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Chair

Mr. Anthony Housefather

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● (0845)

[*English*]

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

I'd like to welcome today's witnesses. It's a great pleasure to welcome Mr. Joe Arvay, who was the lawyer in the Carter case. I have to say that probably one of his greatest accomplishments is being a previous law partner of Mr. Rankin, or we could say the reverse, perhaps, too.

We have Mr. Graydon Nicholas, who is a former lieutenant-governor of New Brunswick.

We have Professor Udo Schuklenk, who is a professor and holds the Ontario research chair in bioethics at Queen's University.

We're going to go to Mr. Arvay to start.

Mr. Joseph Arvay (As an Individual): Thank you, Mr. Chair and members of the committee, for allowing me to appear before you today.

As the chair indicated, I was the lead counsel in Carter. In that context, I think I probably know better than anybody what this case is about and what it stands for, because I was involved in framing the case. Framing the case means what we decided it was going to be all about, how we pled the case, how the government responded to our pleadings, the evidence presented in the case, the arguments in the case, and the findings in the case.

I can tell you, based on all of that, which I'll elaborate on in the time permitted, that the definition of “grievous and irremediable” in Bill C-14 is clearly inconsistent with the Carter decision, and that in my view, an unquestionable view, it is clearly unconstitutional; and that if the bill is enacted, it will be struck down.

I tell you this not only because of my involvement as lead counsel in Carter. I've been litigating the charter since its very inception—that was 34 years ago—and I probably have more experience litigating the charter than any lawyer in private practice in Canada does, and I've had some notable successes. So when I say that in my view this bill, if the definition of “grievous and irremediable” is left in, is unconstitutional, I say it actually with great confidence.

There are really two issues I want to address in the time I have. One is whether there is anything in the Carter decision that would allow Parliament to enact this bill, insofar as it includes the “reasonably foreseeable” phrase, the meaning of which you all know, as well as the phrase dealing with an “advanced state of irreversible decline”, and, for that matter, “incurable”. I say there is nothing in the Carter decision that allows for these. In fact, there's much in the Carter decision that is inconsistent with these words.

I've handed out a fairly lengthy brief in which I walk through many of these more technical issues, and I'm not going to repeat it in the time I have. I asked the clerk, however, to hand out something to you just now, which I only discovered after I wrote the brief. It is a transcript from the Supreme Court of Canada hearing just last January, when the federal government was asking for an extension of six months in order to allow Parliament more time to enact the law.

You should have it; it's the Supreme Court of Canada case, Lee Carter v. Attorney General of Canada. It is an excerpt of an exchange between Justice Karakatsanis and Rob Frater, the federal government's lawyer, and also Justice Moldaver.

This is very telling, I think. If you go to bottom of page 18, at line 19, Justice Karakatsanis says,

> Mr. Frater, can I ask you this: Does your position on the Québec legislation mean that you accept that it complies with Carter? I'm thinking particularly about somebody has to be a la fin de vie whereas in Carter we rejected terminally ill.

That can't be any clearer. The Supreme Court of Canada, in Carter, rejected any requirement that a person be terminally ill. If you go on, there's an exchange between Justice Moldaver and Mr. Frater in which he says that the Quebec legislation is “under-inclusive”. By that he meant that it didn't go as far as Carter required, and this obviously raises serious questions about the constitutionality of the Quebec legislation.

I can tell you the way we pled the case. It was my co-counsel and I who chose the words “grievous and irremediable”; those were our words. We deliberately left out “incurable”, because “incurable” doesn't capture the necessary requirement. We used “grievous and irremediable.”

The government asked what we meant by that. As you see in our brief, we spelled out what we meant by that, and it didn't include “terminal”. Then, in argument before the trial judge, the government lawyer said—and again, this is set out in the brief—that the problem with the plaintiff's definition of “grievous and irremediable” is that it doesn't include “terminal.” The trial judge may have used the word “terminal” a hundred times in her reasons, by reference to other regimes, etc., but she didn't require that a person be terminal in order to avail themselves of physician-assisted dying.

● (0850)

As I said, the Supreme Court of Canada, in its ruling, in its declaration as to who was entitled to physician-assisted dying, didn't limit it to “terminal”. You may say that “reasonably foreseeable” is different from terminal. Well, it's not different from terminal; it's just that there are different ways of defining terminal. Some people define terminal in an arbitrary way as six months from the end of life”. Other people define it in a vague way, such as “at the end of life”, as in the Quebec legislation.

This bill defines it in a similar way, but it's all to the same effect. It's imposing “terminal”, and that's simply contrary to Carter. The reason it's unconstitutional is that by defining those entitled to physician-assisted dying—I guess it's supposed to be called “MAID” today, medical aid in dying, and that's fine—Parliament has excluded an entire group of individuals who otherwise would enjoy the charter rights that the Supreme Court of Canada gave in Carter, and that group is the physically disabled, whose death is not reasonably foreseeable.

In the few minutes I have left, I want to tell you—and I've set this out in my brief in some detail—that as a physically disabled man, I was very sensitive and alive to the arguments made by the disabled rights organizations, organizations whose cause I ordinarily support, but on this point I thought they were just fundamentally wrong, insofar as they suggested that all physically disabled people are not really disabled. You're going to hear from Ms. Pothier and Mr. Baker. If they don't use the term “the social model of disability”, I can tell you that their entire premise before the trial court and the Supreme Court of Canada is that we're not really disabled; we're just impaired, and that society disables us because we live in a city where there are stairs to the buildings or in which ableist society has its own notion of what a dignified life is.

I accept that there's no one conception of a dignified life, but I reject the idea that people with serious medical illnesses or conditions, whatever the cause, are capable of suffering intolerably and capable of saying that this is not a dignified life, even if most disabled people conquer their disabilities and accept that what they have to do to get through the day is not undignified. The premise of Bill C-14, insofar as it has this reasonable foreseeability clause, is that most disabled people, all whose death is not foreseeable, are somehow incapable of making an informed decision about whether or not to seek assistance in death.

I've already read—and you will hear again—that the reason for this, they say, is that the disability could be transitional, situational, or transitory, and if you let a disabled person choose death, they might regret it later. You have to try to get your head around that. The trial judge heard all those arguments and rejected them. The idea that a disability may be transitional, transitory, or situational is something that the disabled groups put to the Supreme Court of Canada. The Supreme Court of Canada rejected that, yet this bill essentially provides that all disabled people are simply taken out of the protection of rights that the Supreme Court of Canada gave them in Carter. Parliament can't do that.

Parliament can't do that by claiming that it's a section 1 justification. Section 1 was fully argued in the Carter case. Carter created a floor of constitutional rights and entitlement, not a ceiling. Parliament can provide further rights and entitlements, and the courts can provide further rights and entitlements, but Parliament can't take away any of the rights and entitlements that the Supreme Court of Canada gave to the disabled. Bill C-14 actually carves right out of the Carter decision the rights given to the physically disabled, and it can't do that.

● (0855)

I see that my time is up. I'm obviously open to questions.

Thank you.

The Chair: Thank you very much, Professor Arvay.

Mr. Nicholas, you're next. Welcome.

Mr. Graydon Nicholas (Former Lieutenant-Governor of New Brunswick, As an Individual): Thank you very much. I appreciate the opportunity to be here with honourable members on this matter that is very important to our country as well as here in Ottawa.

I filed my submission, and the three areas I addressed are the sanctity of life, palliative care, and freedom of conscience. I hope you've had a chance to read it; it's limited by your limitation of 750 words.

I want to say first of all that I think it is important to acknowledge two things. One is that I'm here as an aboriginal person. My tribe is Wolastoqiyik from New Brunswick. Maliseet is what the English call us; in French they call us *Malécite*. In my teachings—from my elders, of course—life is respected in all of its stages. I mention this in my brief. Also I'm here as a Catholic. A principle of our Catholic faith as well is that life is respected in all its stages.

Since I was coming here, a friend of mine gave me a copy of legislation entitled an act to establish Pope John Paul II Day, which was enacted by Parliament and assented to on December 16, 2014, in which Parliament acknowledged the important role that Saint John Paul II played not only in this country but in the world as well.

I want to refer in particular to his “Prayer for Life”. If you don't mind, I'm going to hold on to my eagle feather, Mr. Chairman.

> O Mary, bright dawn of the new world,
> Mother of the living, to you do we entrust
> the cause of life: Look down, O Mother,
> upon the vast numbers of babies not
> allowed to be born, of the poor whose
> lives are made difficult, of men and
> women who are victims of brutal
> violence, of the elderly and the sick killed
> by indifference or out of misguided mercy.
> Grant that all who believe in your Son
> may proclaim the Gospel of Life with
> honesty and love to the people of our
> time. Obtain for them the grace to accept
> that Gospel as a gift ever new, the joy of
> celebrating it with gratitude throughout
> their lives and the courage to bear witness
> to it resolutely, in order to build, together
> with all people of good will, the civilization
> of truth and love, to the praise and glory of God,
> the Creator and lover of life.

That was on March 25, 1995.

With respect to the issue of palliative care, when two ministers announced Bill C-14, the Minister of Health indicated that there would be some money invested in palliative care. I'll refer honourable members to a study that was done, the report from which was called “Not to be Forgotten: Care of Vulnerable Canadians”. It was done by a parliamentary committee here in 2011. It's an extensive report, a comprehensive report, but I would recommend that at least your researchers look at it, because there's a very strong statement in it about looking at palliative care and making sure that governments uphold this portion. It requires simply an amendment of the Canada Health Act for it to happen. Many people are placed in hospices and other centres and literally wait for their time to die. I know many people, my friends and relatives and family, who have been in that situation. It's important that the government make life as comfortable as possible for these people in the last days of their lives.

The other area I will concentrate on is freedom of conscience. Of course we know it's a fundamental right within our charter.

I remember when this was being debated in 1980. Mind you, I was on the other side; I was advocating for indigenous and aboriginal rights back then throughout our country, making sure that the document would in fact protect our people.

One of the writers of the Universal Declaration of Human Rights was an individual from New Brunswick, Professor Humphrey. Article 18 of that document says that “Everyone has the right to freedom of thought, conscience and religion”. This same phrase, of course, is also repeated in the International Covenant on Civil and Political Rights, again in article 18.

● (0900)

Canada not only acknowledged the existence of these particular declarations, but Canada as a country also signed what's called the optional protocol, which allows a citizen of this particular country to question the decision-making power of Parliament and whether it is in fact fulfilling the obligations under international instruments.

My cousin Sandra Lovelace of course was the first one who took the optional protocol to the United Nations, and she's a senator now. It was about dealing with her identity as an indigenous woman who had lost her rights through marriage to a non-native. Ultimately, Canada was sanctioned by the United Nations, and Canada changed the law in 1985.

I put that on record maybe because as I look at this legislation, I'm not sure if the advisers at the Department of Justice examined this legislation in terms of conscience rights—because there's an absence there—so does it in fact comply with international law? Does it comply with the instruments at the United Nations level? Of course, the Department of Justice has all kinds of experts. I just raise that with the committee, Mr. Chairman, because I think it's something that shouldn't be overlooked. I remember how in the 1980s, when legislation was passed and they would sometimes say, “Okay, hold your nose and let it pass, even if you don't agree with it.”

Conscience is so important and so critical. If you force somebody to do something against their will and they have firm beliefs, what's going to happen to the medical profession? What's going to happen to those institutions that exist and do not wish to participate in this particular arrangement that's going to be enacted by Parliament? Almost everybody is saying that it's inevitable that it's going to pass, but there has to be a reason, and I think parliamentarians should realize that this thing has to be studied. Although they say they'll study it five years from now, you can't wait five years. Circumstances change.

That is what I wanted to put on the record, Mr. Chairman and honourable members, because I understand that all three parties are represented here. I want to thank you very much for allowing me to come here.

I asked to be here because from May 31, 1991, when I was appointed as a provincial court judge, to October of 2014, when I finished my term as lieutenant-governor of the province of New Brunswick, I was in a virtual sphere of silence. As a judge, you can't make comments on public issues, and definitely as a representative of Her Majesty you're not allowed to, so finally, then, I was relieved of this particular burden in October of 2014. I come here today saying that there should be great compassion for people who are ill, suffering, or facing death, but we all should also make their lives comfortable in those last stages.

Thank you very much, Mr. Chairman and members of the committee, for listening to me. I want to wish you well, but I also want to let you know one thing. In my term as lieutenant-governor, I visited schools in New Brunswick. There are certain schools, believe it or not, that pray for parliamentarians and pray for judges every day, because it's part of their school regime. I was impressed. I didn't realize they were doing that.

Even today, as you're meeting here and as you continue your debate, you have people in certain schools in the province of New Brunswick who are praying for you, and prayer is powerful. We need prayer; we need a higher power, and we need a higher authority in order to make just decisions.

Merci beaucoup.

● (0905)

The Chair: Thank you very much, sir.

Professor Schuklenk, you're up.

Dr. Udo Schuklenk (Professor and Ontario Research Chair in Bioethics, Philosophy, Queen's University, As an Individual): Thank you.

Looking at your briefing document, I thought I should spend at least one minute telling you who I am, because you probably don't know me.

Between 2009 and 2011, I chaired an international expert panel that was tasked by the Royal Society of Canada with drafting what they hoped at the time would be a landmark national report on end-of-life decision-making in our country. We recommended at the time that medical aid in dying be decriminalized for decisionally competent people.

We further recommended that terminal illness—and this I think is the thing I want to talk about most today—not be made a threshold condition for a person to be eligible for medical aid in dying, for two reasons. One reason was flagged already and it is correct: there's no precise science to providing a prognosis of terminal illness in terms of a specific length of time. Second, if the term ”terminal illness” is made a necessary condition of the statute, by necessity it would be under-inclusive; there can be no doubt about it.

The Supreme Court justice in Carter v. Canada concurred on the subject matter. The justice department tried to justify the limitation that it seeks in the draft legislation, to be for persons with foreseeable natural death, and it says basically that the justice has stated in paragraphs 1 to 7 in Carter that they were responding to the factual circumstances before the court.

What the department fails to mention is that immediately preceding that statement, the court clearly stated that the impugned sections of the Criminal Code are void insofar as they prohibit physician-assisted death for a competent adult who clearly consents to the termination of life and has a grievous and irremediable medical condition.

The thing is this. The statement about the circumstances must be read in light of the criteria that were laid down. The court applied its criteria to the factual circumstances and not the other way around. Its clarification cannot be read to justify the inclusion of terminal illness, then, as a threshold condition for access to “MAID”, to medical aid in dying.

As it is proposed now, throwing everyone other than those near foreseeable death in a catch-all category of “vulnerable” inevitably will result in the very excessive breadth and gross disproportionality that the Supreme Court identified when it struck down the current Criminal Code provisions.

It seems to me the justice department is quite cognizant of the fact that its proposed legislation is too restrictive. Yet it fails to provide a sound rationale for its terminal illness threshold, because when you think about it, respect for human life surely is not undermined when we accede to a competent person's request for medical aid in dying who suffers from an intractable clinical condition that renders their life not worth living to them.

Denying such patients' requests for medical aid in dying serves no desirable objectives and it certainly does nothing to protect the vulnerable. If anything it condemns these very same vulnerable people to continue in suffering and arguably to haphazardly undertake suicide attempts. I could give you plenty of examples if you were to ask me about individual situations that I'm very well aware of in which exactly that happened. It's not just a theoretical exercise here.

Last year, in the *Journal of Medical Ethics*, I published an article jointly with a clinical professor at Erasmus University medical school, Suzanne van de Vathorst, I argued that competent patients who suffer, for instance, from intractable depression, should be eligible for medical aid in dying. While I can't go into the details of that paper today, I want to tell you that fundamentally it's based on the recognition that some intractable psychiatric illnesses are known to cause severe suffering that is just as painful as the most painful physical ailments, and that existing treatment modalities fail a significant number of these patients. We're looking at about 30% of people with clinical depression. The depressed patients are not per se incompetent, and their evaluation of their quality of life is often actually very realistic.

There's nothing in the Charter of Rights and Freedoms that suggests that if we label such people as mentally ill or vulnerable we are justified in removing their agency in questions of life and death, because this is what is proposed in the current draft legislation.

A lot has been said, and you have heard some of this from various expert witness statements with regard to this category of patients. Dark warnings were sounded about supposed dangers involving our most vulnerable. The substance of these expert witness accounts was rejected unanimously by the justices of the Supreme Court. In fact, you will hear right after us from Harvey Chochinov, whose expert witness account was completely rejected by the Supreme Court. It was also rejected by the expert panel advising the provinces and territories on this subject matter as well as the joint special parliamentary committee.

The justice department in its misrepresentations of the current legal and policy situation in Belgium, for instance, relies on its legislative background document, not at all on peer-reviewed, large-scale research studies, but on a handful of cases—think about it—that make the rounds on the Internet. That's the level of expertise that we have gotten with this background document.

● (0910)

The Supreme Court has in fact rejected this anecdote-based approach to this issue. I quote from the judgment:

> The resolution of the issue before us falls to be resolved not by competing anecdotes, but by the evidence.

The fact of the matter is this. Any major piece of peer-reviewed research on this subject matter has come to the same conclusion: medical aid in dying does not constitute a threat to vulnerable people. The existing evidence base also puts to rest arguments suggesting that we first need to study what the implications of a regime that meets the court's criteria would likely be. The reason for this is that all the available scientific evidence on any of the jurisdictions that have decriminalized assisted dying does not support abuse-related concerns made even by some disability rights activists, as we have pointed out earlier.

I want to talk quickly about this a bit, because you have heard a lot about it. I want to give you some data about both Belgium and the Netherlands, because these are the two straw men that are being used in this context.

Today, neuropsychiatric cases involve about 4% of all medical aid in dying cases in Belgium. That translates into about 70 cases out of more than 1,800 euthanasia cases. The vast majority of requests from such patients are rejected, arguably out of an abundance of caution. It's true that the overall percentage of such cases has slowly increased over the last few years, but it appears to have plateaued at its current levels. Typically, these cases are actually handled by specialized teams of clinicians.

The same is true for the Netherlands. In 2013 they had 42 psychiatric patients; in 2014, 41 patients; and in 2015, 56 patients. There is no sudden deluge of euthanasia cases involving psychiatric patients. Depression is mentioned in about half of these cases. The backgrounder that you got from the justice department tells you about a letter that 65 psychiatrists and psychologists wrote to the local newspaper or a newspaper in that country, no kidding.

The Dutch psychiatric association, the actual professional association in the country, represents about 3,600 psychiatrists. They have drafted specific guidelines for these kinds of cases, requiring that each patient be seen by two psychiatrists and another physician. That ensures that they're competent and that no treatment options have been overlooked. That's the reality in that country.

I think these figures illustrate that there's a fairly small number of psychiatric patients receiving medical aid in dying, but it is patients such as these that the current legislative draft would condemn to continuing needless suffering, and this is why it's so important that this draft legislation be amended.

The ongoing public debate about eligibility criteria features phrases such as “reasonable compromise” and “a cautious approach”, using some of the same rhetoric that was deployed by the justice department, and I think this misses something rather basic. The rather basic thing is this: the Supreme Court actually has stipulated clear minimum criteria that the new legislation must meet. These criteria would have been developed with a view to reasonable limits in section 1 of the charter. The proposed draft legislation, for the reasons mentioned, does not actually meet those criteria.

I urge you, then, to amend the existing draft legislation as outlined in my witness statement, keeping in mind that the Supreme Court's minimum standard is this: the request for medical aid in dying must be made by a competent adult; the condition must be intractable; and life must be considered to be not worth living by the patient. There's nothing else to it beyond that.

Let me quickly in the last minute talk about both advance directives and mature minors. Today, we allow patients to make advance decisions about what types of care they will accept when they are no longer capable. Such advance decisions may even have the effect of hastening death, for instance. These kinds of advance directives are generally respected.

It is fair to say that the Supreme Court arguably does not require government today to admit advance directives in the context of medical aid in dying or to include mature minors among those eligible for medical aid in dying. It is my considered view, though, that both are desirable and logical extensions of the rationale driving the judgment. I recommend therefore—and you have this also in my witness statement—that these subject matters be studied during the next 18 to 24 months and that this be a statutorily mandated process codified in the act.

Thank you for your time.

The Chair: Thank you very much to all of the witnesses for your very compelling testimony.

Now we're going to move to the questions section, and we're going to start with Mr. Nicholson.

● (0915)

Hon. Rob Nicholson (Niagara Falls, CPC): Thank you very much.

I'd like to welcome all of you to the panel today and thank you for your representations.

I will express a special welcome to you, Mr. Arvay, and I know that Mr. Bittle will agree with me. You come from our part of Canada, originally, so we're pleased to have you here.

I'll start with you, Mr. Arvay. You have as much experience as anyone, I guess, in terms of arguing cases and making sure of the constitutionality of various pieces of legislation. You've had a career in that area.

I'd like to have your opinion on the provisions within this law in terms of protecting people on matters of conscience with regard to whether they would participate in this. Do you think that would stand constitutional scrutiny if that had been...? Of course, it depends on how it's drafted, and I appreciate that, but what are your thoughts on that area in general?

Mr. Joseph Arvay: Mr. Nicholson, I appreciate the question, and quite frankly, those portions of the bill are not something I've put my mind to. I've come here to deal with the definition of “grievous and irremediable”.

Hon. Rob Nicholson: This is free legal advice on this—

Mr. Joseph Arvay: Yes, I appreciate that.

I can say this, though. Certainly when we argued the Carter case, it was our position that no doctor should be forced to provide physician-assisted dying, and the Supreme Court of Canada accepted that.

Beyond that I'm not prepared to answer that question. I'm sorry I can't be more helpful.

Hon. Rob Nicholson: That's fair.

Mr. Nicholas, congratulations on the interesting and fulfilling career that you've had in the province of New Brunswick, in serving New Brunswick and this country.

As a judge and someone who has studied this area, you'd be very aware of the history. I think since I've been a member of Parliament, the whole question of assisted dying has been rejected three times by Parliament, but that's not the world we're living in right now. The court has indicated that in fact it is constitutional and we have to deal with it. I appreciate the fact that there are people praying for parliamentarians, and we're very appreciative of that.

How much do you think Parliament can actually do at this particular time? Parliament was clear on its position, but now the courts have indicated very clearly that the present law, the law that's been on the books and maintained by Parliament is unconstitutional. How much can parliamentarians do, in your opinion?

Mr. Graydon Nicholas: My memory goes back to the original charter that was being drafted in the 1980s, and the discussions that would have occurred then; and the notwithstanding clause was put in there for a purpose. I remember specifically why it was put in there: in order to make sure that this would in fact pass not only Parliament, but that it would get 70% of the vote of the provinces across this country.

I'm sure at the time the government would have consulted with individuals as to the effect of the notwithstanding clause. Of course, we know that has been invoked a few times in our country within the jurisdiction of various legislatures. Now we're saying that it's been spent.

I was disappointed that neither the previous government nor the current government explored publicly the notwithstanding clause. That option is off the table, as far as I'm concerned, according to what the current government is saying as well.

The law is the law. The Supreme Court has made its decision, but the judges also know that the ultimate judge is Parliament. Parliament is the one that enacts legislation, and if one of our fundamental rights is freedom of conscience, then I think Parliament has to protect that right as well so that it's not left to a particular province to ask whether these agencies can then force medical people to do this. Mr. Arvay has indicated that the chief justice said not to force.

I think the weakness of this current legislation is that there's nothing in there that respects that fundamental right, and if it's not in there under criminal law, it will be brought up as a defence, and it will be litigated from provincial court all the way to the Supreme Court of Canada, which will probably involve a five-to-seven-year span, and there will be a lot of litigation on this as well.

I don't see why Parliament cannot insert freedom of conscience in that bill for those who don't want to participate, including institutions. For example, the hospice that's been created in Fredericton and the hospice in Saint John have both said there's no way they're going to comply with this law if they're forced to participate in it.

● (0920)

Hon. Rob Nicholson: There certainly has been precedent for that even at the federal level with the Civil Marriage Act. There are provisions in there that someone can't be forced to do something against their conscience.

Mr. Graydon Nicholas: I assume that the Coalition for HealthCARE and Conscience is going to appear here. Here's what they said:

> No other foreign jurisdiction in the world that has legalized euthanasia/assisted suicide forces health care workers, hospitals, nursing homes or hospices to act against their conscience or mission [or] values.

Hon. Rob Nicholson: I agree with you completely.

Mr. Graydon Nicholas: Thank you very much for that—

Hon. Rob Nicholson: Thank you very much for that.

Dr. Schuklenk, you made an interesting comment about the various laws. You talked specifically with respect to Belgium and the Netherlands.

One of the things you said is that there's no evidence that this causes a threat to vulnerable people. Many of us who have dealt with individuals on other levels and in other cases find that there is a group of people who are quite vulnerable. In the last Parliament, we dealt with the situation of people preying on teenagers and encouraging them to commit suicide. This was a considerable problem.

Also, many of us know people—it's not necessarily connected—who sometimes find themselves vulnerable as they advance through life. Those of us who practise law sometimes find individuals who have been taken advantage of and who get pressured by other individuals in a wide range of areas. Many times, it's with respect to money, with respect to taking money away from them and forcing them to do certain things. We do get quite a lot of emails, phone calls, and letters on this area. That is actually one of the areas that has been raised with us. There are people who may be vulnerable, or it may be in their family's interest to have them acquiesce to assisted suicide.

You were quite categorical in your comments here that this does not pose a threat to vulnerable people. I wonder if you could expand on that.

Dr. Udo Schuklenk: Thank you for your question.

My claim is based on how, over many years, ever since these jurisdictions started decriminalizing this, they have basically looked at all the individual cases that were ever reported in those countries and tried to find out what categories of patients were asking for this.

When we talk about vulnerable people, who typically would come to mind? We would think that it might be people who might have trouble accessing health care, for instance, or people who have trouble accessing palliative care because they can't afford it. There are any number of reasons. The reality is that in virtually of these jurisdictions, the vast majority of patients asking for medical aid in dying are in fact late-stage cancer patients. While there is a bit of a fluctuation, these figures are fairly stable. It's the overwhelming majority.

For instance, if there were a serious danger to people with mental illnesses who received medical aid in dying, you would expect that after this having occurred for many years, the numbers would explode at some point. If you are concerned about the abuse claim, you would see that in one year year there were maybe 10 people, then there were 20 people, and then suddenly there were hundreds and thousands, and this is how they get rid of people with mental illnesses. This of course is not what's happening. What is actually happening is that in all of these jurisdictions, including the Netherlands and Belgium, the overwhelming majority of these kinds of patients asking for medical aid in dying actually have their requests rejected. To me, that's a really strong indication that protections are in place precisely for these kinds of vulnerable patients, and I'm glad they exist.

Do not get me wrong. I appreciate completely your concern. I'm just saying that when you look at the evidence, beyond anecdotes there is nothing to support these claims, and yes, I'll stick to that.

The Chair: Thank you very much.

We will now move to Mr. Fraser.

Mr. Colin Fraser (West Nova, Lib.): I believe Mr. McKinnon is going to go first.

The Chair: Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair.

Thanks to all the panellists.

I have questions for everyone but I probably won't have time for everyone, so I'm going to start with Professor Arvay.

Mr. Joseph Arvay: It's just "Mr." Arvay.

● (0925)

Mr. Ron McKinnon: Okay.

Recommendation number one of the joint House and Senate committee is that the term "grievous and irremediable" not require a further legislative definition. I take it you would agree with that.

Mr. Joseph Arvay: I do.

Mr. Ron McKinnon: In the event, however, that it is further defined through the definition provided in this legislation, would you agree that "serious and incurable illness, disease or disability"—I understand your hesitation about "incurable"—and "advanced state of irreversible decline" would adequately define the condition?

Mr. Joseph Arvay: The answer is no.

First of all, it's interesting that although the trial judge in the Carter case used language that was somewhat similar to "an advanced state of irreversible decline", she used the language to say that the person had to be in an advanced state of weakening capacities. We didn't argue that. She came up with that on her own. Interestingly, though, the Supreme Court of Canada did not adopt the trial judge's position on that one point; they essentially adopted the trial judge's position on everything except that one point. I see the clause's words "advanced state of irreversible decline in capability" as very similar to what I think the trial judge was getting at.

One problem I have with that clause is that I really don't know what it means. If it requires some sort of progression of "worseness"—I'm not sure whether that's a proper phrase—then I reject it.

One reason we argued against "terminal" is that we had in mind, most notably, a person by the name of Tony Nicklinson, whom you around this table have probably heard about, the man who had locked-in syndrome. He was struck down by a massive stroke when he was 50 years old. He couldn't move one muscle in his body, other than his eyelids—or, I believe, his eyeballs—and yet he was going to be in that condition for at least 20 years. We thought, it's one thing to suggest that someone might be able to tough out the suffering for a few months when death is imminent, but to suggest that someone has to tough it out for 20 years is just inhumane; it's just cruel; it's a form of torture.

When Tony Nicklinson was struck down by this stroke and had developed something called locked-in syndrome, was he already in an advanced state of irreversible decline in capability? Maybe he was, if all that means is that you're symptomatic rather than having something you worry about, but if it requires some sort of progression, a getting worse, well, he wasn't going to get any worse.

So I have a problem with that clause. It raises more questions than it answers. The whole purpose of this legislation, as I heard when the federal government appeared at the Supreme Court of Canada to request an extension, is provide clarity for the medical profession. The medical profession might be chilled by just the Carter decision alone. This, then, was designed to provide clarity. Well, this just adds uncertainty; it doesn't provide any clarity.

Mr. Ron McKinnon: Thank you.

I understand that you think this particular clause should be removed, but in the event that it is retained, is it better to keep it as an "and" as it is, or as an "or" as with the previous one, as Dr. Schuklenk proposes in his brief? Or is it a moot question because it should be gone anyway?

Mr. Joseph Arvay: It should be gone anyway, but obviously, if I had to choose between the reasonable foreseeability clause and the "advanced state of irreversible decline" clause, I definitely want you to get rid of the reasonable foreseeability clause. If the advanced state of irreversible decline clause could be better phrased to simply mean that a person is symptomatic, then it might be workable. Our position is that you just don't need this definition; the Supreme Court of Canada has already sufficiently defined "grievous and irremediable".

One reason, by the way, that we rejected the idea of "incurable" is that I don't know whether any cancer is actually curable, but there may be some diseases or illnesses that are curable but the cure for them is actually worse than the disease.

One thing I want to say is that I've heard the minister say in the House that the premise of this bill is to alleviate suffering in the dying process. The premise of the Carter decision is to allow physician-assisted dying to remedy or alleviate intolerable suffering in life. The premise of the bill is just at odds with the premise of the Carter decision.

I'll leave it at that.

● (0930)

The Chair: Thank you very much.

You have time for one very short question.

Mr. Ron McKinnon: This is an item that I don't think has been raised by any witnesses yet. One of the criteria for being eligible for medical assistance in dying is that the person is eligible outside of for any applicable residence or waiting period for health services funded by a government of Canada. While I understand the policy purpose of this, it strikes me as a little incongruous to have it in the Criminal Code, and it might detract from the rights of people in general who might otherwise legitimately want to receive medical assistance in dying. Could you comment on that?

Mr. Joseph Arvay: I don't really have much of a comment on that point. I'm sorry.

The Chair: Thank you very much.

Now we'll go to Mr. Rankin.

Mr. Murray Rankin (Victoria, NDP): Thank you, Mr. Arvay.

You've obviously been very categorical here this morning with us when you've said essentially—if I'm not putting words in your mouth—that if we as parliamentarians were to pass Bill C-14 in its present form, we would be passing legislation that is unconstitutional. You've said that I think because you've indicated that even Madam Justice Karakatsanis says "we rejected terminally ill" as an approach.

You've argued here that we should leave "grievous and irremediable", as in the words of the court, for fear that we will undercut what the Supreme Court said through legislation of the kind that's currently before us.

Essentially, you've also said—and here's where I want to ask a question about—that "Carter created a floor and not a ceiling". I think you meant that Parliament cannot take away rights that are provided in Carter. In other words, if Carter creates a large circle, we can't simply create a subset of that circle. Is that essentially what you're saying in lay terms?

Mr. Joseph Arvay: Yes.

Mr. Murray Rankin: Therefore, to go ahead and pass legislation like this that would not protect physically disabled people who are suffering intolerably, as they understand it, and to accept cures that they think inappropriate, would be to fly in the face of the highest court in the land and would therefore open us up to immediate constitutional challenge if this bill goes forward.

Mr. Joseph Arvay: I agree with that.

Mr. Murray Rankin: I need to know, then, what amendments we have to make to this bill in order to make it charter-compliant and Carter-compliant, because one of the witnesses told us earlier that in Quebec there are examples of people who have had to starve themselves to death in order to avail themselves of physician-assisted dying in that jurisdiction.

That is likely the reasonably foreseeable consequence of enacting this bill as well. Would that constitute cruel and unusual punishment for people who are required to do that?

Mr. Joseph Arvay: It would be a perverse outcome not only of Carter but of this bill. This person Tony Nicklinson who I mentioned, actually brought his own case in England, and he was unsuccessful there. He ended up starving himself to death. As anybody who knows anything about starving yourself to death knows, that's pure torture.

The trial judge and the Supreme Court of Canada recognized that, and yet under this bill, a person who, like Tony Nicklinson, has 20 years of utter and intolerable misery and suffering ahead of him, would not be able to seek the assistance of a physician in dying but would nevertheless be able to starve himself to death, and maybe not quite to death, maybe to a point where a doctor would finally say, "You know, if you don't drink or eat something in the next few days, your death is reasonably foreseeable." Then bango, he's entitled to physician-assisted dying because he has opted to engage in this process that, in my view, is cruel and unusual.

That seems to be a very perverse outcome of a bill that's supposed to prevent people from suffering.

● (0935)

Mr. Murray Rankin: You argued against Mr. Frater, the Justice lawyer in the extension application. You brought to our attention today this language from the court, which says explicitly in Carter, "we rejected terminally ill".

Is there any way of reading these sections in this bill in which they define "grievous and irremediable" but saying that it's about temporal change? Can you read it in any other way?

Mr. Joseph Arvay: I can't.

Mr. Murray Rankin: In light of that exchange, how can the government be bringing forward legislation that appears to be limited to terminally ill or late-life conditions in the face of that rejection by the Supreme Court?

Mr. Joseph Arvay: Obviously I have no idea who is advising the government and what's motivating the government, but to be very candid about this, I'm dismayed that I have to be here. We fought a very long, hard, expensive battle on this issue, and we were successful. For reasons that just baffle me, the government lawyers or the government advisers seem to fail to acknowledge or come to grips with the fact that the Carter decision allows all grievous and irremediably ill people, irrespective of whether their death is foreseeable, to avail themselves of physician-assisted dying.

What I think has happened—and it's so regrettable—is that the government has somehow become captured by the rhetoric of the disabled rights organizations. Their rhetoric is that all physically disabled people are presumptively and irrebuttably presumptively vulnerable and that they're incapable of ever making their own decision as to when their suffering is intolerable.

They take that position because many disabled people—and I am one of them—have managed to tolerate and adapt to their suffering and choose life over death. But to suggest that all physically disabled people have to subscribe to that notion is not only patronizing but infantilizing; it's treating all physically disabled people as children, incapable of agency and autonomy. I find that incredibly offensive. The trial judge did; the Supreme Court of Canada did. I don't get why this government doesn't understand that.

The Chair: Thank you, Mr. Arvay.

Thank you very much, Mr. Rankin.

Mr. Fraser.

Mr. Colin Fraser: Thank you very much, gentlemen, for appearing today and for your excellent presentations.

I'd like to start with Mr. Nicholas, if I could.

You talk about palliative care. I know the government is committed to putting money into palliative care. Everyone obviously agrees that this needs to be an important component going forward to ensure there is compassion in end-of-life decisions.

With regard to freedom of conscience, I don't know that anyone would disagree that there should be a right for people to not perform these tasks, if doing so goes against their conscience.

You talk about no other foreign jurisdiction forcing medical practitioners to carry this out. But you'd agree with me that there is no national government within a federation that has dealt with this situation. All of the other ones are not federal governments.

Mr. Graydon Nicholas: You're thinking of the type of government we have in this country as distinct from those in other countries.

● (0940)

Mr. Colin Fraser: Right.

Mr. Graydon Nicholas: Well, irrespective of the form of government, the fact of the matter, in my opinion, is.... This witness is a counsel, and I used to be a counsel, and you cannot foreclose a defence argument in the future on any legislation under the Criminal Code, because it's subject to the charter. All sections are like that. If you don't specifically put into legislation protection of the right to conscience, it's going to be brought up anyway.

If you're silent as a Parliament on this issue, there probably won't be enough courtrooms in Canada to handle all the litigation and defences that are going to occur because of this, because you're dealing with thousands and thousands of people involved in the medical profession.

Mr. Colin Fraser: That's referenced, obviously, in the preamble. There are suggestions to that effect.

With regard to the law itself, what we're doing is amending the Criminal Code, and it lies in the jurisdiction of the provinces and the medical profession itself to regulate and to pronounce on these conscience rights.

Would you not agree with that?

Mr. Graydon Nicholas: With the greatest respect, if you look at the preamble of the Charter of Rights and find out how the courts have used those words in the opening comments, you'll find that it's a nice statement, a flowery statement, but in terms of effect, it doesn't have much, in the actual interpretation of a particular right or a particular section that's being considered.

That's all I'm saying, and I'm not saying anything new. If you talk to litigators, people who defend people in criminal processes every day, they'll tell you that as well. That does not relieve Canada, however, of its obligations under these two instruments.

Canada can't go to another country and say, “you're a terrible government; you're infringing on the rights of your people, which are human rights that the United Nations recognizes”, and then all of a sudden Parliament says, you don't have the right to freedom of conscience. What's that going to do?

Mr. Colin Fraser: You would agree with me, though, that this is an amendment to the Criminal Code and that nothing in here compels any medical practitioner or nurse practitioner to carry out something that is against their conscience.

Mr. Graydon Nicholas: The way it's open-ended now, if you look at those provisions under this Bill C-14, and if you look at the offences that are created because of this, if you don't notice, if you don't do that, you're subject to a criminal charge, and then of course when you're subject to a criminal charge, you have a right to defend yourself.

Mr. Colin Fraser: Where in here does it compel anybody to do it? It's a criminal exemption. Where does it compel?

Mr. Graydon Nicholas: Just look at the offences you've created under this bill. I'm not going to go into a debate. There are offences created under this legislation. For example, proposed section 241.3 is one that is an offence because you're creating a hybrid offence. It could be an indictable offence or it could be a summary conviction offence, and then of course the prosecutors will determine which category under a particular circumstance.... Whenever you have an offence created by legislation....

Mr. Colin Fraser: Sir, with great respect, I understand there are offences in here, but it has nothing to do with compelling a medical practitioner. That's about failure to comply with safeguards. That's not saying somebody has to do it. You'd agree with that at least.

Mr. Graydon Nicholas: Look at the section under what you're contemplating as regulations, proposed subsection 241.31(4). If there is a regulatory scheme that's going to be set up, or whatever this is going to look like, if you don't refer a patient to somebody else, or you don't even want to do that, what's the licensing body in each province going to do?

Mr. Colin Fraser: I'll leave it there.

I'll move to Mr. Schuklenk if I can.

Thank you for being here and for your presentation. You talked about the Netherlands and Belgium, and I'd like to just reference that in each of those jurisdictions there's a difference with regard to a waiting period. In Belgium there's a waiting period for a month if death is not imminent, and in the Netherlands there is no waiting period, as I understand it. Is there any difference, from your point of view, with regard to psychiatric illness, in those jurisdictions where there's a waiting period or there's not a waiting period?

Dr. Udo Schuklenk: Do I think a waiting period is a reasonable thing, like the four-week waiting period in Belgium, for instance? I find it very reasonable. I'm not a lawyer, obviously, but it seems reasonable to me that if somebody is not imminently dying, there's no reason that one should not want to be really certain that this wish is stable over time.

Mr. Colin Fraser: Thank you very much.

The Chair: You have one small question left, Mr. Fraser.

Mr. Colin Fraser: Sure.

Mr. Arvay, thank you for your presentation. Do you believe that simply striking out proposed paragraph 241.2(2)(d) relating to “reasonably foreseeable” make the definition of “grievous and irremediable” in this law charter-compliant?

Mr. Joseph Arvay: It would certainly improve it substantially, but in order to ensure its constitutionality, I would remove the entire definition, because it undermines the clear definition, the clear declaration in the Carter decision. The reference to “incurable” is problematic. The reference to the condition being aggravating is problematic. Obviously the clause that troubles me the very most is the reasonable foreseeability one, but if you really want to ensure that the legislation will withstand constitutional scrutiny, I would remove the whole definition.

● (0945)

The Chair: Thank you very much.

If the panel agrees, I just have one very short question for Mr. Arvay.

Mr. Arvay, thank you very much for your testimony today. It was helpful. I have one question, and it's related to an issue Mr. Rankin brought up and an example you provided. It's a bit of a different question, because I understand very clearly your belief that the drafting as it is now is not charter-compliant. There have been many witnesses at this point who have brought up using self-starvation and self-dehydration so somebody would then stumble into the definition as a result of their own purposeful actions. Whether we agree to drop all of these definitions and go back to the original Supreme Court one, or we stick with the current one—and I understand you think it's not charter-compliant—would it be constitutional for us to amend the bill so that some of these purposeful actions would not allow them to have medically assisted dying because of their decision to starve, or become dehydrated, or do anything else to demean themselves and cause them to stumble into this state? Would that be constitutional?

Mr. Joseph Arvay: Absolutely not.

The Chair: Okay.

I want to thank the panel very much for its testimony.

We're going to take a brief recess so we can get the next panel up.

● (0945)

(Pause)

● (0950)

The Chair: Welcome back, ladies and gentlemen.

I want to welcome our next panel of witnesses. It's a great pleasure to have all of you here with us. On video conference we have Dr. Harvey Max Chochinov, who is a professor of psychiatry at the University of Manitoba.

Dr. Chochinov, welcome.

Dr. Harvey Chochinov (Professor of Psychiatry, University of Manitoba, As an Individual): Thank you.

The Chair: We have Jennifer Gibson, who is appearing as an individual and who is director and Sun Life Financial chair in bioethics at the University of Toronto's Joint Centre for Bioethics.

Welcome.

We have Mr. Josh Paterson, who is the executive director of the B. C. Civil Liberties Organization.

Welcome.

Since I didn't have a chance to talk to Dr. Chochinov, as he is on video conference, let me say that the way it will work, sir, is that we have eight-minute statements by each member of the panel. We would very much appreciate your sticking to the bill itself and your proposed amendments to the bill.

Afterwards there will be questions from members of the committee for each of you. I look forward to all of your testimony.

We always start with the witness who is on video conference, so we're going to start with Dr. Chochinov.

Dr. Harvey Chochinov: Honourable members of Parliament, my name is Harvey Max Chochinov. I hold the academic rank of distinguished professor of psychiatry at the University of Manitoba. I direct the Manitoba Palliative Care Research Unit, and I hold the only Canada research chair in palliative care. I've spent the entirety of my career working and conducting research in palliative end-of-life care. I'm also the former chair of the external panel on options for a legislative response to Carter v. Canada.

It is my privilege today to share some thoughts on Bill C-14 focusing on possible amendments for your consideration. My submission, which you've received, outlines these in more detail and also includes my rationale for why the current limitations described in the bill, including limiting access to patients whose death is reasonably foreseeable and not including provisions for mental illness, advance directives, and minors, are eminently justifiable and prudent.

The amendments I've put before you for your consideration include the following.

Number one, the government should consider an amendment stipulating that medically hastened death will take the form of assisted suicide, so long as patients are able to take lethal medication on their own. Euthanasia would be reserved for instances in which patients are no longer able to ingest lethal medication independently.

International experience reveals that euthanasia and assisted suicide are vastly different in terms of their uptake and lethality. In the jurisdictions that offer only physician-assisted suicide, the latter accounts for about 0.3% of all deaths. In jurisdictions that offer euthanasia, that form of death accounts for 3% to 4% of all deaths.

Extrapolating these figures to Canada and anticipating approximately 260,000 deaths per year, a regime offering physician-assisted suicide exclusively would expect about 800 to 1,000 of these deaths annually. On the other hand, a regime dominated by euthanasia could expect between 8,000 and 10,000 of these deaths annually.

According to experts appearing before the external panel, this vast difference is largely accounted for by ambivalence. Ambivalence is an important dynamic in considering a hastened death. While assisted suicide offers the possibility of changing one's mind—30% to 40% of patients in Oregon who receive a prescription never in fact use it—euthanasia dramatically reduces that possibility, once it has been scheduled and expectations are set for a specific time and place.

The data is clear. This will ensure that thousands of people each year who are ambivalent about an assisted death will not feel pressured by circumstances to proceed before they are ready to die.

Number two, the government should consider an amendment requiring that all patients obtaining medically hastened death should first be provided with a palliative care consultation. This would be over and above the duties of the two physicians described in the current bill and would be critical, so long as the bill limits access to patients whose natural death is reasonably foreseeable and who are in an advanced stage of irreversible decline in capacities.

The palliative consultants would not be in a decision-making role; rather, their role would be to identify all physical, psychosocial, existential, and spiritual sources of distress underlying the request to die; to ensure that patients are fully informed of all options that could be initiated on their behalf; and finally, to document their findings so that prospectively collected, anonymized information could be entered into a national database providing a detailed and objective basis for Parliament's five-year review of Bill C-14.

Number three, the government should consider an amendment requiring judicial oversight and approval for all medically hastened deaths. Judicial oversight would ensure a precedent-based, consistent, and clearly articulated set of benchmarks regarding when eligibility criteria have been met.

Judicial oversight would insulate health care institutions and professions from any perceived or real hazards associated with medically hastened death and would likely increase access, given the increase in number of health care professionals who would be prepared to engage with patients requesting medically hastened death. Oversight would demonstrate profound leadership, indicating that while Canada has made medically hastened death legal, our government does not yet know how this fits into our current system of health care.

Number four, in the most profound way possible, judicial oversight would ensure a commitment to transparency and objective evaluation of all factors, be they medical, emotional, psychosocial, financial, or environmental, that might underpin a request for medically hastened death.

● (0955)

In conclusion, I believe that the limitations and safeguards currently included in Bill C-14, together with these suggested amendments, would see Canada's approach to medically hastened death marked by integrity, transparency, and wisdom. Thank you.

The Chair: Thank you very much.

Mr. Paterson.

Mr. Josh Paterson (Executive Director, British Columbia Civil Liberties Association): Thank you very much.

I'm pleased to be here today. I just want to say that although I'm not addressing all of our concerns today, the B.C. Civil Liberties Association continues to stand by our previous submissions to the parliamentary committee that went before.

Today my focus is simply on making the bill Carter-compliant. Bill C-14, in our view, must be amended in order to ensure compliance with the Carter decision and with the Charter of Rights and Freedoms. I have to say we were shocked when we first saw this bill and we learned that not only did it ignore many of the core recommendations of the parliamentary committee, but it actually cut out part of the heart of the victory that our organization had won in Carter.

In our view, this bill forgets what the Carter case was about. This case wasn't just about helping people with terminal illnesses to have a dignified death of their choosing; it was equally about ensuring that people who are trapped in unimaginable suffering from non-terminal illnesses have the right to escape a lifetime of indefinite suffering. Both of these kinds of people were before the court, and importantly, our organization was granted public interest standing to argue this case as an institution, in respect of various kinds of patients. The ruling was not limited to terminal cases, as we know from the mouth of the Supreme Court itself in January. It did not limit the decision to terminal people or to people who were foreseen to die.

The government says, well, this restriction isn't a restriction to those who are terminal. We say that the effect is the same, that under this bill, someone needs to be dying in order to qualify. The court itself has said that this is wrong.

We won that victory after years of gathering evidence, of tireless work, of fighting a federal government that opposed the realization of this right tooth and nail. We systematically were able to beat each of those arguments that were mustered by the government over multiple years. We knew, in winning, that this would make a real difference for people who would otherwise suffer intolerable and terrible deaths. We knew it would make a difference for people who were suffering unimaginably from grievous and irremediable illnesses in life, and now we see this victory being hollowed out, being taken right out of the bill for half of those people.

In order to remedy this, we support the amendment that was referred to by Professor Downie in her remarks yesterday. We take the position that prohibiting patients whose deaths are not reasonably foreseeable from having the choice of medical assistance in dying violates the charter, and that the entire section referring to the definition of “grievous and irremediable” in the bill should be eliminated. In its place, we believe that proposed paragraph 241.2(1)(c) should be amended to state that a person must have a grievous and irremediable medical condition, including an illness, disease, or disability, that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. This, we believe, will bring the criteria in line with Carter.

If Bill C-14 is not amended to eliminate the requirement that a condition be “incurable” rather than “irremediable”, the requirement that there be an advanced state of irreversible decline, and the requirement that natural death be reasonably foreseeable, the result will be terrible suffering for those Canadians who are barred from accessing medical assistance in dying—and that's what this is about. It's not an academic exercise, or even an exercise, as is often done in this place, quite appropriately, in balancing political interests. It is about the intolerable and unimaginable suffering of real Canadians, and about their rights.

The “reasonably foreseeable” requirement is terribly vague. You've already heard from numerous witnesses who have said so, including The College of Family Physicians of Canada, representing the doctors who are most likely to be dealing with these issues. We believe this requirement, in particular, of reasonably foreseeable natural death, is unconstitutional because it violates the charter right to liberty. It deprives a patient of fundamental choice related to their body. The court concluded that the Criminal Code in its original form, through its blanket prohibition on the right to request a physician's assistance in dying, interfered with liberty by restricting the ability of qualifying patients to make decisions concerning their bodily integrity and their medical care.

● (1000)

It interferes with the charter right to security of the person because it causes a patient to continue to endure suffering, and it interferes with the charter right to life. Since individuals are deprived of the choice of an assisted death, there are some individuals who may take their own lives prematurely in order to avoid intolerable suffering, while they are still physically able to do so.

Now, the government suggests that restricting access to assistance in dying to people whose deaths are “reasonably foreseeable” is justified because it will protect the vulnerable. We've heard already from Mr. Arvay that this argument was used by Canada at court, and the court's decision was clear: Parliament cannot rely on a blanket exclusion of a whole class of people to protect the vulnerable when other less-interfering means are available to do the same thing, for example, to assess decisional capacity on an individual basis. Canada even conceded at the trial, in Carter, and I'm quoting from the Supreme Court reasons:

> “It is recognised that not every person who wishes to commit suicide is vulnerable, and that there may be people with disabilities who have a considered, rational and persistent wish to end their own lives”.

There's a really easy way to understand this, and it's that these arguments were made already. As has been described, there is a circle, a class of people, who won a right, who were guaranteed a right. Canada tried to say they didn't have that right; they tried to justify it. Those arguments failed, and that right was recognized. Now the government is taking those same people and trying to pull them out of that protection and use some of the same justifications. This isn't a dialogue. This is the court saying, “This is the law” and the bill saying, “No, it's not the law. We say something else is the law. We say something else is constitutional”. That is just wrong, and frankly, we don't think it will withstand a constitutional challenge, and the result will be costly relitigation of the same point that's already been decided by the Supreme Court of Canada.

In the minute I have remaining, I don't want to spend too much time on it, but I do want to touch on this idea of prior judicial approval that continues to come up in committee. It is a complete departure from current end-of-life practices, and it's one that, of course, as many of you will know, Canada has tried before in respect of abortion, and it was rejected in the Morgentaler decision. The court there held that this procedural barrier of prior approval contributed to violating the charter rights of women by creating delay and, fundamentally, by directly interfering with women's autonomy to make choices about their own bodies by putting a state approval in place in front of their choice. Our experience as counsel with the exemptions right now is that prior approval is costly, time-consuming, prone to delay, and a significant barrier to access. It would be a real mistake for Parliament to reproduce a prior state-approval function for this kind of profoundly personal medical decision when it was soundly rejected nearly 30 years ago in relation to other profoundly personal medical decisions.

Thank you.

● (1005)

The Chair: Thank you very much.

Ms. Gibson.

Ms. Jennifer Gibson (Director and Sun Life Financial Chair in Bioethics, University of Toronto Joint Centre for Bioethics, As an Individual): Thank you.

Good morning everyone, and thank you so much for the invitation to join you. As some of you may know, I co-chaired the provincial-territorial expert advisory group on physician-assisted deaths. Most recently I've been working with the Joint Centre for Bioethics task force on medical assistance in dying, in collaboration with health system stakeholders, to prepare for the implementation of medical assistance in dying in Ontario.

Today, though, I'm speaking as an individual. Although the chair has advised that we should not take a philosophical approach, I will be tapping into my disciplinary expertise in ethics and policy to provide an additional perspective to today's conversation.

Over the last few days I've had the opportunity to listen to the testimony of several panels. It has been fascinating and admittedly predictable to see convergence in some areas and continuing divergence in others. Bill C-14 is fundamentally an amendment of the Criminal Code within the parameters of the Charter of Rights and Freedoms and the charter ruling, and it has implications for the conduct of health care. But it is not the comprehensive regulatory regime envisioned in the Carter decision.

This week's discussions underscore how much of the work that we are collectively undertaking through this consultative process is not just legal, although it's about legislation and proper jurisdiction, nor political, although it is part of a parliamentary process. It is also fundamentally what I would call values work, by which I mean the pursuit of a right balance in C-14 of three ethical goals: recognizing and protecting individual autonomy, alleviating or minimizing suffering, and preventing harm. All three ethical goals have been articulated in witness testimonies over the course of the last three days.

As written, Bill C-14 proposes one way to balance these three ethical goals. Specifically, as noted in the preamble, it seeks to strike the most appropriate balance between

> the autonomy of persons who seek medical assistance in dying, on one hand, and the interests of vulnerable persons in need of protection and those of society, on the other.

It proposes that this balance be achieved by limiting access to medical assistance in dying to competent adults whose natural deaths are reasonably foreseeable.

Is this the most appropriate balance? Testimony in the last three days suggests otherwise, and I would agree. Witnesses have rightly challenged the definition of “grievous and irremediable medical condition” and particularly proposed paragraph 241.2(2)(d), that is, the much-beleaguered “reasonably foreseeable” paragraph.

In my brief, I recommend removing that “grievous and irremediable” portion entirely and amending proposed paragraph 241.2(1)(c) to bring greater clarity, coherence, and consistency with the parameters already laid out by Carter.

Given its definition of “grievous and irremediable”, Bill C-14 denies medical assistance in dying for competent persons who have a “grievous and irremediable medical condition that causes...enduring and intolerable suffering” but who are not—quoting from the legislative backgrounder—“nearing the end of their lives” or “on a trajectory towards their natural death”, and whose medical condition is not itself fatal.

One might argue, as some witnesses have done, that to limit medical assistance in dying this way offers an important safeguard to protect vulnerable persons who might, as per the preamble, be “induced, in moments of weakness, to end their lives”. But if, as other witnesses have argued, persons like Kay Carter would not be eligible for medical assistance in dying, then many suffering Canadians are being left behind by Bill C-14.

To paraphrase Mr. Bauslaugh's testimony from yesterday evening, Bill C-14 rations compassion only for the suffering of those who are dying. For many, including me, the balance of autonomy, protection of the vulnerable, and minimizing of suffering have not yet been achieved with this definition of “grievous and irremediable”.

There is another area that puts into question whether Bill C-14 is successful in balancing these three key ethical goals. Several witnesses yesterday spoke about the exclusion of mature minors, competent persons who are enduring intolerable suffering from psychiatric illness, and competent persons seeking to make an advance request for medical assistance in dying.

These exclusions, possibly temporary pending further study, as per the non-legislative commitment articulated in the preamble, are explained in the legislative backgrounder as necessary to protect “vulnerable persons” in these “complex” situations. However, exclusion of competent persons on the presumption of vulnerability does not serve the end of balancing autonomy and preventing errors and abuse and may, I fear, actually have the opposite effect of marginalizing and further entrenching the social vulnerability of the very individuals we are seeking to protect.

● (1010)

The protection of vulnerable persons turns on safeguarding competence, voluntariness, and consent. Exclusion of otherwise competent persons may be justifiable to the extent that this is proportional and necessary to prevent another injustice. Failing this, though, these exclusions violate the autonomy of competent persons in these groups and unjustly force these individuals to remain in a state of enduring and intolerable suffering.

Waiting until the fifth year following royal assent to address the results of additional study would be neither reasonable nor just. Hence, echoing other witnesses, my brief recommends that Bill C-14 be amended to establish an expedited schedule for study of medically assisted dying involving mature minors, competent persons with primary psychiatric illness, and persons who have given advance consent while competent.

I will close my brief remarks with the final reflection on vulnerability as it relates to Bill C-14. The call to protect the vulnerable is one that we all share, and it's morally praiseworthy. However, we must ask ourselves who decides who is vulnerable. Is it the individual through his or her lived experience, or is it the rest of us in society who decide what type of vulnerability matters and to whom, and what the appropriate response to vulnerability is?

Witnesses have offered different responses to these questions. Some wish to set limits on which competent person should be eligible for medical assistance in dying, excluding those who are perceived to be in need of protection or susceptible to moments of weakness. Others wish to set up procedural safeguards to protect competence, voluntariness, and consent.

Bill C-14 offers an uncomfortable compromise among these different responses, tilting the balance of ethical goals precariously away from preserving individual autonomy and minimizing intolerable suffering of competent persons.

I know we can do much better for Canadians.

Thank you.

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

Now we will move to questions for the panel, beginning with Mr. Cooper.

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

Thank you to the witnesses. I will direct my questions to Professor Chochinov.

You listed a series of safeguards that you think should be included in the way of a legislative response. You mentioned a palliative care consult. You mentioned a review panel. I found it quite interesting, because those were precisely the safeguards that were recommended by the plaintiffs in the Carter decision, and they are cited in Madam Justice Smith's decision at paragraphs 876 and 879. Madam Justice Smith, in the British Columbia Supreme Court decision, at paragraph 854, stated that, based upon the evidence, she could reach no conclusion other than that there are inherent risks in permitting physician-assisted dying; and only after having regard for the safeguards that the plaintiffs put forward, including a review panel, was she satisfied that those risks could be substantially minimized.

Another safeguard that had been put forward by the plaintiffs was a psychiatric evaluation in addition to a palliative care consult. Is that a safeguard that you would see as appropriate in addition to a palliative care consult?

● (1015)

Dr. Harvey Chochinov: Right now the way the bill is worded, it talks about availability for those whose deaths are “reasonably foreseeable”. It's for that reason that it seems to me there is and ought to be a place for palliative care consultation. It's only reasonable that if somebody is going to give valid, informed consent, they be aware of all of the things that are available to them so they really know what their options are.

With respect to the question, though, of psychiatric consultation, and psychiatric consultation in every single request, I know that the Canadian Psychiatric Association has said that if there is a concurrent psychiatric illness, if there is a question about the degree of competence, then a psychiatric consultation would be reasonable. In not every instance will it be required to have a psychiatric consultation to determine whether or not the person is competent.

Again, given the way the current bill is worded, and given that it's talking about death being “reasonably foreseeable”, I included the provision for palliative care consultation being a part of every evaluation. Psychiatric consultation should not be included because psychiatric issues are not going to be a part of every scenario in which somebody is requesting to die.

Mr. Michael Cooper: Thank you for that.

If, for example, someone was diagnosed with an underlying mental health challenge, it would be your view that in that case someone should undergo a psychiatric assessment to determine capacity to consent. Would that be fair?

Dr. Harvey Chochinov: I think so. Again, two physicians are involved in making those evaluations, and certainly physicians are involved in determining things around competence, but if there is an underlying psychiatric issue that is felt to be clouding the way that person is presenting, and making it difficult to determine whether or not there are underlying psychiatric issues that are driving them towards a wish to die, then the role of psychiatry would seem to be supported.

Mr. Michael Cooper: Right now the legislation simply provides that two physicians, any two physicians out of the some 80,000 who are certified to practise in Canada, could determine whether or not someone meets the criteria. It wouldn't even have to be two physicians. It may be two nurse practitioners. Do you as a psychiatrist think that when we're dealing with something that may be a determinant of whether someone has the capacity to consent, a nurse practitioner or any physician in Canada could undertake that type of analysis?

Dr. Harvey Chochinov: I think we have to go beyond the issue of whether they have the capacity to consent. When our panel was doing our various consultations around the world, I remember when we were in the Benelux countries we met with physicians, some of whom were engaged in this practice. Those who were practising it in a way that I thought was perhaps the most careful and responsible were saying that their duty is not only to determine whether or not they meet eligibility criteria but also to find out the antecedents of a wish to die. What is underpinning a person's request to end their life?

When you look at people's reasons for seeking a hastened death, medical circumstances alone are in the minority. Much of the research I have done over the last 15 years actually began with the fact that in Holland loss of dignity was the most highly cited reason for people seeking an assisted death. If you go to Oregon, on the other hand, it's not about physical pain. It is, in most instances, about loss of autonomy. There are existential issues. There are things that cause people to feel as though they are a burden on others.

The reason I suggested earlier that there needs to be some form of larger oversight, and I suggested judicial oversight, was that the sources of distress that underpin a wish to die aren't just within the area of expertise of physicians who can evaluate whether or not somebody is in pain or who can evaluate some of the physical sources of distress; there are also going to be social issues and financial issues and environmental issues. All of those things need to be evaluated if we're going to do a good job of determining whether or not we understand why somebody is seeking out a hastened death.

● (1020)

The Chair: Ms. Khalid is next.

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

Thank you, panellists, for your great presentations today.

I want to start off with Dr. Chochinov if I may.

You mentioned in your presentation and also in your brief the requirements to have palliative care as a “must” prior to the administration of MAID. We also know that the Constitution really does separate jurisdiction and the powers between the federal government and the provinces, and health care does fall into the provincial realm of administration and governance.

My question to you, then, is, would such a requirement of a mandatory palliative care consultation perhaps fall within the provincial jurisdiction in terms of the actual administration and the process of MAID?

Dr. Harvey Chochinov: I think you'll have to speak to the lawyers, who have more expertise than I have in those matters. I'm just the lowly physician on the panel.

On the other hand, the Government of Canada is initiating a policy that will allow for medically hastened death. If that is the case, they also want to make sure that people are giving valid, informed consent. Part of getting valid, informed consent is that somebody know and be aware of all of the options available to them.

It seems to me that a palliative consultation—not just, by the way, for somebody who is requesting medically hastened death, but for any dying patient who is experiencing intolerable suffering.... It seems unimaginable that in the Canada we know and love, a palliative consultation and the availability of palliative care expertise wouldn't inform what we would want to be in place and available for all patients before a decision was made that a hastened death would be provided.

Ms. Iqra Khalid: I'll turn to the lawyers to give a comment on that.

Ms. Jennifer Gibson: I struggled a bit with whether or not we must require a palliative care consult in all cases. Indeed, if we look at what clinical practice actually looks like these days, you might have a patient before you and, given the needs of that patient, you might bring in any number of consults: you might bring in somebody with a social work perspective to help inform the work; you might bring in somebody from palliative care; you might invite a psychiatric consult—but all of that is driven by the needs of the patient.

It is here that I think there is a divide between what we might like to see in a Criminal Code amendment and what is really the domain of good clinical practice, which falls under the jurisdiction of the provinces.

Ms. Iqra Khalid: Mr. Paterson.

Mr. Josh Paterson: I don't have anything to add to what Ms. Gibson said.

Ms. Iqra Khalid: Okay.

Dr. Chochinov.

Dr. Harvey Chochinov: I was going to ask whether I could respond to that as a follow-up.

The Chair: I think so.

Is that right, Ms. Khalid?

Yes.

Dr. Harvey Chochinov: As Ms. Gibson said, it's true that in clinical practice one could call on any one of a number of disciplines. I think the reason for talking about palliative care consultation per se is that palliative care more than any other discipline in medicine is implicitly multidisciplinary. We would have people who have expertise to tap into the psychosocial, existential, spiritual and physical sources and dimensions of suffering.

I think the other reason to mandate a consultation—and again, not just for people who request a medically hastened death but for all dying patients who have intolerable suffering—is that if it is mandated and if the information collected then is entered into an anonymized national database, it provides the basis for Canada's five-year review.

Parliament is committed to a five-year review. If we don't do something a priori to start collecting that information, five years from now what will there be to review? What are we going to say? Are we simply going to say, here's the number of people who have done it and there don't appear to have been any complaints? I say that is not enough; I think we need to be thinking not only about the next five years, but the five years after that, and we need to have some information available to provide the basis for Parliament's review.

● (1025)

Ms. Iqra Khalid: Thank you.

Dr. Chochinov, you also mentioned that we need to have judicial oversight, and Mr. Paterson rather contended against what you said. I'm wondering whether both of you can add a comment.

I would think that such judicial oversight would cause further delay with respect to patients who are wanting to go through with MAID. We already have 15 clear days of consent and a cooling-off period that's required, as is indicated in the bill. I'm wondering how much of an additional time-processing requirement judicial oversight would create and whether such a process is necessary.

May I have your comments on that, and then Mr. Paterson's?

Dr. Harvey Chochinov: Sure.

How is judicial oversight working now in terms of the constitutional exemption? Are there inordinate delays?

My sense is that this doesn't appear to be the case.

I think it's worth reviewing that data and looking at it. Certainly it is not meant to cause inordinate delay, although Mr. Paterson hearkened back to the abortion experience. We're several decades after the fact. We have technologies that should be able to allow virtual connections so that people can have more expedited review.

The even broader issue to consider with judicial oversight is whether there is a public interest in knowing how this takes place and in being as transparent and objective as we can so that Canada can say to itself and its countrymen and to the international community that although the Supreme Court has made this legal, that does not necessarily mean that it has made it medical. We have not yet figured out whether or not this clearly fits into the system of health care.

Having been on the external panel, I went around the world and spoke to different physicians, and I can tell you nobody comfortably responded to the question that yes, this is part of medicine. We had one physician in Oregon who described this as an act of love. We had a physician who was engaged in these practices in the Benelux countries, who himself was directly involved in this, and he said this is not medicine; this is a social act; this is a change in our social contract.

Well, again, if that's the case, wouldn't Canada want to commit to the most transparent process possible, the most objective process possible, and for the first five years insist on judicial oversight, not to create inordinate delay, but to say we're going to do this in a very transparent way, and we're going to be courageous enough five years from now to live with the outcome of that data? If the data says that we have been too restrictive, then I think all of us need to be adherent to the data and say that it is time to open it wider. If the data says that there have been many instances vis-à-vis judicial oversight where people have been found to be vulnerable, and other steps needed to be taken, then we have to stand back and say, well, perhaps we are narrow enough, or we need to be even narrower.

Those are the rationales that I would offer for judicial oversight.

The Chair: Thank you.

Mr. Paterson, you can have a last word on this. Then we'll go to Mr. Rankin.

Mr. Josh Paterson: I'm happy to offer the last word on it.

Despite the passage of time since Morgentaler, there's no meaningful shift in the reasoning that was used there.

Justice Bertha Wilson, in that case, concurred with five different judges, and they all gave different decisions. She remarked that this section

> takes the decision away from the woman at all stages of her pregnancy. It is a complete denial of the woman's constitutionally protected right under s. 7, not merely a limitation on it.

She then goes on to say that:

> The purpose of the section is to take the decision away from the woman and give it to a committee.
>
> It asserts that the woman's capacity to reproduce is to be subject, not to her own control, but to that of the state. This is a direct interference with the woman's physical "person".

Those same rationales would apply forcefully here.

With regard to the benefits to which Dr. Chochinov points in terms of our needing to know how this is being done and so forth, there are many other ways of finding out that information, of gathering data and so forth, that have nothing whatsoever to do with saying this is a decision that ought to be made by some delegated body exercising state authority under a statute.

If I may, I'd like to respond to Mr. Cooper—

● (1030)

The Chair: Sorry, you can't.

We have to go to Mr. Rankin. We have a deadline, and you can't just respond to Mr. Cooper at this point.

Mr. Rankin.

Mr. Murray Rankin: Thank you.

First of all, I'd like to say thank you to each of the panellists separately.

Dr. Chochinov, we had the benefit at the Senate/House committee of your colleague Maître Pelletier, who was very helpful. You weren't able to be there so it's good to meet you here. Thanks for your work on the expert panel.

Dr. Gibson, your leadership in the provincial and territorial task force is really quite remarkable, and thank you so much for all of the work that you have done respectively.

Of course, Mr. Paterson, than you for your dogged litigation in the Supreme Court as an intervener in Carter. We're very fortunate to have you here.

I want to start with you, Dr. Gibson, on the issue of vulnerability. I want to give you an opportunity, because you were going quickly at the end of your remarks on the issue of vulnerability.

Could you elaborate a little for us and put it in the framework of BillC-14 and explain how we can do much better in conclusion?

Ms. Jennifer Gibson: Some of my current concerns are about the way in which, in a sense, the shift from the Carter decision to Bill C-14 seems to have been motivated by a real concern about vulnerable populations. We've heard from Mr. Arvay this morning about this having led to certain exclusions of persons who have been labelled and classified as vulnerable.

I think that's a dangerous shift, actually, because as long as we label somebody as vulnerable, we are eroding their capacity. We are presuming that they are not capable, and in so doing we are treating them as unequal to the rest of us in society. I think that's a dangerous direction to be moving in.

At the same time, we are concerned about vulnerability. I think there are other mechanisms through which we can meet that concern. The current safeguards that are articulated here are definitely on the right track, but I start to become nervous when we move in the direction of thinking of prior review, of judicial oversight, which I think is motivated by a concern sometimes framed as enhanced transparency but more often as a way to address issues of vulnerability, while we have mechanisms within health care practice that would better serve that goal, and indeed, from a patient perspective, ensure a much more seamless experience for them at the end of life.

With regard to the judicial review process, we have had some experience over the last three months of cases going through the judicial review process to receive access to assisted death. One of the individuals who went through this process pleaded that this not be the mechanism by which they access assisted death because it is a burden, at the end of one's life, to be going through that particular process.

Mr. Murray Rankin: Mr. Paterson, you were very passionate in saying things such as that this bill cuts the heart out of your victory in Carter. You said it hollowed out half of the people from your victory.

Those are provocative phrases. I want to give you the opportunity to elaborate on why you think this bill, in its current form, would be contrary to the Carter case.

Mr. Josh Paterson: There are a number of reasons. I've enumerated some of them, and our written submissions describe the matter in a little more detail.

Let's say there was another charter rights case in which there was a class of persons who won a right. Take gay marriage, for example. Let's say that in response to a case on gay marriage—or pension rights, or that kind of thing—the government of the day said, we're going to bring in a bill, but because the plaintiff was a gay man, and although yes, there was mention of lesbians and trans people throughout, and so forth, we're going to just restrict it to gay men, and it will be up to lesbians at some point in the future to bring another case.

In some ways this feels very analogous to that. There was a right recognized for an entire class of people. Now this bill is reaching in and taking people out of it. The dialogue, if I may say so, between Parliament and the courts is meant to be, in terms of rights recognition, about the implementation of the right. We can all have different views on how many doctors and how many witnesses and waiting times, and so forth. The committee will know our views; others have different views.

That's what the dialogue is about. It cannot be about simply cutting people out.

A great example comes from not even the “reasonably foreseeable” context, but the “incurable” context, wherein, as you'll note in our written submissions, you could very well have a person in late-stage cancer—anal cancer, in the example we used in our written submissions—for whom further rounds of very painful and difficult treatment could potentially, for her, cure her illness, could eliminate the cancer; yet she may very well say, “That is going to cause burns to my vulva and to my anus and cause me to have sexual dysfunction and cause all these other awful things—even in potential success, if I do succeed—but I don't want to face that.” That person could very well be cut off because of this “incurability”.

What the Supreme Court said was “irremediable”. Then they defined it: they said “by any means acceptable to the patient”. There have been some questions about this. I know Mr. Bittle had an exchange the other day with the Department of Justice about it and about whether this is the same or different. The minister and officials have tried to suggest, I think, that it's the same, but fundamentally it appears different to us.

The minister contended that while there's still a piece about the pain or suffering not being remediable by conditions acceptable to the patient, it's different:, because that individual could already be knocked out by the “incurability” criterion, because a doctor might well say, we could potentially cure this for you, and then, the fact that there might be some other remedy or series of remedies, some of which are acceptable to the patients and others which aren't, is irrelevant, because we've made incurability the baseline.

Those are just a few different ways in which we think this doesn't comply with the Carter judgment.

● (1035)

The Chair: Thank you.

We're going to go to Mr. Bittle now.

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

Mr. Paterson, I want to give you a brief opportunity. You wanted to respond to something Mr. Cooper said.

Mr. Josh Paterson: I did. Thank you very much.

Mr. Cooper made remarks, Mr. Chair, to the effect that the plaintiffs had suggested there be various safeguards, including mandatory psychiatric evaluations and other things. Those were in our submissions replying to Canada, which speculated regarding individuals whose capacity we couldn't be sure about.

We've been clear all this time that in respect of individuals, when a doctor isn't sure, of course there are other methods that can be used, including psychiatric evaluations and capacity assessments and all kinds of other things. We were not asserting in the air that we think all of those kinds of restrictions are necessary or desirable. They are tailored responses to individual issues. What this bill does is create a blanket exclusion because of some concerns we may have about some individual issues.

Thank you.

Mr. Chris Bittle: Thank you.

Dr. Chochinov, having read your brief, I will ask you whether “reasonably foreseeable” means “terminal”.

Dr. Harvey Chochinov: That's an interesting question. There's been a great deal of debate on what it means.

It's a difficult term. I think it means that somebody is on the course towards death. There has been a variety of terms used, whether “terminal” or “less than six months” or “reasonably foreseeable”. I think this term provides perhaps some further latitude than what currently exists in Oregon, for example.

Oregon, as you know, uses “less than six months”. In reference to Oregon, when we visited there, what Eli Stutsman, the lawyer involved in drafting the legislation for both Oregon and the State of Washington, said is that even after 17 years of experience with the Death with Dignity Act, there is no appetite whatsoever to extend the criteria beyond six months. Even when he was asked about 12 months and about whether he was excluding people who might otherwise access dying with dignity, he said there is no appetite, even amongst the strongest proponents; and that six months or less is what they've restricted it to after 17 years of experience.

The fact is that we're going to have to set the bar somewhere, and I think “reasonably foreseeable” death is probably a prudent place to set that bar, and that we should see, after five years' experience, where it takes us.

● (1040)

Mr. Chris Bittle: Thank you so much.

It's probably not fair of me to ask, since you're not a lawyer, but we have received a transcript from the Supreme Court explicitly saying that they rejected the concept of “terminally ill”.

I'll move on to a different point concerning judicial oversight. I know you're not a lawyer, but this seems to me to be a typical lawyer answer to a problem: just add more lawyers and it will fix everything. I'll give you the example of a jurisdiction that's to the west of my riding, which is Haldimand County.

It has a small courthouse. The motions court, which would hear applications, sits once a month. The last time I brought an emergency application in the St. Catharines court, which is a much busier jurisdiction, it took me three weeks to see a judge—on an emergency basis.

I'll open this question up. Aren't we just prolonging suffering? Perhaps this is great in the vacuum of legal theory, but we're just prolonging suffering based on judicial resources. Isn't that true?

Dr. Harvey Chochinov: First of all, are we committed to moving forward in a way that is transparent? Are we moving forward in a way that also acknowledges that many of the things that drive a wish to die extend beyond the purview of medicine?

To ask doctors to be making evaluations on things that have little or nothing to do with medicine is placing them in a very difficult position. Even those who are strong proponents and who wrote the report for the Royal Society said that it might not ideally be physicians who should be involved in making these determinations. The availability of judicial oversight acknowledges that we are going to be open to including all areas of expertise, whether it's of physicians, social workers, or lawyers, to determine what is driving the wish to die.

If the issue is whether this is going to be too arduous a process, I would say that we're talking about life and death; these are very important decisions. In this day and age, we should be able to put the resources into it so that we can expedite the process, so that we are not prolonging suffering.

Mr. Chris Bittle: Mr. Paterson or Dr. Gibson, would you like to respond?

Mr. Josh Paterson: Sure. Thank you.

As it is, this bill proposes a number of restrictions and hurdles that are not the case anywhere else in life-and-death decisions in medicine—decisions that are made every day to withhold and withdraw life-sustaining treatment, decisions that are made every day that involve death by some action or intervention taken. Whether it's administering something or yanking something out and taking it away, an action is taken and people die. We don't do this for anything else.

The courts have been clear. It was argued, but it was not accepted that there was any ethical distinction between assistance in dying as contemplated in Carter and these other forms of treatment that result in death. We thus see no justification for putting in some kind of state decision-making process. Whether or not it's actually government officials, if they are using authority delegated from Parliament, they are making a decision using the state's authority.

Putting state decision-making in the way of patient decision-making just makes no sense. It will increase delay; it will intimidate people potentially; it's just bad policy, and it doesn't make sense in the context of the medical profession.

The Chair: I can see Dr. Chochinov is putting his hand up, but we're out of time on Mr. Bittle's round.

Did you have anything you wanted to say that was different, Ms. Gibson? He did ask all of you.

Ms. Jennifer Gibson: No, I just want to concur with my colleague.

The Chair: Okay.

We've been asked to have a lightning round. The rules for it are that the question can be no longer than 30 seconds and the answer no longer than 30 seconds. Whoever has one, we're going to it.

Who has a question?

Mr. Nicholson.

● (1045)

Hon. Rob Nicholson: Thank you very much.

I'll pose this to you. We talked about whether Parliament should be carving out groups that are either vulnerable or potentially vulnerable, but wouldn't you agree that we do that already with respect to children? Whether it be the Criminal Code or all sorts of legislation, we specifically refer to them because of their potential vulnerability. That could be the argument as to why they are not included in this bill.

Mr. Josh Paterson: Can I grab that for 30 seconds?

The Chair: I think it was addressed to you, Mr. Paterson.

Mr. Josh Paterson: Yes, governments make provisions for different classes of people all the time. In this case, the Supreme Court has already said that these classes of people—people with terminal illnesses and people who don't have terminal illnesses who qualify—are entitled to this right. The constitutional floor has been set. It's no longer open for Parliament or government to pull people out. It just isn't open to them.

Hon. Rob Nicholson: Is that including children?

Mr. Josh Paterson: Well, children were not in the judgment; it was competent adults. Children are another question.

Hon. Rob Nicholson: So you have no problem with the exclusion —

Mr. Josh Paterson: We have other issues about that, but in terms of respecting Carter, it's not open—in fact, it's unlawful—for the government to pull people out.

The Chair: Mr. Bittle, did you have a lightning question?

Mr. Chris Bittle: Yes.

We talked about and discussed in numerous panels mandatory consultations in various areas. Is it the federal government's responsibility—and I look to Dr. Gibson and Mr. Paterson—to start regulating in the medical profession, when it hasn't ever done so before?

Ms. Jennifer Gibson: Through our own consultation, what we heard from multiple actors and stakeholders was that this is provincial jurisdiction, and that is the right place for it.

It's also a regulatory role. The regulatory bodies are designed for serving the public interest. There are mechanisms in place to ensure that their members are actually behaving in appropriate ways, and I think that's where we need to be putting the focus.

The Chair: Thank you so much.

Is everybody okay?

Let me again thank the witnesses.

Thank you for testifying by video conference, Dr. Chochinov.

Thank you very much, Ms. Gibson and Mr. Paterson, for coming in. We really appreciate it.

The meeting is adjourned.

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