HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

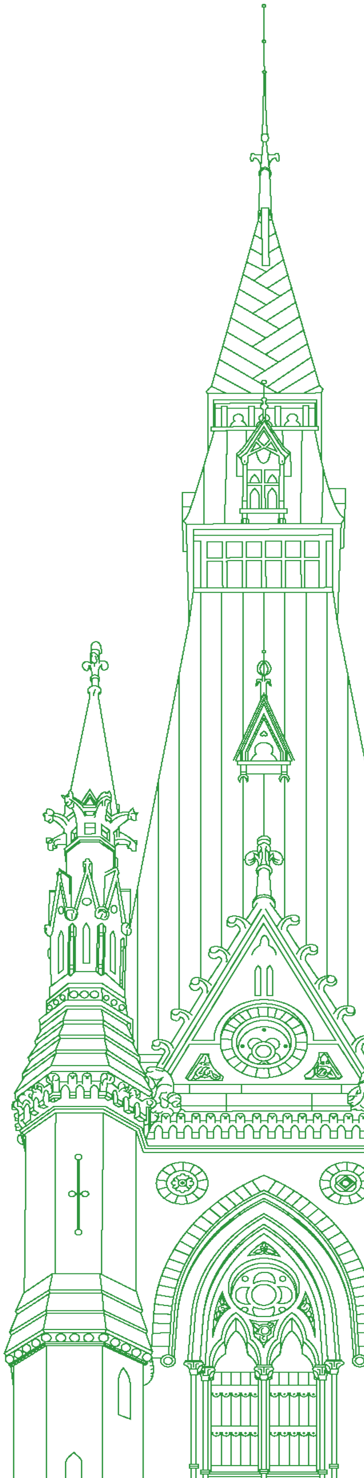
43rd PARLIAMENT, 2nd SESSION

Standing Committee on Justice and Human Rights

EVIDENCE

NUMBER 006

Tuesday, November 10, 2020



Chair: Ms. Iqra Khalid

Standing Committee on Justice and Human Rights

Tuesday, November 10, 2020

● (1100)

[*English*]

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

Today's meeting is taking place in a hybrid format, pursuant to the House order of September 23, 2020. The webcast, just for members appearing virtually, will show only the person speaking, rather than the entirety of the committee.

There are a few rules to follow. Members and witnesses, you may speak in your official language. Please ensure that at the bottom of your screen, you select the interpretation for the language you would like to hear.

Before speaking, please wait until I recognize you by name. Please click on the microphone icon to unmute yourself. For those in the room, your microphone will be controlled as usual during the proceedings, as we've done in the past. When speaking, please speak slowly and clearly. When you are not speaking, please ensure that your microphone is on mute.

With regard to the speaking list, the committee clerk and I will do the best we can to maintain a consolidated order of speaking for all members, whether they are participating virtually or in person. You will see that I have a one-minute card and a 30-second card for members and witnesses to let you know how much time you have remaining when it comes to the rounds of questions.

At this time, and I know this issue has been raised at past meetings, I will remind members of routine motions that we've passed in our previous meetings. I will read this out.

With regard to timing for opening remarks and questioning of witnesses:

> That witnesses be given five to seven and a half minutes, at the discretion of the Chair, to make their opening statement; and that, at the discretion of the Chair, during the questioning of witnesses in the first round there be allocated six minutes for the first questioner of each party as follows: Conservative Party, Liberal Party, Bloc Québécois, New Democratic Party; that for the second and subsequent rounds the order and time for questioning be as follows: Conservative Party, five minutes, Liberal Party, five minutes, Bloc Québécois, two and a half minutes, New Democratic Party, two and a half minutes, Conservative Party, five minutes, Liberal Party, five minutes.

I thank you for allowing me the discretion to Chair this meeting in an equitable fashion, and I hope we can continue that. I raise this because of the challenges we've had in the past with respect to rounds of questioning and timing, but more importantly, because one of the witnesses today has asked for accommodation to be allowed for extra time to speak where we normally give five minutes for witnesses. Using my discretion, I will be allowing Mr. Foley seven and a half minutes to be able to complete his remarks in the first round.

With that, I would like to welcome our witnesses. Appearing as an individual is Julie Campbell, who is a nurse practitioner for the provincial care coordination service. We have Mr. Roger Foley, who is accompanied by his lawyer, Ken Berger. We also have the Association for Reformed Political Action Canada. Appearing on their behalf is John Sikkema, who is legal counsel, and André Schutten, who is legal counsel and director of law and policy. We also have Inclusion Canada. Their representative is Krista Carr, who is the executive vice-president.

Thank you all for being here today. We'll go right into questioning. We will start with the first person on my list, Julie Campbell.

Ms. Campbell, you have five minutes for your remarks. Thank you very much. The floor is yours.

● (1105)

Ms. Julie Campbell (Nurse Practitioner, Provincial Care Coordination Service, As an Individual): Thank you, Madam Chair, and good morning, everyone.

I am Julie Campbell. I speak today as a MAID assessor and provider, and also from my experience coordinating, navigating and providing leadership in this area. I want to commend this government on the thoughtful investigation that's been undertaken to understand this work and, most importantly, our patients. I am also very pleased with how inclusive ministers have been in their language in recognizing the important work of both nurse practitioners and physicians.

Each month I speak to more than 140 new patients and families and present to community groups. By far the top concerns expressed to me are the lack of advance consent and the 10-day reflection period, so I am grateful to see these addressed. I am also grateful for the changes around witnessing requests. Patients requesting MAID should be afforded the same privacy rights as patients for any other medical procedure. Allowing care providers to sign is a positive step for this confidentiality. A specific statement allowing virtual witnessing would be beneficial.

I do this work, as do most of my colleagues, because we can make a difference in reducing suffering for patients who feel this is the right personal choice for them given their circumstances, their values and their experiences. I want to share with you a few key reflections that I feel are important for the implementation of this legislation at the front line.

Patients in rural areas may benefit most from the option of oral self-administered MAID. This is because patients can be assessed virtually, and our knowledge of this and its safety has been tested during this pandemic. For one particular patient who received oral self-administered MAID in a remote community, their prescriber was a significant distance away. They were monitored by local physicians and nurses who maintained communication with the prescriber. This supports the conscience rights of clinicians and supports patients to receive access in remote areas. I believe Bill C-7 should be amended to require the presence of a regulated health care professional authorized to pronounce death, rather than limiting the physical presence to the prescriber.

In the area of Ontario where I most frequently work, I calculated the number of unique providers of MAID in the past 12 months. I counted 49. However, 12 of the 49 assessors completed 84% of the 307 MAID provisions that year. The majority of MAID work is done by a small number of providers who have garnered expertise in this work through their experience. This highlights how we need to continue the current practice of careful, thoughtful patient-centred assessments, where an assessor reaches out to colleagues with various expertise when they feel that's needed. Should the wording require the same person to have expertise in the condition and have expertise in MAID eligibility assessment, some of our most complex patients will surely not have access due to the complexity of their condition or the number of qualified assessors in their area. This causes delays and enduring suffering where consultation, when needed, could maintain safeguards without compromising equity of access.

It is imperative that the wording defining “grievous and irremediable medical condition” be left without amendment, as these criteria are understood among MAID assessors. This would maintain that the suffering could be related to either the illness, disease or disability or the advanced state of decline and need not be related to both.

I would also like to ensure that Bill C-7 provides the same safeguards and supports for patients with respect to advance consent. This would allow an authorized alternative signer to make the written advance consent at the direction of the patient when the patient is unable to sign and date for themselves.

Lastly, I would be remiss if I did not mention that at the heart of implementing this federal legislation is collaboration with provincial governments. Inequities of access for patients exist regionally, provincially and nationally due to these differences. Examples include coverage for oral secobarbital, scope-of-practice limitations that are either provincially or employer-based, support for travel to remote areas, and remuneration for nurse practitioners. The law will only provide Canadian patients choice if it can be implemented.

I appreciate your time and I thank you for your hard work.

● (1110)

The Chair: Thank you very much, Ms. Campbell. That is much appreciated.

We'll now go to you, Mr. Foley. As per my discretion, you have seven and a half minutes to give us your remarks.

Go ahead, Mr. Foley.

Mr. Roger Foley (As an Individual): My name is Roger Foley. I'm 45 years old. I was born with spinocerebellar ataxia, which is a severe neurodegenerative disease.

Despite my disabilities, I achieved two degrees at Carleton University, in economics and history. I was a caregiver for my father, who had cancer, heart troubles and kidney problems. I helped him live eight years beyond his original diagnosis. He was a front-line Canadian World War II veteran. I worked at the Royal Bank of Canada as their e-business manager and was awarded several RBC top performer awards. I was independent and active in the community and in sports, and as a musician and a writer.

Unfortunately, my disabilities got worse over time and now I have become totally dependent. I can no longer walk, have very limited ability to move and great difficulty even swallowing. I need help with everything, including bowel movements, bathing and medications. I have invested a lot of time and money into making my apartment accessible, but the health care system denied direct funding home care to have the personal attendants I need to remain living in my own home.

With the assisted dying regime in Canada, I have experienced the lack of care and assistance I need to live. I have been denied food and water. I have not been assisted to transfer, take my medications and go to the bathroom. I have been abused and berated because I have disabilities and told my care needs are too much work. My life has been devalued.

I have been coerced into assisted death by abuse, neglect, lack of care and threats. For example, at a time when I was advocating for assistance to live and for self-directed home care, the hospital ethicist and nurses were trying to coerce me into an assisted death by threatening to charge me $1,800 per day or force-discharge me without the care I needed to live. I felt pressured by these staff raising assisted dying rather than relieving my suffering with dignified and compassionate care.

Hospital staff failed to provide me with the necessities of life. I was starved and denied water for up to 20 days. I became severely acidotic. An expert who reviewed the case concluded a failure to provide necessities of life and gross negligence.

Facing these ongoing attacks, I started researching how and why this was happening in Canada. I found out the entire assisted dying regime is all based on false propaganda, bias, conflicts of interest, blindness, a complete abdication of the health and legal systems and the law failing to protect me. Judges who were completely biased and had conflicts of interest decided the assisted dying cases. They were supposed to be fair and impartial, but instead let our country down and failed to protect our most vulnerable.

What is happening to vulnerable persons in Canada is so wrong. Assisted dying is easier to access than safe and appropriate disability supports to live. Committee members, you cannot let this happen to me and others. You have turned your backs on the disabled and elderly Canadians. You or your family and friends will all be in my shoes one day. You cannot let this sliding regime continue.

The Truchon decision is an illegitimate decision made by a biased and compromised judge. Christine Baudouin made her decision because her father's works were used as evidence by the plaintiff's lawyer. She should have recused herself and declared her conflicts of interest. The same issues of bias, conflict of interest and misleading Canadians about assisted dying happened in Carter, during the Lamb case and with the Audrey Parker situation.

The grave mistakes by our legal and health care systems and the failure to protect our most vulnerable need to end.

I read an email from Jean Truchon prior to his death revealing all he needed was 70 hours of home care per week to live. Instead, he was wrongfully assisted to die by your health and legal systems.

● (1115)

I made complaints to the United Nations. The special rapporteur completed a country visit. Her report is very critical. She is extremely concerned about people with disabilities being asked to consider assisted dying.

I made a complaint to the special rapporteur on the independence of judges about the lack of independence and impartiality of our courts as related to assisted dying. I also plan to assist with the motion to retract Truchon in Quebec, as I do not believe the judgment is legitimate, and it puts all persons with disabilities in grave danger.

You are all highly intelligent individuals dedicated to public service. You are not so gullible, are you? Are you persuaded by propaganda, misinformation and a lack of objectivity by decision-makers? Your constituents expect you to scrutinize what has actually happened with the sliding practices of assisted dying and what you need to do to protect all citizens. Please move away from the dogma and see things how they really are.

Do you want to help vulnerable people who want to give back to society and be a part of our community, like heroes such as Terry Fox, or do you just want to be misled and have blood on your hands? My blood will be on your hands if you allow the illegitimate Truchon decision to tear down our laws. I will not survive, and there will be thousands of wrongful deaths.

Help Canada to be the country it should be and not what it is currently sliding toward.

Thank you for your time.

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

We will now move on to the Association for Reformed Political Action Canada.

You have five minutes. Please go ahead.

Mr. John Sikkema (Legal Counsel, Association for Reformed Political Action Canada): Thank you. I'm glad I could be here.

Just a few days ago, my wife gave birth to our daughter. During her pretty long labour, doctors presented her with different options that were new to me—misoprostol or oxytocin—to move things along. They needed to move things along faster: an epidural, forceps or vacuum. Also, a C-section was discussed at one point. In our vulnerable state, we trusted that the options the doctors presented were good options. We also wanted to know what the doctor thought was the best option and, frankly, we went with that every time.

Medical assistance in dying—or assisted suicide, or consensual homicide, or whatever you want to call it—is not health care. At least, it is fundamentally distinct from any other medical service. Advising somebody to have a C-section or chemotherapy or pain medication is not a crime, but encouraging or inducing someone to end their life is a crime.

If MAID were simply another health care service, we wouldn't be here today discussing substantial amendments to the Criminal Code. Medical services are not regulated by the Criminal Code. We are wrestling here with when we as a society will permit some people to kill others. That's why this is before Parliament.

The fundamental problem with this bill, as we see it, is that it fails to take this seriously enough. It's almost flippant in its treatment of the—

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): I'm sorry, Madam Chair, but the interpreters are unable to translate Mr. Sikkema's comments because he is speaking too quickly. You don't seem to have been informed of the problem.

I apologize to Mr. Sikkema, but I think we should be able to properly hear witnesses' statements for the sake of fairness.

[*English*]

The Chair: Thank you.

Mr. Sikkema, could you please slow down a bit in your remarks? I've stopped the time, so you won't get penalized on this.

Could you also move your microphone just a bit between your nose and your mouth so that we don't hear that popping sound? Do you want to give it a go? Thank you. Go ahead.

● (1120)

Mr. John Sikkema: My apologies to the translators.

Our current law, as amended by Bill C-14, is already interpreted to allow doctors to euthanize patients who have a decade or more of life ahead. Our current law already fails to prevent doctors from suggesting MAID without being asked, or at least listing it as an option, which can send a powerful message to the sick and disabled that someone thinks their life isn't worth living.

Bill C-7 not only fails to address those problems, as identified by the United Nations special rapporteur, among others, but it makes them worse. If Bill C-7 passes, it will be possible for a person with a serious illness to go to their doctor's office, have their doctor suggest MAID as an option for them, have the doctor's secretary pop in to witness a written request and then be killed as soon as the second opinion is acquired. Of course the doctor would have to mention other options, but that's just the basic rule of informed consent.

That's the fast and easy track. The slow track isn't much better. For those in the ambiguous category of not reasonably foreseeable death, Bill C-7 says that other options should be discussed and consultations offered, which isn't much, and one would think that such basic steps should already be there for the fast-track cases.

As for the 90-day waiting period, palliative care physicians have already pointed out that it's inadequate because it often takes longer to help people manage their symptoms and to find satisfactory treatments, and so on. We share that concern. We would also point out that the 90-day waiting period is itself ambiguous given that it begins, not on the day a written request is signed and dated, as with the 10-day waiting period that would be cut, but on the day the doctor begins to assess a patient's eligibility, which could be months earlier.

Many people seem to think further expansion of euthanasia is inevitable. This is not true. The Carter decision was very limited in scope, as the court stated at the beginning and end of its decision. This is about Ms. Taylor and persons in her position. She was near death with a known fatal illness and the court said, “We make no pronouncement on other situations where physician-assisted dying may be sought”, at the end of its judgment. It bookended its judgment with those things.

The lone judge who decided Truchon failed to appreciate this and failed to recognize Parliament's objectives in limiting MAID to the end-of-life context. It is the responsibility of Parliament and this committee to listen to the concerns of all parties, including disability rights advocates, palliative care physicians and others; to be clear about its objectives; to defend them against a particular judge; and to enact more responsible policies.

Thank you very much.

The Chair: Thank you very much, Mr. Sikkema. If you could please send us your written submissions or your speaking notes, it would be helpful for members. Thank you for that.

We'll now move on to Inclusion Canada, Ms. Carr, who is the executive vice-president.

Please go ahead, Ms. Carr. You have five minutes.

Ms. Krista Carr (Executive Vice President, Inclusion Canada): Good morning.

I'm Krista Carr, executive vice-president of Inclusion Canada, formerly the Canadian Association for Community Living, Canada's national organization for people with intellectual disabilities and their families.

Inclusion Canada has advocated for safeguards in MAID since we intervened in the Carter case. Our biggest fear has always been that having a disability would become an acceptable reason for state-provided suicide. Bill C-7 is our worst nightmare.

Inclusion Canada stands united with all national disabled persons organizations in calling for MAID to be restricted to the end of life. The disability community is appalled that Bill C-7 would allow people with a disability to have their lives ended when they are suffering but not dying. This is not how we respond to the suffering of any other group of Canadians, much less any other charter-protected group.

We're told that this abrupt pace of passage through Parliament has been set by the Superior Court of Québec, yet amending the Criminal Code to satisfy a superior court decision appears unprecedented. We're told Canadians want this, yet every national disability organization is opposed.

If Canadians supported assisted suicide for being indigenous or a member of the LGBTQ2S+ citizens, for example, who are suffering as a result of being indigenous or because of their gender identity, we would not be here today. Canadians recognize that suicide is more prevalent amongst those who experience systemic racism or societal devaluation. Thus, prevention is a necessity, and every life lost is a tragedy. Why is it not just as great a tragedy for an indigenous person with a disability or someone with any other identity who has a disability? I hope you will hear from indigenous organizations as part of this committee.

The human rights of a charter-protected group must never be a matter of public opinion. Equating assisted suicide to an equality right is a moral affront.

There are three points I'd like to cover.

First, why us? As no other charter-protected Canadian life is being put at risk by this bill, there is only one answer to this question: that the lives of Canadians with disabilities are not of equal value. Language and perceptions are powerful. Including disability as a condition warranting assisted suicide equates to declaring some lives as not worth living, a historically horrific premise with consequences that should terrify us all, and that clearly terrify the disability community and their families.

Second, people with an intellectual disability and their families are in a constant struggle for inclusion, a universal human right not yet realized in Canada. When people with intellectual disabilities suffer because of their pervasive exclusion and marginalization, families now fear that their family members will be encouraged to end their lives. Rather than addressing their suffering, as we do for every other Canadian who tries to end their suffering through suicide, their lives are now judged as not worth saving.

To be clear, inclusive life remains elusive for the majority of adults with intellectual disabilities. There is no right to adequate supports in Canada. Seventy-five per cent of adults with an intellectual disability are unemployed. They are four times more likely to be living in poverty, and four times more likely to experience violence. Also, a staggering amount of people with an intellectual disability remain housed in institutions and long-term care facilities.

Canada is failing its commitments under the UNCRPD to uphold the rights and inherent dignity of all people with disabilities. Persons with disabilities in Canada suffer an inadequate patchwork of supports, with extensive wait-lists for services. A state-sanctioned death is not the solution.

Third, and lastly, until now, MAID has been restricted to end of life. The end-of-life requirement was the only safeguard whereby disability was not the sole criterion. By having a disability itself under Bill C-7 as the justification for the termination of life, the very essence of the Charter of Rights and Freedoms would be shattered. Discrimination on the basis of disability would once again be entrenched in Canadian law.

People with disabilities have been historically devalued and marginalized in Canada, and that remains to be sufficiently remedied. Bill C-7 further devalues the lives of people with disabilities and fundamentally changes MAID from physician-assisted dying near the end of life to physician-assisted suicide on the basis of disability. The lives of people with disabilities are as necessary to the integrity of the human family as any other dimension of humanity, and this threat to the lives of people with disabilities is a threat to us all.

● (1125)

We urge the committee to seek an amendment to MAID to sustain MAID as available only to those who are dying and unequivocally restrict anyone with a disability from having their life ended unless their natural death is imminent.

Thank you.

The Chair: Thanks very much for that, Ms. Carr.

Thank you to the witnesses.

We'll now move on to our first round of questions. The first round of questions will be six minutes each.

Mr. Moore, please go ahead. You have six minutes, and your time is starting now.

Hon. Rob Moore (Fundy Royal, CPC): Thank you, Madam Chair.

Thank you to all of our witnesses. You all bring something different to this discussion, and I really appreciate your very informed presentations.

It concerns me, when we're dealing with something that's literally life-or-death, the dramatically reduced time in which we're dealing with this important issue. We're only taking four days of meetings to discuss this. Parties are only going to have about one round of questions to ask you important questions. When I hear Inclusion Canada, an organization that works with those in the persons with disabilities community from coast to coast, describe this as a “worst nightmare”, I really, truly believe that we need to have more discussion on this. The government would have us believe that this is an open-and-shut case and that there is a great deal of unanimity among doctors.

I am going to ask my first question of Krista Carr, with Inclusion Canada.

There is a group called “Physicians Together for Vulnerable Canadians”. We received a letter from them, and I know your organization works deeply with vulnerable persons. It was signed by 800 medical doctors throughout our country, from every province. These are people who are working with people who are vulnerable.

I know the position of Inclusion Canada was that the court of appeal decision should have been appealed even to the Supreme Court. That happens to be the position as well of the Conservative Party, that this decision should have been appealed. However, this bill goes far beyond even responding to the Quebec decision.

My question for you, if you could answer it quickly, is this: Is Inclusion Canada of the opinion that this bill needs more review to analyze the impacts, even those we heard about today, on safeguards for the persons with disabilities community?

● (1130)

Ms. Krista Carr: Thanks, MP Moore.

Yes, we are of course of that opinion, and we feel very strongly that the only way to make this bill not discriminatory is to keep it to end of life. Anybody who is at end of life and is suffering intolerably has access.

When you open it up and make it based on the grounds of things like disability—this is already a very vulnerable population in our society today that experiences a tremendous amount of systemic ableism in the health care system already, and we've seen that pervasively throughout the COVID-19 pandemic in everything from triage protocols to deprioritizing their lives, and the list goes on—we're on a very dangerous slippery slope.

I think we have to stop, hit the pause button and really focus, particularly on a consultation with the disability community. We are speaking. We are trying to speak. We are united, but our voices are getting drowned out by people who do not experience the systemic marginalization, the poverty and the very difficult lack of support in life circumstances that people with disabilities experience, which leads them into situations where either MAID is promoted to them or they feel it is their only option.

Yet—

Hon. Rob Moore: Thank you for that.

That brings me to my next question, on the promotion or the choice that people are being dealt.

Mr. Foley, thank you so much for your testimony today. You certainly bring a perspective that we have not heard at this committee. I think we should hear more of your perspective, with the government expanding access to assisted dying in Canada. I heard the recordings you had, where a doctor was pressuring you into MAID and was saying that the per diem rate to stay at the hospital was $1,500 or so. You mentioned the contributions of persons with disabilities, including Terry Fox, and how much...even what you're doing today by bringing this, standing up for vulnerable people at this committee for this meeting.

Do you feel there should be greater protections in this legislation that we have before us for vulnerable Canadians so they're not pushed as you were towards medically assisted death?

Mr. Ken Berger (Lawyer, As an Individual): Mr. Moore, I'm going to answer that on behalf of Mr. Foley.

Absolutely, there need to be very robust protections here because people with disabilities can be easily exploited. They're subject to abuse and could be at high risk of being wrongfully assisted to die. The other issue is that with such individuals, the disabled, all they really need is good care and support, and 99.9% of the time their grievous and irremediable suffering will be gone. If you do that, you solve the problem. Then for the remaining 0.1%, where you can't relieve the suffering, let's take a look at this. This is a subjective conclusion based on the individual.

The Chair: Thank you, Mr. Berger. My apologies, but we're out of time for Mr. Moore. We're going to move on to Mr. Virani for six minutes.

Go ahead, Mr. Virani, your time starts now.

Mr. Arif Virani (Parkdale—High Park, Lib.): Thank you very much, and thank you to all of the witnesses for their important testimony today. I want to start with Ms. Campbell.

Ms. Campbell, we've heard today and at previous testimony about instances of influence or potential coercion. You are a nurse in the middle of the milieu. Can you tell me whether the appropriate step when such instances are raised is to raise a complaint with both the professional regulatory bodies and/or the police if such influence is being asserted so that it can be investigated? If that is the proper course, what is your knowledge of any complaints resulting in actual prosecutions against nurses or physicians?

If you're able to answer that, thank you.

● (1135)

Ms. Julie Campbell: The answer is no, there haven't been any such instances that I'm aware of move forward, and certainly there are those safeguards and steps in place for patients or families to raise those concerns. Those exist. I believe there's a very big difference in our language between saying that something is available and saying that someone then warrants or needs or should have a certain procedure just because it's available. That's very individual. The same goes for advising about alternatives, which is not the same as encouraging. I think they're very different in how we word those.

Mr. Arif Virani: In your experience, Ms. Campbell, is active encouragement and pressure being put upon individuals to pursue medical assistance in dying?

Ms. Julie Campbell: No, in fact what I find is that more people come and say, “I wish I knew that those were my options earlier. Nobody mentioned them it to me”. I think it's very important not to encourage anyone to pursue a particular option, but it's equally important that all patients know all of their options and get to decide for themselves which option is right for them.

Mr. Arif Virani: Turning to Ms. Carr, I respect the work that you do and all of the groups you represent in your interventions in previous court cases, etc. I'm just struck by the fact that when I look back at the Truchon decision, the two individuals in that case, Mr. Truchon and Madam Gladu, were themselves persons with disabilities. They themselves brought forward their claims to that judge in the Superior Court of Québec. I looked back at paragraph 681 to paragraph 690—it's a long decision—while you were testifying and found that the judge addressed head on the issue that you're raising, the equality rights of these individuals. You compared the rights of persons with disabilities with indigeneity or people who experience racism, etc. Those are important rights. This is an area I practised in prior to coming to Parliament.

What the court found is that, when you look at it from an equality rights analysis perspective, the section 7 and the section 15 rights of Mr. Truchon and Madam Gladu were in fact being violated by virtue of their inability to pursue MAID because it was restricted to the end of life. Therefore, they did do that analysis, but the conclusions are vastly different from what you indicated in your testimony. I'm just wondering if you could comment to us on that portion of her decision, because in paragraph 681 she clearly said:

> By seeking to counter only one of the stereotypes that the disabled face—vulnerability—the challenged provision perhaps perpetuates another probably more pernicious stereotype: the inability to consent fully to medical assistance in dying.

What she explained is that we need to empower and give autonomy to persons with disabilities, the same autonomy that is granted to people without a disability. Could you perhaps comment on that point, Ms. Carr?

Ms. Krista Carr: First of all, I want to point out that Jean Truchon was presenting himself for a medically assisted death because he couldn't get a good life, and that was very clear in the proceedings. He was forced to live in an institution. He didn't want to live there. His life was not good. There were multiple attempts for him to live in other places and have a better life, and nobody seemed to be able to get him out of that place. That's how he ended up there in the first place, and that's the thing we lose quite a bit when we talk about the Truchon decision.

The second thing is about the rights piece. We talk about this being all about autonomy, all about individual choice and decision, but it is a balance of autonomy rights and equality rights. That's what section 1 of the charter is for. We say that we can violate autonomy rights if it's for the public good.

We have to keep in mind that for people with a disability, this is not a choice. Every day of their lives, the lives that they are forced to live because of inadequate supports, poverty and society depriving them of inclusion, causes their suffering. That suffering could be remedied through many, many other means, but because we don't respond and governments don't provide the supports, and communities and society don't include people, they're forced into situations in which they feel they have no choice.

Sure, they're presented with options. For example, the bill says we need to let people know what services are available, but letting people know what's available doesn't get them services and supports; it doesn't get them off wait-lists; it doesn't get them out of institutions; it doesn't make their lives better. Until we're committed to making sure that everybody has the opportunity, an equal opportunity, to live a good life, medically assisted death on the basis of disability is not the solution.

● (1140)

The Chair: Thank you very much.

Thank you, Mr. Virani.

[*Translation*]

Mr. Thériault, go ahead for six minutes.

Mr. Luc Thériault: I thank all the witnesses for their testimony this morning.

Mr. Foley, your testimony is pretty moving and troubling.

In a debate like this one, there must absolutely be no confusion in the concepts. Yet the criterion of reasonably predictable natural death has been problematic for practitioners.

As of 2015, a terminally ill patient in Quebec receiving palliative care could decide to request medical assistance in dying. Improvements still must be made to palliative care. It is one thing to call for better conditions for patients, but it is another to encroach on their free will and take away their freedom to choose. Paternalism must be avoided.

An individual's dignity is not based on their physical or psychological autonomy—in other words, their cognitive abilities. Those factors contribute to autonomy. Dignity is based on the respect of an individual's moral autonomy, and the respect of an individual's moral autonomy is rooted in the respect of their freedom of choice and their ability to exercise their self-determination. In biomedical terms, this is called free and enlightened consent.

Mr. Foley did not end up in a situation of free and enlightened consent, and he is before the courts. I will stop here because I don't want to comment on that specific situation. That is not what we are discussing this morning. This is rather about providing a choice to individuals already in an irreversible process or terminally ill. I'm thinking of people like Ms. Gladu, who has not yet exercised her right to die with dignity. However, she said she at a meeting that she was already relieved and was suffering a bit less because she now had that choice, which was previously taken away from her.

However, things should not be confused. On the one hand, there are suicidal patients. We are talking about a reversible state, and society should in fact fight against suicide. On the other hand, there are requests for medical assistance in dying from humans who have led a full and complete life. Mr. Foley told us he was living a full and complete life, even though he is now somewhat more limited. Since the patient comes first, it is up to them to make the decision.

Ms. Carr, are you against that principle?

[*English*]

Ms. Krista Carr: No. We're against the systemic discrimination of allowing people to be euthanized or put to death on the basis of their disability, when they can't get the supports they need to live well within their communities.

They may very well find themselves in the medical system, with the suffering they're experiencing being caused by the lives they are living, while they can't get the supports they need to live the lives they want to live. The medical system alone cannot get those supports for them, so having access to ending one's life, as opposed to being able to live a good life....

If somebody is already dying, we already have it in the legislation, or if they're already suffering intolerably and their death is reasonably foreseeable, they can access MAID anyway. Anyone can do that. What we're doing with track two, Bill C-7, is singling out one particular charter-protected group of Canadians and saying it must be so terrible to live their lives that we're going to assist them to end them when they show up in the system and need supports to live. I know we're not necessarily doing it intentionally, but that is what happens. We have examples, which I'm happy to send, of case after case of exactly this thing.

● (1145)

[*Translation*]

Mr. Luc Thériault: Ms. Carr, after all, it is not to you or me or anyone else that the patient must define their tolerance threshold. That is what self-determination and respect of a person's dignity are about.

It is true that we must fight for people to have the best possible care, but at the end of the day, you will agree that it is up to patients themselves to determine their tolerance threshold and make that decision.

[*English*]

The Chair: You have 20 seconds, Ms. Carr.

Ms. Krista Carr: Having respect for people means trying to make their lives tolerable and bearable, the same way we do for any others who are not identified as having a disability and who try to commit suicide or end their life. We intervene in every possible way we can to help make their lives better.

The Chair: Thank you, Ms. Carr.

[*Translation*]

Thank you, Mr. Thériault.

[*English*]

We're moving on now to Mr. Garrison.

Mr. Garrison, you have six minutes. Please go ahead.

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

I want to thank all the witnesses appearing before the committee today.

I also thank the members of the disability community and their advocates for their passionate presentations, both today and away from this committee table. I believe we need to hear more on these issues. That's why, as I've said before, I am disappointed that we have not yet started the statutory review of medical assistance in dying, which I believe deals with some of these larger issues being raised today.

The court decision took reasonable foreseeability off the table, whether we like that or not. Whether it has been appealed or not, I believe it would likely be upheld in the higher courts, so what we're left with is an attempt to deal with that decision and to deal with some other urgent issues in medical assistance in dying.

I want to turn back to Ms. Campbell, who raised issues I've heard a lot about in my constituency, which include relieving suffering caused by the 10-day waiting period and also by the inability to waive final consent. I believe those are urgent things we must deal with, which justify a speedy consideration of Bill C-7. Could you say a few more words about those issues, Ms. Campbell?

Ms. Julie Campbell: Patients who call me are not calling me the first time they have ever considered medical assistance in dying. These are people who have really considered.... They've often been in the health care system for a long time and have been presented with many options. They are knowledgeable people, who have evaluated their own values and experiences. Many of them have discussed this thoroughly with their family before calling. They're not jumping at making that phone call, but they are making the call to determine what other options may be available to them so they can best consider those, so I think they're frustrated with then having to wait another 10 days once they've come to that decision.

Advance consent is the one I actually hear the most about. I hear that more from patients who are really at risk of losing their capacity, such as in the Audrey Parker case. I also hear it from many community groups who are really concerned that, should they be in that position in the future, those rights would not be available to them.

● (1150)

Mr. Randall Garrison: Thank you.

In testimony from Dr. Daws, who is also a MAID assessor and provider, she said to the committee, and also in her written brief, that she didn't meet anyone who wanted to commit suicide. She didn't meet anyone who wanted to die. She met people who wanted to deal in a dignified manner with what nature was presenting them with. Can you comment on your experience with this?

Ms. Julie Campbell: Yes. My experiences are very similar. If I could give my patients anything, I would give them life, but life isn't necessarily the option they're being presented with. When they look at their different options, they're considering MAID as one of those options, but many of them are choosing between very hard choices. My wish for them to be better certainly doesn't make that so, although I would do everything I could to assist with that.

Mr. Randall Garrison: I know that time is very short, but could you give us a very brief comment on the role of witnesses? We sometimes seem to assume that witnesses are judging whether the assessment has been correct, when in fact they're judging the identity and the signatures on documents, I believe. Can you tell me if I'm correct with that?

Ms. Julie Campbell: You are. The witnesses generally are independent volunteers with no medical contacts whatsoever. They're simply noting that the person signed that form or directed a third person to sign on their behalf when they're not able to do so.

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

In the interest of time, I'll conclude my questions there.

The Chair: Thank you very much, Mr. Garrison. You still have a minute and a half, but that is okay.

In that case, we'll move on to our second round of questions. We'll start with Mr. Cooper.

You have five minutes. Go ahead.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you very much, Madam Chair, and thank you, witnesses, for your very helpful testimony.

I want to direct my first question to Mr. Sikkema and Mr. Schutten, as well as Mr. Berger.

In the Supreme Court's Carter decision, the court adopted the pronouncement of the trial judge, wherein the trial judge stated that risks associated with physician-assisted death "can be identified and very substantially minimized through a carefully-designed system" that imposes strict limits.

We have heard some fairly compelling testimony about how vulnerable persons could be put at risk as a result of the removal of important safeguards passed in Bill C-14. Can you speak to any charter issues that you see in that context, Mr. Sikkema, Mr. Schutten or Mr. Berger?

Mr. Ken Berger: Perhaps I could respond to that very intuitive question.

The charter also involves "the right to life...and security of the person", which seems to have been forgotten. Clearly, the trial judge in the Truchon case did not, in my opinion, pay sufficient attention to that. The fact is, as you mentioned, that there need to be strict limits. The problem, as I was mentioning earlier, is that this is a subjective decision based on potential influence and coercion. All we have here is government questionnaires with leading questions.

With respect to anyone who is making a decision—the MAID assessors—there's the risk of confirmatory bias. If they believe that assisted dying is right, they are more likely not to see issues with capacity, not to see issues with the consent and not to see coercion, because they think what they're doing is something humane and right. So there need to be robust, strict protections here, including not only substantive protections of only doing it near end of life, but having committees decide this, and not a physician who's actually doing the act, because they're more likely to find that what they're actually doing is correct. There need to be substantive safeguards and procedural safeguards that are strict and rigid.

Thank you.

● (1155)

Mr. Michael Cooper: Thank you for that.

Mr. Sikkema, I'll give you a chance to weigh in on my question as well.

Mr. John Sikkema: I'll add to what Mr. Berger said. I think the expert report of Dr. Madeline Li in the Lamb case is quite instructive on this. She actually developed and oversees the MAID program at the University Health Network in Toronto. In her expert report, she describes the case of a woman who had bone cancer and depression. She was assessed by two experienced MAID providers, not by her oncologist and a psychiatrist, and they approved her for MAID. She changed her mind during the 10-day waiting period and decided to do palliative care instead.

Later, during another crisis, she requested MAID again and her MAID providers decided again that she was eligible. They apparently had no concerns about her ambivalence. Then she ended up changing her mind again during the next waiting period. You're talking about the waiting period not mattering as a protection. This is right there in an expert report by someone who designed the system in Toronto. It's quite remarkable. I recommend looking at that expert report.

Mr. Michael Cooper: Do you have any comments on charter issues, specifically?

Mr. John Sikkema: My colleague André is on the call. He's writing a paper about how practically this means that the criminal law does not protect your life as strongly—I'm speaking for him here—when you have a disability or a chronic illness, because your death wouldn't be investigated to the same extent. We talked about equality earlier on this call. I can't get MAID because I'm not disabled, so the disability equality angle has kind of two sides there. I think that's important to recognize, that section 15 goes the other way, too.

Mr. Michael Cooper: Thank you.

The Chair: We'll now move on to Mr. Zuberi until the end of this panel.

Go ahead, Mr. Zuberi.

Mr. Sameer Zuberi (Pierrefonds—Dollard, Lib.): I want to thank all the witnesses for joining us today.

I wanted to put this question to Mr. Foley and others who want to contribute to this.

Essentially, I know that many of you are advocating against opening up MAID to non-reasonably foreseeable deaths. I appreciate that. It's something we're considering. However, I want you to open up. Let's say for a moment that we actually do consider non-reasonably foreseeable deaths. In your opinion, how do we protect those with disabilities, from your vantage point, and vulnerable persons?

It's for Mr. Foley and others who would like to contribute.

Mr. Ken Berger: Madam Chair, I don't believe it's possible to protect the disabled if you open it up. There are already cases with the existing law demonstrating that the disability community is in danger and this is just going to exacerbate that. In my respectful submission, without limiting it to close to death, there is no way of limiting it.

Mr. Sameer Zuberi: Thank you.

Just very quickly—I have another minute—would anybody want to actually flesh this out? If we open it up, how could we protect disabled persons? I feel this is really important, given what we're studying.

Mr. Roger Foley: The current safeguards are already failing under Bill C-14. Taking away those safeguards, there's absolutely no way to protect vulnerable and disabled persons from a wrongful assisted death. I'm disabled, and I know that if you pass Bill C-7, I won't survive and there'll be thousands of wrongful deaths. You'll see the numbers pile up. So I urge you to please not allow this regime to continue to slide.

The Chair: Thank you very much.

We are out of time.

My understanding is that there was a little bit of interpretation of Mr. Zuberi that was interrupted, but I think it was resumed. If anybody has any issues with respect to that interpretation, please do reach out to the clerk and we'll get you that text.

I'd like to take this moment now to thank all the witnesses who appeared today for their testimony. Thank you again for being here today.

We will be suspending now to move on to our second panel.

● (1155)

____________________(Pause)____________________

● (1205)

The Chair: Thank you, Mr. Clerk.

Welcome to the witnesses. I welcome you to our second panel.

I will quickly go over the rules before we start.

You can speak in your official language. Just ensure that you have the proper interpretation language selected at the bottom of the screen. Please speak slowly and clearly, and when you're not speaking, your microphone should be on mute.

With respect to the speakers list, the clerk and I will do our best to ensure that we're maintaining that speakers list. I have a one-minute card and a 30-second card that will allow us to keep time for the questioning.

At this time, I'd like to welcome our witnesses. Appearing before us today as individuals, we have Dr. Catherine Frazee and Dr. Ewan Goligher. Appearing on behalf of the Council of Canadians with Disabilities, we have Dr. Heidi Janz and Taylor Hyatt. From Living with Dignity, we have Michel Racicot.

I understand that Ewan Goligher, who was having difficulties getting here, is now in the virtual room. Welcome.

I'm excited to have all of you. I understand that some of the witnesses have audio recordings, so we'll go ahead and start and try to provide as much as possible.

Dr. Catherine Frazee, please go ahead. You are our opening witness. You have five minutes.

Dr. Catherine Frazee (Professor Emerita, School of Disability Studies, Ryerson University, As an Individual): I speak today from Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq people. I am a settler here, bound by treaties of peace and friendship and mindful that we are, all of us, treaty people.

Madam Chair, I am sorry for any discomfort that my words may trigger, but with so little time, I must speak frankly and without reserve.

Bill C-7 begs the question, why us? Why only us? Why only people whose bodies are altered or painful or in decline? Why not everyone who lives outside the margins of a decent life, everyone who resorts to an overdose, a high bridge, or a shotgun carried out into the woods? Why not everyone who decides that their quality of life is in the ditch?

Surely the answer rises up in all of our throats: That's not who we are. We dial 911, we pull you back from the ledge and yes, we restrain you in your moment of crisis—autonomy be damned. We will get to the heart of the problem that drove you out into the woods and we will beckon you back toward a life that is bearable, unless your suffering is medical or disability-related. Then, and only then, there will be a special pathway to assisted death.

Universality is the bedrock of our health care commitments. Why, then, does Bill C-7 depart so radically, dropping the threshold for MAID for one social group known to bear the trauma of suicide at catastrophic rates, but not for others who suffer and die before their time?

What is it about disability that makes this okay? Why is there such breathless confidence that Bill C-7 will bring no harm to disability communities? Honestly, I do not know, but as we marshal our evidence for the legal challenges that will follow if this bill is passed, this is what we hear in reply.

Some say that the suffering from a disabling medical condition is unlike other suffering, that it is somehow more cruel than the overwhelming pain of any healthy, non-disabled person who turns to premature death by suicide. But there is no evidence to support this.

Some say that the suffering of disability defies all hope, as it did, they claim, for Jean Truchon, but the deprivations of institutional life that choked out his will to live were not an inevitable consequence of disability. Did we learn nothing from Archie Rolland's harrowing struggle and his final *cri de coeur* before his assisted death? It was not the ALS that was killing him, he said.

Some say that the suffering from disabling conditions falls in the domain of medicine, but the agonizing quest of Sean Tagert teaches us otherwise. Let's not forget that he called the bureaucratic denials of needed care a “death sentence”, just days before his assisted death.

Some will fall back on the mantra of choice. They say that not everyone wants to live that way, but not everyone wants to live with the indignities of poverty either. No one wants to live under threat of racial or gendered or colonial violence. No one wants to live hungry, incarcerated, abject or alone.

Madam Chair, will our lawmakers carve out other shortcuts to assisted death for those who do live in such conditions, or will you rise to the defence of human rights? If it is the latter, I respectfully urge that you start with us, for our equality is right now on the line.

● (1210)

Thank you.

The Chair: Thank you very much, Dr. Frazee, for your testimony.

We'll now go to Dr. Goligher.

Please go ahead.

Dr. Ewan Goligher (Assistant Professor, Interdepartmental Division of Critical Care Medicine, University of Toronto, As an Individual): Madam Chair and honourable members of the committee, I speak to you as an academic physician-scientist, a critical care specialist who frequently provides end-of-life care, as the father of a child with physical disabilities, and as a very concerned Canadian citizen. I wish to address you specifically on the ethics of moral objection to euthanasia.

The first patient I was ever asked to examine in medical school was a young man with profound disability from primary progressive multiple sclerosis. I will call him Nathan, though that was not his real name. Nathan was paralyzed from the neck down, bedbound, and blind. As I interviewed him, he began to speak of his experience as a person living with serious disability. He spoke especially of the deep loneliness that he felt, the isolation from the rest of the world, the absence of meaningful friendship. His pain was primarily not that of physical suffering but of deep despair of ever enjoying meaningful human contact or relational intimacy.

All these years later, I wonder if Nathan would have considered seeking a doctor’s help to commit suicide. I invite each of you to imagine that you are the one to fulfill that wish for someone like him. You place the intravenous line. You inject the sedation to put him to sleep. You inject the paralytic agent to halt his breathing. Within minutes his heart stops and he is gone. His loneliness and hopelessness are ended, and so is he.

We must all agree that this patient’s loneliness and despair are tragic. We all agree that he deserves the very highest level of care and compassion, that we must work to uphold his dignity and his quality of life. Yet with respect to the ethics of causing his death, many, like me, find a variety of important reasons to object to participating in such an act. First, we argue that euthanasia devalues the patient by treating them as a means to an end. In order to make Nathan’s suffering go away, we would make him go away. We intentionally target and end his person in order to resolve his loneliness and despair. In doing so, we are treating him—his person—as a means to an end, rather than as an end in himself. True respect for the intrinsic and incalculable worth of persons requires that they always be treated as ends in themselves. We do not destroy that which we regard as profoundly and intrinsically valuable.

Second, since respect for persons is the moral foundation of the duty to respect autonomy, by treating persons as means to ends we undermine the very basis for respecting their autonomy. If persons can intentionally be rendered non-persons, then what makes their autonomy inviolable?

Third, in participating in the patient’s act of suicide and causing his death, we are implicitly declaring that we agree that his life is not worth living. We are affirming his perception that his existence is no longer desirable, that we are supportive of his non-existence. Nathan’s loneliness and despair highlight the way that even while we may be autonomous, we are also deeply dependent on others for affirmation and value.

Bill C-7 declares that an entire class of people—those with physical disabilities—are potentially appropriate for suicide, that their lives are potentially not worth living. Indeed, were it not for their disability, we would not be willing to end them. I cannot imagine a more degrading and discriminatory message for our society to communicate to our fellow citizens living with disabilities.

Now, reasonable people may disagree over the ethics of euthanasia. Given the concerns raised here, it is understandable and eminently reasonable that many physicians and nurses object to participating in the provision of euthanasia in general, and to those with disabilities in particular. Contrary to the claims of some, objecting to euthanasia is not motivated by selfish concern for personal moral sensibilities, but rather by a profound moral concern to uphold the value of the patient and to maintain high-quality medical care.

Moreover, the Canadian experience has shown that protecting conscience presents no obstruction to patient access. Bill C-7 should be modified to clearly ensure that Canadians' fundamental freedoms of conscience are upheld and supported in ways that Bill C-14 failed to accomplish.

Finally, I implore you to ensure that if this law is passed, it requires that the physical, social, psychological, existential and spiritual needs of patients like Nathan have been thoroughly and systematically addressed before they are considered to be eligible for euthanasia. He and others like him deserve the best opportunity for living before they conclude that their existence is pointless and should be ended.

Thank you for your consideration.

● (1215)

The Chair: Thank you very much for that, Dr. Goligher.

We'll now move on to the Council of Canadians with Disabilities. They have asked for an extra amount of time. Given my discretion, I will allow them seven and a half minutes between the two witnesses who are appearing. Ms. Janz will be making her opening statement through an audio file to be played. It will be text-to-speech. She will be taking six and a half minutes.

Go ahead, Ms. Janz. Thank you very much.

Dr. Heidi Janz (Chair, Ending-of-Life Ethics Committee, Council of Canadians with Disabilities) (via text-to-speech software): Madam Chair, it's Dr. Janz, please.

The Chair: Dr. Janz, my apologies.

Go ahead, Dr. Janz.

Dr. Heidi Janz (via text-to-speech software): Justice committee, I appear before you as the chair of the Ending-of-Life Ethics Committee of the Council of Canadians with Disabilities, a national organization with a mandate to preserve and promote the human rights of people with disabilities.

I feel compelled to spend a few precious moments of my allotted time to register my concern, indeed my alarm, at the breakneck speed at which this committee is operating. This committee has been convened to study the potential impacts of expanding eligibility for medical aid in dying to include ill and disabled people who are not dying. Those in charge of this committee are very aggressively rushing the important and complex work of the committee. All of this is happening in the middle of a global pandemic, when our focus as a country has been on taking measures to protect the lives of our most vulnerable citizens. At best, this is extremely ironic; at worst, it is hypocritical, irresponsible and extremely unethical.

As someone who relies on assisted and augmentative communication, I had to request additional time beyond the two and a half minutes allotted for my testimony. This incident illustrates the reality of systemic ableism within a society designed by, and for, typically functioning people. Ableism causes the support needs of people with disabilities to be viewed as excessive and unsustainable. This has enormous and very dangerous implications for the expansion of MAID.

Disability scholar Veronica Chouinard defines ableism as “ideas, practices, institutions, and social relations that presume able-bodiedness, and by so doing, construct persons with disabilities as marginalized...and largely invisible 'others'.” Like racism and sexism, ableism classifies entire groups of people as “less than”, and perpetuates harmful stereotypes, misconceptions and generalizations about people with disabilities. Unlike racism or sexism, however, ableism remains, in the words of Canadian disability scholar Gregor Wolbring, “one of the most societally entrenched and accepted isms.”

People with disabilities are at a higher risk of suicide due to systemic and internalized ableism, yet they face substantial barriers when trying to access suicide prevention services. Medical professionals overlook typical sources of stress. Problems arising from relationship breakdowns, depression and isolation are wrongly attributed to disability. The removal of “reasonably foreseeable” natural death as a limiting eligibility criterion for the provision of MAID will result in people with disabilities seeking MAID as an ultimate capitulation to a lifetime of ableist oppression. In a truly just and progressive society, suicide prevention measures should be applied equally to all people.

More and more Canadians with disabilities find themselves in extreme financial distress as the pandemic drives up costs while already meagre provincial income supports remain stagnant. What's more, some provinces have recently been publicly musing about reducing, or altogether scrapping, their income support programs for people with disabilities. Recent news reports indicate that some people with disabilities living in poverty are being driven to end their lives through MAID because they lack the means to survive. Physicians report that patients with disabilities are requesting MAID upon learning that the wait time for accessible housing with the supports they require is 10 years or more.

Given the demonstrated ongoing prevalence of ableism in Canada, the Council of Canadians with Disabilities is recommending the following amendments to Bill C-7 in hopes of limiting the bill's capacity to weaponize ableism in this country.

One, the receipt of adequate housing, income support, palliative care and home-based services should be prerequisite eligibility requirement for MAID. The onus for providing these supports at the level required must fall on governments. A person with disabilities should never bear the burden of trying to lobby for adequate supports.

Two, refer to the Supreme Court of Canada, by way of constitutional reference, Bill C-14's existing protections limiting MAID to cases where a person's natural death is reasonably foreseeable.

Three, any changes to Canada's MAID law must meaningfully respond to last year's end of mission statement by the United Nations special rapporteur on the rights of persons with disabilities, wherein Ms. Catalina Devandas-Aguilar communicated her serious concerns about "significant shortcomings in the way [all levels of Canadian government] respect, protect and fulfill the rights of persons with disabilities". Specifically, she noted that there was a lack of "protocol...to demonstrate that persons with disabilities have been provided with viable alternatives when eligible for assistive dying", and that she had received "worrisome claims about persons with disabilities in institutions being pressured to seek medical assistance in dying, and practitioners not formally reporting cases involving persons with disabilities".

● (1220)

Four, Canada's amended medical assistance in dying law should follow the judicial directive of the SCC in the Carter decision, which required a "carefully-designed system" that imposes stringent limits that are "scrupulously monitored and enforced."

Five, remove Bill C-7's provision allowing a disabled person's health care or personal care provider to be an eligible witness to that person's request for MAID.

Six, retain Bill C-14's mandatory 10-day waiting period requirement, as it currently stands, and the requirement for independent verification of all MAID requests by two witnesses.

Seven, in response to the prevalence of medical ableism, add language to Bill C-7 that will ensure that all discussions surrounding MAID are patient-led and not prematurely initiated by the physician.

Eight, remove Bill C-7's provisions waiving Bill C-14's important and necessary final consent requirements.

Bill C-7 would enshrine a legal form of ableism into Canadian law by making medical assistance in dying a legally sanctioned substitute for the provision of community-based supports to assist people with disabilities to live. The Council of Canadians with Disabilities, along with the entire disability rights community in Canada, is therefore pleading with policy-makers to rethink and revise Bill C-7 in light of the reality of systemic ableism. You must ensure that MAID does not weaponize systemic ableism in Canada.

Thank you.

● (1225)

The Chair: Thank you, Dr. Janz.

We'll now go for the remaining one minute to Taylor Hyatt.

Please go ahead.

Ms. Taylor Hyatt (Member, Ending-of-Life Ethics Committee, Council of Canadians with Disabilities): Thank you.

One domain where we are particularly concerned ableism will appear is in the medical system.

I'd like to give you an example of what that looks like.

Nearly three years ago in January 2018, I became ill with a bad flu. I went to a walk-in clinic and was sent home with the usual advice: rest, Advil and chicken soup.

Contrary to what I was told to expect, my condition worsened and I began to struggle to breathe a few days later. I called the Ontario Telehealth line and was advised to go to the ER. I called a few friends, hoping to get a ride there, but no one could be with me until the next day. I took a cab to the hospital and was immediately admitted. A couple of hours later the doctor was no closer to finding out what caused my illness. When she finally came to see me, she said, "The only thing we know is that this infection affects your breathing and you may need oxygen. Is that something you want?" My answer was, "of course". She seemed surprised and unconvinced so she asked again. My answer was unchanged.

The Chair: Ms. Hyatt, my apologies.

I'm going to stop you here and ask for the consent of the committee, because we are over the seven and a half minutes that's allowed under my discretion.

I turn to the members of the committee to allow Ms. Hyatt to finish her testimony.

Some hon. members: Agreed.

The Chair: Go ahead, please.

Ms. Taylor Hyatt: My answer was unchanged. I said, "of course".

In that moment, I would have been able to refuse treatment and be permitted to die. Or, in a moment of weakness, bought into the stereotype that my life wasn't worth living and requested and received a lethal injection. Breathing supports would be considered standard treatment for a non-disabled person in my situation, especially somebody in their mid-20s as I was. That's supposed to be the prime of your life. All the doctors seemed to see was a disabled woman alone, sick, tired, and probably tired of living. This is nothing new.

A study by Carol Gill of the University of Illinois at Chicago shows that doctors often perceive disabled people's quality of life to be significantly worse than disabled people's own views. Whether disabled or not, Canadians look to these professionals as guides. Doctors have power to shape the perspective of others and they should wield it with great care.

Both my age and the effects of my disability gave me an advantage. I was able to advocate for myself without support and be taken more seriously by non-disabled observers than many others would be, yet this still happened to me well before the expansion was on the table.

Here's how my story ends. I was diagnosed with pneumonia and thankfully never even needed the oxygen. I received antibiotics, came home after a week, and I'm here today.

If this bill goes through, how many more disabled people at their lowest moments could have a drastically different and decidedly unwanted ending to their story?

Thank you, everyone.

The Chair: Thank you very much for that, Ms. Hyatt.

We'll now go into our first round of questions, starting with Madam Findlay.

You have six minutes. Please go ahead, Madam Findlay.

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

Thank you very much to all the witnesses. It's really quite humbling to be here with you today and to hear your many stories.

My first question is for the Council of Canadians with Disabilities representatives who are here today.

Dr. Janz, you talked about how we as a government and a society are aggressively pursuing one course of action through a pandemic lockdown to save lives and on the other hand seem to be rushing through this legislation. It's a great concern to me that we are doing so in a rushed way, to expand the ability to end life instead of putting increased resources to support for living and, when it comes to it, palliative care.

The government says they've consulted widely on this bill. I'm wondering if, from the perspective of the Council of Canadians with Disabilities, you believe this consultation was extensive enough, and does it address the concerns of Canadians with disabilities?

● (1230)

Dr. Heidi Janz (via text-to-speech software): Thank you for the question. I believe the consultation was moderately extensive; however, I believe that the consultation was geared towards a predetermined outcome. That is evident by the types of questions that were asked in the online survey and which seemed to be assuming that MAID would be expanded.

Hon. Kerry-Lynne Findlay: Thank you, Doctor.

Dr. Frazee, you have previously raised concerns about severely disabled people not being able to access the care they need.

I'm mindful that we've heard testimony that 70% of Canadians don't have access to palliative care. We've also heard testimony this morning on what was called “an inadequate patchwork of supports”. Do you feel that this bill addresses that?

Also, do you agree that MAID should only be available as a very last resort, as it is in many other countries, or, in other words, only once every other treatment option has been exercised?

Dr. Catherine Frazee: Madam Chair, if I may speak to the question of your member, yes, absolutely, MAID should be an intervention of last resort, but only when a person's natural death is reasonably foreseeable.

Absolutely, I agree, and I think all of the evidence points to the reality that there are far, far too many Canadians with disabilities and disabling conditions who have no access not only to palliative care, but to an array of in-home supports that would permit us to continue to live autonomously, to be the captains of our own ships, as it were, and to be included and participating in the communities in which we are able to thrive.

All of these are things that disabled Canadians are being deprived of. As a result, I think we have begun to see a real trend towards seeking MAID—yes, as a choice of last resort, but a choice among two choices: either to continue to live in deprivation or to die. I think that is the essence of what members of the disability community are trying to convey here, that it's an insufficient choice to support a robust account of autonomy.

● (1235)

Hon. Kerry-Lynne Findlay: Thank you.

This question is for Mr. Racicot. As a lawyer myself and a former litigator, I have a great concern that this matter from the Quebec Superior Court was not appealed and that the mandated review simply didn't take place before the expanded bill we now have before us was drafted. Do you think it should have been appealed to the Supreme Court of Canada?

Mr. Michel Racicot (Lawyer, Living With Dignity): Yes, it should. Maybe it's not over yet. As some earlier participants mentioned, there is always a possibility of referring Bill C-7 to the Supreme Court of Canada directly.

More importantly, I think Bill C-7 goes much beyond what is required to comply with the Truchon decision. It takes away with or dilutes many of the safeguards that are already—

The Chair: Mr. Racicot, my apologies, but we're very much out of time, of which I'm very cognizant. Thank you. I hope this will come out in later testimony.

We'll now move to Mr. Kelloway for six minutes.

Go ahead, Mr. Kelloway.

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

I'll be sharing my time with MP Powlowski, if that's okay.

The Chair: Yes.

Mr. Mike Kelloway: That's wonderful.

I have a question for Dr. Frazee.

First, what part of Mi’kma’ki are you from or calling from today? I'm just curious.

Dr. Catherine Frazee: I'm in Kings County, Nova Scotia.

Mr. Mike Kelloway: The reason I ask is that I'm calling from Cape Breton. It's the absolute Maritimes thing to do to ask where you're from, so I appreciate your response to that.

Dr. Frazee, as you may be aware, Minister Lametti and officials held consultations with a number of stakeholders before informing Bill C-7. These round tables were issue-specific. They were with ministers, parliamentary secretaries and officials, and there were extensive consultations with disability advocates. I wonder if you can tell us what you know about these consultations and what your impressions were of them.

Dr. Catherine Frazee: I was fortunate enough to participate directly in those consultations. I think Dr. Janz has already suggested and indicated that there was very much a predetermined outcome. Given that we were extremely nervous about that predetermined outcome, we invited members of the vulnerable persons standard community to submit duplicate copies of their questionnaire submissions to us so we could tabulate what we call the “voices from the margins”. I would point to—and I could submit to the committee separately—the report we compiled with essentially an overwhelming degree of concern and alarm at the direction Bill C-7 was heading with the removal of the requirement for the reasonable foreseeability of natural death. Given the limits of time, I would simply say that it is not a popularity contest; it's not a question for polling when you are considering whether or not to respect the human rights of part of your population. Of course we're are a minority—a significant minority of Canadians but a minority nevertheless. I think our voices need to be given particular attention, and they are in no way reflected in Bill C-7.

Mr. Mike Kelloway: Thank you so much.

Madam Chair, how much time do I have?

The Chair: You are at three minutes right now.

Mr. Mike Kelloway: Thank you very much.

The Chair: Mr. Powlowski.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I understand that the disabled are, on good grounds, concerned about removing the reasonable foreseeability of death criterion. However, I would say that it wasn't the government that decided to do this; it was the Truchon decision. As I've heard other people say, basically the reasonable foreseeability criterion is off the table and it was the court, in its Truchon decision, that took it off the table, and our government felt that the Supreme Court would only uphold the Truchon decision. That's one problem.

The other problem is that although I agree with almost everything I've heard from the disabled, there are people out there who insist—and I have spoken to a lot of people who feel it is very important to them—on being able to make such a fundamental choice should it arise for them.

Now this proposed legislation is here. It's before us. The Truchon decision was made. Is there not, in your opinion, any way we could amend the proposal to make it more acceptable to you? There are certainly a lot of safeguards in it, including proposed paragraph (3.1)(g), which requires from a medical practitioner or nurse the following:

> ensure that the person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care;

Hence, there is a requirement to tell people who might be contemplating using MAID about alternatives that would make their lives better.

Could we not amend what is here? Do you have any suggestions, or is the only way we can deal with this to appeal the Truchon decision or use the notwithstanding clause?

That's for anybody wanting to take it on.

● (1240)

Dr. Catherine Frazee: Madam Chair, I am not a lawyer but I will say that the legal advice we've have is that it is unprecedented for the Government of Canada to amend the Criminal Code on the basis of a lower court decision.

I'm not sure that I would agree or that the people who have advised me would agree, and in response to the core question I would say that you cannot tinker at the edges of a fundamentally norm-shattering piece of legislation.

I am sorry to say that.

The Chair: Thank you, Dr. Frazee.

Before I go to Monsieur Thériault, it is my oversight that we didn't go to Living With Dignity, Michel Racicot, for five minutes as a witness.

Go ahead, Monsieur Racicot.

[*Translation*]

Mr. Michel Racicot: Thank you, Madam Chair.

As a lawyer and former president of the Living With Dignity network, I thank you for giving us this opportunity to share some observations. I will be very brief, as everything else is provided in our brief.

The Living With Dignity network was founded in 2010. This is a citizen network of over 5,000 allies that is closely following the evolution of end-of-life care in Quebec and in Canada. We have been there for all the stages, including the latest cases such as Lamb and Truchon.

Unfortunately, since the provisions on medical assistance in dying came into force in 2015 in Quebec, and in 2016 in the rest of Canada, we have been seeing increased relaxing of the safeguard measures, be it stemming from court rulings or the interpretation of those who implement medical assistance in dying.

We understand that the Government of Canada must now amend its legislation, but Bill C-7 goes much further by making numerous changes to safeguards that had, however, been deemed necessary in June 2016. I feel it is really dangerous and rushed to do this right now, during a pandemic, when the consequences of the current safeguards have not been analyzed in the review of current legislative provisions, which should begin soon. So we are asking that those safeguards be kept for everyone who is at the end of their life.

Concerning provisions that affect those who are not at the end of their life, we have heard the message from the entire community of persons with disabilities and their advocacy groups. They raised the same issue on Bill C-14 when the Senate proposed removing the end-of-life criterion. They are mostly ignored now, given the proposed amendments.

It is hard to understand how the federal Parliament can adopt the proposed measures, which would make Canada the most permissive country in that area, while making fine statements of principle in the preamble of Bill C-7, as it had done in the preamble of Bill C-14.

Finally, given certain court rulings that have undermined caregivers' conscientious objection, especially in Ontario, it would be desirable for the current legislative provisions to be strengthened to clearly stipulate that nothing in this bill can force anyone not only to practise medical assistance in dying or to assist someone in that practice, but also to refer an individual who is asking for medical assistance in dying to a colleague who does provide that service.

● (1245)

[*English*]

The Chair: Thank you very much, Monsieur Racicot.

I will go on to Monsieur Thériault.

[*Translation*]

Mr. Thériault, you have six minutes.

Mr. Luc Thériault: Thank you, Madam Chair.

I will be quick, as I have only six minutes.

I first want to say to all the witnesses that I am very sensitive to their plea for better care. It is essential to continue calling for this. As I have already said several times, deficiency, whatever kind it may be, does not have to lead to a disability. A disability is a social issue, but a deficiency is not. So I am very sensitive to this fight and to what you have told us today.

However, the terms must be defined. Mr. Racicot, I really like the name of your network, Living With Dignity. It seems to me that living with dignity is above all about having the ability to exercise at any time our freedom of choice, our free will, our capacity for self-determination, especially in medical decisions. The idea is to be able to give free and enlightened consent without anyone affecting it.

That said, I have seen two issues in your brief's conclusion, and I will read to you the penultimate paragraph:

> This legislative project, like those that paved the way for euthanasia in this country, gives the false impression that a person's dignity is essentially dependent on his or her autonomy. By administering medical assistance in dying to the person who requests it, one would supposedly respect his or her dignity (a dignity, however, that is inherent in every person, irrespective of their degree of autonomy). In such a discourse, it is implied that in order to die with dignity one must necessarily die earlier, from a death that is administered, chosen and above all anticipated. What a sad state of affairs.

It is indeed a sad state of affairs. However, the issue is that the Quebec Superior Court itself struck down legislation currently in force that stems from former Bill C-14 and evoked the same reasons—that it was forcing the individual to commit suicide, to put an end to their life before they had even reached their own tolerance threshold, which was violating the individual's right to life.

It should be pointed out that the autonomy discussed here is not physical in nature. I hope that is not what you are referring to. In fact, physical autonomy is only a condition fostering moral autonomy. Psychological autonomy is a necessary condition. When an individual loses their cognitive abilities, they can make no moral, practical or adequate judgment, so they cannot provide their free and enlightened consent.

You will agree with me that physical deficiency has nothing to do with autonomy, as defended here, in this bill. I hope you will not confuse all this.

● (1250)

Mr. Michel Racicot: I'm not confusing all this, Mr. Thériault. However, I don't agree with you. We mustn't only look at the conditions in which people exercise their autonomy. We must first and foremost ensure that our society gives those people conditions to live.

I don't know whether you are aware, but I have met a lot of people at the end of their life, including my own wife, as well as some who were suffering from amyotrophic lateral sclerosis, ALS. What I have seen in practice is that, when we take care of people, when we support them, they want to live and not die.

Mr. Luc Thériault: Absolutely.

Mr. Michel Racicot: I am thinking of Martin Lauzon, who had ALS and has now passed away. He had to fight for months to get a voice activated wheelchair. It would have been easier for him to request medical assistance in dying than to obtain the appropriate care, and that is what we are hearing from everyone suffering from degenerative disease or disability.

I remind you that, in Quebec....

Mr. Luc Thériault: That's not....

Mr. Michel Racicot: Let me finish.

Mr. Luc Thériault: That's not what Sue Rodriguez was saying, or Ms. Carter, or Ms. Taylor, or Ms. Gladu, or Mr. Truchon.

I understand your personal experience, and I agree with you. As I said at the outset, care for disabled individuals must be demanded and improved. However, that is not what we are talking about here.

Mr. Michel Racicot: No, but this bill talks about removing or weakening a number of safeguards, even for people at the end of their life, but the legislation should be reviewed.

Mr. Luc Thériault: It is precisely because terminally ill people are suffering needlessly, even though they are receiving optimal palliative care. It is possible for palliative care itself to be a source of suffering. I could provide you with much testimony on that.

Mr. Michel Racicot: Listen, the idea is not to make people suffer....

The Chair: Thank you, Mr. Thériault and Mr. Racicot.

[*English*]

Thank you.

We'll move now to Mr. Garrison for six minutes.

Please go ahead, Mr. Garrison.

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

I want to start again by thanking the witnesses and paying tribute to the people from the disability community and their advocates. No change for disadvantaged groups ever comes without the very hard work and very principled stands taken by those people from their own community and from their advocates.

Of course, it's still my hope that these broader issues that are being raised will be dealt with in the statutory review of MAID legislation, because I think they have implications far beyond the narrow focus of Bill C-7.

That said, I have a couple of specific questions. My first question is for Monsieur Racicot.

Given that medical services are quite often limited in rural and remote communities, the question of referrals becomes a question of access to services for many Canadians. You were very clear that you believe that the duty to refer should not apply in the case of medical assistance in dying. Is that a consistent opinion you share for all medical services, or is this specific to medical assistance in dying? In other words, based on their beliefs, can physicians refuse to refer in other areas or is this specific to medical assistance in dying?

Mr. Michel Racicot: Let me first say that once a person demands a particular medical treatment, a physician, in his own professionalism, is not forced to provide that service. He will seek the service that is most appropriate for the patient.

As to the referral, I understand that the situation in rural areas may be difficult, but it is not necessary for a particular practitioner who objects, for conscience reasons, to refer somebody who doesn't share that objection. There are other means of making these referral services available to the population across a province. You just have to put in place an appropriate information system and do it.

Mr. Randall Garrison: My question was very specifically whether you believe the conscience right to refuse referrals applies to other medical services or practices, other than medical assistance in dying.

Mr. Michel Racicot: Absolutely. Absolutely.

● (1255)

Mr. Randall Garrison: Thank you very much, Mr. Racicot.

My next question is for Dr. Janz.

In your presentation, you went very quickly through some recommendations for Bill C-7. What I believe you said was that you oppose removing the waiver of final consent; you oppose eliminating the 10-day waiting period; and you oppose reducing the number of witnesses. I'd like to ask whether you believe that those provisions provide particular risk to members of the disabled community or whether you simply oppose those in general.

Dr. Heidi Janz (via text-to-speech software): Thank you for the question.

I believe that those elements of the bill pose a particular risk to people with disabilities given the realities of medical ableism and the potential that people with disabilities, upon hearing repeatedly that they should want to hasten their death, then succumb to that message.

Mr. Randall Garrison: Thank you very much.

If I could ask the same question of Dr. Frazee, do you think that the provisions regarding witnesses, the 10-day waiting period and the waiver of final consent pose specific risks for people from the disability community, should they qualify for medical assistance in dying under the very high standard that remains in place?

Dr. Catherine Frazee: Madam Chair, to respond to that, I have to first ask a question.

For the purposes of responding, am I assuming that we now have medical assistance in dying for people who are not at the end of their lives? Is that implied by the question?

Mr. Randall Garrison: Certainly, Bill C-7 says for those practices, we're talking about those whose death is reasonably foreseeable. Those provisions specifically relate to what is sometimes called the “first track”.

Dr. Catherine Frazee: All right. Thank you.

That was not the principal focus of my preparation, but I think it is important to recognize, as Dr. Janz alluded to, the very subtle ways in which our messaging, even the delivery of our care at times, can nudge a person. The best example I can offer is one that was given to me by a colleague in human rights who was describing racism. He said it's like a hair that brushes your cheek. Other people can't see it, but you can feel it. You know exactly where it is. People with disabilities feel ableism in very much the same way in how we are regarded.

We have to remember that the original Carter decision described the risk of persons being vulnerable to inducement to seek, in a moment of weakness, a route to end their lives. I think those safeguards are there in large measure to ensure, or at least to help, people get past those weak moments when we are at rock bottom.

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

Mr. Garrison, that concludes your six minutes of questioning.

I see that we are at 1 o'clock. Do I have the consent of the committee to go for a second round of questions?

Yes? Okay. Thank you.

With that, Mr. Lewis, you have five minutes, starting now.

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

Thank you to the committee. I certainly appreciate this time.

To all of the witnesses, your stories were incredibly compelling today. They're obviously vital to this conversation, so I thank you very much. It is a little disappointing that this legislation isn't getting the due attention that I believe it deserves. I would like to have 40 meetings to call witnesses, not four. That is just as a point of interest.

Dr. Goligher, are you concerned, sir, about the removal of the 10-day reflection period? If so, would you like this committee to consider a shorter time rather than see it abolished?

● (1300)

Dr. Ewan Goligher: I would say that I am very concerned about the removal of the 10-day waiting period. It strikes me that this is such a serious decision to be made, with such care and consultation, with the assurance that all of the underlying issues that drive people to seek death—those issues are well documented in the palliative care literature—have been thoroughly addressed. MAID should always be seen as an option of last resort. The goal of health care is to help the patient flourish. Palliative care is about helping the patients flourish even as they go through the dying process. I think anything that accelerates or hastens that process and doesn't give the opportunity for reflection and so on is of serious concern.

Mr. Chris Lewis: Thank you, Dr. Goligher.

Next, can you explain how Canadians can access MAID without effective referral and why that's important for providers? Further, what provinces require effective referral in existing policy? What have other provinces done to better balance conscience rights and access?

Dr. Ewan Goligher: Ontario and I believe Nova Scotia are the only jurisdictions in the world that require an effective referral. In every other jurisdiction in Canada and around the world, patients are able to obtain access without the requirement for an effective referral. There are already mechanisms in Ontario, where I practice, whereby patients can seek access to medical aid in dying without an effective referral.

It's quite clear that systems can be constructed, as Monsieur Racicot already suggested, through telehealth, etc., and organizations representing health care conscientious objectors have made very reasonable and constructive proposals in this regard, so if there were a will on the the part of the federal government, there is undoubtedly a way this could be done so that we would not be required to aid and abet the euthanasia of our patients.

Mr. Chris Lewis: Thank you very much, Doctor.

Through you, Madam Chair, to Madam Hyatt, thank you very much for sharing your moving story of how a doctor in the hospital presumed you might want to die from your pneumonia because of your disability. We have heard heartbreaking testimony that this type of coercion can be subtle but is indeed common.

What protections would you support to ensure that MAID participation is only voluntary participation through the whole process?

Ms. Taylor Hyatt: Most of all, I would like to see an amendment put in place ensuring that discussions about medical assistance to end one's life be raised only by the person who wants to die.

I would never want a medical professional to begin the conversation about life-ending initiatives as a result of assumptions they make about what it's like to live with my disability. Otherwise I would not feel comfortable seeking certain forms of medical treatment. I want to be seen by a doctor who will care for me as a whole person, including taking my status as a disabled woman into account, and who will support me in living and thriving in the only life I have, which is as a disabled woman.

Thank you.

Mr. Chris Lewis: Thank you very much.

I'm sorry, Madam Chair. Is that 30 seconds that I have left? I'll go very quickly to Mr. Racicot.

Should MAID be considered a therapeutic option equal to current standards of medical care?

Thank you.

The Chair: Be very brief, sir.

Mr. Michel Racicot: I am not a doctor, so it's very difficult for me to say so, but certainly we do not consider MAID to be medical care. Killing a person is never “care”. This is why it needed an amendment to the Criminal Code to allow that across Canada.

We have fought in Quebec against Bill 52, saying that it was not under provincial jurisdiction, but fell under the exclusive federal jurisdiction over the criminal law, so certainly MAID, is not, in our opinion, health care.

● (1305)

The Chair: Thanks, Mr. Lewis.

We'll now move on to Mr. Virani for five minutes.

Go ahead, Mr. Virani.

Mr. Arif Virani: Thank you very much, Madam Chair.

There has been a lot of discussion about the consultations that took place. As somebody who has participated in them, I think it's important that the committee testimony reflect that there were 125 experts and stakeholders who were met with in a series of round tables that took place around the country with ministers and various parliamentary secretaries. There were also 300,000 people who submitted feedback via a questionnaire.

I also think it's important to put on the record that the testimony we heard today is very important and very critical, and the advocacy is being heard and being listened to. The statements that have been put on the record in the chamber, including at the committee, should reflect, as we all do as parliamentarians, that all lives are valuable, particularly the lives of persons with disabilities. What we need to reflect also is that pressure is never appropriate in terms of any coerced choice. If there is ever pressure that is untoward, it needs to be investigated and, if necessary, prosecuted.

I will ask Dr. Goligher a question and then I'll ask Mr. Racicot a question.

Dr. Goligher, I think you used the terms aiding and abetting a death. Just to reiterate, there are actually four protections with respect to conscience rights found in both the preamble and the text of Bill C-14, in the sixth to last paragraph, if I remember correctly, of the Carter decision, and in section 2 of the Charter of Rights and Freedoms. Also, the effective referral regime was actually litigated at the Ontario Court of Appeal and was found to be constitutional.

I'm going to ask you to comment on another aspect, because you also mentioned the equality rights of persons with disabilities, and it's an important point. I've found another paragraph here where this actual issue was put to the court in Truchon, and the Truchon court found that by not changing the regime, the equality rights of persons with disabilities would be compromised, and section 15 would thereby be violated.

This quote is from paragraph 678:

> The requirement at issue reveals a legislative regime within which suffering takes a back seat to the temporal connection with death. Where natural death is not reasonably foreseeable, the consent and suffering of the disabled are worthy only of the sympathy of Parliament, which has adopted a protectionist policy towards every such person, regardless of his or her personal situation. As soon as death approaches, the state is prepared to recognize the right to autonomy. This is a flagrant contradiction of the fundamental principles concerning respect for the autonomy of competent people, and it is this unequal recognition of the right to autonomy and dignity that is discriminatory in this case.

There is no doubt that discrimination is a live issue in this context, but in fact, the conclusion of the Truchon case was exactly the opposite of some of what we've heard today.

I was wondering if you could comment on that, Dr. Goligher.

Dr. Ewan Goligher: Sure. I'd be happy to comment. Thank you, sir, for the question.

I'm not a lawyer, so I can't comment on the integrity and validity of the legal reasoning involved, but I will say in general, with respect to both the superior court decision in Ontario about the effective referral regime as well as the Truchon and Gladu decision, that the mere fact that the judge reached a decision does not imply that the decision was correct. Therefore, I don't think we can simply argue on the basis of the fact that the judge reached the decision that these concerns being raised are invalid.

Mr. Michel Racicot: Maybe I could chime in.

Mr. Arif Virani: Mr. Racicot, if I could ask you one other question, you can answer both.

You said in in your submission, I believe, that Canada is looking like “the most permissible country in the world concerning MAID.” I'm giving you an opportunity to correct the record. I believe that as a lawyer you're probably aware that the Benelux nations allow medical assistance and dying for minors, as well as for situations where mental illness is the sole underlying condition. Neither of those two apply under Bill C-14, nor would they apply under Bill C-7.

Perhaps if you want to clarify the record in that regard...? Also, would you want to comment on paragraph 678 of the Truchon decision?

Thank you.

Mr. Michel Racicot: Thank you.

First of all, when I talk about the most permissive regime, if you take the example of Holland, in Holland there is a requirement not only that some of the treatments be available, as it is in Bill C-7, but also that everything has been tried. This is not present in Bill C-7.

Secondly, on the other issue, I should say that on the reasoning of the court, I'm not saying that we're trying to appeal it, but the reasoning of the court was focused on ignoring two of the objectives of the law, which are still present in Bill C-7: the inherent dignity and equality of each human life and that suicide is an important problem.

As for what the court said—and I have the French version—the judge said that she could not recognize the first two objectives in affirming the value, because these objectives were stipulated in a manner that was too vague. She chose to ignore that, and she chose to consider, as the court did in Carter, that the only objective of Bill C-14 was to protect persons who could succumb to MAID in a moment of vulnerability. I think we need to take a look back at that decision and—

● (1310)

The Chair: Thank you, Mr. Racicot. I appreciate that.

Thank you, Mr. Virani.

We will now move on to Mr. Thériault for two and a half minutes.

Go ahead, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: Mr. Racicot, you just said that you think medical assistance in dying is not end-of-life care.

The Quebec legislation has managed to include into a continuum of care a request to die stemming solely from the patient's desire and will, when the dying process has already begun and is irreversible. That should happen in a comprehensive context of palliative care.

Let's think of Cicely Saunders and Elisabeth Kübler-Ross. Palliative care is comprehensive support for the dying. It is an alleviation of psychological and physiological suffering. That is care, and a patient in palliative care sometimes gets better. Palliative care can slow down the dying process, which is irreversible, and cause undesirable effects that may be related to pain medication.

Do you think that medical assistance in dying requested by a so-called comprehensive palliative care patient, in the best of cases, is not end-of-life care?

Mr. Michel Racicot: I don't consider it care. It is not care to such an extent in the medical and legal sense of the term that Bill 52 amended the Act Respecting End-of-Life Care to clarify that providing a patient with a substance to cause death has become a medical act. That was not previously the case. None of the Quebec legislation on health care ever mentions alleviating.... Although, according to the World Health Organization's definition, palliative care can in no case be an act causing death. Of course, there may be....

Mr. Luc Thériault: Sorry, Mr. Racicot, but palliative care is not about letting the person die. It is care provided to alleviate pain, and in the alleviation of pain, a last dose will be administered that will be fatal. It is false to say that palliative care does not cause death. It will end up causing death, as you know very well.

We should wish for all humans on their death bed to be serene and ready to go. They should feel well supported in dying. I wish it to you, in any case.

[*English*]

The Chair: Thank you, Mr. Thériault.

Mr. Michel Racicot: Can I respond?

The Chair: No. Unfortunately, we don't have that time.

We now have Mr. Garrison for two and a half minutes.

Please go ahead, sir.

Mr. Randall Garrison: Thank you, Madam Chair.

Could you just clarify when this session will be ending? We are considerably overtime. We may have to make some other arrangements.

The Chair: After you, we have only another 10 minutes.

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

Given that we're drawing to a close here, I'd like to give my last time to Dr. Janz, having heard the questions and the presentations made here today, to make any final comments she would like to make to the committee.

Dr. Heidi Janz (via text-to-speech software): Thank you.

I think any civil society is based on a delicate balance of individual rights on the one hand and social responsibility on the other. We have seen from our neighbours to the south what happens when individual rights take precedence over social responsibility. A lot of people die needlessly. Do we as a country want to take that approach to MAID? Because that is what Bill C-7 currently does: It makes us into the U.S.

Thank you.

● (1315)

The Chair: I'm sorry, Mr. Garrison, but that is all the time you have.

I will go now to Mr. Moore for five minutes.

Go ahead, Mr. Moore.

Hon. Rob Moore: Thank you, Madam Chair.

Thank you again to all of the witnesses. There has been very informed and relevant testimony today. It raises grave concerns with me about the sufficiency of the amount of time the government has put forward to deal with this legislation. I feel that we should be having more meetings of this committee because we're hearing new perspectives now that we haven't heard in previous testimony.

It's been put out there that there's been some kind of unanimity and great support among the medical community, but, Dr. Frazee, we've seen a letter signed by almost 800 doctors who have expressed serious concerns about how Bill C-7 opens up the medical assistance in dying regime in Canada. I want you to comment specifically on something.

Bill C-14 had a number of safeguards in it. After the Truchon decision, the government responded with Bill C-7, but in doing so, it has stripped out a number of safeguards that it didn't have to: the 10-day reflection period, the requirement that there be two witnesses—things that could provide an element of safeguard for those who are engaged in this process. I'd like your comments on that, because I think it's greatly troubling when we see safeguards that were put in place very recently and then, at the first instance, we're stripping them away.

Dr. Catherine Frazee: Yes, absolutely. We have been actively documenting—and we can provide ample evidence, anecdotal evidence—cases that come to our attention through the mainstream press and on social media of instances of how, even with the universally applied requirement of the most fundamental safeguard of reasonably foreseeable natural death, we see adverse impacts on people with disabilities. This has led to the raising of a human rights concern, as Dr. Janz mentioned, with the special rapporteur from the UN on the implementation of the Convention on the Rights of Persons with Disabilities.

We know there are problems with the existing law and we also understand that there is a review of that law scheduled at some point in the future, at which point I think we would advocate for much more rigorous and independent monitoring of the current practice of medical assistance in dying to ensure that it is applied and that its effects are equally felt and equally autonomy-promoting. At such a time, it seems really alarming to us—more than alarming, fundamentally wrong—to be removing safeguards, the most critical of which, as I've already said, is the requirement that you be at the end of your life.

● (1320)

Hon. Rob Moore: Dr. Frazee, we heard prior testimony today from Krista Carr from Inclusion Canada. She described this situation now as the "worst nightmare". That's pretty strong language for those persons with disabilities. What is the government missing here in what I think is an overreach in this response?

Our position was that this should have been appealed. It was a lower court decision in Quebec and it should have been appealed. When you have a brand new bill, as Bill C-14 was, it's the government's responsibility to defend its legislation and at the first instance, it gave up on its own legislation and the safeguards that were in it.

I'd ask you to speak to why this would be described as the worst nightmare for those persons with disabilities.

Dr. Catherine Frazee: Absolutely. There was a delicate balance between autonomy and equality struck in Bill C-14. If Bill C-7 proceeds, that delicate balance will simply no longer exist. It is a nightmare scenario, both in terms of the message it will send and in its immediate consequences.

Sorry.

The Chair: Thank you very much for that, Dr. Frazee.

We'll now go on to Dr. Powlowski, for five minutes.

Go ahead, sir.

Mr. Marcus Powlowski: Thank you.

I am, by my nature, not overly enthusiastic about MAID, having spent 35 years trying to do the opposite, providing people with life. That's certainly one of the reasons.

I have worked a lot in developing countries. It seems to me questionably ethical that we're putting all this money into helping people to die here when so many people around the world, but for a few dollars, die in other places.

Having said that, Bill C-7 was drafted after extensive consultation, including with the disabled.

Specifically on the question of removing the reasonable foreseeability of death criteria from the law, we've heard a lot of people today who are against that. To those people, I ask, what do you say to somebody who has a high spinal cord injury and ends up quadriplegic at a young age?

Dr. Goligher, as a fellow emergency room doctor, I'm sure you've seen some horrible injuries—burns, disfiguring injuries. I certainly hope that all those people manage, and we've seen them at least with the specific injury, and we certainly hope their life remains worth living, but for some people that may not be the case. Even though we provide them with all the assistance we can, they can still decide that they don't want to live that life with those disabilities. If, God forbid, this happened to any of my six kids—and certainly if it did I would do my best to make their life worth living—at some point should they decide they don't want to live, and you love them, shouldn't we be giving them the opportunity, should they wish to end it?

What is your proposal, then? Should those people not be given the option?

I throw that to anyone out there.

Dr. Ewan Goligher: I'd be happy to address that.

There is no question that these patients may suffer greatly, but the thing that never fails to amaze me is the resilience of the human spirit. I have seen many patients with spinal cord injury and one of the things that is well documented in the literature, and as other witnesses have already said, it is that we often and nearly always profoundly underestimate the extent to which those patients value their lives and value other persons.

I have presented reasons why I would not be willing to participate in ending the life of a patient in that condition because it would be treating them as...a means to an end.

Now, it is a free society and some doctors are willing to do this, but if you're going to put this law in place then it needs to guarantee that someone like one of your children, in the terrible scenario that we all fear, which you presented, has all of the potentially reversible determinants of suicidality addressed.

For the patient I spoke of, who was just deeply, profoundly lonely and isolated, we ensure that those kinds of needs and concerns are addressed. This law needs to guarantee that those processes and the infrastructure are in place to meet patients' needs before they arrive at a position where they feel like they have no option left but to seek euthanasia.

● (1325)

Mr. Marcus Powlowski: Does anyone else want to address that question?

Mr. Michel Racicot: One thing that is important is to allow people sufficient time to adapt to their new incapacity, to their new disability. Most often—and the evidence that was presented by the federal government in the Truchon case, showed—people, once they have adapted to their new situation, find a meaning to their life, even to the extent of finding much more meaning than people who are not disabled. The literature supports that as well, as I'm sure you know as physicians.

We need time, and the 90-day period is not sufficient to adapt to this new situation when you cannot even get treatment in 90 days.

The Chair: You have 10 seconds.

Dr. Catherine Frazee: Madam Chair, I saw Dr. Janz had her hand up and I also—

The Chair: My sincerest apologies. I understand the time limitations. If there is information on any questions that need further clarification by witnesses, could you please submit it in writing to the committee through the clerk? We'd appreciate that.

With that, having exhausted our two rounds of questioning, I would like to thank our witnesses for their time today. I will clarify, based on some of the testimony presented by witnesses, that we have established how much time is given for witnesses to be able to make their presentations at committee. We tried to accommodate based on what we could. I really do thank you for taking that time and for working within the confines of our justice committee.

Thank you.

To the members, I have two quick points.

First, the amendments or any proposed amendments you have are due Friday the 13th, by 4 p.m. Please note that if you would like some assistance in drafting amendments, get in touch with the legislative clerk if you have any questions they can answer.

The last thing is that we do have one open slot for this coming Thursday based on how the witness lists ended up landing. We have a written request from the Canadian Nurses Association to be invited, so if I have your consent, we will go ahead and provide that invitation to it to come in.

I see nodding. Just give me a thumbs-up so I can see it.

All right. With that, I thank you once again for a wonderful meeting—

Hon. Rob Moore: On a point of order, Madam Chair, again today we've gone overtime by half an hour. The testimony we're hearing is so important. We're not hearing unanimity; we're hearing different sides. We're hearing people speak with compassion on both sides of what's a really important issue. In light of all of this, I am going to be moving a motion that this committee study this legislation for two more days, two more two-hour sessions, so we can hear more testimony from more witnesses.

I recognize that the government has a timeline it would like to keep to, and I'd like to see us be able to do that, but I really feel that to do our job properly we need to hear more testimony, so I'm proposing a motion that we hear two more days' worth of witness testimony.

The Chair: Thank you for that, Mr. Moore.

I'm just going to turn to you, Mr. Clerk, given that we had passed a motion already on the timing. I come to you to seek clarification as to what the procedural impact of this motion would be.

The Clerk of the Committee (Mr. Marc-Olivier Girard): I would only suggest that maybe what Mr. Moore really meant was to add a few words at the start of his motion saying something like, “Notwithstanding the decision made by the committee on *x*, *y*, *z* date, that”, and then the rest of his motion. That would make it perfectly in order.

Thank you.

● (1330)

The Chair: Thank you, Mr. Clerk.

I see, Mr. Virani, you have your hand raised. I encourage members to use the blue raise hand function on the participants list.

Go ahead, Mr. Virani.

Mr. Arif Virani: Thank you.

I appreciate the comments by Mr. Moore. I also appreciate your work as chair to facilitate and use your discretion to ensure that we're hearing the testimony and to provide accommodation to today's witnesses, and to undertake all of the important initiatives. However, I also think it's important for the committee to respect the decision of the steering committee that was already made with respect to the procedure this committee would follow. There was Conservative representation at that steering committee meeting. Decisions were made. I can't go into details about those because I believe they are—

[*Translation*]

Mr. Luc Thériault: Madam Chair, there is no interpretation, and we are struggling to hear Mr. Virani.

Mr. Virani, you have to speak louder.

[*English*]

Mr. Arif Virani: I'm sorry. I will speak louder.

The Chair: Thank you, Mr. Virani.

Mr. Arif Virani: I apologize, Mr. Thériault.

[*Translation*]

It was just a microphone issue.

[*English*]

I will speak in English now.

While I appreciate the intervention by Mr. Moore, I also appreciate, Madam Chair, your ability to stickhandle today's meeting and provide accommodation to the witnesses where required and to use your discretion to ensure that we had enough time to get through this important testimony. I also believe it's important to stand by decisions the committee has already made, and I'm quite reticent to see decisions being revisited, meeting after meeting, that have already been made. There was already a decision made by the steering committee on procedure. That is why it is constituted, so we can have all the parties come to an agreement as to how we will roll out a study on a given bill.

We do have a court-imposed timeline on this bill. That's an important timeline. We've had agreement, including with Conservative input, on how this bill would be structured, how many days would be devoted to the study and how many days would be devoted to clause-by-clause. Those are important decisions that have already been made, and my view is that we should stick by those determinations. If we need to take a vote on Mr. Moore's impromptu motion today, then perhaps we should take a vote on it.

Thank you.

The Chair: Thank you for that, Mr. Virani.

I have three more people on the speakers list. Obviously I'm cognizant of time. I would ask members to please keep your remarks as brief as possible so we can get through the day.

Madam Findlay, you're next.

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

Firstly, I would second that motion. Committees, the way they are structured, are masters of their own fates. We can revisit anything. There was some confusion about what happened at the subcommittee to begin with, as I recall, when we rolled it out at an earlier meeting. Although that decision was taken, there is nothing stopping us from revisiting any such decision.

I am finding it very difficult, with such an important bill, to have the witnesses rushed as much as they are. There's not much time for good questions. If we are talking to any witness who may be a person with disabilities, we need to give them a little more time, sometimes. This is not the way we should be dealing with such important legislation.

We would still be well within the time allowed by the court. I really urge the committee to consider this so that we are not seen by Canadians to be rushing such an important bill and that we give it the time it needs.

Thank you.

The Chair: Thank you, Madame Findlay.

Mr. Moore, I have you next on my list. Go ahead.

Hon. Rob Moore: Yes, notwithstanding any discussions that took place at the steering committee, when we see how rushed we've been with our witnesses, when we see the interest that there is in this bill, and when we start to hear the testimony, it's perfectly reasonable for us as a committee to say, “You know what? We do need a couple more days.”

I'm not asking that we add 10 days or anything like that, but I think two more days of witness testimony and the ability for members of Parliament to ask questions that we're beginning to explore now. I'd ask the members of the committee to consider that, in spite of all the things that we're hearing, we only have one more day scheduled to hear witnesses.

Really, we get in one round of questions. The witnesses present for a few minutes each. The chair is doing her best to facilitate this within the time constraints that we have. I think, in light of that, we need a little more time. I would suggest that we take two more days. That is my motion.

● (1335)

The Chair: Thank you.

I see Mr. Cooper. We'll have exhausted the list at that time, and then we'll go to a vote.

Go ahead, Mr. Cooper.

Mr. Michael Cooper: Thank you very much, Madam Chair.

Let me just say, as the Conservative who was at the subcommittee meeting, that at no time was it my position that four meetings followed by two meetings of clause-by-clause was adequate. I think, based upon the testimony that we heard today, it's become clearer that it is insufficient and that more time is required.

I know, having served on the Special Joint Committee on Physician-Assisted Dying and then on the justice committee with you, Madam Chair, during the study of Bill C-14, that there was a very thorough process. It not only resulted in more meetings, but longer panels.

This is a very condensed process. It's one of the most complex areas that Parliament could possibly legislate. I think Mr. Moore's motion to simply require an additional two meetings would provide an opportunity for this committee to do its due diligence without, in any significant way, running up against the clock that the government is concerned about.

Again, with respect to that clock, the government wouldn't be in this situation had it chosen not to prorogue Parliament. Thank you.

The Chair: Thank you, Mr. Cooper.

Just—

Mr. Arif Virani: Could I just raise a point of order, Madam Chair?

The Chair: Yes, go ahead.

Mr. Arif Virani: I'm asking for clarification from you and from the clerk.

I, like Mr. Cooper, I believe, joined Parliament in 2015. I'm aware of the fact that when you have an in camera meeting the results of the meeting are made public but not the deliberations, including the positions that were taken. Mr. Cooper seems to have waived that confidentiality and just indicated his position at that meeting. I just don't know whether that's appropriate. I certainly have never done it. I'm seeking clarification from you and from the clerk as to the propriety of that.

The Chair: We'll go to you, Mr. Clerk, to clarify the rules of in camera meetings, and whether what Mr. Cooper has spoken about violates those rules.

[*Translation*]

The Clerk: Madam Chair, I wanted to mention to the committee that decisions leading to the passing of motions introduced at in camera meetings—be it in subcommittee or the committee of the whole—are public, but the deliberation that lead to the committee carrying or defeating a motion are still confidential and must remain so.

[*English*]

The Chair: Thank you for that clarification, Mr. Clerk.

Thank you for that point of order, Mr. Virani.

At this time I would just like to suspend for 30 seconds while I consult with the clerk on a couple of things.

Thank you very much.

In the interest of time, I would ask you, Mr. Clerk, to call the vote and we will come back with a more detailed ruling as to the words and then the point of order raised by Mr. Virani.

Mr. Clerk, could I please ask you to record a vote on Mr. Moore's motion?

Prior to doing that, would you just read out the text of Mr. Moore's motion as well?

● (1340)

[*Translation*]

The Clerk: I assume that Mr. Moore must read his motion again. Did I understand correctly? I apologize, I was on the French channel.

[*English*]

The Chair: Yes, could you just read exactly what committee members are voting on and then we'll record the vote?

Hon. Rob Moore: That, notwithstanding any prior decisions of this committee, this committee undertake two additional days of study on Bill C-7.

(Motion negatived: nays 6; yeas 5)

The Chair: Thank you very much, gentlemen and ladies.

The meeting is now adjourned.

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