medical assistance in dying—with little emphasis on the process beforehand, that consultative process, the lead-up.

We're seeking further clarity on paragraph 241(a), specifically as to whether social workers who will be participating in client care leading to a decision to undergo medical assistance in dying could potentially be seen as counselling or abetting a person to die by suicide. Of course we want to avoid that.

To address this, we would recommend that C-14 be amended to clarify the meaning of “counsel”. Mental health providers like social workers provide therapeutic counselling services and engage in therapeutic conversations with their clients all the time. In this sense, “counsel” has a very different meaning from the one that's intended by paragraph 241(a). We think that this could be easily addressed by simply revising the word “counsel” in 241(a) to “persuades or encourages”, so it would read, “persuades or encourages a person to die by suicide”.

On top of that, we would also recommend creating or amending some language to provide an exemption for social workers who would be engaging with clients on the subject of medical assistance in dying, whereas “engage” could be defined as the provision of therapeutic counselling, the referral to information, supports to clients, their families, and even their broader networks, and of course, referrals to service.

This would just ensure that no social worker who engages with a person or a client on the topic of MAID, or medical assistance in dying, whether preceding or following that person's decision to undergo it, would be party to an offence under paragraphs 241(a) and (b), and equally that no social worker who aids a practitioner or patient by engaging with the person on the topic of MAID would be party to an offence.

I hope I kept that brief.

With that being said, I want to thank you again for hearing from social workers and I look forward to any questions that you might have.

● (0900)

The Chair: Thank you very much. May I just say, that was completely on point and exactly what we were asking for. You stuck to the law and you told us exactly what you wanted to amend.

Dr. Boer, over to you.

Prof. Theo Boer: Ladies and gentlemen, I would like to thank the committee for inviting me today. I will make some remarks, but then I'll also go over to the bill itself.

In 2001 the Dutch Parliament adopted a law that is largely similar to Bill C-14.

For 10 years I was a member of a euthanasia review committee, a committee that decides after the fact whether a case of assisted dying was in accordance with the law. In those years I personally reviewed 4,000 euthanasia cases.

A 2012 government study, based on data collected as early as 2010, concluded that the Dutch law was solid. Until this day, the study is quoted to attest to the robustness of the law.

Admittedly, the Dutch euthanasia law does provide relief to many very ill patients. It provides doctors the necessary legal protection, and in doing so, it also provides transparency.

However, since 2010 the landscape has changed. Last week the euthanasia review committees presented their annual report, which I can show you here. It was presented just a week ago. It says that the numbers have gone up considerably, meaning that since 2010 the numbers went up from 3,000 to 5,500. Today one in 25 patients dies as a result of euthanasia, and we have seen a significant expansion in the pathology behind the euthanasia requests. The number of patients, for example, with dementia went up from 25 to 110 in five years. The number of psychiatric patients went up from two to 56 last year. Likewise, the numbers for euthanasia for people suffering from age-related diseases went up from a handful to 200. Contrary to what one might expect, the suicide numbers also went up, by 36% in the same period.

Before the end of this week, a person who is very dear to me will die through euthanasia. He is a man in his thirties suffering from the consequences of a sex-change operation, which he now sees as a crucial mistake. We have corresponded extensively, and I begged him not to make another decision that is irrevocable. However, the possibility of euthanasia has made him unwilling to seriously consider any other solution. In the words of your own bill, under proposed paragraph 241.2(2)(c), he says that this treatment is no longer acceptable to him.

In today's Canada, my friend would still be alive. My friend did not need pressure from outside, because what sufficed was loneliness, despair, self-contempt, and the societal climate in which euthanasia features as a remedy to serious suffering. I honestly think that the law has contributed to this climate. That's why I think Bill C-14 may need some adjustments. I do not doubt that Bill C-14 has good, noble, and important medical intentions, but I question the effectiveness of its criteria, which in its preamble, are referred to as “robust”.

In the Netherlands, we use exactly the same wording about our own criteria. Fifteen years later, however, I can tell you that even the most robust criteria may become like wax. Once new categories of patients start exploring the limits of the law, the criterion of intolerable suffering, for example, has become largely identical to what a patient wishes. After all, when a person insists on having euthanasia, who are we to question the intolerability of his suffering? Or when a person refuses palliative care, who are we to insist there are still ways that his suffering can be eased in a less radical way?

The developments in the Netherlands are even more remarkable given the increase in the quality of palliative care since the 1990s, the so-called pioneering years of the euthanasia law.

In an article in a journal of the Royal Dutch Medical Association, two ethicists and a doctor suggest 10 rules for patients who want to have euthanasia; for example, be verbally gifted but be humble; do not make a depressed impression on your doctor; if you still enjoy your hobbies, don't mention them; stress the seriousness of your physical suffering; etc.

● (0905)

According to an RDMA survey published last year, 70% of physicians in the Netherlands experienced pressure to perform euthanasia, and 64% are of the opinion that the pressure has increased.

Ladies and gentlemen, the decision you are about to take belongs to the most far reaching that Parliament can ever make. The outcome will influence the way that Canadians will die 30 years or 40 years from now. On a more fundamental level, it will impact the way people define suffering and cope with it. Please, therefore, allow me three remarks.

One, Bill C-14 exempts euthanasia from the Criminal Code. In normal life, any person has the right to do anything that is not unlawful. Consequently, doctors will have the right to perform euthanasia under the given conditions. This right to kill is among the most peculiar elements of the bill. To kill means that an intentional, direct, and irreversible act removes a person from the community of the living. Even on request, such a decision should always remain the exception. The society that legalizes euthanasia is bound to have an ambiguous relationship with the same society's resolve to prevent suicide. I do not think that the exemption from the Criminal Code is the right signal. I would suggest the Dutch system, in which physicians are punishable—hard as that may be—until they have provided proof that they have acted in accordance with the exceptions described in the law, in that order.

Two, given the intrinsically problematic, ethical character of killing, I think it is desirable that Bill C-14 contains unambiguous conscience protection for health care professionals.

Finally, I am probably not the only one who is puzzled by the fact that the requirement that a natural death should be reasonably foreseeable contains no specification. In hindsight wisdom, I think the biggest mistake of the Dutch is their failure to include a requirement of life expectation. This has made possible—and I have done research on this—that the average time between a euthanasia and the natural death that was expected has expanded from days or weeks to months, and in certain cases even years or decades.

Of course, any term has an element of randomness. However, not being specific about the term has even bigger disadvantages, because it gives away the only element that is left in the law that has an objective character. I would strongly suggest, even aware of the [*Inaudible—Editor*] advantages of it, to include a clear and unnegotiable term, such as a three-month or six-month requirement; and to initiate consultations, always, to alleviate the suffering; and to see to the needs of the people who have a longer life expectancy. Had the Dutch done so, we would not have seen much of the slippery slope that we find ourselves on now.

Thank you very much.

● (0910)

The Chair: Thank you very much, Dr. Boer. That was much appreciated.

Now we are moving to questions.

We will start with the Conservatives and Mr. Nicholson.

Hon. Rob Nicholson (Niagara Falls, CPC): Thank you very much for your testimony today.

Let me start with you, Professor Boer.

You said doctors in the Netherlands feel considerable pressure to perform this. Are there any conscientious objection provisions in the Dutch law?

Prof. Theo Boer: That is not needed [*Technical difficulty—Editor*] because euthanasia in principle is a punishable act. Nobody can ever be obliged to perform something that is an extreme emergency.

Hon. Rob Nicholson: But you said in your testimony that an increasing percentage of doctors feel the pressure to perform this. Why is that?

Prof. Theo Boer: The former health minister, Els Borst, was a liberal and introduced the law. She had insisted from the very beginning that all health care professionals were free in doing or not doing euthanasia. She also resented the development that doctors were held morally obligated to perform euthanasia. She was killed tragically one year ago.

I would say that it is in spite of the law that we have, there is a strong societal pressure....

Hon. Rob Nicholson: Monsieur L'Espérance, there are a number of assisted suicides and euthanasia taking place in Quebec at this time. Do you think this law will make any difference to what's actually happening there, and if so what difference would it make?

Dr. Georges L'Espérance: As I said, I think there should be a very clear-cut way of doing things and that it should be written somewhere that assisted suicide in our view is not a good thing, because the frontier with suicide is too short. That's why I strongly feel, and I'm not alone, that medical aid in dying should be medical, as said. There's no way that assisted suicide may be something we should go through with, because there are too many problems. The first one, I would say, is that the the person may just fail in trying to commit suicide, and it's horrible.

Hon. Rob Nicholson: In your opinion, will this law make much of a difference to what is taking place right now in Quebec?

[*Translation*]

Dr. Georges L'Espérance: There is no place for assisted suicide in Quebec. It is a medical matter.

[*English*]

It's strictly medical, and I think that is important.

Hon. Rob Nicholson: You mentioned as well that this would have to be carried out by...you mentioned doctors, but you said a clinician of some type. What would be your definition of a “clinician of some type”?

[*Translation*]

Dr. Georges L'Espérance: Under Quebec law, practical nurses are not included. That is why we are stressing that

[*English*]

it depends on each province's legislation, because in the federal law there's the perspective of a nurse clinician. That's why.

Hon. Rob Nicholson: Ms. Faure, do you think this law should be expanded to include minors?

Dr. Nacia Faure: In Quebec, as you know, the law has been ongoing for a few months from the time everything was done well. I believe the number of patients was, the Collège des médeciins thinks, about 15 or 20. Everything has gone very smoothly; everything is good.

As far as expanding the law to minors is concerned, I think it's a little early for us. These are very delicate questions. The population has to be—

● (0915)

Hon. Rob Nicholson: In your opinion, in the long term would it include minors?

[*Translation*]

Dr. Nacia Faure: We will have to consider this later. For the time being, we have an important law for patients and we will let it operate for a few months or a few years. We will discuss this possibility later on, bearing in mind the experience of other countries. For now, we believe that it would be premature to include minors.

Dr. Georges L'Espérance: There is also a difference between a minor who is 14 and one who is 16.

[*English*]

These are very difficult concepts and problems, and we should engage in more reflection here.

Hon. Rob Nicholson: Ms. Guy, I don't have a copy of your proposed amendment. I'd be interested in getting it from you. Maybe you have tabled it here; I'm not sure. I don't have it, but if you have some wording for it, that would be interesting to see.

Ms. Sally Guy: I have it clearly written out in the submission we did online. It's not in the oral notes, but I can certainly provide it.

Hon. Rob Nicholson: I look forward to getting it. Thank you for your testimony.

Those were my questions, Mr. Chair.

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

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

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

Thank you everybody for appearing today and for your testimony. It's very helpful.

[*Translation*]

My first question is for the Quebec Association for the Right to Die with Dignity, specifically for Dr. L'Espérance.

Certain organizations and members of this committee maintain that a person with mental health issues should consult a psychologist before a physician can provide medical assistance in dying. What is your position on this?

[*English*]

Dr. Georges L'Espérance: There are two parts to your question.

[*Translation*]

The first part of your question pertains to persons eligible for medical assistance in dying who have a specific illness and who have been suffering from psychological problems of some kind. In Quebec, these patients must be evaluated by a psychologist and/or a psychiatrist. We completely agree with this requirement and it seems essential to us. The second part of your question pertains to patients with a primary psychiatric disorder. It is still too early to talk about medical assistance in dying for patients with a primary psychiatric disorder.

Society and the medical profession alike must examine this issue much more thoroughly before taking a position. Most psychiatrists are uncomfortable with this even though psychiatric patients are human beings like anyone else.

There is a problem with the diagnosis of psychiatric illnesses, which can vary from one psychiatrist to another, and above all in the prognosis for psychiatric illnesses. This is why we think minors and patients with a primary psychiatric pathology should be excluded from the legislation for the time being. This requires further consideration, in society and in the medical profession alike.

Mr. Colin Fraser: Thank you.

My second question is also for the Quebec Association for the Right to Die with Dignity.

My question is about the phrase “reasonably foreseeable”. The bill currently requires that natural death be “reasonably foreseeable” in order for a person to be eligible for medical assistance in dying. What do you think of this phrase? Do you think a specific time period should be set?

I would also like to hear your views on the flexible approach set out in this bill.

Dr. Nacia Faure: The phrase “reasonably foreseeable” is certainly open to interpretation.

In palliative care, for example, which is the field that I know the best, we have mostly cancer patients. In their case, it is fairly straightforward because the death of patients who are in palliative care and are in the advanced stages of cancer can be predicted in a reasonable period of time. Defining a “reasonable period of time” is very problematic for people who have chronic and debilitating conditions, such as amyotrophic lateral sclerosis and multiple sclerosis. These illnesses are very painful. They progress very slowly and patients get to the point where they can't take it any longer. They feel there is no longer any reason to live, that life is not worth it any more.

For these patients, it is difficult for the physician to predict how much time the person has left. This is an important issue for these patients. In our opinion, they should have the right to decide to die even if their natural death is not imminent and could be months away. The other issue—which is in the Supreme Court decision—is that these patients are still able to make a decision. They are able travel to Switzerland for assisted suicide in order to die. It is appalling to force them to go to Switzerland and perhaps they go before they are ready. In short, this often precipitates their decision; for this category of patients then, it is important not to impose a specific time period.

● (0920)

[*English*]

Mr. Colin Fraser: Thank you very much.

[*Translation*]

Would you like to add anything, Dr. L'Espérance?

Dr. Georges L'Espérance: I would like to address one final point.

The term “reasonably foreseeable” is very vague in medicine. Physicians, even those in palliative care, who claim they can predict how much time a patient has left are always or very often mistaken, unless the patient is at death's door. Two things in life are certain: birth and death. Between them, most of us have to pay taxes. Otherwise, we are very often mistaken. A whole range of criteria and situations must be examined in order to evaluate a patient. This is why it is impossible to predict exactly how much time a patient has left.

[*English*]

Mr. Colin Fraser: I'm going to move now to Dr. Boer.

This law is being proposed in a fashion that would amend our Criminal Code, so it's arising in a criminal context. I just want to make sure I understood you. You were suggesting that basically the law should make it prohibited unless doctors can prove otherwise that they had the grounds to perform medical assistance in dying.

Did I understand you correctly?

Prof. Theo Boer: Yes, I think that what you are stating is correct. The Dutch word for society is literally *samenleving*, which means living together. This means that the society per se has to protect the life of those who belong to the community. Any act that intends to kill a person should be justified on an individual basis. Some doctors experience that as burdensome. On the other hand, the criteria for euthanasia are so clear nowadays because the review committees have made a jurisprudence so that this is no longer experienced as a serious problem. But you are right: a doctor can never be certain before he has received notification from the review committee that he will not be prosecuted.

Mr. Colin Fraser: I guess—

The Chair: We're out of time.

Mr. Rankin.

Mr. Murray Rankin (Victoria, NDP): I'd like to start, if I may, with you, Dr. Faure. Thank you for coming, and thank you for your support of the joint Senate-House recommendation number 7 on advance directives. I appreciated your words about that.

I believe that Quebec's Bill-52 initially contemplated advance directives but then didn't go there. Could you explain why and what motivates your support for that recommendation of the joint committee.

Dr. Nacia Faure: In the beginning it was written that way.

[*Translation*]

The first version of the bill that was tabled included many points that we considered important. Through discussion, the political parties were able to come to an agreement. It was example of real dialogue. Partisan politics did not come into play. It was discussion among human beings.

Concessions were gradually made to ensure that the bill passed. The issue of advance directives was difficult for some to accept. So they decided to pass a bill that was acceptable for the time being. There would be other opportunities to discuss the issue further.

The bill should certainly be amended because this issue is extremely important to the public. With the huge number of people getting older, people have fears about how their lives will end. This issue is extremely important to our association. The bill will have to be amended.

● (0925)

[*English*]

Mr. Murray Rankin: Therefore, I wondered if you would agree with what Professor Pewarchuk wrote yesterday in*The Globe and Mail*, that to not have the advance directives "would create an environment where those with progressive terminal disease must choose to end their lives prematurely, or risk enduring the full natural course of the illness".

I presume you would accept and agree with that?

Dr. Nacia Faure: Exactly, yes.

Mr. Murray Rankin: My next question is for you, Dr. L'Espérance. I want to ask you about the protection of medical practitioners in Quebec on grounds of conscience. We've heard a lot about that here. Some have suggested that we need to clarify it in this federal law.

Maître Ménard told us that was in provincial competence from a legal perspective, but of course your perspective is medical. I want to ask, number one, if there have been any problems with conscience in the protection of doctors. Number two, you made a distinction between an *individu* and an *organisation*. I presume you're saying that institutions should not be allowed to have conscience protections, but individuals should. Do I understand you correctly?

Dr. Georges L'Espérance: Absolutely.

On the first question, no, there's no problem in Quebec with—

[*Translation*]

conscientious objection.

[*English*]

It's something that is absolutely natural and it's perfect.

[*Translation*]

Whatever the reasons for conscientious objection, it is perfectly normal.

In Quebec, a physician who refuses to provide medical assistance in dying has a duty to refer the patient to the administration of an institution, which must in turn find a physician to provide that assistance. This is exactly the same problem we faced 40 years ago with abortion. It's exactly the same thing. It is perfectly normal.

I would say, however, that an institution cannot conscientiously object, especially a public institution. In the case of a private institution, be it Catholic, Muslim, Jewish or of any other religion—regardless, it makes no difference—, if it is completely private, it must have the right to set certain rules. In our opinion, though, if it receives public funding, it must comply with the patient's wishes.

An institution has a duty to provide care to patients, and medical assistance in dying is the ultimate act of compassionate care. If the physician does not wish to provide it, that's fine, but they must refer the patient to someone else.

Dr. Nacia Faure: I'd like to add another point quickly.

From the time discussions began, I have been sorry to see that the patient is often forgotten. Ultimately, the core issue is the dignity of the patient, of the individual. We should do everything to help the patient. Issues related to physicians and so forth are important, to be sure, but the core issue is often forgotten.

[*English*]

Mr. Murray Rankin: I appreciate your focus on the patient. The reason we talk about it, of course, is that the Supreme Court said in the Carter decision that individual medical practitioners, on rights of conscience, need not perform the service, and we're trying to clarify whether the bill needs that protection.

I want to say, Dr. L'Espérance, that I agree entirely with you. Institutions are different from individuals, and taking money at the same time as denying people constitutional rights is really quite unthinkable.

[*Translation*]

Dr. Georges L'Espérance: If I may say so, I am happy to let the legal experts decide whether conscientious objection should be included in the amendment of the Criminal Code. I am not a lawyer, but it should not, to my mind, be part of the Criminal Code. It should certainly be part of the legal framework though.

[*English*]

Mr. Murray Rankin: Have I got time to ask a question?

The Chair: You have time left for one short question.

Mr. Murray Rankin: To Dr. Boer, you noted in your response to my colleague Mr. Fraser that you had grave concerns with the "reasonably foreseeable" language. You said that "reasonably foreseeable" had no specification.

What would you suggest, then, when you spoke of a requirement of life expectation? It wasn't clear precisely what you thought we might do to change that very vague expression in Bill C-14?

Prof. Theo Boer: Let me just add that we have had conscientious objection in the Netherlands from institutions also. For example, from my research I know that in 41,000 cases of euthanasia, there was not one Muslim. Why then would we oblige a Muslim nursing home to provide that kind of care? I don't see it, and I think it's a matter of a tolerant society that you know that this house will not provide this kind of help, and you will have to make your arrangements and go to another one. We have autonomous citizens, and they know what institution to choose.

In regard to your question, can you repeat just one word, because —

● (0930)

Mr. Murray Rankin: The word was "foreseeable". You said there was no specification in that phrase. How would you fix it?

The Chair: Are you able to hear?

His question related to your comment on the reasonable foreseeability, in proposed new paragraph 241.2(2)(d) of the requirements. You had suggested perhaps a time frame of three or six months in terms of.... He's asking you to clarify what it is you're suggesting.

Prof. Theo Boer: Thank you. I did understand that.

Of course, I know and have indicated that I know that there are many problems. There are moral problems in setting a time limit. For example, why would we give euthanasia to lady A and not to Mr. B? I know there are problems, but you have to draw the line somewhere. Then, of course, there are medical problems, because how can you tell that the prognosis of this patient is, for example, not more than six months?

I would just suggest that, as in some places—in Oregon, for example, and in Switzerland—you make some kind of time frame just out of the embarrassment of not knowing what the best solution is. My point is only that having no [*Technical difficulty—Editor*] at all leads to euthanasia cases, of which the friend of mine who had the operations is just one example.

The Chair: We're going to go to Mr. Bittle.

Mr. Chris Bittle (St. Catharines, Lib.): Ms. Guy, I appreciate your response. We heard from the Department of Justice yesterday, and they made a distinction between suicide and medical assistance in dying, in that if medical assistance in dying is legalized, it becomes a different act from counselling suicide. That being said, is there still a preference in your organization that there be an increased level of clarity, even though the department's position would be that such an amendment as you requested isn't required?

Ms. Sally Guy: If it were made clear in some sort of addendum or other publication directly from the Department of Justice or the federal government that absolutely, counselling professionals, regulated professionals, social workers—that sort of *encadre, en Français*, that group of professionals—are exempt, I don't think there would necessarily be a reason for it to appear specifically in the legislation. We just weren't sure whether it would or not, so in the interest of protecting the public as well as our members, we were looking for more clarity on that.

Mr. Chris Bittle: To the Quebec Association for the Right to Die with Dignity, I have a concern with respect to the 15 clear-day waiting period, which may in fact be 16 or 17 days. I was wondering if you could comment.

My concern comes from the fact if someone declares that they're enduring suffering, why must they wait two weeks or more to receive that? Again, I appreciate the necessity for perhaps a cooling off period, but I was wondering if you could comment on that specific provision.

[*Translation*]

Dr. Georges L'Espérance: First of all, a 15-day waiting period is problematic. Why not 13 or 18 days? For a patient who is very close to death, this makes no sense.

Secondly, the vast majority if not all patients with a terminal illness have had plenty of time to think about their problem. It is not a decision that is made in 15 days.

A 15-day waiting period can be problematic, for instance, if the patient is suffering a great deal, is competent and gives consent to receive medical assistance in dying. If a well-intentioned physician then administers barbiturates or morphine to the patient to relieve pain, the patient might no longer be competent to give consent when the physician visits again, owing to the high doses of narcotics.

To my mind, this is problematic.

Dr. Nacia Faure: In palliative care, there are major fluctuations in a patient's condition: one day the patient is fine, the next they are delirious and, three days later, they are fine again. This makes it very difficult.

We need a bill, and the bill passed sets out the minimum criteria. Above all, the objective was to prevent abuse. The patient's consent is therefore essential. That said, there will certainly be amendments because these provisions very often do not apply in real life. For example, most patients in their final days are comatose and can therefore not give the consent they had already given. This is an important point to be amended.

● (0935)

Dr. Georges L'Espérance: I would like to add a final word, if I may.

As you can imagine, these patients don't show up at their doctor's office one day asking for medical assistance in dying. That is not how it works at all. Many stakeholders are involved, including social workers and nurses, who are with patients 24 hours per day. It's team work. All these people are on site and discuss patient cases. The patients can talk to them.

[*English*]

Mr. Chris Bittle: Dr. Boer, I'd like to clarify an item that Mr. Nicholson was talking about, namely the pressure that doctors are feeling. Are you speaking about societal pressure and pressure from patients? Is that the pressure you're speaking about?

Prof. Theo Boer: It's both, basically. I think there's general pressure from society, so to speak, that sees euthanasia and sees death as the best solution to very severe suffering. I see the pressure on doctors, from the many dossiers I've read, where patients say, “Doctor, I have seen the documentary on television. Euthanasia for patients like me is now allowed, so you'd better do it.” That's a direct pressure from patients.

Then there's a second pressure, and that's of course the pressure from relatives. I do understand that. For relatives, seeing the suffering of a beloved may be just as traumatizing as the suffering the patient has to undergo himself. For example, the end-of-life clinic that has been established in the Netherlands now has about 450 euthanasia cases a year. From my research, it has become clear that in 60% of the cases it was the family members who brought the patient to the clinic in order to be helped. So yes, there's strong pressure, I think.

Then there is maybe a third sort of pressure, and that is the internalized pressure of a patient. I have seen about one in 10 cases where the patient motivates his euthanasia request on the basis that he wants to save his relatives from having to see his suffering. What you see is that the relatives in that case do not put up opposition to that observation of the patient. Rather, they say, "Well, that is very friendly of you. We may find a way to have you have euthanasia." But I would say that the natural reaction of family members to such a motivation would be, "No, please, Mother, don't ask for euthanasia. It's too much for us. It's your life. We will do whatever." Do you see...?

The Chair: We have about four minutes left with this panel. We'll do a speed round, which means that if anyone has any very short questions....

But to the panel, confine yourselves to very short answers—one or two sentences, okay?

Speed round, Mr. Falk.

Mr. Ted Falk (Provencher, CPC): Dr. L'Espérance, in your testimony you used the word "terminal". You also interchanged it with the word "grievous". Would it add greater clarity to the bill and be of benefit to change the references that are used, changing the terminology of "grievous" to "terminal"?

Dr. Georges L'Espérance: There are two kinds of diseases we're talking about here. There are terminal diseases, which are usually very clear, such as cancer, etc., and non-terminal diseases, which are chronic and debilitating diseases. That's why I think there should be both terms, because it's really not the same clinical reality.

The Chair: Mr. Fraser and then Mr. Cooper.

Mr. Colin Fraser: Very quickly, Dr. Boer, I was going to ask you earlier this follow-up question. To your knowledge, has there been any litigation, or any conviction, or any reprimand of a physician who performed, perhaps improperly, medical assistance in dying in the Netherlands experience?

● (0940)

Prof. Theo Boer: Of 42,000 cases, 75 times the report of the doctor was sent to the public prosecutor. However, not not in one single case has the public prosecutor decided to prosecute, because the doctor normally says he will never do it this way again.

The Chair: Mr. Cooper, and then Mr. Rankin.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): To Dr. Boer, it's my understanding that in the Netherlands, similar to what is proposed in this legislation, two physicians can decide whether a patient is eligible for physician-assisted dying. One of the concerns that has been raised is doctor shopping. Could you perhaps comment on whether that has been a problem in the Netherlands?

Prof. Theo Boer: Yes, that happens in two respects. First, there is doctor shopping in respect to the fact that we now have the end-of-life clinic, which means that when your home doctor, your own doctor, will not provide you with euthanasia because he does not think the criteria have been fulfilled, you can then go to the end-of-life clinic and they will provide you as much support for your wish as possible. That's a kind of shopping.

The second kind of shopping is shopping for a second opinion doctor, which means that if the first consulting doctor says "no", you can go to another one or another one or another one. When you have found one that says "yes" you are not obliged to include all four reports. You can just include the one report of the doctor who says "yes" in your report.

The Chair: Mr. Rankin.

Mr. Murray Rankin: This is a question, please, for Ms. Guy.

I wanted to be clear. You've suggested that proposed subsection 241(1) about counselling, and aiding in paragraph (b), ought to be clarified, and you've given us some suggested language we can look at later. I wanted to ask, did you feel, therefore, that your participants, social workers, ought to have a specific exemption from liability the way pharmacists and others do in this bill?

Ms. Sally Guy: It depends on the sort of legal understanding of it. We're nervous about the word "counsel" specifically, because obviously social workers and mental health providers can be said to be counselling their clients or their patients. We would certainly feel better overall if there were a specific exemption for mental health providers or social workers, but we also understand that there could be an amendment or language added that would cover a broader spectrum of professionals who are engaging in these types of end-of-life discussions, just to make sure that no one feels muzzled and can perform their jobs freely and in an empowered way their jobs, their end-of-life discussions with their clients.

The Chair: Thank you very much. I want to thank the members of the panel. It was very helpful.

[*Translation*]

Thank you so much.

[*English*]

Especially, Dr. Boer, we really appreciated your testimony by video conference. Thank you so much. Have a great day.

We'll take a short break and go to the next panel.

●

(Pause)

●

● (0950)

The Chair: We'll reconvene and welcome our next group of panellists.

We very much appreciate your taking the time out of your busy schedules to testify before us.

I'd like to introduce, from the Canadian Medical Protective Association, Dr. Hartley Stern, the executive director and chief executive officer. Of course, as a Montrealer, he used to be the CEO of our Jewish General Hospital. It's a pleasure to have you here.

From the Canadian Society of Palliative Care Physicians, we have Dr. Monica Branigan, the chair of the working group on hastened death.

As individuals appearing together, we have Juliet Guichon, an assistant professor at the University of Calgary Cumming School of Medicine, and Dr. Ian Mitchell, a pediatrician and a professor at the University of Calgary as well.

I really appreciate all of your coming here today. I've explained to you how this is going to work. You each have eight minutes, and we will start with Dr. Stern.

[*Translation*]

Dr. Hartley Stern (Executive Director and Chief Executive Officer, Canadian Medical Protective Association): Hello, everyone. I am Dr. Hartley Stern and I am the executive director and chief executive officer of the Canadian Medical Protective Association.

Honourable members, thank you for giving me the opportunity to take part in this consultation process.

[*English*]

In providing medical legal advice and evidence-based education, the Canadian Medical Protective Association, the CMPA, sits at the intersection of the Canadian health care and legal systems. As such, we are already and will continue to be on the front lines in guiding physicians called upon by patients in individual cases for direction on medical assistance in dying, or MAID.

It is through this lens that we propose recommendations for amendments to Bill C-14 to ensure the legislation provides clear eligibility criteria and safeguards for patients, while ensuring health care professionals are not exposed to criminal sanctions for good faith participation in MAID.

The CMPA is generally supportive of Bill C-14. Given the complexity of the issue, we believe the bill strikes a reasonable balance between access and safeguards and leaves room for adaptation and change over time as we in Canada continue to gain experience with MAID.

As I said before the joint parliamentary committee, it is very important to focus operationally on the issues of eligibility, criteria, and safeguards. These are challenging issues. The Criminal Code amendments are crucial to confirming that physicians providing a patient with medical aid in dying are not in violation of the general prohibition on assisted suicide. This is a fundamental requirement to permit physicians to enter into that trusting and empathetic relationship with the patient that is so essential to the implementation of this policy.

We are pleased that the preamble of the legislation recognizes the need to adopt a consistent approach across Canada to medical assistance in dying, while recognizing the provinces' jurisdictions over various related matters, including the delivery of health care services, the regulation of health care professionals, and the role of medical examiners and coroners.

We do believe that the proposed legislation can be improved and submit the following recommendations to enhance operational clarity. I will touch on a few key points and encourage you to refer to our written submission for more substantive remarks.

On clarity, eligibility criteria, and safeguard requirements, the CMPA is pleased that Bill C-14 has provided clarity regarding the age requirement and the issue of advance requests for MAID. We believe, however, that Bill C-14 should state unequivocally whether or not a patient must be at the end of his or her life to be eligible to receive MAID. Uncertainty exists currently about the intended meaning of the requirement that

> their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

If it is intended that the patient does not need to be at the end of life, then the committee should consider amending the paragraph to state that natural death has become reasonably foreseeable whether or not death is imminent. Conversely, if it is intended that patients need to be at the end of life, then the provision should specify that natural death has become reasonably foreseeable and is expected to be imminent. Patients and their physicians must be provided with a clear understanding of who is eligible and when.

Turning to the provision requiring compliance with provincial laws and standards, we agree that MAID must be provided in accordance with any applicable provincial laws, rules, or standards, as contemplated in proposed subsection 241.2(7). However, we believe that this proposed subsection should be deleted from Bill C-14, since it does not belong in criminal legislation. Health care professionals have to deliver care to patients in accordance with professional standards regardless of such a provision. Those health care providers that are negligent in the delivery of care may face regulatory or civil proceedings, but should not face criminal sanctions for breaching the standard of care or for failing to follow a policy created by the regulatory authority.

Furthermore, as currently worded, the good faith provisions in proposed subsections 227(1) and 241(6) are not available to health care professionals who may fall below the standard of care. Ensuring that well-intended health care professionals are not subject to criminal sanctions for breaching the standard of care is important to ensure access for patients by encouraging the participation of practitioners in MAID.

● (0955)

Turning in respect to protection for counselling a person to die by suicide, we believe that Bill C-14 should be amended to expressly state that no practitioner is guilty of a criminal offence for counselling a person to die by suicide under paragraph 241(1)(a) when a practitioner provides a patient with information about MAID in the course of considering possible medical options.

It is important that practitioners not fear criminal prosecution for raising MAID with their patients, where medically appropriate. Without such a provision, health care professionals may be reluctant to even discuss MAID with their patients.

Regarding the good faith protections, the bill provides for some degree of protection for good faith compliance but only does so with regard to criminal sanctions. The CMPA believes that the protection in proposed subsection 241.(6) should be extended to include civil and disciplinary proceedings for practitioners acting in good faith. Such protection exists legislatively elsewhere.

Reassuring practitioners acting in good faith that they are protected from criminal sanction, civil liability, and regulatory sanction is an important provision that will again help ensure access for patients.

On the issue of disproportionate sanctions, we believe that some of the sanctions provided in Bill C-14 are disproportionate to the relatively minor nature of the offences. Imprisonment for up to five years for failing to inform a pharmacist that the substance prescribed is intended for MAID, and imprisonment for up to two years for failing to comply with reporting obligations, is excessive and unnecessary. It seems to us that a maximum penalty consisting of a fine would be a sufficient deterrent in those circumstances.

On a final note, the CMPA recommends that the brief reference to right of conscience in the preamble of the legislation be expanded, given the importance to practitioners that their personal convictions are to be respected in this area. Consideration might be given to including in the preamble to Bill C-14 language to the effect that nothing in the act compels health care providers to provide MAID.

In conclusion, honourable members of Parliament, it is undeniable that this bill bears great importance to Canadians. We support your efforts in working to ensure that this most complex social issue is dealt with in a manner that respects the importance of the relationship between the patient and health care professionals, and the necessity to ensure that both are protected along this journey.

[*Translation*]

On behalf of the CMPA, I would like to thank the committee for inviting me to speak. We will be very pleased to provide any further information or data you may need.

Thank you very much.

The Chair: Thank you very much, Dr. Stern.

Dr. Branigan has the floor now.

[*English*]

Dr. Monica Branigan (Chair, Working Group on Hastened Death, Canadian Society of Palliative Care Physicians): Good morning. My name is Monica Branigan, and it's a very big honour to represent the Canadian Society of Palliative Care Physicians. We are a society of 500 members, and we are dedicated to improving the quality of life for patients with life-limiting conditions.

We would like to offer some very specific recommendations in the spirit of finding a Canadian way that respects the diversity of views. Underlying the three amendments that we are recommending is the intention to make the right of access to palliative care as robust as the right of access to hastened death. It does not make sense to enshrine in legislation these rights to hasten your death without also having the same protections to receive palliative care.

There are two reasons this is important. As Canadians, we value fairness. The vast majority of Canadians will not avail themselves of hastened death but they can benefit from palliative care, whereas perhaps 3% or maybe 4% of Canadians might want to hasten their death. It also speaks to the issue of voluntariness. Can one actually decide to hasten one's death if there is not a viable alternative?

There are three amendments we would ask you to consider. First, we would ask that the general preamble would read, “And whereas the Government of Canada has committed to develop legislative and non-legislative measures that would support the improvement of a full range of options for end-of-life care, including the establishment of a National Secretariat in Palliative Care...”.

The national secretariat would be charged with implementing a national palliative care strategic plan. This work has already been done by some very respected groups of people. This would allow us to decide what Canadian standards are and how we monitor them. This would allow us to decide how we could best educate all health care providers in the areas of talking about death and dying, advance care planning, goals of care, and palliative care. This would allow us to think about how to support family and caregivers through job protection, income support, or education, and how to have these conversations with their loved ones. At a national level, it would allow us to begin a discussion about how we shift funding from institutions into the community, which is where patients want to die; and lastly, it would allow us to begin a public education campaign about options at the end of life and about how to demystify death and dying, because that, by itself, will reduce a lot of suffering.

Our second suggestion refers to the eligibility criteria, which would be included in proposed section 241.2. Under the criteria in proposed paragraph 241.2(1)(d), that patients will have made “a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure”, we would ask that you consider adding “or lack of access to services required to address the root causes of the request, including, but not limited to, palliative care”. Really we're asking how a decision can be voluntary if there is not an alternative. This is something we need to absolutely pay attention to. We do not want somebody choosing this because of the lack of an alternative. I do not think that we as Canadians would choose that.

● (1000)

Our final recommended amendment would follow in that same section, but would add a new element to provide documentary evidence that the eligibility criteria have been met using federally established standards. This is really just a way of recording the fact that the roots of suffering have been explored, that patients have been informed about options, and that options are available.

This is going to give you really good information about why people request this service. You have committed to a review in five years. It is also going to inform that kind of decision-making, and without really good evidence, it is just going to be a matter of opinion.

Thank you.

The Chair: Now we'll go to Dr. Guichon and Dr. Mitchell.

However you want to divide your time, please go ahead.

Mrs. Juliet Guichon (Assistant Professor, University of Calgary Cumming School of Medicine, As an Individual): Thank you very much for your invitation to address a section of Bill C-14. We are both from the University of Calgary medical school. Whereas I am trained in law with a doctoral degree and called to the bar of Ontario, my colleague Ian Mitchell is, as you have heard, a pediatrician who is a specialist in pediatric respirology and in ethics.

Proposed subsection 241.31(3) concerns regulations about creating, collecting, using, publishing, storing, and disposing of information about requests for and provision of medical assistance in dying generally. We respectfully make two recommendations concerning this subsection, but before we do that we respectfully recommend that this subsection of the Criminal Code should be based on the following two principles. First, all deaths that occur in Canada must be recorded accurately, and second, medical assistance in dying must be monitored scrupulously.

The proper implementation of these principles would foster protection, prevention, health promotion, health planning, and in rare cases, prosecution. Because the field of death reporting and death monitoring is not well known, we presume very briefly to describe it.

First is accurate reporting of death. Vital statistics are valuable only if the reports are accurate. An accurate report of how a person died is required to be contained in the medical certificate of death in common-law Canada, and in the *bulletin de décès* in Quebec.

Stating how someone dies entails identifying and stating truthfully the cause and the manner or circumstances of death. These two terms are terms of art, which are best understood by experts. It is not unusual for physicians without forensic training to have difficulty distinguishing between cause of death and manner of death, or to have difficulty naming the immediate antecedent and underlying cause of death. Consequently, in many provinces, medical certificates of death, which were originally completed by physicians, even in natural deaths, are routinely reviewed and corrected by forensic pathologists, medical examiners, or coroners, who have sub-specialty training in accurate death reporting.

Coroners exist in all provinces and territories except four. Those four are Alberta, Manitoba, Nova Scotia, and Newfoundland and Labrador. These four provinces have adopted the medical examiner system of death reporting. For our purposes, however, coroners and medical examiners perform the same functions. Sometimes, only these experts are permitted to establish cause and manner of death, and to complete the medical certificate of death.

For example, in Alberta, Manitoba, Prince Edward Island, and Nova Scotia, when a death occurs within 10 days of surgery, only the medical examiner or coroner may complete the medical certificate of death. Such requirements ensure that death is reported accurately.

Dr. Mitchell will discuss scrupulous monitoring.

● (1005)

Dr. Ian Mitchell (Paediatrician and Professor, University of Calgary Cumming School of Medicine, As an Individual): Scrupulous monitoring of death means not accepting at face value what some people say is the cause and manner of death. Scrupulous monitoring entails expert analysis of the evidence and the conduct of those investigations necessary to determine the answers to five questions. Firstly, who died? Then, how did the death occur? Thirdly, where did the death occur? Fourthly, when did the death occur? And finally, by what means did the death occur?

Because of the value we place on human life, every province and territory requires certain facts of death to be notified to the coroner or medical examiners. For example, in Alberta reportable deaths include those that appear to have no explanation; occur unexpectedly; or as the result of violence, accident, or suicide; or when the person was in the custody of the state, such as in prison, in a mental health facility, or in child protection.

Mandatory reporting of certain deaths ensures that the person best qualified in death reporting answers the important questions surrounding the death. Coroners and medical examiners are qualified to determine the cause and manner of death accurately, to report this information truthfully, and to know when further investigation is necessary. I may say that both of us, both Dr. Juliet Guichon and I, have had professional experience with the Alberta medical examiner system or with the B.C. coroner system, and can attest directly to the professional manner in which they have conducted investigations.

It is important to note that deaths that occur by the injection or ingestion of lethal doses of medication are already mandatorily notifiable deaths in at least nine Canadian jurisdictions. Therefore, in at least nine jurisdictions medical assistance in dying is already mandatorily notifiable to coroners and medical examiners. All jurisdictions should require that medical assistance in dying be notifiable to coroners and medical examiners because the Supreme Court of Canada, in the Carter decision, required scrupulous monitoring of physician-assisted dying.

There are at least three ethical reasons to ensure that all medically assisted deaths are notifiable only to coroners and medical examiners, and require them to transfer aggregate data to the federal government. Such a system would limit disclosure of sensitive health information; provide families and loved ones with truth, which can aid grieving; and help ensure that Canadian vital statistics are accurate. At a practical level, using only the coroner and medical examiner offices to determine and record these deaths would accept that coroners and medial examiners in nine jurisdictions are already required to monitor such deaths, avoid problems of creating new and untried offices, and avoid the problems of fragmentation of accountability and confusing multiplicity of oversight mechanisms. As well, using the current reporting structure would benefit from the coroner and medical examiner's expertise in determining cause or manner of death and in reporting on trends of interest and concern; employ the existing structures that govern coroner and medical examiners and that hold them accountable; and reduce public expenditures by avoiding the creation of probably very expensive new offices.

No strong argument has been advanced, either in court or by expert panels, for health professional regulatory authorities that can justify excluding coroner and medical examiners from reporting on this new form of non-natural death. Although there is much that seems new about medical assistance in dying, non-natural death is neither new nor is the expertise of our coroners and medical examiners. They have unique experience in distinguishing among manners of death. It would be wrong to discount history, specifically in the United Kingdom, where a physician killed over 215 people. This is just one example why scrupulous monitoring in dying is essential.

● (1010)

Mrs. Juliet Guichon: Accurate reporting and scrupulous monitoring reflect the value Canada places on human life. These expert activities ensure the investigation of deaths that occur in uncertain, dangerous, and preventable situations. They result in recommendations to benefit others, and they satisfy the public that the circumstances surrounding death will not be overlooked, concealed, or ignored.

Therefore, we respectfully make two recommendations. First, we recommend that the ministers of justice and health invite chief coroners and medical examiners and the Forensic Pathology section of the Canadian Association of Pathologists to a meeting to agree on terminology of cause and manner of death for the practice of medical assistance in dying. Second, we recommend that this committee require, under subsection 241.31(3), that reports of the provision of medical assistance in dying come to the federal government only from the provincial or territorial coroner and medical examiner's office without exception.

These two recommendations would help the federal government to ensure that medical assistance in dying is reported and monitored by the book. They would help safeguard patients, the general public, and physicians, and generate reliable data that would reveal trends of interest and concern.

In sum, we respectfully ask that you establish the reporting and monitoring of medical assistance in dying in a manner that is accurate and scrupulous and in these ways excellent.

Thank you.

The Chair: Thank you for your very interesting testimony.

We're now going to move to questions.

We're delighted to have Mr. Genuis join us today. Mr. Genuis, you're first.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Thank you, Mr. Chair. It's an honour to be here.

Since this is my first time subbing in this venue, I want to start by complimenting the committee and you, Mr. Chair. I've seen the list of witnesses and it seems that you're going to hear a broad range of perspectives. One of my concerns, frankly, about the special committee is that I think there were many perspectives that were missed. I look forward to the deliberation that's going to happen here.

I want to focus my questions on the issue of advanced review. Specifically, Mr. Stern, I really appreciated your comments about the need to clarify “reasonable but foreseeable”. We've heard arguments from some that this flexible criterion trusts doctors and gives them flexibility. However, what I've heard from physicians is that they would appreciate legal certainty so that they have a clear understanding from the legislation about what is and is not allowed.

I understand the point you're making about physicians not facing criminal prosecution if they act in good faith but fall below the standard of care. However, I think that patients might also have the concern that if rules were not followed, if they didn't meet the criteria, or if they had failed to obtain consent, someone could escape prosecution if they could demonstrate—at least beyond a reasonable doubt—that they had good intentions. We have to balance concerns about patient safety with the concerns of doctors not wanting to face prosecution.

Doesn't this underline the need for some kind of advanced legal review? An advanced legal review would protect patients by giving them the certainty that they had consented, that the criteria were followed, and that they would be protected. It would also give physicians a certainty that, once a particular case had gone through advanced legal review, they wouldn't have to worry about prosecution, because it would be clear that criteria had been met and legal expertise had viewed it. I'd be curious to hear your comments.

● (1015)

Dr. Hartley Stern: From our perspective, we have no problem with the concept of advanced legal review. That's not in the legislation, as we understand it. I think there are reasons that it's not in the legislation. We want our physicians to enter into a relationship with the patient and feel comfortable, just as you have suggested, in providing access to medical assistance in dying. We see a prejudgement with a legal review as an obstacle—it would create delays, it would create a time lag, and it would make it more difficult to care for patients.

We sit at the coal face between the legal system and the health care system. We think that the legislation as it exists—which we think is the right way to go—offers enough protections at the provincial colleges, on the regulatory side and in civil matters that in an extraordinarily high percentage of times, physicians will act in good faith and do the right thing under the legislation. If you want to change the legislation and put those legal provisions in, our organization will walk our members through it. If you're asking my opinion, however, I'm thinking that it will add undue delay, and compromise the comfort of patients.

Mr. Garnett Genuis: Could I just ask a follow-up question then? It seems to me that you're saying on the one hand that the safeguards are adequate but on the other hand that physicians should be able to avoid prosecution if they can demonstrate some degree of good faith, even if they take someone's life who didn't consent or didn't meet the criteria. It would seem to me that you wouldn't be worried about that protection from prosecution if you thought the safeguards were adequate.

I'll further note that there are many processes for—

Dr. Hartley Stern: Could I answer that? I didn't say that.

Mr. Garnett Genuis: Sure. Okay, go ahead.

Dr. Hartley Stern: I didn't say that a physician should be able to escape prosecution if he acted in bad faith. That's a criminal act. We think any physician who does not act in good faith should bear the consequences. We're saying that a physician who does act in good faith to do the right thing should be exempt from criminal prosecution. Those are two very different things, sir.

Mr. Garnett Genuis: That's right. Maybe I misspoke. I understand what you're saying. You're saying that if somebody acts in good faith but still ends up taking the life of a patient who doesn't consent or doesn't meet the criteria, provided that they acted to some extent in good faith, there shouldn't be any kind of criminal prosecution. I just disagree with that and I think many potential victims might disagree as well. I know we'll have more time to talk about that.

I do want to get in a quick question for Dr. Branigan before my time runs out.

I really like what you have in suggested amendment number two. You've underlined very well the importance of dealing with palliative care, not as a separate issue but in the context of this issue, because patients are going to be evaluating choices, and the only way they can have genuine autonomy is if they have palliative care offered.

I wonder who you think would do the evaluation and how the evaluation would work under amendment two. I think what you have here is very good, but again in my view, it maybe underlines the value of having some kind of a review process as well. Maybe you could comment on how that would actually work.

Dr. Monica Branigan: If I understand correctly, you're asking how you would be able to document or record that there was access to the services required. I think that's what we're proposing in amendment three.

In terms of how somebody would know, I don't think it would actually require a judicial review. I think you could set some very basic criteria, such as if a patient is dying at home and requesting assistance in hastening their death, do they have access to a palliative care team that is available to them 24/7? That could be simple, and it's a yes-or-no kind of answer.

Have I interpreted your question correctly?

● (1020)

Mr. Garnett Genuis: I guess my concern generally about the allowances for doctor shopping and things like that would be that, regardless of whether someone has actually received the services that they should be receiving, they could seek out—as one of the previous witnesses was talking about in the previous panel—two doctors who would sign off.

If you're going to have this criteria and make it meaningful, you would need some kind of evaluation, someone who was competent to make the assessment of whether these services were provided or not, and wouldn't someone not have the option of going from doctor to doctor to find someone who would sign off and say they had? Does that make sense?

Dr. Monica Branigan: I think those are two different issues. Whether there are services to deal with the root causes of suffering and whether somebody is doctor shopping are, as I see it, two separate things.

You're asking if there is a potential solution to doctor shopping. I think that one of the solutions is going to be in the coordination system that you set up. If there is a centralized coordination system, that's where patients, institutions, and other physicians refer to so they're dealing with professionals who are experienced, consistent, and well trained.

You're not just going doctor shopping. If you have such a coordination system, you're going to somebody who's been identified as a willing and trained provider, so it's much easier to set up: “You've already talked to two of our evaluators, and we've said no.” I think that would be a way of addressing your concerns.

Mr. Garnett Genuis: I think that's a great suggestion, but it's something that I would personally like to see written into the legislation, not just left in the hope of some future process.

The Chair: Thank you.

We now go to Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): My questions are for Dr. Stern. As you mentioned, you are the intersection between the legal and the medical community, so you might have a unique perspective on the law and how it impacts medicine.

A number of people have given us opinions about reasonable foreseeable death, and you have given some remarks on that as well. The Justice Minister considers this to be a medical decision, and we've heard some lawyers suggest it should be a legal decision. We need much more clarity.

There's also a concern about whether there should be a time frame. Some people say there should because it provides a bit more certainty in how to interpret the act. Others say no because it's difficult to put a specific time frame on a condition. It could be months. It could be years.

Could you give us some more clarity on those points?

Dr. Hartley Stern: Thank you. I will try to deal with the foreseeable future issue first.

We will support whatever the legislation ultimately states. I want to reiterate that we see our position as to help the physicians have confidence that if they enter into this dialogue with the patient and operationalize it and have interpreted the legislation correctly, they will be free from prosecution when they act in good faith. That means they have consent, that they did all the things and interpreted the law correctly.

What we're saying is that the wording as it currently exists is not clear. Whether you want it to be, as legislators, broader with a longer time frame, or narrower where imminent death is definable by whatever time frame you choose, we will support that.

We want you to say it clearly so when the physician phones—and they will call us for advice—we can say this is what we understand the legislation to mean, and this is what we're advising you to do as you enter into and provide access to the patient who receives medical assistance in dying.

The fuzzier the legislation is, the more difficult it is for us to interpret and the more difficult it is for us to give guidance to the physician who will want to act in good faith believing they are doing something that is an appropriate medical act, but don't want to be prosecuted.

We're agnostic about which way you want to go. Just make it clear which way you want to go.

● (1025)

Mr. Ron McKinnon: Would you be able to suggest any language that would define the clarity you're looking for?

Dr. Hartley Stern: I did suggest it, and it's in our written submission, so I'll repeat that section if you'd like.

If your intention is that the patient does not need to be at the end of life—so there's no time constraint—we suggest that you add under the section that says natural death has become reasonably foreseeable the words, “whether or not death is imminent”, if that is what you intend. Conversely, if your intent is that the patient should be at the end of life, we suggest you add the words, “natural death has become reasonably foreseeable and is expected to be imminent”. That would allow our physician advisers and our lawyers, who will be answering the phones talking to these doctors who want to provide access, to give them the clarity of thinking they absolutely deserve in helping the physician walk through this process. Choose one or the other.

Mr. Ron McKinnon: I guess that addresses a slightly different point than what I was looking for.

Dr. Hartley Stern: I may have misunderstood you.

Mr. Ron McKinnon: I may have misstated it. I'm concerned more about what reasonably foreseeable death means. As I mentioned, the Justice Minister indicated that would be a medically determined condition. A doctor would say, “I think this person has a reasonably foreseeable death“, but some people feel there needs to be a much clearer legal standard for what reasonably foreseeable means.

Dr. Hartley Stern: My sense is that these are neither medical terms nor legal terms, albeit I'm not a lawyer. My counsel is with me and if you want to get our legal opinion on this, Mr. Crolla would be happy to speak to it.

I see the confusion and the discomfort a lot of people have because it's neither medical nor legal. It depends on what you want, if you wanted his opinion.

Mr. Ron McKinnon: Dr. Branigan would like to interject here.

Dr. Monica Branigan: I chair the working group on physician-hastened death. This is something that we have discussed. One of the things that you might consider is to say something like, “for patients entering the last year of their life as best we know”. The protection that can be put in there is a proportional waiting period. For example, if somebody is clearly dying within days to weeks, then 15 days may not be reasonable. If somebody has maybe a year, maybe longer, maybe there should be a longer cooling-off period. That is a way to balance it and offer some sort of protection.

Among my colleagues, not only palliative my care colleagues, “reasonably foreseeable“ does not have a medical meaning, because it is reasonably foreseeable that we will all die. It's too vague.

The Chair: Mr. Rankin.

Mr. Murray Rankin: Dr. Stern, you were very helpful during our Senate/House deliberations. You were equally helpful today. I take your testimony very seriously because, of course, as you say, you're on the front lines. You're at the intersection of medicine and law, and you're the ones who decide whether a doctor is going to get coverage if they're sued for trying to implement this law in good faith.

We didn't have an opportunity to read your very careful submissions in advance. I want to make sure we do justice to them.

I want to pursue something that Mr. McKinnon and you were discussing, namely, the issue of Bill C-14 trying to provide clarity through the words “reasonably foreseeable”, which it seems most witnesses have told us has not occurred. You make a couple of suggestions depending on which way we want to turn, namely, to add the words, “whether or not death is imminent” or otherwise.

In the testimony and legal commentary, many of us have been hearing about the implications of the Carter decision, the Supreme Court case, and that it was deliberately not to be left to terminal patients, not to be limited to people at the end of life. The justices were deliberate in their choice of the words, “grievously and irremediably ill patient”. There was no suggestion of terminality.

The euphemism that their natural death has become “reasonably foreseeable”, it will be argued, is inconsistent with what the Supreme Court said. If that's accurate, then your choice about adding the phrase “whether or not death is imminent” is a non-starter. With respect, I would say that the alternative that you're suggesting for this provision, that “natural death has become reasonably foreseeable and is expected to be imminent”, is equally ambiguous.

I'm not quite sure where to land on this. Other witnesses, such as Mr. Ménard from Quebec, said yesterday that we should just eliminate this section, because it adds nothing. We've heard today that it's neither legal nor medical.

I'm wondering why your recommendation didn't simply say to get rid of that ambiguity, we should delete that phrase.

● (1030)

Dr. Hartley Stern: When we were asked to testify, we were asked to comment on specific areas that we felt were in need of revision. In as a thoughtful a way as we could, we gave you two options. You've declared a third. Our point on this would be that we believe that if you add one or other of our options....

The first one “whether or not death is imminent” would be consistent with the first point you made. It's not inconsistent with the notion that we want to broaden this beyond the time of death being in short sight.

In the alternative, if you wanted to delete the entire paragraph, there would have to be some commentary replaced with something. Again, I want to emphasize that our objective is to make it easier for physicians to participate. We seek clarity so that physicians are comforted that they're doing the right thing to provide access, that they're not in contravention of any statute.

Mr. Murray Rankin: I wish we had time to go over each of your very thoughtful recommendations. Obviously, I won't have time to do it, and hopefully others will pick up on it.

You mentioned that the first recommendation was that proposed subsection 241.2(7) be deleted. Could you elaborate a little bit on that? Why would you say that it should be deleted? It was the first of your specific recommendations.

Dr. Hartley Stern: It's because it doesn't add anything to existing provisions, and it's not a criminal act. Why add it when each province has provisions now that would deal with this quite adequately? It doesn't add anything, and in fact makes it a bit fuzzy. We will be able to provide guidance to our physicians better if that section is deleted.

Mr. Murray Rankin: I won't have time, as I say, to go through your point about disproportionate sanctions, but I thought you made a very sound argument there. It seems completely disproportionate; I would agree with you.

One of the other things you talk about is interaction with any provincial or territorial legislation. Quebec has a law and other provinces will soon have laws, one assumes. Certainly, their colleges will have regulations to deal with this.

You say it wouldn't be a concern if the provincial legislation is more restrictive; however it's possible that some provincial frameworks could be less restrictive than Bill C-14. Then access to medical assistance in dying might be affected if practitioners are uncertain about which legislation will prevail based solely on the doctrine of paramountcy. So you're saying that, whatever we do, we should give you some clarity about which rules apply, provincial or federal. Normally, it will be the federal one because of paramountcy but you're saying, wait a second, that might be problematic if it's more restrictive.

Is that correct?

Dr. Hartley Stern: Let me use an example.

If we were to include in this legislation, for example, mental health being the sole criterion, a patient having a mental health problem only....

Sorry, it's the other way around. If the province were to entertain legislation that permitted medically assisted dying for a purely mental health reason, and the federal legislation does not address that, there will be confusion in the eyes of physicians as to whether they're going to be subject to a criminal sanction as a consequence of that. It appears that there's no conflict between the current Quebec legislation and the current federal legislation, as it's drafted. If the other provinces become substantially similar to what the federal legislation contemplates here, we're fine. It's only if one of the provinces gets broader and includes things that are not in here that our members are going to get in conflict.

● (1035)

Mr. Murray Rankin: Here's a final point because I'm going to be cut off.

Or am I being cut off now?

The Chair: You've exceeded the time.

If you are able to do it in 20 seconds, back and forth, go ahead.

Mr. Murray Rankin: You've made some very specific recommendations, very deeply concerning recommendations.

Would you recommend coverage for doctors in light of the uncertainties in this bill that you've pointed out?

Dr. Hartley Stern: Let me make it clear. We have been around for 100 years, and we'll continue to provide protection to our members, no matter what. What we're concerned about is giving them the best advice. This is about operationalizing a new law. This is about making it easier for a physician to enter into that relationship with the patient to allow this to happen. The clearer you make this legislation, the easier it is for us to provide that protection for the physician. That's our intent.

The Chair: Thank you so much.

We're going to go to Mr. Hussen.

Mr. Ahmed Hussen (York South—Weston, Lib.): I have a number of questions.

I'll start with Mr. Stern.

Under Bill C-14, the legislation only requires one request to be made for medical assistance in dying. Other jurisdictions require more than one request.

How do you feel about that? Do you think that's adequate to have one request?

Dr. Hartley Stern: We think this is consistent and sufficient based on our understanding. We're not the experts on world systems or the other jurisdictions under which this law or similar laws are enacted. We think the committee has been thoughtful in the way it brought this forward. We will work with it and we'll advise our physicians accordingly. We're agnostic as to whether it should be two or three, or one physician and one nurse. We will advise our physicians to comply with the regulation as written.

Mr. Ahmed Hussen: In terms of your duty to protect medical professionals, do you feel that Bill C-14 provides adequate protection from criminal prosecution for medical practitioners who provide medical assistance in dying?

Dr. Hartley Stern: I made several points around adding some clarity regarding the good faith provisions.

I think the honourable member at the first was a bit confused as to our approach here. We think that physicians who act in good faith, and that means those who understand and ensure that the criteria set out in the legislation are accounted for—including appropriate consent, appropriate discussion, and all of the other elements that are in here—if drafted the way it is, protects the physician from criminal prosecution.

Where we're concerned is that it doesn't protect the physician from civil prosecution or from regulatory matters. We recommend that you add that good faith—doing all the things that are suggested in here—in this action, should limit the physician's exposure to sanctions from civil prosecution or from a regulatory body.

Mr. Ahmed Hussen: The next question is for Dr. Mitchell.

Bill C-14 requires a 15-day waiting period between the time the request is made for medical assistance in dying and the request is signed, and the day on which medical assistance in dying is provided. The bill also allows for medical personnel to use their discretion where a loss of capacity to provide informed consent is imminent.

In your opinion, is it generally possible to assess whether the loss of capacity is imminent?

● (1040)

Dr. Ian Mitchell: I would suggest that it's a bit like the imminence of death. It can be very difficult to assess the imminence of loss of capacity. It can be quite immediate in end-of-life situations.

Mr. Ahmed Hussen: In your opinion, would the ability to use the discretion by the medical practitioner with respect to the waiting period apply to individuals with dementia, or only to those who are more likely to become unconscious?

Dr. Ian Mitchell: If I could ask the honourable member for clarity, in terms of the dementia, do you mean those with established dementia—

Mr. Ahmed Hussen: Yes.

Dr. Ian Mitchell: —and they have something in an advance directive? Because I understand that the proposed act does not deal with.... Or, are you suggesting it's those who develop dementia in the 15-day period?

Mr. Ahmed Hussen: No, those who already have dementia, versus those who are more likely to become unconscious in that 15-day period.

Dr. Ian Mitchell: As I understand it, those who already have dementia would not meet the Carter decision.

An hon. member: [*Inaudible—Editor*]

The Chair: I just don't want to continue on the line of questioning. You're correct they would not be....

Go ahead, you have another minute and a half.

Mr. Ahmed Hussen: My last question is for Mr. Stern.

In your opinion, does Bill C-14 respect the conscience rights of health care practitioners who do not want to participate in medical assistance in dying?

Dr. Hartley Stern: I think it does so, but perhaps not as strongly as we would like.

I made suggestions about adding some wording in the preamble. As I understand it—again, I'm not a lawyer, I'm a physician—adding it in the preamble sets the context and the tone of the law. We feel that by adding those words in the preamble, it will help to strengthen that protection.

The Chair: Ms. Branigan, did you want to get in on that?

Dr. Monica Branigan: I think sometimes when we're talking about conscience protection, we tend to focus on whether people want to be involved in the act of hastening death itself. There's a very important concern about conscience for making an effective referral that isn't alluded to. I understand that the Canadian Medical Association will speak to you on this matter. Again, the solution is to have an effective coordinating system that will take care of that.

I think that is going to be a significant issue, to force physicians to make a referral that they feel complicit in the act. I'm not sure that needs to be put into the Criminal Code. I think in terms of implementation, to have a separate coordinating system will absolutely ensure access to patients and will give the conscience protection that physicians need and deserve.

Dr. Hartley Stern: Could I make a a small, supplementary comment on that?

The Chair: Yes, sure.

Dr. Hartley Stern: In our submission to the joint parliamentary committee, we recommended that the wording and the way it was drafted in Quebec, I think, would be a very useful addendum for this parliamentary committee. That would ease the concerns of those people whom my colleague is concerned about, those who have even a difficulty referring. The legislation in Quebec is very thoughtful on this matter.

The Chair: We're going to do our lightning round right now. I have one very quick question for the panel that I'd like each of you to answer.

I understand there are some people—Mr. Rankin suggested this—who believe that the concept of reasonably foreseeable death should simply be dropped, but presuming that it is there.... You've asked for clarity. I think you've asked for clarity, Dr. Branigan. I'm interested to see, if we use the concept that they use in Oregon or in the United States, where we say that death is medically likely to occur within six months or a year, or whatever time frame we say, would you prefer that to the concept that is in the bill right now?

Dr. Stern.

Dr. Hartley Stern: Yes.

The Chair: Dr. Branigan.

Dr. Monica Branigan: Yes, and it would be evaluated in five years.

The Chair: Absolutely.

Dr. Guichon.

● (1045)

Mrs. Juliet Guichon: Yes, provided that those are the only two choices.

The Chair: Yes. Well, those are the choices I'm giving you. It doesn't mean that's a choice everyone else will give you, but those are the choices I'm currently asking about.

A voice: Yes.

The Chair: I didn't say I was consistent. I just asked that question. Thank you.

Mr. Cooper, you had a quick question.

Mr. Michael Cooper: Dr. Stern, you alluded to the need for conscience protections for physicians. What about for health care institutions? What are your comments on that? I know that in the Loyola decision, Chief Justice McLachlin recognized that under section 2 of the charter, the conscience rights of physicians and institutions are intertwined.

Dr. Hartley Stern: I run an organization that protects physicians. This is a most complicated area. I don't feel that I'm the right person to tell you what to do, or to give you advice on institutions.

I used to run an institution. I no longer do that. I can't help you on that one.

The Chair: Dr. Branigan, yes.

Dr. Monica Branigan: Sorry, I would like to jump in here and talk about how that's where the coordination system comes in, so that if you are a religious institution and you opt out, you have a built-in way of having an easily accessible access plan for the patients in your institution. If you set it up in that way, then you can accommodate a lot more people and beliefs.

The Chair: Perfect.

Are there any other lightning questions?

Mr. Falk, the last one.

Mr. Ted Falk: There's guilt by commission but there's also guilt by omission. The way the bill's drafted right now, it would provide an escape hatch for omission.

I think when we're talking about killing people, and we're talking at a very high level of professional individuals, I don't think the escape hatch that's given in proposed subsection 241(6), “reasonable but mistaken belief”, is appropriate being in there.

What are your thoughts on that, Mr. Stern?

Dr. Hartley Stern: Sorry, I'm not quite sure what you intend in your question. Could you give me a minute to look at the proposed subsection?

Mr. Ted Falk: Well, it reads that, “For greater certainty” if the person invoking the exemption “has a reasonable but mistaken belief about any fact that is an element of the exemption”.

Dr. Hartley Stern: I think this is the good faith provision I've been talking about. Sorry, I didn't quite get the point.

The Chair: It is.

Dr. Hartley Stern: If the physician or the nurse practitioner acts in good faith, deals with all the criteria, gets the appropriate consent, has the appropriate discussion, follows whatever guidelines there are around the second witness, and acts in good faith, and is subsequently sued by a family member because he or she didn't believe that dad really meant it when he asked for assisted death, we believe that the provision of good faith should stand and should protect that physician from prosecution.

The Chair: Yes, Dr. Guichon, the last word.

Mrs. Juliet Guichon: We came from Calgary because we wanted an important matter not to escape your notice, which is that it is not well understood at the moment the importance of accurately recording and scrupulously monitoring this practice. In the court applications that have come forward, three of them have resulted in judges ordering physicians to falsify medical certificates of death, and in Quebec it's the case that professional organizations have—

The Chair: Yes, you can't say the actual reason. You can't write “doctor-assisted suicide” on the death certificate, as I understand it.

Mrs. Juliet Guichon: That's right, and it puts the physician in a conflict of interest. It removes the oversight of the coroner or medical examiner, and we strongly believe that it is a matter that could be corrected at the federal level by obtaining national uniform data for monitoring this purpose, and also to be sure that this practice is not used for purposes that it was not intended.

The Chair: Thank you very much. We have the points and we will read the briefs.

Thank you all to the members of the panel. We really appreciate it.

I'd like to ask the members of the committee to stay for just one second.

The meeting is adjourned.

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