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Chair

Mr. Anthony Housefather

Standing Committee on Justice and Human Rights

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● (1630)

[*English*]

The Chair (Mr. Anthony Housefather (Mount Royal, Lib.)): Ladies and gentlemen, sorry for the delay. I would like to call the Standing Committee on Justice and Human Rights to order. It's a great pleasure to have with us today from the Department of Justice Carole Morency, Joanne Klineberg, and Julie Besner. From the Department of Health, we have Helen McElroy and Sharon Harper. Thank you for coming.

Ladies, it's very nice to have you. We are going to be doing a clause-by-clause review of Bill C-14. This is the first clause-by-clause review this committee has undertaken. The parliamentary clerk has provided me with some instructions that I would like to give members of the committee so that you all know about clause-by-clause review and how it works, as some of us have not done this before. As the name indicates, this is an examination of all the clauses in the order in which they appear in the bill. I will call each clause successively, and each clause is subject to debate and a vote. If there are amendments to the clause in question, I will recognize the member proposing it, who may explain it. The amendment will then be open for debate. When no further members wish to intervene, the amendment will be voted on. Amendments will be considered in the order in which they appear in the package that each member received from the clerk. If there are amendments that are consequential to one another, they will be voted on together.

In addition to having to be properly drafted in the legal sense, amendments must also be procedurally admissible. The chair may be called upon to rule amendments inadmissible if they go against the principle of the bill or beyond the scope of the bill, both of which were adopted by the House when it agreed to the bill at second reading, or if they offend the financial prerogative of the crown. If you wish to eliminate a clause of the bill altogether, the proper course of action is to vote against that clause when the time comes, not to propose an amendment to delete it.

Since this is a first exercise for many new members, the chair will go slowly. I've been advised by some members that I seem to go fast, so I'm going to try to go slowly to allow all members to follow the proceedings properly. If during the process the committee decides not to vote on a clause, that clause can be put aside by the committee so that we can revisit it later in the process.

As indicated earlier, the committee will go through the package of amendments in the order in which they appear and vote on them one at a time unless some are consequential and dealt with together. Amendments have been given a number in the top right corner to indicate which party submitted them. There is no need for a seconder to move an amendment. Once moved, you will need unanimous consent to withdraw it. During debate on an amendment, members are permitted to move subamendments. These subamendments do not require the approval of the mover of the amendment. Only one subamendment may be considered at a time, and this subamendment cannot be amended. When a subamendment is moved to an amendment, it is voted on before another subamendment may be moved. The committee may consider the main amendment and vote on it, and that would be “as amended”. Once every clause has been voted on, the committee will vote on the title and the bill itself. If amendments are adopted, an order to reprint the bill will be required so that the House has a copy for use at report stage.

Finally, the committee will have to order the chair to report the bill to the House. That report contains the text of any adopted amendments as well as an indication of any deleted clauses.

[*Translation*]

I apologize for speaking only in English, but it would take too long to go over the text again. I hope that you have still all understood by listening to the simultaneous interpretation.

[*English*]

I had a conversation with both Mr. Rankin and Mr. Falk to try to agree on some way that we can move through the numerous amendments in a very concrete way without going through prolonged debate.

One of the things we are going to try to do is this. In the case where the mover of the amendment—I think it's only the case with the Conservatives—is not a member of the committee, I will ask a member of the committee to put forward a motion. It doesn't mean you necessarily agree with it, but put it forward for debate, and then I will allow the Conservative member who put forward that motion to speak to it for the two minutes. Again I'd ask everybody's co-operation.

The same would be true for NDP or Green or Bloc amendments. In the case of the Bloc and the Greens, I will allow Ms. May and Mr. Thériault to speak to the amendments themselves, even though they are not members of the committee. They will be given the same rights as anyone else. It will be two minutes to speak as the mover, and then one minute for everyone else in the committee who wants to intervene. Then I will go back to the mover, in that case, or in the case of the other member who proposed it, for a 30-second rebuttal at the end.

Of course, we will see how this goes, because it's the committee's right to change this as we go through. My goal is to try it that way, and if it's not working, we'll talk with the other members of the subcommittee and try to see how we should change it.

My role as chair is to try to be as fair as possible in the process, to hear people out and to not apply my judgment to anything. I will try to be scrupulously fair and also maintain procedure. That's my goal.

Of course, if there is an amendment that is clearly going to the principle of the bill and is one of the major amendments.... I'll just put two examples: the question of deleting the clause in proposed paragraph 241.2(2)(d) related to "reasonably foreseeable", or an amendment related to conscience. I'm going to give more time to that amendment for a fulsome discussion, at least the first time that we deal with it. If we've dealt with it five times on five amendments, I think we'll stumble back. But at the very least, where there's a really big issue, I'll try to give people more time.

That being said, the first thing on our agenda is to deal with clause 1. I don't believe there were any amendments proposed for clause 1.

By the way, just for people who are not familiar, we skip the preamble. The preamble comes at the end, because amendments to the preamble should be based only on amendments we have made to the bill in the context of this committee.

● (1635)

[*Translation*]

We will move to clause 1, which would replace section 14 of the Criminal Code, pertaining to consent to death.

[*English*]

Do we have any debate on this clause?

(Clause 1 agreed to)

(On clause 2)

The Chair: Now we are on clause 2, and there are a number of amendments. The amendments we will be dealing with on clause 2 include CPC-1, CPC-1.1, CPC-1.2, CPC-2, CPC-3, and CPC-3.1.

We're going to move to CPC-1. This has been proposed by Mr. Viersen. Mr. Viersen, we've had a conversation about this. I believe this is out of order, but I will give you a chance to convince me that it's receivable if you so wish.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you, Mr. Chair.

I proposed this amendment due to the fact that I really feel this is not health care we're dealing with. I wanted to take any reference to health care out of it, and I wanted it to be a licenced individual...that the justice department could issue licences to allow it. I put it forward to the drafters to say how we could change it to be a licence rather than a medical procedure.

I took reference from the firearms licence. It's illegal in Canada to own a firearm except if you own a licence, so I gave that to the drafters and asked if they could come up with something. This is the amendment they helped me to draft, and I submitted it. If it's inadmissible, it's inadmissible, I guess.

The Chair: I very much appreciate that. Unfortunately, it goes beyond the scope of the bill. I think it's pretty clear. There is no concept in the bill of licencee, and it just goes beyond the scope of the bill, so I'm forced, unfortunately, to rule out of order this amendment, along with the other amendments that are associated with this, which I believe are CPC-4, CPC-26, CPC-28, CPC-29, CPC-30, CPC-31, CPC-35, and CPC-40, all of which you submitted along this line to consequentially tie together.

I have to rule them inadmissible. I'm sorry.

The good news is there are not that many I've seen that are inadmissible. I'm sorry we started with one, but the good news is most of them are not. We'll have plenty of things to debate.

Is there anything I need to do beyond rule?

The Clerk of the Committee (Mr. Philippe Méla): No. That's it.

The Chair: Perfect.

Now we will move to one that is receivable, amendment CPC-1.1, which is Mr. Falk.

Amendment CPC-1.1 would have the effect of removing "nurse practitioner" from line 35 on page 2.

I'll turn it over to Mr. Falk.

● (1640)

Mr. Ted Falk (Provencher, CPC): Thank you, Mr. Chairman.

Many of the amendments I'm moving forward have come out of our study and witness testimony, and also input that we received from members who participated in the process through last week while we were listening to various testimony.

Effectively, this amendment would say that a nurse practitioner is not someone who would be eligible to qualify for the exemption for medical assistance in dying. There are also probably about another half a dozen amendments that would change that terminology throughout the bill, which means it would have to be a medical practitioner who does the assessment, makes the decision, and does the administration.

The reason for this is that we don't even allow nurse practitioners today to issue prescriptions with narcotics. We don't allow them the ability to ask for an X-ray. When we're looking at something as sobering as physician-assisted suicide—the assessment, the prescription, and the administration of that—I think it needs to be somebody at the medical practitioner level. For that reason, I've made this amendment that would exclude nurse practitioners from that category.

The Chair: Thank you very much.

Is there any debate?

Mr. Fraser.

Mr. Colin Fraser (West Nova, Lib.): With regard to this amendment, I would not support it. I believe it was clear in the witness testimony we heard that nurse practitioners do provide a service in order for people in remote areas to have access to this sort of health care provision.

With regard to the CMA, they were okay with it. With regard to the nurse practitioners' presentation, they were okay with it as well.

As well, it's up to the provinces to deal with the substance of regulating the profession, and that could vary from province to province. Obviously, we heard from the minister that she would like to have a pan-Canadian approach.

I believe it is appropriate to have nurse practitioners carry out this function.

The Chair: Thank you.

Mr. Casey.

Mr. Sean Casey (Charlottetown, Lib.): The intention of the government certainly was to ensure that medical assistance in dying would be available across the country. Medical practitioners are as rare as hen's teeth in some parts of the country, including rural and remote areas. If there's a decision taken by the committee to rule out the provision of medical assistance in dying by nurse practitioners, there will be a lot of Canadians effectively denied this service, as was pronounced by the Supreme Court of Canada.

The Chair: Does anyone else wish to intervene?

If not, I'm going to turn it back to Mr. Falk for his closing.

Mr. Ted Falk: Again, I would just like to say that this is a very serious procedure. It's a very serious assessment. If we're going to allow someone to do this who we don't even allow to issue a narcotics prescription or to ask for an X-ray, it seems to me a little inconsistent there in what is permissible by that particular profession. I think this needs to be taken with much more care and seriousness than what is being suggested here.

The Chair: That closes debate.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: I'll leave it to Mr. Falk to tell us whether he wants to introduce his other amendments that tie in or not, when we get there. We'll have to go number by number. I don't know the numbers.

We're going to go, then, to amendment CPC-1.2. It is also Mr. Falk's.

Mr. Falk.

Mr. Ted Falk: Mr. Chair, it's the same situation. It's the same issue.

The Chair: Will you not put that one forward, then?

Mr. Ted Falk: I'll withdraw it.

The Chair: The next one we get to is CPC-2, which is Mr. Genuis.

Mr. Genuis, one of the other members has put it forward, Mr. Nicholson. Please speak to your amendment.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): This amendment removes the section that protects somebody from prosecution who kills someone who does not meet the criteria. Certainly a major goal of this process has been to protect the vulnerable, those who do not consent, those who do not meet the criteria. Obviously it's very important that the legislation is structured to ensure that the only lives taken are of those who meet the criteria prescribed by the legislation, whatever those criteria are. But this clause says that somebody who takes the life of a person who does not meet the criteria, perhaps doesn't consent, perhaps isn't able to consent, perhaps is not ill, would still escape prosecution if this person taking the life had a reasonable but mistaken belief that the criteria were met.

I think it is imperative that we put the obligation on the person who's doing this to ensure that the criteria are met, and we make them responsible for killing a person who does not meet the criteria, because if we don't do that, I think we render the criteria largely meaningless and we make effective prosecution of those who take life in this context outside of the criteria virtually impossible.

What sense is the criteria if all a person has to do to avoid prosecution is demonstrate beyond a reasonable doubt that they had a reasonable but mistaken belief? Of course, the implication of this is that a person might be prosecuted who tried to act reasonably but was mistaken. But we have categories of crime like manslaughter where if you take a person's life, if you do something extremely serious, and you didn't take the necessary precautions to ensure that you weren't going to do that, then you are responsible. This is serious. This is necessary for protecting the vulnerable to make sure the people who don't consent don't lose their lives in this.

● (1645)

The Chair: Debate?

Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): I think the point of these two paragraphs is that it is the medical practitioner or the nurse practitioner who's actually performing the function who has the onus to ensure that the qualifications are met, and someone who helps them in doing this has a fair expectation that they are acting correctly, and it's a reasonable expectation.

I would vote against this amendment.

The Chair: Mr. Rankin.

Mr. Murray Rankin (Victoria, NDP): Chair, I'm not sure if this is the appropriate place in which to make this observation, but you'll recall the evidence we heard from Mr. DelBigio and Mr. Fowler of the criminal defence lawyers association where they talked about the need for this to be amended to say rather than “reasonable but mistaken”, “honest but mistaken”, and they said that, as I recall, for a couple of reasons. The first was that “honest” is a subjective determination and they thought that given that this is a defence to first-degree murder, it made sense that it be changed in that way.

I realize it doesn't go exactly where my colleague wants it to go but I thought I'd use this as an opportunity to put it out. I would be voting against the amendment as presented.

The Chair: What I would say, Mr. Rankin, is that if you wanted to put something like that forward, you'd have to put it forward as a separate amendment because it goes against the principle of the amendment put forward by Mr. Genuis.

Mr. Murray Rankin: Thank you.

The Chair: But you'd have to do it now because we're at this line. So you'd have to do it right after.

Mr. Murray Rankin: As I say, I speak against the amendment.

The Chair: I understand.

Mr. Murray Rankin: Do you want me to repeat what I said?

The Chair: Yes, if this amendment is defeated, then we're on this line and that would be, I believe, the place that you would put forward any amendment you had but you'd have to write it out and give it to the clerk.

Mr. Fraser.

Mr. Colin Fraser: I agree with what Mr. Rankin said and I remember that testimony.

With regard to it being on a reasonableness standard, it is an objective standard, which is a higher standard obviously than the subjective. With regard to criminality, exempting this person doesn't mean there's no sanction involved. Obviously there are sanctions later on in the bill that deal with the fact that somebody who maybe had a reasonable but mistaken belief who didn't follow the criteria set out in this bill wouldn't be held to account.

I believe that this amendment is unnecessary and goes against the spirit of the bill and I won't be voting for it.

The Chair: Monsieur Genuis, I don't think there are any more intervenors. Would you like to close?

Mr. Garnett Genuis: I want to respond to what Mr. McKinnon said. What you're saying makes perfect sense, but that's not what the clause says. If the clause specified that it was only those who were assisting, but not the actual physician who was responsible for doing it.... The act is designed such that the person who approves it is the one who's doing it. I think that person should be the one responsible and making sure.

With respect to the comment about other sanctions, I don't think that's sufficient, proportionate, or satisfying to the victim. If somebody kills a member of your family, and that member of your family isn't consenting, the criteria isn't met. I don't think saying that person is going to be unable to practice medicine for the next year and a half is a sufficient sanction.

If you take the life of a person who does not consent, and who does not meet the criteria, we can't walk away from proportionate sanctions for taking life. That's the only way to ensure the continuing sanctity of medical environments in which people feel safe. We have a narrowly defined exception, but we can't allow lives to be taken outside of those narrowly defined exceptions.

● (1650)

The Chair: Thank you very much.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We're going to move to the next one, which is CPC-3. CPC-3 is also from Mr. Genuis, so will somebody put it forward for the purpose that we can debate it?

Thank you, Mr. Falk.

Mr. Genuis.

Mr. Garnett Genuis: With respect to this, I think the court decision was clear that it created a right for an individual to avoid prosecution, but it does not confer a positive right for an individual to have death inflicted on them. I think that is a very important distinction, because a right for a person to have death inflicted on them could be further developed and inferred in all kinds of different contexts beyond what, I think, is the intended narrow scope of this legislation.

Some of the discussion already around this has implied there is a charter right to this. There is clearly an established charter right by the court decision to avoid prosecution, but this is something distinct from a right to die, in any case. I think this clarification is important in terms of the context we're operating under.

The Chair: Is there any debate on the amendment?

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We're going to move to CPC-3.1.

Mr. Ted Falk: I'll withdraw it. It has to do with nurse practitioners again.

The Chair: Thank you.

Mr. Rankin raised the question of a different amendment. Mr. Rankin, we've now gone through all the amendments on clause 2. If you or anyone else has another amendment on clause 2, now is the time you have to put it forward, or else we have to move to the vote on clause 2, and then there's no further possibility to put forward amendments on clause 2.

Mr. Murray Rankin: I have it in writing.

It came up as a consequence of this.

Can I say it now?

The Chair: Yes, and a copy goes to the clerk.

Mr. Murray Rankin: I move that clause 2 be amended such that line 7 on page 3 be replaced with the following: “as an honest, but mistaken belief about any fact that”.

The Chair: I rule that as receivable as an amendment.

Mr. Rankin, do you want to speak to your amendment?

Mr. Murray Rankin: I think those on the committee who were able to hear the testimony of the criminal lawyers' defence association might have, like myself, been compelled to conclude it would be an improvement, given the nature of the criminal law we're dealing with. We're talking about a defence to a crime of culpable homicide, or first-degree murder. They were persuasive in suggesting that a subjective foundation—namely, an honest belief—was preferable in the circumstances, and that's what motivates my proposed amendment.

[*Translation*]

The Chair: For those who do not understand the proposal, of which we still have no copy, in French, we would be replacing the term “raisonnable” with the term “honnête” on line 7. I'm not sure whether the member will find a different translation. I think it will probably be “honnête”.

[*English*]

It's only reasonable for people to say that they want to see this in writing. Is there anybody who feels they need to see reasonable changed to honest in writing before we proceed to debate?

An hon. member: No.

The Chair: Mr. Fraser.

● (1655)

Mr. Colin Fraser: Could the department provide an opinion on this?

The Chair: Ms. Klineberg.

Ms. Joanne Klineberg (Senior Counsel, Criminal Law Policy Section, Department of Justice): I would like to provide the committee with a little bit of context that may be of use with regard to the provisions on self-defence, which actually were amended by Parliament just a few years ago. It's the one defence, actually, at present, that can be invoked when a person is charged with murder.

It speaks of a person having a reasonable perception that they are being assaulted or threatened. In other words, mistakes in terms of the application of self-defence or the use of force in self-defence, even killing a person in self-defence, will only be available if those mistakes were reasonable in the circumstances.

Just to have a little bit of context, in common law, it's the courts that told us that, when interpreting the old self-defence provisions in the context of exculpatory claims, mistakes should be reasonable ones. In the context of interpreting an offence itself—so where an offence includes a mental element—a mistake that's unreasonable would still negate the mental element for the crime and result in the person not being convicted. But where it's an exculpatory claim, which is really society's way of saying this was criminal, but not notwithstanding that it was criminal, we wish to give you an excuse so you won't be convicted. The courts have, on the whole, tended to say—and this is what's reflected in the self-defence provisions—that mistakes must be reasonable ones.

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

Mr. Hussen.

Mr. Ahmed Hussen (York South—Weston, Lib.): I want to ask a question of the officials.

Mr. Garnett Genuis: I don't know if you can because you're not a committee member.

An hon. member: Neither is Mr. Casey.

The Chair: Mr. Casey was allowed to intervene to give the opinion of the government. I will judge that on a case-by-case basis.

I'm allowing you, though you're not a member of the committee, to propose motions. I'm not allowing interventions by just anyone at the table on anything, otherwise we're going to go into—

Mr. Garnett Genuis: On a point of order, Mr. Chair.

It's perfectly reasonable if the committee decides that non-members can't speak outside of moving their own amendments, but there should be a consistent policy.

It was the decision of the government not to put their parliamentary secretaries on as members of committees. That was their choice. Traditionally, they have sat as members of the committee. As long as government members are not members of the committee, for them to have privileges as members that other non-members don't have is inconsistent and unfair to the opposition parties.

The Chair: Your point is noted. I am trying to be, as best as I can, scrupulously fair to everyone in this process, including allowing people who put forward motions to speak, which we could have not allowed. I accept your comments on that. I will be judicious in recognizing people who are not on the committee.

Mr. Falk.

Mr. Ted Falk: I agree with Mr. Genuis's evaluation of the situation. The government did make a decision not to put their PSs on the committees and I think we need to respect that.

The Chair: I understand. Again, going forward, I appreciate that.

On this very unusual occasion, because I allowed Mr. Genuis to chime in, I'm going to allow Ms. May to chime in.

Ms. Elizabeth May (Saanich—Gulf Islands, GP): When one has a longer institutional memory than the last 10 years, it is not traditional to have parliamentary secretaries on committee. It was something that was only done under the previous Conservative majority. When we're going through clause-by-clause, it's appropriate to allow the parliamentary secretary to intervene, to explain the government position, and that does not represent inconsistency. In this matter, I want to put the longer historical view forward and agree with your decision, Mr. Chair.

The Chair: Thank you. Again, I'm going to be judicious. If I believe there is something that needs to be responded to, I may allow it. If there's something I believe that you need to say, I may allow it.

In this case, we're debating an amendment that Mr. Rankin has put forward. You have three Conservative members who are here who, theoretically, could debate it. You could always sub in for one of them if you really feel that you need to debate something. There is an alternative which, for example, members of the Bloc and the Green Party don't really have.

Let's try to figure out the right solution for this.

In the meantime, we're on Mr. Rankin's amendment.

Mr. Hussen.

Mr. Ahmed Hussen: It's not debate. I want to put a follow-up question to Ms. Klineberg, if I may.

Regarding the reasonable standard, in my limited knowledge, isn't there a reasonable standard based on the circumstances of the offender at the time that the offence took place? We're talking about the second part, right?

Ms. Joanne Klineberg: Yes, reasonableness is always in the circumstances that the person found them in. The question is, imagine another reasonable person in those circumstances, would they have formed the same belief?

● (1700)

The Chair: Is there any other discussion?

Then we will come back to the mover. Mr. Rankin.

Mr. Murray Rankin: I'll simply say that I understood the explanation by the departmental official about the law of self-defence. I'm not entirely sure this is applicable in the circumstances. I'm trying to get my head around whether this is a subset of the self-defence defence. I was very persuaded by what the defence lawyer said at the time, and I wanted to bring it forward today, because of their powerful intervention. I can't say any more than that. You all heard the same testimony.

The Chair: Fair enough, and it's now before the committee to vote on.

(Amendment negatived [See *Minutes of Proceedings*])

(Clause 2 agreed to [See *Minutes of Proceedings*])

(On clause 3)

The Chair: We have Parti Vert-1.

Ms. Elizabeth May: Thank you, Mr. Chair.

I will say, briefly and parenthetically, that the process by which you're giving me an opportunity to speak to my amendments is part of the motion the committee passed. This was identical to the motion developed under the previous government to deny me the rights I really want, which are to put forward amendments at report stage. Coming to committee with amendments is not the process I would have liked. As an example of why it's so impractical, I wasn't even able to get to this committee to ask that you not pass the motion, because I was simultaneously at another committee where they were dealing with the same motion.

I propose to amend the language found in clause 3, line 21, by replacing the word “counselling” with “persuades or encourages”.

I know the committee will remember the evidence from a number of groups, like the Canadian Psychological Association and the Canadian Association of Social Workers. They pointed out that using the word as it currently reads in 241(1)(a) “counsels a person to die by suicide” still makes one guilty of an indictable offence.

The Canadian Psychological Association pointed out that the word “counsel” has a specific legal and professional meaning. In their brief, they say that “mental health providers like psychologists can be said to regularly provide counselling to their patients”. In this sense, “counsel” has a different meaning than that intended by 241 (1)(a).

The amendment I put to you is from their brief. The purpose is to avoid using a professional term that will be used in the course of their work to provide counselling and to replace it with the more precise term, which I think is the point of this section of the bill, namely, to ensure that anyone who persuades or encourages a person to die by suicide is not within the scope of the exceptions in the Criminal Code.

The Chair: Thank you.

Mr. Fraser.

Mr. Colin Fraser: I will not support this amendment. I understand the rationale behind it. Liberal-1, which I'll be moving later on, and which slightly changes the wording in the package, will address this issue. We heard from witnesses on this point. With regard to changing the wording to “persuades or encourages”, I'm concerned that we'd be changing, fundamentally, a term that is known to the criminal law and has been interpreted by the courts. We'd be capturing, perhaps, people who were not meant to be exonerated for certain criminal activity.

Since the word was carefully chosen and has been interpreted for quite a long time in the criminal law, I think it should remain as it stands, and I hope we can address the problem in Liberal-1.

The Chair: Mr. Rankin.

● (1705)

Mr. Murray Rankin: I will speak in favour of the proposed amendment for the reasons that the mover suggested. Social workers, possibly nurses, certainly the psychologists were all saying that to apply a term used in the criminal law to day-to-day life would be hugely problematic. Finding a simpler way to say it, a plain language way, improves the wording. The words “persuades or encourages” does the job without causing the unnecessary concern. So I suggest that it makes sense to make this change.

The Chair: Mr. Nicholson.

Hon. Rob Nicholson (Niagara Falls, CPC): What Ms. May is saying is quite reasonable, and it's consistent with some of the concerns we heard at the committee. One of my colleagues says he prefers to keep it as a legal term. That was part of the challenge Ms. May was bringing to our attention just now; so this is a reasonable amendment and should be supported.

The Chair: What is the legal definition of “counsels” in the Criminal Code?

Ms. Joanne Klineberg: “Counsels” is a word that's been part of the criminal law for decades, if not centuries. There is a definition of “counsels” in section 22 of the Criminal Code that applies throughout the code, so it's also not a word that is limited to being used in the context of section 241. It applies in a variety of other places.

It's been interpreted by the Supreme Court to essentially mean “actively inducing a person with the knowledge that the thing you're inducing them to do might happen”. In law there's no possible way that the word “counsel” in this provision can be interpreted to mean therapeutic counselling. If the word is changed, there is a danger that it would need to be reinterpreted. It would be Parliament indicating that it means something different from “counsel” as “counsel” appears in other provisions of the Criminal Code.

The other thing I would note is “abet” in subsection 241(1) is interpreted to mean “encourages”. So this amendment would create some uncertainty over how “abet” should be interpreted if “encourages” is also added. The final point I would make about this amendment is that “persuades”—unlike counselling, which is how a person tries to convince someone else to do something —“persuade” might be limited to the circumstances where they succeed in getting that other person to do the thing they said.

So it doesn't say “attempts to persuade”, it just says “persuade”. Persuasion might have to be successful for persuasion to be made. So there are some criminal law implications for this one.

The Chair: Thank you.

Ms. May.

Ms. Elizabeth May: The Liberal-1 amendment still uses the word "counsels", and I appreciate the advice from the Department of Justice, given the concerns from so many professional associations. I'm a former lawyer myself. I know we have a specific meeting around "counsels". But this does create concerns for people in the profession and as the phrase is "or" not "and", I don't think it will create confusion with "abet". It's one or the other and the situation may create redundancies, but certainly no conflict.

The Chair: Thank you very much.

Not hearing any further debate, let's move the question.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We're going to move on to CPC-4.1.

Mr. Ted Falk: I withdraw that amendment.

The Chair: Thank you.

[*Translation*]

We will now move to Bloc Québécois' first amendment. Mr. Thériault will move amendment BQ-1.

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

You will recall that the Barreau du Québec advised us to clarify the details of offences related to counselling someone to commit suicide. In keeping with the discussion we just held, and taking into account section 241.1, the Barreau du Québec representatives made a suggestion. As part of honest discussions with patients on all potential care, health professionals should be assured that they are not vulnerable and do not risk being exposed to criminal charges. They must be able to adequately inform their patients if the bill clearly states that counselling an individual to commit suicide constitutes a criminal offence.

The amendment reads as follows:

> (2.1) No medical practitioner or nurse practitioner commits an offence under paragraph (1)(a) or (b) if they provide a person with information about the care that is offered in connection with medical assistance in dying.

So this is about being consistent with the spirit of the law.

● (1710)

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

Are there any comments regarding this amendment?

Mr. Thériault, do you have anything else to add?

Mr. Luc Thériault: No.

The Chair: Okay.

We will move to the vote.

(Amendment negatived)

The Chair: We will now move to amendment CPC-4.2.

[*English*]

Mr. Ted Falk: That's connected to nurse practitioners, and I'll withdraw.

The Chair: Thank you.

Mr. Ted Falk: As is 4.3.

The Chair: Thank you very much for your incredible co-operation in allowing us to go faster.

We will move to Liberal-1.

Mr. Fraser.

Mr. Colin Fraser: Thank you very much.

I'd like to make a modification to what was submitted, so the amendment would now read as follows: "That Bill C-14, in Clause 3, be amended by adding after line 12 on page 4 the following: (5.1) No psychologist, psychiatrist, social worker, therapist, or other health care professional commits an offence if they provide information to a person on medical assistance in dying."

I can provide that to the clerk in writing.

The Chair: Please do.

I judge that it's receivable. If you have a copy to give to the clerk, that would be great. It's so that we can read it back and everybody can assess exactly what was read.

As I understand it, "No psychologist, psychiatrist, social worker, therapist, or other health care professional commits an offence if they provide information to a person on medical assistance in dying."

Mr. Fraser.

Mr. Colin Fraser: With regard to the proposed amendment, this does respond to what Ms. May was speaking to earlier with regard to the evidence that we heard from various groups, including social workers in particular, who were pretty adamant that they were worried about the term "counselling" and how, in their professional capacity, it could be misunderstood.

I believe this clarifies that this law obviously does not disallow them to provide information to those people who need information in order to make a properly informed decision about receiving medical assistance in dying. I don't believe that there is any harm done by adding this provision in there to provide greater certainty that it doesn't include these people.

The Chair: Mr. Rankin.

Mr. Murray Rankin: I agree entirely and will be voting in favour of the amendment. Thank you for bringing it forward.

This is a friendly amendment that may not be necessary, but I'll flag it because, when I read the words "other health care professional" and tried to apply them to social worker, I was at a loss, because I thought social workers were, in fact, not health care professionals. They have a different category. I wonder if you might consider an amendment to provide broader protection for that group who aren't necessarily working in the health care field.

The Chair: The social worker is there, though.

Mr. Murray Rankin: No, but the way it's worded is "no psychologist, psychiatrist, social worker, therapist or other health care professional". A social worker is not necessarily a health care professional.

The Chair: I understand.

[*Translation*]

Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP): Therapists aren't either.

[*English*]

The Chair: What was your proposal then, exactly?

Mr. Murray Rankin: I was suggesting taking out the word "other", saying "or health care professional of any sort", so as to not flag that we thought that social workers were included in that category.

● (1715)

The Chair: That's a subamendment. The debate will then begin on the subamendment proposed by Mr. Rankin.

Mr. Murray Rankin: It was meant to be a friendly amendment.

Mr. Colin Fraser: I realize the problem and I appreciate that.

What I'm wondering is if the wording wouldn't make more sense, since it's "social worker" that you're significantly concerned with, and rightly so, if maybe we put that at the beginning and then say "or" and include all of the rest.

Mr. Murray Rankin: I agree with that, certainly.

The Chair: How would that read then?

Mr. Colin Fraser: "No social worker or psychologist, psychiatrist, therapist or other health care professional."

Mr. Murray Rankin: I think that works better.

The Chair: I am perfectly happy, but I understand the motion went forward. Am I allowed to accept that as the new motion without going through a subamendment process?

The Clerk: Yes.

The Chair: Good, okay.

Please read it one more time, Mr. Fraser.

Mr. Colin Fraser: "No social worker or psychologist, psychiatrist, therapist, or other health care professional commits an offence if they provide information", and you have the rest of the words—

The Chair: "to a person on medical assistance in dying."

Mr. Colin Fraser: Right.

The Chair: All right, excellent.

Mr. Cooper.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): I support the objective of the amendment. I guess there's just one point of clarification, Mr. Fraser. In terms of "health care professional", I presume that would encompass the medical practitioner and nurse practitioner.

Just to put my comment in context, when I looked at Mr. Thériault's proposed amendment, it's quite similar inasmuch as it provides that no medical practitioner or nurse practitioner commits an offence for providing information in relation to medical assistance in dying. I voted against it on the basis that your amendment, which was after, seemed to be more expansive to take into account that there may be others who need to be covered. I just want to make sure that we're covering everyone who falls within the parameters of providing information to persons who are seeking information.

Mr. Colin Fraser: That was certainly the intention.

The Chair: Can I ask, though, given our friendly amendment—moving through like this—why don't we say "therapist, medical practitioner, nursing practitioner, or other health care provider". However it was worded, we would just add in those words so that Mr. Cooper feels comfortable, too.

Mr. Colin Fraser: Yes, I thought it would already have been covered, but for information purposes, providing "a medical practitioner or a nurse practitioner", that's what you're looking at?

Mr. Michael Cooper: I'm just thinking that those two terms should be incorporated for consistency so there is no ambiguity as to who we're talking about.

Mr. Colin Fraser: Yes, I have no problem with that.

Do you want me to read it again, then?

"No social worker or psychologist, psychiatrist, therapist, medical practitioner, or nurse practitioner, or other health care professional commits an offence if they provide information to a person on medical assistance in dying."

The Chair: Got it.

This is very collaborative.

Mr. Hussen.

Mr. Ahmed Hussen: I would just like to get the official's view on the efficacy of this change.

Ms. Joanne Klineberg: Well, there are a couple of things for the committee's consideration, again.

One, if we think about the exemptions that have been created for people who might aid the physician or the nurse practitioner, it was drafted to say "any person" because there might be other types of professionals. For instance, someone might actually consult a lawyer to determine how they might proceed to obtain medical assistance in dying. That wouldn't be captured.

Also, given the information I provided a few minutes ago, there is no legal possibility that the offence could be interpreted so as to.... Sorry, that was with respect to a slightly different point. But it's really not possible to interpret the criminal offences as though they would prohibit simply giving someone information about a lawful process, so for the committee's consideration for clauses like that we usually draft for greater certainty.

Finally, the definition of "medical assistance in dying", in Bill C-14 is such that the definition itself doesn't include the eligibility criteria and the safeguards. The definition is merely a nurse practitioner or a medical practitioner who administers a substance to cause the death of a person. So the committee might wish to consider adding words like "obtaining information on the lawful provision of medical assistance in dying" so that you're not capturing other things that a physician might say that would not be within the lawful boundaries of medical assistance in dying.

● (1720)

The Chair: Thank you very much.

Mr. Fraser.

Mr. Colin Fraser: Yes, could I just ask to have repeated the last part on the lawful...? What was the wording you used?

Ms. Joanne Klineberg: Yes, "information on the lawful provision of medical assistance in dying".

The Chair: Did you also want to add "for greater certainty" at the beginning?

Mr. Colin Fraser: The intention was that it was for greater certainty, because I believe it's correct that it is not in any way meant to catch these people, but it was to reassure those groups that did come before us and testified. I would be happy to add "for greater certainty", and I don't see any reason why.... I thought it went without saying that it was for the lawful provision on medical assistance in dying. Again, I have no problem with adding that wording if that makes any difference, somehow.

The Chair: Okay. Would you read it back one more time, Mr. Fraser?

Mr. Colin Fraser: It is, "For greater certainty, no social worker or psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner, or other health care professional commits an offence if they provide information to a person on the lawful provision of medical assistance in dying."

The Chair: Thank you for everyone's contributions to that very stellar debate.

Mr. McKinnon.

Mr. Ron McKinnon: I have a question about whether we actually need this list of people. Anybody can tell anybody about the lawful provision of a service. I don't know that we need to have this enumerated list of professions to do that. That's simply a suggestion.

The Chair: Is there any further debate or discussion? No.

We'll go back to Mr. Fraser to tie it up.

Mr. Colin Fraser: I think the wording, as proposed and read the last time, covers the concerns of all those around the table, and I appreciate the input from the department as well. I think it is important to cover off that issue that was raised by several groups that testified.

(Amendment as amended agreed to [See *Minutes of Proceedings*])

The Chair: It's unanimously approved. We moved forward with lots of collaboration. That was great. Let's hope that continues.

On CPC-5, which is Mr. Genuis. Would somebody move that one, please?

Mr. Falk, thank you.

Mr. Genuis, go ahead.

Mr. Garnett Genuis: Thank you, Mr. Chair. I want to say that I didn't mean to imply, by point of order, that you're not being fair generally. I think you're doing an excellent job in a complex situation here.

I want to motivate this on a similar basis as the one I motivated on a previous amendment. I think the "reasonable but mistaken" provisions in this section, again, do not give much comfort to people who may find themselves in hospital and want to have the assurance that they will not have their life taken if they don't want it taken.

The task we have, the task we were actually given by the Supreme Court, is to be very careful about the safeguards we put in here to ensure that whatever criteria we establish are practically met. I don't think you do that by having an escape hatch that says that if the criteria are not met, and someone has their life taken who doesn't consent or doesn't meet criteria, their killer can evade prosecution on the basis of a reasonable but mistaken belief. It should be incumbent on those who take life, if we choose to allow such a thing, that they take every possible precaution and that the law is there to ensure that they take every possible precaution.

I've said that before, but I think it needs to be said again.

● (1725)

The Chair: Thank you very much.

Is there any other member of the committee who wishes to intervene?

All right, then we'll move to a vote on this amendment, CPC-5.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We will move to the next amendment, which is CPC-5.1.

Mr. Ted Falk: I'll withdraw amendments CPC-5.1 and CPC-5.2.

The Chair: Then we have amendment CPC-5.3.

Mr. Falk.

Mr. Ted Falk: It will need further amendment because, as it is written, it also made provision that there wouldn't be a nurse practitioner included in there, so that would need to be added in. In the spirit of collaboration we have seen here today, that's probably doable.

The Chair: Can you let us know how you want to amend it, and we can do it on the fly.

Mr. Ted Falk: I'll read it to you: "(a) That prescribing or providing by a medical practitioner or a nurse practitioner of a substance to a person, at their request so that they may, while under the supervision of the medical practitioner or the nurse practitioner, self-administer the substance and in doing so cause their own death; or (b) If a person is—"

The Chair: Do we add "nurse practitioner" also again there, Mr. Falk, in the second one?

Mr. Ted Falk: In the second one, yes.

The Chair: In both cases where it mentions "medical practitioner", you'd put "nurse practitioner".

Mr. Ted Falk: Yes. My thinking there in the first section under paragraph (a) is that if a person has the ability to self-administer, that person should do that under the supervision of a medical practitioner or a nurse practitioner. In the instances where the person doesn't want to self-administer, then the medical practitioner or nurse practitioner would administer.

Those are the changes.

The Chair: Just so that I'm clear, what I understand in the page that has been distributed is we are inserting, in line 2 of paragraph (a), in line 4 of paragraph (a), after the words "medical practitioner" "or nurse practitioner" and the same is true in paragraph (b). In the third line after "medical practitioner" we're writing "or nurse practitioner", and the rest is the same as on the paper.

Mr. Ted Falk: That's correct.

The Chair: Perfect. Do you want to add anything further to that?

Mr. Ted Falk: No, I've changed that last part so a person may self-administer the substance and in doing so cause death. It is important, and that's why I've switched the order around, that a medical practitioner or a nurse practitioner be present at the time and that the person not self-administer alone. This captures that spirit. To have either one present during the administration of the lethal dose is prudent, and that, in essence, is what's happening here.

The Chair: I'm sorry, I'm just trying to work my way through this. It's the first time I've seen it.

Paragraphs (b) and (a) are reversed. In essence, that's what you're doing. You're reversing the order of paragraphs (b) and (a) that were in the amendment to this.

Mr. Ted Falk: I'm not sure why they reversed it. They just did that.

The Chair: I'm going to give everybody time to read this.

Mr. Ted Falk: We had testimony from several witnesses on some of the implications of prescribing a concoction people could take home and self-administer at their own discretion and when they were prepared to do that. What this would do is indicate that a nurse practitioner or medical practitioner needs to be present at the time it's done. That's a good idea for several reasons. We're not dispensing harmful medications unnecessarily that could end up sitting in somebody's medicine cabinet for years. We were told that possibility exists today, and that people have very lethal doses of medications in their medicine cabinets. We were also told that between 30% and 40% of individuals who pick up those prescriptions don't use them. There is a danger of people being coerced into it. Perhaps, at the time the prescription was filled, it was something the person wanted to do. All of a sudden, in the course of contemplating this action, there's been a change of heart and a change of mind. If there is no one present during the administration of it, there is the possibility that someone could be coerced into it. If somebody has some nefarious intentions, that could happen. In the worst-case scenario, if that drug were left unattended and someone else had access to the medication, it could have lethal implications for individuals not intended—

● (1730)

The Chair: I would like to hear your arguments as to receivability, in one sense. Maybe it is a simple question to you. The way I understand (b) is this. I believe what it is now saying is that the only way a medical practitioner or a nurse practitioner can administer a substance causing death is if the person is physically incapable of self-administering. Is that the intention—that somebody who is in the hospital, for example, could not have a doctor or nurse help them with the procedure if they are physically capable of doing something themselves?

Mr. Ted Falk: Correct. If they have the ability to do it themselves, they should do it.

The Chair: I am having issues with receivability, because it radically changes the definition in the law. I want us to keep thinking about that. In the meantime, let's have the debate on the substance while I think about that.

Mr. Rankin.

Mr. Murray Rankin: I certainly appreciate and respect Mr. Falk's motivation for this. I think I come to a different conclusion on the merits, though. Yes, it is true that, in the evidence we heard, 30% to 40% of the people never use the medication prescribed. However, the point that was made over and over again was the fact that they had the choice. As they said, finding that the door was not locked was one of the key things that made people, in fact, not take the medication.

I also don't know why we would limit it so people have to have the supervision of a medical practitioner in the circumstances. I think many people have talked about having all the conditions met and having addressed the issue of coercion—which is critical, but which we address through so many other safeguards in the bill. I wouldn't want to change the spirit of what we are trying to create here by requiring a stranger—a medical practitioner or someone—to necessarily be there. I think it changes the bill significantly. I don't think the issue of coercion—which I am very alive to—is really addressed significantly, because we have so many other safeguards that do that job.

I will be voting against the amendment, if it is acceptable.

The Chair: I am still pondering that.

Mr. Fraser.

Mr. Colin Fraser: I agree with Mr. Rankin's point, which is well made.

The only other thing I would say is that we did hear evidence, as well, that pharmacists, of course, dispense medication that, if improperly taken, would perhaps have lethal implications. This happens all the time.

I think it is unnecessary, and for the reasons Mr. Rankin gave, I will vote against it.

The Chair: I have one question for the officials. Do you consider this a substantive modification to the definition? Maybe that shouldn't be what I ask. It changes the definition. How does that affect the bill, based on the change of definition?

I am still struggling with receivability.

Ms. Joanne Klineberg: I will start by saying that the way I think we would read this is that it would set as the default mode of medical assistance in dying the self-administration by everyone who is capable. Then, for those who are not physically capable, the administration of the substance by the practitioner would be possible. It is addressing the modality of the provision of medical assistance in dying.

I think in previous appearances we indicated that addressing these kinds of modalities was something the medical colleges or provinces and territories could do. It is really a policy choice about the latitude that the committee considers should be there. Our colleagues from Health Canada might be able to opine on whether it might create some access issues, if it is structured in this way.

On the substantive question, that is a good question.

● (1735)

The Chair: Thank you very much for your help.

I don't know if Health has anything they want to add.

Ms. Helen McElroy (Director General, Health Care Programs and Policy Directorate, Strategic Policy Branch, Department of Health): I would agree with my colleague from Justice that it could create access issues. It may also reflect on the autonomy of individuals who wish to operate on their own steam, shall I say, in particular circumstances. I think those two things could be considered, as well.

The Chair: I think this is how I'm going to rule. The interpretation clause of the bill is not really the place to put a substantive amendment, and I think this is a substantive amendment to definitions, but I would like err on the side of giving the committee discretion, if they think this is really wonderful, on voting on it.

I'm not going to rule it out of order at this point. I will let Mr. Falk close by defending it, and then it will be up to the committee whether you want to change the definition or not.

Mr. Falk.

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

As amended before including the nurse practitioners in these clauses, I think it actually strengthens the bill and puts the onus back on the patient who has requested the procedure. You are asking to die. You have the ability to make it happen. We're willing to give you the cocktail that will facilitate that. We have given you the legal ability to do that. We're just going to make sure that you administer it properly.

I think there's a lot of danger in mis-administration when it comes to self-administering at home. What if they don't take the whole thing, they take half of it? There are just too many opportunities for things to go sideways if there's not a medical practitioner or medical nurse present at the time of administration.

If the person has the ability to self-administer, they should do it. This is physician-assisted suicide, and we're providing medical aid in doing that. That's what this is.

The Chair: We're going to the vote on the amendment, CPC-5.3.

(Amendment negatived: nays 6; yeas 3 [See *Minutes of Proceedings*])

The Chair: We now move to CPC-7 by Mr. Kmiec. Will somebody move it so Mr. Kmiec can speak to it?

Mr. Nicholson. Thank you very much.

Mr. Kmiec.

Mr. Tom Kmiec (Calgary Shepard, CPC): The reason I'm moving this amendment is just to bring greater clarity to what we mean by the practice of medicine, just trying to stay within the spirit of the Carter decision. I'm using the example I know best, Alberta. Alberta has a Health Professions Act. The professions that are involved in health care are regulated by one act, and they have regulations that are separated out for each of them.

I have the definition here actually of what is a medical professional. Psychiatrists—we were debating that Liberal motion—is within the definition of a person practising medicine in the province of Alberta. But it goes on to other ones as well including plastic surgeons, general pathologists, doctor of osteopathy so chiropractors. It includes things like dermatologists, osteopathic practitioners. I just feel that to stay within the confines of the Carter decision we should then add "as a registered physician".

I used to be the registrar for the human resources profession in the province of Alberta. Our act is voluntary so people don't have to conform to it. We're regulated by the Societies Act there. But the other professions have an act they conform with.

I think it also would allow the different provincial governments to determine how best to regulate access, and what types of physicians and medical professionals would be able to provide this form of health care. This should be only the physicians, not everybody, so a dermatologist wouldn't be able to do the procedure. I just think it brings greater clarity by amending the definition.

● (1740)

The Chair: Thank you very much.

Debate.

Mr. Colin Fraser: I'd like to ask a question to the department just for clarity. Medical practitioner, as I understand it, is a term that's used elsewhere in the Criminal Code, and defines it as a physician.

Is that correct?

Ms. Joanne Klineberg: A qualified medical practitioner is a term that's in the impaired driving provisions of the Criminal Code. These are people, I think, who can do the Breathalyzer or something related to taking breath samples.

It's defined as a person duly qualified by provincial law to practise medicine so we adopted the same definition.

I think I would also note that there's subparagraph (7), which talks about the practitioners having to comply with any applicable provincial laws or guidelines and so on. It's always open at the provincial level or the medical college level to be saying that certain types of people who might otherwise meet the definition are not entitled to engage in medical assistance in dying.

The Chair: Does anyone else wish to intervene?

Mr. Kmiec, do you wish to close?

Mr. Tom Kmiec: I'll just say that this amendment would basically make clearer what we mean by "medical practitioner" to make sure that only people who are physicians as determined by the college that regulates them are actually doing it and not, as an example, dermatologists.

The Chair: Understood. We'll now go to the vote on Mr. Kmiec's amendment.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We will now move to CPC-7.1.

Mr. Ted Falk: Mr. Chairman, I'll withdraw that motion.

The Chair: Thank you very much.

We will move to CPC-7.2.

Mr. Ted Falk: I move that Bill 14, in clause 3, be amended by replacing line 6 on page 5 with the following:

> dying only if a judge of the superior court in the province in which the person is ordinarily resident, on application by the person, makes an order stating that the court is satisfied that the person meets all of the following criteria:"

In essence, this is prior judicial approval. It will certainly take a lot of the onus off our health care providers, our nurse practitioners, and our physicians as well, because the judge will be the one who makes the final decision. I think what we've noticed in the time since the Carter decision until the present is that this system seems to have been working quite well. The application comes before a judge and the judge looks at it thoroughly to make sure the conditions are consistent with the Carter decision today, and going forward, once this bill receives royal assent, a judge will review each situation and will make sure that the situation is compliant with Bill C-14.

I think it's a very important check and balance, and it also creates protection for health care providers all the way down, because a judge would be doing the final sign-off and making sure that all the i's are dotted and the t's are crossed.

The Chair: I think there was another one put forward by Mr. Genuis on the same subject in a different place, but I'd like to continue with debate while I think about receivability.

Again, I think there is a receivability issue, because it really goes beyond the scope of the bill to impose a substantial condition on medical assistance in dying. Also, I'm not sure about "superior court". I think it's a provincial court in some provinces too. Can I think about that for a second and we'll continue debate?

● (1745)

Mr. Ted Falk: Yes.

The Chair: Perfect.

Mr. Nicholson.

Hon. Rob Nicholson: I guess that's the question I was going to ask the Department of Justice. The Criminal Code is administered both by provincially appointed judges and by superior court judges, so do you see any issue with confining it only to superior court judges, the federally appointed judges?

Would this be unusual within the Criminal Code to have it singled out for only one type of judge as opposed to others? That's why I'm asking. Generally, provisions of the Criminal Code are administered and dealt with by either provincially appointed judges or superior court judges, federally appointed judges. Could I have your thoughts on that?

Ms. Carole Morency (Director General and Senior General Counsel, Criminal Law Policy Section, Department of Justice): The thing that I would draw to the committee's attention—and maybe the member who sponsored it could explain if there's a different rationale—is that it looks to me like it's similar to the process that the Supreme Court has stated as a result of the additional four-month extension on the suspension of the Carter decision, which is that individuals who wish to seek out medical assistance in dying can do it currently through an application to a superior court in the province in which they reside.

It's a different approach from what Bill C-14 as introduced has proposed. I'm not sure if some of the witnesses had spoken to the implications, but certainly, there are different access implications for individuals, such as time constraints, perhaps, and resource implications of going through that process. We haven't seen the motion to amend before, but those are some of the initial considerations.

The Chair: Thank you, Madam Morency.

Mr. Bittle.

Mr. Chris Bittle (St. Catharines, Lib.): I had the opportunity to speak with a lawyer before the legislation came down. He was excited that such a provision may be included because he was going to make a lot of money off it, and it just seems to be a make-work project for lawyers that only wealthy people will have access to. I spoke about this at an earlier meeting. In certain jurisdictions, a motions court may only meet once a month, or it may be limited. This really restricts medical assistance in dying to only those who have money and those who can access the court system, which really limits what we're trying to do in this legislation.

The Chair: Thank you.

Mr. Hussen.

Mr. Ahmed Hussen: In addition to what my colleague has just said, I think the other issue in this amendment is that even if you forget about the folks who can't access the court services due to financial limitations, in addition to that, even for those who can access it, they'll face significant delay. Our court system is already backlogged and I think this amendment would impose an extra amount of delay, a substantial time delay, and that would really affect the ability to access this service, in addition to the cost concerns expressed by my colleague.

The Chair: Ms. Khalid.

Ms. Iqra Khalid (Mississauga—Erin Mills, Lib.): I think that if the Supreme Court had wanted this matter to stay in the courts, they wouldn't have given Parliament the time to come up with this legislation. I agree with my colleagues here in that it is very restrictive and will clog up the court system, so I do not agree with this amendment.

The Chair: Mr. Rankin.

Mr. Murray Rankin: Yes, I agree with the points made by Ms. Morency as well as those that have been made by my colleagues. This is about access and court delays, time, superior court. In my province, people living in remote communities would not have access and I think we would be ignoring.... We struggled with this at the Senate and House committee. We heard lots of testimony on it and I think we came to a very reasonable conclusion not to go to prior judicial review. For all the reasons that are summarized in that report as well, I think we should reject this idea.

The Chair: Thank you.

Mr. Nicholson.

Hon. Rob Nicholson: It seems to me that where there have been delays in matters of civil litigation that might get dragged out, when there are questions of some urgency the superior courts have acted very quickly. An injunction is a perfect example. If an injunction is necessary, the application is brought, it's generally dealt with very quickly because it has to be. It seems to me this would be treated in the same manner. An application to a superior court judge, I believe, would be handled in an expeditious manner, just as they do with all matters that need to be looked at very quickly.

● (1750)

The Chair: Thank you.

Mr. Fraser.

Mr. Colin Fraser: In addition to that, though, you would still have the cost element that would have to be dealt with, and that would be prohibitive and a barrier to some.

On the comment dealing with Carter, because Carter was mentioned, Carter obviously, even in its writing, contemplated the fact that this was going to come before Parliament in order to put in place safeguards that weren't in place when that decision was rendered, and that's why I feel it was mentioned that it had to go to superior court because those adequate safeguards weren't in place.

This legislation does it and therefore it doesn't need to go to court.

The Chair: Are there any further interventions?

Mr. Genuis.

Mr. Garnett Genuis: In terms of the cost element, doctors' time is more expensive than lawyers' time. The reason it doesn't cost you anything to see a doctor is because the government covers it, but there's no reason the government couldn't cover the lawyers' time in this case if they wanted to.

With regard to the claim that there are additional safeguards in place now, there are criteria established by the Carter decision. There are criteria established by the legislation. I don't think either is substantively narrower than the other, so to say that the court imposed a judicial review in one case doesn't mean it would want one in another. I don't think that follows, given the relatively similar spectrum of those exceptions.

The Chair: Thanks very much.

Any further debate on this? If not, I'll go back to Mr. Falk to close.

Mr. Ted Falk: When it comes to this piece of legislation, I think if I'm going to err on anything, I'm going to err on the side of caution. The legislation proposes to do a review and that review will enable us to do an analysis based on data, as it's called today, science and data, and to make amendments that we will want to make at that time.

This is an important safeguard, that there's a judicial sign-off. I don't think there's a problem with access to the court system on an issue like this. They're going to make it available and I think the courts can work expeditiously. It's not going to make anybody go broke to do this. It's a safeguard for people. It's a protection for health care providers, and you know, we make it sound as though this is like an appendix surgery. It's not. There's not going to be a lineup of people here waiting to exercise their rights under this legislation. I'm hoping very much that we'll have very few applicants, but I don't think we're going to be clogged up anywhere so I don't think we need to worry about timeliness or access or cost. I think these are issues that we need to consider very seriously. This is a very serious matter and I would much sooner err on the side of caution than start off running before we even know how to walk.

The Chair: Thank you very much for everybody's comments. On receivability, I've heard the whole debate, and in the same way of erring, I'd rather err on the side of the committee making the decision. I'm going to judge it receivable even though I have questions. Let's have a vote on the amendment, as drafted.

(Amendment negatived)

The Chair: We now have NDP-1.

Mr. Rankin.

Mr. Murray Rankin: Mr. Chair, it's a strange way in which this issue of advance request finds its way into the bill. On the advice of legislative counsel, this is the way we have proposed to bring it forward.

The Chair: I judge it receivable even though I also thought it was a strange way.

Mr. Murray Rankin: It was on the basis of advice, so that's the reason it was done this way. I would have wanted to have a stand-alone advance request provision, but because we were working with an existing bill, you'll understand that we were told no other way but to do it.

This issue is the advance request issue. I was proud to be a member of the Senate-House committee. We spent an awful long time hearing a lot of witnesses on this issue. We as a committee, with three exceptions, the Conservative members of Parliament on that committee, but not I should note the Conservative senators, the Liberal senators, the NDP, and Liberal members all supported the idea of advance request.

The group Dying With Dignity claimed, through polling they have done, that the vast majority of Canadians want and expect our committee to address this issue. If we believe in patient-centred health care, this is a clear example of it.

At community meetings I've held in different provinces of the country, the first issue that comes up where people seem to be most engaged is this issue. There's a palpable desire to deal with the situation where people have been given a diagnosis, not when they're healthy, that they are going to have Alzheimer's, and they can identify in advance the time at which they would like to avail themselves of physician-assisted, or medical aid in dying.

That is the common denominator in so much. We've heard many stories told to our committees, both here and at the Senate-House committee, of the terrible tragedies where people have not been able to do that despite their wishes. This is a natural progression from do-not-resuscitate orders and living wills, and so forth. Parliament is mature enough to do what the vast majority of Canadians wish us to do.

● (1755)

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

I wish to note because I promised to provide clarity when one amendment would mean other amendments could no longer come forward.

NDP-1 has line conflicts with CPC-10 and CPC-11. If NDP-1 is adopted, CPC-10 and CPC-11 would fall because those would conflict with lines amended in NDP-1. I'm going to keep everybody in the loop on that one when I can find it.

Mr. Cooper.

Mr. Michael Cooper: I, with respect to Mr. Rankin, would oppose this particular amendment. The Supreme Court was clear in its decision that one of the criterion for medical assistance in dying is that one gives fair clear consent. I believe that by clear consent the Supreme Court was contemplating contemporaneous consent.

This motion seems to conflate, on the one hand, the inability to give instructions with the ability to change one's mind. It sets a very dangerous precedent. I would note that in the province of Quebec, which we've been reminded studied Bill 52 for six years, in three national assemblies, three Quebec governments, the advance directives were in the initial legislation, but they were withdrawn on the basis that the risks could not be sufficiently mitigated.

There was a clear body of evidence before the special joint committee and evidence before this committee that there are inherent risks involved. The government, in the legislation, has said that there may be an opportunity. In fact, the government's intention is to study this further.

I'm not opposed to studying any issue further, but I believe that given the time in which Parliament needs to pass legalisation and having regard for the inherent risks that have been identified and the underlying complexities involved in advance directives, it would not be responsible to amend the legislation at this time to include advance directives.

The Chair: Thank you very much.

Mr. Fraser.

Mr. Colin Fraser: While I appreciate very much the comments by Mr. Rankin, I would note as well that the Liberal caucus will be putting forward a motion later on dealing with independent review. That's in the package now, to have an independent review no later than 180 days after the day on which this act receives royal assent. That's a change from what had previously been anticipated.

I tend to agree that we need more study on this. We need to hear from and consult broadly with all Canadians to make sure that we get this right. For that reason, I cannot support this amendment at this time.

The Chair: Is there any further discussion?

Mr. Rankin, would you like to close?

Mr. Murray Rankin: To Mr. Cooper, I agree that the issue of clear consent was very much front and centre of the Supreme Court's decision; however, I don't think there was any effort to limit it to contemporaneous consent. As long as we're legislators, I think it's certainly open to us to do what other countries have done.

Secondly, on the point of changing your mind, my objective would be to allow that as long as the person is competent—to be able to do that at any time.

Lastly, Quebec's experience is certainly not determinative of what's open to us. I agree with the point that was made. They did decide not to proceed on that in the end. That, of course, doesn't mean it's not open to us. I note that the provincial-territorial task force that studied this in detail spoke to the need of advance requests in their proposals.

I think the time has come. I think Canadians are certainly ready and will be very disappointed if this committee decides to pass it to another time, to another review, when we could do the job now.

● (1800)

The Chair: Thank you very much.

Mr. Hussen.

Mr. Ahmed Hussen: I think there is only one country in the world that has advance directives in its law. Despite the fact that there are many countries that allow for medical assistance in dying, only one country has moved on this. It goes to show you how careful many countries in the world are with respect to advance directives. It think it's incumbent upon us to move slowly on this to make sure we get it right.

The Chair: Actually, I think there are only four countries plus four U.S. states right now, so it's not that many. Only the Netherlands has advance directives. But it's a good point.

Thank you very much, Mr. Hussen.

Thank you very much, Mr. Rankin. It's a very important issue that we at least deal with and have the debate on.

I'm not hearing any more debate.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: Now we will move to CPC-8.

[*Translation*]

I promised to point out any problems. I will provide explanations in this case.

Amendment CPC-8 conflicts with amendment BQ-2. If amendment CPC-8 is adopted, Bloc Québécois' amendment cannot be moved. I did not receive that amendment beforehand.

There is another problem. Amendment CPC-8 conflicts with amendment CPC-8.1. If CPC-8 is adopted, CPC-8.1 cannot be moved.

[*English*]

We go in the order that they were received. CPC-8 came first. I'm going to ask one of the members of the committee to please propose it, and then Mr. Viersen to speak to it.

Thank you, Mr. Falk.

Mr. Viersen.

Mr. Arnold Viersen: I propose that we change the words "grievous medical condition" to "terminal medical condition" in that I'm looking to protect vulnerable people with disabilities. Often, if you suffer from a disability, this is a grievous condition, but it's not necessarily terminal. I don't think it should be.... We've heard evidence from members from the disability community saying they are concerned about the direction that this is going in. I'd like to reassure them and say this will be available only to people who have a terminal medical condition. That is the impetus for this amendment.

The Chair: Thank you very much.

I think you meant to say you're proposing to replace the word "irremediable", not "grievous".

Mr. Arnold Viersen: You're right, irremediable, as it says.

The Chair: Mr. Bittle.

Mr. Chris Bittle: The Supreme Court was clear, not only in its decision in Carter, but in the transcript we received from Mr. Arvay on the extension application. They were clear that it was not limited to individuals with a terminal condition, so I'm voting against it.

The Chair: Thank you very much.

Mr. Cooper.

Mr. Michael Cooper: With respect to Mr. Bittle, the Supreme Court of Canada made no such pronouncement. There was simply a question posed by a judge in a transcript that was not part of the decision in any way. You can interpret the Supreme Court decision as to whether or not it would preclude terminability, but the Supreme Court never specifically addressed that.

The Chair: Mr. Falk.

Mr. Ted Falk: I said before that when we err, we should rather err on the side of caution to begin with. The comment was made by one of the witnesses at committee that the Supreme Court gave us an area like this, and what part of this legislation does is reduces it to this. Well, when I tell my child to go in the backyard and play, if he chooses to play in one corner of the backyard, he's still being completely compliant and completely obedient. If we narrow that window from what the Supreme Court has said we can do, there's nothing wrong with that. This just gives it much more clear definition. I support this. I think we should define it very clearly that it needs to be terminal.

● (1805)

The Chair: Mr. Rankin.

Mr. Murray Rankin: I don't accept the analogy. We have a unanimous Supreme Court telling us that the yard is this big. We don't now say that the yard is this big. We can't take away from what people who won that hard-fought battle achieved in their victory. To take this and limit it to terminability would be to fly in the face of the unanimous Supreme Court judgment. Indeed, as Mr. Bittle said, it would fly in the face of what the judge specifically said in the extension application, where she said we are not limiting it to terminability. We have no right to do this, in my judgment, if we are to be faithful to the Supreme Court and to the rule of law.

The Chair: Are there any further comments?

I'm going to go back to Mr. Viersen to close.

Mr. Arnold Viersen: This amendment came out of a wish to protect the vulnerable, specifically the disability community. I will make that argument again, and hope for this amendment to pass.

The Chair: We're going to put this amendment to a vote.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: May I suggest we take a short health break?

Some hon. members: Agreed.

● (1805)

(Pause)

● (1825)

The Chair: Ladies and gentlemen, we're going to reconvene.

[*Translation*]

The next amendment for consideration is CPC-8.1.

[*English*]

Mr. Falk.

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

[*Translation*]

The Chair: I apologize.

I also have to tell you that there is a conflict between amendments CPC-8.1 and BQ-2. I said it earlier, but I am repeating it so you would know that, if amendment CPC-8.1 is adopted, amendment BQ-2 cannot be moved.

[*English*]

Mr. Ted Falk: We want to change the definition under eligibility requirements for medical assistance, paragraph 241.2(1)(c), "they have a grievous and irremediable medical condition". We're proposing to amend it to "they have a terminal medical condition".

I think there's merit in that. An end-of-life scenario I think is probably not a bad place to start, if we're going to open up legislation for physician-assisted death. Along that theory of walking before you run, a terminal medical condition is definitive, and we don't, by mistake, allow people to access this for other reasons.

We had a similar motion.

I'd be prepared to leave it at that.

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

Does anybody else wish to speak to this?

The Chair: Perfect.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: I'd like to welcome Mr. Warawa to the committee. He is replacing Mr. Nicholson.

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

[*Translation*]

The Chair: We will now move to amendment BQ-2.

I give the floor to Mr. Thériault.

I want to point out that amendment BQ-2 conflicts with amendments NDP-2 and NDP-3. Therefore, if amendment BQ-2 is adopted, amendments NDP-2 and NDP-3 will be negatived.

Mr. Thériault, go ahead.

Mr. Luc Thériault: Thank you, Mr. Chair.

Under the bill, for medical assistance in dying to be provided, it must be shown that an individual is in an advanced state of irreversible decline in capability and that their natural death has become reasonably foreseeable in all of his or her medical circumstances, without requiring a specific prognosis in terms of their life expectancy. The lawyer who argued that issue before the Supreme Court, Mr. Arvay, as well as the Carter family lawyer and the Barreau du Québec have told us that those criteria are not part of the Carter decision rendered by the Supreme Court of Canada.

Moreover, the reasonably foreseeable death criterion poses interpretation issues, even taking into account other criteria that can affect patients' exercise of their right to assistance in dying, as it leads to a legal uncertainty. As we know, the devil is in the details. That is why the Barreau du Québec told us it would be better to limit ourselves to the definition set out in the Carter decision. Through this amendment, we are making a connection between the eligibility criteria part and a few elements that define grievous and irremediable health conditions.

I will read the amendment:

> (c) they have a grievous and irremediable medical condition, whether an illness, a disease or a disability, that causes them enduring and intolerable suffering given their medical circumstances;
>
> (b) by adding after line 19 on page 5 the following:
>
> (1.1) For the purposes of paragraph (1)(c), the person need not submit to treatment that is not acceptable to them in order for their condition to be considered irremediable.

So we feel that, by doing this—and we will propose another amendment later on that will consist in completely eliminating definitions of grievous and irremediable medical conditions—we touch on all the eligible elements under the charter and under the Carter decision.

● (1830)

The Chair: Thank you very much.

I'm launching the debate. Would any committee members like to speak to this issue?

Mr. Rankin, go ahead.

[*English*]

Mr. Murray Rankin: Thank you, Chair.

I'd like a procedural intervention here. I very much support the thrust of what Mr. Thériault is suggesting.

My amendment goes to the same place and tries to do it in a more concise way. I would make some distinctions.

Do I speak to his or talk about mine instead? How do you want us to proceed?

The Chair: Theoretically from a procedural vantage point, if you prefer yours, you should vote down his so you can come to yours, but I'm happy to let you argue why you're doing that. It could be that you believe yours is better.

Mr. Murray Rankin: I agree entirely with the thrust of what Mr. Thériault has tried to do. That is use the language the Supreme Court of Canada used.

My proposed amendment, which is NDP-2, follows his in the material. You will see that the language, if not verbatim, is as close as we could draft it to be to what the Supreme Court of Canada said.

You will notice that Mr. Thériault has tried to do the job with two sections. I've tried to use one section for simplicity and clarity.

There are also some technical differences. For example, he talks about “causes them enduring and intolerable suffering given their medical circumstances”.

The words of the court don't say “medical circumstances”. Similarly, they don't use the word “intolerable” just “enduring”.

Again, I very much appreciate what Mr. Thériault has tried to do, but I believe our version of accomplishing that objective is a cleaner, simpler way to do so, and it's entirely in line with the Supreme Court of Canada's unanimous decision.

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

Does anyone else wish to intervene?

Mr. McKinnon.

Mr. Ron McKinnon: These paragraphs go to the heart of the bill. I'd like to address this amendment plus Mr. Rankin's amendments.

They are about who can or cannot avail themselves of physician-assisted dying.

I appreciate this amendment because it swings the true focus to the patient's enduring and intolerable suffering rather than the nature of the disease or ailment and whether or not it's terminal or represents some manner of decline. I feel that the salient part of the bill is the patient's enduring and intolerable suffering.

However while I appreciate these amendments, I fear that if any of them pass, this bill will not pass the House so while I can't vote against the amendments, I can't support them either so I will abstain from all three.

● (1835)

The Chair: Is there any further debate?

[*Translation*]

Mr. Thériault, do you want to close the debate on the matter?

Mr. Luc Thériault: The NDP amendment uses practically the same terms: "... that causes them enduring suffering that is intolerable to them in the circumstances of their condition;".

We have to make a distinction between the final stage of life and the final stage of an illness. Someone may in fact be in the final stage of an illness and live for a very long time, but individuals with certain degenerative conditions could be in a vegetative state—a situation that average people deem to be completely unacceptable. I noticed earlier that there was some confusion over this.

I feel that, by adopting these amendments, we would be complying strictly with the Carter decision and would avoid any issues related to legal challenges. An individual can find themselves in a situation where someone would claim that their condition can be healed or a treatment can be administered, while palliative care has been accepted and considered a good medical practice for a long time. I'm talking about imposing treatments that constitute aggressive therapy.

The Chair: Thank you very much, Mr. Thériault. We will vote on amendment BQ-2.

(Amendment negatived)

The Chair: We will now move to amendment NDP-2.

[*English*]

Mr. Rankin, can I just ask, again, procedurally, the difference between NDP-2 and NDP-3? You're repeating the same thing but you're adding a paragraph in NDP-3.

Is NDP-3 an alternative to NDP-2 if NDP-2 doesn't pass?

Mr. Murray Rankin: Yes. Now in terms of the very helpful intervention by Mr. McKinnon, I'd just like to reflect on what I understood him to say. He's giving us a political judgment about what was acceptable, if I understood. You said it couldn't pass in the House. I find that a very troubling observation. This language is my best effort to capture as closely as I could the exact wording of what a unanimous Supreme Court of Canada told us.

At the risk of using an inappropriate analogy, it's like saying, after the Civil Marriage Act was passed for same-sex marriage, that we can't necessarily deal with it in the House because we don't agree with it, or we're uncomfortable with it. It would have been the same with abortion, had there been legislation after the Morgentaler case.

I fail to understand as a matter of law how we can say we can't go along with what the court unanimously told us they meant. I have a lot of trouble understanding that argument.

The Chair: Do you want to further intervene to explain your motion or do you feel you've explained enough?

Mr. Murray Rankin: That's my explanation. Those are the words of the court judgment. That's all it is.

The Chair: Mr. Fraser.

Mr. Colin Fraser: With regard to the provisions here that deal with the fundamental essentials of the bill, this was a response to the Carter decision on particular facts of the cases before the court at that time. It's up to Parliament. In fact, the decision anticipated, of course, that Parliament would draft a bill that would respond to Carter that would be able to perhaps define things such as "grievous and irremediable". I believe it's up to us as parliamentarians to do our best to craft a bill that responds to the Carter decision and also takes into account other cases that will be across the country.

I believe that the bill strikes the right balance. This amendment would clearly go against the essential elements of the purpose of "grievous and irremediable" being attempted to be defined in the bill, and I believe it complies with Carter. I also believe the evidence we heard from Professor Dianne Pothier, for example, that clearly states that it's up to Parliament. Parliament has the ability to do this, and I believe it's in keeping with the spirit of that evidence before our committee that I'll be voting against this amendment.

● (1840)

The Chair: Mr. Warawa.

Mr. Mark Warawa: Chair, I would agree with Mr. Fraser. I think he's captured it quite well. This is Carter-compliant and I think Bill C-14 as written is superior to what is being proposed in the amendment, so we will be voting against the amendment and supporting the language of Bill C-14.

The Chair: Thank you very much.

Members, is there any further comment? If not, I'm going back to Mr. Rankin to close.

Mr. Murray Rankin: Thank you, Chair.

To the point that somehow Carter was limited to the particular facts of Carter is to ignore, as Joe Arvay told us so clearly, that the B. C. Civil Liberties Association intervened specifically to take it beyond the specific fact situation of the two litigants primarily involved in that case. He also said it goes against the essential elements of Carter. He claims that it was unquestionably unconstitutional and, if left unchallenged, bound to be repudiated by the Supreme Court of Canada. For that reason I fail to understand why it would not be acceptable by this committee.

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

Now, for clarity, we're going to be voting on NDP-2.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: Now we move to NDP-3.

Mr. Rankin.

Mr. Murray Rankin: I think it has to be withdrawn as a consequence.

I'm not moving it.

The Chair: Next we get to CPC-9, which is Mr. Viersen, moved by Mr. Falk.

Mr. Viersen.

Mr. Arnold Viersen: Thank you, Mr. Chairman.

This amendment is to deal with people who are suffering from mental illness, depression, or the sort, to ensure that they're not suicidal essentially.

In the past when somebody stepped up on the railing of a bridge, we consoled them and we told them to come down because their life had value; it's not worth it. With this bill, I do think that we are to some degree letting them stand there. I'd like to ensure that we talk people back off the edge of the bridge, tell them their lives have value, and ensure that they have the psychological counselling they need, so this is my amendment.

The Chair: Thank you very much.

Mr. McKinnon.

Mr. Ron McKinnon: I'd like to comment on the use of the word "counselling". We recognize it as a problem elsewhere. We might want to address that wording. It's confusing. There is counselling in a therapeutic sense versus the counselling referred to in the Criminal Code.

Mr. Arnold Viersen: In this case, that is typically what the word means. I understand there might be some confusion when we use the same word with two slightly different meanings. Counselling services generally are what it refers to.

The Chair: Mr. Falk.

Mr. Ted Falk: I think this is a good amendment. I think it's incumbent on legislation and this committee to recognize that there are instances where people have momentary lapses in judgment. Sometimes those lapses last months, sometimes years. They may think that dying is their only way out, their only solution. That simply is not the case in many situations. I would support this amendment. I think it's a great amendment. People should at least go through the process of determining if there's a psychological issue that needs to be addressed.

The Chair: Are there any further comments from any members of the committee?

Ms. Khalid.

Ms. Iqra Khalid: I think that this is more a matter of provincial jurisdiction. The relationship between a medical doctor or nurse practitioner and their patient is not a one-off. It is an ongoing relationship that doctors and patients have. I think it's up to the province to make sure that this relationship is regulated.

I do not support this amendment.

● (1845)

The Chair: Are there any further comments?

Then I'm going to turn it back to Mr. Viersen to close.

Mr. Arnold Viersen: My argument is the same as before. I feel that in the valleys of life we will make decisions and not see the hope. I think those who don't see the hope should be given the opportunity to hope again.

Thank you.

The Chair: Now I'm going to move to a vote.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: Next we move to CPC-9.1.

Mr. Ted Falk: This recommendation comes out of testimony that we received at committee. At the end of paragraph (d), where it reads "and", I would like to add "a result of external pressure or lack of access to services required to address the underlying cause of the request, such as palliative care, chronic pain care, and geriatric care; and".

I think this is a very important amendment because it looks deeper into the situation, rather than just looking at the request. It asks whether, for example, there's an absence of proper palliative care. It asks about the reason for the decision.

I had the good fortune, on Friday night, of attending an event in my riding, where there were three other doctors sitting at the table. One of them and his wife were palliative care experts. We talked a bit about this bill. They said that people in end-of-life situations, even in acute situations of suffering and pain, have two concerns. Their number one concern is their pain. They're scared of the pain in the process of dying, and they want help with it. The other one is that they want help with fear and anxiety in that end-of-life stage. People are quite fearful because they get that drowning sensation towards the end.

They were quick to assure me that both of those issues could be dealt with effectively through physician assistance. They told me they could mitigate the pain and discomfort. They said they could also deal with the fear and anxiety.

I think this amendment is important because it addresses the palliative care aspect. It ensures that people have the opportunity to explore whether there are options for making a different decision, and it asks how their situation relates to palliative care. That's what this is doing. It asks whether it's an absence of palliative care that's causing someone to make this decision.

The Chair: Is there any debate?

Mr. Fraser.

Mr. Colin Fraser: With regard to this amendment, while I respect the points made by Mr. Falk, I'm not supportive of this amendment. The word "voluntary" precedes this in the section, and the voluntary request for medical assistance in dying is key.

My belief is it should be left to the health practitioners, the medical practitioner and the nurse practitioner, to assist in making a fully informed consent and making sure that person is giving informed consent, having regard to things such as palliative care, consultation, chronic pain care, and all those types of things.

I don't believe it's appropriate to put it in the bill. I think it's better left to the health care practitioners to have that conversation and satisfy themselves they're receiving informed consent.

The Chair: Mr. Warawa.

Mr. Mark Warawa: I appreciate the attempt to deal with the issue of suffering and the need for appropriate palliative care to be offered. I'm just having difficulty dealing with the language and how it connects. We're talking under line 17, page 5, so it would read: "that they have a voluntary request", this is eligibility for medical assistance in dying under (d), "that in particular was not made as a result of external pressure or lack of access to services required to address the underlying cause of the request such as palliative care, chronic pain".

It's saying you do not have access to this, and I think the language is confusing. The special committee and committee members have heard numerous times of the importance of palliative care. We heard from CMA that 70% of people who need palliative care don't have it. We've heard from the government there's a plan to deal with the provinces, and short of an amendment to the Canada Health Act requiring palliative care

I appreciate the attempt, but I don't know if this is going to change what is hoped for, and maybe another part of the bill would be a better part to deal with this. The language is confusing, and I don't think it will get the hoped for results. I'll abstain on this one.

● (1850)

The Chair: Is there any further debate? May I turn back to Mr. Falk to close?

Mr. Ted Falk: This is an amendment that addresses the whole issue of palliative care and whether that was an underlying cause. It's like another box in the checklist. You tick off the box, yes, I've asked that question. I've investigated that particular aspect of the situation and a lack of palliative care is not the situation, so then a person would continue to qualify.

That's all it is, and I respect my colleague's comments here. I'm less than thrilled with the wording as well.

The Chair: Thank you very much for the honesty.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We're going to now move to CPC-10, and I'd like to advise that CPC-10 and CPC-11 have a conflict. If CPC-10 is adopted, CPC-11 would fall.

Mr. Ted Falk: I so move.

The Chair: Mr. Genuis.

Mr. Garnett Genuis: May I just get a clarification on that? Although the wording on Mr. Kmiec's amendment overlaps with the wording of my proposed amendment, if I have this right, he doesn't modify the section I'm seeking to modify.

The Chair: My ruling would be you're both modifying line 18, and if his amendment is accepted, you'd add the word "written" into 18; which would then make your amendment to line 18 not receivable anymore.

Mr. Garnett Genuis: Okay. I suppose he could change his amendment to be just—

The Chair: He could, or he could try to incorporate your point into his amendment. That's my ruling for the moment.

Mr. Kmiec.

Mr. Tom Kmiec: This amendment is defining the mode under which consent is provided. That's all I'm doing. In section (e) it's "written", in section (f) it's "recorded". It just brings it into more consistency with section 241.31. With the regulations the Minister of Health can define how information is collected.

This would give greater certainty that after the fact there's a means to double-check whether written consent or informed consent was provided, so we don't fall into the situation where in some other jurisdictions, which do have medical assistance in dying, that after the fact they found situations where a person had not consented to the procedure being done.

This is just to create consistency between different sections of this act.

The Chair: Ms. Khalid.

Ms. Iqra Khalid: I have some concerns with the request being recorded, as I think it may overstep boundaries of privacy, so I am not supportive of this amendment.

The Chair: Is there any further discussion?

Not hearing any, Mr. Kmiec, do you want to close in any way?

● (1855)

Mr. Tom Kmiec: To address Ms. Khalid's point, the minister has the power to determine how information is released thereafter. In fact, this is stated later in the act, but for this type of information, obviously, doctor-patient confidentiality would apply. I don't see a situation where it would be released.

The privacy concerns are covered by that doctor-patient situation, so I don't think there's any issue there. That would be my only point.

The Chair: Thank you.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: Now we can move to Mr. Genuis' amendment, CPC-11.

Mr. Falk, will you move it? Okay.

Mr. Garnett Genuis: This adds "and uncoerced consent". To some extent that's implied, but I think it's one of these for-greater-certainty things, to ensure that those who are checking the situation against the criteria are aware of it, and putting a strong emphasis on ensuring there is no coercion going on.

I don't imagine there's anything in here that members would find particularly objectionable, and it would give you the chance to include a Conservative amendment.

The Chair: Mr. Rankin.

Mr. Murray Rankin: As much as I would like to do that, Chair, I would worry about a situation where, in other sections, we leave it as merely "consent". Then people would say, "That must be coerced consent", which frankly is a contradiction in terms.

Putting the word "uncoerced" here would add nothing, and would only create uncertainty elsewhere. For that reason I can't support this.

The Chair: Thank you very much.

Mr. Fraser.

Mr. Colin Fraser: I completely agree with Mr. Rankin. There's no such thing as valid consent that is coerced. It's meaningless and could perhaps cause problems with understanding other sections.

For that reason, I don't see why we would make that amendment.

The Chair: Mr. Falk.

Mr. Ted Falk: Proposed paragraph 241.2(1)(d) just prior to that says that the decision was not made as a result of external pressure, so to me it seems redundant as well.

Mr. Mark Warawa: Yes.

Mr. Garnett Genuis: I'm persuaded. I'll withdraw it.

The Chair: (Amendment withdrawn [See *Minutes of Proceedings*])

The Chair: Now we will move to CPC-12.

Mr. Cooper.

Mr. Michael Cooper: This amendment simply provides that a person who is suffering from an underlying mental health challenge undergo a psychiatric assessment to determine their capacity to give informed consent.

The body of evidence, both before the justice committee and the Special Joint Committee on Physician-Assisted Dying indicates that physicians and nurse practitioners may have the ability to diagnose an underlying mental health challenge, but to undertake something that is more complex, such as determining the capacity to consent in the context of physician-assisted dying, someone with further training such as a psychiatrist is required. What's more, the evidence before the justice committee was that psychiatrists are precisely equipped and trained to make this type of assessment.

It's a very straightforward amendment to protect the group of persons who are perhaps the most vulnerable of any, those who suffer from underlying mental health challenges.

The Chair: Thank you very much.

Mr. Bittle.

Mr. Chris Bittle: This is just an attempt to delay the process and cause undue delay.

Psychiatric services are so difficult to access. I had a client of mine who had a complete psychotic breakdown, and it took three days to get an emergency appointment on an emergency basis. I think this is one of those things where it's best to leave it to the colleges across the country...who is best to deal with these types of situations under their own rules of practice.

● (1900)

The Chair: Mr. McKinnon.

Mr. Ron McKinnon: In order to activate this clause, it presupposes that the medical practitioner or physician who is contemplating performing the medical assistance in dying would recognize that. I think if they recognize that this person has a mental condition, as part of their own due diligence they would seek this kind of clarification as a matter of course. I think the amendment is redundant, and I will not support it.

The Chair: Mr. Warawa.

Mr. Mark Warawa: I would suggest otherwise. We did hear from medical professionals who spoke to the committee, who said that physicians may not have that talent, that skill level, that expertise, to be able to determine whether or not the patient, the person requesting assistance in medical aid in dying.... That medical GP or nurse practitioner may not have that expertise, and in some cases will not have that. Yet, Bill C-14 will give them the authority to make that assessment without any expertise. We heard clearly from the CMA and other medical professionals on the importance of having a proper assessment.

We've also heard comments of the importance of being Carter-compliant. It was a competent, consenting adult. If somebody is not competent, who has an underlying medical or psychological or psychiatric condition, and you have somebody who is not an expert to determine whether or not they're competent, you'll end up putting at risk vulnerable Canadians.

I think the amendment is very appropriate. It's not redundant; it's necessary. For clarity of the legislation, it should be supported.

The Chair: Mr. Falk.

Mr. Ted Falk: I think this is a unique amendment. It's not an amendment that's going to be applicable to every single case. There's a qualifier there: “if they suffer from an underlying mental health condition”. I think it's very important to note that, because if that is known, then there is every reason under the sun that a person should say, “Hold on here, let's just do a little check-in ourselves here, and let's get a second opinion from an expert in that field.”

If it's an individual who is just suffering from an intolerable and grievous medical condition, apart from a history of mental health, this wouldn't be applicable. This is applicable to a small number of cases of individuals who suffer from mental health, and it's just another check and balance to make sure we're getting it right, and that these people are actually competent to make the decision that they're making here.

The Chair: Mr. Fraser.

Mr. Colin Fraser: While I understand the point of the amendment, we rely on health care providers to make this determination every day with regard to informed consent, with regard to accessing expert services, if required, in order to satisfy themselves that this decision is being made freely and voluntarily.

I believe what Mr. Bittle said earlier, that instituting safeguards that they feel are appropriate in order to address the issue is clearly something that should be left up to the medical profession and the provinces to deal with. I don't believe it's appropriate for the Criminal Code to be placing this onus on them when we rely already on health care professionals every day to make the determination about what is valid consent and not. I would note that we don't require any sort of similar scheme for other issues dealing with end of life, whether it be withdrawal services, for example. I believe this is adequately addressed by the medical profession. We should trust our doctors and nurse practitioners to make those decisions, which we rely on every day.

The Chair: Mr. Warawa.

Mr. Mark Warawa: Chair, I'm thinking back to a meeting I had with a very well-known and well-respected retired internist. This former physician shared a number of stories where there had been a drop of continuum of care, where a person entered an emergency ward and somehow their chart was not being followed by the next doctor or the nurse. In the process somebody said that because of the pain, the patient was terminal. They were treated as a terminal patient, were over-prescribed a narcotic, and died.

In another example, the person had colitis, was in terrible pain, was not treated properly, and ended up with a perforated bowel. There was example after example. There are examples where physicians, because of the business or whatever...they are human beings and can make mistakes and not follow normal procedure.

If we're talking about an issue of competence, if you are not competent because you're bipolar and you're in a three-month low and you cannot buy a cellphone on a contract, but you cannot be assessed to see whether or not you qualify, the Carter decision says you must be competent to provide that. We're saying if it's a mental issue, you don't send somebody to a family doctor. A specialist has to determine whether or not you're competent. I think the amendment is reasonable considering we're talking about somebody with a mental or psychological issue. I support the amendment.

● (1905)

The Chair: Thank you very much.

I'm going to go to Mr. Cooper now to wind things up, unless somebody else has something to say.

Mr. Michael Cooper: Like other members of the committee, I trust medical professionals, but this legislation doesn't leave it to any one medical health professional to make a decision with respect to someone accessing physician-assisted dying. We say two medical professionals. Why? Because we want to mitigate risk. We don't simply say that someone can give an oral request to a physician, trusting that physician to understand the oral instruction. We say it has to be in writing.

In that regard, I believe this amendment is very much in line with other safeguards included in this legislation, that are good safeguards, and I believe this would enhance the legislation. It's not about delay. It's not about referring every patient. It is about ensuring. I believe that most physicians would refer a patient to a psychiatrist. I'm not questioning physicians. I think it does no harm and does a lot of good to be absolutely certain to the greatest extent that we can be that vulnerable persons do not fall through the cracks. I did not hear any evidence to indicate that any physician or any nurse practitioner is equipped to undertake that kind of analysis, so that's why I think this needs to be amended.

The Chair: Thank you very much.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We will move now to amendment CPC-13.

Mr. Garnett Genuis: Mr. Chair, may I make an amendment to the text of this amendment?

The Chair: Yes, you may.

It's your motion, so you can move it however you want.

You wouldn't even need to amend, you'd move it differently.

Mr. Garnett Genuis: I would like to strike the first phrase up to the comma.

The Chair: How would it read?

Mr. Garnett Genuis: It would read, “they consulted a medical practitioner regarding palliative care options and were informed of the full range of options”.

The Chair: So you'd not have the words “in the 15 days prior to making the request”, the sentence would just start with “they”?

Mr. Garnett Genuis: Yes.

The Chair: And that's how you're going to move this?

Mr. Garnett Genuis: Yes, I think that's clear.

The Chair: Would you put that on a piece of paper and bring it to the clerk?

Mr. Garnett Genuis: Okay.

The Chair: Excellent.

Let the record note that I put my thumbs up.

Mr. Falk, will you move that on behalf of Mr. Genuis?

Mr. Ted Falk: I so move.

The Chair: Mr. Genuis, over to you to speak to your motion.

Mr. Garnett Genuis: There has been a lot of discussion in the context of this debate about the importance of palliative care. I think there is a consensus about the importance of palliative care. There's nobody who is against palliative care here.

It has been a matter of concern among the different witnesses, both at the special joint committee and the study here at the justice committee, that there is not adequate palliative care in this country right now. I think there's a consensus about that and various proposals and plans for addressing that deficiency.

What this does is ensure that somebody who is seeking euthanasia, suicide, or whatever you want to call it, is consulted, is given the information about available palliative care. When I talk to people about this issue, so often people may talk about pain in a certain context being unmanageable and I happen to know, because of my connection to the medical profession, that pain in that particular case is not unmanageable, but perhaps was not managed well in that particular context.

A concern I have is that people will think their pain is unmanageable and they will think they cannot be helped, when in fact they can.

● (1910)

Based on a consensus around the importance of palliative care and also making sure that people have proper information about what is available in terms of pain management, I think that asking that people have some consultation and information about palliative care is important.

I want to note that this doesn't slow down the timeline at all, so I wanted to remove that little phrase to clarify that point. The legislation obviously has people visiting a physician already; they have to have consultations with various physicians. Therefore, including the assurance of receiving detailed information about available palliative care options, the fact that there's already a waiting period for someone, even in the midst of that waiting period to be able to get that information, I think, clearly isn't going to slow down anyone's access to this service, but it does provide an important safeguard so that people know exactly what their alternatives are before they take this very final step.

The Chair: Thank you very much.

Mr. Falk.

Mr. Ted Falk: Again, this is an issue for a final check on whether palliative care is an issue and whether they've had the full consultation to see whether there's any further palliative care that could be extended or would make it foreseeable for those individuals to avoid making this decision. This is a very permanent decision that they're making and we want to make sure that all the options have been explored.

I think it's a great amendment. Again, it's another safeguard.

The Chair: Thank you.

Mr. Rankin.

Mr. Murray Rankin: I hesitate to speak against the proposed amendment because I know it to be well intentioned. The reason I'm speaking against it is, I suppose, twofold. First, it comes up as a condition for eligibility. That is, the way it's put in the bill, where it fits in the bill, is that this would be a condition precedent to actually being able to be eligible. It bothers me to think that in every case, particularly for those people living in remote communities, they would be denied their ability to take advantage of this service unless they could find a medical practitioner who could describe, perhaps non-existent, palliative care options.

The minister herself told us 15% to 30% of Canadians may have access to palliative care. I would have thought that the practitioner, or those people who counselled, encouraged, or persuaded people about the service in the past, who talked to them—social workers, psychologists and the like—would have talked about that. Health care practitioners would have already done that as part of what normal team medicine is in the 21st century, so I don't think it's necessary. But it troubles me that we would make it an absolute bar to doing so, where it may be difficult to obtain that advice.

The Chair: Mr. Cooper.

Mr. Michael Cooper: I certainly take Mr. Rankin's point about the fact that palliative care is not available, according to the minister, to 70% or 80% of Canadians, and I think that's a problem. But as I read this amendment, all it is saying is that a medical practitioner would provide information to the patient to make them aware of palliative care. It doesn't require a patient to undergo palliative care as a prerequisite. It is really informational in nature. Of course, it doesn't seem to indicate that a palliative care doctor or practitioner is required to oversee the consultation with the patient.

● (1915)

Mr. Murray Rankin: I'm sorry, but that's not what the section would say. It says they have consulted a medical practitioner regarding palliative care options. It's a condition that they consult somebody who, in Nunavut, they may have a lot of trouble finding, let alone a nurse practitioner, which I notice is absent as well. I find it to be unworkable.

Mr. Garnett Genuis: Can I make a quick comment, and I'll make it without necessarily closing off? I think it is important to acknowledge telephone consultations happen regularly with physicians, especially in remote communities, and could easily happen in this case since what's required is not a physical exam. It's simply a verbal consultation about available palliative care options, so that should hopefully address Mr. Rankin's concern about access, at least as far as that goes.

The Chair: I have a receivability question.

My question, Mr. Genuis, is about the physician who is checking afterwards, and has to to check to make sure all of the requirements of subclause 241.2(1) were met, which would now include your proposed paragraph (f). How is it your view that the physician or nurse practitioner would check to see the other physician, if it was a different physician, informed the individual of all of the full range? Would one of them have to call or correspond with the other physician to make sure a full range of options was provided, or are you presuming it's always one of the two referring physicians, the nurse practitioner or medical practitioner, who are involved? That's going to help me clarify how receivable this is.

Mr. Garnett Genuis: Sure. Mr. Chair, I don't think this is a problem at all. When it goes to a second physician, that physician is going to have to receive some kind of documentation from the first physician. The only way you demonstrate there were two doctors is if the second doctor knew about the first doctor, so it would be not at all onerous to include in whatever that correspondence was a line to acknowledge that the required information about palliative care had been provided, or that the required information about palliative care hadn't been provided, in which case the second physician would have to provide that information.

The Chair: You're seeing it as one of the two. You're seeing this being done by one of the two.

Mr. Garnett Genuis: In the event that neither of them felt competent to do the procedure, it would require a third physician. I can't imagine that happening in the vast majority of cases, but, on Mr. Rankin's concern about access, this is the kind of thing, unlike.... I presume the meetings with the two physicians who are signing off on this will require in-person meetings and some kind of physical examination. A consultation with respect to palliative care options would clearly not require a physical examination. It could be done very easily remotely. To suggest that added a degree of an onerous condition, that was substantially greater than the existing conditions, doesn't make a lot of sense to me.

The Chair: I'll check that it is receivable.

Is there any further discussion or debate?

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: I believe amendment CPC-13.1 should be next, which is Mr. Falk.

Mr. Ted Falk: This amendment has to do with safeguards and final checks. The amendment says quite concisely that part of the conditions is that the patient has received the written consent of the Minister of Health to the administration of medical assistance in dying. This is of a serious nature. This is a bill that gives physicians and nurse practitioners the exceptional ability to legally administer a lethal dose of a cocktail of medicine to kill somebody. It is nothing short of that. It's nothing short of killing someone, and that requires a lot of seriousness, and it requires a lot of oversight. This amendment says that it needs ministerial sign-off. It's very clear, and very simple.

● (1920)

The Chair: Mr. Bittle.

Mr. Chris Bittle: It seems to be another amendment, though perhaps well intentioned, that just creates layer upon layer to make medical assistance in dying inaccessible to a large number of people, and this goes toward that. To require that makes it inaccessible, and it goes against the spirit of what the Supreme Court wanted in Carter.

The Chair: Mr. Fraser.

Mr. Colin Fraser: I have another concern with this. I agree with Mr. Bittle. It is creating another barrier, another layer to overcome in accessing medical assistance in dying, which the court clearly says is something that should be available to Canadians in certain situations.

I don't know what expertise the Minister of Health would have in signing off on this. I note as well that it would be a minister of health as a politician, a political person, who would then be making decisions in this regard after the court has already ruled that it's something that has to be accessible for certain Canadians.

I have a couple of different problems with that, and I can't support the amendment.

The Chair: Mr. Warawa.

Mr. Mark Warawa: The committee has said no to prior judicial oversight. The only form of oversight at this point...and the Carter decision...were that we had a regime with strict safeguards, including enforcement. To this point, Bill C-14 does not have that oversight, other than two physicians or two nurse practitioners. But there is no oversight—no judicial oversight, no oversight whatsoever. We're relying on two people of that competence to end a life, to assist in the ending of a life of an individual at the individual's request.

If we want to amend this, I'd be in favour of amending it, but you would need...and we heard this from testimony. I'm thinking of the special committee; I'm not sure if this committee heard that from the witnesses. There was an encouragement to make sure you do not have the physicians putting themselves in a very dangerous position where the government of the day says that in this case, if there was a charge or a complaint made against a physician or a nurse practitioner, they did this inappropriately. Maybe a family member would not be happy with how the situation was handled, and now we have these physicians in a very dicey situation where they could be charged with homicide.

The encouragement was to have some sort of oversight. I think this is an attempt to provide some oversight—if not judicial, because of concerns it would delay, then in another way.

In the spirit of what is being attempted here, if we don't want a minister of health, is there an appetite to have any oversight? I think it's needed. We've heard that it was needed. Without it, you're going to leave physicians vulnerable to possibly being charged. I appreciate the spirit of it. Maybe we need to find another way.

The other thing, Mr. Chair—and I think it's salient—is that we have one approved amendment to this point. It was a Liberal amendment—and that's good. It was a good amendment; it actually got unanimous support. But that was it. I think that when we, through the discussion, through the debate, highlight some needs for changes, we need to seriously consider them and amend them, if appropriate.

The Chair: Mr. Falk.

Mr. Ted Falk: I think Mr. Warawa has very much captured the essence of this motion.

I would have very much liked to withdraw this motion had the judicial oversight been accepted, which I think, actually, is more appropriate than ministerial oversight. But there needs to be some form of oversight.

There are several things we have to remember from the Carter case. First of all, one thing we don't talk about a lot but is recorded in the decision is that there needed to be a respect for the sanctity of life. So far I have not heard a lot of that here this evening—respect for the sanctity of life. We're just trying to make laws and conditions so that we can fast-track these applications just as quickly as we can, not providing proper safeguards and checks and balances. I'm concerned about that.

The Carter decision was also granted on an exceptional basis. It's not a new standard; it's not a new right. The Carter decision never said there was a right to physician-assisted suicide. It was being granted on an exceptional basis. We need to remember that. When that happens, there needs to be proper oversight.

This particular amendment isn't my preferred amendment, but in the absence of the better amendment, which was rejected by my colleagues on the other side, we have to have some kind of oversight. It's absolutely critical.

● (1925)

The Chair: Thank you very much.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: The next one coming up is CPC-14, which is Mr. Viersen's.

Mr. Viersen, it is identical to CPC-8, which was defeated, so my suggestion is that this one not go forward because it was already defeated using exactly the same words. Agreed? Okay.

We're going to bypass that one and move to the incredibly complex NDP-4 amendment.

Now, it doesn't look to be incredibly complex. It's a very short amendment. However, we would not be able to put forward the following amendments if NDP-4 is adopted. We would no longer have them.

[*Translation*]

Amendment NDP-4 is totally identical to amendment BQ-3. If one is adopted, so is the other one, and if one is negatived, the other one is, as well. We will not continue with BQ-3 because it is identical to NDP-4.

Mr. Luc Thériault: Will I be able to take the floor, Mr. Chair?

The Chair: Yes, I will give you an opportunity to speak to amendment NDP-4, as it is identical to your amendment.

Mr. Luc Thériault: Okay.

[*English*]

The Chair: The following proposed amendments would not be allowed to go forward: Liberal-2, Green-2, Green-3, Liberal-3, CPC-14.1, Green-4, CPC-15, CPC-14.01, CPC-14.2, CPC-14.3, and CPC-15.1. The effect of the NDP motion, if it is adopted, would be to take out all the lines that these were proposing to amend.

I will now turn to Mr. Rankin to speak to NDP-4.

Mr. Murray Rankin: I want to say at the outset that, as you'll note, the objective of this is to delete the definition appearing between lines 20 and 35, in accordance with the recommendation of the Senate-House committee, which counselled very strongly that we not try to gild the lily, that we not try to change the language that was so carefully reached in the Supreme Court of Canada and undercut its effect, as I believe this section would do.

If I am unsuccessful in persuading the committee to do that, my counter, my fallback position, would be—I have it handwritten—that we simply delete in particular lines 31 to 35, which would take out the famous "reasonably foreseeable" clause, but my—

The Chair: There are other amendments that propose that and that will be heard going forward if this one fails.

Mr. Murray Rankin: Right, so my fallback would be to do that.

The reason that I believe this is really important—and I note that the Senate-House committee agreed—is that it's safest to simply leave the language to what the Supreme Court crafted in its unanimous decision. It therefore would be less likely that a future court would have to reinterpret their handiwork. We're opening up an awful lot of opportunities for more litigation by suffering people having to go to the Supreme Court to seek clarity on our handiwork. We're here to legislate, and we're creating more obstacles than we need to in order to be consistent with their decision.

It would remove the additional restrictions, which I must emphasize were nowhere to be found in the Supreme Court of Canada's decision. For example, instead of the word "incurable", they used the word "irremediable" in the courts, for good reason. The patient was entitled, they said, to say that yes, their particular kind of cancer could be cured, but their particular kind of cancer would be so painful in the cure, and perhaps the prognosis of success was so limited, that they would have the ability to say no to that treatment if, in their autonomous judgment, they thought the cure was worse than the disease. They very explicitly didn't use that word, so why would we do so?

Secondly, "advanced state of irreversible decline in capability" is another phrase that comes out of nowhere. When I talk to doctors—and I've talked to many—they have no idea how it would be utilized.

Also, of course, there is the famous "reasonably foreseeable" clause that I won't bother reading. It's so problematic. We heard such an amount of testimony from people about this that I just don't understand why we would want to saddle future suffering people with the need to persuade a particular doctor or doctors or health practitioners that their natural death has become reasonably foreseeable. Once again, it's undercutting the victory of the people who argued successfully that they need not be at the end of life or have a death that's reasonably foreseeable naturally occurring.

For all those reasons, I want to go back and do what the special joint committee did, and that would be to delete this and leave the term to be defined in the common law, as we do with so many other parts of our law. Leave the words "grievous and irremediable" to be determined by jurisprudence going forward. If I'm unsuccessful in persuading people that this is the proper approach, then I would for sure wish to move the amendment that we remove "reasonably foreseeable"—at the very least.

● (1930)

The Chair: I understand, Mr. Rankin.

[*Translation*]

I will give the floor to Mr. Thériault, as his amendment is identical to Mr. Rankin's.

Go ahead, Mr. Thériault.

Mr. Luc Thériault: Mr. Chair, we have talked a lot about vulnerable individuals today, but is there anything more vulnerable than a person with a degenerative medical condition or someone experiencing intolerable suffering? However, in order to prevail, that person would have to go to court. As Mr. Rankin pointed out, all the criteria established in this provision are confusing and subject to interpretation.

I have had a look at the Liberal amendments a bit further down, and I think they feel that subsection 241.2(2) of the bill—as is or nearly—is in line with the Carter decision. I would like someone to manage to convince me that paragraph 241.2(2)(d) belongs in this bill. The Minister of Justice's claim that Ms. Carter would have had access to medical assistance in dying under this provision leads me to say the same thing others have mentioned. The only way to interpret natural death becoming reasonably foreseeable is to base the interpretation on age discrimination, and that would be completely dismissed.

I previously said that, by wanting to clarify matters, we end up imposing obligations that run totally counter to the charter and to the Carter decision. So instead of saying nothing, the Liberals should put forth some arguments and try to convince me. I have read the amendments, and the Liberals are refusing to remove paragraph 241.2(2)(d). If this amendment gets defeated, I would at least like them to tell me why they want to keep this provision that has been dismissed by all the legal experts who followed the Carter case.

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

We will now move to the debate.

Mr. Fraser, go ahead.

Mr. Colin Fraser: Thank you very much for your comments, Mr. Thériault.

[*English*]

I'd like to hear from the department with regard to that issue on Ms. Carter, because I know a legislative explanation came out at the same time as the bill, and it provided some insight as to where the Minister of Justice and Minister of Health were coming from with regard to all of the medical circumstances that were at play.

I'd like to hear from the officials with regard to the point Mr. Thériault was making.

Ms. Joanne Klineberg: The ministers explained that the objective of the choice that was made was to enable people who are suffering while in decline on a trajectory towards death to have a peaceful method of dying.

That being the case, there are choices about how the legislature could describe or define with precision those circumstances. We know the U.S. states chose a model that is limited to individuals who are dying from a terminal disease. The decision the ministers made here was to make it available to all persons who are suffering while in decline on a trajectory towards death, the objective being to enable people to have a peaceful death if the dying process they would otherwise have would be a painful one, a prolonged one, a frightening one, or one that they might consider to be undignified.

That is, I think, the explanation for why this element was drafted in the way that it was, so that the entirety of the person's circumstances could be taken into account to determine if they were in fact on a trajectory towards death.

It's not intended to be limited to those people who are dying from a fatal disease. It can include individuals who are dying in the natural course. If they also happen to be in a state of decline and suffering unbearably, the decision was made that this manner of dying should be available to them as well.

● (1935)

The Chair: Mr. Fraser.

Mr. Colin Fraser: I appreciate that explanation very much.

I think Carter was pretty clear that it anticipated Parliament actually acting on the decision, and anticipated that it would probably put in place a legislative framework, which we're here doing.

I note as well that we heard evidence, and I think it's pretty clear, that the only way to make sure this thing is charter-proof is to use the notwithstanding clause. Clearly the government's not going to be doing that.

Of course we want to anticipate future cases to make sure that this will be compliant with Carter and with the Charter of Rights. That's very important, and I believe the explanation is reasonable in that regard. We're not going to be able to make this charter-proof and I think the amendment therefore is not consistent with regard to meeting the aims described in order to respond to Carter.

For that reason, I would vote against the amendment.

The Chair: Mr. McKinnon.

Mr. Ron McKinnon: Notwithstanding the observations on the other subclauses of this clause, subclause (c):

> that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

This is the heart of the Carter decision.

If we delete these lines, there's nothing left. Whether we delete (d), (a), or (b), we cannot delete (c). On that basis I vote against this.

The Chair: Thank you very much.

Is there further discussion?

[*Translation*]

Welcome, Mr. Deltell.

Mr. Gérard Deltell (Louis-Saint-Laurent, CPC): Thank you very much, Mr. Chair.

Good evening, everyone.

I would propose to vote against our colleagues' amendment for the following reason.

Bill 52, passed by the Quebec National Assembly, clearly defines the issue and to whom it pertains. I remind you that the Quebec experience is based on six years of detailed and painstaking work under three different governments and three different premiers. I know what I'm talking about because I was there. I think that my colleague from the Bloc Québécois was also there for some of the work. He may have arrived a bit later, but he is still a former colleague from the National Assembly I salute.

Back then, in Quebec, we were careful to thoroughly define the issue in question to avoid the lack of clarity that kind of treatment could involve. We understand full well that the matter is extremely delicate, as we are literally talking about a life or death situation. Quebec's experience was very painstaking in terms of that. We still have concerns over some of the provisions, especially paragraph (d), lines 31 and 32, where it says, “their natural death has become reasonably foreseeable”.

I had an opportunity to say that this expression, which is actually very hard to remember, was overly vague in our opinion. In Quebec, we defined this issue clearly by referring to “end-of-life care”. We may be able to come back to this, but I wanted to review the situation in light of the Quebec experience. It's better to have clear guidelines instead of vague statements that may leave room for interpretation and even some rather unfortunate situations.

The Chair: Mr. Thériault, let me check whether any other committee members would like to intervene before I give you the floor.

[*English*]

Mr. Oliphant.

Mr. Robert Oliphant (Don Valley West, Lib.): They gave me a sign.

The Chair: I've been allowing people to participate when they have motions that are on the floor, and I've been allowing non-members who put forward a motion, in this case Mr. Thériault, to intervene. I'm not usually recognizing anyone else.

Mr. Robert Oliphant: If those are the rules of the committee, that's fine.

The Chair: Those are the rules.

However, out of deference, I'm happy to let you speak on this one point. Go ahead.

Mr. Robert Oliphant: I'm speaking in favour of the amendment. I wanted the committee to be clear about a case that the Court of Queen's Bench of Manitoba ruled on last Friday. This is the case of a woman referred to as patient No. 2, the second case under the four-month interim regime from the Supreme Court of Canada, where each province defined its own system with a pre-authorization by a judge.

The judge heard the case of a woman in her fifties who has ALS and has an expectation of living three to five years. She has a disease that is irremediable. She has suffering that is intolerable to her. However, one would not be able to say her death will take place in the reasonably foreseeable future, nor is she necessarily in a decline.

One can argue that her status is very similar to Kay Carter's. However, she is about 30 years younger. I have heard it argued that Kay Carter was elderly. Therefore, her death was foreseeable in the future. This would not be the case of patient No. 2. The judge in this case was taking her leave from the Carter decision and applying it in this case.

If this amendment is not passed, would this patient be allowed a dignified death if Bill C-14 passes unamended? That would be my concern, and that is why I speak in favour of the amendment.

It's important for the committee to be clear that there are cases in which people may be seeking death right now, before this bill is passed, because they fear they would be ineligible to receive the right granted under the Carter case at this time.

That is a grave concern I have. I believe this case should be strongly considered by a judge who has read the law well and is concerned about the nature of this bill. That's all I have to say.

● (1940)

The Chair: Thank you very much.

Out of courtesy, in the same way I recognized Mr. Oliphant, I will now recognize Mr. Casey to respond.

Mr. Casey.

Mr. Sean Casey: Thank you, Mr. Chair.

I just want to give you the government's position with respect to this amendment. The government opposes this amendment. There is no certainty or clarity around what is meant by "grievous and irremediable medical condition". The Canadian Medical Association has stated that there is no shared meaning of what constitutes "grievous condition".

If practitioners interpret it broadly, for example to apply to persons with permanent physical disabilities who are otherwise in good health or persons who have just been diagnosed with a degenerative disease, it could increase the risks posed by medical assistance in dying to vulnerable persons, could contribute to the stigmatization of the quality of lives of persons with disabilities, and potentially undermine suicide prevention.

This amendment is also fundamentally contrary to the government's policy choices as reflected in Bill C-14. As introduced, Bill C-14 contains the clarity that is needed to give confidence to medical professionals to undertake what is otherwise a criminal act.

Thank you, Mr. Chair.

The Chair: Thank you.

Mr. McKinnon.

Mr. Ron McKinnon: I feel that the debate at this point is largely around (d), and whether or not that should be retained. But this amendment is about a whole whack of things, right?

The Chair: We'd need to strike all four portions.

Mr. Ron McKinnon: Correct. If we strike (c), the requirement for enduring intolerable suffering exists nowhere in this act. It's not part of the eligibility for physician-assisted dying, nor is it part of the definition of what a "grievous and irremediable condition" is. For that alone, irrespective of the arguments around (d), I think we have to defeat this amendment.

The Chair: Thank you very much,

[*Translation*]

I will give the floor to Mr. Thériault, and we will wrap up with Mr. Rankin.

Go ahead, Mr. Thériault.

Mr. Luc Thériault: Mr. Chair, I think that our debate concerns one of the crucial points, and one of the conceptual and legal nodes, of this bill.

I would personally be very comfortable with a subamendment to eliminate paragraph 241.1(2)(d), while keeping the rest, so as to go along with Mr. McKinnon's arguments.

● (1945)

The Chair: There are already amendments that focus solely on paragraph 241.1(2)(d).

Mr. Luc Thériault: They eliminate paragraph 241.1(2)(d) in its entirety.

The Chair: Yes.

Mr. Luc Thériault: In that case, I have something to say.

It is very clear that paragraph 241.1(2)(d) can definitely not meet the Supreme Court's requirements, as it creates age-based discrimination. My earlier question was not answered. Under paragraph 241.1(2)(d), how can it be interpreted that Kay Carter could have had access to medical assistance in dying?

Moreover, in Quebec, medical assistance in dying is part of a continuum of end-of-life care in the final stage. People who want to have access to assisted suicide must currently go on a hunger strike to obtain it. It would absolutely go against the most basic humanitarian considerations to allow that to happen again. So it seems essential to me that paragraph 241.1(2)(d) disappear completely.

The Chair: Thank you.

Mr. Rankin, go ahead.

[*English*]

Mr. Murray Rankin: I agree with Mr. McKinnon. This really is a critical part of our exercise. Of course, NDP-2 would have dealt with the language that you rightly say would be eliminated, but that is a matter of style. It is critically important that it be included, but we had that forward as another way of doing it.

I would like to note and to thank Mr. Oliphant for coming. He was a superb co-chair of the Senate-House committee, and that was the committee that recommended we don't define it, for reasons that are articulated in that report, which I won't repeat.

I would like to repeat, however, that Mr. Arvay, the counsel; Mr. Ménard, from the Quebec bar association; and the Canadian Bar Association have all pointed out the problems with this bill.

I would like to read what the Canadian Bar Association wrote to the Senate on May 4:

> The CBA Working Group does not believe that this definition is consistent with the criteria established by the SCC in Carter.

Nor do I. Nor does Mr. Arvay. Nor does Mr. Ménard. We have had no independent legal opinion. The Department of Justice's perspective was, with great respect, advanced unsuccessfully in the court. Now we have amendments that would undercut, in the name of certainty. Mr. Casey tells us that somehow this would not provide clarity.

With all due respect, I heard two doctors on *Cross Country Checkup*, one saying Kay Carter would be covered, one saying she wouldn't. Is that clear? We have "reasonably foreseeable" language, which has been the subject of ridicule across the country, and to suggest that this provides clarity is simply inappropriate.

Last, to say that this would do harm will be contrary to the policy choices of the government in Bill C-14. I would like to remind the committee why we are here. We are here to put meat on the bones of a unanimous Supreme Court of Canada decision. This does not do that. It undercuts that. With great respect, I simply disagree, and I hope people will be persuaded that we have a job to do. We have to apply the law of the land, and this does not do it. The Canadian Bar doesn't think so. The counsel who argued it doesn't think so. Mr. Ménard doesn't think so. I hope you will agree that it can't be done. In the name of clarity, it certainly doesn't do the job.

The Chair: Thank you very much.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: Next, we have BQ-3.

[*Translation*]

Amendment BQ-3 is identical to amendment NDP-4. With amendment NDP-4 being negatived, amendment BQ-3 is also negatived.

Mr. Luc Thériault: I wanted to speak first, Mr. Chair.

The Chair: I still acted as if you were the one who proposed it.

Mr. Luc Thériault: Thank you.

The Chair: I will now move to the next amendment.

[*English*]

We have amendment 14.01, which I think is identical in some ways to some of the ones that have been defeated, but I am going to allow—

Mr. Ted Falk: I withdraw it.

● (1950)

The Chair: Next, we move to Mr. Fraser, LIB-2.

Mr. Fraser, go ahead.

Mr. Colin Fraser: We heard testimony regarding.... Perhaps it was Mr. Falk who asked the question about adding the word "and" after each clause, but that wouldn't normally be done. As far as I understand, it is a stylistic point. However, I think this would satisfy that concern, which some have mentioned. It is just for greater clarity, to add a condition "if they meet all of the following criteria", which is similar to proposed subsection 241.2(1). It is the same language, so it is consistent.

It would read, "A person has a grievous and irremediable medical condition if they meet all of the following criteria".

Then, there are four: (a), (b), (c), and (d).

I think this just makes it more certain that all four need to be met in order to meet the criteria of "grievous and irremediable medical condition".

The Chair: Mr. Falk.

Mr. Ted Falk: Agreed.

The Chair: Ms. Khalid.

Ms. Iqra Khalid: If I may, I would propose a friendly amendment. Proposed subsection 241.2(1) says "only if they meet all of the following criteria". I propose that we also include "only", just for the purpose of keeping it consistent.

The Chair: Where is that?

Ms. Iqra Khalid: Under proposed subsection 241.2(1), it says "A person may receive medical assistance in dying only if they meet all of the following criteria".

In proposed subsection 241.2(2), what we are proposing to amend is "A person has a grievous and irremediable"—

The Chair: You're proposing to add the word "only" to make it consistent with the top.

Ms. Iqra Khalid: Yes.

The Chair: Mr. Fraser.

Mr. Colin Fraser: Sure. That's the same thing, but I appreciate the point for consistency that I prefaced in my comments, so it would make sense.

The Chair: Mr. Casey.

Mr. Sean Casey: It seems to me this is a drafting issue. I wonder if the officials might have a comment on it.

The Chair: In future, if a member of the committee asks, I will allow that. I'll allow it in this case, but I would prefer that it come from a member of the committee.

Ms. Klineberg.

Ms. Joanne Klineberg: To advise the committee, from a drafting perspective, we've been reassured numerous times by the legislative drafters that this is not legally necessary.

The only thing I would mention is that consideration would have to be given to the French version because if we add "only", it makes the two English versions look quite the same, but taking care of the French translation might be a little bit more nuanced.

The Chair: I can understand that. It was drafted in English and the parliamentary clerks, I assume, translated it in the way they thought.

[*Translation*]

It says the following: "graves et irrémédiables lorsqu'elle remplit tous les critères ci-après:".

[*English*]

Why would that be a problem?

Ms. Joanne Klineberg: It doesn't match the French under 241(2)(1) that's all.

The Chair: I understand, but the translation, in my view, does achieve the same thing. I think that's okay. In the end, if there is something that needs to be fixed in the translation, we can note that we are relying on the English and we're asking for any proposal to better translate the French.

Ms. Joanne Klineberg: That's fine.

The Chair: We'll note that. If the department wants to come back and say the French needs to better reflect what the English says, we can definitely live with that.

The Chair: All those in favour of LIB-2?

Those opposed?

(Amendment agreed to [See *Minutes of Proceedings*])

The Chair: Next we move to PV-2.

I'm noting that conflicts with CPC-14.1, so in the event PV-2 is adopted, CPC-14.1 cannot be moved.

Ms. May.

Ms. Elizabeth May: Thank you, Mr. Chair.

There probably isn't going to be a more important debate in clause-by-clause than the one we were just having on Mr. Rankin's amendment and my attempt here, through three different amendments, to fix what's wrong here.

What's wrong here is that the draft legislation states at subclause (2) "a person has a grievous or irremediable medical condition if". That's language from the Supreme Court.

We then purport to define the Supreme Court's unanimous decision by language that contradicts the Supreme Court decision.

Through (a), (b), and (d), the draft legislation actually contradicts the reasoning of the court and contradicts the court's conclusions.

It's disturbing that this is before us. There is no question—and I want to say this with respect to all members around the table with all the different concerns we have about an issue as important as this—that the issue is difficult.

As lawmakers we have an obligation to ensure that the legislation we put forward does not so badly depart from the logic of the Supreme Court that we bring forward legislation, which is currently, in the view of Joe Arvay who litigated on behalf of Kay Carter, actually worse than nothing.

It would be better to leave a legal situation where once the Criminal Code provisions are removed, public policy and the conduct of medically-assisted dying would be guided by the court's decision and not by this act.

I'll move the first one quickly because I have about 20 seconds left.

In my recommendation here, we would take subclause 3(a), lines 22 to 23, and remove the word "incurable." That's basically the essence of what I'm trying to do here. It is unnecessarily and unfairly restrictive as drafted.

● (1955)

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

Mr. McKinnon.

Mr. Ron McKinnon: This is more in line of a question for Ms. May.

I'm wondering if the latter part of subparagraph (c) "that cannot be relieved under conditions that they consider acceptable" would not suffice for this latter part of this proposed paragraph (a), "for which there's no treatment that is acceptable to them".

Ms. Elizabeth May: I appreciate your effort to bridge a gulf here around an understanding of what the Supreme Court of Canada told us in Carter was their intention with "grievous and irremediable". However, it's very clear that the word "incurable" goes against what the court decided.

For instance, it was not part of the decision in Carter, but in the discussion of extending the time in January, Madame Justice Karakatsanis was very clear in saying that in Carter they rejected "terminally ill". I don't know what the definition of incurable is or if it's very different from terminally ill, which the court has very clearly said they rejected.

The Chair: Thank you very much.

Is there any further discussion or debate?

I'm going to go back to Ms. May to close.

Ms. Elizabeth May: I appreciate, Mr. Chair, the latitude to those of us who are pulled to committee by the motion you passed and don't have the opportunity to present it at the report stage.

I appreciate the chance to plead once again with the Liberal members of this committee to consider that passing Bill C-14 with the language that you find in subparagraph (a)—and then I'll come back to (b) and (d) on other amendments—will have the effect of passing legislation that is not charter-compliant. It will be one that does not meet the standards of section 7 of the Charter of Rights and Freedoms and will create more litigation and more uncertainty instead of doing what's required of lawmakers, regardless of personal opinion or lobby efforts by groups that failed at the Supreme Court of Canada. We have a unanimous Supreme Court of Canada decision, and it's our obligation to meet its terms.

The Chair: Thank you very much.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We will now move to CPC-14.1, which conflicts with CPC-14.2 and CPC-14.3.

Will one of the Conservative members move it so that Mr. Genuis can speak to it?

Mr. Genuis, please go ahead.

Mr. Garnett Genuis: Thank you, Mr. Chair.

This obviously adds a "terminal" requirement here.

Now, I understand that we have a Supreme Court decision, and maybe at some point someone could clarify the margin by which that Supreme Court decision happened, but I do think it's very much still worth motivating this amendment.

With respect to the Supreme Court decision, they did say that they would show a substantial degree of deference towards the legislature and they gave us terms that it was up to the legislature to define. We have a lot of language that does not have a sort of common medical meaning. Things like "grievous and irremediable", as has been discussed, are not legal terms as such and they are not medical terms as such.

I think there is an opening there for us to come up with a definition, and I think "terminal" puts the finger on what most people think of when they think of this. They don't think of someone who has a serious illness at some point in life that they may overcome. They don't think of it as transitory; they think of it as a very final kind of thing. Just some of the existing language, "death being reasonably foreseeable", as has been said, is very unclear, but I think narrowing it to a point where, at least at this stage, we clearly understand what it means medically and legally, is the safest way to go at this stage.

● (2000)

The Chair: Mr. McKinnon.

Mr. Ron McKinnon: My problem with this is that it drops the idea that the treatment has to be acceptable to the patient. The wording of subparagraph (c) says that "it cannot be relieved under conditions that they consider acceptable". I think that's a critically important part that is omitted by this and, on that basis, I can't support it.

The Chair: Mr. Genuis.

Mr. Garnett Genuis: In terms of that, obviously a patient doesn't have to accept treatment that they don't regard as acceptable, but it shouldn't very well be, in my view at least, a sufficient basis for seeking assisted suicide or euthanasia. There is treatment available to someone, potentially treatment that could cure their condition. They just decide that they don't want to go forward with that.

It's their option to refuse treatment, of course, but to say that someone doesn't want to have their suffering alleviated in a way that the medical system can alleviate it, that their desire not to have it alleviated is a sufficient basis for allowing them to access this, at that point you might as well allow anyone to commit suicide legally.

It doesn't make sense to me that the desire not to have your suffering alleviated is a sufficient basis for accessing the service.

The Chair: We're now voting on CPC-14.1.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We will now move to PV-3.

Ms. May.

Ms. Elizabeth May: Thank you, Mr. Chair.

As I suggested in the opening to my last amendment, in a series of amendments I'm attempting to restore proposed subsection 241.2(2) to a status of definition that's compliant with the Carter decision.

I note that some of the witnesses before the committee asked that this subclause be removed in its entirety. In this one, I haven't gone as far with my amendment as the Dying With Dignity witnesses asked you to do, but what I have done is remove the word "advanced," so it would now read, "they are in a state of irreversible decline in capability" as opposed to "in an advanced state of irreversible decline".

The position of Dying With Dignity was that this would force years of severe, unwanted suffering upon people who have a grievous and irremediable medical condition, but who have not yet reached the end stages of their medical condition.

The use of the word "advanced", again speaking of terms that are imprecise, speaking of areas where we don't have clear medical guidance, in this context is unhelpful in meeting the guidance that we have from the Supreme Court of Canada, and imposes on people who otherwise meet the tests of BillC-14 unnecessary, additional suffering and grievous harm, denying them of their rights for longer than legislators should do.

The Chair: Mr. Rankin.

● (2005)

Mr. Murray Rankin: I know that the next amendment is on the same point with slightly different language, under the hand of Mr. Bittle. It would help me to hear what he has to say on this in order to best understand how to vote.

The Chair: Mr. Bittle.

Mr. Chris Bittle: I'll be withdrawing the amendment that comes up next.

The Chair: Any further discussion?

If not, I'm going to give it back to Ms. May to end the discussion.

Ms. Elizabeth May: I think especially now, knowing that Mr. Bittle's amendment is being withdrawn, this is the only chance to amend proposed paragraph 241.2(2)(b) to ensure that we are not insisting upon an additional condition.

It was not part of the Supreme Court of Canada rationale. There was no suggestion in the decision of the court in Carter that one must have an advanced state of irreversible decline and capability. Again, the Dying With Dignity group asked that this entire clause be struck.

I'm hoping that my compromised effort here will meet with support from Liberal members of this committee.

Please pass at least one opposition amendment to BillC-14. I think it will improve our sense of a healthy democracy.

The Chair: Now we're going to go to a vote on PV-3.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: Mr. Rankin abstained.

[*Translation*]

I did not see Mr. Deltell's vote, but I assume he was opposed to the amendment.

Mr. Gérard Deltell: I was very discreet.

The Chair: Yes, very discreet indeed.

[*English*]

That will lead us to the next item on the list.

As I understand it, you're not putting forward Liberal-3, Mr. Bittle?

Mr. Chris Bittle: No.

The Chair: That then takes us to amendment CPC-14.2, which is Mr. Viersen. Mr. Falk will move it so Mr. Viersen can speak to it.

Mr. Arnold Viersen: Thank you, Mr. Chair.

The Chair: Sorry, Mr. Viersen. I just want to make sure you know that amendments CPC-14.2 and CPC-14.3 are conflicting, so if CPC-14.2 is adopted, CPC-14.3—

Mr. Arnold Viersen: I wouldn't say they're conflicting. I'm quite convinced the same person wrote them.

The Chair: You're probably right.

Mr. Arnold Viersen: I submitted this amendment because I felt we needed to ensure that those with psychological suffering were given the help they need. Once again I'll go back to my "standing on the edge of the bridge" analogy. We need to ensure that we give hope to those who feel there is no hope in this world, and just allowing them to use the mechanism of physician-assisted dying is not giving them hope. I would like to take "psychological suffering" out of this debate at this time, which is why I put forward this amendment.

The Chair: Is there any debate by members?

I do not hear any debate, so is there anything you want to say to close, Mr. Viersen?

Mr. Arnold Viersen: No, I've made my argument.

The Chair: We're now going to vote on amendment CPC-14.2.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: Amendment CPC-14.3 was identical, so Mr. Falk is withdrawing it, which brings us to amendment PV-4, which is by Ms. May.

I will just let everybody know that amendment PV-4 conflicts with CPC-15 and CPC-15.1, so if PV-4 is adopted, CPC-15 and CPC-15.1 cannot go forward.

Ms. May, the floor is yours.

Ms. Elizabeth May: Thank you, Mr. Chair.

This, again, is part of an effort to fix what I find to be quite an unfortunate series of definitions of the Supreme Court term "grievous and irremediable" that take it in a direction that conflicts with the court's ruling. Earlier we heard from Mr. Rankin about the somewhat farcical nature of "natural death has become reasonably foreseeable". I don't know how to break it to all of us here today, but I think we do know none of us is getting out of here alive. This is a mortal life. All of our deaths are "reasonably foreseeable", and then we have the further addition of them being without any prognosis about the specific length of time we have remaining. In cosmic terms, we don't count for much at all. There's been life on earth for four billion years. If you look at our lives, we're kind of a cosmic blink of an eye.

It's an odd provision. It's odd. What it seems to be trying to say is that the condition has to be terminal, but that, again, conflicts directly with what the Supreme Court said in Carter. I find proposed paragraph 241.2(2)(d) to be so difficult that there's nothing to be done with it except to delete it, and that is the purpose of amendment PV-4.

● (2010)

The Chair: I see nobody wants to debate this. Given the controversial nature of this provision, that seems surprising, but I'll let that go.

I'm going to turn it back to Ms. May to close.

[*Translation*]

Mr. Thériault, you would generally not be able to take the floor, but I will still give you both 30 seconds.

Mr. Luc Thériault: Thank you, Mr. Chair.

You are very nice, and I appreciate it.

I entreat the Liberal Party members to think before they vote against this amendment. According to what I have seen, none of those amendments are proposing changes to this section or its deletion. Since the beginning of the evening, they have been voting as a block against everything we have proposed. The vote in the House will be an odd one. That is not how consensus is created. Practically no substantive amendment that was at all tricky has been agreed to, and I am deeply saddened by the Liberal Party's attitude this evening.

The Chair: Thank you.

[*English*]

Mr. Rankin.

Mr. Murray Rankin: I made all my arguments during my effort to persuade the committee that it is wrong-headed to proceed with this, but I note that the NDP, the Bloc Québécois, and the Green Party have all proposed this to no effect. We're going forward to create more uncertainty. It's very, very unfortunate.

The Chair: Thank you very much.

Ms. May, I'll let you close.

Ms. Elizabeth May: Thank you, Mr. Chair.

I'll quote Joe Arvay, a very respected counsel for the Carter decision, and an eminent lawyer who has succeeded in many significant cases in Canada. “There's no question in my mind that this bill, insofar as it has a reasonably foreseeability clause, is contrary to the Carter decision and is unconstitutional....”

By accepting my amendment, you can make a significant effort to ensure that this bill will be viewed as constitutional as opposed to deviating so seriously from the Supreme Court of Canada's rationale as to create yet another court case where the Criminal Code provisions will be struck down again.

The Chair: We'll now move to the vote on PV-4.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We will now move to CPC-15, which is also to amend those same lines.

Mr. Falk, will you put it forward on behalf of Mr. Genuis?

Mr. Genuis, the floor is yours.

Mr. Garnett Genuis: We're all proposing some amendments that clarify the language, and it's interesting that there seems to be a consensus on both sides of this issue that there is a need for some clarification, whichever direction the clarification comes from.

This shifts from the language of “reasonably foreseeable” to the language of “imminent natural death becomes foreseeable”. It doesn't go so far as to propose a specific timeline, but I think it gets more effectively at what a lot of people have said the intent of the reasonably foreseeable provision is.

It ensures we're talking about people who are approaching death but not just in the sense that death is reasonably foreseeable for all of us, but in a sense that death is very imminent.

I think this makes sense. Some may object to it on underlying philosophical grounds, but it certainly provides some of the clarity that if the committee weren't interested in providing in one direction, perhaps they wish to provide on the other side.

The Chair: Mr. Fraser.

Mr. Colin Fraser: I will not be supporting this amendment. I believe the word “imminent” is flawed with regard to the Carter decision, and that's not consistent with the parameters around which the Supreme Court of Canada passed it on to the legislature to make a legislative framework.

It's very limiting. It definitely is different language from what we've proposed in the bill, which we feel in listening to the government's explanation—I feel, anyway—does strike the right balance. Adding the word imminent is too limiting and would not be consistent with Carter. Therefore, I cannot support it.

● (2015)

The Chair: Thank you very much.

Monsieur Deltell.

[*Translation*]

Mr. Gérard Deltell: Thank you, Mr. Chair.

I think that the proposal of my colleague Mr. Genuis is closest to the Quebec experience, which clearly indicates that care has to be provided at the end of life.

As for the government's initial proposal regarding the term “reasonably foreseeable”, we have all spent three weeks trying to explain it without really being able to find a clear definition of what they are taking about.

Mr. Genuis' amendment is appropriate, as it truly clarifies that an individual is at the end of their life when, “their imminent natural death has become foreseeable”. Having spoken to a few physicians who worked in Quebec under the regime of former Bill 52, An Act respecting end-of-life care, I believe this definition is necessary. In addition, that care must truly be provided at the end of life, and the prognosis must be made and all the processes undertaken at the end of life. That is why the term “imminent natural death”, as proposed by our colleague Mr. Genuis, is very fitting.

The Chair: Thank you, Mr. Deltell.

Would any other committee members like to speak to this?

[*English*]

I haven't heard any so I'm going to turn back to Mr. Genuis to close.

Mr. Garnett Genuis: Thank you, Mr. Chair.

I note Mr. Fraser says that “imminent” is not in the court decision. Of course, neither is “reasonably foreseeable”. Both of us are proposing language that is not in the court decision, but which provides some further definition to the terminology in the court decision that is relatively vague, the terminology of “grievous” and “irremediable”.

I will note with respect to the constitutionality of this that Mr. Deltell quite ably pointed out that this aligns with the Quebec experience. In their extension the court did not apply the extension to Quebec, as I understand it, because they said Quebec has its own law in place already. One might reasonably infer that the court viewed the Quebec law as being constitutional.

If the Quebec law is constitutional, then surely it is at least within the range of options available to us to follow their model and include similar language, in this case the word “imminent”.

The Chair: Now we're voting on amendment CPC-15.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: Next we move to another alternative, CPC-15.1.

Mr. Falk.

Mr. Ted Falk: To start with, I would like to amend it a little bit. This is an amendment that actually puts a definitive time frame on life expectancy. I'd like to amend it down to 30 days from six months.

The Chair: You'll propose it using the words "30 days" instead of "six months"?

Mr. Ted Falk: Yes.

It would read then, "their natural death is expected within 30 days, taking into account all of their medical circumstances".

We heard lots of testimony through our witnesses that they had a great deal of problem with the term "reasonably foreseeable". They said that definition was not adequate in making a determination because none of us—as has been said here before, and as Ms. May so aptly pointed out—is getting out of here alive. We'll all die at some point, and that is very foreseeable.

The Chair: Hopefully she didn't mean this room, though.

Mr. Ted Falk: I don't think that's what she meant at all.

Mr. Murray Rankin: I hope not.

Mr. Ted Falk: Even in that case, if you're a follower of biblical literature, you know that there's an exception there as well at some point. Hopefully some of us are able to fall within that exception.

I think 30 days is reasonable. The intent of this motion is to make a defined statement that this is an end-of-life situation and it shouldn't be applied except in that particular situation, where it is an end-of-life environment that the individual find himself in and they don't want to go through the excruciating ordeal of those final 30 days.

● (2020)

The Chair: Ms. Khalid.

Ms. Iqra Khalid: While I appreciate your trying to define "reasonably foreseeable", I have a concern. The bill elsewhere requires that 15 clear days be given with respect to having second thought or time for reflection. I think limiting it down to 30 days, of which 15 are basically spent in reflection, is too restrictive, and I do not support that at all.

The Chair: Mr. Fraser.

Mr. Colin Fraser: Yes, it's just a quick point.

This follows on the discussion we had on imminent death. Obviously this, in my view, would be even more limiting than that; therefore, I can't support it. I know there can be disagreement and some debate over other language being used, but clearly Kay Carter would not have been able to avail herself with 30 days; she had more than 30 days to live. Clearly that would fail Carter, and therefore I can't possibly support the amendment.

The Chair: Are there any other interventions? If not, I'm going to go back to Mr. Falk.

Mr. Ted Falk: I was actually somewhat surprised that somebody didn't make a subamendment to adjust that 30-day time period to something that was more palatable. The Belgian model has a 30-day cooling-off period, from what we heard from our testimony.

We've proposed in this legislation a 15-day period. That would still provide adequate time to reconsider one's position, given the amount of time that would be required to make this decision.

It's a starting point. As I've said before in some of the other amendments, let's proceed cautiously with this. We can open the floodgates four or five years down the road from now if we decide this is too limiting, but why wouldn't we advance cautiously?

The Chair: Now we're moving to the vote on CPC-15.1.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We will now move to CPC-15.2.

Mr. Falk.

Mr. Ted Falk: This is withdrawn.

The Chair: We'll move to amendment CPC-15.3, which is also yours.

Mr. Ted Falk: Paragraph (a) of proposed subsection 241.2 (3) says that the "medical practitioner or nurse practitioner" needs to:

> be of the opinion that the person meets all of the criteria set out in subsection (1)

I'm thinking that we need to strengthen this provision and that the person making that decision should have reasonable proof that the person meets all of the criteria set out in proposed subsection 241.2 (1).

I think it's not unreasonable to have reasonable proof, rather than just an opinion. Anybody can have the opinion, but this puts in another check and balance and safeguard: to actually have proof in your hand that yes, the person does qualify, does meet all the criteria set out previously in this bill.

I think it's important. We have to put proper safeguards in here so that we protect vulnerable people.

The Chair: Mr. Bittle.

Mr. Chris Bittle: To me this seems redundant, because the reasonable proof is always going to be the medical opinion. Even if it's before a superior court judge, as Mr. Falk has recommended, it will always be based on the medical opinion, and that will be the proof. Again, this is an attempt to limit...

[*Technical difficulty—Editor*]

The Chair: Mr. Bittle, I'm sorry you were interrupted.

● (2025)

Mr. Chris Bittle: That's okay. I'll finish up. This is just another attempt to limit medical assistance in dying, and I would vote against it.

The Chair: Okay. Are there other interventions on this amendment?

Mr. Falk.

Mr. Ted Falk: Mr. Chair, I would very strongly disagree with Mr. Bittle's interpretation of this amendment. It is not at all an attempt to limit access to physician-assisted suicide. In fact, it's exactly the opposite. This is to provide access, to provide unequivocal access, not just an opinion. It's not just a case of , "Oh, I thought the witnesses were independent" and "I thought the witnesses had signed". No, this means that you have to have a reasonable proof, and that's what this amendment is saying.

It's not a delay tactic; it's not trying to prevent anyone from accessing this procedure. This is saying that if you're going to kill somebody, you should have reasonable proof, not just an opinion.

The Chair: Thank you very much.

Now we're going to move to a vote on amendment CPC-15.3.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: We now move to amendment CPC-16, which is, I think, tied to CPC-12.

Mr. Cooper.

Mr. Michael Cooper: Yes, and in light of the fact that amendment CPC-12 was defeated, I will withdraw this one.

The Chair: Thank you.

Amendment CPC-16 will not be moved, which brings us to CPC-17, I believe, which is Mr. Viersen's.

[*Translation*]

There is a conflict between amendments CPC-17 and BQ-5. Should amendment CPC-17 be adopted, amendment BQ-5 cannot be adopted.

[*English*]

Mr. Falk moves it.

Mr. Viersen, go ahead.

Mr. Arnold Viersen: This amendment comes out of the desire to ensure that there is indeed consent. One thing is that if somebody is unable to consent.... I understand, if somebody can only wink or move their eyebrows or something like that in the form of giving their consent; I wish that there be a video recording of that, with the date on it and things like that. That's why I've moved this motion.

I think there's another motion, which comes up later, dealing with video recording as well.

In the past we have debated in this place on capital punishment, and the reason we went away from capital punishment was for the sake of one innocent person's life's being lost. In this instance, it's for the sake of one person who didn't consent having their life taken that I would see us put in all the safeguards possible, to ensure that those who "consent" actually did consent.

The Chair: Mr. Falk.

Mr. Ted Falk: I think this is a good amendment. I don't have to think any further than about the Honourable Steven Fletcher, who doesn't have the ability to move his hands or anything. If ever he, as someone like that, would be in a situation to request this procedure, a video recording would be audible and visible, and I think it would provide the evidence and the consent that this bill should require.

The Chair: Mr. Fraser.

Mr. Colin Fraser: I won't be supporting this amendment.

I don't see how it helps us to determine whether the person was actually voluntarily giving informed consent. A video recording would also, perhaps, encroach on the person's privacy rights, and I would be concerned as well about where that tape would go. Largely, the reason is that, to my mind, it doesn't really get to the salient issue, which is whether there was valid, informed consent. It doesn't help in that regard at all.

I would not not support this amendment.

The Chair: Mr. Genuis.

Mr. Garnett Genuis: The proposal to have video or audio recordings has come up a number of times, and there has been an objection with respect to privacy.

Of course, physicians retain patient medical records on all sorts of very private matters; it's just that they're in written form instead of in recorded form.

It's not obvious to me how having a recording in the file as opposed to having a written note in the file raises any additional privacy considerations, provided you're not uploading it somewhere, of course. In fact, the movement toward e-health records particularly underlines the fact that there's no substantive difference between an audio or video file and a written file, from a privacy perspective.

● (2030)

The Chair: Thank you.

Mr. Viersen, do you want to close?

Mr. Arnold Viersen: This amendment comes out of the fact that my grandparents are from the Netherlands. They're elderly, so their friends tend to be elderly. They have a significant concern that if they go to the hospital, they will be euthanized, so they tend to steer clear of the hospital.

One of the other things is this. I go to church with a number of folks who are convinced that their grandmother was euthanized against her will. Had there been some sort of video recording that showed the time at which she gave her consent, that might have alleviated some of their concerns.

The Chair: We're now going to vote on amendment CPC-17.

(Amendment negatived [See *Minutes of Proceedings*])

The Chair: Mr. Falk, I think amendment CPC-17.1 is the same as the one about nurse practitioners.

Ladies and gentlemen, I've been advised that we're now at 8:30, which apparently tonight is a "heart-stop".

Ms. May, you are next, with amendment PV-5. Would it make your life easier if we were to deal with your amendment now as opposed to making you come back tomorrow?

Ms. Elizabeth May: I plan to come back tomorrow.

The Chair: We'd be delighted to have you back.

Ms. Elizabeth May: If it facilitated your effort to get through the bill, we could do my amendment now, if you wish. But I think people really want to leave. I'm in your hands and I'll be here either way.

The Chair: No, not at all.

Thank you, everyone, for your co-operation.

The meeting is adjourned.