HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Justice and Human Rights

JUST • NUMBER 012 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Tuesday, May 3, 2016

Chair

Mr. Anthony Housefather

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● (1600)

[*English*]

The Chair (Mr. Anthony Housefather (Mount Royal, Lib.)): Welcome to this meeting of the Standing Committee on Justice and Human Rights.

For those of you on video, hello. My name is Anthony Housefather. I'm the chair of the committee. I'll be introducing you to people as we take their questions, going forward, but you can rest assured that you have all of the Liberal members, the Conservative members, the NDP members here with you, and we're all very anxious to hear your testimony. Thank you so much for joining us today.

Joining us today in the room we have one witness, Shanaaz Gokool, who is the chief executive officer of Dying With Dignity Canada.

Welcome.

On video, we have three groups. We have from London, Ontario the Christian Legal Fellowship represented by Derek Ross, the executive director, and Jonathan Sikkema, associate counsel.

Welcome.

From Toronto we have the Coalition for HealthCARE and Conscience, represented by Cardinal Thomas Collins, who is the archbishop of the Archdiocese of Toronto, and Laurence Worthen, who is the executive director of the Christian Medical and Dental Society of Canada.

Welcome.

Finally, we have the Canadian Civil Liberties Association, represented by Cara Zwibel, who is the director of the fundamental freedoms program.

Welcome.

Given that we are going to go to the video first, we want to make sure we take it in time. You all have eight minutes to deliver your remarks—we have four groups each with eight minutes—following which you will receive questions from all of the members of the panel, rotating between six minutes to the Conservatives, six to the Liberal, six to the NDP, six to the Liberals, and you can go back and forth with the questions.

We will start with the Christian Legal Fellowship.

Mr. Ross and Mr. Sikkema, please go ahead.

Mr. Derek Ross (Executive Director, Christian Legal Fellowship): Good afternoon.

Thank you, Mr. Chair.

I am Derek Ross. I serve as executive director and legal counsel to the Christian Legal Fellowship. With me is Jon Sikkema, associate legal counsel at the CLF.

We wish to thank this committee for affording us the opportunity to make these submissions.

CLF is a registered charity and a national association of more than 600 legal professionals who share a commitment to the Christian faith. As an organization of lawyers, we seek to advance justice and the public good by drawing attention to fundamental principles of law.

One of those core principles is the sanctity of life, which the Supreme Court recognized as one of our most fundamental societal principles in Carter. That principle affirms that every person's life, no matter how old, disabled, or infirm the person may be, has inherent equal worth and value.

As the Supreme Court recognized in Rodriguez, the active participation by one individual in the death of another is intrinsically, morally, and legally wrong. That principle, expressed by Justice Sopinka, was not challenged or overturned in Carter, although Carter does now allow a legal exception to it in certain circumstances.

The challenge for us, and for you the committee and for Parliament, is the question: how can we best protect and preserve the equal value and inherent worth of all people in a post-Carter Canada?

We have framed our submissions in answering that question on the presumption that Parliament will legalize euthanasia and assisted suicide, which we'll refer to as MAID, in certain circumstances, although there are other and in our view more appropriate options available to Parliament, which we've explained elsewhere.

However, because the bill before this committee takes the path of legalization, we urge Parliament to be forward-thinking and to proactively guard against some of the negative impacts, perhaps unforeseen and unintended, that Bill C-14 might have—negative impacts that can be at least partially reduced with certain amendments that we and others recommend.

We urge Parliament to consider the following questions.

How will the legalization of MAID affect our societal attitudes towards suicide?

How might it contribute to normalizing suicide as a choice-worthy option, not just in the MAID context, but generally?

We know that the drafters of Bill C-14 are attuned to this issue, as the preamble acknowledges that suicide is a public health issue, not just a private one, and the Department of Justice's background paper also says that MAID is not being made available in wide circumstances, because that could undermine suicide prevention initiatives and normalize death as a solution to many forms of suffering.

The government is right to be concerned about those potential consequences and needs to be even more deliberate in guarding against them. We need to protect the efforts of physicians, health organizations, and charities to prevent suicide. We are concerned that such groups may avoid steering individuals away from suicidal ideations for fear that they will be seen as interfering with MAID or access to it.

This is evident in Quebec, where the college of physicians recently discovered that emergency room doctors were allowing suicide victims to die, when life-saving treatment was available. In media reports, the legalization of assisted death in that province was cited as creating ambiguity about the need to intervene. Parliament must eliminate any such ambiguity here and play a lead role in combatting the normalization of suicide.

What specifically can this committee do within the framework of this bill?

We say that Parliament should specifically affirm in the preamble to Bill C-14 that suicide prevention remains an important public policy goal. In addition, the preamble should state that sanctity of life remains one of Canada's most fundamental societal principles; that it is not contrary to the public interest to express the view that participating in causing a person's death is intrinsically, morally, and legally wrong; and that MAID should be considered only as a last resort, not as a measure to be presented to patients as just another treatment option among others.

This, in our view, is an important means of sending a clear signal, even if Parliament chooses to allow MAID, that MAID is not to be seen as a new normal medical response to suffering or even just as one option among and equal to others. This also means that Parliament should protect the charitable status of organizations devoted to preventing suicide as well as religious organizations and health care facilities that decline to provide MAID at their facilities, and should do so through clear amendments to the Income Tax Act, which we set out in our brief.

● (1605)

These amendments will serve to promote freedom of religion, conscience, and expression, but just as importantly, respect and preserve a medical and societal culture in which treatment is promoted as a solution to suffering, not suicide.

Similarly, we need to protect patients from being pressured to obtain MAID. Counselling or abetting a person to commit suicide will wisely remain illegal under this bill. This provision, section 241 (a), addresses suicide only, and does not seem to address things like voluntary euthanasia, which is considered homicide and not suicide. This may be a drafting error, but either way it must be remedied. The reality is that patients will face external pressures to obtain and receive MAID. Bill C-14 acknowledges this. Under the legislation, as drafted, when this happens, the only consequence is that a patient may be considered ineligible for MAID, and only if the patient's doctor determines that the request was made because of, and a result of, that external pressure. Even if the physician determines that the patient was ineligible, the patient can still seek MAID from another physician, potentially under continued pressure from that same third party. The second, or tenth, or twentieth physician may fail to detect the external pressure on the patient. With respect, this is a significant oversight that leaves even the most malicious and prolonged forms of pressure and coercion seemingly free of prosecution. We recommend specific provisions to remove any ambiguity in this regard, and make it an offence to counsel, encourage, intimidate, or coerce a person to die by suicide or homicide, including euthanasia.

We also urge Parliament to explicitly protect the rights of those who object to participating in MAID, such as health care providers. I know others will be speaking to that matter this afternoon. In legalizing euthanasia, Bill C-14 places the most vulnerable members of society at risk. CLF endorses the recommendations contained in the Vulnerable Persons Standard. In addition, we recommend a number of amendments to Bill C-14, to protect the most vulnerable from abuse, which are set out in our brief. It is our submission that the court's ruling in Carter does not preclude Parliament from doing any of these things, and all of these provisions and amendments are necessary, not only to protect the vulnerable, but to preserve a culture that celebrates the equal and inherent value of every life.

Thank you.

● (1610)

The Chair: Thank you very much. It's much appreciated.

We will now move to the Canadian Civil Liberties Association, Ms. Zwibel.

Ms. Cara Zwibel (Director, Fundamental Freedoms Program, Canadian Civil Liberties Association): Thank you.

Mr. Chair, members of the committee, on behalf of the Canadian Civil Liberties Association I want to thank the committee for the invitation to make submissions on Bill C-14.

The CCLA fights for the civil liberties, human rights, and democratic freedoms of all people across Canada. Founded in 1964, we are an independent, national, non-governmental organization working in the courts, before legislative committees, in the classrooms, and in the streets, protecting the rights and freedoms cherished by Canadians and enshrined in our Constitution. CCLA's major objectives include the promotion and legal protection of individual freedom and dignity, and for the past 51 years we have worked to advance these goals.

Like many of the groups and individuals you may be hearing from, the CCLA was an intervenor in the Carter case. We argued in that case that the absolute prohibition on medically assisted death was a violation of section 7 of the charter that could not be upheld. The Supreme Court's decision clearly affirmed that this is the case and recognized that to deny assistance to individuals who were suffering from grievous and irremediable medical conditions violates their most basic rights.

The government's decision to table Bill C-14 recognizes the need for national legislation on this issue, and to a certain extent, some of the provisions in the bill are in our view in line with the court's decision.

We have concerns about some aspects of the bill, and in our view it suffers from at least one significant and fatal flaw. That is where I will begin to focus my submissions.

The bill defines who is eligible for medical assistance in dying by requiring a “grievous and irremediable medical condition”, and that language is in keeping with the court's language in Carter. But the bill goes on to define the criteria required for establishing that condition by stating that the individual's

> 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.

In our view, this requirement is not in keeping with the language or spirit of the court's decision in Carter. The focus of the ruling was on suffering and quality of life, not quantity. The reasonable foreseeability requirement will cause confusion, is unnecessary, and in our view should be removed. It's a clear departure from the court's decision and one that needs to be acknowledged and addressed by this committee.

The language of reasonable foreseeability is vague in the context of life and death: the death of every human being is reasonably foreseeable. Presumably this requirement connotes some proximity to a natural death, yet it's very unclear how this will be interpreted or assessed.

Adding to the confusion, the government has released background documents and the minister has made speeches suggesting that this requirement should not be a barrier for individuals such as Kay Carter, who suffered from spinal stenosis and was one of the people at the centre of the Carter case. Those explanations and justifications in our view do not sit comfortably with the bill's actual language.

If the government doesn't intend to create a barrier here, Parliament should amend the legislation accordingly. We have included a specific recommendation on this point in our written brief.

In particular, we propose that proposed subsection 241.2 (2) of the Criminal Code be amended to delete its paragraph (d) so that its remaining paragraphs would form the exclusive criteria for establishing a grievous and irremediable medical condition. We've included some language that we think should be added for greater certainty.

The second point I want to briefly address is the bill's exclusion of mature minors and its failure to allow for advance requests.

While the government's introduction of the bill was accompanied by a commitment to engage in further study on these issues, we are concerned that this further study will mean delays and suffering for individuals.

As I think we all know, the assisted dying issue is a controversial one. Parliament has in the past been unwilling to address the issue without the impetus of a judicial ruling. The fact that the Supreme Court's decision in Carter does not squarely address mature minors or advance directives does not in our view diminish the government's or Parliament's obligations to respect charter rights or to guard against needless suffering.

● (1615)

In CCLA's view there is no principled reason to distinguish between mature minors and competent adults, since the definition of a mature minor is someone who has been assessed to be capable of making a particular treatment decision. Amendments, in our view, should be made to allow for advance requests for medical assistance in dying where an individual is otherwise eligible. We see no principle basis to exclude an advance request when such requests are already permitted to allow an individual to consent to termination of life-sustaining treatment.

The third point I want to address is a smaller one, and it relates to one of the safeguards that's included in the bill, which dictates that a person's request for medial assistance in dying is signed before two independent witnesses. The bill goes on to exclude certain individuals from acting as independent witnesses. To be clear, CCLA doesn't object to this kind of safeguard in principle, but looking at the language of the safeguard, and who is excluded from acting as an independent witness, we are concerned it may be difficult to find individuals to fulfill that function. I am not sure how Parliament can best address this issue. It might be included in terms of a regulation-making power for the Minister of Health to address the permission of witnesses. We appreciate there are division of power issues here, but I did want to bring that issue to the committee's attention. In our view, failing to address it could pose a practical barrier for the effective implementation of this legislation.

Finally, I'd like to address a question in terms of the process before this committee. Witnesses invited to submit briefs to this committee were given very little notice and advised to keep written submissions brief. I appreciate your sitting tonight for a marathon meeting, and that a number of the meetings over the next few days are quite lengthy, but the committee is only spending four consecutive days on this important issue. The limits that are placed on the scope of submissions being made and the truncated timeline for consideration of the bill is cause for concern. We appreciate there was significant work done by the federal external panel, and by the interprovincial advisory group, and the special joint committee of the issue of physician-assisted dying, but the reality is this committee is the first opportunity anyone has had to look at a piece of legislation, and consider it, and make submissions in relation to it. This is an issue on which every Canadian is a stakeholder, and a more robust process for considering the legislation is warranted. We say this because the CCLA believes that the fact the declaration of invalidity will take effect in early June creates a legal vacuum.

The Minister of Justice, in introducing this bill, has said the bill falls within the parameters of the Carter decision, but that if no federal legislation is in place on June 6, it's the parameters of that decision that will govern. While we do believe national legislation on the issue is important and beneficial for a number of reasons, this doesn't mean we should rush to enact a law that hasn't been sufficiently considered through a meaningful democratic process.

Thank you.

● (1620)

The Chair: Thank you very much.

Now we'll move to Cardinal Collins and Mr. Worthen.

Cardinal Thomas Collins (Archbishop, Archdiocese of Toronto, Coalition for HealthCARE and Conscience): Good afternoon, and thank you for providing the opportunity to speak with you about Bill C-14, legislation that will have a profound impact on Canadian society for years to come.

I appear today on behalf of the Coalition for HealthCARE and Conscience. Joining me is my colleague Larry Worthen, the executive director of the Christian Medical and Dental Society of Canada, which is a member of our coalition. We represent more than 5,000 physicians across Canada and more than 110 health care facilities and almost 18,000 care beds and 60,000 staff.

As we have previously stated, because of our mission and our moral convictions, we cannot support or condone assisted suicide or euthanasia. We understand, however, that the Supreme Court of Canada has directed the federal government to pass legislation on euthanasia/assisted suicide by June 6 and that Bill C-14 comes as a result of that decision.

Today we will address the need for amendments to Bill C-14 to protect conscience rights for physicians and health care facilities. Our members are committed to caring for their patients at every stage of life. We know what it is to journey with those who are facing great suffering in mind and body. We are committed to serving those who suffer with a compassionate love that is rooted in faith and expressed through the best medical care available.

What our members cannot do is perform or participate in what is being referred to as medically assisted death. To be clear, by participation I also mean playing a role in causing death by arranging for the procedure to be carried out by someone else through a referral.

We acknowledge that the draft legislation tabled on April 14 set aside, at least for the moment, some of the most disturbing recommendations from the parliamentary joint committee. We remain concerned, however, that the bill does not protect the conscience rights of health care workers and facilities with moral objections to euthanasia and assisted suicide.

We see no reference to conscience rights in Bill C-14. The preamble to the legislation notes that the government respects “the personal convictions of health care providers.” While that respect is appreciated, it does not carry the same legal weight as legislative protection. No foreign jurisdiction in the world that has legalized euthanasia/assisted suicide forces health care workers, hospitals, nursing homes, or hospices to act against their conscience or mission and values.

It appears that the federal government is leaving this issue to the provinces and territories for consideration, but if the federal government enacts a law that establishes euthanasia/assisted suicide across Canada, it needs to provide robust protection of conscience rights across Canada.

It is essential that the government ensure that effective conscience protection is given to health care providers, both institutions and individuals. It is simply not right or just to say to an individual, “You do not have to do what is against your conscience, but you must make sure it happens.” It is equally unjust to require a health care facility to repudiate its institutional conscience or mission. We would note that no health care facility in Canada makes every procedure available to its patients.

We will continue to journey lovingly with our patients every day. We ask that you protect all health care workers and the institutions that are successors to the pioneers of health care in our country to ensure that they may continue their mission of care and healing.

Larry.

Mr. Laurence Worthen (Executive Director, Christian Medical and Dental Society of Canada, Coalition for HealthCARE and Conscience): Thank you, Cardinal Collins.

Members of our coalition support the right of patients to refuse or discontinue treatment at end of life, allowing the underlying illness to take its course.

We wish to make it clear that should Parliament legalize medical aid in dying, we will not in any way obstruct patients who decide to seek that procedure, and we will never abandon our patients.

We know there are many ways to respect patient decisions that do not violate the conscience of health care workers or institutions. The Canadian Medical Association and other experts have said there is no necessity for there to be a conflict between these two values.

Our own proposal recommends the use of transfer of care and direct patient access, so patients have the choice of staying with their physician for care or transferring care to another physician.

Facilities that cannot provide the procedure on their premises are prepared to help transfer patients to the facility of their choice if the patient so desires.

To force providers to act against their moral convictions is to breach section 2 of the Charter of Rights and Freedoms. We know hospitals and regulators all across the country are right now developing policies on this subject. For example, the College of Physicians and Surgeons of Ontario has already provided a provisional policy that will force doctors to provide a referral for euthanasia and assisted suicide. At the same time at least seven other provincial colleges have not taken that approach.

Legislation from Parliament would send a clear signal that the charter rights of caregivers all across Canada can be protected. Canadians should not have to deal with a patchwork approach.

Parliament has legislated matters that overlap into provincial or territorial jurisdiction in the past. Consider, for example, the Civil Marriage Act passed by Parliament in 2005 to legalize and regulate same-sex marriage. While marriage falls under provincial jurisdiction, this is federal legislation that governs marriage. The act contains language in its preamble and a specific clause recognizing that officials of religious groups are free to refuse to perform marriages that are not in accordance with their religious beliefs.

Our coalition recommends Parliament use the same legislative approach in Bill C-14, including language both in the preamble to the bill and in a specific clause that confirms that individuals or faith-based health care institutions that oppose euthanasia or assisted suicide are not to be compelled to engage in it and are not to be discriminated against as a result of their opposition.

Our proposed amendments to the preamble of Bill C-14 read as follows, and in the interests of time I will read two of those that we submitted in our brief.

> Whereas Parliament respects and affirms freedom of conscience and religion for health care practitioners and faith based institutions, and whereas nothing in this act affects the guarantee of freedom of conscience or religion, and in particular the freedom of health care practitioners and faith based institutions to refuse to provide or participate in the provision of medical assistance in dying.

Our proposed amendments to the body of the act would read as follows:

> It is recognized that health care practitioners are free to refuse to participate in medical aid in dying, either directly or indirectly, if doing so is not in accordance with their conscience or religious beliefs.
>
> For greater certainty, no person or organization shall be deprived of any benefit or be subject to any obligation or sanction under any law of the Parliament of Canada solely by reason of their exercise or refusal to exercise in respect of medical aid in dying of the freedom of conscience and religion guaranteed under the Canadian Charter of Rights and Freedoms.

In closing, we would like to mention that the Carter case clearly stated that no physician could be forced to participate in assisted death. The court also said this was a matter that engaged the charter freedoms of conscience and religion.

It is not in the public interest to discriminate against the category of people based solely on their moral convictions and religious beliefs. This does not create the kind of tolerant, inclusive, or pluralistic society that Canadians deserve.

Thank you.

● (1625)

The Chair: Thank you very much.

Now we will move to Ms. Gokool.

Ms. Shanaaz Gokool (Chief Executive Officer, Dying With Dignity Canada): Good afternoon.

Thank you to the justice and human rights committee for inviting Dying With Dignity Canada to this hearing today.

We have been on the assisted dying file for well over 30 years. If anyone recognizes the historic moment that our country is now in, we certainly do. However, we are very concerned about Bill C-14 and its unjustified deviation from many of the core recommendations of the special joint parliamentary committee.

We are concerned that the government's definition of “grievous and irremediable” does not meet the minimum standards of Carter. If Carter is the floor for assisted dying, we're now in the basement. We are also particularly concerned that there is not a provision for advanced consent for people who have a diagnosis of a “grievous and irremediable” condition such as dementia or Huntington's.

While Dying With Dignity Canada's policies are informed by our physicians' advisory council, we're not doctors and we're not lawyers. We represent the 85% of Canadians who support the Carter decision and the 80% of Canadians who support advanced consent with a diagnosis. As such, our organization has a responsibility to discuss the vulnerable groups of people who will be left behind if Bill C-14 is not substantively amended. The people I will mention today are but a snapshot representation of the thousands of Canadians who will not be able to find comfort in Bill C-14 and who may have to go to court to establish their charter right to die.

The following is not an exhaustive list of concerns, but it does highlight some key exclusions.

The government's legislation redefines “grievous and irremediable” and introduces new terms, such as “incurable”, “advanced state of irreversible decline”, and “reasonably foreseeable”. These new terms will exclude people who have serious chronic medical conditions and will exclude people who are not imminently dying.

So who are we talking about? Who's going to be excluded?

This is Linda Jarrett. Linda was diagnosed at the age of 50 with secondary progressive multiple sclerosis. At 68, she can no longer walk, and the years ahead are deeply troubling for her. She does not want to stay in a 24/7 long-term care facility for what could be years on end. She wants choice and the comfort of knowing that she will be able to make a choice, if her condition and her suffering becomes too much to bear.

This is Ronald Phelps with his daughter Laura. He had a debilitating stroke that left him bedridden and losing his ability to speak. Further complications meant doctors were going to have to amputate both of his arms and both of his legs. Instead, he chose to starve and dehydrate himself to death, which, as his daughter Laura said seemed really to be piling torture onto torture. Others like Ronald Phelps deserve compassion and choice, not more suffering to find peace.

Here is Drew Sperry, who died painfully from ALS and whose greatest fear was not dying, but living, in his own words, “trapped inside my body gasping like a fish on the wharf”.

Let's not forget about Jean Brault, a Quebec man who had a blood clot in his brain and over a period of years suffered from a series of debilitating strokes. Mr. Brault thought, when the legislation came into effect in Quebec, that it meant release from his torment. He was told by his doctors that he met the criteria: he couldn't walk, he was losing his ability to speak, and he was in an incredible amount of pain. But he was also told he wasn't dying fast enough, so he starved himself for 53 days and dehydrated himself for eight days before he was able to qualify for an assisted death. He told the media that he had to self-mutilate to be liberated from suffering.

The government needs to ask whether these are the only choices available to people like Linda, Ronald, Drew, and Jean: to suffer horribly for years or even decades before dying a protracted, painful death or to starve and dehydrate themselves to death, and now, with this narrow and restrictive legislation, to show courage in the face of their suffering and to go to court to fight for their right to die.

We ask that proposed section 241.2 be amended to use the court's language in Carter and to strike “incurable”, “advanced state of irreversible decline”, and “natural death has become reasonably foreseeable”.

Now I will turn to the issue of advance consent. Without advance consent people with a diagnosis for a “grievous and irremediable medical condition” such as dementia, Huntington's, or Parkinson's will face a cruel choice.

● (1630)

This is the one the courts sought to avoid in Carter, to try and take their own lives far too early while they may still have months, or even years left ahead, but while they are still physically and mentally able to do so, or to die in a manner they would describe as horrific.

This is Gillian Bennett, a B.C. woman who was diagnosed with dementia. In the summer of 2014 she took her own life while she was able to, and in her words “I, Gillian, will no longer be here. What is to be done with my carcass? It will be physically alive, but there will be no one inside”.

Here's Margot Bentley, a former dementia nurse who in a cruel twist of fate said she wanted to be allowed to die if she ever developed dementia. She has now been living and dying with dementia for 17 years. As her daughter Katherine says, she is indeed terminally ill, she and people like her. In 2011, in Canada, over 740,000 Canadians are living with dementia. That's 15% of the population over the age of 65. They are completely excluded from this legislation. They cannot ask for an assisted death in advance under this legislation, and they can't ask for it while they are still competent. They will not qualify.

In the summer of 2015 Lee-Anne Peters, who was 30 years old, took her own life after a number of attempts. She was in the mid stages of Huntington's disease, and she knew what was coming for her. Her mother Lisa said Lee-Anne prayed every day to be allowed to choose her own time where she could no longer enjoy life, but because there was no legislation, she was forced to end her life early, alone, and without friends or family, while she was still able to.

Gillian, Margot, and Lee-Anne represent hundreds of thousands of Canadians who have already been given a life sentence. By excluding advance consent, the federal government has acknowledged their Charter of Rights will be violated. The legislation must be amended immediately to include advance consent, or the federal government must provide a sincere commitment to ensure whole groups of people based solely on their medical condition are not discriminated against, and add a statutory mandatory mandate requiring an independent expert study of the issues with a prescribed deadline of 18 months to report back to Parliament with possible amendments to the Criminal Code. This remedy may also be applied for the inclusion of mental illness and competent minors.

In conclusion, if this legislation is not significantly amended then we can expect to see more seriously ill, chronically ill, sick, and dying Canadians who will have to go back to court to access what we believe will be their charter rights. Haven't enough sick and dying people already sacrificed so much for us, and haven't they already gone to court to establish the Charter of Rights for people who are grievous and irremediable ill?

Thank you.

● (1635)

The Chair: Thank you very much.

I'd like to thank all four of the different groups who testified before us today for their compelling presentations. We're going to start with questions from the members. We'll start with the Conservatives. Mr. Cooper, you will go first.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): I want to thank all of the witnesses for their testimony.

My first question is to Ms. Gokool. You made reference to advance consent, and you conflated that with the Carter decision. You went on to suggest that it was charter right, and I was wondering if you could point to the paragraph in the Carter decision that says advance consent is a right under section 7 of the charter.

Mrs. Shanaaz Gokool: For the concept of consent in the Carter decision, the court didn't define when consent had to be established in order for a request to be considered valid. We would say the Carter decision was neutral on advance consent. We would say that discriminating against whole groups of people based solely on their medical condition may very well be a charter discrimination, and a violation of their charter of rights.

Mr. Michael Cooper: In other words, the court never did say it was a charter right. My next question is to Cardinal Collins. Cardinal, you spoke about the need for conscience protections. I'd like to ask you about conscience protections for faith-based health care institutions. There are some who are not supportive of conscience protections for faith-based institutions. They seem to distinguish between health care providers as individuals on one hand and institutions on the other. In so doing they characterize institutions as bricks and mortar. This view seems to be inconsistent for example with the pronouncement of the Supreme Court in the Loyola decision wherein Justice McLachlin recognized that under section 2 health practitioners and institutions are intertwined when it comes to freedom of religion and freedom of conscience. I was wondering what your comments might be on those who would say health care institutions are merely bricks and mortar, and therefore are not worthy of conscience protections.

Cardinal Thomas Collins: I think that with health care institutions, what we call their conscience we called “mission”. From the earliest days of our country, the religious sisters who founded health care in our country were driven by their mission of serving other people. That is the heart of who they were, and it is to this very day.

I live right next to a Catholic hospital that presents itself as the Urban Angel protecting the people, and it does that. That spirit, that mission at that hospital, is something profound. It is what I would call an institutional conscience. It is something very precious.

Institutions such as Catholic hospitals and others of other faiths are not bricks and mortar; they are the spirit of the people there who are helping. I think that's a very narrow and misguided view of groups of people who give their life to help others and without whom this country would be a colder, harsher, rougher place, without the love and care of people serving a mission, as in a hospital. It's not just bricks and mortar at all.

● (1640)

Mr. Michael Cooper: In the absence of conscience protections, could you comment on what you're hearing in terms of the impact that may have on health institutions, many of which have been providing quality health services for decades? I know that in the province of Alberta, Covenant Health is one such example, wherein the absence of conscience protections becomes a major problem.

Would you be able to comment on the impact, if Parliament doesn't act with conscience protection legislation?

Cardinal Thomas Collins: I think it would be a very serious impact. I noticed when we got together to make a statement in the parliamentary press room a while ago that the Salvation Army also was standing...we were side by side, because they also have hospitals that are very concerned about this.

I think it's the institutions, these health care facilities that are there to serve.... If they are not allowed to do so, it would be a very serious problem. Of course, there are the individuals as well. Individual health care providers are the doctors, nurses, pharmacists. These are people who also need to be protected, and it's not just about their conscience rights not to perform these procedures but also not to effect a referral to make them happen.

Mr. Michael Cooper: My last question is directed to Mr. Worthen. You read a proposed conscience protection clause. I haven't seen the text of it. You may have submitted a brief, but I haven't had an opportunity to review it. Based on what I heard, is it modelled after section 3.1 of the Civil Marriage Act? Is that effectively the structure of this specific proposed amendment? It sounds awfully similar.

Mr. Laurence Worthen: It is very similar. It was based upon that legislation.

The Chair: Now we will go to Ms. Khalid.

Ms. Iqra Khalid (Mississauga—Erin Mills, Lib.): Thank you, Chair.

I'd like to thank everybody for making your presentations. Your viewpoints are very much appreciated, I think, in guiding the government on how to take a balanced approach to addressing this complex and very sensitive legislation.

I want to talk about balance and really about balancing a person's civil rights, and then about the rights and protections that vulnerable persons must be assured of.

My question is to the Civil Liberties Association. In your brief you have mentioned that there is no reason to distinguish between mature minors and incompetent adults and that the age requirement set out in the bill should be eliminated.

My question to you, then, would be: how do you propose that we protect vulnerable groups such as minors when it comes to physician-assisted dying?

Ms. Cara Zwibel: Our view is that the issue of minors is something that's addressed regularly by people who are practising in the health care field. These decisions about who is a mature minor, and who can make treatment decisions, are decisions that health care providers make on a regular basis.

I think it's reasonable to assume, and it's important to understand, the mature minor decision is not a stamp you get at a certain age or at a certain point in time. The mature minor assessment is generally made in relation to a particular treatment decision. Someone would be assessed in relation to this particular treatment decision. Are they capable of making a decision to request assistance in dying?

I think it's reasonable to assume that physicians who are charged with making those decisions are likely going to have a higher bar than they would for other types of treatment decisions, such as can you consent to a blood transfusion, or can you consent to surgery or to emergency treatment.

The idea behind a mature minor assessment is you're someone who can make a decision with the same capacity as an adult, and there isn't, in our view, a principle basis for distinguishing.

I appreciate there are concerns. I guess I have confidence our medical professionals are not going to view this decision lightly. They are going to take this responsibility very seriously. I think that's implicit in the fact the legislation does vest so much power and influence in the assessments of medical professionals. We think that's how you would address it.

I appreciate it's a complicated issue, people are concerned about it, and it certainly makes people uncomfortable to think about young people choosing to end their lives. To the extent the committee does decide this is something that requires further study, then I certainly agree with Ms. Gokool from Dying with Dignity that there should be a timeline put on this consideration, so we don't wait and have people suffering because Parliament is unable to act.

● (1645)

Ms. Iqra Khalid: Ms. Gokool, as you had also mentioned this is something that should be removed from the bill, can I please have your opinion as to how we should go ahead with the protection of vulnerable persons?

Mrs. Shanaaz Gokool: I think the first thing I would say is when we talk about vulnerable people, there seems to be this dialogue that there are vulnerable people, and then there are people who are suffering and need help to die. They are the same group of people. People who are suffering intolerably and have enduring suffering are also very vulnerable.

If there's some question as to the policies and protocols that need to be developed within medical practice to deal with advanced consent of mature, competent minors, I would say for our organization—and we have worked on this issue for decades—the issue of mental illness as a sole criteria and competent minors is a fairly new component to the discussion. Even for us, it's fairly new.

I think it's not unreasonable for the government to need more time to understand, through more consultation with people who are going to be social workers and medical health care providers, how parameters can be developed to ensure we're not discriminating against people arbitrarily based on age, or arbitrarily based on their medical condition.

In the legislation, in the preamble and the non-legislative component, the government has indicated they would study this within five years. That feels for a lot of us that's just kicking the can down a dead-end road. There was a sincere commitment and understanding that there may be a need to have some thorough discussion to understand what those policies and protocols might be, and that there be a timeline of 18 months to strike a committee, and I would say in the next three months to study and report back with legislative guidelines. We don't have all those answers, but at the same time, we don't want to arbitrarily exclude people and not find ways to ensure their Charter of Rights will not be violated.

The Chair: A very short question.

Ms. Iqra Khalid: Again, to the Civil Liberties Association, a very short answer, please.

In your brief you had mentioned that the reasonably foreseeable death is vague. Would adding a specific timeline of perhaps six months, eight months, or a year make it more clear in your opinion?

Ms. Cara Zwibel: I think it would make it clearer and would arguably also make it unconstitutional. I think the clear direction from the court in Carter was that this was not about proximity to death; it was about quality of life. To impose that kind of requirement, first of all, is asking physicians and health care providers to do a very difficult task. I think most physicians find forecasting with that level of specificity difficult. I would argue that while it makes it clearer, it undermines the animating purpose for this legislation.

● (1650)

The Chair: Thank you very much.

Mr. Rankin.

Mr. Murray Rankin (Victoria, NDP): Thank you to all the witnesses.

I noticed, just to build on what my colleague just asked, Ms. Zwibel, that you recommended that proposed paragraph 241.1(2)(d), which contains the “reasonably foreseeable” natural death, be removed. It's the same recommendation Ms. Gokool made, and many others as well.

You said you were an intervenor in the decision, so you were present, and you conclude that this is contrary to the letter and spirit of Carter. I would like you to elaborate on why you think that's true.

Ms. Cara Zwibel: The focus in Carter was on suffering; it wasn't on a timeline. The organization was an intervenor before the court in Carter. We were not involved in compiling the record of evidence, so it's been a while since I've examined it closely. But my understanding is that Ms. Carter, for example, whose daughter and son-in-law were applicants, was suffering from a disease that would not have lent itself to that kind of characterization: that death was reasonably foreseeable in any sort of proximate way.

The fact that the court was examining that among other specific cases and found a right under section 7 of the charter to medical assistance in dying for those suffering from a grievous and irremediable condition says to me that proximity to death is not a component of that decision.

Mr. Murray Rankin: Ms. Gokool, you had a very provocative introduction in which you said that if Carter is the floor for physician-assisted dying, we're now in the basement. Then you named Linda, Ronald, Drew, and Jean Brault, who, you said, were excluded under Bill C-14.

Is it your evidence that they would be allowed to use medical assistance in dying, under your interpretation of the Carter case itself?

Mrs. Shanaaz Gokool: I'm going to pick up where my colleague from the Canadian Civil Liberties Association left off.

We think that we are in the basement, because it's either not clear or the government isn't saying what they really mean when they use terms such as “incurable”. In the Carter decision, the court made it quite clear that “irremediable” had to be qualified by “for which there was no treatment acceptable to the person”.

When the government uses the language that a natural death has to be “reasonably foreseeable”, it's either nonsensical, because everyone's death is reasonably foreseeable, or it's unacceptably vague. Doctors who are going to be examining people are going to be asking the same question all of us are, “Why don't they just say 'terminal', because I think that's what they really mean?” If that's the case, then all the people I've listed would not meet the definition in the government's legislation, but would meet that in the Carter decision, because the Carter decision wasn't just about dying; it was about people who were suffering intolerably. I think that's something we have to make clear here: this bill is for people who are imminently dying.

Mr. Murray Rankin: Thank you; that's fine.

I'd like to ask the Christian Legal Fellowship a question about their request that the preamble of the bill talk about suicide prevention and inherent rights. I ask the question because we already have in the preamble an affirmation of the inherent and equal value of everyone's life, and we already have in the preamble a reference to suicide as a significant public health issue, so I'm really unclear what you think your suggested language would add.

Mr. Derek Ross: Yes, we do think that these additional wordings are necessary. We recognize that the preamble is a good start and that it addresses suicide as a public health issue. It does not, though, specifically affirm that suicide prevention remains a public policy goal. It simply states that it's a public issue and can have negative effects.

We want it to be abundantly clear, in part because this issue—suicide prevention as a legislative objective—was not really considered in Carter. Carter, in determining whether the law was overly broad and vague, looked at the law solely through the lens of whether it achieved the objective of protecting vulnerable persons. It didn't address these bigger societal issues that we think need to be clearly and specifically affirmed.

It's the same thing the inherent—

Mr. Murray Rankin: Thank you. I'm only concerned about time. I think I understand what you're saying on that point.

If I had the opportunity, I'd like to ask one final question to the Coalition for HealthCARE and Conscience, for either Cardinal Collins, or Mr. Worthen.

The Chair: Yes.

Mr. Murray Rankin: There was talk about institutional conscience. There was talk of mission and that institutions ought to be provided conscience protection in the bill. I wasn't sure if you could speak to the requirement, if any, of a transfer to another facility if a particular institution is not willing to provide this constitutionally guaranteed service.

I'd like your position on whether that institution or that practitioner with conscience objections should be required to make a transfer or referral of a patient.

● (1655)

Mr. Laurence Worthen: If I could just respond to that.

Part of the problem in this debate is the definition of referral. When we talk about referral, we're talking about a formal referral, which is essentially a recommendation.

If patients are in a facility that is not able to provide assisted death on the premises, then our moral beliefs allow us and physicians within that facility to facilitate a transfer of the patient to the facility of their choice where they can get access to that procedure.

Similarly if a patient comes into a doctor's office and wants assisted death, and the doctor is a conscientious objector, there are number of ways to deal with that. One of them is to transfer to another physician. Another is if the provincial government were to develop a process of direct access for this, the patient could keep their physician.

There are many ways we can ensure patient requests are respected, while at the same time protecting conscience.

The Chair: Thank you Mr. Rankin.

Next we're going to Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you to all the witnesses.

My question is again for the Canadian Civil Liberties Association, Ms. Zwibel.

I understand you consider that section (d), we're taking about foreseeable death, should be dropped and cannot be repaired by adding a specific time element to it. Is there any other way you can imagine it could be corrected without dropping it entirely?

Ms. Cara Zwibel: The suggestion in our written brief was an addition for a greater certainty clause. I suppose the answer to your question depends what that reasonable foreseeability requirement is trying to accomplish.

I have to agree with Ms. Gokool, that if the goal is to make a terminal illness a requirement, that's not something we would support and not something we have suggestions of how to achieve.

If—as it seems from the background documents that I've read, and from the minister's statements, and the statements in the House that I've seen—this is intended to apply to people like Ms. Carter, whose death was not necessarily reasonably foreseeable or proximate, then in our view it's appropriate to drop it and to add in a greater certainty clause that makes it explicit that a terminal illness or proximity to a natural death is not a requirement.

Mr. Ron McKinnon: Thank you.

In your view, with another paragraph of that part, regarding an “advance state of irreversible decline”, do you think that is an appropriate constraint?

Ms. Cara Zwibel: That's one I have to acknowledge I haven't looked at as closely. That one seems less vague to me. It seems like a physician would likely be able to appreciate what that requirement means.

Whether it's in line with what Carter requires, I'm not convinced that it is. In our view, the biggest problem is this reasonably foreseeability requirement.

Mr. Ron McKinnon: I believe this section is about trying to put some clear definition around the concept of “grievous” and “irremediable”. It does introduce new terminology, such as “incurable in illness”, and “advance stage of irreversible decline”, and things like “reasonable foreseeable death”.

I'm wondering if you feel that it does successfully narrowly enough define the concept of “grievous” and “irremediable“, or do you think this section is useful at all?

Ms. Cara Zwibel: I am a bit torn about whether “grievous and irremediable”, that language on its own, is sufficient. I don't fault the drafters of the legislation for trying to put some more meat on the bones, so to speak, and be more specific about what that means and provide some guidance. I would say that to the extent it requires an incurable illness or condition, I would interpret that in line with the Supreme Court's decision in Carter in terms of incurable to the extent that any treatment is not tolerable or acceptable to the individual in the particular circumstances.

I think the effort of trying to define grievous and irremediable is probably a valuable one, but as I said, the biggest problem I see is with the reasonable foreseeability requirement.

● (1700)

Mr. Ron McKinnon: Thank you.

Another question that has come up a number of times is the idea of a 15-day waiting period, a clear 15 days, which could mean more than 15 days. This could force individuals to undergo an extra number of weeks of suffering. Some have suggested this might be unconstitutional.

Would you like to give us an opinion on that?

Ms. Cara Zwibel: Our submission on this point was that we weren't opposed in principle to a brief period of reflection, what some people call a cooling-off period, as long as there were opportunities for exceptions. I think the legislation does make an exception. It does allow for that 15 days to be abridged in circumstances where...I'd have to look back at the legislation, I'm not sure if it's where the suffering would be intolerable or where the view is the individual doesn't even have that much time, but allowing for a period of reflection and allowing also for exemptions from it is not inappropriate.

The Chair: Thank you very much.

Given the short time we have, and the number of panellists today, we can only do one round of questions. I want to thank all of you profusely for your contributions to our deliberations. Rest assured we'll carefully read each of your briefs and take what you've said under advisement.

Thank you all so much for joining us. We appreciate it.

We're going to take a brief break to get our next panel set up.

● (1700)

(Pause)

● (1705)

The Chair: We're going to reconvene. I would like to thank our next witnesses, who are all by video conference, for having joined us. I hope you can all hear me.

My name is Anthony Housefather, and I'm the Chair of the committee.

As we go, I will introduce you to the people who are going to be asking you questions. We're going to start with each of you, or each organization, having an eight-minute presentation: there are three. That will be followed by a round of questions where we will have the Conservatives asking six minutes of questions, the Liberals asking six, the NDP asking six, and the Liberals six. We'll then see if we have any time for a speed round.

I would ask all of you to keep your remarks to eight minutes. That would be much appreciated. If you would stick to proposed changes to the legislation, as opposed to general overviews that might have been heard by the special committee, that would also be appreciated. We're not here to reinvent what the special committee heard. We're here to talk about the proposed law.

I would like to introduce, as an individual, Ms. Carrie Bourassa, who is a professor of Indigenous Health Studies at First Nations University of Canada. Welcome.

From the Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society, we have Margaret Birrell, who is a board member, and Angus M. Gunn, who is a counsel.

From Communication Disabilities Access Canada, we have Hazel Self, who is the chair of the board of directors.

Welcome all of you.

We will start with Ms. Bourassa. The floor is yours.

● (1710)

Professor Carrie Bourassa (Professor, Indigenous Health Studies, First Nations University of Canada, As an Individual): Thank you. I hope I've prepared this properly. I apologize if I haven't. At the last parliamentary committee where I was asked to present, I read something in a similar format, but not the same content. Forgive me if I haven't done it correctly.

I want to start by saying that in terms of the bill that's being proposed, many first nations communities are not fully prepared for the implementation of Bill C-14. For that matter, in my opinion, neither is the Canadian health care system, due to the interconnectedness of the ongoing oppression, especially the intergenerational effects of the residential school system and the lack of general awareness of this ongoing oppression, as well as the need for further development of cultural safety models in health care systems.

The First Nations Health Authority states that today first nations are still affected by colonization and assimilation, systemic discrimination and racism; child apprehension; land dispossession; loss of tradition, language, and culture; the legacy of residential schools; and intergenerational trauma and its effects. The residential school system and intergenerational trauma often overshadows the other forms of ongoing oppression, and rightly so, due to the recent conclusion of the Truth and Reconciliation Commission.

As a result of the residential school system and its intergenerational effects, first nations are likely to suffer from mental health issues, including depression and suicidal ideation. This would include the older aboriginal population. While attention has been most recently focused on the epidemic of youth suicides in first nations communities, globally, suicide in many countries is as high or higher than suicide rates for young people. Due to the current research gaps in the area of aging for the older aboriginal population, this is an area clearly in need of further research in order to understand how the elderly are being affected by suicide.

The older aboriginal population could be more at risk for suicidal ideation due to the cultural genocide of the residential school system, whereby the loss of parenting skills that allowed for a child to grow in a traditional home environment and learn cultural norms; the loss of traditional healing methodologies; and the loss of traditional knowledge and history, including gender roles and the role of the elderly in society, were significant impacts.

Included in the loss of traditional knowledge and history would be whether assisted dying was practised, and if so, under what circumstances. The high suicide rates in the aboriginal community, combined with the loss of the aforementioned, create a situation where the introduction of assisted-dying legislated practices could create significant problems. How will high rates of suicide among the elderly affect their ability to neutrally determine the right to die? How will a lack of knowledge of traditional customs affect the ability of the elderly to determine the right to die?

The intergenerational impacts of the residential school system discussed for the elderly are just as applicable for the ill and the disabled. How does a significant loss, the cultural genocide of the residential school system, impact first nations today in the valuation of their lives?

When first nations communities can positively state they are in a period of stabilization in terms of community wellness, maybe that would be a time to consider introducing such legislation, but not now when too many communities are just beginning to recover from ongoing oppression, and particularly that of the residential school system.

The Health Council of Canada calls for awareness and understanding of the history of colonization, institutional discrimination, and power imbalances when cultural safety models are developed and implemented. The ongoing oppression of first nations is not well known to the general Canadian public or to health care practitioners, despite some efforts, including an understanding of this, such as mandatory introductory courses on indigenous health for nursing students offered here at First Nations University of Canada.

Regardless of these initial efforts, cultural humility, a key component of cultural safety, reminds us that a four-month class or a 12-hour course is not the equivalent of a lifetime of enduring the impact of ongoing oppression. Ongoing relationships between patient and health care practitioner need to be developed and nurtured in order to create trust for the patient.

● (1715)

Relationships such as these take time.

Evidence of the general lack of cultural awareness and sensitivity can easily be found in the media when familiar former political figures offer relocation strategies for youth suicide epidemics in northern remote first nations communities. The lack of mass Canadian public outcry at this strategy is indicative of the systemic problems that need to be overcome.

Without relevant cultural safety models being implemented for health care practitioners to offset the historically compounded views of first nations in society and academia, what kinds of relationships will health care practitioners have with first nations patients who are elderly, ill, or disabled? Will it be a long-term relationship, or two strangers meeting to decide life or death?

Will it be remembered that first nations have a wealth of knowledge and history that at times needs to be nurtured back from the effects of ongoing oppression, especially the residential school system? Will the resiliency of first nations, a clear reminder of how first nations have endured and overcome adversity, be remembered?

Without an understanding of this, would it not be too easy for a client to accept assisted dying without truly giving informed consent, or a health care professional to accept such flawed consent?

Meegwetch, and thank you.

The Chair: Thank you very much, Professor Bourassa.

Next we will move to the Alliance of People with Disabilities. Ms. Birrell and Mr. Gunn, the floor is yours.

Mr. Angus Gunn (Counsel, Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society): Honourable members of Parliament, Mr. Chair, thank you for the opportunity to appear before you this afternoon. Before you is Margaret Birrell, who is president of the alliance. My name is Angus Gunn, and I have served as litigation counsel for the alliance since 2011.

I have been asked to deliver some prepared remarks, and Ms. Birrell will be pleased to respond to any questions the committee might have.

The members of the alliance that I represent are leading advocates for disability rights. The alliance sought and obtained intervenor status at all three levels of court in the Carter litigation to advocate for the right that was ultimately recognized by the Supreme Court of Canada.

In these prepared remarks, the alliance makes four recommendations for suggested amendments to Bill C-14. The first is to restore the efficacy of advanced directives. Bill C-14 does not take up the special joint committee's recommendation that the use of advance requests be permitted. The charter rights of those who suffer from dementia are not less deserving of protection just because their enduring and intolerable suffering results from an illness that also robs them of decision-making capacity.

The government has provided two rationales for excluding advance directives, neither of which we say withstands scrutiny. The first is:

> Advance directives generally do not provide reliable evidence of a person's consent at the time that medical assistance in dying would be provided.

Advance directives do provide highly reliable evidence of a person's consent while the capacity to give consent is intact. Dementia ultimately destroys the capacity to give consent. To insist on such consent at the time of medical assisted dying is to require the impossible. Are there really individuals who decided they would rather die than weather the storm of Alzheimer's for example, but then later change their mind because Alzheimer's isn't so bad after all? Even if these people do exist, why should their vulnerability trump that of the thousands of individuals whose wishes have not changed, but whose illness robs them of the ability to confirm that fact. Why is the blanket ban the Supreme Court of Canada rejected for sufferers of ALS acceptable for sufferers of dementia? Excluding advance directives will cause needless suffering for thousands of Canadians and will condemn us to protracted charter litigation simply to define the perimeter of Carter's cruel choice.

The second rationale offered by the government is that disallowing advance directives guards against the effects of inaccurate assumptions about quality and value of life. The reality of Alzheimer's at late stage is not a matter of assumption. If a competent individual makes an informed decision that at a certain stage of decline the quality and value of life will have degraded to a point where medical assisted dying is desired, why isn't that decision entitled to respect? Who is the state to discard that decision as reflecting inaccurate assumptions? The alliance urges the committee to restore the efficacy of advance directives in relation to medical assisted dying.

The second amendment is to remove the requirement that death be reasonably foreseeable. Bill C-14 rations the availability of medical assisted dying upon an individual's natural death being reasonably foreseeable. Nowhere is that requirement visible in the Carter decision. To the contrary, Kay Carter suffered from the non-life-limiting, non-terminal disease of spinal stenosis.

The government suggests that to permit medical assisted dying for those not approaching natural death could undermine suicide prevention initiatives, could normalize death as a solution to many forms of suffering, or could de-prioritize respect for human life and equality.

● (1720)

These objectives are already well served by other elements of the Carter test, including the need for a grievous and irremediable illness or condition, the need for enduring an intolerable physical or psychological suffering, the requirement that suffering be incapable of relief, the need for a medical or nurse practitioner opinion, and the 15-day waiting period. The controversy over whether Ms. Carter could have won her litigation, but be ineligible under Bill C-14, illustrates the problem with this provision.

Wherever one lands on that debate, Canadian criminal law adheres to the principle of certainty. Prohibited conduct must be fixed and knowable in advance. It offends this principle for conduct to be criminalized, or not, based on a case-by-case application of ambiguous concepts such as “reasonably foreseeable” and “not too remote”. Canadians who experience intolerable suffering, and physicians who wish to assist, should not have to guess about the criminality of their actions based on a retroactive application of concepts with no settled meaning. The alliance urges the committee to remove the requirement that natural death be reasonably foreseeable.

The third reform is that independent recommendations on mature minors and mental illness should be required by statute. At the moment, the preamble to Bill C-14 makes only a non-binding pledge to explore these other situations, but these topics are too important to be left to such an uncertain process. The act, we submit, should mandate a panel of independent experts be asked to make recommendations on these two subjects on a defined and limited deadline.

Finally, the alliance urges that two legislative drafting choices that are visible in Bill C-14 should be amended. First of all, Bill C-14 confusingly uses the word “they” to refer to individuals. An example is subsection 227(1), which says:

> 227 (1) No medical practitioner or nurse practitioner commits culpable homicide if they provide a person with medical assistance in dying in accordance with section 241 (2).

This use of the singular “they”, aside from being jarring to the eyes and ears, fails to harmonize with the bulk of the Criminal Code, which generally achieves gender neutrality not by using the singular “they”, but rather by using such phrases as “that person”, or “the person”, or “he or she“, or “his or her”. Alternatively the provisions can be reworded altogether to avoid the problem: “No valuable practitioner commits culpable homicide who provides a person with medical assistance in dying.”

Bill C-14 also uses em dashes in several clauses, which make for complicated and lengthy clauses that need to be read multiple times just to be understood. It also inappropriately demotes, as parenthetic asides, language that plays an important role in the bill itself. Clarity and ease of reference would favour the use of lettered subparagraphs instead.

The alliance thanks you again for the opportunity to provide these prepared remarks and to participate in the important work of this committee.

● (1725)

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

Now we will move to the Communication Disabilities Access Canada. Ms. Self, you have the floor.

Ms. Hazel Self (Chair, Board of Directors, Communication Disabilities Access Canada): Thank you very much.

Good afternoon, ladies and gentlemen. I want to present a rationale and propose two amendments to Bill C-14 to ensure that people with speech and language disabilities are given appropriate communication accommodations and supports in order to provide informed consent in the context of medical assistance in dying.

I am chair of the board of Communication Disabilities Access Canada, which is a national non-profit organization that promotes accessibility and human rights for over 450,000 people in Canada who have speech and language disabilities due to disabilities such as cerebral palsy, autism spectrum disorder, fetal alcohol syndrome, cognitive delay, Down's syndrome, traumatic brain injury, aphasia after a stroke, dementia, ALS, Parkinson's disease, Huntington's disease, and multiple sclerosis.

Bear in mind that with any condition I've just mentioned, the individual could be also suffering from terminal cancer. They may have cerebral palsy but also have cancer.

A person with a communication disability may have speech that is slurred or difficult to understand, or they may have little or no speech and communicate by pointing to letters, symbols, or pictures, or by using a communication device. Some communication disabilities, such as aphasia after a stroke, impact on a person's ability to understand and process what others are saying, but do not affect their cognitive ability to make decisions.

The incidence of speech and language disabilities increases with age and includes people with pre-existing and age-related disabilities, as well as communication challenges related to typical aging, such as hearing and vision loss, reduced comprehension of complex sentences, and word-finding difficulties.

Effective communication is essential for all patients facing end-of-life decisions. Successful communication is a two-way process in which messages are correctly and unambiguously understood by both the patient and the medical practitioner. This includes getting and understanding information about one's diagnosis, prognosis, treatment, and palliative options, weighing up information to reach a decision, and communicating that decision and the reasons for the decision.

These are complex communication issues for anyone and are further compounded for people who have compromised speech and language abilities due to disabilities that affect their ability to understand spoken and written language, retain options and appreciate consequences to options, and to ask questions, give opinions, and communicate a decision. However, with appropriate communication accommodations and supports, many people with speech and language disabilities can make and communicate informed decisions.

There is ample evidence to demonstrate that many people with speech and language disabilities experience significant barriers when interacting with medical practitioners about their health care, and specifically within informed consent situations. Unlike people who are deaf and who may require sign language interpreters, or people who require oral translators, there are currently no protocols or directives in place to ensure that people with speech and language disabilities are provided with appropriate communication accommodations and supports.

People with speech and language disabilities report that health care professionals often overlook and misunderstand their wishes. They are very anxious about the lack of safeguards in Bill C-14. They report that medical practitioners often do not know how to make spoken or written information accessible to them; do not understand what they are communicating when they use ways other than speech to convey their messages; assume their speech and language disability is a cognitive disability; underestimate their capacity to make their own decisions and end-of-life directives; defer to family members and personal support staff to communicate on their behalf; and rely on untrained people to assist with their communication where an arm's-length, mutual, qualified professional communication assistant is required. They also undervalue, typically, the quality of their life and their need for health care interventions.

● (1730)

CDAC is asking for stronger safeguards for people with communication disabilities. These safeguards must include a directive to medical practitioners to engage a communication professional to assess the patient and to provide any required accommodations and supports.

We are proposing the following amendments to C-14 to ensure that people can effectively communicate about medically assisted death. If there is any question about the communication process as identified by the medical practitioner or the patient, then a neutral independent professional with expertise in the patient's communication needs must be engaged in order to assess the required communication accommodations and/or to provide direct communication support. Communication accommodations and supports are required if the patient has challenges understanding information provided to them, retaining and weighing out the consequences of options as part of the decision-making process, and accurately and authentically communicating their decisions. Communication accommodations include picture or letter boards, speech output devices or communication support from a sign language interpreter, deaf-blind intervenor, speech language pathologist, language translator, or cultural interpreter.

Our second directive has to do with the subclause titled “Unable to sign”, regarding proposed subsection 241.2(4),

> If the person requesting medical assistance in dying is unable to sign and date the request, another person—who is at least 18 years of age and who understands the nature of the request for medical assistance in dying—may do so in the person’s presence

to which we would like to add “under their direction on their behalf”.

Thank you.

The Chair: Thank you very much, Ms. Self.

I really appreciate the testimony offered by each of the different witnesses.

We're now going to move to questions. The Conservatives have the first six minutes. I'm going to pass it to Mr. Kmiec, who is going to ask the first questions.

Mr. Tom Kmiec (Calgary Shepard, CPC): I might share my time with my colleague Ted here.

Thank you very much to all the presenters.

My first question is going to be on the definition of medical practitioner. I want to get your thoughts on this.

My home province of Alberta has something called the Health Professions Act, and schedule 21 actually defines what a medical practitioner is. It covers, basically, everything from a generalist to things like osteopaths, so chiropractors. I want to get thoughts from each of you on this. Should two chiropractors be eligible to provide medical assistance in dying, say in a remote community or just in a private setting where they have a practice of their own? This is for each of you, and maybe we can start with Professor Bourassa.

● (1735)

Prof. Carrie Bourassa: I think particularly if you're thinking about a rural northern community, from my perspective when there's already a shortage of physicians, if they're a licensed physician and they're practising, then I think it would be important to allow them to, because we already have such a shortage.

I should have outlined the practical amendments I wanted made to the bill, I suppose, but one of the issues that is key for me is that there are not enough licensed physicians or nurse practitioners in northern and rural areas and certainly not on or near reserves.

I think if there's a licensed practitioner who is appropriately trained—and that's another key issue—then that is certainly worth consideration. I think training is particularly important. I don't think that just anybody with a licence is necessarily capable of signing off or advising on this. That's where I think training is really important.

Ms. Margaret Birrell (Board Member, Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society): You were talking about people being able to use chiropractors. I think we need to come to that decision on each individual case. If in fact the person's disability requires them to have a chiropractor, then chiropractors would be the most specific specialist the individual could use. I don't think practitioners should be removed without looking at what are the needs of the individual who is actually requiring some assistance.

The Chair: Did you also want to comment, Ms. Self?

Ms. Hazel Self: From our perspective, I believe it would be a physician who would have the authority to do that, but it does go back to training. Our issue, of course, is around communication. To us, physician-chiropractors are often lacking training in the communication needs of people with speech and language disabilities. We would see that as a key piece in the training.

Mr. Tom Kmiec: I'm going to pick up on something that Professor Bourassa said.

Should one of the safeguards that we could add to this bill be that the attending physician, the medical practitioner responsible for ensuring that all the requirements are met, be required to understand the underlying condition the patient has, before being one of those who are allowed to sign off in documenting that the patient is eligible for medical assistance in dying? Should that training and knowledge be a requirement in the bill?

I'll go back to Professor Bourassa for an answer to that.

Prof. Carrie Bourassa: Yes, I absolutely think that, and I think the training needs to be broad and comprehensive.

My argument is that the physicians and nurse practitioners who are going to be involved actually need training in cultural safety, for example. I argued for that in the other parliamentary committee, and maybe I shouldn't be arguing it here, but I do think it's a key point. I think it's very important.

I know that others will argue for other training, and I won't step on toes, but I think there needs to be a certain array of training that needs to be checked off before they're eligible.

The Chair: Mr. Falk.

Mr. Ted Falk (Provencher, CPC): Professor Bourassa, I would like to make some observations on your comments.

One of the first comments you made in your intervention was that first nations communities are not prepared for this legislation. You went on to talk about the experiences of the residential school system, and about the oppression that your peoples are experiencing, which has led to depression and suicidal tendencies.

Attawapiskat has been much in the news in the last several weeks. It certainly is a tragedy and a crisis when there have been 105 suicide attempts in the last six months. I would think that legislation like this would send a confusing message to many indigenous communities. I would appreciate your comments on that.

Could you also say what we could do in this legislation that would help to address the concerns you have for your indigenous communities that might be receiving conflicting messages?

● (1740)

Prof. Carrie Bourassa: Thank you for your comments.

It is quite confusing. The reason I mentioned the suicides is exactly that. When we have incredible rates of suicide right now, it is the last thing people are thinking about when I talk to them about medically assisted dying, physician-assisted suicide. They are thinking about all the suicides they are trying to prevent in their communities, and it is a difficult topic to even think about in many cases.

Having said that, it is the case that we have extremely high chronic diseases and lots of palliative care issues. I have worked in palliative care for 10 years, and we see more and more young people in palliative care. We have a crisis on our hands.

It is very confusing. In terms of what can be done, there are a few things. I think the communication around medically assisted dying in communities is really important. One thing that I think is difficult for you to do—because the bill is already going through—is to open up those lines of communication with first nations communities around medically assisted dying: how it could be beneficial in communities, and what that might look like for different communities.

I think that sometimes first nations communities are brought in at the end of things, and that is frustrating for them because it is not a chance to really engage communities at that point. I think communication is one thing.

The other thing is that cultural safety training is real, and it is important. At this time, I think we are experiencing first nations people feeling unsafe in many respects, or else not having access to care.

This is a worry for me and for many people. If people are ever going to engage with this, understand what it is, if they were to access it, who is going to be engaging with them? Are they trained? Are they going to understand their communities? Are they going to be culturally competent and safe clinicians working with them? That is a real issue.

Also, think about investing in the communities themselves, about aboriginal navigators in communities where there are these exacerbated suicide rates.

I think those are some things that could be considered by the committee.

The Chair: Thank you very much.

We are now going to move to the Liberal side. Mr. Bittle, go ahead.

Mr. Chris Bittle (St. Catharines, Lib.): Thank you.

Dr. Bourassa, as you understand, this committee is responding to a Supreme Court decision. Should legislation not be passed, medical assistance in dying becomes legal without a framework.

Do you have specific recommendations for amendments to this bill to address some of the concerns or any of the concerns that you mentioned?

Prof. Carrie Bourassa: I should have laid them out more clearly, I suppose.

As I just mentioned, number one on my top priority list would be to ensure that physicians and nurse practitioners who are going to be engaged in medically assisted dying receive appropriate training and —if I am so bold—mandatory training. This is a very sensitive issue. I don't know how well received it will be in many communities, if it will be well received at all.

Because it is, as you said, something that is inevitable, and there is going to be a framework, I think you have the ability to at least create some safety around it. That is really what we are talking about here, patient safety. In doing that, I think it is important to create a framework that allows for patient safety, and that is for sure a cultural safety training that I think should be required for physicians and clinicians.

I am also worried about the communication piece. I have wrestled with how you could come up with a communication dialogue piece for communities—because I think there is going to be a lot of confusion around this—and some clear and plain language so that communities understand what the implications of this are, and some engagement around this. I think the engagement piece could really happen, as I mentioned, through the support of aboriginal navigators. I don't know if that happens in partnership with the cultural safety training and with physicians, but I think it is important to support those ideas.

● (1745)

Mr. Chris Bittle: Thank you so much.

I gauge from your comments as well that it's important to distinguish—and I believe the bill does this—between suicide, which is a public health issue that needs to be addressed, and medical assistance in dying, which is what we're addressing here.

My next question is for the Alliance of People with Disabilities. This may be an unfair question for the amount of time we have left. Could you take me through a brief section 7 analysis of advance directives and why you believe that absence is a violation of the charter?

Mr. Angus Gunn: Perhaps I'll field that one.

I think it's understood that in Carter “the right to life, liberty and security of the person” is engaged by legislation that would prohibit an individual's right to self-determine their own medical treatment and choices. The question would be not whether there's a breach of life, liberty, or security of the person, but rather whether it's being done “in accordance with the principles of fundamental justice”, which is the language at the end of section 7.

Again, in the Carter case, the court seemed to have little difficulty in concluding that the infringements that were considered in Carter were not done in accordance with the principles of fundamental justice. In my submission, the same conclusion would flow here.

The fact of the matter is that Carter was being decided in a factual context, and none of the plaintiffs in Carter were individuals who were trying to rely on advance directives, so obviously the court decided what it had to. That wasn't an issue before the court, but in my submission, the analysis that was used by the court in Carter applies with equal strength to a person in the situation of someone who is having to rely on an advance directive.

The only distinction, of course, is that the person relying on the directive is unable to, as it were, repeat the provision of consent at the time of the medically assisted death. That's the only factual difference, but in my submission, that does not give rise to any legal distinction that permits that case to be distinguished from the people who were under consideration in Carter.

Mr. Chris Bittle: Colleagues around the table have mentioned that the absence of advance directives from the Carter decision poses a problem, in that Carter does not envision it. Do you see that as an issue going forward with the absence from the Carter decision in terms of your analysis under the charter?

Mr. Angus Gunn: Well, I don't think it can be said that Carter compels the extension of this opportunity to advance directives. I think the logic of Carter, however, compels that conclusion.

I think what you can be assured of is that if advance directives are not incorporated into this bill, there will be litigation over that issue. I think it's a given that either it will be put into the bill or its absence will be challenged. This is not an issue that I think will be left to the legislature ultimately. I think the courts will be asked to opine on this point if Bill C-14 remains silent on the point.

● (1750)

The Chair: Thank you very much.

Now we're going to move to Mr. Rankin for the NDP.

[*Translation*]

Mr. Murray Rankin: Ms. Sansoucy will ask our questions.

The Chair: Ms. Sansoucy, it is a great pleasure to welcome you to our committee.

Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP): Thank you, Mr. Chair.

I would like to thank the witnesses for their presentations.

Ms. Bourassa, I would like to ask you a question again that was asked earlier.

With my colleague, Murray Rankin, I had the privilege of sitting on the special joint committee. Some of our caucus colleagues who represent aboriginal communities are especially concerned. You have really given a clear description of the confusion they may feel because of the specific circumstances. I will ask you to be even clearer.

You talked about the amendments you would like to see made to the act. In terms of training, I will say that I would leave that to the provinces, because it is more their concern. However, when you talk about communication and navigators, I think you are talking more about the application of the law than about amendments to the bill that is before us.

Is the issue about ensuring that this law is a good fit with your communities? Should it instead be amended so that aboriginal communities are comfortable with it?

[*English*]

Prof. Carrie Bourassa: Well, I definitely want the bill to be amended so that they're at ease with it, because I know it's going to go forward. I wish I would have pulled the recommendation that went forward in the last parliamentary committee, because an amendment was made and there was a recommendation for cultural safety training. I'm not sure how they did it, because I realize training is a provincial jurisdiction, but the last time I presented on physician-assisted dying, an amendment around the need for cultural safety training was made. I'm not sure how the wording happened. I'm not sure how the committee managed it, but this is why I'm bringing it up again.

I do feel there is a need to talk about cultural safety, whether in terms of training or the need for cultural safety in our health care system. Health care on reserves is actually a federal responsibility, so I think there's something to be said for that. I'm not sure how to word it. I'm not sure how to wrangle it, but I think it is going to be difficult to create a sense of ease in the communities if that issue is not addressed. I think it's going to be difficult anyway. I was asked about the issue of suicide. In our communities, in our traditional languages, there wasn't even a word for suicide. It's difficult to discuss the issue of medically assisted dying. I know it is not the same as suicide, but in our communities....

[*Translation*]

Ms. Brigitte Sansoucy: I am sorry, but our time is limited. Thank you for clarifying that at the federal level, the question of training is also relevant to us in your case.

Mr. Gunn, my second question is for you.

I found your four recommendations very interesting, particularly the ones concerning advance directives or advance medical requests, and the disputes this can lead to. Ultimately, this will result in people having to go to court.

In your presentation, I found it very interesting that an alliance representing people with disabilities is concerned about the interpretation problem that doctors will be facing.

I would like to hear you on this subject because it is important that our law be very clear and not put doctors in a difficult position because of interpretation problems. I would like you to talk more about the difficulty for doctors in interpreting the words "reasonably foreseeable death" in particular.

● (1755)

[*English*]

Mr. Angus Gunn: The general proposition that I was citing for the committee, particularly when we're dealing with the criminal law, was that it's critical that persons subject to that law know what their legal jeopardy is in advance of performing the act. So, to the extent that language describing the criminal offence incorporates terms that are almost impossibly vague, that dilutes the force of that principle and exposes individuals to criminal jeopardy when they ought not to be exposed. That is a problem, as the honourable member says, for physicians. It's also a problem for individuals. One should not have to undertake a course of action without knowing what its criminal consequence is likely to be. So in my submission, the criterion of being reasonably foreseeable is laden with that type of ambiguity. It's not required. It's not required by Carter, and it's not required in principle. In my submission, it simply adds a further layer of ambiguity to this provision.

[*Translation*]

The Chair: You have time left for a very short question.

Ms. Brigitte Sansoucy: I have a very brief question to ask our last witness, Ms. Self.

You talked about the importance of communication professionals being present. I am concerned about eligibility and the constraints associated with the fact that there are no such professionals in remote areas or in the whole of our territory. To your knowledge, are there any in all of our territory? Are you talking about speech therapists? What professionals are you talking about, exactly?

[*English*]

Ms. Hazel Self: In terms of trained speech pathologists, on our website www.cdacanada.com we have a roster now of what we call communication intermediaries. Over 200 speech language pathologists are trained to be in court with someone, for example, not just to be a communication assistant. These are individuals who understand the complexity of communication. For example, they can illustrate to the court how the person's communicating, and demonstrate how their message is authentic—and theirs. They're not filling in the gaps for them, etc.

We have that roster across the nation of 200 speech language pathologists as communication intermediaries. I know that wouldn't necessarily reach every corner of the country, but it's a massive start, this work we've been doing.

The Chair: Thank you very much.

We'll now go back to the Liberals.

Mr. Fraser.

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

I appreciate everybody's attendance today, and the presentations. Thank you.

I'd like to start with the Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society. In response to one of my colleague's questions earlier, there was a question regarding advance directives and the compliance with Carter. Carter is silent on advance directives. You mentioned that you believe it should be included in the bill, some allowance for advance directives, because of the section 7 arguments that are bound to come before the court. I'm wondering, given the preamble to the bill, which does recognize there would be some further study of this....

In number four of your recommendations you talk about mature minors and mentally ill, and going to further study, but by a more robust or ambitious type of independent expert who would make recommendations that would come back to Parliament, I presume. We heard from a witness earlier today that with regard to advance directives, one thing we could do is send it out to independent experts and report back to Parliament within 18 months.

I'm wondering if you would agree that doing that for advance directives, as well as for the mature minors and mental illness, would be satisfactory.

● (1800)

Ms. Margaret Birrell: I'd like to talk about the advance directives. The minister recently said that those amendments will be looked at within the next five years—five years. The government may not be in place to be the government at that time. We need to look at advance care directives now, not five years from now, and not putting off all the other issues that were raised by Mr. Gunn today.

We have to move on advance care directives, because what we are saying is that—

Mr. Colin Fraser: If I can just interrupt for one moment, maybe I didn't make myself clear, and I apologize for that. My question really is this. A witness earlier today testified that we should send it to an independent expert panel and report back to Parliament in 18 months, which is similar to what you are recommending for mature minors and mentally ill patients. That's different from what's in the preamble now.

Would that satisfy your concern?

Mr. Angus Gunn: The reason we differentiated advance directives on the one hand and those other two subjects on the other is that, as I think we all recognize, the issues with regard to mature minors and mental illness are a level of complexity that does call for additional study.

In our respectful submission, the issue of advance directives has already been the subject of extensive consideration. It was of course the subject of a recommendation by the joint committee. It's not of the calibre that necessitates that further study. In our submission, enough is known about that issue to take it forward. The same is not true of the other two, in our submission. That's why we drew that distinction.

Mr. Colin Fraser: Okay. Fair enough.

A specific provision that I don't believe was mentioned is the one requiring basically a second consent just before the moment that medical assistance in dying is provided. I guess that's under the safeguard provisions of proposed paragraph 241.2(3)(h). So this requirement, where you get the second consent immediately before medical assistance in dying, is provided. There has been some commentary that this could lead to situations where somebody who's on medication has to be taken off morphine, for example, in order to then be capable of giving that second and final consent.

Do you have any comment on that?

Mr. Angus Gunn: Each requires that the person be given an opportunity to withdraw a request and ensures that the person give express consent, so it is a premise of that provision that the person be capable and competent to give express consent. An advance directive is obviously a context in which that's not going to be true, and there may be situations, as you indicated, in which the level or type of medications used impairs decision-making capacity. Age is going to be a problem for the legislation if it intends to facilitate advance directives.

Mr. Colin Fraser: Thank you.

I'll move now to a question for Communication Disabilities Access Canada. I appreciate your presentation and the difficulties that people with communication challenges face when dealing with physicians.

Are you aware of any legislation or any requirements currently in place that would require a physician to refer out somebody who does not have the capability?

Ms. Hazel Self: No, there is none, and that's actually another crusade we're on. It's totally lacking. There are other parallels. For instance, if you need sign language interpretation, etc., that's mandated to be provided by the organization. There is nothing equal for someone with speech language disability. No legislation exists.

Mr. Colin Fraser: Thank you.

Finally, I have one quick further point.

Professor Bourassa, thank you for your testimony today. The current bill indicates that either two medical practitioners, i.e., physicians, or two nurse practitioners, or one of each can be involved. There's been some discussion that perhaps there should be at least one physician, one medical practitioner, and that the other person could be a nurse practitioner. Given your comments regarding access in remote areas and the fact that indigenous people may have trouble accessing two physicians, do you have any difficulties with it being just two nurse practitioners or would this satisfy any concern you have?

● (1805)

Prof. Carrie Bourassa: I wouldn't have any problem with it being two nurse practitioners as long as, again, the training was appropriate.

The Chair: Thank you very much.

I'd just like to ask one short question, if everybody is okay with it, to Ms. Self.

Ms. Self, I agree with you that for proposed subsection 241.2 (4), there needs to be clarity in this provision with respect to the fact that this person has made their request very well known, I think not only to the person signing on their behalf but also to the two witnesses. Therefore, to my mind, if they couldn't write, they would have to verbally make clear to the three people—the other person signing and the two witnesses—that they were asking for this.

For people who cannot write and cannot verbally communicate, is there some other means that we should provide for in this context?

Ms. Hazel Self: I think that's where you have the professional there to guarantee that it's the person's directive on signing. We're saying “under their direction”, but all through this process, if someone has speech language disability or communication disability, we need that professional in there supporting the accommodations. It's an accommodation issue.

The Chair: Witnesses, I want to thank all three of you again for your very compelling testimony. We're going to read your briefs very carefully, and we thank you very much for agreeing to join us today.

For the members of the committee, and all those who are here, we have about a 15-minute break before the next panel of witnesses. I encourage everyone to take that break, and we'll reconvene in 15 minutes.

● (1805)

(Pause)

● (1820)

The Chair: Take your seats please.

[*Translation*]

We are back in session.

[*English*]

I want to thank all of the members of this witness panel for joining us. It's a great pleasure to have you here.

I believe we have Mr. Smith on video.

I just want to explain what is going to happen. There are three groups presenting, and each group will have eight minutes to present, and then you will receive questions from the MPs. You will receive six minutes of questions from the Conservatives, six from the Liberals, six from the NDP, and then we'll see how much time is left.

I'm very pleased to introduce Mr. Derryck Smith from Vancouver, who's testifying via video conference as an individual. It's a pleasure to have you, sir.

From the Euthanasia Prevention Coalition, we have Ms. Amy Hasbrouck, who's the vice-president; and Mr. Hugh Scher, who's the legal counsel. It's a pleasure to have you with us.

From the Association for Reformed Political Action, we have Mr. André Schutten, who is the legal counsel; Mr. James Schutten; and Mr. Pieter Harsevoort. It's very nice to have all of you here.

Mr. Smith, the floor is yours.

● (1825)

Dr. Derryck Smith (As an Individual): Thank you.

My name is Derryck Smith, and I'm a medical doctor and a practising psychiatrist. I appreciate having the opportunity to speak to the committee, and I particularly admire the hours that you're keeping in bending your minds around this thorny issue.

My name is Derryck Smith. I'm a medical doctor and a practising psychiatrist in Vancouver. I was an expert witness in the Carter case, and I'm on the board of Dying With Dignity Canada, but I'm presenting my own personal views tonight.

My amendments, which are in my brief, really try to get us back to the recommendations of the special joint committee and the language of the Carter decision.

The issues that resonate for me with this issue have to do with the autonomy of individual citizens in terms of the autonomy to control our lives and the autonomy to have some control over our deaths. This was first articulated by Sue Rodriguez when she appeared before the Supreme Court more than 20 years ago. My concerns are that the forces who are opposed to aid in dying have rallied their forces and are attempting to water down or narrow the findings that came out in Carter and the special joint committee. I see that as a detriment to the issue of assisted dying for Canadians.

I recently attended a forum in Vancouver that was purported to be a meeting of the Faculty of Medicine to give the Minister of Justice our views about physician-assisted dying. I initially wasn't invited; I had to get myself invited. I was one voice amongst a group of others. I think the deck was pretty much stacked so that the minister would hear only from those who were opposed to physician-assisted dying, including palliative care doctors, who are on record as opposing physician-assisted dying, doctors from Catholic hospitals, and witnesses who had appeared before Carter to testify for the government and who had their testimonies rejected by the court.

This group of people I think collectively were recommending that we go further, saying that we can't let two doctors decide on these issues, but that we must have a judicial hearing for each and every case. I've had experience with two judicial hearings in western Canada, one of which took place yesterday, in which the suffering elderly patient, who has a “grievous and irremediable” illness, was in front of a judge asking to have assistance in dying. Suddenly the Attorneys General of Canada, Alberta, and British Columbia appeared to oppose them. This puts a huge burden on individuals who are having to pay for a lawyer and are having cases adjourned. I see this as being a real burden of suffering if we go down that road, so I'm certainly speaking against that kind of amendment.

The three issues that resonate with me are the issues of dementia, mental illness, and, to a lesser extent, individuals younger than age 18. The reason for individuals younger than 18 being one of the issues is a relatively minor problem, because the number of individuals is going to be relatively small. Similarly, in regard to mental illness, the numbers of individuals who have grievous and irremediable mental illness will be very small in number. We know that from other countries.

The issue that really resonates with me is the issue of dementia. I speak on a very personal level, because I witnessed my mother-in-law and father die from dementia. This is an ugly, debilitating illness. In the latter stages of dementia, we end up being incontinent of urine and feces, being speechless, and having no idea of who we are or who our families are. This is a state that can go on for months, if not years. I for one do not want to live like that, and I cannot imagine that most Canadians do.

We already have advance directives in legal force, such that we can have do-not-resuscitate orders, and we urgently need the ability to attach advance directives to the ability to have aid in dying at a time when we may not be competent. There's going to be a large number of Canadians who are negatively impacted by dementia over the next few years.

● (1830)

My concern is that if we study these three issues over the next five years, a certain number of Canadians are going to suffer needlessly. We do not need to do that. Personally, I don't see that there's much need for additional study with the issue of dementia at all. I would urge you to take up my recommendations and move amendments to get us back to the joint special committee's recommendations, or at least back to the language of Carter.

Thank you. I think I'll conclude my comments there.

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

I note that we don't have a copy of your written submission. I think you meant to send it, but it didn't come through with the email. I'd appreciate it if you could resend your written submission so that we can look at your proposed amendments.

Dr. Derryck Smith: I will do that but, I can't do it during this conference call.

The Chair: No, I didn't mean that at all. I meant after the hearing today. It would be great if you would do that, because of course we want to read it.

Dr. Derryck Smith: I'd be pleased to do so.

The Chair: Thank you very much.

Now we're going to go to the Association for Reformed Political Action.

Mr. Schutten.

Mr. André Schutten (Legal Counsel, Association for Reformed Political Action): Thank you very much, and good evening, honourable members.

My name is André Schutten. I'm a lawyer with ARPA Canada. We were intervenors in the Carter case, and we have analyzed the various legislative and policy proposals that have been published since that decision was released in February by the Supreme Court.

I want to emphasize at the beginning that Parliament is not forced to pass a law legalizing euthanasia or assisted suicide. If Parliament passes such a law, it does so willingly and cannot wash its hands simply because the Supreme Court made you do it.

In fact, the Supreme Court made an error, and Parliament has a moral duty to correct that mistake. Parliament has a legal option—and I'm not talking about the notwithstanding clause—to fully protect all human life by prohibiting euthanasia and assisted suicide. I would be happy to discuss during the question period how that can done as an amendment to Bill C-14.

If Parliament insists on choosing to legalize assisted suicide and euthanasia, it will put the lives of vulnerable people at unacceptable risk, thus violating their constitutional right to equal protection of the law. The *Supreme Court Law Review* just published an article that I wrote making that very argument. Again, during the question period, I'd be happy to take questions on how Bill C-14 and the Carter decision actually violate section 15 constitutional rights of men like James and Pieter, who are sitting beside me.

Now I'm a healthy, able-bodied Canadian, as are all of you, including the doctor you just heard from, but I don't think we fully appreciate the disadvantage that Bill C-14 puts on some of our fellow Canadians who courageously face many obstacles that we will never face. Instead of me trying to convince you of those types of things, I've asked two such Canadians to share their perspectives directly with you, to comment on how Bill C-14 affects them, and then to share changes that they believe are necessary in order to make them feel a little more secure living in a post-Carter Canada.

I'm going to turn it over to James first, and then to Pieter.

● (1835)

Mr. James Schutten (Association for Reformed Political Action): Hi. I am James Schutten. Thanks for the opportunity to speak to you about this important issue.

When I was two years old, I was diagnosed with spinal muscular atrophy, which has left me with serious physical disabilities. I require someone to set up my feeding tube, suction my trach, turn me over in bed, take me to the bathroom, and scratch my head. I am not telling you this to make you feel sorry for me. I don't feel sorry for myself. However, you need to know that these professionals and family members need to care about my life and whether I live or die.

This is why I needed to talk to you about your draft law legalizing doctor-assisted death, and how that law will affect me and others like me.

I've gone to the hospital because of illness, and medical staff questioned whether extreme measures were worth it. This makes me very nervous, because I feel as if I am not worth the trouble. Thankfully, my family has my back to speak with the doctors on my behalf. If I have anxiety now, how much more if Bill C-14 comes into effect?

What if society started from the perspective that I do have value? What if people didn't view me as a burden for others to carry? I am one of those people who the Supreme Court of Canada thinks should have this right to doctor-assisted death. What if, instead, I had the right to palliative care or resources to help me continue to be a productive member of society?

I believe others like me feel the same way, but this right to die makes me feel as if society thinks I should choose to die.

Therefore, I urge you to add to proposed subsection 241.2(3) the requirement that palliative care is meaningfully made available to the patient.

Look past my wheelchair, and see that I am an asset in my community. I volunteer at a nursing home a few days a week and help out at an elementary school, all of which I really enjoy.

I don't believe that anyone has the right to choose exactly when to die. God alone decides, and he does not make mistakes. He has a purpose for everything. My faith and family add value to my life. Instead of investing money into a bill which normalizes the choice of death, our country should invest time and money into giving people with illness, disabilities, and old age a will to live.

I have one last thing to say. I want you to know that I am not a public speaker. I was very nervous to come here, but I feel that this goes far beyond just me and my insecurities and limitations. I need to speak up because this is so important. Please remember me when you make your decision.

Thank you.

Mr. Pieter Harsevoort (Association for Reformed Political Action): I thank you all for allowing me to come here and for the privilege of speaking to you, members of the committee.

I'd like to echo James's concerns and add my own two cents. I do have concerns with Bill C-14, including it's lack of linguistic precision.

Sadly, I feel the bill is dangerously dependent on euphemisms. Throughout, “medically assisted dying” is used to describe what is, in reality, physician-assisted suicide. This is problematic in the way that it undercuts palliative care. After all, what is palliative care if it is not medically assisted dying? I urge you to please use accurate terminology so that termination of life is not confused with palliative medicine.

Furthermore, the proposed law necessitates that, in order for someone to assist an individual with suicide a medical professional must be of the opinion that the person meets all the criteria, including the opinion that they have a grievous medical condition. Since the term “grievous” is vague, an attempt is made to make that definition more specific in proposed subsection 241.2(2).

However, even here, Bill C-14 runs into problems. How is one to define “intolerable suffering” as opposed to “tolerable suffering”? The reality is that intolerable suffering is relative. Suffering is modified by many diverse factors. Therapies and treatments are readily available to address all of these factors. Not only is unendurable suffering relative, but it is too much to ask a physician to judge whether or not someone is indeed experiencing intolerable suffering.

In order to ensure that physicians don't approve euthanasia for vulnerable persons like James and myself in moments of weakness, specifics must be added to clause 3. This means including the need for reasonable proof, rather than mere opinion, in proposed paragraph 241.2(3)(a), and the addition of a specific prognosis in proposed paragraph 241.2(2)(d) to replace the phrase “natural death has become reasonably foreseeable”.

Proposed subsection 241(5) provides an exemption for aiding an individual to self-administer a substance for the purpose of ending their life. In an attempt to respect autonomy, the key checks and balances put in place elsewhere in the bill are hereby bypassed. We cannot just assume that people will be protected by the safeguards outlined in proposed subsection 241.2(3).

Most importantly, there must be oversight to ensure that patients are given the opportunity to revoke the request as outlined in proposed paragraph 241.2(3)(h). We must be careful that the appropriate balance mentioned in the preamble to the bill is not skewed too far towards autonomy, at the expense of vulnerable persons in need of protection, such as James and me.

The only true protection of the sanctity of life is a ban on euthanasia, but barring that, these recommendations will improve the situation for the disabled and ill.

● (1840)

The Chair: Thank you very much.

Mr. Schutten and Mr. Harsevoort, I just want to tell you how much we all appreciate you making the effort to come here today. Your testimony was very touching and meaningful. We will all take it under advisement. It is very much appreciated.

Now we'll move to the Euthanasia Prevention Coalition.

Mr. Scher.

Mr. Hugh Scher (Legal Counsel, Euthanasia Prevention Coalition): Thank you, Mr. Chairman and members of the committee. My name is Hugh Scher and I'm the lawyer for the EPC. I'm a constitutional lawyer with over 20 years experience. I was counsel before the Supreme Court of Canada in the Carter v. Canada decision, and I've been engaged in almost all end-of-life cases, including Rodriguez v. British Columbia, R. v. Latimer, and Cuthbertson v. Rasouli, at the Supreme Court and other levels of court.

EPC seeks to raise four fundamental points for the attention of the committee. First, we seek to address the concern about blanket immunity relative to any person who participates in acts of assisted suicide or euthanasia under the bill. Such examples would include proposed subsections 241(3) and 241(5) which state that no person is subject to “an offence” if they assist with, or otherwise engage in, such actions pursuant to the things...provided they are doing so in a manner that does not expressly violate...but again, the language is not clear. There is no such meaningful blanket immunity in any jurisdiction in the world where euthanasia or assisted suicide are legalized. I would simply put out there that the blanket immunity that's applied for those who assist or otherwise engage in this conduct is not something that is found around the world in those jurisdictions where it is in place. Ms. Hasbrouck has other suggestions in that regard.

The second point I would address is the concern related to the limited safeguards that are contained in the bill, and the fact that they are, in many respects, woefully inadequate in terms of addressing the kinds of concerns other witnesses have here testified to today. The limitations are extremely narrow in scope. They are the same kinds of limitations that would apply in the context of a health care decision-making process, such as voluntariness, consent, capacity, and then the need for a doctor or two to sign off. These are not adequate safeguards and they will become, and have become, illusory in those jurisdictions that have them in place, in Belgium for example.

In the Flanders region of Belgium, based on the death certificate studies that were conducted, we know that in 32% of cases of euthanasia, people were killed without request. They were killed without consent, despite a legal requirement for those things to occur. In 47.1% of those cases, not one of the doctors who engaged in these actions, contrary to the law, was prosecuted. These statistics are found in the documentation that was before the Supreme Court of Canada, and indeed, in the Supreme Court's reasons themselves.

The third point I would address is the question of oversight. I would submit to you that, contrary to what you heard earlier about the concerns around legal oversight and adjudicative oversight, the reality is that what the Supreme Court of Canada has now put in place in terms of judicial oversight is what is required in order to ensure a level of independent assessment and adjudication by a third neutral party, to determine that the criteria, whatever they may be, established by the Parliament of Canada are, in fact, addressed and adhered to.

We have serious concern about the notion of simply leaving these oversight measures in the hands of the doctors and nurses who are themselves engaging in and carrying out the acts that are the subject of the legislation. What the Supreme Court of Canada has put in place, by way of an interim measure, is to provide for a level of judicial oversight. That seems to have been working fairly well and relatively unobtrusively. I would urge this committee to seriously consider implementation and continuation of the measure that the Supreme Court of Canada has itself put in place in order to ensure a level of independent oversight that the Supreme Court itself felt was appropriate to the circumstances.

The fourth point I would address is a question around fraud and transparency. The bill, to some extent, addresses this, but we know in other jurisdictions, in the province of Quebec for example, that death certificates are effectively falsified by doctors not to reflect the actual cause of death as being euthanasia, but rather relating back to the underlying illness of the person. It is impossible to have reasonable and meaningful transparency and oversight on a system predicated and based upon a fraud. I urge this committee to bear that in mind, and to implement measures that will ensure that that kind of fraud and transparency are addressed expressly in the context of the legislation itself.

● (1845)

The failure to do that makes it almost impossible to monitor and oversee these practices, both on a present level and on a go-forward basis, in which case it becomes impossible to meaningfully assess and to actually in fact address the kinds of abuses that may well be a concern and may well actually take place. How can you do so based on a system that doesn't allow for proper, effective, adjudicative oversight?

I'm going to turn it over to Ms. Hasbrouck to continue and to address you further in questions.

Ms. Amy Hasbrouck (Vice-President, Euthanasia Prevention Coalition): Thank you very much, Hugh.

My name is Amy Hasbrouck, and I'm the director of Toujours Vivant—Not Dead Yet, and I'm also here in my capacity as vice-president of the Euthanasia Prevention Coalition. I've been a disability rights activist for over 30 years, and I've worked on this issue, opposing euthanasia and assisted suicide, for 20 years. I was a lawyer in the United States and I have worked in health law and mental health law as well.

My major concern about this law is that it does not provide access to palliative care, while it provides access to death on demand. Palliative care is what people need to answer the question, “Why am I suffering?” Most surveys in which people are asked if they want palliative care, people say yes, but people are often confusing the concepts of palliative care and medical aid in dying. When people are asking for death, they're asking for help. Not providing adequate palliative care—which is the case in this country, where only about 30% of people have access to palliative care—means that people are dying needlessly. We should put the horse before the cart and put the palliative care before the death.

I have submitted proposed amendments, in English and in French, that would address that. You can read them at your leisure.

The second concern I have is that in the Carter case, the court expressed very specific concern about vulnerable persons, and not wanting vulnerable persons who might be induced to commit suicide in a time of weakness to be victimized by this law. Yet, there's no provision in this statute, other than some nice words in the preamble, to protect people who are vulnerable. That is the subject of some other amendments that I have included in my submission.

Third, the safeguard section includes several subjective criteria against which physicians and nurses would determine whether somebody was eligible for assisted suicide. That kind of subjective determination might not be such a problem but for the fact that most medical professionals view a disabled person's quality of life as being lower than a disabled person does. This kind of disability discrimination is rampant in the health care system, and when someone's quality of life is underestimated, the idea comes straight to mind that the person might be better off dead. I don't know a disabled person, myself included, who's never been told that they'd be better off dead. That kind of thinking is really what's at the bottom of this law, that non-disabled people fear so much being disabled, fear so much, as Mr. Smith said, being incontinent, that they would rather be dead.

These are the kinds of things we are battling against, using small amendments to try to rectify the language in the face of this law, a law that is going to go into effect, and that is going to present some worse depredations. Our concern and our hope is that some of the priorities could be changed so that palliative care and vulnerability assessments become part of the law and that judicial oversight provides more structured and more effective guardianship over the lives of people with disabilities who are subject to these laws.

Thank you.

● (1850)

The Chair: Thank you very much. We very much appreciate that intervention as well.

We're going to move to questions.

Mr. Cooper.

Mr. Michael Cooper: Thank you and I want to thank all of the witnesses, in particular Pieter and James for your courageous testimony here this evening.

My first question is to Mr. Smith. In your testimony, you talked about the legislation needing to go back to the language of Carter. You then went on to cite advance directives. In the Carter decision, the Supreme Court set out certain parameters. The parameters that the court set out were that persons suffering from a grievous and irremediable condition who were suffering intolerably and gave their clear consent met the criterion for physician-assisted dying.

How does the language of Carter square with advance directives where you would not necessarily have a grievous and irremediable condition but the anticipation that you may have a grievous and irremediable condition, and you wouldn't necessarily be suffering intolerably?

You would be anticipating that you would suffer intolerably and there would be no clear consent, certainly no clear contemporaneous consent as contemplated by the court.

● (1855)

Dr. Derryck Smith: You're quite correct that the advance directives were not in Carter. They were in the report of the special joint committee and that's what I was referencing. As I said previously, we already have advance directives in Canadian medicine. We can agree to not be tube-fed, not be resuscitated, and all manner of other things.

I am suggesting to the committee that we need to follow the advice of the special joint committee and make it available generally to Canadians who can consent to something when they are competent anticipating that two or three years down the line, they are going to be living in misery and condemned to that state for an extended period of time until they finally die.

I would agree with you. It's not in Carter, but it is in the special joint committee which is a committee of Parliament and the Senate of Canada.

Mr. Michael Cooper: I'm certainly well familiar with it as I served as a co-chair on that committee and thank you for your acknowledgement that it doesn't square with the language in Carter.

My next question is to Mr. Scher. You talked about the issues of abuse in the Benelux countries. You noted that evidence was before the Supreme Court in Carter, I believe, from Professor Montero's affidavit and perhaps there was other evidence as well.

One of the recommendations that you brought forward here was judicial oversight. I must say that in many ways judicial oversight makes a lot of sense. However, every time the issue comes up, as counter-arguments to it, there are issues related to cost for applicants, for access, ensuring access for persons who meet the criteria, and also timeliness to physician-assisted dying.

How would you respond to those three primary objections, cost, access, and timeliness?

Mr. Hugh Scher: The first thing I would note is that the Supreme Court of Canada itself has implemented this regime as a desirable regime in terms of assuring effective oversight. That's number one.

To respond to your points, in terms of access, I would suggest that if there is an expedited application process to the Superior Court of the province, that would then allow an expedited mechanism to proceed. You'd have a panel of judges within the court who would build up a level of expertise over time in addressing the issue. There would be a streamlined process. It would largely be dealt with based upon affidavit evidence from experts, from clinicians, and from family members and the individual. To the extent that those can be dealt with without the need for expressed oral argument, that could be addressed. Or, there are other ways it could be dealt with, through video conferencing or otherwise in appropriate cases. Where there's a challenge, then it may well be appropriate and necessary to have testimony called in order to assess.

The whole point of oversight is not simply to rubber-stamp these kinds of determinations, but rather to ensure an effective process—not an obstructive process, but an effective process—to ensure that the criteria set out either by the Supreme Court or by this Parliament are in fact respected and adhered to.

I think that can readily be done. The Supreme Court of Canada certainly felt it could be done. They've done it. I think for Parliament to simply implement what the Supreme Court has indicated would be to ensure the level of effective oversight that the court had in mind, number one; and, number two, enable the process that is now in place.

I'll note that in British Columbia, Alberta, and Ontario, there are specific guidelines that have been established by the courts that provide for processes in terms of addressing these applications. I would also note, on a different level, that in Ontario, for example, we have the Consent and Capacity Board.

The Consent and Capacity Board has very tight timelines. It has counsel appointed for the individuals in question where there's a consent to treatment question in dispute. The doctors attend before a tribunal member, and the witnesses attend, and these are dealt with on the kinds of determinations that Mr. Smith was talking about in the health care setting.

Now let me be clear. What we're talking about here, in my respectful view, is not health care. The intentional killing of patients by doctors is not and should not be considered to be health care. What we are talking about is a carved-out exception to the Criminal Code of Canada, as endorsed by the Supreme Court of Canada. We're not even talking about a constitutional right to die. That's not what the Supreme Court said. We're not even talking about a constitutional right to euthanasia or assisted suicide. That's not what the Supreme Court said.

What we need to do is twofold. Number one, we need to ensure an expedited process to allow for effective judicial oversight, modelled perhaps off the same model as the Consent and Capacity Board model under the Health Care Consent Act in Ontario. Number two, we need to differentiate and to carve out, if you will, the federal jurisdiction from the provincial jurisdiction.

My concern, in part, with this bill is that it's blurring the lines between federal jurisdiction over criminal law and provincial jurisdiction over health care. Care must be taken to ensure and safeguard that the acts of euthanasia and assisted suicide contemplated by this bill are deemed to be exceptions to the Criminal Code of Canada as reflected by this bill, and in fact are separated out from other health care measures that are otherwise the responsibility and purview of the provinces.

● (1900)

The Chair: Thank you very much.

We're now going to move to the Liberal side.

Mr. Hussen.

Mr. Ahmed Hussen (York South—Weston, Lib.): Thank you, Mr. Chair, and thank you to all of the panellists for coming in.

I have a number of questions, and I'll start off with Mr. Schutten.

In your submission, you indicated that you'd like to have removal of the words “or psychological influence”, and add to the subsection 241.2(2), the following: “(e) a mental illness or psychiatric disorder is not a grievous or irremediable medical conditional for the purposes of this section.”

The rationale is that you say psychological suffering on its own cannot qualify a person for euthanasia, assisted suicide. My question has to deal with the actual subsection. The illness, as I understand, is illness, disease, or disability, or that state of decline causing the person undue physical or psychological suffering. My reading of it is that the psychological suffering is emanating from the underlying disease, illness, or disability.

Do you have a comment on that? In other words, is the psychological suffering in my readings not occurring on its own?

Mr. André Schutten: I think it's not clear from the reading. The language is not straightforward. The fact that a Criminal Code provision is vague and open to interpretation would suggest to me that someone who is suffering from purely a psychological condition might also qualify here. That being said I think that the psychological impairment that comes from intense or chronic pain automatically puts into question whether that individual is able to give informed consent and has the capacity to do so. Psychological impairment automatically lowers the ability of that patient to be able to give a clear consent that is not inhibited by psychological factors.

Mr. Ahmed Hussen: Staying with you, the same question I have is with respect to your submission, item number 6, “unable to sign”.

Again, my reading of the section says if the person requesting medical assistance in dying is unable to sign and date the request another person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying may do so in the person's presence on their behalf.

There is emphasis on who understands the nature of the request. I don't think you've addressed that in your submission. I'm giving you an opportunity to do so.

Mr. André Schutten: My concern there is that there is nothing built into the code as it's drafted, that is, Bill C-14. There's no oversight for somebody else signing for another individual. Both James and Pieter are unable to sign for themselves. Under this provision as it's written somebody else can sign on their behalf. James and Pieter would both testify that they have very supportive families so it wouldn't be an issue for them. Perhaps there is a family where they see a family member such as James or Pieter as a burden. They could sign on their behalf possibly without Pieter or James being fully aware or possibly under coercion and there are no checks or balances. There's no clear oversight to test whether that signed statement is then voluntarily being given by someone like James or Pieter.

If you're going to get consent through written means then there are other ways you can get that from someone like Pieter or James. I would recommend that this committee consult experts in this field. You could find different ways so the consent comes directly from the patient involved, not some other proxy.

● (1905)

Mr. Ahmed Hussen: Mr. Scher, you've expressed concerns about the limited safeguards in the bill and you would like judicial oversight to be in place under Bill C-14.

I question the practicality of that in terms of the backlogs in our court system, the costs involved, and the time. What additional safeguards would satisfy you to keep this with the medical professionals and move away from judicial oversight? In other words, medical practitioners in the bill's view would be the ones who would carry out the procedure.

Mr. Hugh Scher: I think it's fundamentally important to have an independent level of oversight. I don't think that the doctors or nurses, the ones carrying out the acts of euthanasia and assisted suicide or otherwise engaged in that system, are able to provide the level of effective, independent, neutral oversight that the importance of these decisions requires.

A lot of resources and costs are to be put into the whole process of having a euthanasia-on-demand system. Clearly, if one's going to go down that road one should want to put in place the most stringent and rigorously monitored and enforced levels of safeguards that are appropriate to ensure effective oversight. Indeed, those were the words used by the Supreme Court of Canada and they were the basis upon which they agreed to strike down the Criminal Code of Canada relating to this issue. It was only based on the premise that Parliament would implement a level of rigorously enforced, monitored, and effective safeguards and oversight that the Supreme Court went that next step, agreed, and overturned its earlier decision in Rodriguez to strike down the Criminal Code prohibition.

In that respect I would suggest that the need for an independent level of oversight, through a judicial body or a tribunal that's independent from the medical profession, is essential. Absent that, I don't think it's possible to have the doctors who are themselves the ones administering the processes to be the ones effectively overseeing the process. It's effectively leaving the fox in charge of the henhouse.

The Chair: Thank you very much.

Mr. Rankin.

Mr. Murray Rankin: Thank you.

I'll start with a question for you, Dr. Smith. I would like to acknowledge your leadership, sir, not only at the joint Senate-House committee, where your testimony was invaluable, but in your presidency of the B.C. Medical Association and your work with the CMA. I want to thank you for your testimony.

You acknowledged in an answer to a colleague's question that advance directives were not identified in Carter but were recommended as part of the medical assistance in dying by that Senate-House committee. We were told by the Dying With Dignity witness earlier today that a majority of Canadians have spoken in favour of this in polling.

I'd like you to talk about your experience with this. You talked about advance directives in the context of do-not-resuscitate orders. I'd like you to speak more as a leading physician on how this would work in practice were we to implement it.

Dr. Derryck Smith: You're quite correct. It was the special joint committee that recommended advance directives that could lead to physician-assisted dying. Now, to me, the issue always comes back to patient autonomy or, in other words, our ability to make meaningful decisions over how we live our life and how we die. I see no reason why, simply because I happen to become demented, I should lose my ability to have an advance directive to choose not to live in a state that I know is coming down the line in a number of years. I would encourage members to visit any ward that houses demented people to see how horrible a situation that is for the individual, in spite of the best possible care.

I think there's a strong appeal there for Canadians, many of whom are going to die from dementia. It's estimated that there are going to be a million people suffering from dementia.

I for one, and family members and many of the people I know, do not want to live in that state. We need a pathway to get from where we are now so that we can make decisions later on. We do this with wills. We do this with advance directives. There are many ways of allowing Canadians to have a say in what's going to happen to their lives when they become old and demented.

The risk of not doing something is this, in that absent from these discussions is what has happened in Switzerland. In Switzerland, you can have physician-assisted dying. In fact, Kay Carter, the person referenced in the Supreme Court case, died in Switzerland. The risk is that what we're going to be doing is leaving a two-tiered system, whereby those Canadians who have means are going to be able to fly to Switzerland and receive medical aid in dying, and those who are impoverished or of modest means are not going to be able to do that. That's another dimension that I think parliamentarians need to seriously consider in this weighty matter.

● (1910)

Mr. Murray Rankin: Thank you. That's a perspective we haven't heard yet, to my knowledge.

As well, I want your comments as a physician on the definition of “grievous and irremediable” that appears in the bill. You'll know that it includes a number of things that were not found in Carter—you indicated you were an expert witness in Carter—one of which is this controversial proposed paragraph 241.2(2)(d) that talks about how “natural death has become reasonably foreseeable”. I'd like your comments on whether that's workable from a physician's perspective.

Dr. Derryck Smith: Well, I don't know what those words mean. When I spoke to the minister last week on this, I said that it was reasonably foreseeable that I would be back in my office within an hour, and it was also reasonably foreseeable that I would be dead in 50 years. That's a huge time frame, and I don't think doctors are going to be comfortable with seeing something as “reasonably foreseeable”. I don't like that language, and I think we should take that out of the bill.

One of the senses I'm getting from this whole hearing, though, is that many of the arguments that are being put before the committee are the very same arguments that were put before the courts in British Columbia and Canada, and the arguments were found wanting. Having lost the battle, if you like, with Carter, the case is trying to be retried here in front of a parliamentary committee, and I simply don't like that. I think we already have had a judicial body give due thought and consideration to these matters, and it has passed a 9-0 decision, and now we have people trying to undo that and to place a huge burden on the suffering Canadians who are going to have to go to judicial reviews at great cost to themselves and families, with huge time delays.

As I mentioned, just yesterday the Attorney General of British Columbia intervened, and a woman who was seeking death now has to wait for a court adjournment, an open-ended court adjournment. This is not a good thing to happen when you're at the end of your life and suffering grievously and irremediably and you have to fight the Attorney General and the Government of British Columbia and have an adjournment in your case. I think this is cruel and unusual punishment for individuals.

I think we need to have an easy way for Canadians to express their autonomous wishes to have a timely and painless death, because, after all, suicide is legal in this country. We're not talking about an illegal act here. We're talking about giving Canadians autonomy over ending their lives at a time and a choosing that they want.

Mr. Murray Rankin: Someone suggested there are no protections in this C-14 for the vulnerable, which, of course, is absurd. One of them is the eight conditions listed in 241.2(3), so-called safeguards, one of which, Dr. Smith, is to provide the opportunity to withdraw consent at the end and in a sense require you to confirm your consent to receive medical assistance in dying at the very last, immediately before the medical assistance in dying is provided. I'd like your views on whether that's workable in the real world of morphine drips and intense pain at the end of life. Is that workable, in your judgment?

● (1915)

Dr. Derryck Smith: I believe it is. It's workable in a number of different scenarios. Regarding the first one in which the patient is given a prescription for lethal medication, we know from Oregon that about a third of the patients never take that medication. We know that one of the principals in the Carter case, Ms. Taylor, had the right to have physician-assisted dying and never took that option that was open to her uniquely at that time. Before doctors administer lethal medication, as they have been doing for the last four months in Quebec, we know that the last thing that happens before the injection is that the physician confirms with the patient that they wish to proceed. I think those are adequate safeguards.

When we look at the issue of vulnerability of the disabled, it's nice to talk about that in theory, but these issues were before the courts. There was no shred of evidence that was held by the court to show that anywhere in the world the disabled community is being taken advantage of with these kinds of legislative processes. I simply don't know why we're reconsidering what the courts have already carefully thought about and have rejected.

The Chair: Thank you.

Thank you very much, Mr. Rankin.

On behalf of the committee, I just want to point out that even in the Carter decision, the court recognized a role for Parliament to legislate in this area. While I appreciate the concern about re-litigating, Parliament clearly does have a role to play in designing legislation, and we have a right to hear from witnesses on different points. I appreciate that.

I'm going to go to Mr. McKinnon.

Mr. Ron McKinnon: Thank you, Chair.

Thank you to all the witnesses.

Mr. Scher, in your presentation you mentioned that the first problem with Bill C-14 is that it provides legal immunity to any person who directly participates in euthanasia and assisted suicide. I submit to you that's over-broad. It provides blanket immunity to people who assist in medical assistance in dying, which is a much more constrained circumstance.

Would you like to comment on that?

Mr. Hugh Scher: I don't think that's accurate.

First of all, it says that people who assist in a suicide, even if they're not a medical practitioner, are nevertheless subject to immunity. No, it's not limited to doctors and to nurses, it expands even to broader members including potentially family members, friends, strangers, or community members. It's a very broad clause, something that's not found in any jurisdiction in the world.

The Chair: Provided that it relates to somebody who helped somebody self-administer a substance that was prescribed by a doctor and dispensed by a pharmacist.

Mr. Hugh Scher: Yes.

The Chair: I'm clarifying.

Go on, Mr. McKinnon.

Mr. Ron McKinnon: What I'm reading here is that no person commits an offence under proposed paragraph 241(1)(b) if they do anything at another person's explicit request for the purpose of aiding that other person to self-administer a substance that has been prescribed for that other person as part of the provision of medical assistance in dying.

Mr. Hugh Scher: My question becomes: how do you enforce that? How is it in any way possible to enforce that? You've got third parties, friends, family, whoever, who are effectively giving the person the drug behind closed doors in their homes or wherever they are without medical oversight, without judicial oversight, without any oversight, yet they are nevertheless immune from prosecution regardless of the circumstances.

Mr. Ron McKinnon: I think that's a fair point, but it's actually a different question.

The immunity is not blanket. What I'm hearing here—

Mr. Hugh Scher: It's blanket for that category of people, sir. That's what I'm trying to say.

Mr. Ron McKinnon: From this panel there is certainly resistance to the whole concept. I see that a lot of people are fearful that this will not be a solution that is freely chosen by people but one that might be imposed upon them unwillingly. Is that fair?

Mr. Hugh Scher: I would be hesitant to overgeneralize in terms of the community as a whole. I have been involved in these issues for 25 years on behalf of the disability community, which is a very diverse community including members who are on all sides of this debate. I spent seven years as the chair of human rights with the Council of Canadians with Disabilities, which is Canada's largest disability rights advocacy organization. I have been engaged in this debate from all sides and all angles.

I don't think it is fair to say simply that the perspectives of the people you are hearing here are coming from one monolithic viewpoint. What I would say is that there is a generally held consensus about a lack of effective oversight and sufficiently precise measures to give effect to what the Supreme Court of Canada has said.

I am not trying to relitigate what the Supreme Court of Canada said. I may try to clarify it. For example, when I say that it didn't commit a right to die—it didn't commit a right to euthanasia, and it didn't commit a right to assisted suicide—that is the reality. People may try to advocate other viewpoints, but the reality of what the court did and had the power to do was not that. What it did was strike down as unconstitutional a Criminal Code prohibition against either culpable homicide or assisted suicide. That is what it did. That was its jurisdiction. Then it went on to address various other points. In terms of that issue of blanket immunity, we have talked about it in that context.

The Supreme Court of Canada made this point clearly, and I urge it on this issue and also on the question of advance directives. Despite what I have heard here today, the Supreme Court of Canada did address the question of advance directives clearly. They said they were concerned that there was a need for actual consent at the time of the act and, for that reason, they were not prepared to engage in and allow for advance directives as part of their ruling.

It is not that they didn't address it. On the contrary, they addressed it squarely, and they said that there needs to be clear voluntary consent at the time of the act in order to allow for this measure to proceed. In that context, that applies both to the question of advance directives and to the issue of immunity that I was speaking about earlier. How do you determine that there is actually clear, voluntary, uncoerced consent at the time of the act when you are allowing third parties effective immunity to engage in providing people with medications, often weeks, hours, or months after the time of a prescription, to effectively end their lives? You can't. It is entirely impossible to enforce.

● (1920)

Mr. Ron McKinnon: On another point, you speak in terms of a medical practitioner's opinion as to whether the conditions are met as being insufficient. You want some manner of proof. What manner of proof do you envision that does not at some point involve a medical opinion?

Mr. Hugh Scher: The way the system works now, under the existing ruling of the Supreme Court of Canada—which is what I am urging continue—is that there is evidence brought forward, which would consist of information from physicians and from the individuals, stating what their wishes and intentions are, allowing the physician to determine the nature of their medical condition and the extent of it, the fact that they have informed what the nature of the diagnosis, prognosis, and other elements of the condition are, and the fact that all aspects of treatment have been discussed and reviewed with the patient, and the opportunity has been provided to allow for those things.... The way the existing bill reads, none of those things are effectively addressed.

All we are trying to do here, in this bill, is to effectively have two doctors say, “We have conferred, and we agree that the person has consented to this act.” Two witnesses have signed to that effect, and that's the end of it. There is no requirement that says that.... In fact, doctors have taken the steps to ensure that all the required steps of voluntariness, consent, proper diagnosis, and a level of understanding of the options for the patient, in terms of treatment and otherwise, are made known and available to the patient, and to ensure that the requirements of both the Supreme Court and what I would urge this body to implement are in fact adhered to and met.

The way it would work is that there would be, presumably, affidavit evidence from the individual and affidavit evidence from the doctors, including medical notes and records, which would be submitted to a court to determine that all the requirements that ought to have been met, of the Supreme Court's ruling and of what Parliament may enact, have in fact occurred, and that it is not simply a rubber-stamping exercise.

Mr. Ron McKinnon: Let me interrupt you there. I hear what you are saying.

The Chair: We have exceeded the time. Do you have a very short question?

Mr. Ron McKinnon: No, that will be fine.

The Chair: I would like a very short answer, Mr. Scher, to understand what you just said.

I have read Carter many times. My understanding of Carter is that absolutely the court did not say that there was any right for people who were not competent to pronounce themselves at the time to physician-assisted dying, because they were confining themselves to the people involved in this case, who were both mentally competent.

I agree with you that there was no substantive right that the court recognized, but it sounded to me as if you said the court said that you absolutely couldn't. Obviously, you acknowledge that there is a political choice that could be made to have advance directives that wouldn't be in violation of a court ruling. Is this correct? What you were trying to state was that the court never recognized a right for that subcategory of people in Carter, because they were confining themselves to the people involved in the case.

● (1925)

Mr. Hugh Scher: I would go a little broader than that. They never recognized a right period, but they did leave it open for Parliament to determine if such a right would be...If Parliament chose to engage and determine such a right, that's in Parliament's power to do so, and not just with regard to advance directives but with regard to the whole notion of euthanasia and assisted suicide.

As I indicated before, the actual effect of the Supreme Court ruling was not to confer a positive substantive right to any individual to access assisted suicide or euthanasia. On the contrary, the Supreme Court determined that the existing prohibitions under the Criminal Code of Canada, to the extent that they did not provide for a level of exception with regard to the people the court identified as having irremediable conditions that led to a pronounced and prolonged level of suffering and difficulty...that those people should nevertheless be then not subject to the Criminal Code blanket prohibition against assisted suicide and culpable homicide.

The Chair: I understand and I think that's very clear. I just wanted a clarification in relation to Mr. McKinnon's question.

Dr. Smith, thank you so much for appearing from far away by video conference. To all of the witnesses here, I want to thank you profusely for having come. We'll take great note of what you had to say with great passion.

We're going to take a short break for the next panel to come up.

● (1925)

(Pause)

● (1930)

The Chair: We're going to reconvene with the next panel of witnesses. It's a pleasure to have each and every one of you with us today.

We are joined by Steven Fletcher, a former member of Parliament and a new member of the Legislature of Manitoba. Congratulations on your election.

We are joined by the Centre for Israel and Jewish Affairs, represented by Richard Marceau, a former member of Parliament, who is the general counsel and senior political adviser. Welcome, Mr. Marceau.

We're also joined by the Canadian Association for Community Living, Mr. Michael Bach, who is the executive vice-president. Welcome, Mr. Bach.

Each of you has eight minutes, then we're going to move to questions. As all of you know, we're studying Bill C-14, so we would very much appreciate if you would comment on the bill itself and the proposed amendments to the bill, and not general comments you may have made to the special committee.

That being said, Mr. Fletcher, the floor is yours.

● (1935)

Hon. Steven Fletcher (As an Individual): Okay, thank you, Mr. Chairperson.

Thank you everyone for the opportunity to comment on Bill C-14.

My comments are going to be brief and focused on the bill. I've already spoken in front of the joint committee, and I initiated some private members' bills in the previous Parliament on this issue. I've also written a book called *Master of My Fate* on the parliamentary process.

I would like to first of all commend everyone involved. This is a difficult issue. There are some very good things in the bill. I found in many ways that it mirrored the private members' bills that I had introduced. This includes the provisions around making sure that people who may have a vested interest in the demise of an individual are not involved in the decision-making process. I encourage you to keep that in the bill. It's not an amendment; it's a thumbs-up for what is there.

I would also say that on the age of consent at 18, the bill is probably realistic at this time.

I think, though, that we need to collect empirical data over the next few years to find out where the demands and the needs are, and why people would request a physician-assisted death, by having a mandated parliamentary report that is public, with empirical data. It could perhaps be funded through the Canadian Institutes of Health Research. In order to make good public policy, you need good empirical data, especially on such a difficult issue as this.

Now, on the amendments, the Supreme Court was very clear that sections 241 and 14 of the Criminal Code unjustifiably infringe on section 7 of the charter and are of no force or effect at this time. Moreover, the Supreme Court made it very clear that the prohibition for physician-assisted death for a competent person “who...clearly consents to the termination of life and...has a grievous and irremediable medical condition (including an illness, disease, or disability) that causes enduring suffering that it is intolerable to that individual in circumstances” that they find themselves in....

The bill clearly is not consistent with the Supreme Court decision on the issue of terminal illness and that you have to be on a trajectory of end of life in order to take advantage of one's charter rights. I can understand, politically, why this was done, but it is quite frankly something that will go to the courts, and it will be changed to what the Supreme Court says. You cannot deny someone their charter rights because they happen to have a disability that may last 40 years, or an illness that goes on forever.

● (1940)

There are unfortunately many such situations that exist, such as ALS. There's also MS or stroke victims. There are many permutations of illness, and by saying that they have to be on a death spiral essentially denies them their charter rights.

The other comment I would have is on proposed paragraph 241 (b). It's not clear to me that someone would be made aware of all their charter rights, including physician-assisted death. It seems to say that, if you raise it with someone, you are in deep trouble. I think people would like to know the entire range of options is available to them, including physician-assisted death in some cases. It seems to forbid medical practitioners from expressing that—or anyone else for that matter.

Regarding advance consent, I think this should be part of the mandate of whatever you decide to do for the future. It may be a bridge too far this time around. We've come a long way in a couple of years, but I can understand the challenges with that. But again, if someone has dementia or something happens to them in the future, why can they not state what their preferences are before they lose their cognitive ability? There's nothing in the Supreme Court decision that would prevent that.

Finally, there's been a lot of drama around the Supreme Court decision in the last year, and people are trying to weave their way through a difficult legislative process. I very much get the challenges that you have as MPs, but at the end of the day, it's all going to come back to what the Supreme Court has said.

Committee, without the amendments, particularly in proposed section 241, you're going to have to decide if you are going to force people who are disabled or have a disability or illness to go to the Supreme Court to exercise their charter rights or if you accept what is inevitable and just replace the wording with what the Supreme Court said in the first place.

I'd like to thank everyone for the opportunity to be here today. Of course we always have to realize that offering more resources for people is important, but sometimes all the resources in the world don't make a difference or can't make a difference, and people are suffering every day. We need to be empathetic to those people.

Thank you very much.

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

[*Translation*]

We will now give the floor to Mr. Marceau.

Mr. Marceau, we are listening.

Mr. Richard Marceau (General Counsel and Senior Political Advisor, Centre for Israel and Jewish Affairs): Thank you, Mr. Chair.

My name is Richard Marceau. I am here on behalf of the Centre for Israel and Jewish Affairs, better known by its acronym, CIJA. CIJA is the advocacy agent of the Jewish Federations of Canada.

We have no comprehensive formula for dealing with all aspects of medical assistance in dying. We are not proposing an interpretation of Jewish religious law on this question.

We do not represent any particular denomination of our community. We do not claim to be presenting the uniform position of all Canadian Jews.

[*English*]

You might know the old saying, “Two Jews, three opinions.”

[*Translation*]

We believe, however, that our position accurately represents the key elements of agreement within the Jewish community on this extremely personal and controversial issue.

● (1945)

Some of our members support medical assistance in dying, focusing on the fate of people who have an incurable or debilitating illness for which there is no remedy. Others oppose it, based on traditional religious grounds or thinking that it would precipitate the practice of euthanasia.

Although there are differences of opinion, a broad consensus exists within our community on the fact that, in response to the decision of the Supreme Court in the Carter case, important measures must be taken: to protect health care providers who object to medical assistance in dying for reasons of conscience; to ensure that eligibility for medical assistance in dying is sufficiently regulated to protect vulnerable individuals; and to provide genuine access to quality palliative care.

I would like to start with the question of conscientious objection. Many health care professionals oppose medical assistance in dying based on their deep professional, religious or moral convictions.

Unfortunately, Bill C-14 is silent at present on the question of the freedom of conscience of the doctors, nurses and pharmacists who could be asked to provide medical assistance in dying. Some health care providers believe that merely recommending medical assistance in dying to a patient is an unacceptable act.

We are encouraged by the fact that Bill C-14 does not force doctors to refer patients directly. If that had been the case, Canada would have been the only country to impose that requirement, which probably could not comply with the Supreme Court's direction to strike a balance between doctors' and patients' rights.

However, I would stress that any accommodation concerning the approach taken by health care professionals should not limit patients' access to medical assistance in dying.

[*English*]

Several models have been proposed to balance these rights. For example, the Canadian Medical Association has proposed a separate central information, counselling, and referral service to which objecting physicians could direct patients seeking physician-hastened death.

Dr. Hershl Berman, a specialist in internal medicine and palliative medicine at the Temmy Latner Centre for Palliative Care in Toronto and an associate professor in the Faculty of Medicine at the University of Toronto, recently proposed another model in *The Hill Times*. He wrote:

> Rather than actively referring patients, all physicians should be required to report any request for assisted death to the provincial Ministry of Health or a regulatory body. Physicians would be required to register if they are willing and qualified to provide MAID, and indicate how many additional patients they are able to take on per year. If the report is from a doctor willing to provide the service, he or she would receive confirmation. If not, the registry would connect the patient with a nearby practitioner.

“MAID” stands for medical assistance in dying.

Dr. Berman noted this as well:

> In addition to respecting the beliefs and values of physicians who object to MAID, this process has an additional benefit. Many physicians, especially specialists, have a limited network of colleagues to whom they are accustomed to referring. In isolation, particularly in under-serviced areas, any doctor may have difficulty finding a colleague willing to accept the patient. If the process is managed centrally, a registry can ensure more effective and timely access for patients who wish to hasten their own death.

[*Translation*]

I would now like to talk about eligibility. We sympathize with patients who have not reached the age of majority, who have a health problem and would like to have recourse to medical assistance in dying. We also have to consider the serious difficulties that would face both the minors who would make such a serious decision themselves and the parents who would make the decision on behalf of their child.

Considering the finality of medical assistance in dying, we believe in the need to take a cautious approach to the criteria relating to consent. We believe the government has struck a fair balance in Bill C-14 by limiting access to medical assistance in dying to competent adults aged 18 and over. This approach is consistent with the laws on medical assistance in dying in Quebec and other jurisdictions in North America. We believe, as Bill C-14 provides, that if medical assistance in dying is allowed, it should be limited to adult patients on the brink of natural death.

● (1950)

[*English*]

We acknowledge those within our community who would prefer that medical assistance in dying be available more broadly, along the lines of the situation in some European countries, and we empathize with their motivations. However, these concerns appear to be beyond the scope of what the Supreme Court intended in its decision, which stated:

> ...high-profile cases of assistance in dying in Belgium...would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions.

[*Translation*]

Many members of our community believe that Canadians should be able to give consent to medical assistance in dying before suffering physical or mental deterioration, and give advance instructions in the event they were to become incapable of acting. Some people consider this to be a fundamental component of any effective scheme. Others, however, have expressed concerns.

After diagnosis, a patient might justifiably not want to continue to live during the terminal phase of their illness. However, that does not necessarily mean that they will continue to want medical assistance in dying when they become eligible, when they are no longer competent to revoke their consent. If the committee chooses to amend Bill C-14 to include advance directives, we believe they should adhere to the same rigorous guarantees defined in the bill to ensure informed consent. Patients will have to meet those requirements when they are capable of giving informed consent, and their directive will be respected once they meet the eligibility criteria.

In conclusion, I would like to discuss a matter on which there is broad consensus: the need to provide high quality, universally available palliative care as an end of life option. Medical assistance in dying cannot be a substitute for palliative care, home care or support for patients in the terminal phase and their caregivers. It is essential that medical assistance in dying not be the only option or the default option available to Canadian patients.

Thank you, Mr. Chair. I will be pleased to answer questions in the language of your choice.

The Chair: Thank you very much, Mr. Marceau. We can ask questions in the language of your choice.

[*English*]

We're going to go to Mr. Bach.

Mr. Bach, welcome. The floor is yours, sir.

Mr. Michael Bach (Executive Vice-President, Canadian Association for Community Living): Thank you, and good evening honourable Chair and members of the committee.

On behalf of our association, I'm pleased to present our brief outlining specific proposed amendments to Bill C-14, a brief we title “Medical Assistance in Dying: A Private Request, a Public Act”.

Let me begin why we chose this title for our brief. Our membership has been struck by the reactions to our proposals and efforts to advance robust safeguards for vulnerable persons, often with the following comments. “This is someone's private decision”. “What business does the state have being involved?” “It's a matter of choice; why should that choice be questioned?” “The focus has to be on enabling people to get what they need, so they can die in dignity”. We appreciate the depth of the concern, the first-hand experience, the desperation, and the frustration that motivate these kinds of reactions to proposals for robust safeguards.

One of the main difficulties in the debate is that it is actually not as straightforward as some commentators seem to suggest, to design a public service to respond to people's request for what Bill C-14, calls medical aid in dying. After all, we are talking about a public service designed to end people's lives, not to provide palliative care or other supports. The Minister of Health has made clear that's for future conversation and consultation with the provinces and territories.

We're now engaged in building a new public service in Canada designed to make people dead. I put this starkly, not to be provocative but so that we can bring as much clarity as possible to what it is that we are actually doing with eyes wide open, about what is at stake.

The Supreme Court of Canada, in paragraph 2 of the Carter decision, made the stakes clear. On the one hand stands the autonomy and dignity of a competent adult, who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable. It goes on to say people who are vulnerable to being induced to commit suicide.

We think there are two main policy questions to answer in order to deliver on these policy goals. Who is the service intended for, and how can we best ensure that delivering the new public service will only be to those who are truly autonomous and not to those who are being induced to die by suicide?

The first question, who is the service intended for? We fully support the definition of eligible persons for this service as laid out in Bill C-14. We concur with the conclusions of constitutional law expert, Professor Dianne Pothier, who wrote, in a piece published in *Policy Options* just last week, that the Supreme Court's silence on the particulars of the definition of grievous and irremediable should not be taken to tie Parliament's hands. Indeed, the court was very clear that it was up to Parliament to define this term and the parameters of the system.

As Professor Pothier notes, the trial judge actually defined the term and she did so quite clearly. The Supreme Court neither rejected the definition nor added to it. The trial judge defined the term to include only those conditions that left the person in an advanced state of weakening capacities, with no chance of improvement, and specifically excluded those whose source of intolerable suffering was psychosocial in nature. In granting the constitutional exemption to Ms. Taylor, the criterium was that she would be terminally ill and near death, and there was no hope of her recovery.

Although the Supreme Court of Canada did not define grievous and irremediable, the fact that it adopted the trial judge's terminology, without comment, offers a strong inference that it found the trial decision definition and the criteria valid, otherwise, the court would likely have altered the criteria or rejected the terminology. We also support, very clearly and for reasons the Professor Pothier has laid out, the inclusion of a criteria of reasonably foreseeable natural death.

Second, and we can get into a discussion on that later, how can we best ensure that we're delivering this new public service only to those who are truly autonomous and not to those who are vulnerable to being induced to die by suicide?

A main challenge in designing this service is to identify and respond to people who may be induced to use the new system to die. One of the challenges is that it's not a straightforward exercise to identify who, in fact, is vulnerable to being induced.

What do we mean by being induced to die by suicide in such a system? There's a large body of clinical research on inducement to suicide, and recent evidence and case examples from Oregon, the Netherlands, and Belgium. We've recently undertaken a review of this research, which points to five main ways in which people can be induced.

First, there can be distorted or disordered insight into one's condition and options available to a person as a result of the mental health issue.

● (1955)

Second, there can be hopelessness arising from self-stigma associated with negative cultural messages and stereotypes about one's condition.

Third, there can be direct coercion, and there are many examples in the Oregon and Belgium-Netherlands systems of direct coercion. One that we've shared is of a caregiver in Oregon who said to her husband, you either use the system to die or you go into long-term care. He didn't want to go into long-term care, so he chose the system to die. Given that 40% of elderly persons in long-term care in Canada are either clinically depressed or show symptoms of clinical depression this should be a real concern for us, and given also the lack of family supports.

A fourth form of inducement is through what the psychiatric literature calls the psychodynamics of the relationship with health care professionals, where physicians may feel a sense of guilt from not being able to heal a person and a person comes to feel like a lost cause. This is called in psychiatric terms transference and counter-transference.

A survey of psychiatrists involved in consulting on request for physician-assisted death in the Netherlands indicated that such dynamics influenced 25% of the requests in which they had provided psychiatric consultation and 19% of cases they consulted on physician-assisted death went ahead to be authorized by physicians, even though the psychiatrist had advised that issues of transference and counter-transference appeared to be influencing the decision.

A fifth way of people being induced is because of a lack of access to needed support or information about what options might be available, meaning effectively that people are not making informed decisions.

Our proposed amendments to address these concerns are laid out in our brief and include, in summary, an expansion of the preamble to include a study on independent prior review. We believe that a system for prior review is essential to guard against the very real risks and complex nature of the reality of inducement that is pervasive in the systems that exist and to ensure that the legal criteria Carter laid out are met.

Second is a clearer standard for informed consent. The bill only references external pressure. The Supreme Court was clear that people who were induced to die by suicide needed to be safeguarded. The standard should include reference to inducement, undue influence, and coercion.

As well, there are only five provinces and territories that actually have statutory standards of informed consent across the country, and colleges also have varying guidelines.

A proposed additional safeguard is that before medical assistance is provided, the medical practitioner or nurse practitioner must confirm that a qualified clinician has provided the person with a palliative care consultation, outlining the full range of treatment, technology, and support options and provided written confirmation that the person had the capacity to refuse those options.

Fourth, we believe that until further study is done, either the current system of superior court prior review should stay in place or proposals advanced for putting a tribunal system in place should be incorporated into the bill.

Here are a couple of final ones. The bill provides that the Minister of Health may make regulations related to information to be gathered. We believe that should be amended to say the minister must make those regulations and those regulations should come into force on the day the law comes into force, so that we can be assured that information is being gathered about requests, the socio-demographic information, the reasons people are refusing options, and the reasons they are requesting this service.

Finally, we believe that the bill should include a requirement that the ministers of Justice and Health table a report in Parliament on an annual basis based on analysis of the information that is collected under the regulations.

Thank you.

● (2000)

The Chair: Thank you very much, Mr. Bach, for your very informative presentation.

I encourage all the members of the committee to look at the very detailed amendments that were proposed in the submission.

Now we're going to go to questions. Before we go to questions I want to say what a pleasure it is to have Ms. Vecchio here with us today.

I'm going to pass it over to Mr. Falk.

Mr. Ted Falk: Thank you, Mr. Chairman, and thank you to all of our witnesses for your presentations.

To my friend, Steven Fletcher, I want to congratulate you on your election victory in Manitoba. I want to start off by asking you a question.

You talked about the need for empirical data in developing the law further than what it is. You've got lots of experience, having been a member of Parliament for many years, in how legislation works and how reviews work and what typically happens during the review and which direction usually legislation goes after a review.

My question is, would your opinion be that we should take a conservative approach? I don't mean that in a partisan way, but should we take a less liberal approach to expanding the parameters of the legislation in your view at the outset with the review that is mandated to start at the beginning of the fifth year?

Hon. Steven Fletcher: Well, Ted, I thought we were friends, but after a question like that....

Look, I think collecting empirical evidence is important. If the empirical evidence shows that maybe some of the assumptions that have been made are wrong, it could go both ways. This is not a normal issue or a normal piece of legislation. This is about morality, autonomy, and charter rights.

I think the most important part that we're discussing is what the Canadian Association for Community Living mentioned, and that is, are we talking about “terminal” or not? They make the argument that it's not terminal or it is terminal. I'm making the argument that the Supreme Court intended it under any circumstance, and that there are situations where people can live for decades while meeting the criteria of the Supreme Court.

My suggestion to the committee on this question is to refer it to the Supreme Court. See what they say. We did that with the marriage debate. The Liberals did that on the marriage debate, and we did something very similar on our democratic reform legislation. We got the Supreme Court to tell us what they meant.

Mr. Ted Falk: Thank you for that.

Part of the Carter decision also referred to, as I think you've rightly noted, how this is also a moral decision, and Carter references “the sanctity of life”. In your opinion, Mr. Fletcher, have we adequately addressed the sanctity of life inside the legislation?

● (2005)

Hon. Steven Fletcher: The sanctity of life.... Wow, that is a very profound question, and way above my pay grade. I think that's between an individual and their Maker. We just hope that as legislative people we make the best decisions possible.

Life is precious, but life can be terrible too. You'll recall that a few years ago I had fairly major surgery. It was a dire situation. I told the doctor, “If I'm going to have to get a brace or if I'm going to end up with anything that affects my cognitive function, walk away from the table.” Though the Liberals would argue that I have had cognitive impairment since then—

Voices: Oh, oh!

Hon. Steven Fletcher: —the fact is that there wasn't any and I was able to move on.

I'm disabled enough. Life is tough, and I know it can be a lot tougher. I'm lucky relative to many other people. I thank God every day that I am a Canadian and live in a great community that supports someone like me, but that isn't always there, and there are people who suffer much more than I do. Talk to them.

Mr. Ted Falk: Thank you, Mr. Fletcher.

I'll defer to Mr. Cooper.

The Chair: Mr. Cooper.

Mr. Michael Cooper: Thank you, Chair.

I'll direct my question to you, Mr. Bach. With respect to your recommendation of judicial oversight, I for one see a lot of merit to judicial oversight, or at least the serious consideration of the same, yet there seem to be at least three common criticisms from those who do not support judicial oversight. They cite cost, timeliness, and access. I guess also a fourth consideration is taking it out of the medical realm and putting it into the judicial realm.

I was wondering how you would respond to those critiques.

Mr. Michael Bach: I appreciate the concerns about cost and timeliness. However, the Supreme Court saw fit January 15 to impose judicial oversight rather than turning it over to two doctors to make this decision, so the Supreme Court must have felt a lot was at stake in terms of ensuring the constitutional protections of the right to life of vulnerable persons. That's how I think we could understand that decision.

I don't think it's a long-term solution, but because of the risks and because of the duty of Parliament to ensure the constitutional protection for the right to life of vulnerable persons, from our perspective the options are to do that or to put in place the tribunal option that has been proposed in extensive detail by Gilbert Sharpe and David Baker.

In terms of the critique that it makes it a legal decision, well, I think it is. The court said it didn't strike down a ban on assisted suicide. It provided that, in very specific circumstances, there could be legal exemptions to that ban. So there is a legal determination to be made. One half of the equation is a medical equation: Does someone meet the medical criteria? The other half of the equation is whether they meet sufficiently the criteria for the exemption to the Criminal Code prohibition on assisted suicide.

That's why from our perspective, certainly reasonable foreseeable natural death is not a medical category. Don't expect physicians to be trained in assessing reasonable foreseeable natural death. Reasonable foreseeability is a legal term, and so it should be, because we're providing an exemption to a ban on assisted suicide.

The Chair: Thank you very much.

We're going to pass it over to Mr. Fraser.

Mr. Colin Fraser: Thank you very much.

Gentlemen, we appreciate each of you appearing and giving your evidence before this committee. It's very helpful for us in considering all sides of the issue.

Mr. Fletcher, I'd like to begin with you. You talked about the reasonably foreseeable death clause in the bill. Are you saying you would like to see that term completely taken out?

● (2010)

Hon. Steven Fletcher: Yes. That is what I'm saying. I'm saying use the wording of the Supreme Court decision. Then you know for sure you're in coherence with the Supreme Court decision and the charter.

If there's a question about any of the definitions, kick it back to the Supreme Court and get a definition from it. We've done that collectively many times.

Mr. Colin Fraser: Thank you.

With regard to the 15 clear days' waiting period between when consent is given and when medical assistance in dying is actually carried out, and I recognize that can be abridged in cases where there are good reasons and the medical practitioner agrees with it being abridged, can I have your thoughts on the 15-day waiting period and whether you think that's reasonable?

Hon. Steven Fletcher: As I mentioned before, the government bill in many ways mirrors the private member's bill I introduced, including in terms of this 15-day waiting period.

My thoughts have evolved since introducing that to say that advance care directives should be allowed. So it should be 15 days at a minimum, but there's nothing to say that it couldn't be 20 years or 30 years, on one hand.

When you're in pain, unable to breathe, and in terror, 15 days might as well be an eternity, so I think we need to reflect on the pain and suffering that could be incurred over that time, so I would be fine with it being reduced.

Mr. Colin Fraser: Can you suggest what it could be reduced to that would be reasonable?

Hon. Steven Fletcher: Maybe 4.25 days. I don't know. It depends on you all.

There should be a delay, but two weeks plus a day is probably too much, and 24 hours is probably not enough, so somewhere in that range.

For the pain and suffering, when you're in pain, and there's no hope to come back, and there is the terror of drowning in your own phlegm, and there's no hope, why would we wait? Why would we prolong suffering?

In many cases, we don't. That's why we increase the morphine drip a bit. People starve themselves to death. People destroy themselves in violent ways because they don't want to be faced with the prospect of a horrible death, even though in most cases that's probably not what's going to happen.

Mr. Colin Fraser: With regard to another provision, I'd like your thoughts.

One of the bill's safeguards is the necessity of consenting twice. You consent initially, but then immediately before the medical assistance in dying is carried out there's a final opportunity for you to withdraw your consent. We've heard it may result, for example, in someone who's on a morphine drip being taken off that medicine in order to regain capacity or have capacity at the time they give that final consent.

What do you think of that?

Hon. Steven Fletcher: I'm okay with that because that creates doubt in the person's intent, and if there is significant doubt you'd probably have to err on the side of life. It's situational and very dependent, but if someone indicates they do not want the procedure to take place, even at the last moment, the procedure should not take place.

● (2015)

Mr. Colin Fraser: Mr. Bach, thank you very much for your presentation.

One thing you talked about was with regard to judicial oversight. You mentioned the Carter case in that regard, where the court saw fit to have judicial oversight in place, but you'd agree with me that's in the context of course of not having a legislative framework in place, and that's what we're trying to do here today.

Mr. Michael Bach: Yes, I agree, but my point was the court saw fit to establish that judicial oversight, and not to simply say that if you have two or three physicians who can attest to someone meeting the eligibility criteria, you can proceed.

All I'm saying is the court must have seen judicial oversight as to be consistent with its parameters in its decision and with the charter.

Mr. Colin Fraser: It did so in also mentioning it's up to Parliament now to put together a legislative framework and put it in place.

Mr. Michael Bach: Absolutely, yes.

Mr. Colin Fraser: In regard to some of the safeguards you mention in your brief—I appreciate you sharing that with us—you mention the term “qualified clinician”. What do you mean by that?

Mr. Michael Bach: A clinician who is qualified to do palliative consultation.

Mr. Colin Fraser: Okay. With the written palliative consultation report you talk about, wouldn't that go to the whole issue of informed consent itself?

Do you not see that's going too far in an amendment to the Criminal Code to start talking about what kind of informed consent there should be? Don't you believe that should be up to the provinces or the medical profession to decide?

Mr. Michael Bach: The Criminal Code has established a standard of external pressure. That's the one criterion it stated for informed consent, and given that we're talking about an exemption to a Criminal Code prohibition on assisted suicide, I think we absolutely need to have a uniform standard of informed consent for this exemption to the Criminal Code.

Absolutely I think it needs to be in the Criminal Code. Our concern—others are proposing this as well, to have a palliative consultation—is that physicians are not generally trained in the range of psychosocial causes of suffering that may be at work for someone who's at the end of life, and that a palliative consultation can identify that full range of options for people.

Mr. Colin Fraser: Mr. Marceau, thank you for your presentation.

Is “reasonably foreseeable” death, as stated in the bill, beyond the scope of Carter?

Mr. Richard Marceau: We don't think so.

Mr. Colin Fraser: Thank you.

[*Translation*]

The Chair: Thank you.

Ms. Sansoucy, it is a great pleasure to have you with us, and we welcome Mr. Thériault as well.

Ms. Sansoucy will share her time with Mr. Thériault.

Ms. Brigitte Sansoucy: Thank you, Mr. Chair. I will make a brief comment and then give Mr. Thériault the floor.

I would like to thank the witnesses for their presentations.

Mr. Fletcher, than you for sharing your personal experience with us, but especially your legislative experience. You have given me a lot of information about the amendments that should be made to the bill to bring it into line with the decision in Carter.

Mr. Thériault, you have the floor.

Mr. Luc Thériault (Montcalm, BQ): I like having time.

Mr. Fletcher, with all due respect to the other witnesses and meaning them no offence, I came here this evening, after a very busy day, to be sure to hear you because, for one thing, you are inspiring. Some people claim to be well-wishers and do-gooders when it comes to vulnerable individuals. By interfering with their self-determination and their autonomy, they imagine themselves, in all their paternalism, to be doing good, when we know very well that this is not the case.

Yesterday, the Barreau du Québec said exactly what you have said this evening. I don't know whether you find it reassuring, but there are others who share your opinion of Bill C-14. That is simply a comment, an expression of appreciation. I also share your reading, because we are talking at all times about vulnerable individuals. However, the Supreme Court has specifically taken a position under section 7 of the Canadian Charter of Rights and Freedoms to protect vulnerable individuals, in particular when it says that a total ban, as is the case at present, infringes not only a person's security and freedom but also their right to life, in that it could lead to the person taking their life prematurely, when, in fact, individuals with a degenerative disease, for example, are not suicidal. They want to live as long as possible, until the time comes, at the point where their condition appears to be completely unbearable, when they are no longer able to end their own life. Those people are the sole judges of their condition. On that point, your testimony seems very eloquent.

Mr. Marceau, you are familiar with the law in Quebec. I think there is some confusion in Bill C-14. What do you think about the Quebec law, on which there was consensus after six years of discussion, and that the National Assembly passed by a vote of 94 to 22? What do you think about Quebec's act respecting end-of-life care?

● (2020)

Mr. Richard Marceau: In terms of the process itself, everyone agrees that it was remarkable. The people in civil society were listened to and heard. I would particularly note the remarkable work done by Véronique Hivon, whom you met with yesterday, I think. I also know her personally.

Quebec has been exemplary in its consideration of this issue. It also had the time to come to a position that was quite broadly shared. You said that 94 out of 125 members of the National Assembly were in favour of that position, as compared to only 22 who opposed it.

I know that you are very familiar with politics in the National Assembly. It is very difficult to manage to achieve that level of consensus on an issue like this. It is quite remarkable.

The work in front of you as federal parliamentarians is very difficult, because you have very limited time. You are still here and it is nearly 8:30 p.m. You have spent the day working on this issue. I am familiar with the work done by the justice committee, and Bill C-14 is quite complex. It takes a lot of concentration, and that is a demanding task.

Personally, I am an admirer of the Quebec law on this subject. Knowing the institution where you sit, and a number of you around this table, I am sure that the work you will do will also be serious, limited though the time is. I am sure you would have liked to have more time, but that is unfortunately not the case. I am sure that the work you are doing and will be doing will result in a position that will both comply with the decision of the Supreme Court of Canada —we have the rule of law in Canada and we must respect that Court's decision—and, I hope, meet the aspirations of the largest possible number of people.

The Chair: Do you have another question to ask, Mr. Thériault?

Mr. Luc Thériault: The reason I asked you that question is that the Quebec law deals with a situation that is completely different from the one addressed by Bill C-14.

The Quebec law, rather than positing two opposing situations—palliative care and a request to die—treated it as being a continuum of end of life care. Euthanasia itself, or medical assistance in dying, is possible only in the terminal phase of life, where the process of dying has been irreversibly set in motion.

● (2025)

Mr. Richard Marceau: When it has begun, that is.

Mr. Luc Thériault: Here, we are facing a different challenge: how to legislate in respect of assisted suicide. Bill C-14 uses the same terminology as the Quebec law. However, there is confusion about what the Quebec law covers, and so this bill still does not completely govern assisted suicide, in the belief that it answers the question of what medical assistance in dying should be.

You told us that medical assistance in dying should be limited to "adult patients on the brink of natural death." In fact, the words "natural death" are problematic for me. That seems to be based more on the Quebec law. However, a person suffering from a degenerative disease—for example, ALS—is not entitled to make an advance request and is ultimately condemned to become a prisoner in their own body and to die choking on their own mucus because the law does not give them the right to assisted suicide. When that happens, the person is very far along in the process. A person can be in the terminal stage of a disease without being in the terminal phase of life.

What do you mean by natural death? In palliative care, death is induced by the sedation you are given to control pain.

Mr. Richard Marceau: We could debate this at length. Mr. Thériault, allow me to go back to your comment about what you call "the continuum". Is medical assistance in dying part of the same continuum as palliative care or are we talking about two things that are completely separate? I will not be telling you anything you don't know when I say there is quite a fierce difference of opinion on that subject.

A lot of people who testified before the special joint committee, on which a number of you sat, are of the opinion that we are talking about two separate things. Apart from that philosophical distinction, there are very significant practical aspects.

I am sure we will have an opportunity to continue this discussion, perhaps in another forum. No matter what direction the committee on which you sit takes, it is very important not to make medical assistance in dying the default option because the supply of palliative care does not meet the demand, particularly in an aging society.

That is why I said earlier, in my conclusion, that we cannot exclude discussion about improving the supply of palliative care in the society we live in today.

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

[*English*]

We'll go now to Ms. Khalid.

Ms. Iqra Khalid: Thank you, Chair.

Thank you very much, gentlemen, for your testimony today and for sharing your expertise on the matter. It's very much appreciated.

I have some initial questions for you, Mr. Bach, with respect to some of the safeguards you propose in your brief. The administration of dying by physicians and medical professionals is a very sensitive topic. We need to be sure that where there is consent, as per the Supreme Court decision, people be allowed to go through this process. At the same time, there's that balance we have to strike for vulnerable persons. I think that's what you're trying to address in your safeguards as you list them here.

You list your safeguards in section C. You also recommend prior review by a superior court. I'm just wondering if you've thought about how long the whole process would take. For example, if a person wanted to begin the process of ending their life, they would go to a doctor and tell them, “This is what I want to do”.

As per your safeguards, could you please walk me through the timeline with regard to how long the palliative care consultation would take, along with the other requirements of the safeguards that are already in the proposed bill?

● (2030)

Mr. Michael Bach: In talking with palliative care experts—you'll have the opportunity, I believe, to speak with Dr. Harvey Chochinov, who will be appearing here—about this palliative consultation, the suggestion is that you can do a good consultation in an hour and a half. A palliative care physician could assess the situation, examine the sources of suffering, and identify the range of options.

Now, sometimes there are more extensive needs. I mean, one of our main concerns is around such social determinants as the causes of psychosocial suffering, people living in isolation, the burden on family caregivers—

Ms. Iqra Khalid: I'm sorry, I don't mean to cut you off, but I'm just looking at the time. I'm being very cognizant—

Mr. Michael Bach: All right. I'll give you this. On the timing related to the judicial oversight, the fuller proposal on this is for a tribunal. It could be modelled on the Consent and Capacity Board in Ontario, which hears 6,500 requests a year. They're bound by legislation to turn around responses within four to five days. My understanding from members who serve on that tribunal is that responses can be turned around in a day. They also do hearings now by video.

It's actually a very efficient system.

Ms. Iqra Khalid: Just to be clear, the bill already requires 15 clear days from the first consent to the second, so, plus what you're proposing, do you think that would be a little excessive in terms of prolonging suffering, including the court procedures and the extra hoops to jump through for persons who have already made that decision?

Mr. Michael Bach: I guess our concern is that, at the root of this, we think the integrity of the health care system depends on physicians doing their job, which is to examine and address causes of suffering, not to be authorizing intentional interventions intended to cause death. We should separate that out from the health system and keep that on the legal determination, which is why we propose the tribunal. We think that's an important safeguard.

We recognize that there isn't a lot of time to put that in place. That's why we propose that there be at least a commitment do a study on this and that this be embedded in the tribunal.

Ms. Iqra Khalid: Thank you.

Mr. Marceau, I would like to pick your brain on providing a section 2 analysis, conscience rights, and also religion. We've had recommendations put forward to this committee asking that medical examiners or coroners pronounce on the certificates that the death has been physician-assisted. Do you think that would be a problem for religious organizations or persons who are religious, but choose to go through this process?

Mr. Richard Marceau: Not to be caricatural and play the role of a Jew, but can I ask you a question back? What do you mean?

Ms. Iqra Khalid: A lot of people do carry a lot of faith with them, and most religions frown on concepts of suicide. It may be an individual choice, but a family would carry that certificate with them. Do you think the Jewish community would be opposed to having that pronunciation on the last piece of paperwork for that individual?

The Chair: If you commit suicide you can't theoretically be buried in a Jewish cemetery; they bury you outside the cemetery. We've had proposals from coroners and others that the death certificate should say the person was medically assisted in dying, so that we can track everything properly. Do you think this would be a problem within the religion, that it would cause the family embarrassment and have adverse reactions, is what she's asking.

Ms. Iqra Khalid: Thank you for that. I appreciate that, Anthony.

The Chair: Any time. You can save me next time.

Mr. Richard Marceau: Maybe it's more the lawyer speaking than the Jewish person. I would like an official document to state the truth.

Ms. Iqra Khalid: Thank you.

This has come up a lot in the committee from different organizations as well as colleagues around this table: protecting the conscience of medical personnel, physicians and nurses, etc. What is the opinion of all three of you on making it an offence in the Criminal Code to coerce a physician into administering death under this bill?

● (2035)

Mr. Richard Marceau: To make it a criminal offence...to coerce a physician.

We're going to the balance of competing rights here. Those two rights were recognized by the Supreme Court in Carter. I'm not sure we need to go that far as I do believe, as per Carter and as we suggest, that there's a way to make sure the the conscience and religious rights of medical practitioners be respected in that process. Otherwise, it wouldn't make it more legal. If those rights are not respected, this process is not legal per se, and we could go back to the court and take years. You can craft the right balance between those two rights that a lot of Canadians are looking for.

People are for medically assisted dying by the way, and people are opposed to it. If there's one place where I believe there's consensus between those two competing visions, it is this.

Mr. Michael Bach: You solve the problem by going with advance review, because then physicians aren't authorizing this. They're doing their job as physicians, and that's our proposal to address that concern. It also means that you can have many more physicians in Canada, beyond the one-third who are saying they would do this at this point, who would be willing to step up, because they're not authorizing it, they're just examining causes of suffering and putting options on the table to address it, which is what we should be hoping and expecting of physicians in this country.

Ms. Iqra Khalid: Mr. Fletcher, do you have some remarks on that?

Hon. Steven Fletcher: Yes. In Canada you cannot force a physician to do anything. I am aware of a physician who refused to see people who smoked. There was nothing the college could do. It was his choice. What we have to make sure of is that people are not denied their charter rights, and that is the concern I raised earlier about section 141(1)(b). It's not clear that people are made aware of all the options available to them. In fact, it seems that it would be against the law if they were to raise the prospect of death. That is, essentially, a denial of charter rights. But nobody will force anybody in the medical profession to do anything they don't want to do. They don't have to do it now and they will never be able to force someone to do it. The Supreme Court was very clear.

The Chair: Thank you very much for the very good questions.

Can I just clarify something that was just said? I'm a bit confused. A lot of people from all sides of the debate, as Monsieur Marceau said, have come forward and said that conscience rights should be protected more clearly than is currently the case, in that only the preamble makes some reference to a conscience right. Ms. Khalid suggested one way that could be done, through a criminal prohibition. There are other ways.

Mr. Bach, you seemed to suggest that was unnecessary provided there was the review process, but the review process would only ascertain that the person was competent and willing and that all of the requirements of the law were met. There would still be a physician who in the end would be there—

Mr. Michael Bach: —to administer the act.

The Chair: In order to prevent a physician, a nurse, a pharmacist, or anybody who didn't want to do that from being fired or from being coerced into doing it, the thought was to find a way to still add conscience rights. I don't understand how having that added process would stop or change that there would be people of conscience who wouldn't want to do this.

Mr. Michael Bach: I wasn't suggesting that conscience rights shouldn't be protected.

The Chair: Okay. I was confused. Thank you. By the way I do appreciate your very clear provisions at the end about what the minister should require. I thought those were very well drafted, and I just want to say I really appreciate the way you set them out so clearly. Whether we accept them or not, I just want to compliment you on that.

Ladies and gentlemen, that puts an end to this committee meeting. I want to thank our witnesses.

● (2040)

[*Translation*]

Have a good evening, and see you tomorrow.

The meeting is adjourned.

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