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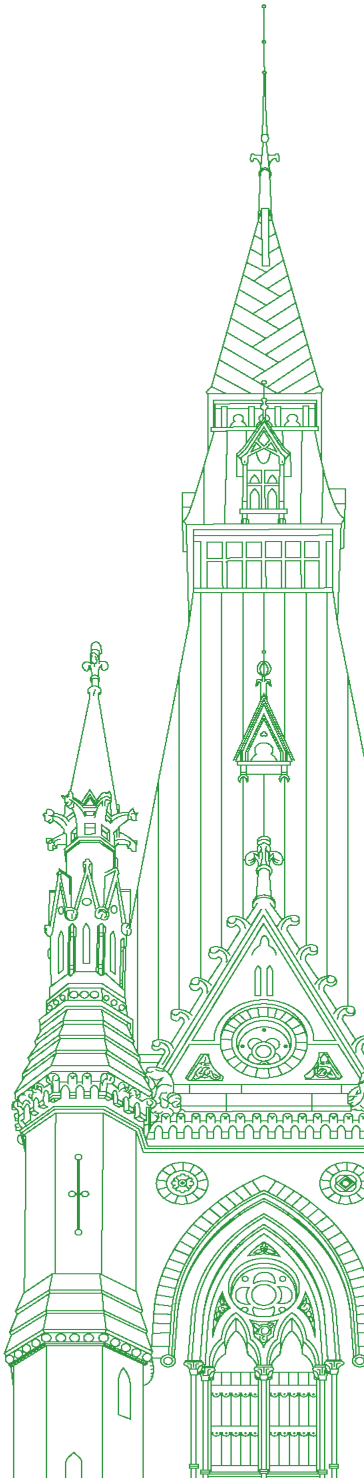

Chair: Ms. Iqra Khalid

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● (1105)

[*English*]

The Chair (Ms. Iqra Khalid (Mississauga—Erin Mills, Lib.)): I call this meeting to order. Welcome to the fourth meeting of the House of Commons Standing Committee on Justice and Human Rights.

As you all know, today's meeting will be in hybrid format. The proceedings will be made available via the House of Commons website. Just so that all of you are aware, the webcast will show the person speaking rather than the whole committee.

To ensure an orderly meeting, I would like to outline a few rules to follow. Members and witnesses may speak in their official language. Just make sure that you're picking the correct interpretation at the bottom of your Zoom call, whether it's the floor, English or French. For members participating in person, please ensure that you're following health protocols on masking for the safety and security of you and staff.

Before speaking, please allow me to recognize you by name. For those participating virtually, please click on the microphone icon to unmute yourself. For those in the room, your microphone will be controlled by the proceedings and verification officer. Use the blue “raise hand” function if you would like to speak. That is the best way for us to know that want to speak.

I remind you that all comments by members and witnesses should be addressed through the chair. When speaking, please speak slowly and clearly, and when you're not speaking, please be on mute.

With regard to the speaking list, the clerk and I will do the best we can to maintain a list of the speaking order. With respect to timing for those who are speaking, I have two cards. I have a one-minute card and a 30-second card that I will show to ensure that we're keeping the whole meeting on track.

Before we proceed with hearing our phenomenal ministers today, I will allow a short five-minute presentation by the legislative counsel for Bill C-7, Alexandra Schorah, and Philippe Méla, the procedural clerk. They will tell you how things will operate with any amendments to the bill.

At this time, please go ahead, Alexandra and Philippe. You have five minutes. Any questions the members may have will be referred to you via email instead of in this forum.

Hon. Rob Moore (Fundy Royal, CPC): On a point of order, Madam Chair, we have the ministers with us for one hour. I'm very eager to hear from them and ask questions of them. Perhaps we can have the presentation from the legislative clerks at some other time, because right now we're talking about the bill. Amendments are going to come later, so I think we can have that type of discussion once the ministers have left in 59 minutes.

The Chair: Thank you for raising that.

Monsieur Thériault, is that on the same question? You had your hand raised, sir.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): I had raised my hand well before, but you did not see it.

I just wanted to point something out. When witnesses, be they ministers or others, are reading or quoting from documents, they should speak more slowly, so that interpreters can properly render their statements in the other language. So I would like people to keep in mind the fact that someone is trying to simultaneously interpret what is being said.

Madam Chair, I would like you to be especially vigilant about this, since we are beginning the study of a delicate bill where every word counts.

Thank you.

The Chair: Thank you for your comment, Mr. Thériault.

[*English*]

I will try my best to speak as slowly as possible and to make sure that everybody in our committee does the same.

Going back to the question, Mr. Moore, it would take five minutes. I will ensure that it's equitable. I do feel it's necessary for everybody to hear from the legislative clerks. I will ask for a quick thumbs up or thumbs down from the committee for us to hear the legislative clerks at this time, or we can schedule them at a later time.

I see we don't have consensus.

Philippe and Alexandra, we will invite you in at a later time.

It gives me great pleasure to introduce and welcome the ministers. We have the Honourable David Lametti, Minister of Justice and the Attorney General of Canada; the Honourable Patty Hajdu, Minister of Health; and the Honourable Carla Qualtrough, Minister of Employment, Workforce Development and Disability Inclusion as witnesses before this panel.

You will have four minutes each for your opening remarks.

Minister Lametti, we'll start with you. The floor is yours. Please go ahead.

[*Translation*]

Hon. David Lametti (Minister of Justice and Attorney General of Canada): Thank you, Madam Chair.

Thank you for the invitation to appear before this committee to discuss Bill C-7, An Act to amend the Criminal Code (medical assistance in dying).

I want to acknowledge my colleagues Ms. Hajdu and Ms. Qualtrough.

I want to specify that François Daigle, associate deputy minister, is here with me and is ready to assist me as needed.

[*English*]

Good morning, colleagues.

Bill C-7 proposes an important change to our medical assistance in dying, or MAID, regime. It would repeal the eligibility criterion requiring that natural death be reasonably foreseeable, and this is in direct response to the decision in the Truchon case. This legislation will prioritize the individual autonomy of Canadians who are suffering to choose a peaceful death if they determine that their situation is no longer tolerable to them, regardless of their proximity to death.

[*Translation*]

Other aspects of Bill C-7 are associated with this important change.

First, Bill C-7 proposes to exclude persons whose sole medical condition is a mental illness, who would otherwise become eligible through the removal of foreseeable death as a condition for eligibility.

Experts disagree on whether medical assistance in dying can ever be safely made available in such cases. While those with mental illness can suffer unbearably, unpredictable illness trajectories mean there is always the possibility of improvement and recovery, and it can be especially difficult to tell whether a desire to die is a symptom of the illness, or a rational response to it.

The exclusion gives Parliament more time to reflect on this complex question, which is fraught with serious risks, to determine whether it is possible to craft a safe MAID regime for this category of persons. I fully expect this issue will be examined in the course of the parliamentary review of the MAID legislation.

● (1110)

[*English*]

Second, the bill proposes to tailor procedural safeguards to the risks associated with assistance in dying for persons who are not nearing death. Ending the life of a person whose suffering is based in the lived experience of their medical condition is different than alleviating the suffering associated with the dying process that is already under way. Bill C-7, therefore, proposes different safeguards based on whether natural death is reasonably foreseeable.

Reasonable foreseeability of natural death refers to a temporal but flexible connection to death. It does not require imminent death or a specific prognosis, but a practitioner must be able to anticipate the person's death, based on their individual medical circumstances, in the near term.

[*Translation*]

Safeguards for those whose deaths are not reasonably foreseeable are built around the existing safeguards with some important enhancement that seek to ensure that adequate time, expertise and exploration of alternatives are devoted to assessing MAID requests from this group.

The existing set of safeguards for those whose death is reasonably foreseeable would be maintained, with two modifications that my colleague will discuss, as they are tailored to this context.

We believe these changes to the safeguards strike the right balance between individual liberty and public safety, for both groups of eligible persons.

[*English*]

Bill C-7 also proposes to allow for the waiver of final consent in specific circumstances, so that people whose death is foreseeable don't choose to die earlier than they want, or refuse pain medication, because they fear not being able to consent on the day of the procedure. This targeted and prudent change would address unfairness in these situations.

I will turn it over, Madam Chair, to my colleagues for their remarks.

Thank you.

The Chair: Thank you very much, Minister Lametti.

We will now go to Minister Hajdu for her remarks, please, for four minutes.

Hon. Patty Hajdu (Minister of Health): Thank you very much, Madam Chair, for inviting us today to speak about the proposed amendments in Bill C-7.

[*Translation*]

I believe the proposed changes to Bill C-7 will expand freedom of choice for people who are suffering intolerably, strengthen safeguards to protect vulnerable individuals and respect individual autonomy.

[*English*]

Over the past four years we've heard from Canadians, from families and health care professionals, who have told us that there are critical issues with medical assistance in dying that need to be addressed. With Bill C-7 we are doing that work.

Among the feedback that Canadians gave is the mandatory 10-day reflection period. I must note that a dying person's decision to pursue medical assistance in dying is a carefully considered one. We heard that story over and over. We heard that the 10-day reflection period prolonged suffering, so we removed this requirement for people whose natural death is reasonably foreseeable.

[*Translation*]

We also heard that the requirement for two witnesses creates a barrier to access. After careful consideration, we reduced this requirement to one witness.

● (1115)

[*English*]

There is a strong public desire for consideration of advance requests, but this is a complex issue, and we believe it ought to be pursued in the context of the parliamentary review. We also believe we should address those situations where an individual nearing the end of life has requested and has been declared eligible for MAID but finds themself worrying about the time of their medical assistance in dying procedure. They could be worried because they don't know whether they'll lose capacity before their procedure, if they choose a date that would extend their life.

The majority of practitioners consulted on this issue are in favour of permitting a waiver of final consent in these limited situations.

[*Translation*]

I know there is a concern that these changes go beyond what is required to respond to the Truchon ruling.

[*English*]

Let us remember that the Truchon decision in effect created the need for a two-stream system of access to MAID: one for individuals who are suffering grievously but whose death is not imminent; and the other for those whose death is reasonably foreseeable and who have been eligible since 2016. It is essential that we set a higher bar, in terms of safeguards, for the first group while providing some modest relief from barriers to access for the second. That is what we are doing in Bill C-7.

[*Translation*]

The proposed amendments in Bill C-7 are informed by our health care system's experience in delivering MAID and reflect the opinions and perspectives shared by Canadians and a wide range of stakeholders.

[*English*]

They represent a balanced and compassionate approach, with respect for personal autonomy while ensuring that adequate safeguards are in place to protect vulnerable individuals. They also reflect the many hundreds of thousands of voices that took the time to consult with the government.

Thank you very much, Madam Chair.

The Chair: Thank you, Minister Hajdu, for your remarks.

We'll go to Minister Qualtrough now for four minutes.

Please go ahead, Minister.

Hon. Carla Qualtrough (Minister of Employment, Workforce Development and Disability Inclusion): Thank you and good morning, everyone.

I'm here today with my cabinet colleagues to share the perspectives of persons with disabilities on this important and personal issue. Medical assistance in dying is a human rights issue.

The proposed legislation recognizes the equality rights of personal autonomy as well as the inherent and equal value of every life, something that disability advocates have fought tirelessly for for decades. In doing so, it remains true to the Charter of Rights and Freedoms, the United Nations Convention on the Rights of Persons with Disabilities, and the principles of the Accessible Canada Act that everyone must be treated with dignity, that everyone must have meaningful options and be free to make their own choices, and that everyone must have the same opportunity to make for themselves the life that they are able and wish to have, regardless of their disabilities.

As we looked to broaden access to MAID as directed by the court, we were very aware of the need for Canadians to know their options, to ensure that their consent was informed, and to have a real choice. Equality rights, personal autonomy, human rights, meaningful options and the opportunity to make a good life for oneself are top of mind. If our systems, processes, programs and services don't offer these options and if our citizens don't see that these options are available to them, then their equality rights are not being fully realized.

This proposed legislation recognizes the significant role that social, mental health, disability and community support services play in the full realization of equality rights. Accessing MAID should not be easier than accessing disability supports. The new legislation makes it the responsibility of the medical practitioner to ensure that individuals are made aware of the supports that are available to them and that those have been seriously considered. The harsh reality is that many Canadians with disabilities are not living with dignity, in the sense that they are not properly supported, they face barriers to inclusion and they regularly experience discrimination.

The pandemic has shown us that many of our systems are not able to truly support and include all Canadians. Canadians with disabilities as well as many other marginalized communities rightly demand that governments address these inequities.

Moving forward, we'll continue to work with the disability community. We'll not shy away from the long-overdue conversations that we need to have in our country with respect to disability inclusion and the system of barriers to inclusion that continue to persist. We'll also take action, as laid out in the throne speech, by bringing forward the first ever national disability inclusion plan, one that provides systemic changes to how the federal government interacts with and supports its citizens with disabilities.

We have before us legislation that seeks to balance making medical assistance in dying available without undue obstacles to those who choose it with safeguards to ensure that this decision is truly informed and voluntary. A truly progressive medical assistance in dying law is one that recognizes without compromise the equality rights of everyone.

Thank you.

● (1120)

The Chair: Thank you very much for that, Minister Qualtrough. I really appreciate the succinct and quite informative remarks by all three ministers.

We'll go right into our rounds of questioning, starting with the Honourable Rob Moore for six minutes.

Go ahead, please, sir. Your time starts now.

Hon. Rob Moore: Thank you, Madam Chair, and to our three ministers for being here today on this important piece of legislation.

Minister Hajdu mentioned that the Truchon decision created the need for a two-track system with regard to assisted dying. In fact, nothing could be further from the truth, which leads me to my question.

It was the failure of this government to defend its own legislation, legislation that it passed as a majority Liberal parliament in June 2016. Just three short years later, when this legislation was challenged in a lower court, instead of appealing as we called on them to do, instead of appealing as the disability community called on them to do, this government chose at the first possible opportunity to in fact not defend its own legislation. There were numerous organizations that raised alarm bells over the expansion of MAID last year in response to this Quebec Superior Court decision,

We've all had the opportunity to hear from many in the disability community—those who are most vulnerable in our society—and the message that this legislation sends, that you no longer need to be dying to access assisted dying, is a fundamental change in our country.

A letter was sent to the offices of Minister Lametti and Minister Qualtrough. It was signed by 72 organizations across our country that assist Canadians with disabilities. They do honourable work helping those who are most vulnerable. They wrote that a failure to appeal the decision would be a failure "on the part of your government to defend persons with disabilities from significant and tangible harm."

We know that the bill before us strips away many safeguards that it's not even required to do under the Truchon decision. So my first question to Minister Lametti is why didn't your government take the concerns raised by these organizations that help Canadians with disabilities when deciding not to appeal this lower court decision? It is the job of the Attorney General and it's the job of a government to defend its own legislation.

Thank you.

Hon. David Lametti: Thanks very much, Mr. Moore, for that question. It's an important one.

It was a difficult decision. We did hear various voices, including voices from the disability community.

We took the decision, put quite simply, to reduce suffering. It was hard to see cases like those of Nicole Gladu and Jean Truchon, and Julia Lamb out west, and not see the suffering they were going through, with no recourse to medical assistance in dying that other Canadians had.

When the legislation was passed, there were concerns raised about whether the proposed regime was in conformity with the charter, and in particular the Carter decision.

Given the very positive experience with MAID that Canadians have had since 2016 and the real moving of the goal posts that had occurred from 2016 to 2019, we felt that we could reduce the suffering of Canadians by moving simply to implement the Superior Court decision, without waiting for further suffering, appeals and that sort of thing, and also to meet the very legitimate concerns raised by the disability community about valuing the dignity of life. We think we've done that in this bill.

Hon. Rob Moore: Thanks, Minister.

Madam Chair, this government decided not to defend its own legislation at the first instance, which is incredibly unusual and, in fact, offensive to Parliament, which passed the legislation.

Minister, we know that rather than appealing the Superior Court decision, you chose, instead, to introduce this bill, which in fact goes far beyond simply responding to the decision. This was all done before a parliamentary review that was supposed to take place under your government's own legislation.

Why did your government choose to skip an important parliamentary review that was supposed to look at MAID in the Canadian context after Bill C-14 was passed? Why did you skip that review and, instead, go beyond what was required in the Truchon decision?

● (1125)

Hon. David Lametti: We're not skipping anything. We're still going to go ahead with the parliamentary review. That review is going to look at very important issues that were identified and that were further studied by the Council of Canadian Academies, among others. These issues are the question of advance requests, the question of mental illness as the sole criterion for MAID, the question of mature minors, as well as many other things that came up.

Again, from the experience since 2016, we were going to reduce the suffering and respond to the Truchon decision, and we saw that there were other cases, such as Audrey Parker's, where Canadian society had moved. We had the lived experience from the medical profession and from families to say, here are some changes that can be made right now to reduce people's suffering. We've chosen to do that.

This is a very responsible thing to do, but by no means are we skipping the larger parliamentary review. That's critically important to moving forward as Canadian society moves forward.

The Chair: Thank you very much for that, Minister Lametti and Mr. Moore.

We have Mr. Kelloway next, for six minutes.

Mr. Kelloway, the floor is yours.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thank you, Madam Chair.

Hello, colleagues, staff, and ministers.

Thank you, ministers, for coming today.

My question is for Minister Lametti.

Audrey Parker was a strong woman who lived in my home province of Nova Scotia. In Audrey's case, the issue around advance consent or waiving final consent was very heart-wrenching.

Can the minister please explain how that case informed his decision to propose the final consent waiver outlined in Bill C-7?

Hon. David Lametti: Thanks very much, Mr. Kelloway, for reminding us of Audrey Parker's courage.

As you know, she was in the final stages of terminal cancer. She wanted to spend one last Christmas with her family, but because of the regime currently in place, she was very fearful that she would lose the ability to finally consent to the procedure and didn't want to continue to live in her situation after that, so she took MAID before being able to spend that final time with her family. It was a gut-wrenching set of facts and it resonated across the country. In English and in French there was an outpouring of support for Audrey Parker and for someone's ability to give advance consent, or waiving final consent, as we have framed it in this legislation.

To meet the Audrey Parker example where a death is reasonably foreseeable, when someone has been assessed and approved and they've made an arrangement with their MAID practitioner to waive final consent if they do lose capacity at the end, then the MAID practitioner can go through with it.

The other thing that was happening was that people weren't taking their pain medication at the end, for fear of losing that final capacity.

Again, all we're doing here is alleviating suffering. There is wide consensus and widespread support across Canada for this particular amendment to be added now.

Mr. Mike Kelloway: Thank you, Minister, for that very thoughtful answer.

Minister Lametti, you stated that during consultations you heard that the 10-day waiting period between signing a request for MAID and receiving MAID is an unnecessary prolonging of suffering. I can only imagine how trying these 10 days must be.

Can you please elaborate on these findings in the consultation process?

● (1130)

Hon. David Lametti: Again, as Minister Hajdu pointed out in her remarks, what we heard almost universally, from coast to coast to coast in Canada, from people who were helping to provide MAID as a service—doctors and nurses and people in the health profession—as well as families who had gone through MAID, is that the decision was already made. They had gone through the evaluation; they had taken it seriously; they had to wait another 10 days, suffer another 10 days, to get to the end of that 10-day period.

Again, even after we proposed this bill, I've had friends who have lost family and had access to MAID who said to me that we've got to get rid of the 10 days. All it does is to increase people's suffering. The decision was made; it was serious, and they said that we should let people and their families get on with it.

Hon. Patty Hajdu: Madam Chair, can I add to that response? I'm sorry to jump in.

The Chair: Please go ahead.

Hon. Patty Hajdu: Thank you so much.

I want to point out that this reflection was also on behalf of the practitioners who were providing medical assistance in dying. I've never met a more thoughtful group of people. They're helping people make very profound decisions and all the practitioners noted to us that they felt that the additional 10-day waiting period was, in many cases, undue cruelty. They felt that by the time a person got to a place where they had thoroughly searched their soul, thoroughly explored their options with their family members, etc, and knew that their days were final, this reflection was deep, considered and profound, and the additional 10 days did nothing to help that person reflect. In fact, all of that reflection, the assessment period and the offering of additional services had already happened prior to the request for MAID.

I want to reiterate that this was not just from the perspective of the families and, obviously, the patients whom we have some very famous examples of, but also from the perspective of the practitioners, to whom we owe a debt of gratitude because they are truly some of the most thoughtful practitioners we have, doing immensely, deeply important work in our society.

Mr. Mike Kelloway: They are incredible people.

Thank you, ministers.

The Chair: We are moving on to the next speaker.

[*Translation*]

Mr. Thériault, go ahead for six minutes.

Mr. Luc Thériault: Thank you, Madam Chair.

Ministers, respected colleagues, welcome.

I would like to begin by saying that, while we are asking questions to clarify this bill's intentions, people are suffering. People have been suffering since Bill C-14 was passed. We cannot ignore this.

In her ruling, judge Baudoin stated that this suffering was unreasonable under section 1 of the Canadian Charter of Rights and Freedoms. What is more, she said that Bill C-14 was a violation of a fundamental right set out in section 7 of the charter: the patient is entitled not only to safety, but to life. Owing to legislative provisions, the patient was being forced to shorten their life, out of fear of no longer being able to give their consent after losing their faculties. Minister Lametti talked about Ms. Parker's case. That is what we must take into account, and that is the perspective we should use in our work today.

Over the course of this debate and this study, two philosophical views will clash: on the one hand, paternalism of the state, which manifests in medical paternalism; on the other hand, a vision based on the legal principle whereby all individuals are entitled to self-determination.

The question we should ask ourselves is the following: what are the limits of the state intervention power at a patient's most intimate moment in life? Why would the state meddle in a patient's decision that concerns their own death, that has to do with their right to self-determination?

Contrary to my Conservative colleague, I would today like to congratulate Minister Lametti for putting forward this bill, which I feel has a broad consensus.

Mr. Lametti, do you have any figures showing the acceptability of Bill C-7 across Canada and Quebec? I know that Quebec has a broad consensus, but is that the case elsewhere in the country?

● (1135)

Hon. David Lametti: Thank you for your comment and your question, Mr. Thériault.

Consensus is similar across Canada. I have seen a number of figures concerning Quebec, but about 70% of Quebeckers are in favour of this. That's the case elsewhere in Canada, as well. So there is support.

I would like to add a remark to yours, Mr. Thériault. One of the biggest changes to occur since 2016 is what has happened in the medical community, which had concerns in 2016. As minister Hajdu mentioned in her answers, during our consultations held across Canada and online, it was practicians—for example, physicians and nurses—who made positive suggestions. They have accepted the fact that dying with dignity is a positive step in people's life. I must say that this paradigm shift shocked me.

Mr. Luc Thériault: What practicians need is clear legislation. Yet the criterion of reasonably predictable natural death was not a clear criterion. It lent itself to numerous interpretations and excluded people such as Ms. Gladu and Mr. Truchon, who then won the case. Mr. Truchon used medical assistance in dying. That criterion probably did not pass the test in Ms. Carter's case. Had there been certainty that Bill C-14 passed the test, the Supreme Court would have been asked for its opinion.

Let's now move forward. The patient is the standard, but they have to be heard.

Currently, palliative care is sometimes being pitted against medical assistance in dying. Because resources allocated to palliative care are lacking, proponents of that care are opposed to medical assistance in dying. To them, that's an escape route that lacks the necessary guidelines. There could be some division in that area.

Have you noted this opposition between palliative care and medical assistance in dying, in the sense that proponents of palliative care find that not enough is being done, while this was meant to be the solution for dying with dignity?

Hon. David Lametti: I will start the answer, but I think I will let Minister Hajdu finish it.

During the consultations we had, I noted that a number of practicians were doing both. They saw medical assistance in dying as an option that could be combined with palliative care. That was part of an array of responses to tragic circumstances, certainly, but responses that are not necessarily negative.

Of course, we must work with the provinces to ensure that palliative care is adequate. In addition, as Minister Qualtrough just said, options for living with dignity must be provided and the necessary support must be available. The options must be well supported, very clear....

[*English*]

The Chair: My sincerest apologies, Minister Lametti, but we are out of time.

I will go to Mr. Garrison for six minutes.

● (1140)

Mr. Randall Garrison (Esquimalt—Saanich—Sooke, NDP): Thank you very much, Madam Chair.

I would like to give the Minister of Health an opportunity to comment, since she wanted to answer that question.

Hon. Patty Hajdu: Thank you very much, Mr. Garrison.

I am excited to talk about palliative care, because things are improving in that area. Budget 2017 committed $6 billion to the provinces and territories to ensure they could increase access to palliative care, something that is intertwined with this issue, as so many MPs have noted and as the minister himself has noted.

MAID does not exist in isolation outside of a palliative care framework. In fact, the majority of Canadians who have accessed MAID have utilized palliative care, some 82%. Even those who didn't access palliative care, the remaining 13% or so, had access to palliative care in most cases.

Is that to say we can't do more and we can't do better? To use an often repeated phrase, we can always do better. The provinces and territories, as you know, have largely the jurisdiction to improve health care services, but the federal government has been there all along to help improve access to palliative care, and will continue to do that.

When the physicians talked to us, they really felt this was not an either/or conversation. This was really about adding on, as Mr. Thériault pointed out, a certain degree of autonomy for people to decide at what point they wanted to die with circumstances they could control themselves, regardless of the situation of palliative care.

Palliative care, as we know, is a critically important component for people who are experiencing long-standing severe illness or approaching death, but in some cases people, even with palliative care, still want to end that suffering. That is the premise of this bill. It's based on dignity and choice, concerns we heard echoed by the practitioners who were so generous with their time to share their experiences with us.

Mr. Randall Garrison: Thanks very much, Madam Minister.

I want to do something now that the Westminster parliaments don't often allow for, which is for opposition members to acknowledge the work of the government minister.

I first ran across requests for medical assistance in dying at the height of the AIDS crisis, when an HIV diagnosis was a death sentence because we didn't have treatment at the time. The minister knows I've been dogging her for a long time on getting better access to testing and treatment for HIV. I want to acknowledge the approval yesterday of the first HIV self-test kits, which will help us down the road toward eradicating HIV. I know that doesn't happen often, but I wanted to take a moment to do that.

When it comes to Bill C-7, I do want to say the same thing that many others have said. There is real suffering going on in the system for those who face terminal illness. It's suffering by the patient and also by their families. I'm very happy to see Bill C-7 come forward at this time to try to address especially the cases of those who have already been assessed and approved for medical assistance in dying and fear losing capacity. We've had famous cases and we've had, in my own riding, personal cases when I've had friends who have had to go early for fear of loss of capacity. I think this bill is important.

My question this morning to Minister Lametti is about the other issues and the statutory review. It's very important that we deal with the very complex question of advance directives. I believe it's also very important that we thoroughly the examine the question of mental illness and those who are suffering from mental illness, and the question of mature minors, which were all mandated in the statutory review.

As the minister knows, I would like to add to that statutory review the question of whether there are adequate safeguards when it comes to other vulnerable populations and people with disabilities.

My question is very simple. I've been after the minister for months on this. I would like to see us starting the larger statutory review at the same time that we're examining Bill C-7 so that we have a place for those concerns to be fully aired and fully studied in public.

Mr. Minister, when will we see a mandate for the statutory review and when will we see a proposal to get it under way?

Hon. David Lametti: Thank you, Mr. Garrison, for your question and your comments.

You know that I agree with you in principle that we're committed to that other review. I can't commit to the form yet. My priority is Bill C-7, but I'm going to work with you and other members around this table—all parties—to make sure that we fulfill our obligation.

I'm sorry that I can't say more than that right now.

● (1145)

Hon. Patty Hajdu: Madam Chair, can I just jump in for one second? I want to clarify that the $6 billion we gave in budget 2017 included palliative care, but it was also for things like mental health and home care.

The Chair: Mr. Garrison, you have 30 seconds if you'd like to add anything.

Mr. Randall Garrison: I want to say to the minister that I do fundamentally disagree with him when he says his priority is Bill C-7. Yes, Bill C-7 is important for those who are suffering, but the other issues on medical assistance in dying are equally important. I firmly believe that Parliament could walk on two legs here and that we have the capacity to deal with Bill C-7 at the same time as the statutory review.

Hon. David Lametti: I don't dispute at all the importance of the.... I know they're equally important. I agree with you on that. We'll have to disagree procedurally for, hopefully, a very short period of time.

The Chair: Thanks very much, Minister.

Keeping a close eye on the time, we're now moving into our second round of questions. We have five minutes for the Conservatives, five minutes for the Liberals and two and a half minutes each for the Bloc and the NDP. I'm hoping to get to the last 10 minutes between the CPC and the Liberals as well. Please try to be as concise as possible. I'd really appreciate it.

Mr. Cooper, you have five minutes. Please go ahead.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you very much, Madam Chair, and thank you, honourable ministers, for being here and for your presentations.

Minister Lametti, you stated that the legislation excludes sole mental illness. It is true that the legislation does provide that mental illness is not considered an illness, disease or disability. However, I would note that with regard to the criteria, physical or psychological suffering is the test.

Could you address the concern about ambiguity, in that when you remove “reasonably foreseeable” and leave “psychological suffering”, arguably the legislation does in fact provide for, or could open the door to, mental illness?

Hon. David Lametti: Thank you, Mr. Cooper, for your question. It's a very good question and a very important question. The reconciliation of those two points is the following.

Certainly psychological suffering is a factor that can be part of a larger set of factors that would potentially qualify a person for medical assistance in dying. What we have done is to say that mental illness can't be the sole criterion at this stage. We need to study that further. As I mentioned in my opening remarks, there isn't consensus, and it's a very deeply felt fear in the experts to whom we have spoken in the medical community and in the CCA report as well. We still need to know more.

In terms of being a sole criterion, it can be a factor with other criteria present. That's the specific reconciliation of the point you bring up.

Mr. Michael Cooper: But it would not have to necessarily involve a physical illness. You would concede that.

Hon. David Lametti: If it is the sole criterion, then that person at this stage will not be eligible for MAID. That will wait, and sadly, because these are tragic situations and people are suffering. There is certainly no view on our part that psychological suffering is any less serious than physical suffering, but it can't be the only criterion, as we have outlined.

Mr. Michael Cooper: I guess the upper concern, just to follow up on that, is that the legislation provides for mental illness being excluded, but there is no definition of mental illness. There is no definition of mental illness anywhere, in fact, in the Criminal Code. It leaves practitioners in an arguably difficult position to understand and interpret the legislation correctly when you strike down the “reasonably foreseeable” criterion, which did make it very clear that psychological suffering or some form of mental illness could never, or should never, constitute a basis on which the procedure could be carried out.

● (1150)

Hon. David Lametti: Look, we were listening to the medical community, we were listening to experts and we were listening to families and others. They were suggesting this particular wording. We can look at the wording to see if there's a way to make it clearer, but as I certainly made clear in my response to Mr. Garrison, this is an important issue that needs to be studied. It needs to be studied quickly and it needs to be addressed quickly, because people are suffering out there. We want to help reduce their suffering and give them the full set of options that every other Canadian has.

Mr. Michael Cooper: Lastly, I will ask you, Minister, if you can address expanding the criteria to provide for an advance consent, in albeit limited circumstances, despite the fact that the expert panel working group provided that there were significant knowledge gaps and a lack of consensus. Why is the government proceeding with that in the face of those concerns, all the while pre-emptively moving ahead of the legislative review?

Hon. David Lametti: Those CCA studies in this particular regard don't represent Canada in 2019. In Audrey Parker's case and other cases, it became clear that a very limited kind of consent, as we are proposing in this legislation, was in fact widely reflective of a consensus across Canada. The outpouring of support for Audrey Parker and an Audrey Parker-type amendment was clear across the country.

Therefore I would disagree with you, Mr. Cooper, that there was no consensus on this particular point. I would say that the Council of Canadian Academies' report on this particular point would actually be outdated. There is a clear consensus on this, and that's why we're doing it.

The Chair: Thank you very much, Minister Lametti.

Thank you, Mr. Cooper.

Mr. Sangha, the floor is yours for five minutes.

Mr. Ramesh Sangha (Brampton Centre, Lib.): Thank you, Madam Chair.

Thank you very much, Minister Qualtrough. I have two questions for you.

Number one, Minister, in your remarks in the House on October 21, you discussed the government's effort to engage in extensive consultation with the disability community to hear their concerns about medical assistance in dying. Can you share how the concerns of the disability community are reflected in the legislation?

Hon. Carla Qualtrough: Thank you for your really important question.

There has been extensive consultation, as my colleagues have said, and we all have spoken directly with disability advocates, disability rights groups, and individuals.

As I said in my remarks, we heard about the long-fought battle for personal autonomy and choice and also about the concern that nothing we do in any way should devalue an individual's life by saying that some lives are more valuable than others. That's a really important distinction to be made, because in my mind and our mind, they are not opposing views. It's not as divisive as sometimes it has been portrayed.

Listen, we have been very clear that this law is based on equality rights, both the personal autonomy rights and the equal value of each right, but what we heard was that we had to make sure that people had a choice in front of them, that they knew what options were available to them, that they weren't going to choose to end their life because they didn't have the proper disability supports around them to make their lives meaningful and valuable and productive and healthy.

That's why we went so far in the non end-of-life track to make sure that people knew, and that there was an obligation on medical practitioners to discuss counselling, mental health supports, disability supports, community services, and palliative care and make the assessment a minimum of 90 days.

As I said, we know that in some places in our country, it's easier to access MAID than it is to get a wheelchair. That shouldn't be the case. That isn't what this law is about, but we wanted to make sure we spoke about the charter and the UN convention. I am committed to working with my provincial colleagues to make sure people are making the choice for reasons related to their circumstances, but not their social circumstances, not their lack of housing, not their lack of equipment, not their lack of employment.

It's really hard to talk about this in the context of amending the Criminal Code, but it still needs to be talked about. That's why we put such effort in the second track to provide access to alternatives for people who might not think they have any.

● (1155)

Mr. Ramesh Sangha: Thank you, Minister.

For my second question, we have heard from parents who have children with disabilities about their fears that their children, when they grow older, will pursue MAID because of their disabilities.

Minister, can you please help alleviate the anxiety of these parents and share how this legislation will prevent this from ever happening, and perhaps more importantly, can you please discuss the steps our government has made to create a more inclusive nation and treat persons with a disability with equity and equality?

Hon. Carla Qualtrough: Again, they're really important conversations. We're not shying away from these conversations. It worries me deeply that any child would be sent a message that their life isn't valuable or equal to another's, and we are, for lack of parliamentary words, hell-bent on making sure that's not the case.

We have moved a long way in this country on disability rights in the past five years, starting with the Accessible Canada Act and the consultations in that act, and committing to, in this legislation, a human rights-based approach to disability inclusion, which lets us get at the underlying systems.

A lot of it's provincial, and I'm not saying that as an excuse to suggest that we don't have an important role at the federal government. What it means is working collaboratively with provinces to make sure people have meaningful options. We have a commitment to work with the provinces and territories on this.

We have committed, as I said, to a very action-oriented disability inclusion plan. It includes the Canada disability benefits, which will give people income and maybe open up their choices, and it includes an employment strategy, again providing options and choices, and it includes an overhaul of federal government eligibility for disability programs and services, again giving people options.

I don't want anybody in Canada to think that their lives are less valuable than anyone else's, and we are very committed to making sure that message is not sent.

The Chair: Thank you very much, Minister Qualtrough.

I'm sorry, Mr. Sangha, your time is up.

Mr. Ramesh Sangha: Thank you.

The Chair: I'm moving on Monsieur Thériault. You have two and a half minutes, Monsieur Thériault.

Please go ahead. The floor is yours.

[*Translation*]

Mr. Luc Thériault: I will be brief.

Minister, Mr. Garrison raised an important issue: the bill is worthy of merit, but it leaves a number of delicate elements behind.

The legislative amendments enacted by Bill C-14 were supposed to be reviewed in the summer of 2020. Similarly, I imagine that you could commit to the consideration continuing, after Bill C-7 passes, to work on weak points, as a number of stakeholders from various backgrounds would like.

Wouldn't that be a positive compromise to reconcile Mr. Garrison's position with yours? Would you commit today to us looking into those delicate elements following the passage of Bill C-7?

Hon. David Lametti: You know my opinion on that, Mr. Thériault. I would also like to discuss these issues, as they are important. That is what I said to Mr. Garrison.

I can commit to doing my best to come to an agreement with Mr. Rodriguez, who is our party's leader in the House of Commons, and to work with you in the House to strike a committee as soon as possible. However, I cannot promise anything concrete in that respect, as, in the parliamentary context, there are other elements to consider as regards House leaders.

● (1200)

Mr. Luc Thériault: You agree that we shouldn't wait four years, or even one year, right?

Hon. David Lametti: I completely agree. You know that this is a priority for me, as demonstrated by my past actions.

Mr. Luc Thériault: It is important to note that there is a difference between mental health problems and cognitive degenerative diseases, and that implies the obligation to deal with this whole issue of advance requests.

Hon. David Lametti: Exactly. I am hearing from people from across Canada, and they are saying the same thing. This is important for many people.

Mr. Luc Thériault: My time is now up.

[*English*]

The Chair: Yes, your time is up. Thank you, Mr. Thériault, for recognizing that.

I recognize that it's now 12 o'clock. I would ask for the consent of the committee and the witnesses to be able to go through maybe two and a half minutes each for Mr. Garrison, Mr. Lewis and Mr. Zuberi.

If I have the consent of the committee, just give me a thumbs-up so that everybody has the option to be able to ask their last round.

Thank you very much.

Mr. Garrison, please go ahead for two and a half minutes, followed by Mr. Lewis and Mr. Zuberi.

Mr. Randall Garrison: Thank you very much, Madam Chair.

One of the reasons I'm very confident that there's public support for Bill C-7 is that it maintains a very high bar for accessing medical assistance in dying. A person seeking MAID must be suffering from an incurable condition, must be in an irreversible decline and must face intolerable suffering.

Some, however, who I think oppose the concept of medical assistance in dying, have been using some catchy phrases. I don't think they are designed to promote real debate about the issues, but I would like to give one of the ministers a chance to respond to those who are talking about Bill C-7 creating “death on demand” or creating “same-day dying”. I do not believe the bill does this, but I think we need to address the attempt to distort the bill.

Hon. Patty Hajdu: Thank you, Mr. Garrison.

You're right. I think the phrases you've mentioned—I can't repeat them exactly—and also referring to this bill as “euthanasia” legislation, which I have heard in the House of Commons, are incredibly demeaning to the dignity of people who are attempting to access this service and incredibly demeaning to the professionalism of the incredible physicians and other MAID assessors whom I had the privilege of meeting while I did the consultation.

This is incredibly personal, detailed work, which a physician and practitioner does sometimes within a team and sometimes on their own within a hospital setting or clinical setting, with people who are in what might arguably be some of the worst conditions of their lives, who are struggling and suffering, and who want, above all, compassion and empathy.

I think we all need to understand that no one, especially in the medical profession, takes life frivolously. As a practitioner, no one considers this lightly. As a matter of fact, one of the challenges we've had in people accessing medical assistance in dying is that we don't yet have enough practitioners who feel that they have the skills and the ability to do this work.

I think we need to respect that the professionals who are providing this support for Canadians in some of the darkest times of their lives are doing so with a high degree of respect for life and a high degree of respect for individuals who, as the practitioners themselves have pointed out, have deliberated on this decision for way longer than they've even told their practitioners. I don't think it does any of us a service in Canada when we demean the individuals who desperately want this help and demean the people who are doing the work.

The Chair: Thank you very much for that, Minister Hajdu, and thank you, Mr. Garrison.

We're going to move on to Mr. Lewis for two and a half minutes.

Mr. Lewis, the floor is yours. Please go ahead.

Mr. Chris Lewis (Essex, CPC): Thank you, Madam Chair.

Thank you to all the ministers for appearing today at committee. We certainly appreciate that, and it's an honour to be here.

I have just a few statements, and I know that two and a half minutes go by very quickly, so I'm going to make the statements and then allow Minister Lametti, hopefully, to answer my question.

First and foremost, on the 10-day reflection period, I realize that the way the bill is written now, it would go down to zero. I guess I really question why we wouldn't at least start with the number five and give people some time to get together with family to really reflect on the decision that's being made.

With regard to witnesses—down from two to one—that's incredibly concerning as well, because we'd all love to believe that all families get along very well, but unfortunately there's a lot of back-and-forth in families. I have a real issue with that.

Would it not be a fair statement that doctors being forced to refer patients to another doctor to administer MAID directly contradicts the very constitutional right that they are entitled to? Further, would it not be a fair statement to suggest that forcing physicians to refer MAID to another physician to administer MAID is no different from someone saying, “I don't believe in robbing banks, but here are the keys.”

Minister Lametti, you spoke of suffering in your opening remarks. Would you not agree that while the physical state of suffering of those requiring MAID is indeed met, for these physicians who have to refer patients to another against their will, it will indeed inadvertently create emotional and mental stress, which they will need to live with?

● (1205)

Hon. David Lametti: Thanks, Mr. Lewis, for your questions; they're important questions.

First, let me start with the 10-day reflection period. All the work, all the family consultations, all the consultations, the assessments and the medicals have already been done. All the 10-day period was, was effectively that you've made your decision, and now you have to wait 10 days just in case you change your mind.

Universally in our consultations, medical practitioners and families told us that all this did was force people to suffer. It was a form of torture, a period in which people didn't take their medication in order to be able to make a decision after 10 days. The kinds of reflections you're referring to had already been done, so it was seen to not be necessary.

The two witnesses are just witnesses who are effectively doing a pro forma witnessing of identity. This isn't in any way medical or in any way part of the medical assessment. Again, that's already been done. All the witness is doing is saying that Mr. X is Mr. X , and that can be anybody. Again, we're told by practitioners and by families that sometimes it was an impediment. You don't need two people.

With respect to freedom of conscience, the bill enshrines freedom of conscience. No medical practitioner is forced to give the procedure in any way, shape or form, and we've protected that. It already was protected, and we further protected it back in 2016 in the legislation.

The requirement to give a referral comes from a decision of the Court of Appeal for Ontario, so the courts have told us that. That's true in any medical setting in a variety of different areas, not just MAID, where there is a health care obligation to refer someone to a service so that people who have a right to a service can get it, even though the person who is referring has a freedom of conscience objection to providing that service himself or herself. There is a right to get the service, and health care services across Canada, which are provincial, have an obligation to provide that.

The Chair: Thank you very much for that, Minister Lametti.

Finally, Mr. Zuberi, if you can keep your question pretty tight, that would be great. Go ahead. The floor is yours for two and a half minutes.

Mr. Sameer Zuberi (Pierrefonds—Dollard, Lib.): I want to thank the ministers for being with us today on this very sensitive and important matter.

My question relates to safeguards. We know that the legislation, as it's being put forth, has safeguards when death is not reasonably foreseeable. Those safeguards include that physicians have expertise, that one is informed about how to alleviate one's suffering, and that there is serious consideration given to the person in question, who is considering ending their life, in terms of those means to alleviate their suffering.

Can you touch upon why those safeguards are not included when it comes to the question of the death not being reasonably foreseeable?

Hon. David Lametti: The first set of safeguards, in the end-of-life regime, where we've used the reasonable foreseeability of a natural death to be a channelling criterion and not an eligibility criterion, were well known by medical practitioners and by families. For the most part, we have kept them. We have taken out the things they have told us were prolonging suffering unnecessarily. Those are the vast majority of cases: terminal cancer, people near the end, everyone preparing for the inevitable. We feel we have made that part of this more compassionate for the vast majority of people.

In the non-end-of-life regime, as Minister Qualtrough pointed out, we wanted to make sure that people had adequate support and information to make a decision, either about how they wanted to live or about how they wanted to die. We were told again by experts, families and practitioners.... In the case of catastrophic accidents, for example, your first reaction is often that you'd rather die. It's only after a few weeks and seeing what the alternatives are that you come to the conclusion that you have a lot of things to live for, and you could live this way or that way, given the right information and the right support.

We wanted to make sure those safeguards were embedded in our regime. Some countries require six months. We have required 90 days for the assessment period. It's not a waiting period, but it's the assessment period when the person is consulting with their family, their doctors, their nurses and getting the appropriate options, getting consultations on supports that will be available should they choose to live, and how they might live.

We're trying to balance two different types of scenarios. The non-end-of-life scenario is the less frequent number of cases. As I said, the vast majority of cases are the end-of-life scenario. It is what medical practitioners and MAID service providers are used to working with, and we think we've made that better.

● (1210)

The Chair: Thank you very much, Minister Lametti.

As we have concluded our two rounds of questions, I will take this opportunity to thank Minister Lametti, Minister Hajdu and Minister Qualtrough for taking the time to answer these very important questions about Bill C-7 and medical assistance in dying. Thank you for your efforts and your hard work.

We will suspend the meeting for a minute while we switch in our witnesses for our second round.

Thank you, everyone. Thank you for joining us, Ministers.

● (1210)

_____________________(Pause)_____________________

● (1215)

The Chair: We will get started. I take note of the time; it is almost 12:20. The meeting concludes at one o'clock. I will do my best to have an equitable distribution of time for questions from all the members.

If I can ask the witnesses, I know we had initially said five minutes for your opening remarks. Can you please aim for three minutes? I will make sure you finish your thought before I ask you to move on.

I will introduce our witnesses: Dr. Ramona Coelho, physician; Dr. Tanja Daws, family physician. From Dying with Dignity Canada, we have Senator James Cowan, chair of the board of directors, and Helen Long, chief executive officer. Then we have Dr. Georges L'Espérance from the Quebec Association for the Right to Die with Dignity.

We'll start with Dr. Ramona Coelho. Please, the floor is yours.

● (1220)

Dr. Ramona Coelho (Physician, As an Individual): My name is Dr. Ramona Coelho. I practised home care in Montreal and now practise in London, Ontario.

My home care patients were ill or disabled and homebound. In London, I care for many Syrian refugees and other people. I would say that half of my practice comprises people with disabilities.

I am here today to say that suicide prevention must remain a priority and that standard medical care must be given to Canadians. I work with vulnerable patients and I am concerned that I won't be able to protect them from transient suicidal ideations if this bill goes forward without some amendments. Also, an amendment protecting conscience is equally necessary, to respect diversity and autonomy on this controversial issue.

Many of us who work with the ill and disabled, regardless of religion, could not facilitate a lethal injection by request solely on our medical judgment. I had a lovely 70-year-old lady losing weight and requesting death for months. Looking into her condition for cancer and other issues didn't give me clarity; it turned out that her son, who had moved in some months before, was stealing her money and not feeding her. Following my clinical workup benefited this lady, but I know that if I had a 90-day framework to try to outrun her death wishes, I would have facilitated a death driven by elder abuse and financial abuse.

As I shared, many of my other patients have disabilities, rheumatism, fibromyalgia, multiple sclerosis, organ failure and many others. The existential crises and hardships of these people are real, but their death wishes are often transient and we need time to apply good medicine.

We will become a place in Canada where you can receive a lethal injection before the standard of good care is actually applied, if this bill passes without amendment. Pain clinics, psychiatry, rheumatology, neurology, they all take more than 90 days to initiate contact and meeting, and then education and treatment plans. Bill C-7 is currently constructed so that vulnerable patients can choose the 90 days to have a lethal injection and only know that services exist, without actually having gone through the standard of good care to see if that resolves their suicidal ideations.

There should be some amendment that lethal injection for those who are not dying should be only for people who have gone through psychosocial education, who have had actual good medical care, not just been offered it. To know that an injection for pain relief exists and be offered it is very different from actually experiencing that pain relief—and wait times, at least where I am in London, Ontario, are very long.

I also urge a conscience amendment. In Ontario, many doctors have retired or left palliative care and other things, and none of these outcomes increase patient services anyway.

With this bill, many physicians across all specialties will find themselves under duress. We have a MAID to MAD statement, with 945 doctors across all specialties, across Canada, who are saying that this bill needs amendments.

Thank you.

The Chair: Thank you very much, Dr. Coelho. We really appreciate your concise remarks.

We will move on now to Dr. Tanja Daws, for three minutes as a minimum.

Dr. Tanja Daws (Family Physician, As an Individual): Thank you for allowing me to speak.

I'm a family physician from Vancouver Island, servicing rural communities. I have been a physician for 20 years in total and have done MAID since 2016.

I want to thank Parliament for the time it has given to study Bill C-7, because I know that for some it will seem to never be safe enough. From reading House of Commons Debates notes, I could see that for many there were specific fears relating to disability, vulnerability and slippery slopes, and frustration by other members that the bill never seems to go far enough.

I want to specifically focus on two issues, but in my brief I did provide more information specifically addressing the MAID process as to how we assess patients and the nuance and detail involved. I share the same practice profile as my colleague and can state that in the four years of doing MAID I have never seen vulnerable patients being abused. That is something that we are specifically looking for in MAID assessment. We spend much more time than we spend with regular patients—over months, if needed—to come to eligibility decisions, even if there was just a 10-day wait period in the past.

As MAID providers, we bring an added level in that many are palliative care physicians and many work with disabled patients to start with, and we feel that our moral grit is strong enough to ensure that we are another layer of comfort and care for those patients, more so than just being MAID assessors.

I want to take the time to spend some attention on two separate issues that I think will flow forward on a practical level in MAID from Bill C-7. The first is around the clarification of expertise.

In this brief, I wanted to focus on the fact that family physicians and nurse practitioners provide the majority of the backbone of Canadian health care by doing primary care and also by being copilots with our specialty colleagues. Where "expertise" is mentioned in the bill, we realize with appreciation that it's not to change the equitable access to MAID, but rather to ensure that people are more in place to assess these patients thoroughly, especially when we talk about vulnerability and disability.

I do, however, feel that most family physicians, specifically those who deal with these people for decades of knowing them, for decades as their primary caregivers, are probably in the best position to help them. Most MAID providers come from this field, the same as nurse practitioners. In medicine, when you feel you are not equipped medically or knowledge-wise, or you feel you're missing something, that's when you always phone a friend and refer to a specialist or another colleague.

I don't think that in MAID assessments that process will be different. We have shown that in the MAID community more MAID providers have done palliative care courses, and we are all looking at courses to help us with cultural sensitivity as well as with vulnerability and sensitivity. We are all willing to do training to ensure that we will have enhanced skills to make it safer.

I do think the one thing that will be very difficult with how expertise is defined in Bill C-7 is that it may be very difficult in some illnesses to have a MAID assessor feel that they are an expert. It may be impossible, for instance, to find a neurologist who is willing to be an expert and be a MAID assessor.

I would like to propose the idea to the committee that perhaps the two MAID assessors, if they feel they are at the expert level, could continue in that role, but where they feel that none of them could be expert enough, they could perhaps refer to a third expert, such as an addiction specialist or a pain specialist. They are not actual specialities per se, like surgery, but they can ask for a consultant opinion, which is pretty much what we are doing at the moment with Bill C-14, when we refer patients for a formal capacity assessment. Their assessors, who are usually psychiatrists or geriatric psychiatrists, are not comfortable being MAID assessors or providers, but they're happy to be consultants.

Third, I would just like to address, in terms of the final waiver, that the specified day as a choice for patients can provoke unintended harm by causing anxiety. It's very hard to write down a day, but patients may be more comfortable writing down a period that they would give for that advance consent. This should also be transferable to other providers, as we do have holidays and conferences, or we may be in COVID quarantine, and another provider may have to act on that waiver.

● (1225)

Finally, we are concerned with obstruction from third parties, as in the recent Nova Scotia case. If we deem that the patient is not suffering and the family agrees, then we can stand back.

The Chair: Thank you very much, Dr. Daws. I appreciate your time.

We will go on to Dying With Dignity Canada, with Senator James Cowan and Ms. Helen Long.

Please go ahead. Your time starts now.

Ms. Helen Long (Chief Executive Officer, Dying With Dignity Canada): Good afternoon and thank you for the opportunity. Senator Cowan and I will be splitting our time.

For 40 years, Dying With Dignity Canada has been committed to advancing end-of-life rights and helping Canadians avoid unwanted suffering. Our role is to represent the 86% of Canadians who support the 2015 decision in Carter v. Canada, which struck down the prohibition on physician-assisted dying. We've done a number of studies and surveys over the years around end of life, and our results are largely consistent with those of the federal government in the spring consultation.

In our view, the experience of Canadians within the MAID regime has been overwhelmingly positive. However, experience and research would demonstrate that there is a need for some improvement.

We're here today to speak in support of the legislative amendments that have been put forward in Bill C-7, although we will briefly address concerns. The changes do address the need for personal autonomy and also importantly demonstrate compassion for individuals.

We were pleased to see the removal of the reasonably foreseeable natural death eligibility requirement, which infringes "life, liberty and security of the person" guaranteed by section 7 of the charter. Removing this clause ensures constitutionality for the individual and also their choice to end their life at the time they choose.

Jean Truchon and Nicole Gladu spoke for hundreds of Canadians who have been excluded from existing MAID until this point because they are not imminently dying, although they are still experiencing constant physical pain and suffering that is intolerable to them, and they have carefully considered their decision.

We commend the government on the inclusion of Audrey's amendment, allowing the waiver of the requirement for final consent for those who are assessed and approved for MAID but who may lose capacity in advance of their date. This is something that 85% of Canadians support. We believe that this waiver of final consent should also be extended to those whose death is not reasonably foreseeable.

Many of you will be familiar with Audrey's story. Sadly, it's one we hear every day. We are forever grateful to her for her advocacy, and we appreciate the acknowledgement of the pain caused to individuals like her in this amendment.

Senator.

● (1230)

The Chair: Go ahead, Senator.

Do we have him on the line?

Senator Cowan, can you hear us? I can see you, but we can't hear you.

Ms. Helen Long: Shall I finish the statement, Madam Chair?

The Chair: Maybe we can come back to Senator Cowan.

We'll move on to the Quebec Association for the Right to Die with Dignity, with Dr. Georges L'Espérance. Perhaps I can, in the meantime, have somebody from IT give Senator Cowan a call to fix his issues.

Go ahead, Dr. L'Espérance.

[*Translation*]

Dr. Georges L'Espérance (President, Quebec Association for the Right to Die with Dignity): Good afternoon, ladies and gentlemen. Thank you for this invitation.

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

As a retired neurosurgeon, I provide medical assistance in dying and am part of a private discussion group in Quebec. The group consists solely of physicians who provide that last compassionate and ethical care. This enables highly judicious and educational exchanges. The following remarks enjoy a strong consensus among us and inform the association's reflections for our fellow citizens.

I use this opportunity to thank Minister Lametti and his team for listening to patients and practicians in the development of this latest bill.

The bill proposes highly relevant adjustments, more specifically for people who are alone. First, the bill allows there to be a request for medical assistance in dying in writing with a single independent witness. In addition, someone whose job is to provide health care or professional care now has the ability to act as an independent witness. What is more, the 10-day reflection period has been shortened, and this adjustment is the fruit of simple clinical logic. Finally, the waiver of final consent immediately prior to care is, once again, a response in line with the clinical reality we are all experiencing.

We completely agree with the previously drafted opt-out provision, as well as with proposed new sections (3.3) and (3.4) concerning manifestations through words, sounds or actions of refusal for the substance to be administered. However, we suggest this last safeguard measure, in section (3.4), must be revised in two years. Based on experience acquired, it could eventually be shortened.

We feel there are still three major points to Bill C-7 that should be improved.

First, we are asking that the concept of “reasonably foreseeable natural death” as a safeguard measure be pulled from Bill C-7. The other criteria set out in Bill C-7 have proved in Canada that the most vulnerable individuals don't need any other protection to guarantee their fair and safe access to medical assistance in dying. Otherwise, our patients and us, the physicians on the ground, will once again remain stuck with a vague and non-medical concept. Life expectancy is actually a notion that affects the average, and not specific individuals.

If, despite everything, the legislator wants to hold on to this measure, they should at least remove the 90-day minimum assessment period for the same reasons as those mentioned regarding the 10-day period. That so-called period of reflection is an insult to our patients' intelligence and suffering.

The removal of that criterion will also make more seamless access across Canada possible, since the decision in terms of medical assistance in dying will be subject to a strict objective medical process.

As far as mental illness goes, with all due respect for those Canadians and because those issues are complex, we suggest removing that exclusion provision and keeping a 12-month legal non-application period, during which the regulatory colleges within each province will have to work together and be under the legal obligation to define a common clinical framework.

Finally, any capable individual who has been diagnosed with a cognitive neurodegenerative disorder of the Alzheimer type should be able to indicate in their advance medical directives, with a supporting witness, that they wish to obtain medical assistance in dying at a time they deem appropriate, according to their values and regardless of their cognitive state at the time.

In closing, I would like to reiterate that the Quebec Association for the Right to Die with Dignity firmly and unwaveringly defends the absolute prohibition on using medical assistance in dying, under threat of criminal penalties, in the case of individuals who have always been incapacitated—here we are talking about mental deficiency—or individuals who became incapacitated before providing advance medical directives.

Thank you for your attention.

● (1235)

[*English*]

The Chair: Thank you very much for that, Dr. L'Espérance. It is much appreciated.

We will go to Senator Cowan if he is able to communicate at this time. We will do a check.

No, we still don't hear you. Can you check on your mute button and just ensure that it is your headset that is selected for your microphone? You're on mute now, so even if we could hear you, we can't hear you.

Unfortunately, we still don't hear you, Senator. As we are running very short on time, what I will do is ask if you can provide some written submissions, which I know you may have done already, with respect to your comments today.

Could I please have IT call the Senator so he can at the very least participate through the question and answer period?

We will go to six-minute rounds now. We will start with Madame Findlay. We will go on to Mr. Virani, then Mr. Thériault and Mr. Garrison.

Go ahead, Madame Findlay. The floor is yours for six minutes.

Hon. Kerry-Lynne Findlay (South Surrey—White Rock, CPC): Thank you, Madam Chair.

My questions are primarily for Dr. Coelho, whom I found to be a very compelling witness.

Doctor, in 2017 you expressed concerns about the duty that doctors who don't wish to participate in MAID have to refer patients to another physician who is willing to give the patient the end-of-life procedure.

Could you speak to this referral issue and how the expansion of MAID to those whose death is not imminent would affect doctors who are not willing to participate?

Dr. Ramona Coelho: Thank you very much.

The preamble of Bill C-14 did speak to conscience protection, but that is not an enforceable part of the bill. Unfortunately, in Ontario the CPS still has a policy whereby doctors have to arrange for and facilitate medical aid in dying, and what will now be an assisted death, for those who are not dying.

At that time, Hindu, Sikh, Muslim, Jewish and Christian groups, which are part of this submission, all reached out to the government saying that they needed further conscience protection for their adherent physicians.

Regardless of that, everybody has a line, and this is something people feel very strongly about, which I understand. I hear Dr. Daws express how this is, for her, something through which she feels she is being very merciful and compassionate.

I, who take care of very vulnerable people, have come to the opposite conclusion. I feel that they come to me and I try to offer them safety and protection, and when they are in a safe space and express their death wishes, I can try to work on creative solutions for them. I will not deny them information. I will not obstruct them, but my job is to be in their corner and fight for them to want to live again. That's because I've had many patients who have done just that.

It would be very good in Bill C-7 if we had an amendment that spoke to conscience protection, not just in the preamble.

● (1240)

Hon. Kerry-Lynne Findlay: I appreciate that, Doctor, and also your comments regarding transient suicidal ideations and the need to apply a good standard of medical care and time for specialty consultations, which, as you pointed out, and I think we all know, take some time.

Dr. Ramona Coelho: It's not only that. This will make us the most permissive euthanasia regime in the world, in the sense that usually euthanasia is a last resort, once we've tried to help people want to live again. But with the way the bill is written—and again, I want to acknowledge that Dr. Daws said she spends months, so she acknowledges that it takes more time sometimes—having that kind of protection written into a life-ending bill—when other doctors might not be as conscientious as Dr. Daws—I think is very important.

Hon. Kerry-Lynne Findlay: Thank you.

In a recent op-ed you co-wrote for the National Post, you said:

> Instead of using our resources to increase health-care personnel, improve our quality of care, enhance our palliative care options and ensure quicker access to psychiatric care, our federal government seems more interested in fast-tracking death on demand and dismantling the MAID safeguards that were put in place [a short time ago] to protect the vulnerable.

Do you have any examples from your practice where MAID was considered by the patient because the resources for treatment they were receiving were insufficient?

Dr. Ramona Coelho: Yes, I have had many such death wishes by patients who have had strokes, and during COVID there was not enough help to come to the home and open containers so they could eat. I take care of very marginalized patients, those who are constantly fighting for things like housing, resources in the home, social supports, pain control, and access to medications that they can't afford. There are many barriers that lead patients to have death wishes every day, and it is a conscientious doctor on both ends who is going to spend that time with them, but we need that written in the bill.

Hon. Kerry-Lynne Findlay: Thank you.

Advocates for persons with disabilities in my riding are extremely concerned about the specific expansions of MAID under Bill C-7, especially the elimination of any reflection period, and signalling by the Liberal government of a desire to expand it even further through the unnecessarily delayed statutory review.

I wonder if you have a comment on how you see that there could be better safeguards for vulnerable people.

Dr. Ramona Coelho: I think this consultation was supposed to be extensive, and I'm really hoping that it goes forward that way. It is very interesting that most of the people who are here are MAID lobbyists.

The Council of Canadians with Disabilities and the Canadian Association for Community Living have actually said that this bill is very bad. There are 70 signatories, different advocacy groups for people with disabilities.

You guys need disability experts to speak to you about what they consider to be dangerous in this bill. You guys need expert physicians like neurologists, physiatrists, stroke specialists, and psychiatrists to weigh in on safeguards. We're talking about ending someone's life. I understand that some people perceive that as a merciful act, but I think everyone still agrees that there is no problem with trying to make sure that people who have transient suicidal ideation are not killed and that everything is offered to them so that they can go forward.

I strongly suggest to the committee that you have witnesses who are content experts in medicine.

Hon. Kerry-Lynne Findlay: I understand that 70% of Canadian citizens do not have access to palliative care. I also took note of—

The Chair: I'm so sorry, Madame Findlay, but we're out of time. Hopefully we can get to a second round to ask any further questions.

● (1245)

Hon. Kerry-Lynne Findlay: Thank you, Madam Chair.

The Chair: Thank you so much for your patience.

We'll move on to Mr. Virani for six minutes.

Go ahead, Mr. Virani.

Mr. Arif Virani (Parkdale—High Park, Lib.): Thank you.

In my six minutes, just let me say at the outset that I think when witnesses refer to other witnesses on the panel as “lobbyists”, in a derogatory manner, I don't think that's very respectful and perhaps the chair should make some remarks in that regard.

I'm going to ask three questions to three different parties.

The first is for Dying With Dignity and Ms. Long and Senator Cowan. We've heard from others during the course of today's discussions about the fact that the Truchon decision should have been appealed to a higher court, rather than acted upon immediately in terms of alleviating people's suffering. I wonder if Dying With Dignity has any views on that. Minister Lametti was quite clear that it was acted upon immediately in order to address the suffering that was identified in the decision.

Could you answer that in 90 seconds, please, Senator Cowan or Ms. Long?

The Chair: Please go ahead, Senator Cowan.

Hon. James S. Cowan (Former Senator and Chair, Board of Directors, Dying With Dignity Canada): Yes, sorry for the technical difficulties.

We very much believe that the Government of Canada and the Government of Quebec took the appropriate action not to appeal the Truchon decision. We believe, as Ms. Long has said, that the response contained in Bill C-7 is the appropriate response, and we strongly support it.

We do have one reservation with respect to the express exclusion of mental illness. I'd be pleased to address that if I have time, but I know, Madam Chair, that you're short of time, so I'll wait for your invitation. Otherwise, that's covered in our written brief, which we have filed with the committee.

[*Translation*]

Mr. Arif Virani: Thank you.

I will now turn to Dr. L'Espérance.

Dr. L'Espérance, I'd like to talk about the situation as it relates to people with disabilities. The issue has been brought up repeatedly today as well as in the House.

In 90 seconds, I would like to hear your thoughts on Mr. Truchon and Ms. Gladu's case. Beyond their disabilities, it was necessary to recognize their access, autonomy and dignity, while taking into account their suffering. Could you please comment on their autonomy and decision-making power as persons with disabilities?

Dr. Georges L'Espérance: You touched on a big part of the answer in your question.

Both of them testified before Justice Baudouin. I was there for all the testimony, and what emerged was how carefully they had considered the issue for so many years. Like other people with disabilities, the two of them had access to all the necessary supports. Mr. Truchon constantly pointed out that, as a person with a disability, he had all the help he needed on a daily basis. That was not at all the reason why he was seeking assistance in dying. The same is true of Ms. Gladu, but she has not yet followed through with a medically assisted death.

Overall, patients with disabilities are very familiar with their conditions, and they are the ones requesting medical assistance in dying. Neither doctors nor anyone else is forcing them to obtain a medically assisted death.

[*English*]

Mr. Arif Virani: Thank you.

In terms of addressing what I feel is unfairness and not accurate information, the position was put by Dr. Coelho that an amendment needs to be made to this legislation to address conscience rights. In fact, Bill C-14 was amended at committee and validated in Parliament. Subsection 241.2(9) of the old Bill C-14, now in the Criminal Code, says, “For greater certainty, nothing in this section compels an individual to provide or assist in providing medical assistance in dying.” It is in the legislation now. It's also in the preamble. It's also in section 2 of the charter, and it's also in paragraph 132 of the Carter decision, where the court went to great lengths to indicate that no medical practitioner would be forced to provide a service they don't wish to.

In my mind, Dr. Coelho, it seems the concern is actually with the direct referral regime, which has been actually upheld in litigation in your own province of Ontario, where it was deemed to be held constitutional in the approach that is currently done. Direct referrals also occur with respect to any other provisions or treatments that doctors don't feel they want to provide themselves.

Perhaps you could respond to that in 45 seconds, and then give Dr. Daws the time to do the same. Thank you.

● (1250)

Dr. Ramona Coelho: Referral is not something that we pass on when we're not comfortable. It's a continuation of care for what we think is appropriate. I think that explains some ethics that I can't get to in 45 seconds. We do not actually make referrals for things that we think are bad for our patients. That is actually the standard of ethics and integrity in medicine. The World Medical Association, the CMA, the AMA, all support that position, as does the OMA.

The CPSO is actually the deviant here, in terms of the college policy. The fact that multiple religious organizations, like Hindu, Sikh and Muslim—

Mr. Arif Virani: Could we allow Ms. Daws to answer the question, please?

Dr. Tanja Daws: I have a very different viewpoint.

In my experience as a MAID provider, especially for people with disabilities and even advanced illnesses, such as multiple sclerosis, the entire treatment team had been obstructing patients' access to care, and actually inducing traumatic stress in those patients and their families with their personal views that patients should keep on trying when they have really reached the end of the line, after years or decades of illness.

My patients with disabilities who qualify for MAID under Bill C-14 have told me multiple times that they abandoned health care because their practitioners continued to force upon them the concepts of continuing to struggle when they were done.

We found that, initially, providers of health care, including family physicians and specialists, would abandon patient care. That stopped after provincial regulations from colleges made it clear that this was not okay. We now actually find that patients abandon their health care workers and vote with their feet, and actually compromise their disability care and their palliative care. As MAID providers, we then pick that up, and work on that from scratch before we even start to make progress.

There are other unintended outcomes when people who think they're doing the right thing to protect their patient actually take it too far, and there are always two sides to a coin.

The Chair: Thank you very much, Dr. Daws, and thank you, Mr. Virani.

I'd like to address what you had noted earlier. I obviously wanted to ensure that our committee welcomes all witnesses. No matter how much we disagree on opinions, etc., we want to engage in a respectful and collaborative dialogue as we endeavour to make life-changing decisions for Canadians. Thank you all for fulfilling that respectful dialogue. I really appreciate that.

[*Translation*]

Mr. Thériault, you have six minutes. Go ahead.

Mr. Luc Thériault: Thank you, Madam Chair.

Allow me to repeat what you said. We aren't making life or death decisions for patients who are suffering. It is them—and only them—who will make those decisions. All we are doing is empowering them to make a choice. They have had no choice given that, for the past 50 years, accessing palliative care has been held up as the only way to die with dignity, as though receiving palliative care represented the full experience of what it is to die with dignity.

We aren't deciding for patients, on the contrary. The bill seeks to set aside medical paternalism so that patients can decide with freedom of conscience, and provide free and informed consent.

Dr. L'Espérance, you said your organization wanted the bill to go a bit further with respect to cognitive and neurodegenerative diseases. Can you tell us why? Can you describe what those diseases are and how they should be included in the bill?

Dr. Georges L'Espérance: I will answer very quickly.

In the past year in Quebec, 76% of patients who received medical assistance in dying had cancer. Cognitive and neurodegenerative diseases such as Alzheimer's are now the second leading reason why people seek medically assisted deaths.

Why should the bill include the diseases? The reason is that more and more people are going to contract them. As you know, after the age of 60, the older a person is, the more at risk they are. As people age, the more common cognitive and neurodegenerative diseases become.

When patients reach the later stages of disease, which, for Alzheimer's, generally coincides with stage four, they are no longer really capable of making their own decisions. Patients in stage four and beyond spend the last two or three years of their lives living without dignity—at least, in the estimation they held when they were capable.

In Quebec, a committee studied the issue of advance medical directives and released its report in late January. Except from a religious standpoint, a broad consensus exists over the ability to obtain medical assistance in dying through advance medical directives. It is up to the person to decide when they would receive medical assistance in dying. They might decide that it is when they no longer recognize their children, for instance. The person decides on their own beforehand, of course, in the presence of witnesses.

That is a very short answer to a complex question.

● (1255)

Mr. Luc Thériault: Do you think advanced requests should be allowed because these types of diseases follow a predictable course?

Dr. Georges L'Espérance: In the case of Alzheimer's, we know that, once a patient receives their initial diagnosis—say, at stage two—they die within eight to 10 years. Patients who do not die from the disease directly tend to die from complications such as pneumonia, sores and undernutrition. Once a patient reaches stage four, statistics show that their life expectancy is usually three to five years. Obviously, it varies, but that is the average. That's what the literature and clinical practice has taught us.

Mr. Luc Thériault: In other words, the whole problem lies in the fact that the advance request has to be pursued at the right time and a tremendous number of precautions must be taken. For example, it's important to take the time to explain things clearly to the patient, so they fully understand that they will no longer be able to give their consent afterwards.

Dr. Georges L'Espérance: Precisely. A whole mechanism is in place to ensure the process is followed rigorously. That is what the majority of those in the very elderly population want, however, because they do not want to see themselves go downhill cognitively. I think that is entirely reasonable and valid.

Mr. Luc Thériault: I see.

Dr. Coelho, I think it's a very good thing for a doctor to care about their patients and want to do right by them.

When patients are suicidal, the condition can be reversed. Patients who receive proper treatment will no longer be suicidal. Why would a suicidal patient request medical assistance in dying if being suicidal is a reversible condition? Would that happen in a case where you weren't able to provide the patient with the proper care?

Suicide has been decriminalized in Canada. Why? Being suicidal is a reversible condition.

When patients request medical assistance in dying, their condition is irreversible and their pain is intolerable.

[*English*]

The Chair: My sincerest apologies, Monsieur Thériault, but you hit that six-minute mark with the end of your question. Perhaps the witnesses can answer your question in other formats.

Before we go to Mr. Garrison, may I have the consent of the committee to continue past the one o'clock mark, at least to get through Mr. Garrison's question time?

Some hon. members: Agreed.

The Chair: Thank you.

Mr. Garrison, please go ahead for six minutes.

Mr. Randall Garrison: Thank you very much, Madam Chair.

I want to direct my question to Dr. Daws, but first I want to thank her, along with a number of other MAID practitioners who shared precious time with me in getting me to understand the reality of dealing with patients who are facing end-of-life issues or other related, but also serious, medical conditions.

Dr. Daws, you're one of the few witnesses we'll probably have before us who are practitioners working in rural and remote communities. Could you talk to us a little bit about the challenges of providing medical assistance in dying in those situations? In particular, what would be the impact of denial of referrals in rural and remote areas?

● (1300)

Dr. Tanja Daws: I can say, from four years of experience, that it is much more difficult in rural areas, because there are limited alternatives for patients. In simple terms of travel for sick people, using two ferries just to come to Vancouver Island would be a challenge. They might have just one physician on the small remote island, or a physician who might fly in and fly out every two weeks.

It has caused difficulty in the past to get witnesses. That's why we are eternally grateful for the amendments proposed in Bill C-7. It has been difficult for patients with disabilities and with end of life, even from cancer, to get adequate supports, although the work that has been done for that has always been exemplary and commendable. We always feel that as MAID providers we have added another layer of that into it and actually enhanced the reach of palliative care and disability support, and not just done MAID work.

In terms of concerns, it is harder for patients to get alternatives if they feel that they are being blocked or are not receiving information or access, and that has led to significant delays and stress to families. We've also seen that people who did not know about the alternatives often actually had suicide plans in place, and the moment they learned of all the supports....

We actually have a MAID consultation and those things are brought forward. We play devil's advocate to really make sure those things have been adequately addressed and provided, and the suicide plans disappear. Those people may actually end up having natural deaths and not MAID, because they were kept comfortable and had good care and it enhanced their quality of life. However, those who did have MAID had good access, because we made it work.

Mr. Randall Garrison: Thank you, Dr. Daws.

Can you make a comment on the concept of transient suicidal thoughts that some people are introducing in this debate? Do you find that's a real factor in those facing end of life?

Dr. Tanja Daws: We know from our experience that patients are not sick for just a week. They learn that they have cancer for months or years. People with disabilities have told me that they are often insulted by the thought that they have made sudden and urgent decisions after having lived brave and courageous lives dealing with those disabilities. In most cases, they are very well aware of their own vulnerability and they do not take it lightly that other people speak for them. They have told me, “Tell them that I am the real disabled, but I am being trampled on by this pretend concern for my own ability to be autonomous.”

Mr. Randall Garrison: Thank you.

I probably have one minute left here.

The Chair: Yes.

Mr. Randall Garrison: Can we give that to Senator Cowan to make any final comments, if he can deal with his technical challenges?

The Chair: Senator Cowan, go ahead, sir.

Hon. James S. Cowan: Thank you very much for the opportunity, Madam Chair and Mr. Garrison. Sorry for the technical difficulties.

Perhaps I could just conclude on a couple of points.

Dying with Dignity Canada is concerned about the express exclusion from Bill C-7 of those with mental illness and believes this exclusion to be stigmatizing, discriminatory and likely unconstitutional.

It's worth recalling the words of Justice Baudouin in the Truchon decision. She said:

> The vulnerability of a person requesting medical assistance in dying must be assessed exclusively on a case-by-case basis, according to the characteristics of the person and not based on a reference group of so-called “vulnerable persons”.

She went on to say that “the patient’s ability to understand and to consent is ultimately the decisive factor, in addition to the other legal criteria”.

I have one other point, if I may. We strongly believe that the five-year parliamentary review of the MAID legislation and the state of palliative care in Canada, which was scheduled to begin in June 2020, should commence as quickly as possible following the disposition of Bill C-7. More specifically, we expect that the three areas identified for further study in Bill C-14 and addressed in the Council of Canadian Academies report, namely advance requests, mental illness and mature minors, will be considered during that review.

From our perspective, the most pressing of those three areas is the area of advance requests, something that 85% of Canadians support, as confirmed both by our own research and by the government’s consultation. Today, over half a million Canadians live with dementia, and there's no place for them in our current legislation.

● (1305)

The Chair: Thank you very much for that, Senator Cowan.

Thank you, Mr. Garrison, for allowing Senator Cowan to finish his remarks. That really helps me out a lot, and I really appreciate it.

With that, and understanding the time limitations as well, I would like to thank our witnesses for their time today and for their testimony. If you feel there are things you were not able to clarify or further things that you are able to address based on the questions you have been asked, please send in written submissions to the clerk so that we can further include your expertise on the subject matter.

Thank you very much.

We're confirmed to meet on November 5 from 11 a.m. to 1 p.m. The committee will also meet next week, on November 10 and November 12 from 11:00 to 1:00 to complete our hearings on Bill C-7.

I'll confirm with—

Hon. Rob Moore: I have a point of order.

The Chair: Mr. Moore, please go ahead.

Hon. Rob Moore: Isn't it presumptuous to say the committee will meet next week? Next week is not a sitting week, and we've had no discussion on that.

The Chair: My understanding, Mr. Moore, was that we discussed this during our steering committee meeting, and we agreed that we would be able to sit during break week.

I'm not sure if that now is not agreeable to you. Can you please clarify that for me?

Hon. Rob Moore: Not with me, no. We spoke earlier that we would have our six meetings. At the last discussion we had on this as a whole committee, we didn't speak about meeting over the break week. It would be the two weeks following: two meetings this week and two each on the weeks following the break week. When we last discussed this as a whole committee, I don't recall about meeting on the break week. I'd have to talk to my colleagues about their availability.

The Chair: That's absolutely fair, Mr. Moore. Perhaps the most expedient way to move past this is to present a motion to see if we can meet during the break week.

Do I have any members who would like to do that?

Mr. Garrison, please go ahead.

Mr. Randall Garrison: Thanks, Madam Chair.

I would like to move that we continue to sit at the proposed times during the non-sitting week.

The Chair: I don't see any hands raised to speak to this, so I'll ask the clerk to record the vote on the two upcoming meetings.

Thank you.

The Clerk of the Committee (Mr. Marc-Olivier Girard): Before I do so, Madam Chair, Ms. Findlay had her hand raised.

The Chair: Ms. Findlay, please go ahead. I'm sorry, I don't see the blue hand.

Hon. Kerry-Lynne Findlay: I'm sorry; I don't know how to raise my hand when I'm in person.

This has taken me totally by surprise. I am away for a good part of the break week, and I had not heard any discussion whatsoever about us meeting during the break week. I think it's a lot to presume, quite frankly, when we have duties in our constituencies. I thought in whole committee we had come to a consensus decision on the number of meetings we would have and when they would happen. There was no discussion about break week. My availability to do that would be very limited.

● (1310)

The Chair: Thank you very much for your intervention, Ms. Findlay.

I see Mr. Lewis.

Mr. Chris Lewis: Thank you, Madam Chair.

It looks as though the goal posts just continue to be moved all the time. It seems like a lot of last minute on this committee. At the end of the day, we, as MPs, have very tight schedules. I'm spending a lot of time throughout my riding. To continue to throw lob balls out here to have meetings on break week when it's our only opportunity to be with our constituents—safely, of course—is, I think, disrespectful and absurd.

Yes, it's important legislation to be discussed, but I will not be voting in favour of this.

The Chair: Thank you, Mr. Lewis.

Go ahead, Mr. Moore.

Hon. Rob Moore: I think we have to schedule time to have discussion of this type of thing. This is the first I'm hearing about it that I can recall.

There's a reason it's called constituency week. We do our parliamentary work, our committee work, three weeks in the month, and then the following week is a designated constituency week, meaning that committees don't meet. We do not have any real reason to accelerate the study on this bill. We're well within the time frame that the government wanted to deal with it.

I'm certainly not available to meet next week. It's a constituency week, so, like most of you, I would think that we all have a busy schedule for Remembrance Week in our constituencies.

The Chair: Thanks for your intervention, Mr. Moore.

Mr. Garrison, you're up next.

Mr. Randall Garrison: Thank you very much, Madam Chair.

I do believe that, in the steering committee, we did discuss meeting during the non-sitting week. In discussions among the whips, because of the limited resources available to the House of Commons, there was constant discussion that committee time would be made available during non-sitting weeks.

I, too, have a very busy schedule, but I think we have very important work before us—not just this bill and others—and that's why I've moved the motion. I'm sorry if the word didn't get from the steering committee to all members of the committee. It's easier for me to remind other New Democrats on the committee than it is, maybe, for others, but I believe we should go ahead and, if people cannot make it, their parties should provide substitutes.

Thank you.

The Chair: Thanks for that, Mr. Garrison.

Are there any other hands raised at this time? Mr. Clerk, is there anybody from the floor who would like to...?

Mr. Maloney, did you just wave at the camera?

Mr. James Maloney (Etobicoke—Lakeshore, Lib.): Thanks, Chair.

Everybody understands the importance of this bill. Everybody appreciates the significance of getting it done. It's not the government's timeline; it's the court's timeline, Mr. Moore. We've been talking about the time frame in which this needs to be done since we started meeting a few weeks ago, so this is no surprise to anybody.

I wasn't on the subcommittee, but it was my understanding that we would be sitting during the break week. We all have very precious time during the break week—and yes, it is Remembrance Week—but we're not talking about giving up the whole week; we're talking about giving up two hours on two separate days to do something that is critically important.

As tight as the time frame is, if we don't sit during the break week, there's a chance we could run up against the deadline, and we don't want to be put in a position where we have to rush this unnecessarily, which is the concern you have all expressed.

I think we should vote on this right now, Madam Chair, and move on.

The Chair: Thank you, Mr. Maloney.

Mr. Moore, is that your hand raised again?

Hon. Rob Moore: Yes, absolutely, because I don't accept any argument, especially from Liberal members, about any timeline whatsoever, when it was the Liberal government that prorogued the House.

I don't know if we need a refresher on what proroguing means, but proroguing means that all House business shuts down. Every bill starts over at zero. That's what it means to prorogue the House. This government did that, so we don't need to hear any arguments about the delay or any court-mandated timelines that are approaching.

When I look at our schedule, we're on track to meet that timeline. This isn't about anything other than the fact that next week is a constituency week, and I haven't heard one compelling reason we would all adjust our schedules, assuming people have a busy schedule next week, to have these meetings, when we're scheduled to meet the Tuesday and the Thursday when we return and then go into clause-by-clause.

No one has made any compelling argument why we would meet during a constituency week. I think we should adjourn this meeting and meet at our next scheduled time, which is the Tuesday of the next sitting week.

● (1315)

The Chair: Thank you, Mr. Moore.

I will clarify that we discussed at length in our steering committee the timelines, the deadlines and how we were going to meet, the technological challenges we have with respect to our meetings and the scheduling of our meetings over the next couple of weeks and months, to ensure that we are on track and that we are on schedule.

At this time, I believe we have Mr. Garrison's motion on the floor with respect to whether we should be meeting over the break week.

Mr. Clerk, if I can please call—

Mr. Chris Lewis: I have a point of order, Madam Chair.

Obviously, I wasn't on the subcommittee, but could we not go back through the minutes of the subcommittee to find out exactly what was said? Certainly the clerks can tell this committee what was discussed and talked about with regard to sitting during break week.

The Chair: I understand that, Mr. Lewis, and my understanding is also that you had a representative who was there at the subcommittee, who would have briefed your party, as well as all of you, on what was said and discussed during the steering committee.

I believe Mr. Cooper has his hand raised.

Would you like to speak to this, Mr. Cooper?

Mr. Michael Cooper: Thank you, Madam Chair.

I don't believe there was any clear consensus on sitting during a constituency week. I believe the clerk was to come back with a proposed schedule that was to be voted on by the committee as a whole, and that didn't happen.

Nonetheless, we have Mr. Garrison's motion before us, so in that sense we're doing that.

The Chair: Thank you, Mr. Cooper.

In that case, we will call the vote for Mr. Garrison's motion.

(Motion agreed to: yeas 8; nays 3)

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

We will go ahead and have our two meetings on November 10 and November 12 from 11 a.m. to 1 p.m. to complete the hearings on Bill C-7. We do have two meetings for November 17 and November 19 for clause-by-clause. I propose that the deadline for submitting amendments to Bill C-7 would be Friday, November 13 at 4 p.m.

Is that agreeable to everybody?

Mr. Ramesh Sangha: Yes, it's agreeable.

The Chair: Can I have confirmation from everybody that you have understood what the next couple of weeks will look like, so we don't run into a similar issue going forward, when we have discussed something and then we forget we have agreed to something. I confirm November 17 and November 19, which is the Tuesday and Thursday, for clause-by-clause, and Friday, November 13 by 4 p.m. for any amendments you would like to submit.

Is that okay with everyone?

I see Mr. Garrison's thumbs-up. I see Mr. Maloney's thumbs-up, and Mr. Kelloway, Mr. Virani, Mr. Scarpaleggia and Mr. Sangha. Can I please have some acknowledgement from Mr. Lewis, Mr. Moore, Mr. Cooper and Ms. Findlay?

Mr. Lewis, I see your thumbs-up. Thank you.

Mr. Moore.

● (1320)

Hon. Rob Moore: I already had my thumb up.

The Chair: I'm sorry. I didn't see it there. My apologies.

Mr. Clerk, can you confirm for me with the members in the room if they are in agreement with these timelines?

The Clerk: Both of them gave their thumbs-up.

The Chair: Perfect. Thank you very much for that, Mr. Clerk.

I appreciate the wonderful meeting, everybody.

At this time, the meeting stands adjourned until we meet again.

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