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Chair

Mr. Anthony Housefather

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● (1600)

[*English*]

The Chair (Mr. Anthony Housefather (Mount Royal, Lib.)): Ladies and gentlemen, it gives me great pleasure to welcome all of our witnesses to the Standing Committee on Justice and Human Rights.

I want to let you know in advance, that as a result of votes in the House of Commons, we may need to suspend the meeting and have all the members go vote in the middle of testimony. You will not lose any time. We will suspend and come back.

Our panels today will probably drag later and run late as a result. We're very sorry. It's just the way things ended up.

Again, we very much appreciate you all being here.

We have Dr. Catherine Ferrier, president of the Physicians' Alliance against Euthanasia; Mr. Michel Racicot, from Living With Dignity; Wanda Morris, from the Canadian Association of Retired Persons; and from the Canadian Medical Association, Dr. Cindy Forbes, president, and Jeff Blackmer, vice-president, medical professionalism.

Each of you has eight minutes. We'd ask you to stick to the bill itself and propose amendments to the bill. We don't want to replicate the work of the special committee.

We will start with the Canadian Medical Association, Dr. Forbes, the floor is yours.

Before we start, I need the unanimous consent of the committee to continue to proceed while the bells are ringing. Do I have unanimous consent to proceed while the bells are ringing?

Some hon. members: Agreed.

The Chair: Thank you.

We will suspend to vote. The clerk will let us know when we have to go vote.

Dr. Cindy Forbes (President, Canadian Medical Association): Thank you, Mr. Chair.

As you mentioned, I'm Dr. Cindy Forbes, president of the Canadian Medical Association. I'm also a family physician from Nova Scotia. I'm joined today by Dr. Jeff Blackmer, vice-president of medical professionalism. Dr. Blackmer has led the CMA's work on medical assistance in dying.

As the national organization representing over 83,000 Canadian physicians, the CMA has played an instrumental role in the public dialogue on what should be the framework to govern assisted dying. Let me recap our role. It was the CMA's position that making medical assistance in dying legal was for society to decide. We did not take a position on that question.

Following the Supreme Court's landmark decision last year, the CMA has focused its considerable efforts, consulting with physicians and the public on what the framework should be. In the course of our work, CMA has consulted directly with tens of thousands of members. Our position and remarks today are informed by these extensive consultations. Today, we are here on behalf of Canada's doctors to convey one overarching message: the CMA recommends that parliamentarians support the enactment of Bill C-14 as proposed and without amendment.

As the national professional association representing Canada's physicians, the CMA has played an important role in leading the public dialogue on end-of-life care. This in-depth consultation was instrumental to the development of the CMA's "Principles-based Recommendations for a Canadian Approach to Assisted Dying". The CMA's core recommendations address four areas: patient eligibility, procedural safeguards, the roles and responsibilities of physicians, and ensuring effective patient access. The CMA's recommendations on these issues form our position on the overall framework to govern medical assistance in dying in Canada.

Before turning the floor over to my colleague, Dr. Blackmer, who will review CMA's response on the core elements of the legislation, I will provide our response on the overall approach.

Put simply, the CMA strongly supports the government's overall response to the Carter decision. This includes legislative and non-legislative measures. Of particular importance are the commitments to develop a pan-Canadian end-of-life care coordinating system and to support the full range of end-of-life care options, including expanding palliative care.

Finally, the CMA recognizes that there's been significant public discussion regarding the approach for the "Carter plus" issues. These include eligibility for mature minors, advance care directives, and mental health as a sole condition.

The CMA supports the approach proposed by the federal government not to include these issues in Bill C-14 and to study them in greater detail prior to advancing legislative proposals. This approach aligns with the approach taken by other jurisdictions, for example, Belgium.

I'll now turn the microphone over to my colleague, Dr. Blackmer.

● (1605)

Dr. Jeff Blackmer (Vice-President, Medical Professionalism, Canadian Medical Association): Thank you, Dr. Forbes, and committee members.

As mentioned, I will speak to the CMA's response on the core elements of this legislation. We certainly welcome questions from the committee today and at any time over the course of your important study.

First, the CMA's position is that the safeguards proposed in Bill C-14 are robust and are aligned with our recommendations. These safeguards include considerations such as patient eligibility criteria, process requirements to request medical assistance in dying, as well as monitoring and reporting requirements.

Second, the CMA supports the legislative objective to recognize that a consistent framework for medical assistance in dying across Canada is extremely desirable.

In addition to these robust safeguards, the enactment of definitions for medical assistance in dying, as well as what constitutes a grievous and irremediable medical condition in federal legislation, is essential to the achievement of a consistent, pan-Canadian framework.

Our principles-based recommendations reflect on the subjective nature of what constitutes enduring and intolerable suffering, as well as a grievous and irremediable condition, as well as the physician's role in helping make an eligibility determination.

We also support the objective to support the provision of a full range of options for end-of-life care and to respect always the personal convictions of health care providers. To this end, we encourage the federal government to very rapidly advance its commitment to develop a pan-Canadian end-of-life coordinating system. Ideally, this should be in place by June 6.

The CMA is aware that one jurisdiction has made such a system available to support connecting patients who qualify for assisted dying with willing providers. Until this system is available across the country, there may be a disparity of support for patients and practitioners from province to province.

Finally, it is our position that Bill C-14, to the extent constitutionally possible, must respect the personal convictions of health care providers by protecting the rights of those who do not wish to participate in assisted dying or to directly refer a patient to someone who does wish to participate.

We would be very pleased to speak further on this critical issue, one that is also essential for a consistent pan-Canadian framework.

Thank you for your attention.

The Chair: Thank you very much to the CMA. We appreciate the intervention very much.

[*Translation*]

We now move on to Mr. Racicot.

[*English*]

Mr. Michel Racicot (Vice-President, Living With Dignity): Thank you, Mr. Chairman.

As you know, I'm a lawyer with over 40 years' experience in computer and telecom law, so you might be wondering what I'm doing here. I'm here because I've assisted many terminally ill persons, beginning with my wife, who died of cancer at age 37 in 1985 after we had adopted three children.

I am here also because I've seen, on a daily basis and sometimes for several weeks and years, the day-to-day reality of palliative care workers attending to the needs of patients in their last weeks, days, and sometimes hours of life. I'm also vice-president of Living with Dignity/Vivre dans la Dignité, an organization representing over 5,000 citizens who are concerned about the future of our health care system and indeed about our nation.

Governments in this country take great strides with public media campaigns to try to prevent suicide—suicide of young people, of aboriginals, of Inuit—and unfortunately politicians make the headlines when a wave of suicides hits a reserve. But now we're about to authorize doctors to take their patients' lives or to help those patients commit suicide. Are we are no longer going to send emergency squads to try to persuade a person not to jump from a bridge, or are we going to send doctors to push them to their death? This is a dire reality that we are now facing.

Many have claimed that medical aid in dying is now a new charter right. Carter did not create a new constitutional right to death; the court only concluded that the prohibitions of the Criminal Code infringe on the existing rights to life, liberty, and security as guaranteed by the charter. Since the charter is part of our Constitution, the creation of a new charter right to death would have required the Constitution to be amended, which requires the involvement of Parliament and of all the provincial legislatures. This could not have been done by the Supreme Court, and the court did not create a new charter right to death, only an exemption from criminal law.

Before turning to the amendments, let me try to set our perception of what the power of Parliament is. Many have claimed that Parliament is bound to adopt a law within the confines set forth in Carter. Parliament is not held captive by the Supreme Court decision. It need not adopt a law that fits within the parameters set forth in Carter. Carter is based on the premise that the prohibition on assisted suicide and euthanasia is intended to protect only vulnerable people, not to protect all Canadians. Parliament now has the power to set the record straight and to confirm in no uncertain terms in a new bill that the prohibition against assisted suicide and euthanasia is indeed to protect all Canadians. It also has the power to re-enact those prohibitions, despite the Supreme Court decision.

As the Supreme Court itself recognized, between 1991 and 2010 this House and its committees debated no less than six private members' bills that were seeking to decriminalize assisted suicide, and none was passed. I'm calling on you. Should you ignore completely the wisdom of the hundreds of members of the House of Commons who decided not to decriminalize assisted suicide in the past? Or, should you not remind your colleagues that indeed your predecessors acted responsibly and with wisdom in rejecting this approach? You have the power and you have the responsibility to make history for our population, our children, our grandchildren, and their descendants.

Re-enacting the provisions struck in part by Carter requires political courage. It also requires all members of Parliament to be able to exercise their right to freedom of conscience protected by the charter and without being forced to vote according to a party line. This is our call to action.

Of course, if this Parliament does not re-enact these prohibitions, it can still set safeguards. Contrary to what CMA has said, our experience teaches us that these safeguards may not be sufficient to help protect all Canadians. This House has the power to prescribe, as it is said in the charter, “such reasonable limits...as can be demonstrably justified in a free and democratic society”. These limits can be more stringent that those specified in Carter.

● (1610)

The court recognized itself in Carter:

> Parliament must be given the opportunity to craft an appropriate remedy. [....] ... issuing [a constitutional] exemption would create uncertainty, undermine the rule of law, and usurp Parliament’s role. Complex regulatory regimes are better created by Parliament than by the courts.

Let me now turn to certain amendments we're proposing.

In the order that the Supreme Court made last January 15, to prolong the extension of the suspension of their decision, the court said the persons who wanted to avail themselves of medical assistance in dying, as permitted in Carter, could apply to the superior court of their jurisdiction. And the court even said:

> Requiring judicial authorization during [the] interim period ensures compliance with the rule of law and provides an effective safeguard against potential risks to vulnerable people.

We think that this reasoning is not only valid until June 6, but this process should continue beyond June 6, when Bill C-14 comes into effect. Abuses and errors are possible. We know medical errors exist, and as it concerns medical assistance in dying, an abuse or an error will be fatal. We therefore submit that Bill C-14 be amended to provide that medical assistance in dying can only be obtained with the prior authorization of a superior court.

Turning to transparency in data collection and reporting, Quebec has been now experiencing euthanasia for over four months. Several aspects have now become clearer, some of which are frankly very troubling.

One of them concerns the transparency and data collection and the reporting. Under practice guidelines issued by our Collège des médecins du Québec, a physician filling out the certificate of death, prescribed under the Public Health Act of Quebec, must enter the disease or morbid condition that warranted medical aid in dying and led to death as the immediate cause of death. This is not the manner of death—cardiac arrest—but the disease, injury, or complication that caused death.

The college goes on by stating that the term “medical aid in dying” should not appear on the certificate of death. Indeed, if this information were disclosed to family members who had not been informed, it could on one hand go against a patient's wishes to keep the information confidential, and on the other hand cause them harm.

Well, this guideline is forcing doctors to falsify the cause of death in a public document, and this is contrary to the applicable regulation that specified that the physician must indicate the cause of death in the most precise manner possible. Thus, if a doctor follows the guideline of the Quebec Collège des médecins, he might be prosecuted and be subject to a penal offence.

To address this risk, Bill C-14, proposes to add to the Criminal Code the offence of committing forgery in relation to a request for medical assistance in dying. However, the term “forgery” is not defined, and we have to look at section 366 of the Criminal Code for its definition.

In light of the Quebec experience, and of the need to monitor compliance with all required conditions to provide medical assistance in dying in the future, we strongly recommend that proposed subsection 241.4(1) be modified to include the offence of making any false declaration, by any means, to the effect that the cause of death was not medical assistance in dying, but was the underlying medical condition that justified a recourse to it.

Lastly, I'd like to talk briefly about the danger of good faith defences. Bill C-14 proposes that any person who has reasonable but mistaken belief about any fact that is an element of the exemption for medical assistance in dying should nevertheless be able to invoke the exemption from the crime of culpable homicide or the crime of assisted suicide.

Although these provisions are well intended, they do not unfortunately pass any serious examination in light of the experience that abuse of the elderly and sick persons is rampant in our society, as Dr. Ferrier, and other physicians dealing on a daily basis with these types of patients can attest. This is inviting a floodgate of abuse.

● (1615)

For such reasons, we recommend that these provisions of good faith defences be struck from Bill C-14.

I thank you for your attention.

[*Translation*]

The Chair: Thank you, Mr. Racicot. It's truly a pleasure to see you again.

[*English*]

Unfortunately, right now, given the proximity to the vote—we're about 10 minutes away—we're going to have to suspend. We will come back to hear the other two witnesses and move to questions. We very much apologize for the delay.

The meeting is suspended. We will come back as soon as we can. Thank you for your patience.

● (1615)

(Pause)

● (1645)

The Chair: Ladies and gentlemen, we're going to resume. Again, I apologize. I understand you have made an incredible effort to come here, and I feel bad that we suspended like that. I appreciate your patience on this.

Next up we have the Canadian Association of Retired Persons, represented by Ms. Morris.

Ms. Wanda Morris (Chief Operating Officer, Vice-President of Advocacy, Canadian Association of Retired Persons): Thank you. My name is Wanda Morris, and I am the vice-president of advocacy of the Canadian Association of Retired Persons. We are a not-for-profit, non-partisan organization representing 300,000 seniors in 60 chapters across the country. The average age of our members, according to our polling data, is 71 years.

Our members are deeply disappointed in the restrictions in this bill, and as an organization we have been advised that the bill is not only failing to be constitutionally compliant but is also legally and medically unworkable.

CARP has a long history of involvement in the issue of assisted dying. These words were taken from a summary of our 2014 poll: “The vast majority of CARP members approve of legalizing assisted dying, and they have for years, no matter how the question is asked. Agreement is increasing in recent years, as well.” The earliest poll that I have a record of goes back to 2010, where 71% of our members supported assisted dying for patients at the end of their lives. There were no polling questions about patients in other conditions.

The 2014 poll that I alluded to asked our members about their support under other conditions: 81% supported the Quebec bill, and that was before the bill was amended to specifically refer to patients at the end of life; and 82% supported the provisions of Steven Fletcher's private member's bill, which clearly noted that individuals with a degenerative condition would also qualify.

In our most recent poll, taken this year, 80% approved of the recommendations of the special joint committee, that individuals with a grievous and irremediable illness should be given assistance to die. There was no qualification about death being reasonably foreseeable.

Something I hear about very often from our members is the fear of living for decades with dementia. This is also a personal issue for me. My father-in-law died of dementia. In fact, both of my in-laws did, but my father-in-law's death was particularly difficult. He was in England, and as many people do with that disease, he became aggressive at the end of his life. To deal with that aggression, he was strapped into a wheelchair, immobilized, and that is how he spent the last weeks of his life.

In Canada, we don't tend to physically restrain people with dementia, but any study of long-term care facilities and drug use will tell you that we use chemical restraints profusely.

My first exposure to dealing with dementia was as an auditor. Decades ago, I audited a series of long-term care facilities, where many of the patients were deeply, deeply ill, often with dementia. It was that experience that taught me that there are indeed fates worse than death.

You can imagine my delight, and the delight of our members, with the Supreme Court decision. I remember hugging my husband and thinking that, at last, we didn't have to worry about having an out when the worst came to the worst . Even if it meant we had to go early, at least we still had a choice.

Then, when the special joint committee made its recommendations, and they recommended that there be a provision for advance consent, I remember crying and thinking that, not only did I have a choice about being able to go, but I didn't have to lose those days where, perhaps, I'd no longer be competent to make a medical decision to end my life. I would still have quality of life.

You can imagine how bereft I was when this bill came in, which restricted all remedies for people with dementia. I feel we've gone back to that cruel choice that the Supreme Court noted when it said that individuals who are grievously and irremediably ill must either take their lives early, often by violent means, or wait far too long and suffer unbearably.

As a resident of British Columbia, I've seen this situation happen first-hand. Margot Bentley was a dementia nurse in her younger years and she knew what dementia had in store. That's why she told her family and wrote down that, if she ever had dementia, she didn't want to live through it. In fact, she specifically wrote that she wanted to be euthanized.

● (1650)

Now she's in a care facility in stage 7—the final stage of dementia—unable to communicate and unaware of her surroundings, but still being spoon-fed against the wishes of her family.

It was perhaps to avoid that situation that another B.C. woman, Dr. Gillian Bennett, ended her life. As she wrote in her blog, Deadatnoon, by the time you read this, I will be dead. She did not want to live with dementia. That is why I encourage the committee to include a provision for advance consent. If the timing simply doesn't permit, then please include a binding commitment to bring in legislation governing advance consent within 18 months.

An advance consent isn't just an issue for dementia, although it is certainly a significant issue there. Right now, there's a very problematic sentence in the bill, in proposed section 241.2, which requires that “express consent” be given to receive assistance in dying “immediately before” the assisted death takes place. This is contrary to what is the case in Belgium, Luxemburg, and the Netherlands. In Belgium and Luxembourg, advance consent can be provided for up to five years, and in the Netherlands indefinitely.

I also encourage the committee to review the issues around judicial review. I heard one of my colleagues urge the committee to look at judicial review. Every day in our country doctors end patients' lives. They do it right now, through the removal of life support. What do they need to do that? They need the support and consent of the patient or their substitute decision-maker, usually the next of kin. There are no detailed forms to fill out. There are no requirements for secondary doctors.

Now, I'm not protesting those provisions in this bill, but I'm saying that they are more than sufficient. We do not need additional administrative legal or bureaucratic barriers to keep people from accessing a compassionate death. Those would provide little security for individuals who may be vulnerable but would impose significant barriers on those who are already suffering.

Finally, I'd just like to correct an error of fact that I heard in debate. It was about waiting periods. There are indeed many jurisdictions that have legalized assistance to die and do not have waiting periods. There is no waiting period in the Netherlands and none in Luxemburg. In Belgium, the one-month waiting period applies only where death is not imminent. Of course, closer to home, Quebec, in their legislation, has no legislated waiting period.

Thank you.

● (1655)

The Chair: Thank you very much, Ms. Morris. We very much appreciate it.

[*Translation*]

Now we will move on to Dr. Ferrier.

Welcome to the committee.

[*English*]

Dr. Catherine Ferrier (President, Physicians’ Alliance against Euthanasia): Thank you very much.

I'm a physician and I have over 30 years' experience diagnosing, treating, and caring for frail older people, often suffering from Alzheimer's disease and other dementia. In addition to seeing patients in the clinic, I often visit their home as a geriatric consultant to a home care service.

My professional niche, as it were, includes capacity assessment, assessment in intervention for patients and families in crisis because of cognizant, psychiatric, and social problems. I regularly see abused and neglected patients, and I often testify in court for abused patients or for those whose families are fighting over powers of attorney or inheritance issues.

I'm also the President of the Physicians' Alliance Against Euthanasia, a group of doctors who see any law allowing doctors to intentionally end the life of their patients as contrary to the goals of medicine and the good of our patients, especially the most vulnerable and those who cannot speak for themselves. Founded in Quebec in 2012, the alliance now includes over 750 doctors, each of whom has signed our declaration and is supported by more than 14,000 citizens. We are, of course, aware that Bill C-14 will legalize medically assisted dying in some form, as is already the case in Quebec. While remaining completely opposed to these acts, we offer our suggestions for amendments to the bill in an attempt to protect patients' health care environment and the integrity of our profession.

We are somewhat relieved that there is a certain caution in the bill compared with the extreme recommendations of the special joint committee. We also note that the bill does not propose euthanasia and assisted suicide as medical acts or health care, as they are in Quebec. We agree that they are neither, so it cannot be required of our profession to perform them. The international medical community maintains to this day its opposition to these practices.

Since the vast majority of desires for death are caused by mental illness, which can and often does co-exist with the medical conditions that are considered to justify euthanasia or assisted suicide in the Carter decision and in this bill, we are called to exercise extreme caution. Such desires can also be caused by feelings of hopelessness, loneliness, fear, grief, shame, lack of access to support, insufficient palliative care, poverty, unemployment, violence, and abuse. These can also be addressed by health and social service professionals.

In this context my colleague, Mr. Racicot, talked about the fact that they are not charter rights. I argue that neither are they health care. We fail to understand the concerns about access to death that are being expressed in the public debate around this law. Elderly and chronically and terminally ill Canadians do not need access to death, they need access to care—medical treatment, home care, care by family members, residential care—all of which are seriously lacking.

You just heard some descriptions of sorely lacking care of elderly patients. I would argue that the alternative to that is not to kill them but to take better care of them, which we should be doing in Canada in 2016. To facilitate access to death while remaining unable to provide the care our citizens need is irresponsible, to say the least, and is unworthy of a progressive and prosperous country such as ours.

We appreciate the government's commitment to developing non-legislative measures that would support the improvement of a full range of options for end-of-life care, as is said in the preamble to this bill, but that would have to be implemented at truly high speed if we want the choice of life to be as available as death will be before long.

If you wish to show a true commitment to life for Canadians, this bill must contain protection for patients who are at risk of constraint to choose death. As it stands, it's certainly not as bad as it could have been if you had followed all of the committee recommendations, but the criteria are still ambiguous and open to subjective interpretation. This is inevitable to some extent, because it's impossible to define an eligibility criteria that would protect everybody, but we think you can do better.

The only way to ensure patient safety in a regime of legal euthanasia and assisted suicide is to require prior authorization of the death by a judge. In practice in medicine, we use courts all the time for committing patients who are dangerous to themselves or others to hospitals, to ordering that somebody be removed from their home if it's no longer safe.

● (1700)

It's something that's common. It can be done rapidly. It does not need to be a barrier, and the cases we've seen in recent months in other provinces have shown it happened relatively quickly. I think this should also be done after an evaluation of the patient and the patient's situation by health and social service professionals to explore the causes of suffering, as well as any inducements to choose death that could arise from non-medical conditions and circumstances, and that measures should be taken to address these sources of suffering before accepting a request for death.

This should not be seen as gatekeeping of access to death, but rather as promoting life wherever possible, which should be the goal of the law.

I have some brief comments on the criteria as currently written. The requirement that the request be made by a capable adult is essential, but most doctors lack the skills to assess decision-making capacity, and even experts disagree in complex cases. The terms “grievous and irremediable medical condition”, “advanced state of decline in capacity”, and “irreversible decline” are wide open to subjective interpretation and could be understood to include hundreds of thousands of Canadians with serious chronic illness who would be eligible for death under this criteria.

Enduring physical or psychological suffering that's intolerable, and that cannot be relieved under conditions the person considers acceptable, is entirely subjective and opens the door to anyone refusing effective treatment and demanding euthanasia instead. The requirement that natural death be reasonably foreseeable means nothing to us as physicians. Doctors are not able to accurately estimate life expectancy until the last days to maybe two weeks before death. Before that it's a guessing game. Call it “imminently dying”, and then we know what you're talking about.

To ensure a request for death is voluntary and without external pressure requires in-depth psychosocial and family assessment by a team of professionals well beyond medicine. Even then there may be no way of knowing that the patient is acting out of guilt or protecting an abuser. The written consent waiting time and requirement for a second doctor are not protections against abuse or coercion to request death. The first two can be waived, and patients or others can doctor-shop until they find two willing doctors.

There should be no opening even later to children or people with psychiatric illness. I wrote a separate brief in my own name, besides the brief of the physicians' alliance, that speaks to the dangers of euthanasia by advance directive that we can discuss in the question period if you choose.

My second point is about what is often called freedom of conscience, but is also about protecting health care services from becoming death-promoting environments and thereby protecting patients from those environments. I suggest you include in the law a prohibition against requiring any health professional to cause the death of a patient, or to refer a patient to another person to obtain their death—even through a third party, as is the case in Quebec—and against requiring any health care institution to euthanize patients under its care or to assist in a patient's suicide.

There's no justification for imposing any duty to implement this political decision, which is foreign to the medical profession, on medicine as a whole, or on any individual practitioner or institution. Attempts to do so are already being seen, both in Quebec and in Ontario, through requirements to refer. The federal law cannot just leave this question to the provinces. In Quebec, since December, doctors who are unwilling to euthanize patients must refer them to an administrative body that will ensure the death occurs. This does not protect the patient or the professional integrity of the physician. If I were a surgeon and a patient asked me for a procedure I thought was either not going to help them or would be too risky, I would refuse to do it, and I would also refuse to send the patient to someone else who would do it. They would, of course, be free to go and find a doctor of their choosing if they wanted to.

In palliative care in Quebec, one excellent palliative care physician has compared her daily life under this law to living in a war zone. You never know when a death request is going to land on you. You can't be giving hope to dying patients in one room and euthanizing them in the next.

Another doctor retired early the day the law came into effect for this reason. Highly skilled doctors and nurses who have given years and decades to the care of dying patients are suffering burnout, taking sick leave, and being driven from the field by confrontations over a supposed right to be killed, and by threats of losing funding if they insist on caring for people rather than killing them.

Patients are refusing treatment for their symptoms because of their fear of receiving the injection without having asked for it. Some patients who attempt suicide by overdose are not being resuscitated because the notion is being promoted that people who want to die should be helped to do so instead of being saved from their suicidal impulses. We need safe spaces for patients where inflicting death is not an option, and we need to respect the freedom of those health professionals for whom it is a violation of their fundamental principles and institutions whose basic philosophy rejects it.

● (1705)

Patients can be transferred to another professional or another institution, if necessary. This would not cause problems of so-called access, only inconvenience at times. If the professional or institution makes their position clear, the patient need not consult them. The protection of patients should always trump access to death.

In summary, at the very least we need prior authorization by a court after a careful evaluation of the situation, as I discussed. We need to create safe spaces for patients by respecting all individuals and institutions that refuse to collaborate with inflicting death.

Thank you.

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

We'll begin our questions with Mr. Falk.

Mr. Ted Falk (Provencher, CPC): Thank you to all of our witnesses. I too apologize for the inconvenience you suffered because of our votes and procedure in this House.

I'd like to begin my questions with the CMA.

This is just for clarification, because I wasn't sure how many doctors you said you represented. You indicated that you like the bill and you would like to see it adopted without amendment. Is that correct?

Dr. Jeff Blackmer: That is correct. We represent over 83,000 physicians in Canada.

Mr. Ted Falk: Okay.

I find that really interesting, because I haven't talked to one doctor yet who would hold to that position, outside of listening to it here. I'm not sure where these doctors are that you represent.

Dr. Jeff Blackmer: If I may, we've consulted with tens of thousands of physicians over the past two to three years in the course of various national town halls we've conducted across the country. We've done extensive polling, and we've had numerous debates at our national annual meeting.

So we do represent those physicians.

Mr. Ted Falk: Okay. Thank you.

Mr. Racicot, you had a very interesting presentation. You indicated that death is not a charter right, assisted death is not a charter right, and the Supreme Court didn't affirm that it was a charter right. I would like you to expand on that a little bit.

You also said there were alternatives to this legislation if we as parliamentarians only had the courage to exercise the ability we have. You also indicated that there had been previous attempts at passing legislation in Parliament here that would have allowed for physician-assisted suicide, but the members of the House did not agree with it: 300 members wouldn't have agreed in principle, as a majority group, to pass that kind of legislation.

I'd like you to comment a little further on those statements.

● (1710)

Mr. Michel Racicot: The first point is with regard to the absence of creation of a charter right. The court recognized that the rights to life and security of those persons who sought medical aid in dying were at issue. The court stated that these rights are attacked, if you wish, or infringed by the fact that assisted suicide and euthanasia are forbidden in certain circumstances. So in fact the court is making an exception to a criminal act, an exception to the act of culpable homicide, or murder, and an exception to the offence of assisted suicide.

As to the other aspect, I think this House has the power to reaffirm that the intent of the prohibition of assisted suicide, of euthanasia, of murder, of culpable homicide in our Criminal Code is to protect all Canadians. If you do use that premise rather than the premise used by the court, then the judgment falls back, goes away, because the judgment is all based on the fact that the only reason to have these provisions is to protect only vulnerable Canadians. The Attorney General of Canada made the case that it was to protect all Canadians and to protect the life of all Canadians, but the court rejected that.

This House has the power to say these prohibitions remain, there is no exception, and the intent is to protect all Canadians. You have the power to do that. Several private members' bills—mind you, they were not bills of a majority government—were all defeated, and I think there was a lot of wisdom in that.

I'm afraid we're rushing into this thing, trying to implement it before June 6, when really there are alternatives. History will have to judge you. I'm not trying to blame anyone. We're all faced with the situation. There are alternatives, except nobody is addressing them at the moment.

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

Dr. Ferrier, you indicated that you spend a great deal of time working with individuals who are in end-of-life situations. I think you would probably agree that withholding treatment is very different from administering death.

Dr. Catherine Ferrier: Thank you for making that point. That was an error, I think, in what one of the other witnesses said.

Withholding treatment is just admitting that medicine has limits and that we cannot do anything for that person anymore without making them suffer too much. Causing their death directly is a totally different act, from an ethical point of view.

Mr. Ted Falk: I would agree with that.

You also talked about the dangers of advance directives. I'd like to give you an opportunity to expand on that.

Dr. Catherine Ferrier: I regularly inform people of a diagnosis of Alzheimer's disease. That's part of what I do in my work all the time. When they originally receive that information, obviously, it's a source of great distress to them, to their families. They're in a very difficult moment.

One of the things that were recommended by the joint committee was that somebody early on in a disease, such as Alzheimer's disease, would be allowed to write a document saying, "When I reach a certain stage, I would like to be euthanized." Somebody in that situation is not in an emotional state to make a life-changing decision, but at the same time if they delay it, then they might lose the capacity to sign the document, and so they're forced to sign it while they're still in crisis. That's one side of it.

The other is that people's priorities and preferences change over time. Almost all of my patients come to terms with their disease and they live with it for many happy years.

I was distressed by some of the descriptions of people with Alzheimer's disease. I think to say that some people's lives are so bad that they're better off dead is a very unfortunate thing to say, because I think that all of my patients' lives have value, no matter how sick they are. I just can't imagine the scenario, for example, in which maybe the patient has signed this document and then they become demented enough that they can't make a capable decision. Who's going to decide that now is the time? Is it going to be their children? Is it going to be the doctor? How are their children going to live with that decision once it's made? Nothing is so black and white that it can just be a matter of the document.

In the brief I sent you, I quoted an article by a Dutch academic whose father was euthanized through an advance directive. They had all been pro euthanasia when they signed it and the children all agreed to it, but then they felt that they were prisoners of this document and that it was not what they would have chosen, nor what their father would have chosen when the time came, but they felt obliged to carry through with it.

This is a very complex issue. Which should trump which: the wishes of the patient at the time they have more advanced dementia or this paper they signed when they were well or not so well and they were in crisis?

A lot of issues are raised, and I think it's a very dangerous way to go.

● (1715)

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

Mr. Bittle.

Mr. Chris Bittle (St. Catharines, Lib.): My initial questions I'd like to direct to the CMA. There is concern about conscience rights and we've heard that from a number of groups. Are there any other procedures that you know about, apart from medical assistance in dying, in which there is a concern that doctors are forced to or coerced to perform a medical procedure against their will?

Dr. Jeff Blackmer: I would say probably the best analogy is therapeutic abortion. This is a matter over which the medical profession has certainly struggled collectively and individually. There's often a question around conscience rights and a right to objection and whether or not physicians may have an obligation to refer to another practitioner there. That's probably the closest analogous situation.

Mr. Chris Bittle: Are physicians required to conduct a therapeutic abortion?

Dr. Jeff Blackmer: No. There's no requirement for them to do that, and there's only one province that currently requires them to refer someone to a colleague, which is Ontario. Ontario is actually the only jurisdiction in the entire world with that requirement.

Mr. Chris Bittle: Do the colleges across the country, the colleges of physicians of the various provinces, fiercely safeguard the conscience rights of physicians through their own professional regulations?

Dr. Jeff Blackmer: That's correct. I would say that particularly on the point of assistance in dying, we've seen the nine provinces, those outside of Quebec, come forward with regulations. All of them, save Ontario, have wording that very clearly protects the conscience rights of physicians, but we have certainly seen some discrepancies in terms of the exact wording. As I say, Ontario is an outlier in terms of its regulations in that regard.

Mr. Chris Bittle: Perhaps you could speak for a moment about the importance of self-regulation in terms of your membership.

Dr. Jeff Blackmer: Self-regulation is very much a privilege and not a right of the medical profession. It is something we constantly must strive to uphold through our actions, collectively and individually.

As you know, there are members of the public now on these regulatory bodies, and we look to them for guidance as well. This is critical to what it means to be a medical professional—the ability to self-regulate and to hold our members to a high standard.

On issues such as conscientious objection, we often look to the colleges for guidance. This has been a difficult issue, again, because of some of the inconsistencies in the guidance that has come forward.

Mr. Chris Bittle: Perhaps I could direct my next question to Dr. Forbes. You mentioned that you are a family physician. I expect that, in the course of your practice, you have had a number of patients who have gone through suffering at the end of life.

My concern relates to the 15-day waiting period. I know the legislation provides that this period can be abridged, but for the sake of argument, we would say that the average person accessing medical assistance in dying will have to wait 15 clear days. Is there a cruelty in that? We have declared that someone suffering at the end of life must wait over two weeks, in an average case.

Dr. Cindy Forbes: That is certainly a question that has been asked. It does say at least 15 clear days, which allows for a longer period of time, if that is appropriate. However, there is some wording around the fact that if the prognosis is felt to be shorter than that, there would be some special arrangements there.

Do you have the wording?

● (1720)

Mr. Chris Bittle: I was wondering if you could speak more to the patient-centred approach to things rather than the legal—what the patients go through in their last days, the suffering they must endure, and waiting an additional two weeks.

Dr. Cindy Forbes: The whole issue around assisting a patient to die is an issue of compassion, for society to be compassionate to people in this situation, and certainly for any physician willing to participate. It is of highest concern that patients not be unduly suffering. However, this is being weighed against safeguards to make sure there is sufficient time for sober second thought. I think you have to look at it as a balance.

The wording in the bill is that if the two medical practitioners

> are both of the opinion that the person’s death, or the loss of their capacity to provide informed consent, is imminent—any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances

There is a provision there. I think it would be an exceptional circumstance, but at least it does give that leeway. As I said, these are complex issues. We would want to make sure that the safeguards are protecting people at this very vulnerable time in their lives.

Mr. Chris Bittle: This is understandable.

Would the CMA support a shorter time frame, given the balances of which you are speaking?

Dr. Cindy Forbes: I think that as long as there is a provision.... Our original document did suggest two weeks, but we also suggested that in the case where the prognosis was much graver, much shorter, there be some flexibility. I think Bill C-14 actually does provide that.

Mr. Chris Bittle: Thank you.

Ms. Morris, you talked about this bill not being workable medically. I was wondering if you could elaborate on that and explain that comment, again, from a patient-centred approach.

Ms. Wanda Morris: Absolutely.

I think of our members, individuals who are dealing with multiple chronic illnesses, often in great pain. To tell them that they can have assistance to die only if death is reasonably foreseeable is to leave many of them without the compassionate support they are looking for.

When we look at the history of the issue of the right to die in Canada, we see people with ALS, Parkinson's, MS, Huntington's disease—diseases that can cause great suffering but where death is certainly not imminent and, perhaps a doctor may say, not reasonably foreseeable. I think of individuals with multiple chronic degenerative diseases who are suffering greatly and want access to assistance to die. For us to deny them is to thwart the spirit of the Supreme Court's decision.

The Chair: Thank you.

Mr. Rankin, go ahead.

Mr. Murray Rankin (Victoria, NDP): Thank you, Chair, and thank you to all the witnesses for coming and for your patience today.

Dr. Forbes, I first of all wanted to thank you for referencing the pan-Canadian end-of-life and palliative care commitment. When we had Minister Philpott here a couple of days ago, she asked me to keep hammering away at this, and so thank you for giving me that opportunity to once again plug that important thing.

Dr. Cindy Forbes: Thank you.

Mr. Murray Rankin: Dr. Blackmer, we had the benefit of testimony from Dr. Stern of the Canadian Medical Protective Association yesterday. I want to read you a couple of things and ask your comment. Presumably, if I'm right, the CMPA insures doctors from coast to coast to coast so I would have thought these were important to your members as well.

They say this when talking about seeking clarity and the eligibility criteria: “The eligibility criteria for "grievous and irremediable medical condition" in subsection 241.2(2), and the requirement for practitioners to be "independent" in subsection 241.2(6), must be more clearly defined to ensure appropriate access to MAID and to protect vulnerable patients. Bill C-14 should state unequivocally whether or not a patient must be at the end of life to be eligible to receive MAID.”

I suppose I'm asking you to comment on that given that your insurer is so concerned about the bill as drafted. You seemed to say you were content with the bill as drafted.

Dr. Jeff Blackmer: I think it's important to recognize that although we are both medical organizations, we come at this bill with slightly different perspectives and slightly different filters in terms of the way we interpret some of this. I have had a chance to read Dr. Stern's comments.

What I would say is that there has been a lot of discussion around clause (d) and the issue of natural death becoming reasonably foreseeable. We see this as an immeasurable improvement over the alternative, which is to leave it at grievous and irremediable, which has no meaning to physicians whatsoever, and it would essentially leave anyone with any medical condition the ability to request assisted dying.

What the wording in Bill C-14 does is it allows us to understand how grievous this condition has to be. So we would say while it may not be perfect from a physician standpoint—and I've heard colleagues who have said it provides clear guidance, and I've heard colleagues who say I'm not quite sure how to interpret that—it's certainly much improved.

If the committee felt there was additional language that could be added to further improve that, to further clarify that for physicians, we would welcome that.

We also recognize, though, that in a piece of federal legislation you cannot capture all eventualities.

● (1725)

Mr. Murray Rankin: Right.

People who insure you are seeking greater clarity, and I think that needs to be acknowledged.

The other question they, your insurer, have in the bill is that protection in one of the sections should be extended to include civil and disciplinary proceedings for practitioners acting in good faith. The provision provides protection from criminal sanctions, but does not with the rest, and they call for that change.

You're obviously content with leaving it as it is.

Dr. Jeff Blackmer: I think it's important to recognize that these are comments that have been made in front of the committee that we haven't had a chance to vet internally or with our membership. We feel the bill as it stands is sufficient. We certainly respect the opinion of our colleagues within that sphere.

We haven't had a chance to consult with our membership on those changes.

Mr. Murray Rankin: They are your lawyers, though. I point that out to you, sir.

Dr. Jeff Blackmer: They have an important voice.

Mr. Murray Rankin: Ms. Morris, thank you very much for your testimony.

Yesterday, we had the benefit of Dr. Derryck Smith testifying. You may know him. He's a leading child psychiatrist in our jurisdiction of British Columbia and former head of the B.C. Medical Association.

He spoke passionately about advance directives and said the last change he would recommend is inclusion of an advance directive such that individuals with dementia can, when they are still competent, agree to medical assistance in dying at some point down the line.

I'd like you to elaborate. You heard one of your colleagues say this was not something that should be sought in this bill. I've heard you say the opposite. I'd like you to comment on Dr. Smith.

Ms. Wanda Morris: We polled our members on this question. Eighty per cent of them were in support of advance consent, for example, in cases of dementia.

I think this is fundamental to how we apply assisted dying legislation. Are we truly going to be patient-centred and give people what they want?

There was a time when doctors didn't even let their patients know they had a diagnosis of imminent death. I think we've really moved from that to a time of being patient centred.

My colleague suggested that she felt every patient's life had value, and I commend her for that, but really isn't it up to the patients themselves to decide whether they want to continue living in a state where they clearly don't? I think we can be very specific with the wording and the direction of advance consent, laying out particular criteria so we can tightly control it, but I think it is fundamental.

Mr. Murray Rankin: I want to give you an opportunity as well to comment. One of your colleagues on the panel talked about the need for “prior authorization by a superior court”, a judicial authorization. Could you comment on that issue?

Ms. Wanda Morris: That's just a fundamentally flawed comment. What we know from other colleagues working right now with individuals who are choosing assisted death is that it is an onerous and expensive and deeply daunting prospect to go before a court. To me, to add on that layer of administrative and bureaucratic and legal procedure is not necessary. We have already gone above and beyond the procedures required in any other case of informed consent. To go farther than that provides no real benefit but imposes a substantial burden on people who are already grievously ill and dealing with great suffering.

Mr. Murray Rankin: Can I have one more question , or am I out of time?

The Chair: You will be over the time, but if you get a one-word answer....

Mr. Murray Rankin: It's for Dr. Blackmer.

We're struggling with conscience protection in the committee and how to do it, and I noticed you carefully said, “to the extent constitutionally possible”.

Do you have a legal opinion on whether we can do it in this federal law?

● (1730)

Dr. Jeff Blackmer: I'm not a lawyer, but having spoken to a lot of lawyers about this, I've received the interpretation that this would not be possible. If the committee feels otherwise and there is a possibility otherwise, we would support that possibility, certainly.

The Chair: Thank you very much.

Mr. Hussen.

Mr. Ahmed Hussen (York South—Weston, Lib.): I'd like to begin by asking a question of Dr. Ferrier. I'd like to begin by highlighting a section of your submission for the Physicians' Alliance against Euthanasia. It says that since “the vast majority of desires for death are caused by mental illness”, suicide prevention through treatment of such illness and treatment of the self-harm inflicted by suicidal persons are part of the daily practice of many doctors.

I'm curious to know whether you have any research that indicates that the vast majority of desires for death are caused by mental illness.

Dr. Catherine Ferrier: I don't have any particular study at my fingertips, but I can tell you that this is the experience of essentially all doctors ever.

Mr. Ahmed Hussen: Secondly, you also spoke, on the next page of your submission, about there being no justification for imposing any duty to implement this political decision on Canadian doctors and institutions.

Do you feel that Canadian doctors would be forced to conduct medical assistance in dying?

Dr. Catherine Ferrier: In Quebec right now, doctors who are not willing to conduct it themselves are obliged to send the patient along a path that will ensure that it will be done. That, to me, is similar to what Dr. Blackmer said about Ontario, which requires referral directly to someone who will do it. Most people who object to euthanizing patients would also object to sending patients to their deaths, not because of our own needs but because we think it is contrary to the needs of our patients.

Mr. Ahmed Hussen: Mr. Racicot, have you any opinion on that?

Mr. Michel Racicot: The doctors also have a right to freedom of conscience, and a doctor who feels that he or she should not do that for his or her own conviction and for the good of the patient should not be obliged to do it and should not be obliged, either, to refer to someone who will do it, as is the case in Quebec.

It is very important, if we have to have this law apply equally and similarly across the country, that this committee recommend that the objection of conscience, both for individuals and institutions, be implemented. I personally think that you have the jurisdiction, because it's, in theory, within your jurisdiction over criminal law.

In Quebec at the moment, certain hospitals do not perform abortions, and they are not forced to perform abortions, but they are forced to perform medical aid in dying. This is why we need the institutions to be protected as well.

Mr. Ahmed Hussen: Dr. Ferrier, you gave as your opinion that at least for the organization we should limit medical assistance in dying to those who are in the last stages of terminal illness. What about those who are suffering through an incurable illness or disease, who are in irreversible decline and great suffering, and who wish to make that decision?

Dr. Catherine Ferrier: I think we have to look after those people.

Mr. Ahmed Hussen: What if it's their expressed desire to—

Dr. Catherine Ferrier: Well, if it is their expressed desire... I mean, this law is going to pass and there will always be somebody who will be willing to help them.

Mr. Ahmed Hussen: According to your submission, if we limit it to only those who are in the last stages of terminal illness, those folks would not have access to their choice.

Dr. Catherine Ferrier: I think we have to remember that we're talking about killing people, and this is not a medical treatment; it's not some kind of panacea that is going to solve everybody's problems. This is something that we've always been able to do and society always made the choice to not do this, and there are many other things that we can do for people. People who really, really wanted to die in the past have found ways of reaching their goals without involving the medical profession.

Mr. Ahmed Hussen: This is for the Canadian Medical Association, either one of the representatives.

I'd like to know if you have any concerns with respect to Bill C-14 and whether patients will have difficulty accessing medical assistance in dying as it moves forward.

● (1735)

Dr. Jeff Blackmer: That's a very important question. I would point out that when we've done surveys of the membership in the CMA, somewhere around 30% of physicians have said that if this becomes legal they would be willing to participate. That may sound, on the face of it, low; it's actually not. That equates to tens of thousands of physicians. In Oregon, it's less than 0.6% of physicians who participate in assisted dying. In terms of the numbers alone, access won't be a problem. The problem is connecting patients who qualify with willing practitioners.

You can imagine that most physicians aren't willing to put their names out there to advertise that they're going to be participating in this; there are security and safety concerns. What we need, and what the CMA has been calling for, is a system to help connect patients who qualify for assisted dying with practitioners who are willing to provide the service. At the same time this means the physicians who don't want to participate, or don't want to refer, can have their conscience rights protected. It's a way to satisfy both situations.

Mr. Ahmed Hussen: How would that system operate?

Dr. Jeff Blackmer: There's actually a system in Alberta, at the current point in time, that the Alberta government has been working on where physicians can register with a central registry and say they are willing to participate. Patients, or a health care provider, can call that number and find out more information about the legislation and about the service, but also be connected, where appropriate, with a willing provider. They put that in place because of the situation they had where a patient in Calgary was not able to find a willing provider and had to travel outside of the province, even though there were many physicians in Calgary who could have assisted. We desperately need this type of a system to make sure that we connect patients and providers.

Dr. Cindy Forbes: I want to also echo those comments. I can honestly say the most common question I get from my colleagues who know that I've been involved at this level is, do you know who's going to provide the service? They may be willing to refer, but at this point in time they have no idea how, and as Dr. Blackmer pointed out, it's unlikely we're going to have a directory or a list published somewhere. This concept of a central referral, coordinating system would be essential when June 6 arrives, that physicians would know there's a system; that patients would know there is a system. There would be no confusion and it would pave the way to access for the people who really should be accessing the service.

The Chair: Thank you very much.

I have one brief question to CMA. It's a question I've asked all the medical panels that have come before us. Essentially, it follows on Mr. Rankin's question.

When you look at reasonably foreseeable death, if we were to add clarity, if we were to say that the person's death was reasonably foreseeable within the next six months, or a year, based on the model in Oregon, based on the model in all of the states that have passed this type of a law, would that be preferable to you than the vagueness of reasonable foreseeability?

Dr. Jeff Blackmer: I would say, as a general principle, additional clarity would be welcome. I would also say that given the type of association we are, it's very difficult for Dr. Forbes and me to pretend to represent 80,000 members when we haven't had that discussion internally. Certainly the additional clarity, as I say, as an overarching principle, would be welcome.

The Chair: I want to thank all of the members of the panel. I know this was not easy since you had to sit through a break. Thank you so much for sitting there for an hour and forty minutes; it's really appreciated.

We're going to ask the next panel to move forward while we take a brief recess.

Thank you so much, all of you. It was very helpful.

● (1735)

(Pause)

● (1745)

The Chair: Ladies and gentlemen in the back of the room, I am now asking you to please take your seats or to step out of the room. We have limited time and we can't have people talking in the back.

I want to thank the witnesses on this panel, despite the constant disruptions of today, for having stayed and for having understood that we're going to disrupt again for a vote in the middle of the panel.

We have three different associations representing nurses. They are all different associations with potentially slightly different views, but they've been kind enough to find a way to present in a common way. They'll go one after the other.

We have Maureen Klenk, past president of the Canadian Association of Advanced Practice Nurses; Carolyn Pullen, from the Canadian Nurses Association, who is the director of policy, advocacy, and strategy; and Elaine Borg, from the Canadian Nurses Protective Society, who is the legal counsel.

We have two witnesses presenting as individuals. We have Dianne Pothier, who is a professor emeritus with the Schulich school of law at Dalhousie; and Trudo Lemmens, who is a professor and Scholl chair, health, law, and policy with the faculty of law at the University of Toronto.

Welcome to all of you.

I'm going to ask the different nurses associations to present first.

Before we begin, I need unanimous consent from the committee to proceed while the bells are going until 10 minutes before the vote. Do I have unanimous consent?

Some hon. members: Agreed.

The Chair: Thank you.

Ms. Klenk, please go ahead.

Ms. Maureen Klenk (Past President, Canadian Association of Advanced Practice Nurses): My name is Maureen Klenk and I represent the Canadian Association of Advanced Practice Nurses. I am proud to be a nurse practitioner. I believe I may be the only nurse practitioner who will be presenting to you.

I would like to forward three concerns.

First, although Bill C-14 uses legal language, its primary purpose is to provide Canadians and health care providers with protection and accessibility for medical-assisted dying. Counselling is an everyday activity within every patient exchange. There will be much counselling between the time when a patient requests medical-assisted dying and the provider actually writing the prescription. Therefore, we believe the exemption for medical assistance in dying must include both clauses (a) and (b).

Second, an age restriction and requirement is discriminatory. A 16-year-old with a brain tumour will suffer as much as a 36-year-old, and their prognosis is the same. Yet, we do accept as lawful a 16-year-old signing a surgical consent for his two-year-old daughter.

Third, the terms serious and incurable are not medical terminology and provide the practitioner with no descriptive value.

Also, what is a natural death for a 60-year-old who has ALS? He's not going to die from natural causes. His death is going to occur from the horrible complications of ALS. When would a health care professional know that this 60-year-old's death was reasonable and foreseeable? We believe this is not a measurable term in any context.

CAAPN recommends the removal of clauses (a) and (d) from 241.2(2).

Thank you for the opportunity to contribute to this important process.

● (1750)

Dr. Carolyn Pullen (Director, Policy, Advocacy and Strategy, Canadian Nurses Association): Thank you for this opportunity to suggest amendments to the draft wording of Bill C-14 on behalf of the Canadian Nurses Association.

We are the national association for 139,000 registered nurses across Canada, including nurse practitioners. My name is Dr. Carolyn Pullen.

CNA welcomes the federal government's moderate approach to this challenging legislation, and we support the expeditious passing of this bill. CNA strongly endorses the stated intention to work with the provinces and territories on a pan-Canadian care pathway for end-of-life care, which has the potential to reconcile issues related to access and conscience. We are lending our support to harmonized implementation of MAID across jurisdictions by convening nursing stakeholders, including regulators and educators, to develop a national nursing framework to guide nurses in the implementation of MAID.

The CNA recommendations for amendments to Bill C-14 are based on our view that it will best serve patients and health care providers if the legislation can be clearly understood, is possible for professionals to demonstrate in practice, and is practical to implement in the best interests of the patient. In accordance with these principles, our written brief suggests three amendments to the language used in the draft bill.

Our suggested amendments would remove the criteria that refer to “incurable and reasonably foreseeable death”. We respectfully offer an expanded definition of “grievous and irremediable medical condition”, which we believe is in accordance with the Carter decision, which focused on intolerable suffering rather than on timelines for death. By making the amendments we suggest, section 241.2(2) could be deleted from the bill.

The current wording used in section 6(a) and (c) that address independence of practitioners is also problematic. As written, these clauses leave room for questions about business relationships between practitioners as well as factors that could affect the objectivity of practitioners. For instance, if practitioners have only referred patients to each other in the past, does that imply a business relationship? In small communities, does simply knowing each other imply a relationship that affects independent practice? Confusion about the meaning of these clauses, if left as is, could lead to delays in access to MAID, particularly in rural and remote settings, where the numbers of health care providers to draw on may be limited.

While fully supporting the need for these important safeguards, here the CNA suggests revising these clauses so that they can be more clearly understood, demonstrated in practice, and practical to implement in the best interests of the patient.

Thank you for the opportunity to deliver these prepared remarks and to contribute to this important process.

● (1755)

The Chair: Thank you very much.

Ms. Borg.

Ms. Elaine Borg (Legal Counsel, Canadian Nurses Protective Society): My name is Elaine Borg. I'm a nurse and lawyer. I work for the Canadian Nurses Protective Society. CNPS is a national not-for-profit organization. It's a legal defence fund for registered nurses and nurse practitioners. Our focus, as you'll see in our written submission to you, is along the lines of clarity. How do nurses know that they're on the right side of the law as this becomes law in Canada?

The first issue I'll address is that if it is lawful to participate in assisted death, it must be lawful to talk about it. Subsection 241(1)(a) of the Criminal Code makes it an offence to counsel a person to commit suicide. Counsel is defined in the Criminal Code at subsection 22(3) as including procuring, soliciting, or inciting.

Health care professionals use this same word, counsel, to describe professional communications within the therapeutic relationship. It is a combination of active listening, patient education, and support. Health care professionals must engage in these activities. The circumstances of assisted death are no exception.

We recommend that the exemption for assisted death in the bill, found at subclause 241(1)(a), overtly and expressly includes the word counsel, so that health care professionals can engage in this normal therapeutic activity without fear that doing so or using the word counsel in this context, for example, in charting and documentation of care, would be misconstrued as criminally prohibited activity.

In the CNPS written submission, we have provided a draft definition of counsel as well as a draft clause explicitly including counselling as part of medical assistance in dying.

The second issue I'd like to address is the criminalization of the civil standard of care. This can be found in the bill's subclause 241.2(7). Failure to comply with this clause could result in the commission of a criminal offence, despite the absence of *mens rea*, the necessary guilty mind. A health care professional may act so as to violate any one of these stipulations in the clause with no intention to do so, no wilful blindness, no recklessness. This is a lower threshold for criminal penalty than is required for criminal negligence, which can be found at section 219 of the Criminal Code.

In addition, it's not known what the rest of the clause means when it talks about provincial laws and standards. We don't know what these are yet. It is reasonable to anticipate that they would include administrative provisions that are not worthy of criminal penalty if violated. The word rule is used in this clause. It's undefined, broad, and vague.

Health care professionals are and will be bound by the civil standard of care, and must practise in accordance with professional standards and ethics. Violations of these result in proportional civil and administrative remedies. For these reasons, the CNPS recommends the removal of subclause 241.2(7) in its entirety.

The third issue is the certainty of the role of the nurse in respect to medication administration. A prominent feature of professional nursing practice is medication and substance administration. The whole care team expects and knows that nurses do this.

Subclause 241.1(a) of the bill defines medical assistance in dying as the administration by a medical practitioner or nurse practitioner of a substance to a person. If the intention of this clause is to ensure the substance is administered personally by a doctor or nurse practitioner, we recommend the inclusion of the word personally before the word administering for the sake of clarity and certainty, given the role that nurses play in medication administration.

My final point is in regard to what constitutes a business relationship. A purported safeguard in the bill is the prohibition that practitioners be in a business relationship. The term is vague. Health care professionals must work together, so what are the parameters of a business relationship such that a practitioner can demonstrate compliance and avoid criminal penalty?

Thank you.

● (1800)

The Chair: Thank you very much. That was a very interesting presentation. I appreciate you all working together to make it into one.

Colleagues, we have 16 minutes until the vote. Do we feel that we have time to hear another one?

Will either of you be able to do this within eight minutes or less, for sure?

Prof. Dianne Pothier (Professor Emeritus, Schulich School of Law, Dalhousie University, As an Individual): That's my plan.

The Chair: All right. We'll go with Ms. Pothier. Thank you.

We'll have to really stick to the eight minutes here.

Thank you so much. Please go ahead.

Prof. Dianne Pothier: Thank you. I appreciate the opportunity to be here.

My expertise is in constitutional law, including charter law. So that's where I'm coming from. Given the limited time, I'm focusing on the constitutional validity of the definition of grievous and irremediable medical condition in proposed subsection 241.2(2).

I think it's important to get the point that in some ways it's as significant what the Supreme Court of Canada in Carter 2015 didn't say as much as what it did say. The Carter decision, in paragraph 95, refers to the protection of the rights of vulnerable peoples as the constitutional rights of vulnerable peoples, but they don't elaborate on that. That wasn't the nature of the claim before them. They acknowledged that there were constitutional rights of the vulnerable, which they didn't elaborate on in the decision, but that's part of the context of what you have to do in responding to the Carter decision.

In analyzing both section 7 and section 1 and acknowledging the protection of the vulnerable, the real challenge in this context is that the vulnerable are not going to self-identify when they appear in this process. The point of saying we're talking about the constitutional right of the vulnerable is that it's for people who are not well placed to identify and defend their own rights. They're going to present as people who want to die, and the issue is, is this a matter of being at a time of weakness and saying you want something, which, if you had the opportunity to reflect on, you would change your mind about, while if your current wish is acted upon you'll never have that opportunity because you're going to be dead.

The issue is complicated by rights that are in a sense competing, but they're competing in an unusual way, because we're talking about difficulties in identifying the people who need protection.

I want to focus particularly on the provisions of proposed paragraph 241.2(2)(b), which is the advanced decline section, and proposed paragraph 241.2(2)(d), the reasonable foreseeable death sections. The question is whether those two limitations are constitutionally valid.

Lots of folks, including those next to me at this table, have said that since those provisions weren't referred to by the Supreme Court of Canada and Carter, that means you can't do that. I'm afraid that's not a very strong analysis, because, again, it's what they didn't say in terms of comparing it to what they did say.

With regard to proposed subsection (241.2(2)(b) about advanced decline, before Justice Smith at trial, the Quebec legislation wasn't in force yet but the Quebec committee recommendation was before her and she picked up their language in terms of advanced decline and capability, and put it into her declaration of invalidity. The Supreme Court of Canada did not incorporate it. They didn't disagree with it; they didn't agree with it. They didn't even acknowledge that she said it.

So to say that by completely not commenting, not even acknowledging, this issue they somehow pronounced upon it is a very extreme interpretation of what the court is doing. It didn't comment at all and it's the language that's picked up in the Quebec legislation and it's picked up in Bill C-14. A reasonable interpretation of the Supreme Court of Canada not commenting is that they're handing it over to Parliament for Parliament to exercise its best judgment.

Similarly the issue of reasonable foreseeability of death is not referred to in Carter, but before Justice Smith, before the Supreme Court of Canada, they canvassed the North American history versus the European history. In some of the North American versions, they do have some sort of end-of-life limitation. European ones don't.

● (1805)

You might have thought they should say what is good and what is bad, and what are the pros and cons. They don't enter into that analysis. Therefore, it seems clear to me that they're saying they haven't preordained what should happen here, and they are sending it back to Parliament for you to decide whether an end-of-life stipulation of some sort is appropriate here. I think the first point is that the Supreme Court of Canada leaves this open.

If you need confirmation that this is what they're doing, they told us that in Carter 2016 at the time when they were granting the extension of the suspended declaration of invalidity. They made a point of saying that they expressed no opinion on the Quebec legislation. The Quebec legislation has both of the things in proposed subsections 241.2(2)(b) and (d). Proposed subsection 241.2(2)(d) is a slightly different version of it, but it's in the same ballpark in terms of being an end-of-life stipulation.

The court has handed it back to Parliament to decide, but the question still is, if you choose to put in proposed subsections 241.2 (2)(b) and (d), is that consistent with section 7 of the charter? My analysis is that it is consistent for both of them. At trial, Canada argued before Justice Smith that if there's even one person who wrongfully ends up dead because of this, that's enough to warrant an absolute ban on physician-assisted death. Justice Smith said that's going way too far, both as a matter of the principles of fundamental justice and as a matter of the section 1 defence for the government. That's going way too far.

Neither Justice Smith nor the Supreme Court of Canada said that there's some magic number here, but they're clearly saying, on the assumption that with safeguards, the risk of error or abuse, of having people prematurely die who ultimately would have changed their minds if they'd had the opportunity.... But if the risk of that is low—

The Chair: I'm sorry. We're going to have to come back.

It will let you think about how you want to wrap up.

Ms. Dianne Pothier: Okay.

The Chair: By the way, I have to say that this is one of the most interesting submissions we've had so far, so I don't want to in any way say that we're not interested. We're very interested. We'll let you finish when you come back.

Ms. Dianne Pothier: I understand.

The Chair: I just don't want to miss the vote.

Voices: Oh, oh!

The Chair: We're suspended.

● (1805)

(Pause)

● (1845)

The Chair: I call the meeting back to order.

Ladies and gentlemen, I want to thank you for your patience again while we went to vote. I know this process is long for you, and I very much appreciate your forbearance.

I have two pieces of good news. The first piece of good news is we won't be interrupted again tonight with votes. The second piece is that you are now the first witnesses appearing before the committee after the bill has actually been referred to us—

Voices: Oh, oh!

The Chair: —so it makes your testimony all the more compelling.

Ms. Pothier, please continue.

Ms. Dianne Pothier: Thank you. I'm told I have two minutes, so I'll have to be brutal about what I talked about.

Before the vote, I was saying that the point of the decision in Carter v. Canada was to say that if the risk of error or abuse is low, then the autonomy claims can prevail, but the obverse of that is that if the risk of error or abuse is high, then the protection of the vulnerable prevails. My point in all of this is that I think proposed paragraphs 241.1(2)(b) and 241.1(2)(d) are consistent with section 7 of the Charter of Rights, consistent with the principles of fundamental justice, or, in the alternative, saved by section 1 of the charter.

If you take away proposed paragraphs 241.1(2)(b) and 241.1(2)(d), then the chances go way up of having somebody face premature death on the basis of a transitory wish, whereas if they'd had the opportunity over decades, they could have changed their mind, found other ways of coping with issues, found a way to make life worth living.

In section 1, the difficulty of protecting the vulnerable is an important factor. It goes beyond the individual claimant.

There are other things I could say, but I just have one final wrap-up comment.

You've heard lots of comments over the last few days to the effect that if you have the restrictions of proposed paragraphs 241.1(2)(b) and 241.1(2)(d), it's only going to produce new litigation to challenge. Yes, it's open for somebody to say, “You haven't gone far enough.” But it's important to remember my starting point; the court recognized the constitutional rights of the vulnerable. The other side of this is, if you go too far, make it too wide open, you're open to a challenge on behalf of the vulnerable. That's an interference with their constitutional rights.

If you want to charter-proof whatever you do here, the only way to do that is by using the notwithstanding clause in section 33 of the charter. I haven't heard any senator or any MP who thinks that's a good idea. There are potential challenges from both ends of the spectrum here. Your job is just to exercise your best judgment.

My submission to you is that proposed paragraphs 241.1(2)(b) and 241.1(2)(d) are important to protect the vulnerable. To include them is consistent with section 7, and would be saved by section 1 in the alternative. To exclude them increases the risk of error and abuse substantially to mean, not only would it no longer breach section 7, you'd invite a challenge from the other side of the spectrum.

● (1850)

The Chair: Thank you very much, Professor Pothier, much appreciated.

Professor Lemmens, over to you.

[*Translation*]

Prof. Trudo Lemmens (Professor, Scholl Chair, Health Law and Policy, Faculty of Law, University of Toronto, As an Individual): I would like to thank the committee for inviting me to share a few thoughts on this important topic, one that affects each and every Canadian.

[*English*]

My submission is informed by research and teaching in health and bioethics, including end-of-life law, informed consent, and professional regulation in health-based discrimination law. I felt particularly compelled to participate actively in the discussion about the legislative changes because the lived experience of euthanasia practice in countries like Belgium, which is my country of birth, is too often ignored in this debate. I have conducted detailed research on euthanasia law and practice in Belgium and published on what this experience means for the debate in Canada.

I'll say something here about one, why I support the bill's definition of what constitutes grievous and irremediable; two, the limitations of the safeguards in the bill and the option to add prior review; and three, the exclusion of advance directives.

With respect to the narrow criteria, it can be very short around the argument about consensuality. I agree with Professor Pothier that the bill's criteria response to the applicants in the Carter case also provides some protection to many vulnerable people whose lives could otherwise be ended prematurely.

It's not just constitutionally required, I think it's also good social policy. This is where the evidence comes in from other countries. Evidence from euthanasia regimes that combine open-ended access criteria with reliance on competency and informed consent assessment by individual physicians and limited—and I would emphasize limited—after-the-fact reviews of self-reported cases shows these regimes lead to a significant expansion of the practice. In Belgium, we have expansion from 347 cases in 2004 to more than 2,000 in 2015. That becomes a significant proportion of the total deaths in the country, particularly in the Flemish region.

Problematically it has led in the last couple of years to an expansion in areas around people with disabilities and now includes couples who want to die together, people struggling with gender identity, and people who are tired of life. I would add to that the problematic expansion in the mental health area for people, not just those are chronically depressed and may be treatment resistant, which in and of itself is a contested concept. I developed that more in some publications and in submissions I gave to the joint parliamentary committee. It's not just people who are chronically depressed, but now in Belgium it also includes people with personality disorders, post-traumatic stress, anxiety, eating disorders, schizophrenia, addiction, autism, and even complicated grief. These cases do raise questions about competency assessment and about the appropriateness of including people, who had potentially many years to live, in euthanasia practices.

Members of the committee should be critical of the claim there are no problems with the Belgian death regimes because this has been carefully evaluated by the trial judge and by several Canadian committees, as has been said before. This is incorrect. The trial judge accepted there could be problems with the Belgian system, as did the Supreme Court, which ruled for the problems that were brought in front of it, they did not have to look at the fresh evidence presented by Belgian developments because these cases dealt with cases outside of the parameters of its reasons, and because Parliament could develop, the Supreme Court suggested, a more narrow regime with more stringent safeguards.

More importantly many problematic developments have become apparent in the last five years. I provide detailed evidence of these controversial aspects of the real-life practice of euthanasia in my written submissions and in other writings I can share with the committee.

Let me say something about competency and consent procedures. A lot of weight is put in the bill on existing competency and informed consent procedures by physicians. It's true they are already used in health care and in end-of-life situations. Competency and informed consent assessment are not fail-proof. They're ideals. They try to create an ideal of autonomy, but challenges are widely recognized. The science of competency assessment is in its infancy. Health care providers admit that, yet others seem to put so much faith in physicians' ability to do this properly and in a much more difficult context of end of life.

● (1855)

In this context, these procedures play a much more important role. They determine the difference between life and death, and in the future in many more cases than in the context of the existing end-of-life practices. The limitations of current competency assessment and current informed consent procedures become more important.

When we expand MAID to situations where people are not at the end of life, the possible consequences of errors become much more serious because of the many years of life that can be lost.

I therefore recommend—and I developed it in more detail but I won't expand on it here—that the competency in informed consent assessments should include a much more sophisticated evaluation of contextual and personal factors that may impact on the desire to die and on the voluntariness of the request. Pain, emotional distress, mental illness, financial or familial pressures, availability of palliative care, and so on are important to look at. In my submission, I propose some changes to that effect to the bill.

With respect to the standards of informed consent, I would say that more rigorous informed consent practices are common, also, in areas of health care where there are concerns about increased vulnerability and the need for caution. I can give you the example of medical research. This is clearly the case here that we're dealing with a context of increased vulnerability in situations where people are suffering and the precise reasons for the desire to die may be unclear. Informed consent is also here integrated in the criminal context as a basis for an exception on a criminal law transgression, so it should be stringent. For these reasons, because of the limitations of informed consent procedures and competency, I personally believe that prior review would offer additional protection.

Prior independent review would not be needed in a perfect world, in which all professionals always respect their professional ethics standards and act cautiously, without error, without excessive zeal, and without pressures of the health care system, but this is not the world we live in. Havoc can be created by a few negligent physicians in the context of other professional practices, so it's clear that it also can do the same in the context of end of life. Evidence from Belgium and the Netherlands shows how just a few doctors—you only need a few doctors—can create problems and lead to a high number of problematic expansions. The claim that the medical profession can adequately deal with it may be generally fine, but prior review would safeguard, actually, against those exceptional cases of physicians who become sloppy or are not acting appropriately.

I'll say something very briefly, in conclusion, about advance directives. I can't expand on it in more detail, but I would suggest you read the submission.

Advance directives are an exception to the rule that people have to provide informed consent for, in this case, a life-ending practice. Second, when people are asked to write an advance directive after the diagnosis of dementia, as has been recommended by the joint parliamentary committee, competency is often already affected, so there are concerns about competency assessment. Third, people have difficulty imagining that they may enjoy quality of life and may find new purpose and satisfaction in life once dementia develops, yet this is often the case. People become different, and there are even changes in the brain that are associated with that. Would we hold people to their previously expressed wish, even if they are now seemingly satisfied and enjoying a good quality of life? I would urge the committee to look at a recent documentary in the Netherlands that highlights, I would say, the horror of forcing someone into respecting an advance directive when she—in this case it's a woman in her sixties—is still functional and still enjoys many activities of life, simply because she had signed an advance directive five years earlier.

I would also mention that there are often family members who may have the most trouble dealing with dementia. It becomes problematic when they then become, with well-intentioned reasons, the ones who have to judge when the life of a family member is no longer worth living.

I would say, and I would suggest you look at the submission, that even in the most liberal systems of Belgium and the Netherlands, advance directives are only allowed under very strict conditions. In Belgium, for example, they are only allowed when there is irreversible unconsciousness of the person. In the Netherlands, they're not binding and are generally not applied because they are so problematic.

Let me close by simply saying that in the context of this debate, many powerful narratives of people who may not have immediate access to MAID under the bill or others who clearly do not qualify because they cannot give consent have been put forward. I urge the committee to look at other powerful narratives of people whose lives were prematurely ended in open-ended systems.

● (1900)

A few of these cases have recently created a heated debate in Belgium and the Netherlands. Many other cases remain hidden, because this involves vulnerable, marginalized people who are no longer there to complain after the indeed terminal relief of their suffering. Family members often remain silent because of the trauma they experienced.

We should learn from the experience of these other jurisdictions and introduce a cautious, prudent, regime that ensures the charter-based duty to protect the vulnerable. Opening up the bill's access criteria, in my view, would put the most vulnerable members of our society at risk.

Thank you.

The Chair: Thank you very much to all the members of the panel for your very interesting submissions.

We'll now move to questions.

We'll start with Mr. Cooper.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you, Mr. Chair.

I'm going to ask my first question to Professor Pothier.

There are some in this debate who have come before the committee or who otherwise, when looking at the parameters set out by the Supreme Court in Carter, have said concerning the parameters of Carter that Carter is merely the floor, not the ceiling.

How would you react to that suggestion?

Ms. Dianne Pothier: I don't think it's a very apt analogy. What I said was that the courts left out a large part of the analysis not because they're incompetent—obviously, they're not—but because they were not dealing with everything, on the theory that it was up to Parliament to deal with stuff. To talk about a floor, when you're saying there are things we've discussed and things we haven't discussed, doesn't make much sense to me.

Mr. Michael Cooper: Right. Really, what the court talked about was balancing on the one hand individual autonomy with the need to protect vulnerable persons.

You cited paragraph 95 of the Carter decision, but I would also note paragraph 105 of the Carter decision. The Supreme Court cited Madam Justice Smith in talking about the need for a properly designed and administered system of safeguards.

Then at paragraph 111 of the decision, the court goes on—and Professor Lemmens referred to it—to an affidavit that had been submitted by Professor Montero with respect to the Belgian experience, wherein the court in response said, we need not consider this affidavit for the purpose of admitting it as evidence before the court, because the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions, would not fall within the parameters of what we are contemplating.

Would you agree that those additional paragraphs also lend support to the idea that when we talk about rights, including those under section 7 of the charter, it's not a one-way street, but a balancing?

Ms. Dianne Pothier: Yes. The whole point of the principles of fundamental justice, the overbreadth, is to say that an absolute ban was going too far. The question is then, what wouldn't be going too far? It is a balancing exercise. It's up to Parliament to try to figure out what the appropriate balance is.

My point is that if you don't have the limitations of proposed paragraphs 241.1(2)(b) and (d), then what you're saying that you need to weigh.... We've had testimony about what seemed to be compelling circumstances of people who fall outside of those two paragraphs, but you need to weigh that against, as Trudo was saying, the people who would just silently die because they're overwhelmed by feelings of hopelessness and helplessness, but who, if they had the opportunity to figure out a way to make life worth living, would have done so.

It's not just saying that this case has no effect on anything else. It's saying that if we make it too wide open, the balance is lost. Yes.

● (1905)

Mr. Michael Cooper: To finish off that thought, if, therefore, the balance is lost, then Parliament is opening itself up in the legislation to section 7 challenges from vulnerable persons who were saying that this legislation threatens or does not protect the life and security of vulnerable persons.

Ms. Dianne Pothier: I would say it's both section 7 and section 15. The Carter claim itself was about section 15 and section 7, and Justice Smith started with section 15, and 7 was a bit of an afterthought. The Supreme Court of Canada said yes to section 7 therefore we don't need to deal with 15.

So the challenge on behalf of the vulnerable could be, again, both, but I think in that context the section 15 equality claims would be the more powerful ones.

Mr. Michael Cooper: That's fine.

Is there any more time?

The Chair: Another minute.

Mr. Michael Cooper: Professor Lemmens, you talked about the experience in the Benelux countries, and in Professor Montero's affidavit that he had submitted before the Supreme Court he talked about many examples of abuses in the Benelux countries.

Can you maybe speak about those in the context of the need for, in your view, a prior review mechanism?

Prof. Trudo Lemmens: Yes, the cases that were brought to the Supreme Court by Professor Montero were considered by the Supreme Court, but were put aside because the Supreme Court basically argued that they were not dealing in their decision with people suffering from psychiatric disorders. They basically sent the message that they were not dealing with that particular category of people who might ask for physician-assisted dying.

The cases have become much more important, of course, and they are important to discuss here, and by the legislator, if people are asking for an expansion of the criteria. The reason that the Supreme Court didn't consider them makes it important to discuss them here.

Are there abuses in the Belgian and the Dutch systems? I would say the cases highlight the importance of prior review.

We have seen circumstances most recently, for example, in Belgium involving a 37-year-old woman. She had suffered from a mental illness in her younger years, but had been out of treatment for 15 years. She encountered a physician who, in the Belgian context, is known to be very supportive of euthanasia for psychiatric patients. She asked four months after meeting her for access to physician-assisted dying, or euthanasia as it's called in Belgium. She was then diagnosed with autism. People who look at this from a professional perspective, from the outside, say this is a strange phenomenon, and wonder why she was diagnosed with autism at this particular stage. Family members had trouble obtaining information about what exactly happened, and why she was diagnosed in that way, and then two months later she was euthanized in the presence of her traumatized family. It then took the family three years to complain about it. Why? Because they went to the Belgium euthanasia commission, which said the legal criteria were fulfilled.

In an interesting way autism fulfills the criteria of the Belgian act. So when individual physicians decide, whether they're well intended or not—and I'm not even saying that this is not a well-intended physician—when they may be overly zealous in believing that their role is to provide access to physician-assisted dying in cases, many other psychiatrists would find it highly problematic because of the fact that these people are worthy of our care and of our attention, and they should not be submitted to euthanasia.

A prior review system would basically provide a safeguard in that it can lead these individual decision-makings. It could question the individual decision-making by physicians who may be overly zealous and sloppy and may act in an incompetent way in cases like that.

● (1910)

The Chair: Thank you.

Mr. Fraser.

[*Translation*]

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

I'd like to thank the witnesses for joining us today and for giving such informative presentations.

[*English*]

I'd like to in particular thank the three groups of nurses for presenting today

Thank you for the work that you and your members do every day to care for Canadians. It's really important work. I know that in this work you do, going forward, palliative care will be an important component of whatever the outcome is with this legislation. I know that our government is committed to making sure the resources are there for palliative care.

Ms. Klenk, I have a question for you with regard to nurse practitioners. The bill allows two physicians, or one physician and one nurse practitioner, or two nurse practitioners to help the patient with medical assistance in dying. I'm wondering about the provincial aspect. I believe you mentioned that the federal government and the provinces and territories will have to work together to come up with a framework, especially with nurse practitioners, and I know that's regulated by the provinces and territories.

Can you help us understand what kind of framework you might see? Would it be a concern that there would be differences between different jurisdictions in Canada in terms of what nurse practitioners could actually be able to do, despite what's stated in the bill?

Ms. Maureen Klenk: The scope of practice of nurse practitioners across the country is very similar. We do have a strong education program that would certainly enable nurse practitioners across the country to be able to assist with medical assisted dying—to enact it, I guess, if that's the word.

There could be jurisdictional differences. I do believe, though, our nursing regulatory bodies in general work very hard to have similarities in our regulation processes across the country. There may be minor differences, but I think in general the processes will be the same across the country for nurse practitioners.

Mr. Colin Fraser: Do you believe it's important, in order for Canadians across the country to have access to medical assistance in dying, to allow nurse practitioners this ability?

Ms. Maureen Klenk: Yes. I believe it is important to have that same process across the country.

Mr. Colin Fraser: Thank you.

Professor Pothier, I very much appreciated your presentation and the brief that you submitted. We talked about proposed paragraphs 241.2(2)(b) and (d). You mentioned that of course the court in Carter did not pronounce on those terms, it's therefore up to Parliament to make decisions on that, and there's nothing disallowing it in Carter.

I'm wondering about the 15-day waiting period. You'd agree with me that there was nothing in Carter talking about any waiting period, so this would be the sort of safeguard framework that would be up to Parliament to decide?

Ms. Dianne Pothier: Yes.

Mr. Colin Fraser: With regard to conscience rights, we've heard in some testimony that conscience rights should actually be explicitly stated in this law. Of course, this is an amendment to the Criminal Code, and I'd like your views on whether you feel that would be appropriate to insert in the Criminal Code itself. It's in the preamble now.

What are your thoughts on that?

Ms. Dianne Pothier: I think suggestions have been made about saying, well, nobody shall be coerced to perform medically assisted dying or participate in it. I think you could put that in the criminal law, but my sense is that this is not the real concern. The real concern isn't coercion in the sense of a gun to your head. The real concern is professional repercussions if you don't participate.

If that's the real concern, I think there are limits as to how far the feds can go. It's not a Criminal Code provision, I don't think, but in federal jurisdiction you have military hospitals in terms of professional consequences. That's not a very big part of the picture. If you're talking about essentially discrimination against people for exercising their conscience rights, the Canadian Human Rights Act has a very limited application, generally and specifically, in a way that could implicate people conscientiously objecting to medical assistance in dying. I think there are some things that could be done. Mostly it would be difficult for the feds to go very far with this.

I mean, the ministers have been saying that nothing in this act requires anybody to do anything. That's true. The question is whether you have more robust statements of that. I think you may be able to go some distance, but if you're looking for the strongest protections, it's provincial jurisdiction.

● (1915)

Mr. Colin Fraser: Thank you.

With regard prior judicial review, this has come up from some witnesses and has been mentioned in the context of Carter. It was stated that in the interim there should be judicial oversight. Would you agree that this was in the context of the court's expecting it to come before Parliament, to put in place a regulatory framework that would put safeguards in place?

Ms. Dianne Pothier: The judicial role at the moment is an interim solution from the court. They are expecting Parliament to come up with a system of safeguards. They said that they thought the judges were part of the rule of law, part of the safeguard system. I think they're leaving it open to Parliament to include judicial authorization as a continued one, but they're also leaving it open to Parliament to find other means of creating a system of safeguards.

Mr. Colin Fraser: Thank you.

I'd like to go to Ms. Borg.

The Chair: Please be brief.

Mr. Colin Fraser: Ms. Borg, you made a statement on 241.2(7), which is the reasonable knowledge, care, and skill clause. Had you submitted in your brief a recommendation of what could replace that, or are you saying to remove it?

Ms. Elaine Borg: Our recommendation is to remove it. The processes that govern this area, whether in the civil courts or regulatory bodies through their own discipline, are already seized of that.

The Chair: Thank you.

Mr. Rankin.

Mr. Murray Rankin: I would like to echo what Mr. Fraser said in thanking all the witnesses, particularly acknowledging the nurses and all the great work you do. It's wonderful to have you here.

I'm going to start with the nurse practitioners. It came as a surprise to a lot of us when the testimony of the deputy minister of justice a couple of days ago confirmed that two nurse practitioners and no physician would be able to provide medical assistance in dying. That's contrary to the recommendations of the special joint committee. Are nurse practitioners content to have this jurisdiction, this power to decide on your own, without any physician's involvement?

Ms. Maureen Klenk: The short answer is yes.

Mr. Murray Rankin: Good. Thank you. I wanted to clarify that.

I also wanted to give you a chance, Ms. Klenk, because it seems like forever ago when we heard your testimony. You gave us two compelling examples. I'd like to take you back to them, because I confess I wrote them down very quickly. A 16-year-old with a brain tumour was compared with a 36-year-old, and then you referred to a 60-year-old ALS patient in the context of natural death. Could you elaborate on those, please?

Ms. Maureen Klenk: My colleagues and I believe that the 16-year-old with the brain tumour would suffer just as much as a 36-year-old, a 56-year-old, or a 70-year-old. Their prognosis is exactly the same once it gets to that irremediable point. Even though we're saying in this bill that nobody under the age of 18 can sign to go forward, we accept as a matter of law, as a society, that a 16-year-old could sign a surgical consent for their own child. On the one hand, we're letting people go to war, so to speak, but then on the other hand, we're saying, no, you can't. I have accepted 16-year-olds signing consents for immunizations. That's legal. That's the one case.

The other case is the natural death. If you are diagnosed with a condition such as a brain tumour, ALS, lung cancer, or any of these horrible diseases, your death is no longer natural. In society, we refer to a natural death as one where the body is played out—you're 110 years of age and your kidneys are slowly packing it in and not functioning anymore. Those are the kinds of things that are thought of as a natural death.

A natural death for somebody with a grievous diagnosis wouldn't happen. As a practitioner, if such a person died, I would not be able to say on their medical release certificate that they died a natural death. I would have to say that they died of complications derived from ALS, or that they died of respiratory failure, or whatever. That's not a diagnosis.

● (1920)

Mr. Murray Rankin: Thank you. I want to thank all three of the nurse groups for giving us very specific language. It's immensely helpful. That's what we're here to do and I really appreciate that.

I want to go to Ms. Pullen for the CNA.

In your brief you recommend that we should simply delete from the current bill the entire clause that defines "grievous and irremediable medical condition", as I understand it. I think the language you've suggested—and I'm not putting words in your mouth—looks identical or virtually identical to what the Supreme Court of Canada said. Is that your intention? I'd like to clarify what you meant by that.

Dr. Carolyn Pullen: Our recommendation is that clause 2 can be completely deleted if revisions are made in the previous clause to allow for an expanded definition of "grievous and irremediable", and we have provided that language specifically. And yes, it is in accordance with the initial description.

Mr. Murray Rankin: It seems that the joint committee essentially tracked the language of the Supreme Court judgment.

Dr. Carolyn Pullen: Yes, and we were satisfied with the original interpretation.

Mr. Murray Rankin: Ms. Borg, again, thank you for the specific language. You make many points that we don't have time, sadly, to explore, but I wondered if you could talk a little more about the *mens rea* requirement and your concern when it tracks the provincial standards—the word "rule" that you've used being very vague. Tell us a little more about your concern in that regard.

Mrs. Elaine Borg: Just as an example, I've tried to bring the following to light as I've discussed with nurses and others. Would it be a rule, for example in Alberta Health Services, which is probably the largest regional health authority in the country, that people receiving medical assistance in dying have a particular drug regime?

As a practitioner working in High Level Alberta, a small town, it doesn't happen very often. The supply chain fails, and this is what I have in the formulary. I don't have what that AHS policy says. Is it a rule, such that if I went ahead, I would find myself in jail or explaining myself to a criminal court when my priority had simply been my patient and they had met the eligibility criteria, but there's been a rule?

It is in situations like that where I think there are unintended consequences. The larger issue really is about civil liability. We don't have examples in the Criminal Code when they talk about criminal negligence and so on. It appears rarely in the code and they really want some kind of marked departure, some kind of taking yourself out of what the civil standard is, which comes to mind as I read subsection (7), which is also almost in the nature of "You should have known better and you shouldn't have done that", rather than that you intended or there was wilful blindness, recklessness.

This is what we are concerned about when we think about what the evil is that is being addressed here. We already know that practitioners are balanced personally. They each have their own personal professional licence to practise. I've worked with CNPS for 16 years. I can tell you that practitioners are more afraid of going through professional disciplines than civil lawsuits. They understand it as a permission to practise and something that can be withdrawn from them if they do not practise according to practice standards and the code of ethics, which change. Therefore they have to stay on top of the changes in their own field, in their own discipline.

When we look at this and say we don't really like what's written there because of the lack of *mens rea*, is it needed at all? Well, we do know—I know this and I do this day in and day out—that nurses are sued for negligence and then the defence comes, so the courts are seized with it. When it comes to regulatory matters, there are statutes across the country that govern colleges of doctors, nurses, pharmacists, psychotherapists, and so on. They all regulate their own members by giving them practice direction, but then they also hear complaints from the public. As we know, there is no statute of limitations on when those complaints can come.

These consequences that normally flow from civil or administrative or regulatory breaches already exist, and there is no barrier to somebody making a complaint in that way or bringing an action in that way if they believe that a practitioner has violated their professional standards.

● (1925)

The Chair: Ms. Khalid.

Ms. Iqra Khalid (Mississauga—Erin Mills, Lib.): Thank you very much for your patience, first of all while we dealt with our issues here in the House, and for presenting such eloquent testimony. Your briefs are very helpful.

My first question is for Ms. Klenk, Ms. Borg, and to Ms. Pullen as well.

With respect to the administration of physician-assisted dying, we know the bill kind of goes toward two streams. One is where the health practitioner is the person who is administering the drug to end life. Then the second stream is where a person is able to get a prescription for the drug and take it home to self-administer. I'd like to know your viewpoint on that. Are you comfortable with persons taking it home to self-administer? Secondly, in what cases would somebody want to take it home to self-administer it?

Ms. Maureen Klenk: The answer to the first question is, yes, I would be comfortable. We all know that there are a lot of dangerous drugs in our communities. There are always risks, no matter what situation you're in. I do believe that, if someone had come to me to ask for assistance and the appropriate safeguards were in place, they would be safeguarding their medication or their family would be safeguarding it. So I can answer that question.

Do any of my colleagues want to weigh in on that?

Dr. Carolyn Pullen: I would only endorse that in the case of oral medication self-administered. The nursing association is supportive of that. I've heard it stated by others that, if any of us looked in our medicine cabinet today, we would find equally toxic cocktails that could be select as an alternative to what might be prescribed. So, while it's a calculated risk, it's one we are comfortable with.

Ms. Iqra Khalid: Do you think that there would be a problem with safely administering the drug at home?

Ms. Maureen Klenk: I think you would certainly do your best to educate and have family agreement or whatever comes into play. But having said that, we allow people to provide palliative care for family members at home and apply very potent Fentanyl patches, and we teach how to discard those Fentanyl patches appropriately. You hope that this gets done.

There is a trust relationship here for sure, and I think in general it works. The trusting relationship works. Will there be some outliers? Maybe, likely, but we'll do our best to make sure there aren't.

Ms. Iqra Khalid: The next question is to all the panellists. We've heard testimony on a number of occasions that the age restriction is 18 years of age and older for eligibility. If such an age requirement was removed, what safeguards would you propose to protect the vulnerable, the ones who may then be persuaded or coerced into doing something that they might not want to do themselves?

● (1930)

Dr. Carolyn Pullen: I will comment first on that. From the nursing association's standpoint, we are comfortable with Bill C-14 as it is currently drafted, with the recommendation that the trifecta of age, mental illness, and capacity assessment, or advance directive, be studied in an expedient manner and in a thorough manner in the coming days. As the legislation stands right now, we are satisfied with that content and the safeguards it includes.

Mrs. Elaine Borg: I will just speak to my past professional life as a nurse. I started working at the Hospital for Sick Children, and I can assure you that children die. At that time we had very little access to palliative care, and years after I left, I saw both to my delight and sinking heart that they finally discovered that children experience pain. We have a long way to go in understanding what we're going to do next with, for example, mature minors.

I think that the government intends to study this issue. One suggestion that we've kicked around in my office is that prior judicial authorization doesn't seem to be necessary if we look at the whole scope of what doctors, nurses, and nurse practitioners do with their patients. It would cause delay. It would be expensive. Who bears the expense?

If I'm settling a civil case for money damages and I'm dealing with a minor or a person with a disability, I need judicial authorization to enter into that settlement. Cannot some of these populations access medical assistance in dying if their eligibility criteria are met, perhaps with the caveat of judicial authorization beforehand because of the special and sensitive nature of these populations?

The Chair: I'll give Ms. Pothier a chance to answer and then we'll come back to you.

Ms. Dianne Pothier: I think at first blush it seems pretty obvious that it's age discrimination to say that those over 18 are in, and those under 18 are out.

But the real point and question—which is why it should give us all pause and why additional study is a good idea—is are the young especially vulnerable? It makes trying to figure out what the right balance is more complicated because the young are more vulnerable. That's the issue you have to wrestle with, so I think caution is in order.

Prof. Trudo Lemmens: I would agree with that.

The best protection is indeed strict criteria, so I think the biggest concern that people would have with open criteria and situations where you could have a 16 or 17-year-old suffering from depression, which is not uncommon.... Having an 18-year-old myself, I know what the challenges are of dealing with an adolescent. So I think strict criteria that avoid our having the kinds of situation where families are confronted with an individual choice they have no say about, where they are worried about individual assessments by physicians, prior review with an additional vulnerability assessment, I think is, in the context of vulnerability lessons, not an unnecessary thing to propose....

If you look at the most liberal systems like those in Belgium and the Netherlands, Belgium introduced access for mature minors, but does require familial consent. In the parliamentary debates, people felt too uncomfortable not to have the family involved in the decision-making process. I would say that it's a difficult area to deal with. Obviously, there is something arbitrary about the cut-off age of 18, but at the same time sometimes we set a certain line and other cases could be dealt with through additional prior review from the vulnerability assessment judicial review. But I would say that familial involvement and narrow criteria already provide, in my view, some of the strongest safeguards and additional vulnerability assessment.

The Chair: Finally, Ms. Klenk, and that will be the last question.

● (1935)

Ms. Maureen Klenk: I think we have to remember that it's the whole package, to put it into context. By removing that, it doesn't mean that you throw everything else out. There are other criteria that a person does still need to go through, and that I, as a practitioner, need to think about. I'm also going to be in a therapeutic relationship with this person and will have thought about coercion and about all those other items that you brought up. That's part of the safeguard and part of being able to counsel and enter into it.

However, whether you're 18 or not, I think you have to ask yourself: does the person have a grievous and irremediable medical condition, and are they suffering?

At the end of the day, I would promote patient-directed care, so I'm going to take it up a little bit more than patient-centred care and move into the patient-directed care. If we focus on that, then can someone who is a mature minor direct their own care?

The Chair: I want to thank the members of the panel for their really excellent briefs. We will read them again afterwards, but there were really compelling presentations, so thank you so much.

We'll take a short pause and get the next panel up here.

● (1935)

(Pause)

● (1940)

The Chair: We're back in session. I'd like to welcome our next panel of witnesses, who have had to wait an awfully long time. On behalf of the committee, I want to express our very deep appreciation for your patience with us tonight as a result of the votes.

I'd like to introduce the members of the next panel. From the Evangelical Fellowship of Canada, we welcome Julia Beazley, the director of public policy, and Bruce Clemenger, the president. From the Canadian Council of Criminal Defence Lawyers, we welcome Greg DelBigio and Richard Fowler. Presenting as individual, we have Gary Bauslaugh, who is a freelance writer. Welcome.

We're going to start with the Evangelical Fellowship.

Mr. Bruce Clemenger (President, Evangelical Fellowship of Canada): We appreciate the opportunity to appear before you this evening.

The Evangelical Fellowship of Canada is a national association of evangelical Christians. We were intervenors in the Rodriguez and Carter cases and have appeared numerous times before parliamentary committees on related issues.

Our affiliates include over 40 denominations comprising 7,000 congregations. Pastors and church members regularly care for people in crisis and those who are nearing death. Some of our denominations have extended care facilities and hospices.

The issue before us is how we as a society respond to the suffering of others. We believe the appropriate response to suffering is care, comfort, and compassion, not the hastening of death. Our belief in and commitment to the sanctity of human life and our calling to care for vulnerable persons animate the care we provide.

It is on this basis that we oppose the decriminalization of assisted suicide and euthanasia, but as the government is proceeding with legislation, we are calling for protection of conscience and religious freedom, for the strictest possible safeguards in order to minimize harm and risk to vulnerable persons, to ensure that occurrences are rare, and to protect our society's commitment to the respect for life.

On the matter of freedom of conscience and religion, the minister, when she appeared on Monday, said that this legislation does not compel medical professionals to participate in MAID. While that is technically correct, the minister also said that MAID is now considered “medically necessary” treatment. This places conscientious-objecting persons and institutions at risk of coercion.

Actually, in looking at it today, someone pointed out to me that proposed subsection 227(4) creates an exemption to section 14, which appears to, at least, delete the caveat of “no person is entitled to”. That seems to create an entitlement “for”.

Our concern is that creating a right establishes a corresponding obligation. If you accept the premise that medical aid in dying is a right, you have an obligation to protect, we submit, the freedoms and rights of doctors and other medical professionals.

The College of Physicians and Surgeons of Ontario, as you've heard, has already decided that all doctors must make effective referrals regardless of conscientious objection. What will this government do to protect medical professionals from being coerced to participate in the killing of another? Even in times of war, conscientious objectors were exempted. Medical practitioners must have the right to refuse to participate in physician-hastened death, either directly or indirectly, for reasons of conscience or deeply held beliefs, including the right not to make a referral.

Also, there has been no commitment made to exempt objecting institutions, thus protecting their staff and the communities that provide care, which we feel is equally important. We recommend that protections be included by express statements in the preamble of the bill. We also strongly recommend that conscience protection be included in the legislation as a stand-alone provision in Bill C-14, or as an amendment to the Canada Health Act, or by creating a Criminal Code offence that prohibits coercion of patients, medical care providers, and institutions in relation to medically assisted dying.

Did you know that the Bank Act forbids a bank from coercing someone to obtain a product or service as a condition of receiving another service, or that it is an offence to coerce someone either to belong or to refuse to belong to an artistic group? We are talking about hastening the death of another in this context. How much more important is it to protect the conscience of medical professionals and institutions?

● (1945)

Ms. Julia Beazley (Director, Public Policy, Evangelical Fellowship of Canada): We are very concerned about the impact going down this road will have on suicide prevention efforts, on attitudes toward suicide, and on rates of suicide generally. In the long term, we believe this will impact the way Canadians understand suffering and the way they respond to it. We appreciate the statement in the preamble recognizing the lasting harm of suicide but feel the legislation needs to contain a stronger statement, acknowledging that suicide is a tragedy that hurts families and communities. We also ask that it be clearly stated in the preamble that the prevention of suicide remains a crucial public policy objective.

We would like to caution the committee against defining hastened death as health care. While this is not done explicitly in the bill, it is implied in the clauses in the preamble relating to the Canada Health Act and to the importance of a consistent national approach to health care. In nearly all public statements from the ministers it is clearly being framed as a form of health care or a medically essential service, as evidenced by the name “medical assistance in dying”.

First, we object to the notion that to deliberately hasten a person's death can be considered health care. Second, what the court allowed for and what the bill does is to create exemptions to Criminal Code prohibitions against culpable homicide and assisted suicide, which is solely federal jurisdiction and needs to remain there. To define this as health care is to relinquish that jurisdiction, and we urge caution on that point.

Further, if hastened death is defined as health care and accepted as such, it will become very difficult to deny access to anybody on any grounds. Such framing of the legislation sets it up for charter challenge.

We were relieved that Bill C-14 does not allow access to hastened death for individuals with mental illness or whose suffering is primarily psychological, but we note with concern that the preamble suggests that it is not so much a firm "no" as it is a "not yet". We believe the risks to vulnerable Canadians are far too high to allow this. It should be an unequivocal "no". To this end, in proposed paragraph 241.2(2)(c), we recommend that the words "or psychological" be deleted, so that the provision describes a condition that causes "enduring physical suffering that is intolerable" to the individual.

On the subject of reasonable foreseeability, we were advised by a lawyer that this concept comes from civil and criminal negligence laws. In the context of hastened death, a vague legal concept is not an appropriate criterion. Since under Bill C-14 it is doctors and nurse practitioners who will be the gatekeepers of eligibility, the criterion must be one that is medically understood and assessed. We suggest that "reasonably foreseeable" be replaced with either a specific time frame, such as six months, as in the state of Oregon, or "at the end of life", as in Quebec. While there is still imprecision and guesswork in either of these concepts, they at least reflect the kind of assessment and judgment that medical professionals are accustomed to making, and therefore are much more appropriate.

We are very concerned that patients will be vulnerable to choosing hastened death if quality palliative care is not available to them as an option, so we affirm wholeheartedly the many calls you have heard for the importance of improved access. As Dr. Branigan said yesterday, we must make the right of access to palliative care as robust as the right of access to assisted death.

We recommend that proposed subsection 241.2(3) be amended to include a requirement that the medical or nurse practitioner ensure that the patient has had a palliative care or other professional consultation to ensure they have been fully informed about the range of available treatments and supports that could ease their suffering. We also affirm the recommendation of the Canadian Society of Palliative Care Physicians that the preamble include a commitment to the establishment of a national palliative care secretariat.

As an additional safeguard, Bill C-14 should require an independent prior review of all cases of hastened death. One way to do this, as you have heard, would be to extend the current requirement for judicial oversight as established by the court when the deadline was extended.

You have heard testimony about the efficiency of the consent and capacity boards in certain provinces. The key for us is this prior review of each case by more than just the two assessing physicians or nurse practitioners. Whether it is by extension of judicial oversight or some other mechanism, we strongly recommend that a straightforward, efficient system can and should be developed for independent prior review of all cases.

● (1950)

Mr. Bruce Clemenger: Last, on the issue of protection and promotion of life, the Supreme Court recognized the sanctity of human life as a fundamental value of Canadian society in both the Rodriguez and Carter decisions. This underlying principle is what animates our society's commitment to universal medical care and to our social welfare system, etc. The Carter decision was a balancing of the autonomy and dignity of a person with a grievous and irremediable condition seeking death, and society's commitment to the sanctity of human life and care for vulnerable persons. Carter was not a "floor"; it was a delicate balance. In Rodriguez, the court concluded that allowing assisted suicide would undermine society's commitment to respecting life and that risks to vulnerable persons were too great. In Carter, the court concluded that limited exceptions to the blanket prohibition, while inherently risky for vulnerable persons, could be balanced with the respect for life and not compromise it. To move beyond Carter exceptions would be to undermine the respect for life and increase the risk of wrongful death.

Given the centrality of the sanctity of human life in the court's deliberations, and to Canadian society, we feel a stronger statement needs to be made to reassert this objective. We suggest that the following wording from the Carter decision be added to the first clause of the preamble ahead of the clause dealing with human autonomy: "Whereas the respect for life is one of our most fundamental societal values, and section 7 of the Charter is rooted in a profound respect for the value of human life". That's a quote from the Carter decision.

The Carter balance is premised on the ability to establish stringent safeguards for something that the court recognizes is inherently risky. The basic difference between the Rodriguez and Carter decisions was whether the safeguards could be put in place to eliminate the risk of wrongful death. The court heard conflicting evidence about this. Parliament is better suited to assess risk, to establish the acceptable threshold, and determine whether the safeguards you establish will be effective.

Thank you.

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

We're going to move to the Canadian Council of Criminal Defence Lawyers. Gentlemen, the floor is yours.

Mr. Greg DelBigio (Canadian Council of Criminal Defence Lawyers): Thank you very much.

The CCCDL was formed in 1992. It has executive representation coast to coast to coast. We are very pleased to have been invited to be here to assist this committee in respect of this important legislative proposal.

Mr. Fowler and I will both be presenting. We are both practising lawyers in Vancouver. I'll make preliminary remarks, and Mr. Fowler will follow. We'll address legal and constitutional issues rather than issues that relate to beliefs and policy.

The Supreme Court of Canada decision in Carter began what is sometimes described in the law as a dialogue between the courts and Parliament. Now, to be constitutional, Bill C-14 must conform to what Carter addressed. Carter defined minimum requirements. Future litigation, I would urge, is to be avoided. It's expensive, it's time-consuming, and it is unfair to those who might avail themselves of this legislation.

The Supreme Court of Canada ruled, and that presents Parliament with options. Option number one is to do nothing. Of course, then, if nothing is done, the legislation will fall, and then there's a legislative void. Option number two is to enact law in accordance with Carter. Option number three is to enact a law that goes beyond what Carter says and what Carter addressed, for example, mature minors. It's my position that it is an example of an issue that is beyond Carter. It doesn't mean that it cannot be included, constitutionally or lawfully included, but it's not necessary to include.

The language that you choose can suffer from legal defects in one of two ways. One is over-breadth, as was addressed in Carter, and that is if the law captures more than is necessary to achieve constitutional objectives. A second way in which language can become legally defective or constitutionally defective is if it is vague. I suggest that, as you're contemplating language to address any of these provisions, you ask yourselves if there a common meaning. Is there a usual meaning? We heard discussion earlier that there may be an agreed-upon meaning within certain medical spheres. Ultimately, though, the meaning of a law is going to be up to a court, and it has to be sufficiently precise that it lends itself to interpretation by the courts.

The issue in Carter was whether it a crime to assist another in ending his or her life. The language of Carter, the constitutional language that resulted in the court striking the legislation, was based upon autonomy, dignity, and the need to protect the vulnerable. The conclusion was that “the prohibition on physician-assisted dying is void insofar as it deprives a competent adult of such assistance where” they give clear consent and have “a grievous and irremediable medical condition”. It is our position that the inclusion of the language of “natural death has become reasonably foreseeable” was not contemplated by Carter. It is a restriction, and, again, Carter addressed restrictions. The reason that the legislation fell is because the restrictions were inconsistent with the autonomy. I suggest to you that it is not necessary to include that limiting language.

More importantly, there are two further concerns. The inclusion of that language might give rise to challenges based upon issues of vagueness. What does it mean? Is there an agreed-upon meaning? Can that meaning be properly understood? Because it is a limitation, it might well invite further litigation, and that, I suggest, is to be avoided.

● (1955)

Mr. Richard Fowler (Canadian Council of Criminal Defence Lawyers): Thank you for this opportunity.

As this committee appreciates, from hearing the many presentations, medical assistance in dying is and will likely remain a subject that deeply divides people, based on ethical, moral, and religious beliefs. It is because of this that those medical and nurse practitioners who choose to provide medical assistance in dying—and I emphasize the word “choose”, because it's their choice—will, not surprisingly, find their actions carefully scrutinized to ensure compliance with the law. I wish to briefly explain how the law, as presently drafted, fails to protect medical and nurse practitioners who, acting in good faith, make mistakes in providing medical assistance in dying. In other words, what could happen to a doctor or nurse who fails to appropriately apply all the safeguards? Bill C-14 essentially sets out an exemption for what would otherwise be a culpable homicide—and that has to be emphasized—more specifically, first degree murder, an illegal act intended to cause death, which did cause death, and was planned and deliberate. Proposed subsection 227(1) of the act provides that a medical or nurse practitioner does not commit a culpable homicide if they provide medical assistance in dying in accordance with proposed section 241.2 of the Criminal Code.

In other words, failing to comply with all of the safeguards and other provisions in proposed section 241.2 would, potentially, leave a doctor or nurse liable to being prosecuted for a culpable homicide. The only logical culpable homicide would be first degree murder, which as you all know, has a minimum life sentence and minimum parole ineligibility of 25 years. So, that's what they have hanging over their heads, as it stands at the moment, with one exception, which I'll come to in a moment, if they get it wrong in good faith.

You have all seen and been referred to the eligibility requirements and safeguards. They are rightly stringent, but they also include matters over which different people, different doctors and nurses, might disagree, particularly, for example, on questions of whether death is reasonably foreseeable. You heard, I think, earlier today a doctor talk about the fact that foreseeability of a death is something that doctors can disagree about. It is because the safeguards are so stringent that it is easy to see how a doctor or nurse might make an honest error.

For example, a request for medical assistance in dying must be signed and dated before two independent witnesses. Proposed subsection 241.2(5) defines who is or is not independent. For example, a person is not independent if they are a beneficiary under the will or a recipient in any other way of financial or other material benefit resulting from the person's death. It is the doctor's or nurse practitioner's responsibility to make the evaluation of independence. What steps must they take? What degree of inquiry must they make to fulfill this requirement? Do they need to go looking for the will? Do they need to speak to the person who is seeking to die? What level of inquiry is necessary to determine independence? If it later turns out that one or both of the witnesses were not independent, the only defence available to the doctor or nurse would be that their mistake was reasonable. Proposed subsection 227(3) of the act provides a defence if a person makes a reasonable mistake in respect of any fact that is an element of the exemption. In other words "reasonable" means by some objective standard, standards that we don't yet know. You've heard that from other people, because this legislation hasn't come into force. A doctor or nurse who had made a mistake, who acted unreasonably but honestly, in that they believed what they were doing was correct, would not be able to avail themselves of that defence in proposed subsection 227(3). It's what we call in law the difference between a reasonable mistake and an honest mistake. One is objective and one is subjective. A person who makes an honest mistake can still be liable to be prosecuted for murder. They act in good faith but they make an honest mistake.

● (2000)

It is our submission that limiting the defence in proposed subsection 227(3) to only reasonable mistakes rather than honest mistakes—a distinction that is very meaningful in the criminal law—is wrong and potentially unconstitutional, particularly with regard to any prosecution for murder, because, as I'm sure many people here will appreciate, you can only be convicted of murder if you have the appropriate subjective state of mind. It's not measured by any objective standard. However, this exemption is measured entirely by objective standards.

It is our submission that proposed subsection 227(3) should be amended to read:

> For greater certainty, the exemption set out in subsection (1) or (2) applies even if the person invoking it has an honest but mistaken belief about any fact that is an element of the exemption.

Thank you.

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

We'll now move on to Mr. Bauslaugh.

Dr. Gary Bauslaugh (Free Lance Writer, As an Individual): Thank you, Mr. Chair and members, for having me speak to you today.

I'm going to speak about an issue that could potentially affect the lives of thousands of Canadians. I'll be speaking specifically about the reasonably foreseeable clause and taking the position that was mentioned by colleagues here, that it's not necessary and is problematic.

My hope and the hope of many other Canadians is that the new legislation will prevent situations like that of Sue Rodriguez, who in 1993 was refused permission to get assistance in dying even though she was facing a situation she could not bear to live with, the prospect of long-term and almost total paralysis. Once paralysed she would be unable to do anything to end her own life, which of course would have been perfectly legal. Suicide is legal in Canada, of course, but she was legally prohibited from getting assistance with this legal act.

She did eventually get help from an unknown sympathetic doctor who risked his or her own freedom to save Rodriguez from the grim fate the law said she just had to endure. This is not good enough for a civilized country. Many of us thought that Bill C-14 would help people like Sue Rodriguez and others who find themselves, to use the Supreme Court terminology, with a "grievous and irremediable medical condition", or to put it in other words, we hoped that the new legislation would be the solution for people in a condition of unrelenting, inescapable misery.

Unfortunately, Bill C-14 would not have helped Sue Rodriguez. This is because of proposed paragraph 242.2(2)(d), which specifies that in order to be eligible for medical assistance in dying, natural death must have become "reasonably foreseeable". Presumably whatever this means, it must mean something to do with death being imminent. Death was not imminent for Sue Rodriguez. She might have gone on living for years trapped in her paralyzed state.

A similar conclusion about the bill was arrived at by the family of Kay Carter, who was a central figure in the B.C. Supreme Court case that led to the unanimous ruling of the Supreme Court of Canada to strike down our assisted suicide law. Kay Carter was not about to die naturally when she went to Switzerland to get aid in dying, yet her case was at the heart of the decision of the courts. Surely now denying assistance in dying to people like Kay Carter would be a violation of the spirit of the decision of the courts.

Of course, there would be other consequences of the reasonably foreseeable clause. Some people would be forced to go on living in a state of grievous and irremediable suffering. Those with money would simply go to Switzerland. Those without money would simply be out of luck. Some of the unlucky ones would choose very grizzly means of dying, such as shooting themselves, jumping off a high place, or starving themselves. Some attempts at suicide, such as taking an overdose of some drug, may fail, possibly leaving people in worse shape than before.

We can anticipate new charter challenges on this reasonably foreseeable clause if the bill stays as written. But if Rodriguez and Carter would not have been helped by Bill C-14, I began to wonder who would be.

My recent book, *The Right to Die*, catalogues all the major assisted death cases in Canada since 1941. There were 35 for which a reasonable assessment could be made. Most of the individuals involved in those cases, like Sue Rodriguez and Kay Carter, would not have been helped by Bill C-14. Of the 35 cases, 27 or 77% would not have been helped by Bill C-14. Of those 27, by far the largest number, 19, would likely be excluded by the reasonably foreseeable clause. This is shown in the table that I handed out earlier, where cases are all listed with an assessment of how each might or might not have been affected by the new law.

Thus we have a bill that does not help most of the people who need such help. The main reason is the reasonably foreseeable clause, as judged by my analysis of real Canadian cases. It does not help those who actually need help most. Why do I say that? If a person is about to die anyway, helping them along can indeed be an act of kindness, but with death imminent anyway, their relief from suffering is limited to the short period of time left. It is surely an even greater kindness to provide wished-for assistance in dying to those with grievous and irremediable suffering that might go on for years.

● (2005)

There are other issues one could take up with Bill C-14, for example, the matters of mature minors and mental illness, which have been talked about a lot today. However, these are rare. No examples came up in my survey of Canadian cases. Moreover, the issue of advance directives is an important one. It came up four times out of 35 cases in my analysis. It is a complex issue, and I don't argue with the bill's treading cautiously here.

The reasonably foreseeable clause, however, is a very big problem. It seriously limits the good we can do with this legislation. The bill is about granting mercy to the suffering. Is there any good reason why such mercy should be a rationed commodity? Why should our compassion be limited to those are on the verge of dying? All of those—not just those who are about to die but all of those—in a condition of grievous and irremediable suffering, in a state of misery that cannot be fixed, deserve to have their wishes respected. All of them should have access to assistance in dying.

Thank you.

● (2010)

The Chair: Thank you very much.

Now we're going to move to questions. First up is Mr. Warawa.

Mr. Mark Warawa (Langley—Aldergrove, CPC): Thank you to the witnesses for taking your valuable time to be with us today.

As I'm sure you're aware, we just had our first vote on Bill C-14. From your comments, I would assume that everybody would be voting against it. Maybe, maybe not, but I don't see anybody who has expressed total satisfaction.

I'm going to assume that if there is support, it's conditional upon amendments. It took Quebec six years and three premiers to pass their legislation, but we're going to do this within just weeks. I'm concerned about the rush-rush, and I wish we had more time to do this properly.

I believe it was Mr. Clemenger who made a comment about the importance of conscience protection. Bill C-14, as we've heard from the minister, does not compel or require a physician, a medical practitioner, a nurse practitioner, or a pharmacist, to participate in assisted suicide against their will. They're not compelled to do so. Yet there are hints that it would be the college of physicians and surgeons within each province that would determine whether a person were required to have an effective referral or not, which some physicians would find objectionable.

I met with an internist, who is now retired but was a doctor who practised medicine in British Columbia, who gave me a long list of examples in which there had been error in the continual care of a patient—people who were misdiagnosed and not treated properly and who ended up dying because of the lack of proper care. I asked, “Is this human error?”, and he said no, it was not. It was negligence in each of the cases that he gave to me. He said, “I'm not here to talk about conscience or the morality of this, just the practical way of dealing with it.”

There are problems in the regime being proposed, but I want to focus on conscience protection. The Canadian Medical Association said that 70% of physicians in Canada do not want to participate or refer in assisted dying. The other 30%, or 23,000 physicians, would be adequate to provide access. Why do you believe there's a push to the effect that the 70% are not protected—not compelled or required, but not protected...? Why is it so important to have conscience protection included in Bill C-14, or should Bill C-14 be amended at a future date?

Mr. Bruce Clemenger: We believe it needs to be amended now, before it is passed, to make clear protection of conscience for both doctors and medical personnel, and also institutions that provide extended care on whose premises someone may request assisted death, should a law pass.

Again, as I said in my comments, the minister did clarify that nothing in the bill says the doctor will be obliged to. However, you look at the “whereas” statements, it's clear that they're creating a regime around Bill C-14 that will deem medically assisted death as medically necessary. Once you create that paradigm, then, in a sense, you're taking what I don't think Carter established: a right to access. It was an exemption from the application of the Criminal Code. If you begin interpreting and framing it as a right to access, then there's an obligation to provide.

The clear example would be the College of Physicians and Surgeons of Ontario, which already requires an effective referral under the current regime while the bill is being suspended for the next four months.

We think it needs to be placed. We think there needs to be a statement in the “whereas” section, clarifying that no one will be compelled to participate contrary to their conscience or beliefs. We think there could be—and you've heard this before—a parallel paragraph inserted in Bill C-14 along the lines of section 3.1 in the Civil Marriage Act to protect it. Also, there have been some proposals—and I know they've been submitted to this committee—that clarify and define Criminal Code provisions against coercion.

● (2015)

Mr. Mark Warawa: Regarding the importance of avoiding vague language, originally the Supreme Court used the wording of “assisted suicide” and “voluntary euthanasia”, but they also used the language of “physician-assisted death”. The special committee changed that definition to “medical aid in dying”. In both of those, that could apply to palliative care. You're using the term “hastened death” or “assisted suicide” to clearly reflect what we're talking about. Would you agree that it's important to avoid vague language?

Ms. Julia Beazley: I would. We've consistently used the language of “euthanasia” and “assisted suicide”, because that is what we're talking about, and we think it's important that people understand what we're talking about.

I started using the language of “physician-hastened death” in response to and out of great respect for testimony that was heard by the special joint committee from different palliative care organizations that spoke of the fact that they assist people in dying, but they never hasten someone's death deliberately.

The palliative care community requested that we use the right language. When we're talking about euthanasia and assisted suicide, we refer to “physician-hastened death”. They also said that it's so important to them that the two be kept separate, because hastening someone's death is not part of what they do in palliative care. We've been using that language to try to respect that, and we're concerned that the language used in the bill does not respect that distinction.

The Chair: Mr. Fraser.

Mr. Colin Fraser: Thank you, everybody, for your attendance and thoughtful presentations. They are very much appreciated.

The Carter decision that we're responding to with a legislative framework was rendered in February 2015, so I can't let Mr. Warawa's comment go unchecked. Obviously, we wish we had more time, but we are under a time constraint given by the Supreme Court of Canada. Obviously nothing was before Parliament between February 2015 and the election.

Mr. Bauslaugh, obviously you do not agree with the term “reasonably foreseeable” in the bill. Are you just saying that it should be eliminated entirely, or are you saying it should be replaced somehow with some other language?

Dr. Gary Bauslaugh: There's no reference to that in the Carter decision. It was added at the end of this bill, and I would take it out of the final clause.

Mr. Colin Fraser: Thank you.

To the Canadian Council for Defence Lawyers, again on “reasonably foreseeable” you talk about vagueness and that term being difficult to understand, especially in the criminal law context. If a time limit were placed in there, would that make things a little more certain, from your perspective with regard to vagueness?

Mr. Greg DelBigio: The time limit will eliminate vagueness, but it is a question about whether or not our time limit otherwise is problematic. If it were to be specified that it's one month or two years, certainly there would be no uncertainty about that time limit, but it is nonetheless limiting and perhaps contrary to the Carter decision.

Mr. Colin Fraser: With regard to the idea that rather than using the terminology “reasonable but mistaken belief”, it should be “honest but mistaken belief”, making it subjective rather than objective, can you give some examples elsewhere in the Criminal Code where the terminology “honest but mistaken belief” is used?

Mr. Richard Fowler: It arises a lot in common law and it has arisen over the years with consent in sexual offences. There's a case called Pappajohn, which permitted a defence to an allegation of sexual assault if a person had an honest but mistaken belief in consent. Legislation dealt with that and has significantly altered that framework.

The difference between sexual assault and murder is that murder has a *mens rea* requirement that is entirely subjective. It's one of the very few criminal offences that requires the highest level of *mens rea*, which is a subjective fault. In other words, you know what you're doing at the time is wrong.

With this legislation, as drafted, if somebody makes an honest mistake, they could still fall outside of the exemption. The exemption, we have to remember, as I said at the beginning of my remarks, is to what is otherwise in all other circumstances the crime of murder. That's the problem.

● (2020)

Mr. Colin Fraser: I would like to turn to the Evangelical Fellowship of Canada. I appreciated your submission and brief. With regard to judicial oversight, which you advocate as something you would support seeing in the bill, I am assuming that you are suggesting that should happen so that there would be some independent oversight ensuring that consent was valid.

Ms. Julia Beazley: There are a lot reasons that it's a good idea. The Supreme Court felt it was a good idea, so it put the system in place and it has been working fairly efficiently. As the defence lawyers were speaking, I was thinking that this would address many of their concerns, because then the final gatekeeper would not be the doctor or the nurse practitioner. They are not the ones making that final decision. It would be a judicial decision or one by some sort of oversight mechanism. As a result, there would be protection for patients, protection for people who are vulnerable, and also protection in that system for the medical practitioners themselves.

Mr. Colin Fraser: With regard to Carter, I appreciate the point. Obviously, that's in the context of it coming to Parliament in order to put the safeguards in place. My follow-up then would be that in a situation where end-of-life issues result in a decision to pull the plug, for example, that doesn't require any judicial oversight and that's dealing with consent. So, what's the difference?

Ms. Julia Beazley: There's a big difference because we're talking about a Criminal Code exemption to culpable homicide or assisted suicide. To withdraw treatment, as you heard earlier from the last panel, we're talking about situations where medicine has exhausted its ability to heal, to comfort, to do all of those things. What you refer to is just the withdrawal of a treatment with consent. We're talking about an intentional act to hasten death. I don't think you can really compare the two.

Mr. Colin Fraser: Even though it's dealing with a decision whether the consent was valid...of a judicial oversight?

Ms. Julia Beazley: Well, that's not the only point of a judicial oversight. One of the points would be consent, yes. There are a whole lot of other reasons why many people are suggesting that judicial oversight should continue, or some sort of prior review, whether it's judicial oversight or not.

Mr. Colin Fraser: Thank you for your help.

The Chair: Mr. Rankin.

Mr. Murray Rankin: Thank you to all the witnesses for coming and for your patience.

There's only a little bit of time, so I'm going to jump right in and ask Mr. DelBigio the following. You said in answer to a question from Mr. Fraser that it would be problematic to attempt to correct the “reasonably foreseeable” criterion by adding a time limitation. I think you said that it might be contrary to Carter.

Could you elaborate?

Mr. Greg DelBigio: The Carter decision was concerned with restrictions. A time limit is almost inevitably going to be a restriction. Whether it is a month, a year, or something in-between, it is going to be arbitrary. I say simply that it's not necessary by Carter and perhaps contrary to Carter.

There would almost certainly—and I will tone that slightly down —be a significant risk of litigation if a time limit of that sort were introduced.

Mr. Murray Rankin: I want to say to you, Mr. Fowler, that you are the first witness who has brought to our attention, very helpfully, that the honest mistake could still be something that would lead to a prosecution for murder. That is very sobering, indeed, when you think of the consequences of that. You've given us a proposed amendment to it.

I'm going to throw something slightly different at you. I know you're the defence lawyer, but the question we had from the civil lawyers who advise the CMPA, the Canadian Medical Protective Association, looking at the same clause that you talked about, was that they ought to extend it to civil and disciplinary proceedings for practitioners, because of, I presume, wrongful death claims, where *mens rea* wouldn't be the standard. It would be a lower standard, and in fact it would be worse for the doctors. If anything could be worse than a charge of murder, they could also find themselves with huge damage claims, because that's, I think, equally relevant there. Do you agree?

● (2025)

Mr. Richard Fowler: It's outside of my area of expertise. Usually, when somebody is charged with murder, some of these other matters tend to become less significant. However, clearly, I appreciate from the perspective of the medical insurance association that the extent and scope of any form of liability for making an error in judgment around what are essentially very complex safeguards is, I think, a very legitimate concern, yes.

Mr. Murray Rankin: I wanted to say thank you to Mr. Bauslaugh for your very sobering testimony today.

I've skimmed through your book. It's very new but very disturbing. When you came here today and said that Sue Rodriguez and Kay Carter would not be helped by this bill, that's a staggering conclusion to think that people could go all the way to the Supreme Court for this relief and that this bill is not going to make what they requested possible.

Dr. Gary Bauslaugh: We're here today because of Sue Rodriguez. She set the climate in Canada for this whole issue to be explored, as well as some other people who came after her. I think it would be a terrible outcome if the legislation that results from all these years of effort would have excluded her consideration. A time limit does not work for somebody like Sue Rodriguez, because she could have lived on for years. So six months or a year would not be suitable.

Mr. Murray Rankin: That's the point you made about how this “reasonably foreseeable” language would add no assistance, I think you said, in 77% of the cases you looked at back to 1941, for people who wished to avail themselves of that.

Tell us a bit about any other of the cases that you haven't had time in your testimony to tell us about.

Dr. Gary Bauslaugh: I can briefly talk about a case that I find very compelling. The cases are listed chronologically in the book.

In 1994, in Stoney Creek, a couple named Cecil and Jean Brush had been happily married for 58 years. He turned 81 in 1994 and was extremely sick with many ailments and had lost his eyesight by this time. He was suffering early dementia, and he had been severely depressed for some time. They had a terrible time coping with life. They had had a great life before that. They had been happy and vital people, but they had just reached a point where life had no value to them, and it was a burden to them.

She tried to have both of them commit suicide by taking pills, and it failed, and they woke up in the hospital. He was taken to a nursing home. She took him out supposedly for lunch one day from the nursing home and took him to their home, and put blankets on the floor, and they both lay down on the blankets. She stabbed him in the stomach several times and then stabbed herself in the stomach several times, thinking she had to die as well if he was dying. They were discovered by their daughter in a pool of blood in their home.

Cecil died, she survived, and was then charged with manslaughter. The judge, a compassionate judge, suspended her sentence because she was obviously guilty. I think the example shows the terrible lengths people go to if they don't have legally sanctioned ways of doing this. She wrote a very compelling letter that's in my book about the situation.

Mr. Murray Rankin: Mr. Clemenger, I'm not sure if I understood this, but when you talked about the conscience protection, have you looked at the legality, the constitutionality, of our putting that in federal laws? We've been struggling to address your concern. Many, including the leading practitioner in the province of Quebec, say it's clearly and utterly provincial jurisdiction, and even if we wanted to, we couldn't do it in federal law. Do you have an opinion on that point?

Mr. Bruce Clemenger: We've talked to a number of constitutional lawyers, and they believe it is possible.

Again, it would be coercion. I gave a couple of simple examples, but the idea would be that it would make it a criminal offence to coerce someone to undertake a certain action that is deeply contrary to their moral or religious beliefs.

It's a reaffirmation of the freedom of paragraph 2(a) of the charter.

● (2030)

Mr. Murray Rankin: Is there anything in the bill requiring a doctor to provide this service?

Mr. Bruce Clemenger: As I said, it's in the context of the bill, as the justice minister and the health minister have said about making it a medically essential service. We already have the example of the College of Physicians and Surgeons of Ontario, which is requiring—

Mr. Murray Rankin: I don't where in the bill it requires it to be an essential service.

Mr. Bruce Clemenger: She said it in—

Mr. Murray Rankin: We're talking about the law. Is there anything in the bill you can point to?

Mr. Bruce Clemenger: I was referring to the "whereas" and then the broader context of what the regime the government is planning to set up in the context of Bill C-14. That's what gives us a concern.

Also, we have a live example of the College of Physicians and Surgeons of Ontario, which is right now requiring effective referral, which is deeply contrary to the religious conscience and beliefs of many doctors. They need protection.

The Chair: Thank you very much for your comments.

Mr. Hussen.

Mr. Ahmed Hussen: I'd like to begin with Mr. Clemenger and Ms. Beazley.

You indicated in your submission that in proposed paragraph 241.2(2)(d) you would keep the focus on those who are dying and replace "reasonably foreseeable" with one of the following: "within reasonable medical judgment will produce death within six months, or at the end of life".

Why did you pick six months?

Ms. Julia Beazley: We didn't necessarily pick six months. That was just one of the time frames that was being discussed.

I think we need to remember that in the Carter decision some of the statements made included the words "vague", "grievous", "irremediable", and those kinds of things. The justices were talking about a specific fact situation and referred back to this concern that somebody would take their life prematurely if they would not have assistance available to them at a later time when their suffering became intolerable and they were unable to end their lives themselves.

This implies that the patient has reached a point where they're nearing the end, and they're no longer able to take their own life. This is a key element in the Carter decision. We're talking about people who are not physically capable of taking their own lives, which implies a state of irreversible decline in capability. It implies that death is reasonably foreseeable.

I am not a lawyer, so I am by no means a legal expert. However, to my understanding, what is in this bill complies very closely with the Carter decision.

Mr. Ahmed Hussen: Sure.

I'd also like to talk a bit about another thing in your submission. You wanted an extension of the judicial oversight process or an independent prior review process for all cases of medical assistance in dying. Could you elaborate on the independent prior review process you have in mind?

Ms. Julia Beazley: I've heard different ideas of what this could look like. Yesterday you heard from Mr. Bach about capacity and consent boards. This is a body that makes final approval on certain kinds of decisions, so it could be made up of lawyers, medical professionals, and so on.

I don't necessarily have an opinion about what exactly the makeup of that body should look like, or what precisely the mechanism should be, unless Bruce has some ideas on that. The key for us, as I said, is that there be some prior review of every case.

All of those safeguards I mentioned earlier are there to protect the patient, to protect the practitioner, and to protect vulnerable people in general.

Mr. Ahmed Hussen: Have you considered the issue around accessibility, costs, and the fact there would be a lot of delay—our courts are already backlogged—if you were to go down the judicial route. Is that something you've looked at?

Ms. Julia Beazley: You've heard testimony that for the capacity and consent boards, it's a quick turnaround. It can be a 24-hour period where a decision is reached and they get the approval to go ahead. It doesn't have to be something that creates a long delay. Again, I'm not a lawyer, but I imagine a system could be established that was fairly simple, straightforward, and streamlined.

I don't like the idea of it being prohibited to individuals based on cost by any means.

Maybe judicial oversight can be modified so that's not a consideration. I don't know the details, but it seems to me there is a way, if we work with the provinces and put our heads to it. We can figure out what is a simple streamlined process that will be efficient, that will not create unreasonable delays, and that will be a safeguard.

● (2035)

Mr. Ahmed Hussen: Thank you.

I'll turn to the Canadian Council of Criminal Defence Lawyers.

Mr. DelBigio, I don't know what your thoughts are with respect to mature minors. Are you comfortable with the law keeping it at 18 and over?

Mr. Greg DelBigio: I will make two remarks with respect to that. It is an example I gave of something being outside the scope of Carter, and so not mandated. I think it is best left to a committee like this to hear expert testimony from others.

I'll use this as an opportunity to say that my suggestion is that a five-year review is simply too long a time period, that it should be a shorter period of review, and that a review clause can specify certain topics that must be reviewed and considered. Perhaps a review clause would mandate that the issue of mature minors, for example, would necessarily, as a matter of law, be considered.

The Chair: I have one short wrap-up question if it's okay with the panel.

You are the first people who have raised the issue of changing “reasonable but mistaken belief” to “honest but mistaken belief”, so I have a question. I'd appreciate your perspective.

I'd like to ask a question, and I'll give you a concrete example. Dr. X has a friend, Mr. Y. Mr. Y comes to Dr. X after this law is adopted and tells Dr. X that the law says only doctors are allowed to perform medically assisted suicide, and his wife has requested medically assisted suicide. He says she is lying in their bed in their home, very sick, and suffering interminably. The wife is lying there, sedated, and Dr. X is told that there is no other requirement in the law other than the one that a doctor perform this act. Dr. X goes ahead and performs this act at the request of Mr. Y.

Dr. X never looked to see what the law said, and he made no effort to be reasonable and understand what the provisions of the law were, but he had an honest but mistaken belief, based on his relationship with Mr. Y, that this was perfectly okay. Based on what I understand, although I have to research what the common law actually says with respect to honest but mistaken belief, this doctor could have had an honest mistaken belief, based on what his friend told him, while doing no investigation whatsoever, and factually, she was out. He was grossly negligent, but he may have been honest. Do you believe that type of person should not be charged with murder or homicide?

Mr. Richard Fowler: No, not necessarily. The point is, we're dealing with this legislation and how this legislation deals with an exemption for what is otherwise first-degree murder. When one appreciates what the mental state is for first-degree murder and one appreciates the way the legislation is presently constructed, it is my view that somebody who has simply made an objective error could be convicted of murder. That's problematic.

The legislation is also internally inconsistent in this respect. There is the offence of “failing to comply” with the safeguards. It's hard to reconcile that offence carrying a maximum of five years, because failing to follow the safeguards would mean that you're also committing a culpable homicide. I don't actually understand what type of conduct that offence is actually gathering, because deliberately.... The offence that's in the statute is about people who knowingly fail to follow the safeguards, which is actually different from the example that I've given of somebody who made a mistake honestly but it was an unreasonable one by an objective standard.

Here, in the statute, you're saying, well, people who flaunt it deliberately and knowingly fail to follow these safeguards face the five-year maximum, but in reality they wouldn't, because they would also be committing a culpable homicide. I find that part of the legislation internally inconsistent.

● (2040)

The Chair: That, I understand. I think a prosecutor would have it open to him/her to charge in either direction. I agree with you that it is an open question. What I think you are actually proposing, then, is that for somebody who had an honest but mistaken belief, theoretically there might be a provision where we say that's a lesser sentence. If they're charged with something, they should not just be charged with first-degree homicide—

Mr. Richard Fowler: Yes, that's—

The Chair: —based on an unreasonable action where they were negligent or grossly negligent.

Mr. Richard Fowler: I mean, that's a possibility. Or there's a possibility of requiring that medical practitioners follow a standard of care, and if they don't, they then could be liable for criminal negligence causing death.

The Chair: I understand.

Mr. Richard Fowler: That would be entirely consistent, because it would be an objective standard.

By the way, criminal negligence causing death carries a maximum of life. It just does not have a minimum sentence of life, nor does it have a 25-year parole ineligibility period.

So there are other ways of dealing with it. You just have to avoid the absolute and necessary possibility, because of the way the exception is crafted, that somebody would have to be prosecuted for first-degree murder. That's the problem with how it's presently written.

The Chair: I understand. You think it's too severe.

Mr. Richard Fowler: Yes.

The Chair: I understand. Thank you very much.

Panel members, I want to thank you for your very clear testimony today. It is much appreciated.

We'll take a brief break and let the members of the next panel come up.

Again, thank you so much.

● (2040)

(Pause)

● (2045)

The Chair: Ladies and gentlemen, we are resuming.

Thank you very much to our witnesses for their incredible patience and for bearing with us given the votes tonight. We really appreciate it. We're ready to give you our full attention.

I would like to welcome Professor Jocelyn Downie from the faculties of law and medicine at Dalhousie University, who is appearing as an individual; from the Canadian Council of Imams, Mr. Sikander Hashmi; and from the Justice Centre for Constitutional Freedoms, Mr. Jay Cameron.

Welcome all of you. We very much are interested in hearing from you. We're going to start with Professor Downie.

Prof. Jocelyn Downie (Professor, Faculties of Law and Medicine, Dalhousie University, As an Individual): Good evening, and thank you for the opportunity to testify before you tonight.

In the time available to me I will not praise the bill, despite the fact there is indeed much to praise in it. I'll instead focus on suggestions for changes to the bill.

The reasons for these suggestions are that Bill C-14 is inconsistent with the Supreme Court of Canada's decision in Carter v. Canada. That is, it is inconsistent with the Canadian Charter of Rights and Freedoms for individuals who meet the Carter criteria. Bill C-14 is also inconsistent with the charter in relation to mature minors, individuals with mental illness, and requests made in advance of loss of capacity.

Unless Bill C-14 is amended, many individuals experiencing enduring and intolerable suffering from grievous and irremediable conditions will be left with three options. They can take their own life prematurely, often by violent or dangerous means; they can stop eating until death by starvation is not too remote or in the not too distant future, such that they will then qualify for assisted death; or they can suffer until they die from natural causes. This is a profoundly and unconscionably cruel choice.

Proposed subsection 241.2(2) unjustifiably limits access to medical assistance in dying. There are a number of problems here. First, contrary to the government's assertions, Kay Carter of Carter v. Canada would meet the Supreme Court of Canada's criteria for access, and yet would not meet the bill's criterion of a reasonably foreseeable natural death. Kay Carter had spinal stenosis. This is not a life-limiting or terminal condition.

There is no indication in it's decision that the Supreme Court of Canada thought that Kay Carter's natural death had become reasonably foreseeable in terms of temporal proximity. There was no evidence on the record before the court that Kay Carter's death was reasonably foreseeable in any temporally proximate way. In fact, it was just the opposite.

To pick but one of many possible examples from the evidence before the court, as Kay Carter wrote in her letter to Dignitas clinic in Forch, Switzerland:

> The neurologist, Dr. Cameron of North Vancouver, assessed me and I had a CAT scan and MRI done. From these tests he told me that I had an ongoing, slow deterioration of the nerves that would never kill me but eventually would reduce me to lie flat in a bed and never move.

Second, the government's position on Kay Carter, mental illness, major physical disability, and Bill C-14 is incoherent. The government has no evidence upon which to conclude that Kay Carter's death was not too remote, apart from the fact that she was old. On the logic of its position, if someone has a non-life-threatening mental illness or major physical disability as their sole condition, as long as they are old, they will be eligible. Yet this is precisely what the government is trying to prevent with proposed paragraph 241.2(2)(d). So either Kay Carter didn't meet 241.2(2)(d), or Bill C-14 allows access to medical assistance in dying for individuals whose sole condition is a non-life-threatening mental illness or major physical disability. The government is trying, but they cannot have it both ways.

Third, the phrase “reasonably foreseeable” is untenable as a criterion for access. “Reasonably foreseeable” is impermissibly vague. The debate about whether Kay Carter herself would meet this criterion makes this point crystal clear. The government's suggestion that “reasonably foreseeable” be interpreted as “in the not too distant future” or “not too remote” flies in the face of common usage where it means predictability, not temporal proximity.

Contrary to claims made by the government, the meaning proposed for “reasonably foreseeable” in the government's glossary and public remarks is not consistent with the meaning of “reasonably foreseeable” in either the criminal law or tort law where it means predictability, rather than temporal proximity. That is, it means you can “foresee that” rather than “foresee when”.

I'll now turn to my proposed solution.

First, delete proposed subsection 241.2(2). Second, add “including an illness, disease or disability that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition” to proposed paragraph 241.2(1)(c). Third, add the following definition: “Irremediable” means “cannot be alleviated by means acceptable to the person”. Fourth, replace references to “reasonably foreseeable” elsewhere in the act.

Now I'll move to my second issue, namely, the exclusion of mature minors, individuals with mental illness as their sole condition, and requests made in advance of loss of capacity. It is important to note that the government has acknowledged that Bill C-14 limits the charter rights, specifically by excluding mature minors, individuals with mental illness as their sole condition, and requests made in advance of loss of capacity. However, it has failed to provide parliamentarians with any reasonable basis on which to conclude that these limits are, for section 7 rights, in accordance with the principles of fundamental justice, or for both the sections 7 and 15 rights, demonstrably justified in a free and democratic society. In other words, you have not been given anything solid upon which to base a conclusion that this bill does not violate the charter.

● (2050)

The government provided a legislative background document to explain why it has concluded that Bill C-14 is consistent with the charter. However, this document's justifications for limiting the rights are grossly inadequate. The document's weaknesses include the following: misrepresentation of legislation in the permissive jurisdictions; misrepresentation of data from the permissive jurisdictions; reliance on unreliable sources of evidence for claims about the permissive jurisdictions; reliance on an ethical distinction explicitly rejected by Justice Smith in Carter; reliance on assumptions that are fundamentally inconsistent with the advance directives legislation in place in provinces and territories across this country; and reliance on a staggeringly unbalanced set of experts.

Contrast it with two other significant documents that are available to help guide you in your decision-making, the report of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, and the report of the Special Joint Committee on Physician-Assisted Dying. Given that they do not share any of the legislative background's weaknesses, I would argue that it is more reasonable for you to rely on them than on the legislative background document, and I would remind you that they both recommend against excluding mature minors, individuals whose sole grievous and irremediable condition is a mental illness, and advance requests.

As for solutions, I think the best solution here would be for you to make amendments to Bill C-14 to make it consistent with the recommendations of the provincial-territorial expert group and the special joint committee, and thereby the charter.

The second-best solution would be for you to have the provisions just mentioned, but have them come into force two years after the act receives royal assent, giving time for the development of policies and procedures and education of health care professionals and the public. However, note that this relates to how, not whether, to include these elements.

As an absolute bare minimum, I would argue that you should delete the preamble's reference to a commitment with no deadline for an exploration of the contested issues of mature minors, advance requests, and requests where mental illness is the sole underlying medical condition. Add a statutory mandate that is in the body of the act for independent expert studies of the contested issues with a prescribed and short deadline—for instance, 18 months—for reporting back to Parliament.

A mere preamble reference to a commitment to do reports on these three pressing issues is too weak when charter rights are being limited and the only question is whether the limits can be justified. Real people suffering in agony will have their charter rights limited every day until the government commissions the studies and then reports back to Parliament. They deserve more than Bill C-14 provides.

Thank you.

● (2055)

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

Now we'll go to the Canadian Council of Imams. Mr. Hashmi, the floor is yours.

Mr. Sikander Hashmi (Spokesperson, Canadian Council of Imams): Thank you very much, Mr. Chair.

Good evening, everyone. I'd like to extend our thanks to each of you for all the long hours that you've put in here doing some very important work for us. Thank you very much.

In the Islamic faith tradition, neither euthanasia nor assisted suicide is supported or encouraged. However, since that matter has already been decided by the Supreme Court, our concerns and recommendations regarding Bill C-14 centre around three things: safeguarding the interests of patients in distress, minimizing errors, and conscience protection for health care providers and faith-based facilities.

Most Canadians would agree that life is sacred and that an effort should be made in most if not all circumstances to preserve it. The Koran highlights the importance of saving a life. In verse 5:32 it says: "Whosoever saves a life, it is as if they had saved humanity entirely." Undoubtedly, the issue of assisted dying is of concern to many Canadians. Canadians are caring people. When we see others in pain and distress, we want to help.

Muslim faith leaders, along with those of other faiths, have a long tradition of caring for the ill. We have witnessed first-hand the terrible toll that illnesses and pain can take on patients and their families. We understand that in some cases, patients experiencing extreme levels of pain and suffering and those expecting the same in the future may desire an end to their life. We empathize with them, and as we draw from our faith traditions, we are instructed to pray for them to gain relief from their suffering and to try our best to make them comfortable by providing the best possible care.

We also know that when a human being voluntarily seeks an end to their life, it is a testament to the extreme pain and distress that they are experiencing or that they are fearing. It is a cry for help.

Whenever an individual seeks to end their life, we as a society know not to grant them their wish. Rather, we offer them compassionate care and assistance with the aim of alleviating the pain and distress that they're experiencing. We never assist them in ending their lives and instead make efforts to dissuade them from doing so.

Requests for death due to pain and distress caused by illnesses or disabilities should be dealt with in a similar manner.

We therefore recommend: first, that under safeguards, Bill C-14 require medical practitioners to ensure that after making a request for assisted death, patients are met by an end-of-life care team consisting of a psychiatrist, a social worker, and, if the patient so wishes, a spiritual care provider; second, that members of the end-of-life care team be required to discuss with patients the reasons for the request and present all available care options to ensure that patients are voluntarily making informed decisions; third, that the end-of-life care team and the medical practitioner confirm that all available treatments and pain reduction techniques have been exhausted and that they have not been able to make the suffering tolerable for the patient under conditions that they consider acceptable.

While Bill C-14 offers some safeguards, we believe there should also be measures in place to ensure that patients and the vulnerable are protected from errors that could have serious consequences. We therefore also recommend that the ability to provide assistance in dying, including access to substances that cause death, be limited to specially trained and certified health care practitioners authorized by the Minister of Health and the Minister of Justice.

This would entail modifying the text of the bill by adding the phrase, “authorized by the Minister of Health and the Minister of Justice” after all references to medical practitioner or nurse practitioner when referring to those permitted to provide assistance in dying.

We are also very concerned about the protection of conscience rights of health care providers and faith-based facilities. Conscience rights should be given the same level of importance as the patient's right to seek assistance in dying. In our view, the level of disengagement from assisted death should be at the discretion of individual health care providers and faith-based care facilities and should be publicly disclosed to would-be patients. This should be specified in the bill.

We firmly believe that as Canadians we must do more to provide compassionate care to those who are ill and to find better and more effective ways to alleviate their suffering and improve their quality of life. We believe it is possible for the federal and provincial governments to respect the Carter decision while promoting the sanctity and value of life.

● (2100)

Instead of encouraging death, let us come together to enhance and cherish life. Thank you very much.

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

Now we'll go to Mr. Cameron.

Mr. Jay Cameron (Barrister and Solicitor, Justice Centre for Constitutional Freedoms): Ladies and gentlemen, thank you very much for having me here tonight. I'm here on behalf of the Justice Centre for Constitutional Freedoms, which is a non-partisan, non-religious charitable organization. Our emphasis is focusing on the charter rights of Canadians, with a special emphasis on the charter rights found in section 2.

I'll start by complimenting the attorney general on Bill C-14, because I think there's much in it that's commendable. While I'm here tonight to talk about conscience rights specifically, I think it's important, given what I've heard here so far tonight, to mention that we believe that Bill C-14 gets a number of things right. It keeps accessibility to this to people who are adults. It keeps the decision with respect to access made for those who are competent at the time of making the decision. We think it gets right that an individual needs a physical ailment and that a person must be mentally sound.

A timely report was released today by what was formerly known as the *British Medical Journal*. It's now called the *BMJ*. It was released today. It's been reported on internationally. What it said was that medical error is the third-leading cause of death in the United States. I just want this committee to think about what that means. That means that the medical community, when they're attempting to save somebody's life and prolonging health, kills almost as many people—the third-leading cause of death—as cancer and heart disease in the United States. The system of reporting deaths in Canada, the U.S., and the U.K. relies on what's known as a mortality coding system. It doesn't capture death from medical failure, so it's unknown exactly how many people are being killed accidentally in Canada by the medical community.

My point in referencing that is simply this: mistakes happen, and there are people who are vulnerable in this country who need to be protected. It's apparent that they need to be protected from the very people who are being given licence right now to assist a person to die. It's with great solemnity, I think, that this issue comes before this committee.

The court in Carter said that “Complex regulatory regimes are better created by Parliament than by the courts.” It was in the context of noting the need for legislative reform to allow for medical assistance in dying that the court discussed and reiterated the conscience and religious rights of medical practitioners, stating that “nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying.” That's at paragraph 132. Instead the court underlined that “The Charter rights of patients and physicians will need to be reconciled...”. It was within the rubric of reconciling those rights that the court in Carter suggested statutory balancing, statutory address. Unfortunately, Bill C-14 fails to do that.

It's our continued recommendation that, in order to comply with Carter, Bill C-14 should codify the protections for the conscience rights of physicians, nurses, pharmacists, and other health care workers, as well as health care organizations and institutions, to refuse to participate in and refuse to refer for MAID.

The applicants in Carter neither sought nor received a charter right to compel doctors or health care workers to provide or refer for MAID. Despite that fact, the colleges of physicians as well as nurses' associations have instituted requirements that their respective members participate in MAID in disregard of members' conscience rights, on pain of professional sanction and reprisal in some cases. This is Parliament's opportunity to bring uniformity and clarity to the issue of conscience rights, and was made for that reason.

I have two pragmatic reasons in addition to the reasons that were set forward before the subcommittee. First of all, tens of thousands of Canadians trust and rely daily on medical practitioners to perform their duties in an ethical and conscientious manner in the provision of service. The provincial colleges of physicians have ethical requirements for doctors, and they expect physicians to be governed by a strong sense of moral and ethical responsibility.

We say that this committee has to consider the ramifications of overriding a physician's conscience in one aspect of service and then expecting that same physician to act in a conscientious or ethical manner in all of these other service requirements.

● (2105)

We also say it's important for Parliament to recognize that what Carter was talking about was a balancing of rights. There is a right to die recognized in Carter, but there are also rights for medical practitioners. It's important not to lose sight of the forest for the trees. The people who under this current Bill C-14 will be implementing MAID are the people who will wake up tomorrow morning, look themselves in the eye, continue on with their daily business, and know that they performed their duties in an ethical and conscientious manner. The people who have availed themselves of MAID will be gone, but the medical practitioners will still be here.

In my respectful submission—I don't mean to be trite—is it a proper balancing, looking at somebody's life on the verge of expiring, weighed against the decades of medical practitioners who still, on a day-to-day basis, must act in a conscientious and ethical manner? Is it not disproportionate to focus solely, or almost exclusively, on the rights of patients as opposed to those who are tasked with implementing MAID?

We say it is. We say a proper balancing would never oblige an individual to participate in MAID. There have been lots of discussions about whether or not it's legal or constitutional to include a protection in Bill C-14 for conscience rights. We say it is.

First of all, it is clear that right now Bill C-14 is dictating how MAID can be implemented and who can implement it. It is making regulations. It is making laws, or it purports to make laws, with respect to how MAID is to be carried out in the province. If the province is the sole entity that can make laws with respect to MAID, then this legislation would be offside. It's clear that this is not the case. We say it's apparent that conscience rights can be protected.

I would direct your attention to the circumstances in this example, one out of a number that we've thought of. Of course, the general rule with respect to culpable homicide is that there's no killing. It's sort of similar to the general rule that if you are a Canadian individual or organization, you have to pay taxes, because federal taxes are the purview of Parliament. Charities are controlled by the provinces, under section 92 of the Constitution Act, 1867, and yet charitable organizations have to make application to the federal government to both obtain charitable status and continue it. The reason that's the case is that otherwise they would not be allowed to do what they are allowed to do, which is accept tax-exempt donations.

In summation, I'll say that there are other analogous circumstances, such as in the Civil Marriage Act, where there are enumerated protections for conscience rights. We say it would be a mistake not to codify the same in this legislation.

Thank you.

● (2110)

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

We will now move to questions, and Mr. Cooper will start.

Mr. Michael Cooper: Mr. Cameron, you stated that it was your opinion that Parliament has flexibility constitutionally to enact conscience rights protections. You cited some examples of where Parliament has enacted laws or regulations in other contexts, but perhaps you could elaborate a little bit on what powers Parliament has to enact conscience rights protections.

Mr. Jay Cameron: We say this is an unusual situation. It's important not to miss that what's happening here is the carving out of an exemption for culpable homicide. Because Parliament is carving out that exemption, we say Parliament can set the parameters with respect to who is instituting MAID and how it's being instituted.

We say the 15-day waiting period, for example, would be constitutional, because that is within the boundary of that exemption that's being carved out. We say it doesn't trench on the provincial powers. We say it's necessarily incidental for the exemption that's being carved out.

We know that the Supreme Court of Canada has given that mandate to Parliament. The expectation, when I read Carter, is that the court expects Bill C-14 to balance those rights, and that is what is conspicuously missing. We say there's nothing wrong with putting that protection in the Criminal Code power—namely, under the Criminal Code power in section 91 of the Constitution Act, 1867.

Mr. Michael Cooper: Right.

I agree with you. Parliament would have ample room in terms of criminal law power to legislate in this area. The Supreme Court at paragraph 53 in Carter specifically said that the area of health care is an area of concurrent jurisdiction, in which both the federal and provincial governments can legislate. So I think it even allows greater flexibility in which to legislate.

Certainly Parliament does have the ability to legislate, but I guess then the question becomes how far Parliament can go in the way of legislating. A similar question was posed to a witness, Professor Pothier, earlier this evening. She seemed to suggest that Parliament could enact conscience protection legislation along the lines, for example, of section 3.1 of the Civil Marriage Act, but she then seemed to say that this would be about all that Parliament could do in the way of conscience protection legislation.

Could you perhaps elaborate on how far Parliament can go to protect conscience rights?

● (2115)

Mr. Jay Cameron: Without a reference to the Supreme Court of Canada, it's impossible to say entirely 100% for sure. I can't say. I feel as though I would be delving into the realm of speculation to say.

Suffice it to say, I think this bill can enact protections with respect to conscience rights. I think that under both the criminal power and the health power, Parliament has that jurisdiction. I also think the Supreme Court of Canada has sort of tipped its hand that it intends to be deferential with respect to this legislation.

That's my response.

Mr. Michael Cooper: I would simply note that if Parliament did not act, it would be left to the provinces, and that would create a patchwork of inconsistencies. Indeed, it could lead to a situation in which there would be no conscience protections anywhere, or at least in certain provinces. That would make Canada unique compared to every other jurisdiction that has some form of physician-assisted dying. In every other jurisdiction there is some form of conscience protection enacted. Canada would have a vacuum in that regard, and that obviously would be very concerning.

I don't know if you have anything further to elaborate, Mr. Cameron.

Mr. Jay Cameron: I would say this, that Justice Dickson at paragraph 143 in the Edwards Books decision counselled the avoidance of inquiries into people's religious beliefs. From our perspective, this doesn't have to be made to be about religious beliefs. There are long-standing beliefs, thousands of years old, with respect to the killing of your patient, which were originally enshrined in the Hippocratic Oath, and the Nightingale Pledge, which is the nurses' version of the Hippocratic Oath. They've been in existence for centuries in various forms, and many, many physicians today—you heard the statistics, 70%—don't want any part of this. You don't erase centuries of conscience protections ingrained in the medical profession with the slash of a pen. They're there, and whether they're ethical or they're conscience or religion-based, or it's just a matter of someone saying, “I feel uncomfortable about it, and I don't want to participate”, people have the right not to do that under the charter. That's our position.

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

Mr. Bittle.

Mr. Chris Bittle: Professor Downie, thank you for your presentation. I have a question outside the realm of what you presented on in terms of the 15-day requirement. Even though there is an exemption such that a physician can reduce the number of days, is it cruel and arbitrary that we, the legislation, or a physician can deem someone to be under enduring suffering and can then make them wait 15 clear days, which may in fact be 17 days? Could you discuss your feelings on that particular provision?

Prof. Jocelyn Downie: Sure. I think there are two problems with the 15-day limit. The first is the 15 days during which somebody is compelled to experience enduring and intolerable suffering in order to prove that their wishes are non-ambivalent in circumstances where it's very clear that they're not ambivalent. It's an attempt to protect against ambivalence, but the problem is it's not dealing with a situation in which ambivalence would be a real concern, and it's enforcing a waiting period on everybody when there is no concern about ambivalence.

The second problem with it is that the provision as drafted allows for flexibility only where the death or the loss of capacity is foreseen. It has to be imminent. The problem is, of course, that you can lose capacity unexpectedly. Somebody could have met every single condition. They have met all the criteria. They have met the procedural safeguards. They're waiting those 15 days; they lose capacity; and they're stranded. They will not get help.

I think it's cruel and it's over-inclusive in an attempt to capture something that is understandable, but it's the wrong tool to capture what they're trying to capture.

Mr. Chris Bittle: I know I haven't asked anyone this. Could you briefly discuss the interplay between section 7 and a breach of fundamental rights, and reasonable limits, and how the courts in the past have viewed breaches of fundamental justice and reasonable limits upon that?

Prof. Jocelyn Downie: If I understand your question, I think maybe we could turn to the Carter decision and see it playing out there very clearly, which is that the court saw that there were limits on the rights, and then it looked to see whether that was in accordance with the principles of fundamental justice. It found that no, that was overbroad. Again, similarly to the 15-day...it's overbroad, and it captures far too many people. That would be a consideration with this bill, so you're running into that tension yet again.

I think we just need to look at Carter and the fact that Carter drew a circle and said that for people within that circle, you cannot prevent them from having access, and yet the people who get access under this bill are within that circle, so it's a violation of what Carter did in terms of its section 7 analysis.

● (2120)

Mr. Chris Bittle: Mr. Cameron, I'd like to turn to you. Leaving aside medical assistance in dying, is there another medical procedure out there in which a physician has been coerced against their will or against their own conscience or beliefs that you're aware of?

Mr. Jay Cameron: I think the answer to your question lies in the history of the medical profession.

Mr. Chris Bittle: Let's not go back to the history of the medical profession. Can you answer based on today in Canada? What other medical procedures are you concerned about that would be a concern, where physicians are struggling with conscience?

Mr. Jay Cameron: I don't know of an analogous situation where the consequence of the act of a physician is the intended death of the patient, so there's nothing analogous I can think of.

Physicians and nurses were trained and raised to care for patients and provide health care. I share the concern that another panellist mentioned tonight that killing a patient isn't consistent with the idea of health care that—

Mr. Chris Bittle: But again, Mr. Cameron, you're venturing off. In terms of the specific individual, there's no other case you can point to, I guess is the simple answer, where there is a concern about conscience rights in the medical profession.

My next question goes to the colleges of physicians across the country that are self-regulating in terms of ethics, as are the bars of the various provinces.

Why are you advocating for regulating the professions, which clearly isn't within the jurisdiction of the federal government?

Mr. Jay Cameron: I'm not advocating for regulating professions, but I would note that every single month there are lawyers who are disbarred for malpractice and for improprieties.

It's clear from the study that was released today that whether it's intentional or accidental, the medical profession makes a lot of mistakes and kills a lot of the patients that it's supposed to be helping.

Mr. Chris Bittle: The medical profession, like the legal profession, gets to determine what is unethical.

Mr. Jay Cameron: Only so far, sir. Parliament decides what's criminal, and there are limits to what is in the purview of both the law societies as well as the medical professions. They have a limited mandate, whereas Parliament's mandate is much larger and broader.

Mr. Chris Bittle: Okay. In terms of conscience rights for institutions, can you point me to any Supreme Court decision that guaranteed conscience rights to a publicly funded institution?

Mr. Jay Cameron: I can point you to the freedom of association under paragraph 2(d) of the charter, which is not just a right for individuals, but also a collective right. Collectives form around the notion of doing what they can do collectively, what they can do individually.

Mr. Chris Bittle: So the answer's no.

Mr. Jay Cameron: In this case.... Well, I don't know.

If you want to tell me what my answer is....

Mr. Chris Bittle: I'm asking you, is there a Supreme Court case that points to that? You're dancing around the subject, but is there a Supreme Court case, yes or no?

Mr. Jay Cameron: I'd refer you to the Mounted Police Association case.

Mr. Chris Bittle: I'm sorry.

Mr. Jay Cameron: It's Mounted Police Association with respect to the associational rights of the collective.

Mr. Chris Bittle: It's a union case, so you can't point to a publicly funded institution.

Doesn't that lead to a slippery slope, that if we grant conscience rights to institutions in this one exemption, we're opening up the charter to issues of employment or access to a publicly funded institution for members of that particular religious group only? How can we limit those charter rights to your very narrow request?

● (2125)

Mr. Jay Cameron: With respect, sir, I think you're blurring the issue. The issue is whether or not a group of individuals who have formed around a common creed can decide whether or not they're going to participate in MAID—that's the question. We say they can —that's the answer.

The Chair: Thank you very much.

Mr. Rankin.

Mr. Murray Rankin: Professor Downie, I want to salute you, first of all, not only for being a professor of medicine and law, which is something, but also for your work with the provincial-territorial advisory group on physician-assisted dying. It's an enormous piece of work.

I was very disturbed by what you said. Essentially, I heard you say that the way it's drafted, proposed subsection 241.2(2) unjustifiably reduces access to medical assistance in dying. Then you gave the example of Kay Carter, whom you said would not be able to avail herself of this service. Then we had another witness today, who said that Ms. Rodriguez would likewise be unable to do so. People who have major physical disabilities, but who may live for a lot longer, are not protected in this bill at all. I think you indicated that it would be unconstitutional—I don't want to put words in your mouth, I want to hear them—for us to limit this protection to terminal patients or those reasonably approaching death, or for whom natural death is reasonably foreseeable. Is that accurate? Have I captured your conclusion right?

Prof. Jocelyn Downie: Yes.

Mr. Murray Rankin: To think that after all this, the fact that Ms. Rodriguez wouldn't be able to get coverage under this law, a lot of Canadians would find very disturbing, I'm sure.

You talked about the “reasonably foreseeable” language, which I remember from tort law was about an event, a predictable thing, rather than of a temporal nature. Yet the government, in its so-called legislative backgrounder, talks about it as if it's about time.

Could you elaborate on that?

Prof. Jocelyn Downie: Yes. I was baffled by it when I saw the provision. Then when I heard the government say that this was an established concept in law, I thought, I've heard “reasonably foreseeable”, but not in terms of temporal proximity. Of course, it can't be about predictability, because if you understand reasonable foreseeability as predictability, we are all qualified right now, because I know we will all die. Predictably, we're all going to die, so clearly they mean temporal proximity. Then you look for temporal proximity, meaning it's close enough, not too remote, then you go looking in tort law, and you find that that's not what it means. You go looking in the criminal law, and find that that's not what it means. In criminal law and tort law, it means this predictability piece.

It's either not what's established in law, i.e. their temporal proximity, or it is what's established in law, and then it's not their meaning.

Mr. Murray Rankin: It applies to everyone, because if it did it would apply to all of us, and so it's meaningless, right?

Prof. Jocelyn Downie: Yes.

Mr. Murray Rankin: With your analogy to a small circle versus a large circle, you're saying that Bill C-14 covers a small circle. I don't want to put words in your mouth, but the Supreme Court intended a larger circle, and they simply didn't get it right in this law. Is that your submission?

Prof. Jocelyn Downie: Yes, that's absolutely right. I think they misread, in part, what the factual circumstances in Carter were, and also, given some of the things that have been said in the past week, maybe deliberately drew the circle inside the circle of Carter and thought they could. I fundamentally don't think they can. The justification that's been given is this notion of dialogue and that there will be deference around the regulatory framework. What's really important to understand is that there will be deference around whether it is 15 days, or 13 days, or two doctors, the procedural safeguards, not the drawing of the circle. Because there's still an absolute ban around the circle, and that's where there isn't a back-and-forth, and you don't get to draw the circle smaller.

Mr. Murray Rankin: The only consequence, if you're right, is that people who are suffering will have to go back to the court to get the court to say again what they said in Carter.

Prof. Jocelyn Downie: Exactly.

Mr. Murray Rankin: You made some very significant statements about the legislative background. You used the words “misrepresentation of data”, which is a very serious thing to say, yet I notice that you made six assertions after that, all of which have footnotes after them, so you didn't just make it up.

I want to give you the opportunity to talk about why you are concerned about that legislative background.

Prof. Jocelyn Downie: I can give examples of each of the elements.

Mr. Murray Rankin: Just choose a couple.

Prof. Jocelyn Downie: Okay. They state that in the Belgian law it was extended to “all minors”. That's not true. It was extended to mature minors; they must have the capacity of discernment, which is the equivalent concept to mature minors, which is what we have.

I'm really concerned about the use of the data when they're talking about what's going on in other jurisdictions and they want to persuade you to believe that there's reason to be concerned about the vulnerable, and therefore you can limit.... Look at endnote 39. It links to a series of websites in the media, not to the decades of empirical research done in Europe, in Oregon, and so on. That's fundamentally problematic.

On the advanced directives piece, I'll quote from it: “Advance directives generally do not provide reliable evidence of a person’s consent at the time that medical assistance...would be provided.” That's a reason for keeping advance requests out. That's a justification for limiting a charter right. It is a fundamental assumption of advance directives across the country that they do stand for what the person wanted and we respect them.

The final one, which is extraordinary—and a lot of us were startled by it—is that when you look at the list and the category of “Canadian academics and experts” in the bibliography that are cited, you see four people. One of them is one of the foremost opponents of assisted death in Canada, and the three others were experts for the crown in Carter. That's not—

● (2130)

Mr. Murray Rankin: That's the crown that lost the case in Carter.

Prof. Jocelyn Downie: Yes, that lost the case. That's the basis of what you've been given, so that you're then turning and asking, “Is that reasonable grounds for us to feel comfortable?” Because you know it's limiting rights. The question is, have you been given reasonable grounds to say that you accept that you can support the claim that it's demonstrably justified in a free and democratic society? That's your document? No.

Mr. Murray Rankin: Do I have any time?

The Chair: If you have a short question.

Mr. Murray Rankin: No, that's fine.

The Chair: Thank you very much for those probing questions, Mr. Rankin.

Ms. Khalid.

Ms. Iqra Khalid: Obviously we want to have a balanced and a fair approach to such a sensitive issue, making sure that we protect the rights of vulnerable people and also providing the right to end suffering should somebody choose to.

Mr. Hashmi, I will address my question to you initially. You outlined three recommendations with respect to the bill. You asked for more safeguards, specifically with respect to having a mandatory psychiatric evaluation forming part of the consent. Secondly, you looked at errors and asked that the substance to be administered be provided to only those who are authorized by the Minister of Health and the Minister of Justice. You also talked about conscience rights for the physicians or medical practitioners who are administering.

To begin with, I want to talk specifically with respect to conscience rights. Now, we have heard testimony from other witnesses who have indicated that there is a coroner's report. They've asked that the coroner's report become mandatory. The cause of death outlined in the coroner's report right now is not mandated to be listed as medical assistance in dying. I want the religious perspective on it. Do you think the cause of death being listed as suicide, in essence, is something that faith-based families would be comfortable with?

Mr. Sikander Hashmi: It could certainly be something that perhaps could be troubling for some. Of course, there are different views and different levels of comfort that people of different faiths have with regard to suicide. If a family finds out that the coroner's report shows that the death was by suicide, it could certainly put them in a situation that they may find uncomfortable.

Ms. Iqra Khalid: Would it be hurtful to families, then, who are dealing not only with the loss of a loved one but also with the negative connotations in society as a whole?

Mr. Sikander Hashmi: I believe so, but different communities and different groups see suicide in different ways. If it becomes something that is known and public and the family find out, or friends, or relatives, or other members of the community find out, then it could be hurtful to the family.

● (2135)

Ms. Iqra Khalid: Ms. Downie, in your brief, you had mentioned that the term “reasonably foreseeable” is impermissibly vague. We've heard testimony over the past week that the term is more of a medical determination on a case-by-case basis by physicians, or medical practitioners, as the case may be. Do you agree with that? Do you think a medical determination would keep it open and more inclusive to those who are seeking it?

Prof. Jocelyn Downie: I think it doesn't serve the purposes of what Carter was attempting to do, which was to provide access for a certain group of people, because people are disagreeing all over the place. Physicians are disagreeing about what it means. What that tells you is that you are going to go to some physicians who will say, “Yes, you're two years away, and I'm going to read it expansively”, and somebody else is going to be fearful of being charged and read it narrowly, or they're going to be opposed to assisted death and so they will choose to read it very, very narrowly, and say, “maybe a week from death”.

The variability we've seen in the interpretations of the expression among the medical community is absolutely persuasive evidence that this is too vague. It isn't a matter of leaving it to medical determination. It will cease to be vague, and they will figure it out. They will splinter on it.

Ms. Iqra Khalid: Right.

We understand at the federal level, and specifically for Bill C-14, that it is an amendment to the Criminal Code, which is what we have jurisdiction over. The administration of MAID would be something that would be implemented by the provinces.

All three witnesses can comment on the following. Do you think the provinces would be able to come up with a consistent approach, specifically the self-regulation of doctors? For those physicians or medical practitioners who do not want to partake in the administration of death, would the self-regulated bodies be able to take ownership of that piece and ensure that everybody's conscience rights are protected?

Prof. Jocelyn Downie: I think this is one of the spots where the federal government deserves a lot of credit, because they recognize that this is one of those issues that is absolutely federal and provincial. How do we do this? They have taken it as an opportunity to exercise co-operative federalism. It's a muscle we haven't been exercising a lot recently, but this is one of those moments, and they've taken it. They've said, “We're going to facilitate the development of this together with the provinces and territories”. They're putting their money where their mouth is on the facilitation of development with the provinces and territories. It's a pan-Canadian care pathway.

What that is about is protecting the conscience of providers, ensuring access for patients, and protecting the privacy of willing providers. They've recognized the need for conscience protection, but it's dealing with it in the way that makes a lot of sense in terms of our division of powers, in terms of our history with respect to where conscience is regulated, and with respect to this sense of co-operative federalism. Where we have shared jurisdiction, let's talk, let's do it together, and let's figure it out and not torture something into a federal act. That isn't the way to do it.

I think that's promising for having some harmonization. I hope that group would bring the federation of colleges and physicians, and the surgeons, and the nurses to the table and say, “We're all sitting down here, and we're not leaving until we figure this out together”, because the colleges of physicians splintered within a week of getting together on this, and that's problematic. The nurses, not so much, and that's fascinating.

Let's say that this is the kind of thing that we solve together, and bring those different levels of regulation together to solve it, because everybody shares the same goals. I want to protect conscience, you want to protect patient access as well, and we all want to protect privacy. I think that's how we have to do it.

The Chair: Thank you very much.

Imam, do you want to chime in?

Mr. Sikander Hashmi: Sure. What's making health practitioners and medical professionals of faith quite nervous is this uncertainty of not knowing how it's actually going to play out. As far as the patient's rights are concerned with regard to assisted dying, yes, the bill is there and everything seems to be quite clear, but when it comes to the rights of conscience, it's not very clear.

We're already hearing complaints from doctors in Quebec, talking about how they're feeling pressured. We heard of one case where there was talk of sanctions against a doctor who was not willing to give an effective referral. It's really troubling to reach where there are actually doctors considering leaving the profession, or that they might have to leave if it doesn't play out to their satisfaction.

I appreciate the efforts that the government may be planning to make, but there should be a lot more clarity at this point with regard to this matter.

● (2140)

The Chair: Mr. Cameron.

Mr. Jay Cameron: Not to be trite, but to be respectful, I would like to think that the current legislation would have helped Sue Rodriguez. The supposition, the speculation, that it wouldn't have helped is misplaced. We never know what would have happened. Watching the attorney general's presentation about the meaning of the term “reasonably foreseeable”, and how that means being on a trajectory, that would have put Ms. Rodriguez—who had been told she had 2 to 14 months to live—within the parameters of this bill, in my view.

The Chair: Let me thank the members of our esteemed panel. It was very helpful to hear your testimony tonight. I really thank you both for your briefs and presentations, and on behalf of all the members of the committee, thank you again for your incredible patience.

I want to thank the members of the committee and everyone here, especially all the staff, who did an incredible job tonight despite some obstacles.

We will reconvene tomorrow morning at 8:45.

The meeting is adjourned.

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