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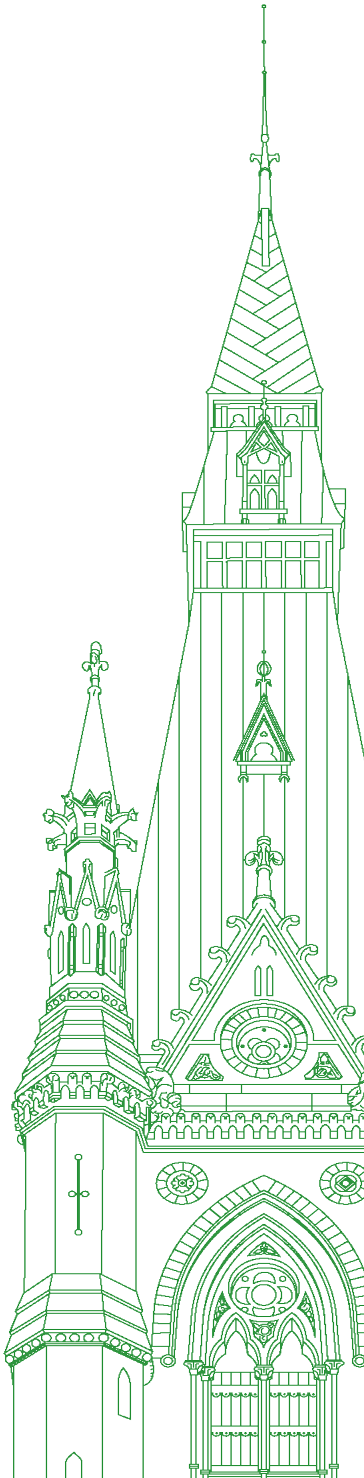

Chair: Ms. Iqra Khalid

Standing Committee on Justice and Human Rights

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● (1100)

[*English*]

The Chair (Ms. Iqra Khalid (Mississauga—Erin Mills, Lib.)): I call this meeting to order.

Welcome to meeting number seven of the House of Commons Standing Committee on Justice and Human Rights. We are studying Bill C-7.

First and foremost, I understand that Mr. Manly from the Green Party is requesting to join our meeting today.

Mr. Clerk, is Mr. Manly with us right now?

The Clerk of the Committee (Mr. Marc-Olivier Girard): He's actually asking to be admitted. I can grant the access right now.

The Chair: Thank you.

I seek unanimous consent from the committee to allow him to be part of this committee if that's okay. Please give a thumbs-up to show your consent.

Go ahead, Mr. Clerk, and allow him in. Thank you.

To ensure an orderly meeting, I would like to outline the following rules. Members and witnesses may speak in the official language of their choice. Interpretation services are available for this meeting. You have the choice, at the bottom of your screen, of floor, English or French for your own interpretation needs.

I remind members and witnesses that all comments should be addressed through the chair. When speaking, please wait until I recognize you. Unmute yourself and speak slowly and clearly for the sake of interpretation. When you are not speaking, your microphone should be on mute.

With regard to the speakers list, the clerk and I will do our best to maintain a consolidated order of speaking for all members. I have time cards. I have a one-minute card and a 30-second card to give you advance notice of how much time you have remaining for your remarks and for your questions.

Mr. Manly has also asked if he can be allowed some time to ask questions. I ask whether there is unanimous consent of the committee to allow Mr. Manly two and a half minutes for the first panel and two and a half minutes for the second panel to ask his questions. You can indicate this by showing me a thumbs-up, or a thumbs-down if you don't agree.

We do not have unanimous consent, but please note that members are able to share their time with Mr. Manly if they should choose to do so. Mr. Manly is welcome to visit and to participate in the committee.

At this time, I'd like to welcome our witnesses. We have before us, appearing as an individual, Dr. Jennifer Gibson, director and Sun Life Financial chair in bioethics at the University of Toronto Joint Centre for Bioethics. We also have Dr. Alain Naud, family physician and clinical professor at the department of family and emergency medicine at Laval University. We also have the Honourable André Rochon, retired justice of the Québec Court of Appeal, and we have David Roberge from the Canadian Bar Association.

Each witness will have five minutes to make their opening remarks. We'll go ahead and start with Dr. Jennifer Gibson.

Please go ahead, Doctor. You have five minutes.

● (1105)

Mr. Arif Virani (Parkdale—High Park, Lib.): Madam Chair, I'm sorry, but just before we commence, I find it a bit less than parliamentary that we're allowing Mr. Manly to participate but not allowing him to ask questions for 2.5 minutes in each of the next two hours. I would ask for a recorded vote on that point.

Thank you.

The Chair: Go ahead, Mr. Moore.

Hon. Rob Moore (Fundy Royal, CPC): I would give my consent for two and a half minutes for each panel. I thought you said two and a half minutes per round, which would be five minutes.

The Chair: No, sir, I said two and a half minutes per hour: two and a half minutes for the first panel, and two and a half minutes for the second panel.

Hon. Rob Moore: That's fine by me.

The Chair: Can I ask again for unanimous consent for two and a half minutes for Mr. Manly? Can I see thumbs-up from everybody? Just to confirm, I see thumbs-up from every single member who is permanent on this committee.

Thank you, Mr. Virani, for raising that. It's greatly appreciated. I will add Mr. Manly to the speakers list at the bottom of each hour.

With that, Dr. Gibson, please go ahead. You have five minutes.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Madam Chair, the witnesses should be reminded to speak slowly and clearly, even if they have very little time to make their presentations. This will prevent us from interrupting them, and the interpreters will be able to do their job well.

The Chair: Thank you, Mr. Thériault.

[*English*]

I made that remark when the meeting opened, but I will remind the witnesses to please speak slowly and clearly so that the interpreters can do their work.

Go ahead, Dr. Gibson. You have five minutes.

Dr. Jennifer Gibson (Director and Sun Life Financial Chair in Bioethics, University of Toronto Joint Centre for Bioethics, As an Individual): Thank you so much for the invitation to join you today. As noted, I'm affiliated with the University of Toronto, but in 2015 I co-chaired the provincial-territorial expert advisory group on physician-assisted dying. In 2017-18, I was co-chair of the Council of Canadian Academies' expert panel on medical assistance in dying, and chaired the working group on advance requests for MAID. Today I am speaking as an individual drawing from these experiences and my disciplinary background in ethics and health policy.

I had the privilege to meet with this committee in spring 2016 in relation to Bill C-14. Over the last few weeks, I've been reflecting on how much has changed in four and a half years and how better prepared we are to contemplate amendments to the legislative framework for MAID in Canada with some confidence. In 2016, we did not have any Canadian experience to draw from, and relied on experience from other jurisdictions. We did not yet have systems and care processes in place to offer MAID to eligible persons and needed to build these. We did not know what actual effect the introduction of MAID would have on Canadians. Would it displace palliative care? Would it make people more vulnerable and not less?

Today, with the benefit of almost five years' experience, we have learned that MAID can be provided safely and compassionately to Canadians. We have Canadian evidence to draw from. We have the lived experience of Canadian families, caregivers and clinicians to shed light on its practice. We have heard from community groups and individual citizens about how, and to what extent, MAID fits within a continuum of supports for persons who are suffering.

Bill C-14 sought to outline a legislative framework, including eligibility criteria and procedural safeguards, but sought ultimately, to the greatest extent possible, to respond to Canadians' suffering whilst balancing the autonomy of persons seeking MAID on the one hand and the interests of vulnerable persons in need of protection and those of society on the other. The project of striking the right balance of these values-based commitments continues today.

Many of the comments from witnesses and organizations who have appeared before this committee have drawn attention to the suitability and appropriateness of key safeguards, both those that are in the current legislative framework and those that are being contemplated in Bill C-7. Such current safeguards, such as the 10-day reflection period and the requirement of final consent, were introduced in order to ensure that only those Canadians who wished MAID actually received it and to protect and promote their autonomy.

Experience of the last four and a half years has shown that the effect of the safeguard may not have been what was originally intended. On the one hand, we have heard from clinicians about some patients who have forgone pain medication and endured preventable suffering in order to sustain their capacity to provide final consent. On the other hand, we have also learned from clinicians, families and caregivers that persons seeking MAID are most often not ambivalent about their choice. In the words of a member of the public who emailed me in December 2015 and who was facing a life-limiting illness, “no patient is going to reach such a decision and request lightly”. Hence, the removal of the 10 clear days and final consent seemed to be a good step forward toward striking a new, appropriate balance in safeguarding Canadians who have already been found eligible for MAID.

There is little doubt about the importance of safeguards to protect vulnerable persons who might, as per the original preamble to Bill C-14, be induced in moments of weakness to end their lives. A lesson we may draw from our experience of the last four and half years is that in developing safeguards, we must be especially attentive to the potential impact of the safeguards, notwithstanding their intent to protect. We must be especially wary of a safeguard if it may reasonably have the effect of rendering some persons more vulnerable. The protection of vulnerable persons turns on safeguarding competence, voluntariness and consent. Exclusion of otherwise competent persons may be justifiable in limited circumstances if there is a strong case to be made from the perspective of justice. Failing this, though, these exclusions violate the autonomy of competent persons of such groups and unjustly force these individuals to remain in a state of enduring and intolerable suffering.

● (1110)

For these reasons, we may wish to consider whether the 90-day reflection period will, in fact, be protective or may instead contribute toward enduring suffering of persons who are already found to be eligible for medical assistance in dying.

The Chair: Thank you, Dr. Gibson. I'm going to have to stop you there. We are at the five-minute mark, and I'm hoping that the rest of your testimony can come out in questions.

Dr. Jennifer Gibson: Thank you.

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

We will now move on to Dr. Alain Naud.

Sir, you have five minutes. Please go ahead.

[*Translation*]

Dr. Alain Naud (Family Physician and Clinical Professor, Department of Family and Emergency Medicine, Laval University, As an Individual): Thank you very much, Madam Chair.

First of all, I would like to thank the committee for its invitation to share my experience with its members.

I have been a family and palliative care physician for 35 years, and I'm a clinical professor. I also acted as a medical expert in medical assistance in dying and palliative care in the trial of Ms. Gladu and Mr. Truchon.

I have personal experience with supporting more than a hundred patients who have received medical assistance in dying and their loved ones. After five years of concrete experience in Quebec and almost everywhere else in Canada, I think it's important to anchor our reflections and decisions in the reality of the field, as well as to listen to the testimonies of patients, their loved ones and the caregivers involved.

Let me give you a few observations.

Medical assistance in dying is compassionate care that is provided by a whole team. The choice for a person to resort to it is never impulsive, but rather the result of a long reflection lasting weeks, months and sometimes years, anchored in the flesh and suffering. To realize this, you have to have met these patients, supported them and their loved ones, and been with them to the end.

There is no opposition between palliative care and medical assistance in dying. They are legitimate and legal end-of-life options that are interrelated and complement each other. In all of our palliative care units, physician-assisted dying is fully integrated as a possible choice and option.

For the past five years in Quebec, medical assistance in dying—or MAID—has been administered very rigorously and with full respect for rights. The problems that have been observed have all be in the obstruction by certain caregivers and certain institutions of legitimate access to MAID. This is where we find the real vulnerable patients who are not protected. In Quebec, this affects 33% of requests, or one patient out of three.

The following elements of the bill should be retained. It contains major improvements that are important to patients. The first improvement is the need for only one witness at the signing, who can be a caregiver. The second is the repeal of the mandatory 10-day waiting period, which for most patients was sheer cruelty. The third improvement is the possibility of waiving in advance the obligation to still be fit at the time of the procedure.

Now the following are the elements of the bill that need to be changed. The phrase “reasonably foreseeable natural death” is the biggest stumbling block to this bill for several reasons that I address in the document you have already received. The term does not meet any medical concept or definition. It doesn't exist in any medical textbook. Yet it is the responsibility of physicians to assess the eligibility of patients.

Removing this term from the eligibility criteria as a safeguard doesn't give it any more meaning or a recognized standard medical definition. Maintaining this term will continue to place an intolerable and unacceptable burden on the shoulders of medical evaluators to interpret a criterion that has no medical meaning and for which there will never be a consensus. The term should be removed. Other measures are largely sufficient to ensure the protection of vulnerable patients.

If Parliament wishes to maintain different safeguards for two distinct categories, I suggest replacing this expression with the introduction of a “prognosis of death of less than 12 months” or “of more than 12 months”, which would avoid the randomness and subjectivity of the answer to be given. The concept of prognosis is very clear, well-defined and used daily in the medical world.

With respect to mental health and psychiatric illness, I have detailed my observations in the document. I believe it is appropriate for the bill to include indications that would allow these patients to see the light at the end of the tunnel, thereby avoiding further legal challenges to the law and suicides.

I think the term “assisted suicide” should be replaced by “medical assistance in dying by oral medication”, which is what it really means.

Items not covered in the bill include advance medical directives allowing access to medical assistance in dying after a diagnosis of Alzheimer's disease or other dementia. In the document, I propose simple and clear guidelines that would provide a clear framework for this care.

Lastly, with respect to the review of applications for denied or non-administered medical assistance in dying, the bill should provide much more explicit and rigorous mechanisms for systematically documenting and reviewing denials and non-administration of MAID. As I mentioned, this where the problems are and where the real vulnerable patients who have not been protected for five years in Quebec and for four and a half years in Canada are.

A summary of my recommendations are on the last page of the document.

● (1115)

Thank you, Madam Chair.

[*English*]

The Chair: Thank you very much, Dr. Naud, for staying within those five minutes on the dot.

We’ll now turn to the Honourable André Rochon for five minutes.

Go ahead, sir.

[*Translation*]

Hon. André Rochon (Retired Justice of the Québec Court of Appeal, As an Individual): Ladies and gentlemen, thank you for your invitation and for this opportunity to share with you our committee's thoughts on advance requests for medical assistance in dying.

In the name of a strong consensus in the country and in order to protect the autonomy and dignity of the person, I propose that the bill before you be amended immediately to give any person suffering from a major neurocognitive disorder such as Alzheimer's the right to MAID. The urgency of the matter is clear to me. In this regard, allow me to provide a brief reminder of the elements that led us here.

In 2015, the Carter decision set out the cardinal rule that, in exercising an individual's right to life, liberty and security of the person, every person must be free to make his or her own fundamental decisions without interference by the state.

Bill C-14 was passed in 2016. It provides for the formation of an expert panel to study three situations, including that of advance requests for MAID.

In 2018, this expert panel stated the following regarding advance requests:

> Having some assurance that their request for MAID would be honoured could provide comfort and relieve anxiety and distress at end of life for those who make this choice.
>
> …
>
> Allowing ARs for MAID might have an impact on the way society values people with capacity loss, increasing stigma and signalling that it is acceptable to consider a life with capacity loss as one not worth living.

In the face of the suffering and distress of all those who receive such a diagnosis, the question is no longer whether the compassion of Canadian society should grant us MAID. The time has come to define the parameters for the granting of this assistance and to put in place guidelines both to ensure the protection of potentially vulnerable people and to respect the clearly expressed will of the person affected.

So when a person receives such a diagnosis, which is likely to progress to severe dementia, they must be allowed to give an advance directive to request MAID when their situation has reached a serious and irreversible stage, provided that the person meets the following criteria: a) they are eligible for government health care; b) they are at least 18 years of age; c) they must be able to express their will freely, without external coercion or undue influence, and must not suffer from a mental condition that affects their judgment; d) a physician must certify that the person meets the above criteria when signing the advance directive.

To be valid, this directive must be renewed in writing after a six-month waiting period from the signature of the initial directive, ensuring that the four previous conditions are still met. This period is an important guideline, which provides a sufficient period of reflection for the person affected and ensures that the decision was not made impulsively or without sufficient reflection.

It goes without saying that this directive may be revoked at any time in writing, as long as the person is capable of doing so. The representative may ask the multidisciplinary team to begin the evaluation process as soon as it has reason to believe that the advanced stage of the disease is reached.

As an added precaution, the directive should be written in a prescribed form. I have appended to my presentation synopsis a template of this directive.

What you are being asked to do today is to provide a choice for anyone diagnosed with an Alzheimer's-type neurocognitive disorder. It isn't a matter of imposing a course of action, but rather of putting in place the necessary guidelines for exercising this choice.

Inspired by our values, this citizen is asking the government to come to their aid and provide them with the necessary care to relieve their suffering, preserve their dignity and respect their decision.

Thank you.

● (1120)

[*English*]

The Chair: Thank you very much, Mr. Rochon, for staying within the five minutes.

Last but not least, we will go to the Canadian Bar Association, represented by David Roberge.

Please go ahead, sir. You have five minutes.

Mr. David E. Roberge (Lawyer, End-of-Life Working Group, Canadian Bar Association): Good morning, Madam Chair and honourable members of the committee.

My name is David Roberge, and I am a member of the Canadian Bar Association's end-of-life working group. Thank you for inviting the CBA to discuss Bill C-7 today.

[*Translation*]

The Canadian Bar Association, or CBA, is a national association of 36,000 lawyers across Canada, with a mandate to promote improvements in the law and the administration of justice.

Our brief was prepared by the CBA end-of-life working group. This working group comprises a cross-section of members drawn from diverse areas of expertise, including constitutional and human rights law, health law, criminal law, wills, estates and trusts law, elder law, children's law, and privacy and access-to-information law.

● (1125)

[*English*]

While we applaud the government's efforts to clarify the law about MAID following the Quebec Superior Court's decision in Truchon, we have several concerns with Bill C-7. I would like to use my opening remarks to outline some of them.

Eligibility for MAID should be aligned with the criteria established by the Supreme Court of Canada in Carter, taking into account the protection of vulnerable people. The CBA supports the Quebec judgment in Truchon and highlights its interpretation of Carter, namely, that the essence of the Supreme Court decision is not proximity of death, but rather the prevention of intolerable suffering, as well as dignity and the autonomy of the person, for those who are capable to clearly consent to the termination of their life. We also support a patient-centric approach for capacity and consent, as adopted by the Quebec court in Truchon.

Returning to Bill C-7, in our view mental illness should not be excluded from the scope of the legislation, especially given the full MAID review initially planned for June 2020, and now pending. This exclusion forecloses a thorough review of the issue and suggests a conclusion that has not been debated or recommended. In Truchon, the court stated that vulnerability must be assessed from an individual perspective through informed consent. In our view, the general exclusion of all persons suffering from mental illness is likely to be constitutionally challenged.

Bill C-7 proposes two different sets of safeguards for MAID, the application of which depends on whether the person's natural death is reasonably foreseeable or not. The criterion of reasonably foreseeable death, which was declared unconstitutional in Truchon, has caused significant uncertainty in practice, and Bill C-7 does not give any guidance on how to apply it. Should the government maintain different sets of safeguards, we recommend that guidance be given to avoid confusion on which safeguards apply and to ensure appropriate access to MAID.

On another topic, the CBA has reservations about the requirement that one of the two assessors must have specific expertise in the condition causing the person's suffering. Appointments with specialists can take several months, and in some communities are not available. There is currently no requirement that individuals seek specialists when applying for MAID. It is up to the practitioners to determine their own level of expertise when assessing informed consent and to make an appropriate referral if need be. While some situations could justify seeking the opinion of a practitioner with specific expertise, a blanket requirement could have a disproportionate impact on some individuals and create a significant barrier to MAID.

[*Translation*]

Lastly, Bill C-7 provides that the final consent waiver to MAID applies only if death is reasonably foreseeable. It is our view that waiver of final consent should also be possible if death is not reasonably foreseeable, since it is possible to lose capacity to consent in both situations.

[*English*]

On behalf of the CBA, thank you again for the opportunity to present today. I look forward to answering any questions you may have during today's session.

The Chair: Thank you very much for that. I really appreciate it.

We will now go into our first round of questioning, for six minutes, starting with Mr. Lewis.

Go ahead, Mr. Lewis. You have six minutes.

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

Thank you to all the witnesses today. It's so vital that we continue to hear from across the country and have these discussions and open dialogue, and we certainly could use a lot more of them.

Dr. Catherine Frazee, a renowned academic with a disability herself and leader of Vulnerable Persons Standard, presented on Tuesday to our committee. She asked the question, why us? Why not indigenous or suicidal healthy young men or other marginalized persons on the fringes? What is it about persons with disabilities that makes it okay to target this character of protected group for a special track to get suicidal completion, and other groups get help, protection and resources?

She went on to point out that a majority of the Canadian population wanting MAID for those living with disabilities don't mean that they should be put in danger and that their minority voice be silenced and ignored.

In our last meeting, Liberal member Marcus Powlowski, in his question to Dr. Ewan Goligher, said that, if his son suffered a spinal cord injury and felt he wanted to end his life, he would support his son. He said this to an able-bodied witness among three other witnesses who live with disabilities. I have to believe that this was interpreted by these brilliant women as an instance of ableism, and this is exactly the kind of discrimination that makes disabled Canadians fear for their lives when Parliament is considering a bill like Bill C-7. It sends them a message that their lives are not worth living.

The impact of allowing MAID, which is an extremely inexpensive and fast-tracked option, in the absence of other options, such as financial support, pain specialists, good housing, and well-trained and sufficient home care, will lead to coercion, as evident already by many witnesses on Tuesday, such as Roger Foley and Taylor Hyatt.

A recent release in the Netherlands shows that there is growing interest in euthanasia from vulnerable people, those less educated, poor, isolated and lonely, and the findings suggest that many of those people would not ask for euthanasia if good social measures were in place.

My question for Dr. Naud is this: What do you think about disability groups unanimously asking for protections and not a suicide completion track in Bill C-7?

● (1130)

The Chair: Go ahead, Dr. Gibson.

Dr. Jennifer Gibson: My apologies, Madam Chair. I thought the question was directed to Dr. Naud.

The Chair: Oh, my apologies.

Mr. Lewis, whom are you addressing the question to?

Mr. Chris Lewis: It was to Dr. Naud, Madam Chair.

The Chair: Please go ahead, Dr. Naud.

[*Translation*]

Dr. Alain Naud: Thank you for the question.

It is often presented as a choice between MAID and resources for vulnerable or marginalized groups. It isn't a choice between the two, but rather a choice to help marginalized groups and give them all the care and resources they need. This doesn't preclude some patients from exercising the free and informed choice to seek MAID because they feel that their life is no longer worth living. The clear message of the Supreme Court of Canada in the Carter decision must be remembered that the right to life must not be transformed into a duty to live.

All of this stems from the concepts of autonomous decision-making, free and informed choice, and the assessment of an individual's capacity to consent. The judgment involving Mr. Truchon and Ms. Gladu highlighted that vulnerability is not intrinsic to a group of people by virtue of their characteristics, and that this must be assessed on a case-by-case basis.

Why should people with severe disabilities be given the option of MAID? Mr. Truchon and Ms. Gladu have already been asked this question. The judgment in this case is very clearly set out over close to 200 pages. It isn't a choice between MAID and access to resources, but all of this all at once, respecting the free choice of an individual based on their own condition. Indeed, the individual is the only witness to their suffering and what they are capable of tolerating or not.

[*English*]

Mr. Chris Lewis: I have one last question for Dr. Naud, please.

What do you think about the stories of coercion that we heard in committee and that are emerging in the news in light of the Netherlands study, which is farther along since the implementation and already has evidence that this is a real issue?

[*Translation*]

Mr. Luc Thériault: Excuse me, Madam Chair.

The interpretation isn't working for this question.

[*English*]

The Chair: Mr. Clerk, can you just confirm that the interpretation is working properly?

The Clerk: It is now working, Madam Chair.

● (1135)

The Chair: Thank you, Mr. Thériault, for pointing that out.

I stopped the clock for you, Mr. Lewis.

Mr. Naud, you have 30 seconds to respond. Please go ahead.

[*Translation*]

Dr. Alain Naud: Would it be possible to translate the question to make sure I've understood it correctly?

Mr. Luc Thériault: Madam Chair, I'd like the question repeated. That was the purpose of my intervention. I don't like to interrupt the witnesses for no reason.

[*English*]

The Chair: Thank you.

Mr. Lewis, please repeat your question.

Mr. Chris Lewis: Thank you, Madam Chair, and thank you for being so fair with this. It is a very important question.

Dr. Naud, what do you think about the stories of coercion that we heard in committee and that are emerging in news in light of the Netherlands study, which is farther along since implementation and already has evidence that this is a real issue?

The Chair: Dr. Naud, you have 30 seconds.

[*Translation*]

Dr. Alain Naud: Thank you for your question, Mr. Lewis.

It's important to be very careful when citing studies from other countries. The Netherlands is a different jurisdiction, a different society. Just because a study shows something doesn't mean that it's true and can be trusted.

The coercion we've observed over the past five years, in Quebec and in Canada, isn't in the administration of MAID, but rather, as I mentioned, in the obstruction that certain individuals and institutions oppose free and legitimate access to this assistance. People are being pressured to withdraw a request for MAID or not to apply for it.

[*English*]

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

I will now move on to the Liberal round of questions. I understand that Mr. Virani will have the first minute and then the remainder is for Mr. Maloney.

Please go ahead, Mr. Virani.

Mr. Arif Virani: Thank you.

I just want to say thank you to the witnesses. Dr. Gibson, thank you for your expertise on this issue over the past many years. I'm proud to call you a constituent.

Dr. Gibson, the issue of autonomy has came up and you underscored this in your testimony. In Tuesday's meeting, questions were put about the autonomy of persons with disabilities. Allegations of discrimination were put into the record as to the idea that by proposing a bill like Bill C-7, discrimination is being perpetuated against persons with disabilities.

I find it actually to be quite the converse, and so do Senator Petitclerc and a former Conservative cabinet minister who is himself a person with disabilities, Steven Fletcher. In the Truchon decision, they looked at this particular idea and said that, if you deny persons with disabilities the ability to make a decision autonomously about when they pass, you're in fact discriminating against them in contravention of the charter.

Given your expertise in bioethics and autonomy, could you comment in 60 seconds on this aspect of the Truchon decision, and how it intersects with what we heard at committee on Tuesday?

Dr. Jennifer Gibson: I think there are a few things here. One is to recognize that we often think about autonomy as individual, but many of our decisions are made in thinking about the people around us. It's a social concept of autonomy, which we all experience in our day-to-day lives. I think there are reasonable concerns that there may be social influences around a voluntary choice.

That said, one of the most interesting things coming out of the first annual report of MAID in Canada, which came out fairly recently, was that it showed that, of those individuals who actually needed disability supports, almost 90% were receiving them at the time they received MAID.

I think what we're seeing is that, on the one hand, we may have a resource access question, but on the other hand, we are also seeing persons with disabilities exercising their autonomy and making a choice for MAID, knowing that they also have supports around them. There may be different issues in play here, not a single issue that we need to be concerned with.

Mr. Arif Virani: Thank you.

It's over to Mr. Maloney, Madam Chair.

The Chair: Go ahead, Mr. Maloney.

Mr. James Maloney (Etobicoke—Lakeshore, Lib.): Thanks, Madam Chair. I'll try to abbreviate my questions.

My first question is for Mr. Roberge from the CBA, and perhaps Justice Rochon could comment.

You've made it clear that the CBA's position is that mental illness should not be excluded in this legislation. As I read your submissions, you support your position in part by saying that this hasn't been fully debated yet, which in my opinion would lead me to the opposite conclusion. I'm a little confused about that.

The second thing you said is that it's going to be challenged constitutionally. Well, part of the reason we're having this discussion is that it has already happened, and I fully expect it's going to happen again in the future.

Perhaps you could expand a little further on why you think mental illness should not be excluded.

● (1140)

Mr. David E. Roberge: Here's what I would say on behalf of the CBA. We believe that the response to vulnerability issues is to ensure there is informed consent. When discussing the issue of people with mental illness, clearly the issue of those people being vulnerable is being raised.

In Carter, the Supreme Court of Canada accepted evidence that vulnerability can be assessed on an individual basis by physicians. While recognizing that risks “are already part and parcel of our medical system”, the court noted that those issues are resolved through the assessment of informed consent on an individual basis.

The issue, in the CBA's view, with excluding all persons with mental illness from the MAID legislation is that contrary to what the Truchon decision has concluded, inferring vulnerability on a collective basis, in reference to a group seen as vulnerable people, may not adequately reflect the diversity of circumstances among that group. That's why we support a more patient-centric approach. That's why we also believe that the exclusion of all people with mental illness is a subjective constitutional challenge.

Mr. James Maloney: I may not give Justice Rochon an opportunity to respond. I'm going to ask my second question because I'm running very short of time.

I was a lawyer for some time before I did this, and I used to hire medical experts to give opinions. In my experience, the divergence of opinion is much bigger when it comes to the psychiatric realm than it is with other illnesses, which is why I am concerned about removing the mental health exclusion.

One of the other points you make in your submission is this piece with respect to experts, saying that it's not necessary. I understand the context if you're living in a remote community and whatnot. I grew up in Thunder Bay. I can appreciate that. My concern is this. Given the expressions of concerns on the mental illness side, are you suggesting that a general practitioner, for example, could give an opinion on mental illness in a MAID situation? Courts don't allow doctors to give opinions outside their area of expertise. I would think the threshold in this situation would be equally as high, if not higher.

The Chair: You have 10 seconds to respond, Monsieur Roberge.

Mr. David E. Roberge: On behalf of the CBA, I think it's really a case-by-case approach.

The concern that the CBA has with this blanket requirement is that, again, it may have a disproportionate impact on some individuals. Our position is to support the patient-centric approach that has been adopted by the Québec Superior Court in Truchon.

The Chair: Thank you very much.

We will now move on to Monsieur Thériault for six minutes.

Go ahead, Monsieur Thériault.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

I would like to thank the witnesses for their valuable contributions. I will address Dr. Naud, Judge Rochon and Mr. Roberge.

Mr. Roberge, do you believe that Bill C-7 would lead to as clear a challenge as with Bill C-14? Are there provisions in Bill C-7 that could infringe on the rights guaranteed under section 7 of the Canadian Charter of Rights and Freedoms and therefore be challenged in court? I am not asking for a thesis in response, just your quick impressions.

Mr. David E. Roberge: Thank you for the question.

On behalf of the CBA, I will refrain from expressing an opinion on how likely it is that this bill will result in a constitutional challenge.

That said, you heard my opening statement. Certainly, the CBA sees a significant risk of a constitutional challenge, particularly in terms of mental illnesses, which are excluded from Bill C-7.

● (1145)

Mr. Luc Thériault: Okay.

Judge Rochon, I want to begin by thanking you for giving us a form with specific wording. It is most valuable in the context of our discussion.

I have a concern about renewing the request every six months. You are advocating for a completely separate regime for neurodegenerative diseases. We are not talking about the 90-day period, but an entirely different regime that would have nothing to do with mental illness.

Why do you say six months and why a renewed request?

Hon. André Rochon: One of our concerns is the emotional reaction of a person who is diagnosed with Alzheimer's disease. Since it is a disease that evolves over a period of seven or eight years, we absolutely want that person to have time, if he or she submits a request, to think about it. A period of six months allows for that exercise of reflection. As I understand it, the reflection would take place over an initial period of six months and would not have to be renewed every six months.

Mr. Luc Thériault: Okay, thank you for that clarification.

Dr. Naud, you talked about obstruction. Patients must have a choice. Respect for a person's dignity implies self-determination and their deeply personal right to make, or not make, a decision about their own death.

You talked about obstruction and I would like you to expand on that. At the end of your testimony, you said that there should be increased monitoring of refusals. I would like to hear your thoughts on that.

Dr. Alain Naud: Thank you for asking that very important question.

When we talk about obstruction, we are talking about people who have signed a perfectly legitimate request for medical assistance in dying, but then someone just puts it in the garbage or on a shelf and waits for the patient to die. As I mentioned, some patients are under pressure to not make, or to withdraw, that request.

Not all of those cases are reviewed. When this happens, there is no accountability on the part of physicians and institutions. The only accountability is in the administration of medical assistance in dying. So we can say that this has been done in an extremely rigorous manner for five years now in Quebec.

Those are the vulnerable patients who are not protected. As I mentioned, in Quebec, one out of every three requests for medical assistance in dying, formulated in a completely legal and legitimate manner, is not addressed and we have no explanation. The blunders that we have observed over the past five years are not in the administration, but in the systematic obstruction by certain opponents for their own personal reasons, or by certain institutions. So it is important to examine that.

Mr. Luc Thériault: This is important, because when a piece of legislation provides for an exculpatory measure, it must not be illusory in reality.

Do you know whether certain units, certain hospitals, certain palliative care homes exclude a patient from palliative care because he or she has applied for medical assistance in dying?

Dr. Alain Naud: Thank you.

You should know that, in Quebec, all publicly funded institutions are required to provide medical assistance in dying. Only palliative care facilities, or hospices, had the option of not providing it. There are 34 of them.

Since the legislation came into effect, half of those hospices now provide medical assistance in dying. For the other half, there are still requests for medical assistance in dying, but those patients are simply discharged from the facility and sent to a public facility to die elsewhere. This is because they dared to apply for medical assistance in dying on the sole basis that they no longer wanted to tolerate their suffering.

In my opinion, what is shameful right now is the way these patients are treated.

Mr. Luc Thériault: Thank you.

[*English*]

The Chair: Thank you.

[*Translation*]

Thank you, Mr. Thériault and Dr. Naud.

● (1150)

[*English*]

We will now go on to Mr. Garrison for six minutes.

Go ahead, Mr. Garrison.

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

I want to extend my thanks to all the witnesses for appearing today and for the submissions. I know that some of them have been made separately.

At the beginning, I always have to express my frustration that some of the issues we're talking about in the committee go well beyond the mandate of the justice committee in studying Bill C-7. I hope we will have a special committee established that can deal with those broader issues, because these cannot be solved by adding one or two sessions to this committee.

My first question is for Monsieur Roberge. We have had testimony that raises questions about why the Truchon decision was not appealed. I would like to hear some comments on the relationship between the Truchon and Carter decisions, because I think there is a view that Truchon is set squarely within the parameters of Carter, and that some of these basic decisions were actually settled in Carter at the beginning of this litigation.

Mr. David E. Roberge: I'm not going to speculate as to why the Truchon decision was not appealed. That said, I think there are, indeed, common grounds between the two decisions, that of Carter and the Supreme Court of Canada and the Quebec decision in Truchon.

I think one of the common grounds for the CBA is, indeed, that both courts recognized the need again to have vulnerability assessed on an individual basis by a physician. While there are risks when discussing MAID for vulnerable people, those risks, the Supreme Court says, are already part and parcel of the medical system in other kinds of end-of-life decision-making, and they could be resolved through a proper assessment of informed consent.

I'm not going to go into the technicalities of the decision, but while the Supreme Court of Canada decision was grounded as an infringement of section 7, the Québec Superior Court also found an infringement of section 15.

I hope my remarks are helpful.

Mr. Randall Garrison: Yes, I believe they are.

I'm going to turn to Dr. Gibson, who raised the elimination of the 10-day waiting period and the establishment of a waiver of final consent.

Again, in the context of the court decision where ending suffering was a primary goal, can you comment on what would happen if we fail to change those two provisions.

Dr. Jennifer Gibson: One thing we might want to keep in mind is that, in fact, both of the two tracks recognized suffering as a primary motivation for somebody to be seeking MAID, except in the one case when it's a situation where somebody has already been very clearly found eligible and is concerned about losing their capacity. It's the dynamic of suffering together with potential loss of capacity, which I think has been really underscored. In fact, just to provide a slight modification to the way we think about what Bill C-7 is doing, it is providing a pathway for advance consent in a very limited set of cases.

When we think about this, we may want to think about what was the purpose of the waiting period such as it was originally envisioned as the 10 days. It was primarily envisioned as a safeguard against the possibility that somebody may be ambivalent perhaps, that they may change their minds. I think what we have learned along the way when we speak to clinicians—and this is confirmed by caregivers and families—is that the persons who seek MAID, and there's some evidence to support this as well, have stable preferences. They are unlikely to change their minds at that point.

To eliminate the 10-day waiting period is actually also to be responsive to the suffering that individuals were enduring whilst they waited for that 10-day period to end.

What we might want to think about is how does that thinking extend to the example of the 90-day waiting period, which is being proposed for the second track, which is not about reasonable foreseeability of death? We might also ask the question of whether individuals who approach the prospect of opting for MAID versus continuing in a state of enduring suffering are not approaching this from the perspective of a considered, well-grounded view.

In terms of the embedded requirement that there needs to be assurance of clinicians that this has been a well-considered decision, many individuals who are approaching a conversation about MAID are coming in with well-considered views. It may be not aligned with what their families and communities might wish for them, but, nevertheless, I think we might want to make a presumption of a well-considered view first, and then explore where there may be decisions where, in fact, there might be misunderstandings or a need to really shore up some clarity about whether or not that person is or is not vulnerable in that circumstance.

● (1155)

Mr. Randall Garrison: Very briefly, is there any reason to believe that removal of the 10-day waiting period or the establishment of a waiver of final consent would have differential impacts on any particular kinds of patients who are seeking medical assistance in dying?

Dr. Jennifer Gibson: I don't think we have strong evidence to support that being the case, but we do know that if we look at the the most recent reporting in Canada on the reasons that people might seek MAID under those circumstances, we see that these individuals are already eligible. They've reached the point where, now, they're waiting for MAID to actually be administered. The 10 days doesn't necessarily protect; it could create circumstances where persons are going to have to just wait longer in a state of suffering, after already having a very solid view on this.

I think it's worthwhile to consider at what point a patient has reached the point of being eligible, making a request and being willing to wait 10 days. These are stable and well-considered views by this point.

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

Thank you, Mr. Garrison.

We'll now move to Mr. Manly for two and a half minutes. Please go ahead.

Mr. Paul Manly (Nanaimo—Ladysmith, GP): Thank you very much, and thank you to the witnesses.

Thank you to my fellow members of Parliament for giving me the chance to ask a few questions.

There are protections and exemptions for mental health in this legislation. I've been hearing from the disability community in my riding about its concerns about people with cognitive disabilities, people who are non-verbal or who have trouble communicating. They obviously have suffering in their lives, but is it related more to the characteristics of the disabilities they're born with?

I am wondering, and I will ask Mr. Roberge this, if he thinks there are enough protections in this legislation for people who have characteristics they're born with and who are dealing with suffering, but may not have the capacity to make these kinds of decisions, or may be coerced into making a decision around MAID.

Mr. David E. Roberge: On behalf of the CBA, what is really important, obviously, is access to proper medical care. It's a key factor. I would leave it to people with more experience, like the physicians who have expertise and experience in this field, who are in contact with patients, to maybe address your question more directly.

But from a legal perspective, I would say that, of course, the quality of the safeguards does matter, as well as the monitoring of those cases. Again, at the risk of repeating myself, for the CBA it's important to still maintain a patient-centred approach to assess those issues on a case-by-case basis.

Mr. Paul Manly: Okay.

Would Mr. Naud would be willing to comment on that same question as well?

The Chair: Be very brief, Dr. Naud.

[*Translation*]

Dr. Alain Naud: Thank you.

In a few words, suffering is only one of the criteria. There are several others, including the ability to consent, all of which must be considered and evaluated very rigorously.

Even if a patient has difficulties speaking, we cannot circumvent the last criterion or all the others that ensure that medical assistance in dying is administered very rigorously and in full compliance with the law. I am therefore not concerned about the possibility that some patients who are ineligible for MAID may have inappropriate access to it.

[*English*]

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

I will move to the second round of questions, starting with Madam Findlay for five minutes.

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

Thank you all for being here with us today.

Mr. Roberge, in a letter to the Minister of Justice, from the Canadian Bar Association, dated February 11, 2020, the CBA wrote:

> Subject to the opportunity to add safeguards to the current Criminal Code MAiD framework, we believe that two additional measures compatible with the Carter decision may be considered:
>
> a longer reflection period before MAiD is administered; and
>
> a psychiatric assessment.
>
> These measures address capacity and consent to the termination of one's life, which are instrumental to the Carter decision.

Given this letter from just a few months ago, does the CBA support Bill C-7's complete abolishment of the 10-day reflection period, or what about a shorter reflection period?

● (1200)

Mr. David E. Roberge: When the CBA wrote about including a longer reflection period, it was with respect to cases where patients were not nearing death. I think Bill C-7 does include a longer period for those cases where death is described as not reasonably foreseeable. Although the CBA never expressed an opinion as to a specific delay or a longer period, I think Bill C-7 echoes the comments of the CBA.

With respect to the other aspect of your question, the CBA raised the possibility that in some instances, notably when capacity is more challenging to assess for physicians, there might be cases where consultation with a psychiatrist could be justified.

Again, I think we have some concerns about making a blanket requirement for all cases to have an expert with specific expertise in the condition causing the patient's condition, while realizing again that practitioners could make a referral if they feel they need more specific advice in this regard.

Hon. Kerry-Lynne Findlay: I'm having some concern about what I see as a gap in the logic. For me as a lawyer in British Columbia, if we are writing up a will, two independent witnesses have to sign it to ensure its authenticity and intention—and that's dealing with asset distributions upon death. Under Bill C-7, there's only going to be the need for one independent witness.

Do you see a gap in logic there as I do, or not?

Mr. David E. Roberge: The CBA working group on end of life did not address and discuss that issue specifically. I would refrain from voicing any opinion on this issue at this stage.

Hon. Kerry-Lynne Findlay: All right. Thank you.

My next question, Madam Chair, is for Dr. Naud.

[*Translation*]

Thank you for joining us today.

[*English*]

This committee has heard from several individuals and groups who are concerned about the bill, believing that it may harm both the medical profession and our country's most vulnerable. We've received a letter signed by 800 doctors from across, who have stated:

> We watch in utter dismay and horror at how the nature of our medical profession has been so quickly destroyed by the creation of misguided laws. We, the undersigned, declare that the passage of Bill C-7, if left unchecked, will contribute to the destruction of much more than our medical profession, but fundamentally, of a Canadian society that genuinely values and cares for its most vulnerable members.

What do you say to these nearly 800 doctors—obviously your colleagues—who are worried about this bill's impact on both the medical profession and vulnerable Canadians?

The Chair: Answer very briefly, please, sir.

[*Translation*]

Dr. Alain Naud: Thank you, Ms. Findlay.

These physicians represent fewer than 1% of the physicians in Canada. There is a world of difference between doctors who are at the bedside of the patients asking for medical assistance in dying, who are involved, who are committed, who know what they are talking about, who are able to testify that it is a rigorous process, and doctors who will talk about medical assistance in dying, but who have never met a single patient, who have never been involved, and who often show contempt for those patients by refusing to meet with them if they have applied for medical assistance in dying. This tiny proportion of doctors—

● (1205)

[*English*]

The Chair: Thank you, Dr. Naud.

We will now go to Mr. Virani for five minutes.

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

In returning to the position about the person with disabilities, Senator Chantal Petitclerc stated in response to what she heard at committee on Tuesday that the persons who appeared cannot possibly—

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

I'm sorry to interrupt, Mr. Virani.

Madam Chair, do we have a second panel starting at 12 o'clock? Are they waiting?

The Chair: Yes.

Hon. Rob Moore: When are we wrapping up this panel and starting the other? We only have an hour for the next panel.

The Chair: You're absolutely right, Mr. Moore. As per the discretion allotted to me, I have been feeling over the past number of meetings that we haven't been able to allow our first panels enough time, so I'm trying to move through as much of the second round as I can to be equitable to all parties.

If members will allow, following Mr. Virani, I would like to give Mr. Thériault and Mr. Garrison two and a half minutes each before we move on to the second panel.

Is that okay with everyone?

Thank you.

Go ahead, Mr. Virani.

Mr. Arif Virani: Thank you.

As I was saying, Senator Peticlerc said yesterday in respect to what she heard from the witnesses at committee on Tuesday:

> They cannot possibly represent and speak for all persons with a disability. Obviously, because you know they don't speak for me.

Furthermore, she said that neither did they speak for Nicole Gladu or Jean Truchon, the two Montrealers who successfully challenged the provision in the assisted-dying law—who committee members know are themselves persons with disabilities.

I want to ask the former judge Monsieur Rochon and Mr. Roberge a question about the Truchon decision. A witness on Tuesday impugned the integrity of that decision by alleging conflicts of interest and bias in deciding the case and said that, in fact, there should have been a recusal of Madame Justice Baudouin in that case.

Mr. Rochon, as a former member of the Quebec court, do you have any comments on that attack on the Quebec court and its independence?

[*Translation*]

Hon. André Rochon: Justice Baudouin's decision has not been appealed. In my opinion, it is well founded and is very much in keeping with the principles of the Carter decision.

Justice Baudouin affirmed two fundamental principles that underlie her decision and that deserve to be recognized. The first is that this assessment is made on an individual basis. The second is that denying people medical assistance in dying constitutes discrimination against them.

[*English*]

Mr. Arif Virani: Thank you.

Mr. Roberge, do you have any comment on that aspect of the Truchon decision?

Mr. David E. Roberge: Not really. Again, it wasn't really within the mandate of the CBA's working group on end of life to address the question you just raised.

Mr. Arif Virani: Thank you very much, Dr. Roberge.

I will turn to Dr. Gibson.

Criticism has been volleyed with respect to the consultation that's happened with respect to Bill C-7. I personally had somebody who participated in those consultations note that these were quite robust and extended to many cities around the country. Three hundred thousand people provided input via a questionnaire, and 125 experts were engaged, of which I believe you were one.

Could you comment from your perspective on the robustness of the consultations with respect to Bill C-7, Dr. Gibson?

Dr. Jennifer Gibson: In fact, I must confess that I thought it was far more robust than I might have anticipated and probably even more robust than what we saw in previous conversations about medical assistance in dying.

From that perspective, I think there were multiple opportunities for folks to weigh in, but I also think, just looking at the witness list, that the individuals and groups who were being invited to this table.... I'm really noting that the committee is canvassing a diversity of views, which I think is the strength of this process, augmenting what you already would have seen from the consultation process across Canada.

The transparency of these meetings, as well as the reporting, I think serves to provide something that citizens as well as individuals from protected groups can look at to see the extent to which their voices have been heard. I think there has been some seriousness taken to ensuring that diversity of views, at least from where I sit from somebody on the outside.

● (1210)

Mr. Arif Virani: Thank you, Dr. Gibson.

I have one final question for you. Can you tell us from an ethical perspective, since you have a Ph.D. in bioethics, about the notion of, as I think you put it in your opening statement, a 10-day waiting period when people deprive themselves of their sedative drugs, and what that does for their suffering simply for the purposes of holding onto the ability to provide final consent?

We're trying to craft a bill in our legislative regime that alleviates suffering. What does a 10-day waiting period do for those individuals? Can you comment on that?

Dr. Jennifer Gibson: What I was trying to suggest is that, when we think about introducing safeguards, we need to think further down the road, not just about protection but also about the possible impact and implications.

What we have learned is that the 10-day waiting period had the unintended and inadvertent consequence of extending a person's suffering, specifically individuals who were eligible for MAID and had well-considered views.

The impact on suffering, I think, is the real concern for us when we're thinking about safeguards.

Mr. Arif Virani: Thank you very much.

That's all, Madam Chair. Thank you.

The Chair: Thank you, Mr. Virani.

Monsieur Thériault, please go ahead for two and a half minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

Dr. Naud, some witnesses and some briefs argue that the conscientious objection rights of certain physicians should be justification for Parliament to not require them to refer a patient seeking medical assistance in dying to a physician who provides it. These conscientious objectors do not want to refer or be required to refer those patients to a physician willing to administer the MAID.

Would that not be unethical?

Dr. Alain Naud: Thank you for your question, Mr. Thériault. It is extremely important and you are quite right.

Conscientious objection is a personal value that a caregiver cannot impose on sick people, let alone vulnerable sick people. Therefore, all colleges of physicians in Canada require their members to transfer a request for medical assistance in dying if they have a conscientious objection. This objection is currently very well protected by legislation and by the guidelines of the provincial colleges of physicians.

I will draw a parallel with blood transfusions. If you are a doctor and a Jehovah's Witness, you are opposed to blood transfusions. If you refuse to give a transfusion to a patient of yours who needs it, or to refer them to a colleague, you are committing serious professional and ethical misconduct.

The same is true with medical assistance in dying. A physician has a perfect right not to participate and this right, which is very well enshrined in current legislation, must be protected. Instead, the bill should impose an obligation to transfer because, ultimately, what is at stake is the patients' well-being, not the protection of physicians' personal, religious or other beliefs.

Mr. Luc Thériault: Not all medical students go into neurosurgery or surgery. Medical practice covers many areas. Given the fact that we have only five years of experience in providing medical assistance in dying and in providing choices to the dying and to patients, do you consider that the current training in medicine is adequate?

Dr. Alain Naud: All medical schools, at least those I know well, in Quebec, have seen great improvements in recent years in terms of medical assistance in dying.

Increasingly, students are becoming aware of this legitimate choice available to patients and I can confirm, since I am with these students, that young doctors starting to practice are very interested in considering and respecting that care.

[*English*]

The Chair: Thank you, Dr. Naud, and thank you, Monsieur Thériault.

Mr. Garrison, please go ahead for two and a half minutes.

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

I'd like to pose the same question on conscience referrals to Dr. Gibson, and hear what she has to say on that topic.

Dr. Jennifer Gibson: I think it's well recognized that individuals entering into a profession are acting from conscience, whether it is to provide and assess, or not to participate at all in medical assistance in dying. It's important for us to continue to protect the conscience of professionals in general.

At the same time, there are duties of professionals to society as well. Many of the systems that have been established across provinces and territories to be able to link patients to willing providers have been ways to find that balance between protecting the conscience of a professional and protecting the rights of individual patients. In Ontario there is a duty to refer, I know that for some health professionals that is seen as something that is not concordant with their conscience, which is why there are systems now in place for patients to be able to link to a willing provider without putting health professionals in a compromised position.

● (1215)

Mr. Randall Garrison: Thank you very much.

Just very briefly, on the question of requiring special expertise in the second track to make assessments of eligibility for medical assistance in dying, can you comment on what impact a strict requirement like that would have in rural and remote areas of Canada.

Dr. Jennifer Gibson: One of the things we have now—and it's partly one of the gifts of COVID—is a much better integrated network of providers, facilitated partly by virtual types of support.

One of the things we've also heard from clinicians is that often they're dealing with complex patients, and in fact many of the providers themselves are very well versed in being able to understand and appreciate the clinical consequences of that particular patient in front of them. While drawing on expertise—and this is a regular part of clinical practice where there's uncertainty—colleagues will reach out to other colleagues to get insight and advice. I think we see that as a key feature, an essential feature, in clinical practice already. In fact, instituting this as a legislative matter may actually reach beyond what is sufficient to provide relevant input and expertise in the care of a particular patient, just as a result of regular clinical practice.

Mr. Randall Garrison: Thank you very much.

The Chair: Thank you very much. At this time I will thank all of the witnesses for their testimony today and their contributions.

If there are any further clarifications that you need to provide, please write to the clerk of the committee with any additional information based on the questions today.

At this time I will suspend the meeting for 30 seconds to allow for our next panel of witnesses to come in. Thank you, everybody.

● (1215)

_____________________(Pause)_____________________

● (1220)

The Chair: Welcome back.

I would like to welcome our second panel of witnesses. We have the Canadian Nurses Association, represented by Michael Villeneuve; the Canadian Society of Palliative Care Physicians, represented by Dr. Anne Boyle and Dr. Harvey Max Chochinov; the DisAbled Women's Network of Canada, represented by Bonnie Brayton; and lastly, the Physicians' Alliance against Euthanasia, represented by Dr. Catherine Ferrier.

Each organization will have five minutes. We'll start with the Canadian Nurses Association.

Go ahead, Mr. Villeneuve, you have five minutes, sir.

Mr. Michael Villeneuve (Chief Executive Officer , Canadian Nurses Association): Thank you, Madam Chair and members of the committee. Good afternoon.

I would like to acknowledge the Algonquin Anishinabe peoples, from whose traditional lands I am speaking to you today.

Thank you, Madam Chair and members of the committee, for responding to CNA's request and extending an invitation for us to speak about Bill C-7. We are honoured and grateful for the opportunity to appear before the committee in the Year of the Nurse and the Midwife 2020. I do not need to tell any of you that it has not been quite the year of celebration that we had planned.

I have worked in health systems for more than 40 years, and 37 of those as a registered nurse. I have had the honour of serving as the CEO of the Canadian Nurses Association since 2017.

CNA is the national and global professional voice of Canadian nursing. We represent nurses living across all 13 provinces and territories and in hundreds of indigenous communities.

Canada's 440,000 nurses touch the lives of patients at every point of care constantly, and no provider has as much face time with the public, where these really complex, human moral issues arise. The transformative legislative and moral decisions being proposed carry huge impacts for nurses who are responsible to live with them and enact them in their practices every day.

Nurses are an integral part of the delivery of medical assistance in dying and it is vital that the committee hears their voices. We have acquired significant knowledge, perspectives and experience from nearly five years of MAID in practice and have valuable knowledge to inform the impending changes to the legislation.

CNA has been actively involved in work related to MAID for several years and was the key stakeholder when Bill C-14 was passed in 2016, as well as during the consultations in early 2020. CNA advocates for safeguards to protect the rights of patients and nurses, as well as for system-level changes, including better access to palliative care and accountability mechanisms. I will turn briefly to Bill C-7 now.

Overall, CNA believes that the federal government has listened to our initial feedback during the consultation phase earlier this year. We are pleased to see that some of our recommendations were included, such as the removal of the 10-day reflection period, removal of final consent for those who lose capacity and the amending of the legislation to allow for one independent witness.

Regarding the new stream for cases where natural death is not foreseeable, we heard from experts that the proposed safeguards are adequate and sufficient. We emphasize that legal expertise for updating MAID guideline documentation will be critical to ensure that all new items in the legislation are acknowledged and fully understood by patients and practitioners.

In general, while we're supportive of Bill C-7, we believe that further improvements and additional clarification in four areas would strengthen the legislation and provide better care for patients and legal protection for nurses.

First, CNA strongly recommends that Bill C-7 includes an additional five-year review period of MAID by a committee of Parliament.

Second, we recommend removing the wording that stipulates that the practitioner providing MAID does not know or believe they are connected to the other practitioner who assesses the MAID criteria.

Third, we recommend clarifying that practitioners can initiate a discussion on the lawful provision of MAID.

Fourth, we recommend clarifying the proposed “preliminary assessment” clause, which we find confusing and that is causing some concerns among nurses.

Furthermore, we strongly recommend that parliamentarians conduct as soon as possible the broader review of MAID to address important issues beyond Bill C-7.

In concluding, CNA would like to state its gratitude to the Canadian Nurses Protective Society, who has been an important partner in our MAID-related work. We submitted a written brief with more information, and I am glad to try to answer any questions.

Thank you again, Madam Chair, for the opportunity to speak to this committee today.

● (1225)

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

We'll now move to the Canadian Society of Palliative Care Physicians, with Dr. Anne Boyle and Dr. Harvey Max Chochinov.

You have five minutes between you.

Dr. Anne Boyle (President, Canadian Society of Palliative Care Physicians): Thank you, Madam Chair and committee members, for this opportunity. I am the current president of the Canadian Society of Palliative Care Physicians. I worked as a northern nurse and have over 32 years' experience as a physician. Since 2004, after a year of additional palliative care training, I have worked as an academic palliative care physician, seeing patients wherever they call home.

Addressing suffering is both imperative and challenging. Our hope is to ensure that necessary services are in place to address suffering and that safeguards are in place to minimize harm. Among Canadians, 98% will not choose a hastened death, and 100% of Canadians need palliative care enshrined in the Canada Health Act as an essential service so that all patients may receive impeccable care in the location of their choice and be able to live well until they die. All Canadians deserve access to high-quality, comprehensive palliative care.

Dr. Chochinov will now speak.

Dr. Harvey Chochinov (Distinguished Professor of Psychiatry, University of Manitoba, Canadian Society of Palliative Care Physicians): Thank you, Madam Chair.

I believe that the data I will be sharing will be important for the committee to consider. The following comes from my written submitted brief.

By way of background, I am a distinguished professor of psychiatry at the University of Manitoba. I am former chair of the external panel on options for a legislative response to Carter v. Canada. I am also a long-time palliative care researcher who has published extensively on psychological matters pertaining to palliative care.

Bill C-7 proposes the elimination of any waiting period between the time a dying patient is approved for MAID and the administration of MAID. Our research group reported that the will to live can be highly fluctuant over intervals as short as 12 to 24 hours. In fact, 40% of patients who were prescribed lethal drugs in Oregon decided not to take a lethal overdose.

Bill C-7 also proposes to eliminate the requirement that a patient have a reasonably foreseeable death. For patients whose life expectancy can be measured in years or even decades, Bill C-7 recommends a 90-day assessment period. The suicide rate in many chronic conditions is very high. A study of 496 patients with traumatic brain injury, stroke or spinal cord compression reported that most of those who were initially suicidal no longer were three to 24 months later.

Bill C-7 also indicates that it will no longer be a requirement to reaffirm competency at the time of administration of MAID. The Netherlands allows for a euthanasia advance directive for those who fear losing capacity. A survey of 410 Dutch physicians reported that only 3% had ever complied with the advance euthanasia directive. Compliance with an advance directive was almost always raised by someone other than the patient. In 72% of instances, the relatives or representatives did not feel comfortable proceeding with euthanasia, but instead settled on forgoing life-prolonging treatment, as did their physicians.

Finally, while Bill C-7 indicates that mental illness alone is not enough to qualify for MAID, mental illness is often accompanied by medical conditions. Together, this may open up the door to MAID for these patients. A landmark Dutch study of patients with psychiatric disorders who had received euthanasia or assisted suicide in the Netherlands showed that nearly 60% also had medical problems, such as cancer, cardiac disease, stroke or neurological disorders. They suffered from depression, psychosis, grief and even autism, conditions that require exquisite and concerted psychiatric care.

In conclusion, the data suggests caution regarding the following legislative amendments. One, the data indicates that the wish to die and the desire for death in the context of terminal illness can fluctuate widely over time. Hence, some period for reflection would seem prudent. Two, the wish to die amongst patients suffering from non-imminently life-threatening conditions, including chronic illness and disability, is not uncommon and can fluctuate over the course of months to years. When the determinants of a wish to die in patients living with these chronic conditions or disabilities are addressed, suicidality can wane. Three, the data strongly indicates that neither physicians nor relatives feel comfortable providing MAID to patients who are unable to state their wishes or convey that they are suffering intolerably. Four, eliminating the provision of a reasonably foreseeable death opens the door for patients with various chronic medical conditions and disabilities, including those with concurrent mental illness.

All of these facts are critical in understanding and mitigating the suffering of those who have lost their will to live.

Thank you for your kind attention.

● (1230)

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

We'll now move on to the DisAbled Women's Network of Canada.

Ms. Bonnie Brayton, please go ahead. You have five minutes.

Ms. Bonnie Brayton (National Executive Director, DisAbled Women's Network of Canada): Thank you, Madam Chair and members of the committee. Greetings to other panel members.

Thank you for inviting me to appear today. I am speaking from the unceded territory of the Kanyen'kehà:ka people. I remind us that truth and reconciliation is not about words; it is about how we conduct ourselves in the face of truth.

We remind the committee that, according to Statistics Canada, 24% of women in Canada live with a disability. DAWN Canada is in its 35th year of service, yet we do not celebrate.

We oppose the removal of the imminent death clause. This is a fatal error, one that you as lawmakers will have to live with. Evidence is absent now as you move this forward, but you will be judged on the evidence and unnecessary deaths you could have prevented if you do not take a pause today. You are all of relative privilege, as am I.

In preparing for today, we have referenced several documents that I leave with the clerk to share and go forward. We will also forward, with her permission, the story of a strong, brave woman named Ruth, a fierce advocate, whose situation is the reason you must pause. In a different Canada, Ruth would receive the support she needs to have a life that has meaning, including dignified housing that keeps her safe and alive. She is intelligent, articulate and would be a good mentor and counsellor to anyone who lives with environmental sensitivities. She knows the ropes, but instead, in her own words:

> My doctors are well aware of my thoughts about MAiD, and have been trying to find me a new home, so that I WOULDN'T resort to using this process. But again, there is no SAFE (smoke-/scent-free), affordable housing for people with ES/MCS who are on ODSP. While I don't really want to go through with MAiD (I had to euthanize my cat on October 4, 2019, just before I was sealed into my enclosure, and it was a TRAUMATIC experience, since she had a bad reaction to the meds), I cannot continue to live in these conditions forever.

You see, Ruth, like so many other people with disabilities, has lost hope. She is not dying, but she meets the new criteria for MAID.

We have also shared our submission to FEWO on the implications for women with disabilities in the context of MAID, which of course will interlock with the discussions today.

I also share the following from the *Ethical Principles for Judges* handbook, edited by Beverley McLachlin in 2014, chapter five, "Equality". Under "Principles", it says:

> The Constitution and a variety of statutes enshrine a strong commitment to equality before and under the law and equal protection and benefit of the law without discrimination. This is not a commitment to identical treatment but rather "...to the equal worth and human dignity of all persons" and "...a desire to rectify and prevent discrimination against particular groups suffering social, political and legal disadvantage in our society."

One of our most learned judges makes a deliberate decision in this chapter to cite Eldridge v. British Columbia, an intervened case at the Supreme Court that centred on systemic ableism in the medical system involving a deaf woman who sought her right to health care and to motherhood itself, from 1997.

In 2012, and again in 2020, DAWN has intervened in Supreme Court decisions that affirm women with disabilities and their equality rights, while reminding all of us that women with disabilities must be believed.

The most recent decision, Slatter, on November 6, reads:

> Over-reliance on generalities can perpetuate harmful myths and stereotypes about individuals with disabilities, which is inimical to the truth-seeking process, and creates additional barriers for those seeking access to justice.

Today, what is your message to Ruth, a desperate and courageous self-advocate during the worst health pandemic in a century? Is this our best answer? “No, Ruth, we cannot help you. It is just too hard for us to do that, but we can offer you MAID.” Really?

You have a moral, legal and sworn responsibility to our Constitution as legislators. It is clear from the highest court in the land that you must, above all else, make laws that respect these tenets, and do no harm. You must do so based on balanced evidence and information about those who will be affected by them.

Thus far, you have failed in your duty with Bill C-7. You have no evidence to support your hurry to pass this bill. You answer to us, all of us. You gave us the Accessible Canada Act after a rigorous, inclusive human rights consultation with people with disabilities. Why not now?

This is Indigenous Disability Awareness Month. As I sit before you, I know we have not had full consultation from a human rights place with indigenous people with disabilities, with women with disabilities, and with the majority of those people who need to be heard in this case.

Thank you.

● (1235)

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

We'll now move on to the Physicians’ Alliance against Euthanasia.

Dr. Catherine Ferrier, the floor is yours for five minutes. Please go ahead.

Dr. Catherine Ferrier (President, Physicians’ Alliance against Euthanasia): I'm a physician, and I've worked since 1984 in the geriatric clinic at the McGill University Health Centre. My focus is on care for patients with cognitive disorders. I often do capacity assessment and testify in court for my patients. My colleagues ask my advice on capacity assessment and refer to me their most difficult cases.

Before seeing a patient, I collect all the information I can from the family, social worker and other sources. You can’t assess capacity without knowing what decisions the patient is facing, the constraints, and the reasons why others consider certain choices to be harmful to the patient. I typically spend two hours with the patient, and sometimes I need to see them more than once.

When we assess capacity, we try to enter into the patient's mind to determine whether any cognitive or mental disorder is interfering with their ability to understand the information needed to make decisions, appreciate how it applies to their situation, reason and express a choice. We also weigh the degree of risk associated with the decisions they have to make, and this may influence our conclusion. All this explains why experts may disagree about the capacity of a patient.

Beyond capacity is the question of agency. There’s no such thing as an autonomous decision free from constraints. This is true for all of us. Internal constraints include fear or other emotions, habit, lack of knowledge of options or a desire to please others. External constraints include marginalization, a lack of options and pressure from others. That’s why the federal correctional investigator called for a moratorium on MAID for prisoners.

Another example of lack of full agency is abuse, where competent adults remain in situations that are harmful to them. I see many victims of elder abuse. One was a widow from eastern Europe who had no relatives in Canada. A woman pretending to be her niece fraudulently obtained power of attorney, emptied her bank account and moved her to a nursing home against her will. She ran away in mid-winter with her walker and was later brought to me for assessment. She didn't have advanced dementia, as alleged. She was not fluent in English, but she was fully capable. She lacked the agency necessary to defend her rights without help.

Suicide is another example. The CCA expert panel couldn’t reach a consensus on whether there is a meaningful difference between suicidal desires and a desire for MAID. The suicide rate after traumatic spinal cord injury is 20 times that of the general population for five years. Those who choose suicide may not be depressed or incapable of decision-making. Their options have been tragically narrowed, and it takes a long time to readjust, but people do. After five years, the rate is the same as that of the general population. They need protection from their despair. That’s why our society responds to suicidal desires with prevention. That’s why we can’t allow MAID after 90 days.

Bill C-7 creates a framework for people not near their natural death that only requires provision of information on other means to relieve suffering and a 90-day waiting period. Giving information has no value if access to the service is not available. It's largely not within that time frame. Often there's not even time to see a specialist, certainly not time to regain some hope of healing.

The bill is proposing a Criminal Code amendment to permit doctors to end the lives of Canadians whose suffering has not been addressed in other ways. We're told that the numbers will be small. Beyond disabled persons, who made their point clearly on Tuesday and today, we could look at a few common medical conditions we see in our practices. Over two million Canadians live with chronic obstructive lung disease. There are 600,000 who live with heart failure. There are 700,000 stroke survivors, and there are five million people with osteoarthritis.

Of course, not all these people will seek MAID, but many of them will be eligible. They have "a serious and incurable illness". The question of whether they are in an "advanced state of irreversible decline in capability" is subjective, as is the presence of "enduring physical or psychological suffering that is intolerable to them".

Everyone with an acute or chronic condition that causes suffering and loss of autonomy will lose the protection of the Criminal Code, which will be reserved for the young and able-bodied. Ageism and ableism are rampant. Seniors and people with disabilities are denied care because their life is seen as less valuable than other people's.

To leave to doctors the decision about providing MAID to anyone who meets the criteria is to entrust them with life-and-death decisions for millions of people in a vulnerable position. Doctors have the same limitations as everyone else does, which may include unconscious bias towards MAID as an option and against living in certain situations. No one should have that power.

It should be made clear in the law that MAID is not a medical treatment on the same level with real treatments. It's not a standard of care. It should be a last resort when all other reasonable options have failed.

Thank you.

● (1240)

The Chair: Thank you very much for that, Doctor.

We will now go into our first round of questions, starting with Mr. Cooper for six minutes.

Go ahead, Mr. Cooper. The floor is yours.

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

Thank you to the witnesses.

I'll address my first question to either Dr. Boyle or Professor Chochinov. At our last meeting, we heard compelling and disturbing testimony from Roger Foley, who talked about the fact that physician-assisted dying was specifically brought up to him without his initiating it, and that he faced considerable pressure and coercion from health care professionals.

In your brief, you make note of that concern, and you state expressly that "health care professionals should not initiate" such a conversation. Why do you believe that this should not occur? Further to that, could you speak to how the Australian state of Victoria has responded legislatively, and would you support a similar safeguard to be legislatively introduced when we consider amendments to Bill C-7?

Dr. Anne Boyle: Thank you, Mr. Cooper.

I think we're all aware that there is a hierarchy and a differential of expertise in the physician-patient relationship. It is actually addressed directly, as you mentioned, in the Victoria law in Australia.

We feel that it's important for patients to raise it, and if they do, for their questions regarding MAID to be addressed by all health care professionals and the issues explored, including their underlying suffering. They should be provided information or directed to someone who is able to provide that information.

We actually support and urge the federal government to reduce harm to vulnerable patients by including this in the current revisions to the Canadian MAID legislation.

Mr. Michael Cooper: Great. Thank you for that.

Another area of concern raised in your brief was with regard to the 90-day waiting period where death is not reasonably foreseeable. We have heard similar concerns expressed by other witnesses.

Can you speak to the inadequacy of a 90-day period from the standpoint of accessing services, whether it be palliative care, psychiatric or psychological supports or counselling, let alone the adequacy of time in order to have meaningful palliative care treatment, for example, up against a 90-day clock?

Dr. Harvey Chochinov: The 90-day clock, as you put it, is very problematic. There have been a number of studies. For example, a Manitoba study actually found that after 90 days of being diagnosed with a major physical impairment, patients reach a peak in their suicidal ideation. They continue to be suicidal, although it wanes, as much as a year later, and thereafter it's still greater than their match cohort, so 90 days is certainly not an opportune waiting time.

The other thing is that we know that it takes a great deal of time for these people to be able to avail themselves of expertise. Patients who are highly at risk, for example those with chronic pain, may have to wait six months or more, depending on what part of the country they happen to live in, in order to get access to care. My specialty is psychiatry. Again, the waiting list for good psychiatric care is in the neighbourhood of months, up to a year, depending on what part of the country you're in.

The 90 days is problematic for all those reasons, which in large measure are data-driven and data-informed.

● (1245)

Dr. Anne Boyle: As well, as Dr. Ferrier mentioned, simply having information about available treatment options is not enough. People actually need the lived experience of having care in order to make informed decisions.

Mr. Michael Cooper: In terms of addressing this 90-day period, how do we fix this in the way of amendments? What would you propose instead? The question is for the same witnesses.

Dr. Harvey Chochinov: I think the 90-day period is problematic. I know that Dr. Ferrier also cited studies that looked at patients who had traumatic injuries. She found that anywhere from three to 24 months later patients continued to experience suicidal ideation, and over the course of that time also saw changes in their suicidal ideation with the advent of treatment or care.

I would say that it's important we maintain the “reasonably foreseeable death” clause because, without that, there is really no differentiation between MAID and those who are seeking out suicide for suffering that might be amenable to treatment.

Mr. Michael Cooper: On one other point, just to finish up on the 90-day period, it's 90 days from the time of assessment rather than the time when one actually executes their wish to proceed with the procedure.

Do you see that as problematic?

The Chair: You're out of time, unfortunately, Mr. Cooper.

Mr. Michael Cooper: Okay.

The Chair: Hopefully you will get to that in the next round.

I'll move on to Mr. Kelloway for six minutes.

Go ahead, Mr. Kelloway.

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

Hello to my colleagues.

To the witnesses today, thank you for being here. It's truly an honour and a privilege to have you here.

My question will be directed towards Dr. Bonnie Brayton.

Madam Chair, former federal cabinet minister and Manitoba member of the legislative assembly, who has been living with quadriplegia since the age of 23, recently spoke to the debates around the MAID legislation. Steven Fletcher said that, given the large range of disabling conditions, no one, including disability rights groups, can decide for someone else what is tolerable. He said that new safeguards and talk of protecting the vulnerable are “insulting” and “condescending”. Further, he said:

> Everyone is a minority of one.... From that perspective, everyone should have all the rights and responsibilities...as everyone else. And when you look at it from that perspective, all those other arguments don't make any sense anymore because we're going to be protecting the rights of everyone, period.

Madam Chair, I think of groups in my riding that are huge advocates for inclusion of individuals with varying physical and intellectual disabilities. Just thinking of inclusion and the words of Mr. Fletcher, I'm curious to hear your thoughts, Dr. Brayton. Do you agree that we should all have the same rights and responsibilities as everyone else, and that not allowing some to participate in MAID would be moving backwards in terms of inclusion and would be an infringement on their autonomy as an individual?

Thank you so much. I look forward to your answer.

Ms. Bonnie Brayton: Thank you for assigning me a doctor's degree. That's wonderful. I appreciate that very much.

Mr. Mike Kelloway: I'll give you one if you give me one.

Ms. Bonnie Brayton: I will be very blunt. Mr. Fletcher is not an expert in this area. He is a white male who is involved in other work but is not an advocate for people with disabilities and has no history of looking at the research, the situation. I think many of the points raised by the panellists here would not be something I would consider Mr. Fletcher to be an expert on.

I have no disrespect for Mr. Fletcher, or even for Senator Petitclerc, in terms of their positions on this. I would remind everyone that these people are members of the political class and are not members of the communities we are talking about and for whom we express concern regarding these changes.

To be really clear, I think if we want to really push this out all the way—and I'm not comfortable doing this, but I think the point needs to be made, if you'll pardon the obvious and not intended pun—if we understand that singling out a rights group in the context of this legislation, specifically saying that it is people with disabilities for whom this applies, that is what is problematic. If Mr. Fletcher takes his argument all the way to the limits of his perspective, then what we end up with is the possibility that everyone should have access to MAID.

Of course, we don't think that's the right solution. I think a lot of experts here made it really clear that palliative care and other solutions are what we need to address the kinds of problems that drive people to a place where MAID is the only option they have, instead of good palliative care or quality of life, as with the example I shared earlier in terms of Ruth.

As I said, while I understand the concept, I think there is a real problem here in terms of the reality, because we're talking about people who are extremely vulnerable, not about Mr. Fletcher.

Thank you.

● (1250)

Mr. Mike Kelloway: Thank you for your answer. I appreciate it.

I'd like to stay on a similar line of thinking, and I was going to say “Dr. Brayton” again. I almost gave you two doctorates.

Disability advocates participated heavily throughout the consultations, and we truly value what we heard from these groups. That's why we believe this legislation strikes the right balance of autonomy and protection of vulnerable people.

I am wondering how you would suggest, Ms. Brayton, striking the right balance of protection of vulnerable people and also allowing them to maintain their autonomy. I wonder if you can do a deeper dive on that, if possible.

The Chair: You're on, Ms. Brayton.

Ms. Bonnie Brayton: I think what's really clear is that there aren't enough social protections for vulnerable Canadians, including people with disabilities, and the reality is that this legislation is an aspirational piece of legislation. While I understand that some people believe this is towards enshrining the rights of individuals to make a choice, they have missed the reality check that I think we all have to have. The majority of human rights complaints in this country are disability-related, sir.

The United Nations has expressed concern to Canada with respect to even entertaining this kind of change in legislation. I really believe that it's an important opportunity for legislators to take a moment, to take a pause, to do the five-year review, as has been suggested by other members of this panel, and to slow down this process.

It's critical that we take a step back. As I said, I don't think anybody here wants to regret making an egregious decision in legislation that's going to take away people's lives, and I'm afraid that's where we are. That's not based on anything that has been presented here, of course, because we haven't had objective evidence presented, and I think that's another key issue.

Thank you.

Mr. Mike Kelloway: Thank you very much.

How much time do I have left?

The Chair: You have 30 seconds, Mr. Kelloway.

Mr. Mike Kelloway: I will forgo the question, because I may give Ms. Brayton a third doctorate.

I appreciate your insight and your perspective. Thank you so much.

Ms. Bonnie Brayton: Thank you so much, Mr. Kelloway.

The Chair: Thank you so much.

We'll now move on to Mr. Thériault for six minutes.

Go ahead, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

Thank you to all the witnesses for their valuable contributions.

The inherent dignity of every human being is not an intellectual conceit. It is embodied in the biomedical context through the principle of self-determination. This is why it is often said in clinical ethics that the patient comes first and that free and informed consent should not be infringed upon. The legislation must ensure that free and informed consent is given.

Dr. Ferrier, in this context, why should medical assistance in dying not be proposed as an option?

Dr. Catherine Ferrier: You mean it is the doctor or the professional who provides that option to the patient?

Mr. Luc Thériault: For patients to be able to make a choice and for their choice to be respected, patients must be informed about those choices. Why not recommend that option?

● (1255)

Dr. Catherine Ferrier: In my presentation, I talked about the number of people who will become eligible for medical assistance in dying with this bill. We are talking about thousands and millions of people.

Mr. Luc Thériault: Let's talk about people who are terminally ill.

Dr. Catherine Ferrier: The bill is no longer just for that group of people, it's for everybody.

Mr. Luc Thériault: I'm asking you about that group in particular.

Dr. Catherine Ferrier: Most terminally ill people don't want to die faster, they want to live as long and as well as possible. The fact that a doctor or a nurse or any other professional comes to a patient and tells them that one of their options is to be killed right away—I know we don't like that kind of language, but that's what we are talking about—is a way of taking away their hope. My colleagues in palliative care could tell you more about this. It is like telling patients that it is not worth continuing to fight for their life because there is nothing more to be done.

Even so, the physician has the power to—

Mr. Luc Thériault: Excuse me for interrupting. You mention that it is telling patients that it is useless for them to fight for their life. But they are in a situation where the process of death has already begun and is irreversible. Hopefully, the dying person is in an optimal palliative care setting; that would be the ideal situation.

Since palliative care is the optimal support for human beings as they move towards death, why would a request to die that comes from an optimal palliative care setting be considered a failure rather than a success? From the moment that a human being is ready, one morning, serenely, to let go, why would that not be a success for the support palliative care provides as death approaches?

Dr. Catherine Ferrier: I think you have changed the subject, Mr. Thériault, but—

Mr. Luc Thériault: I don't think so.

Dr. Catherine Ferrier: You are talking about patients who request it. That's another question and it's not relevant—

Mr. Luc Thériault: However, Dr. Ferrier, in order for him to make the request, he must be aware that he has that option.

Dr. Catherine Ferrier: I don't think there's a problem with that, because he's continually bombarded with information about it, particularly by the media. On the other hand, for our part, we have a hard time defending the option of continuing to live.

You can ask everyone who has been involved in palliative care for the last 40 or 50 years. You mentioned Cicely Saunders the other day, as well as Balfour Mount. So far, all palliative care organizations see promoting death as something that is not part of palliative care but as a waste of valuable time. We have also heard testimony about the patients' possible momentary despair and the fact that the desire to die can fluctuate greatly from moment to moment and from day to day.

Life has a greater value than death. Death is inevitable, and palliative care recognizes this. I think saying so is not the same as saying that it is time to stop.

Mr. Luc Thériault: Okay.

Some people claim that we, as lawmakers, should agree that physicians can refuse to refer a patient to another physician.

Do you agree?

Dr. Catherine Ferrier: Yes, I agree.

Mr. Luc Thériault: Does that not violate your code of ethics?

Dr. Catherine Ferrier: The college of physicians has amended its code of ethics to open the door to medical assistance in dying. In my view, and by age-old medical tradition, taking a person's life is not providing them with care.

Personally, I refer patients to those who will provide them with care that will help them, not care that will do them harm. Sometimes patients ask us for procedures, operations or medications. If we feel that that will do them harm, we refuse. I could give you thousands of examples but I feel that everyone is aware of them.

If a surgeon refuses to do a certain operation, he is not going to refer a patient to another surgeon who will do it. No way. Surgeons can tell patients that they are free to consult other surgeons if they wish. But one surgeon is not going to refer a patient to another surgeon if he is going to harm that patient.

Mr. Luc Thériault: That's talking about a surgical procedure. It's not talking about the end of a human being's life

Dr. Catherine Ferrier: Exactly.

[*English*]

The Chair: Thank you very much, Monsieur Thériault.

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

Go ahead, Mr. Garrison.

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

With apologies to my colleagues, at the beginning of each panel, I feel obligated to point out that many weeks ago I introduced a motion on the Order Paper in the House of Commons calling for the commencement of the statutory review, which would have both the mandate and resources to deal with some of the very important questions that have been raised here with regard to palliative care and people living with disabilities.

This time I would also note, though, that if we do not proceed with Bill C-7, then court decisions will guide the medical practice on medical assistance in dying.

We've heard a lot from physicians, as we should, about the issue of medical assistance in dying, but today we also heard from nurses.

I would like to turn to Mr. Hamza, because I think he's raised some issues that we haven't heard about before in our inquires. I know one of his recommendations is dealing with the question of whether nurses and nurse practitioners will be in jeopardy if they raise the issue of medical assistance in dying with patients.

Can you elaborate on your concerns in that area, Mr. Hamza?

● (1300)

Mr. Michael Villeneuve: Sure, and I'll just tell you that my colleague, who is Ms. Hamza, was unable to be with us.

Mr. Randall Garrison: Oh, I'm sorry.

Mr. Michael Villeneuve: No, that's fine. That's just for your records. She's lovely, though.

Yes, we have concerns in a number of areas. However, as I've been listening to the very interesting comments today, I want to explain that patients have very intense, intimate conversations with nurses in ways that are hard to describe.

I've spent most of my clinical practice over the first 20 years of my career in neurosurgery, spinal cord injuries, brain injuries, many of the kinds of things we've been talking about, and patients and families will often say something to a nurse at three o'clock in the morning in the quiet darkness that they wouldn't say anywhere else. We have many times raised issues on tough things, abortion, treatment decisions, why they are refusing chemo when it could help them.

In the study we've been doing over the last three years, in preparation for the larger review, nurses told us that they feel hamstrung by that, and if there were opportunities, we'd counsel people on the broad range of services in health care, whether we're in a women's clinic or a neurosurgery clinic and so on.

I'm worried that it might be framed as advice that “you should”; it's rather, “Is this something you've thought about?” Very, very often [*Technical difficulty—Editor*] and people will not raise it for a long time. We want nurses to be protected, so that they can have those conversations about the possibility that it may be in the patient's mind.

Mr. Randall Garrison: Thank you very much. I apologize for missing the switch in witnesses. My only excuse is that on the west coast I have to start very early here.

Can you say more about the other issue you raised around knowing or being connected to other practitioners or assessors? I'm assuming this is a large problem in smaller centres.

Mr. Michael Villeneuve: It is. We have been concerned about what might happen, for example, in many indigenous communities where there may only be one or two providers, often just nurses—not “just” but nurses versus physicians, I should say. However, that's a bit of an extreme.

The example I will share is that I have just finished my term of two years as the board chair here at the Winchester District Memorial Hospital in eastern Ontario. As a rural person of 20 years or so now, I can tell you that everybody knows everybody. Yes, we can certainly make a phone call and have an external assessor from a different community come in, but all our physicians know each other and they know the nurses and so on. We are concerned that could hamper the process and hold it up.

Physicians and nurses are deeply ethically bound to a certain code of behaviour. Knowing or not knowing the other provider should not lead to coercion or conspiracy, if that's the fear.

Mr. Randall Garrison: Thank you very much.

Madam Chair, in the interest of time, I will conclude my questioning there.

The Chair: Thank you very much, Mr. Garrison. That was very generous of you, at a minute and a half.

I will now go to Mr. Manly for two and a half minutes.

Go ahead, Mr. Manly. Your time starts now.

Mr. Paul Manly: Thank you very much.

I would like to thank the witnesses for appearing today.

I have a question for Dr. Chochinov about suicide ideation. We should be looking at different types of diseases or declines in health, and parsing them out to provide different timelines for different people. Some of these diseases have an obvious rate of decline. We have talked about people becoming quadriplegics. Obviously, that's not a continued state of decline. That is an accident or something that has cut somebody off.

Would you see amendments that would maybe look at the state of decline? What would you see for amendments that might work in these kinds of situations?

● (1305)

Dr. Harvey Chochinov: It's a difficult question because we're trying to address the issue of suffering and how we can respond to patient suffering, and we're using a tool that is particularly crude, which is euthanasia or assisted suicide.

Suicidal ideation is not uncommon in the general population. There was a Canadian study that showed about 13% of people over the course of their lifetime will experience suicidal ideation. About 4% of them will go on to have plans, and about 3% of them will in fact make an attempt. However, the rate of completion is only about 14 out of 100,000, so suicide continues to be relatively rare when you think about it in the context of the number of people who have suicidal ideation.

As I was pointing out and as Dr. Ferrier pointed out, there are conditions like spinal cord injuries, stroke and head trauma, and we know if we follow these patients over time, as much as 24 months after the fact, they can continue to be suicidal. I think we're going to have to look at individual illnesses and the trajectory of suicidal ideation in order to know how to shape legislation, if it's even possible.

Again, I would suggest that the reasonably foreseeable death at least provides a differentiation between MAID, which is medical assistance in dying, and suicide, which is for people who no longer want to face the prospect of further life.

The Chair: Thank you very much. That brings you to your two and a half minutes, Mr. Manly.

At this time, prior to going into our second round of questions, I seek the consent of the committee to go five minutes Conservative, five Liberal, two and a half Bloc, and two and a half NDP. Can you give me a thumbs-up for us to continue in that way?

Mr. Garrison, I don't see your thumb. I want to make sure you're okay. All right. We will go ahead, then.

I have Mr. Moore next for five minutes.

Go ahead, Mr. Moore.

Hon. Rob Moore: Thank you, Madam Chair, and thank you to all the witnesses today for their important and relevant testimony.

Dr. Chochinov, I have a question for you. We've heard from witnesses who are especially concerned about the impact this bill will have on persons with disabilities. We heard this week from groups representing persons with disabilities. There's been some discussion here about those for whom death is not reasonably foreseeable. Number one, when death is reasonably foreseeable, there's removing the 10-day waiting period, but when death is not reasonably foreseeable, there would be a new 90-day period. We've heard from several people that this is wholly inadequate, the 90-day period, because some people may have barely begun treatment.

Could you provide any insight around this 90-day period between when someone could request MAID or be assessed for MAID, and then receive MAID, when their death is not reasonably foreseeable?

Dr. Harvey Chochinov: Again, the 90 days is a problematic time frame. I come back to the Manitoba study that I mentioned. This was a study that looked at groups of people who had suffered from some physical ailment, and from the time of diagnosis and 90 days hence they found that these people were at their maximum in terms of suicidal ideation. We know that there is a period of adjustment after one has had a change in one's physical status as a result of physical or mental illness that can manifest itself as a wish to die.

There's the other study I mentioned, and I think it's worth looking at the numbers. There are studies that have followed people who have had strokes or who have suffered disabilities as a result of spinal cord injuries or head traumas for as long as two years after the fact. Interestingly enough, when you look at those people who were initially depressed and then received treatment for depression, you see that all of them will go from a state of being suicidal to a state of no longer being suicidal.

Again, I would underscore that in the case of people whose death is not reasonably foreseeable, what these people need are disability supports and a limitation of access to means, because we know that the more people have access to means, such as guns.... Just as a side note, the suicide rate in the United States is more than double that in Canada. It's thought that it's probably because of access to guns.

If we limit the access to means and if we provide people with treatment, we know that people will renege on their suicidal ideation. As a psychiatrist, I have worked with people who had chronic suicidal ideation, even over periods of years. They continue to struggle, but what one does in good psychiatric care is give an unwavering commitment that we will be there with that patient, and we engage in a relationship with that patient, and these individuals have gone on to lead productive lives. They are loved and they do love. They have raised families and they have a meaningful existence.

● (1310)

Hon. Rob Moore: Thank you, Doctor.

Dr. Ferrier, it was mentioned in testimony today that there's a distinction with those whose only underlying issue is one of a mental nature. The point was made today that there are often other underlying mental conditions for people in that situation. Can I get your comments? My concern.... This is only our fourth day of witness testimony, and unfortunately it's scheduled to be our last day of witness testimony. We've seen a real outpouring of testimony from people in vulnerable communities about the impact that this has and the message it sends to those Canadians who are living with disability. Do you have any comment on that?

The Chair: You will have to answer in 10 seconds. I'm sorry.

Dr. Catherine Ferrier: Certainly a lot of people we treat for depression in geriatrics and in primary care have many other physical illnesses that could be their excuse for requesting MAID.

Hon. Rob Moore: Thank you.

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

We'll now move on to the Liberals for five minutes. I believe Mr. Virani and Mr. Sangha will be splitting their time.

Mr. Virani, go ahead.

Mr. Arif Virani: Thank you very much, Madam Chair. I'll try to be very quick. I have a couple of clarification points.

I think there's been a narrative about the legislators on the committee being in a position to “take away people's lives”; I think that's the way it was put. I think in fact what the legislation does—and did in the past, and continues to do—is allow people to be empowered to make decisions about their own lives. The autonomy and the taking is done by the individuals concerned, not by the legislators here. That's the first point.

The second point is that former chief justice Madam Beverley McLachlin was cited in the testimony here. I think it's important, because it talked about equality rights and persons with disability. Madam Chief Justice McLachlin was part of the unanimous court in the Carter decision, which talked about the Constitution requiring an ending of suffering in order to alleviate people's concerns and grant them autonomy. I think it's important that the record reflect that.

I have a question that I want to put specifically to Mr. Villeneuve and Mr. Chochinov.

I'll say parenthetically, Mr. Chochinov, that I appreciate your underscoring the connection between gun control and the prevention of suicide. I believe all parties should be very conscious of that and of the important need for gun control.

We have the nurses represented by you, Mr. Villeneuve, and earlier this question was put to you, Dr. Chochinov. I will now put this to both of you: If pressure is ever deemed to have occurred—duress, influence, undue pressure—I would presume that this should be investigated, reported to authorities, and indeed prosecuted if it comes to that. In your context, Mr. Villeneuve, and yours, Dr. Chochinov, do you have evidence of any such prosecutions occurring in this country with respect to nurses or with respect to doctors?

Mr. Villeneuve, the question is to you first.

Mr. Michael Villeneuve: We do not have that evidence. For nurses, that conversation is a very sacred one. In critical care units, including organ donation and other very difficult conversations. I did not see pressure or coercion ever happening; in fact, it was much, much more the opposite.

I'll turn it over to our other speaker.

● (1315)

Dr. Harvey Chochinov: I can't say that I know of evidence of overt coercion, but there's a form of covert coercion that we need to think about. People who are sick and nearing the end of life, or who are in pain or living with the encumbrances of physical illness begin to feel a burden to those around them. There are subtleties of coercion whereby they begin to feel that it becomes not their right but their obligation to their families to alleviate them of the distress they're living with.

Therefore, as to overt coercion, no, but there are subtleties of coercion. They feel the internal pressure that maybe this is something they need to do or ought to do for the sake of their family, which is suffering during the course of their approaching end of life. That is a dynamic that I have seen played out.

Mr. Arif Virani: That's an important point, but the question I asked you was about medical professionals. You're a psychiatrist in Manitoba. Have any medical professionals been prosecuted for direct or indirect coercion?

Dr. Harvey Chochinov: Not to my knowledge, no.

Mr. Arif Virani: Thank you. I'll pass it over to Mr. Sangha.

The Chair: Go ahead, Mr. Sangha. You have a minute and a half.

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

I'm glad to see the CNA appearing on this matter. The CNA has recommended the inclusion of a provision for an additional period of review by a committee after five years. Why is this required? What do you want to say on that?

Mr. Michael Villeneuve: Our view as nurses is that this change in the Criminal Code is perhaps the most profound one in the history of our country. I'm old enough to remember that we once had a state in which the only person who could end your life was the state. Nobody else could do it.

We are now in the position where we have flipped that around to where the state cannot carry out capital punishment to end a life, but in this very sacred space on earth, a doctor can enter into that arrangement with a patient. It's a profound change in our culture that we haven't begun to understand yet, and we believe it should be reviewed on a regular basis.

The Chair: Thank you very much for that.

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

[*Translation*]

Mr. Luc Thériault: Thank you very much, Madam Chair.

Dr. Boyle and Dr. Chochinov, just now, you stated that eliminating the 10-day period could drive patients towards death. The elimination applies to patients whose death is imminent, we agree.

Witnesses have told us that, in their medical practices, that is a long process, especially for patients in terminal phases like those with cancer. The problem is that palliative care cannot completely manage the pain.

From the time that palliative care has undesirable effects and the patient ends up in a situation where a request for medical assistance in dying is made, how is the elimination of the 10-day period not linked to the desire to not have the patient suffer anymore? Why would that be considered driving them towards death given that, basically, no physician wants to drive anyone towards death, whether they are dying or not? You don't seem to be trusting your colleagues.

● (1320)

[*English*]

Dr. Anne Boyle: Thank you, Mr. Thériault.

We don't disagree that people need to have their rights respected. That's very true. The challenge is that unless people have access to palliative care to help relieve...and we know that universal access to palliative care does not exist in Canada, and that issue needs to be addressed.

Regarding the reflection period, even people with a reasonably foreseeable natural death sometimes need time to address their suffering and have their symptoms addressed, and they may change their minds. It is contextual, as Dr. Chochinov has mentioned, and we need to make sure that we have legislation that addresses that.

The Chair: Thank you very much.

I will now move on to Mr. Garrison for two and a half minutes.

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

I want to go back and assure folks that I did get a notice of the change of witnesses at 5:14 a.m. my time, so I apologize once again.

One more recommendation you had was about the preliminary assessment clause. I would like to give you time to talk about that, because we have not heard about that in oral testimony from other witnesses.

Mr. Michael Villeneuve: I'll be very frank. We looked at it several times and we had trouble understanding what it meant. I figure when a group of nurses with graduate degrees can't agree on what it seems to mean, that's probably a problem. Is it adding a layer? Is it adding another point of accountability? Could it slow things down? Is it meant to be the first conversation?

We believe it's fixable. We think the way it is now is unclear. I will leave it at that for others to speak.

Mr. Randall Garrison: Thank you very much for that.

As you mentioned before, often nurses are the front line, the first contact when it comes to patients grappling with the end of life or with irreversible decline.

I wonder if you could say more than you said before about the difficult situation that arises from the way things are currently configured, which puts nurses in as the first line of contact.

Mr. Michael Villeneuve: You feel as though you have one hand behind your back if you can't raise certain issues. We talk to patients, for example, about why they would refuse cancer treatment that could cure them. Some people don't go along with the decisions we wish they would go along with.

I can assure you that in dealing with a lot of nurses across the country, those of sound mind have not run into any who want to rush into any situation and introduce this. What we heard from experts doing this was that we felt we couldn't have a full conversation. We couldn't even raise this issue.

Eighty-six percent of Canadians in the polls say they want to talk about it. They want the legislation there. We have talked about it for 30 years. The public is not informed on the details, but they are certainly ready to have these conversations, yet we're telling Nurse Betty with a master's degree that she can't talk about it. We have to fix that.

The Chair: Thank you very much.

That concludes our rounds of questioning.

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

The Chair: Go ahead, Mr. Lewis.

Mr. Chris Lewis: Thank you very much, Madam Chair. I appreciate the moment.

A lot has really come to light today on a lot of different fronts. We had fantastic witnesses in both the first and the second rounds. Obviously, I'm really happy that our colleague from the Green Party attended as well. I thought his comments were rather insightful. I believe that's the first time he has had an opportunity to come to this committee. Excuse me if I'm wrong.

I guess equally as impressive was Mr. Virani. He was the one who suggested very powerfully that we give him a voice, and unanimously there it went.

As well, Madam Chair, even you very eloquently earlier on allowed for extra time for the first round of questioning.

My point is this, Madam Chair: I believe that as a committee we are running past an opportunity to have one more meeting. I think we would do a huge disrespect to our indigenous disability community if we don't, as well as our vulnerable women. I heard that point very loudly and clearly from Ms. Brayton.

Madam Chair, I would like to move that notwithstanding the decision of the subcommittee for four meetings, we have one more meeting for two hours, and I would like a recorded vote on that, please.

● (1325)

The Chair: Thank you, Mr. Lewis.

Is there anybody else who would like to speak to this motion at this time? Not seeing any hands raised, Mr. Clerk, can we please administer a recorded vote?

[*Translation*]

The Clerk: Yes, of course—

Mr. Luc Thériault: Madam Chair, could the clerk reread the motion so that we have the exact wording?

The Clerk: Mr. Thériault, as I understand Mr. Lewis's motion, he is proposing that, notwithstanding the committee's previous decision to complete testimony on Bill C-7 today, an additional meeting be held to hear testimony.

Mr. Luc Thériault: I understood that the meeting is supposed to deal with one subject in particular.

Is that correct?

The Clerk: Let us ask the chair to check that with Mr. Lewis. That could well have slipped by me.

[*English*]

The Chair: Mr. Lewis, thank you for that.

Mr. Lewis, is your motion specific to certain witnesses or is this general to having one more meeting on this bill?

Mr. Chris Lewis: Thank you, Madam Chair.

Specifically for my motion, it's specifically to one more meeting. However, I did bring up the community of indigenous people with disabilities and women with disabilities. I brought them up as examples. I personally believe we would be doing our due diligence if we brought them forward. They were purely as examples.

The Chair: Thank you, Mr. Lewis.

Mr. Thériault, does that clarify it for you?

[*Translation*]

Mr. Luc Thériault: Yes, Madam Chair, that is much clearer.

[*English*]

The Chair: Thank you.

Mr. Arif Virani: Madam Chair, I find it's becoming somewhat repetitive that at every meeting, we're entertaining motions to reverse decisions taken by the steering committee, which has representation from all parties, including the official opposition.

I propose we proceed to a vote on this matter.

The Chair: Mr. Garrison, is that what you were going to raise as well? I see your hand.

Mr. Randall Garrison: I tried to raise my hand before we went to the vote.

I would say briefly that I believe the answer is the larger review that we are obligated to do statutorily.

The Chair: Thank you, Mr. Garrison.

[*Translation*]

Mr. Luc Thériault: Madam Chair, so that you do not end the meeting too quickly after the vote, I would like to say that I also have a proposal to make after that vote.

[*English*]

The Chair: We will come to you after the vote, Monsieur Thériault. Thank you.

Go ahead, Mr. Clerk. Would you please record the vote?

(Motion negatived: nays 6; yeas 5 [*See Minutes of Proceedings*])

The Chair: Monsieur Thériault, before I come to you, I will very quickly provide my ruling on the point of order raised by Mr. Virani at the meeting that was held on November 10.

Mr. Virani, at the time of our last meeting, was questioning in his point of order the appropriateness of an intervention made by Mr. Cooper, wherein he referred to a position that he would have taken during the in camera proceedings at our last subcommittee meeting.

House of Commons Procedure and Practice, third edition, pages 1089 to 1090, tells us that, "Divulging any part of the proceedings of an in camera committee meeting has been ruled by the Speaker to constitute a prima facie matter of privilege."

I would like to remind members about that important principle and call for their caution, when they intervene at committee, not to directly, inadvertently or obliquely refer to the nature and content of deliberations that have occurred during these in camera meetings. Please note, however, that positive decisions emerging from such deliberations are considered to be public.

With this issue clarified, I now will consider this matter to be closed. Thank you.

Right before I go to Monsieur Thériault, I will remind members that the deadline for Bill C-7 amendments is no later than Friday, November 13, at 4:00 p.m. If you have any questions with respect to drafting, etc., please do get in touch with our legislative clerk. His email has been provided to you.

With that, we'll go to Monsieur Thériault.

● (1330)

Hon. Rob Moore: I have a point of order, Madam Chair.

The Chair: I'm so sorry, Mr. Moore, I believe Monsieur Thériault has his before yours, so I'll go to Monsieur Thériault first.

Go ahead, Monsieur Thériault.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

I would like to raise the matter of submitting amendments, currently scheduled for 4 p.m. tomorrow. I feel that the session we had today was more substantial than usual and it might be wiser to have a little more time so that we can submit thoughtful amendments.

I therefore propose that amendments may be submitted up to 4 p.m. next Monday, instead of Friday, which is tomorrow.

[*English*]

The Chair: Thank you for that, Monsieur Thériault.

I will go to Mr. Clerk. I regret that we had not allowed our legislative clerk to come to speak to this matter earlier.

Mr. Clerk, can you please clarify for us the reason these timelines have been set and tell us what restrictions a legislative clerk has with respect to providing the full blanket of amendments to all members?

[*Translation*]

The Clerk: With pleasure, Madam Chair.

The people who will be analyzing the amendments to Bill C-7 that members submit will need about 48 hours in which to examine those amendments, to decide if they are procedurally in order and to put them together in a package to be distributed to members so that they can more easily examine each of the clauses of the bill.

If the committee decides to push back the deadline for submitting amendments to this bill to next Monday, it will have to push back the date when it begins to consider each clause of the bill.

If a majority of the committee members do not want such a delay, they will have to stick to the date the committee established, which is tomorrow at 4 p.m. However, additional amendments could be accepted on the morning of Monday, November 16. Those amendments could then be processed as quickly as possible in order to be added to the package going to members of the committee for the consideration that must start next Tuesday.

[*English*]

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

I will remind Monsieur Thériault that we had committed to this deadline based on decisions made in our steering committee. If the member would like to propose a motion, notwithstanding decisions already made, we can do that, or we can do a show of thumbs, allowing for a yes or a no. It's really up to you, Monsieur Thériault, whether you'd like to put forward a motion.

[*Translation*]

Mr. Luc Thériault: I thought I had done so, Madam Chair.

I had introduced a motion that we postpone the deadline of Friday at 4 p.m. to Monday at 4 p.m. Now the clerk is opening the door to a kind of compromise as to when amendments can be received, but I will stick with my motion. If my colleagues are opposed, they can reject it and we can take careful note of the clerk's comment.

● (1335)

[*English*]

The Chair: Thank you very much.

We'll call the vote, then, in that case.

Mr. Clerk, please record the vote.

The Clerk: Madame Chair, before I call the members, I just want to advise that if the committee chooses to put the deadline at Monday, November 16, at four o'clock, we won't be able, as a committee, to examine the amendments for the meeting on Tuesday morning, November 17.

The Chair: Thank you.

(Motion negatived: nays 6; yeas 5) [*See Minutes of Proceedings*])

The Chair: The motion is defeated. Thank you, Monsieur Thériault.

We will move on to Mr. Moore. You had a point of order, sir.

Hon. Rob Moore: Thank you, Madam Chair, for your ruling.

I have a quick point. Members have referred back to the decision of the steering committee. That's not a problem; the decisions are public. However, when members, as Mr. Virani has done on several instances, talk about a way forward for our committee and refer back to the steering committee meeting and say there were members of the Conservative Party in that meeting, it is implying unanimity in the decisions. Implying unanimity in the decision is in fact disclosing what was happening at the steering committee.

If we could limit our discussion around the steering committee to just the decisions, as you said in your decision, I think that would help everyone and make things go a lot smoother.

Thank you, Madam Chair.

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

I stand by my ruling, which is a reminder to all members to keep in mind that “Divulging any part of the proceedings of an in camera committee meeting has been ruled by the Speaker to constitute a prima facie matter of privilege.” I remind all members to conduct themselves cautiously in order to ensure the principles established by *House of Commons Procedure and Practice* are well maintained in how we conduct our committees.

Thank you very much.

Go ahead, Mr. Virani.

Mr. Arif Virani: Madam Chair, my integrity is being impugned by Mr. Moore, and I take great umbrage with that comment.

I guarded my words and used them very judiciously in this committee and in the previous committee. If there is a person who was reprimanded in this committee, it is actually Mr. Moore's colleague, Mr. Cooper, which you did in your ruling and which I found very edifying.

Thank you very much, but I regret the implication. I'm not trying to do through the back door what cannot be done through the front door.

Thank you, Mr. Moore, for your efforts—in vain, in that regard.

The Chair: Go ahead, Mr. Maloney.

Mr. James Maloney: Madam Chair, if it provides any comfort to Mr. Moore, I never interpreted anything anybody said as unanimity, given who's on the planning committee.

The Chair: Thank you for clarifying that, Mr. Maloney.

Again, I remind members to be cautious in your wording so as to maintain the decorum and the principles and spirit of our *House of Commons Procedure and Practice*.

I see no more items on the agenda, so this meeting is adjourned.

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