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# Special Joint Committee on Physician-Assisted Dying

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## Tuesday, February 2, 2016

## Co-Chairs

**The Honourable Kelvin Kenneth Ogilvie**
**Mr. Robert Oliphant**

# Special Joint Committee on Physician-Assisted Dying

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● (1735)

[*English*]

**The Joint Chair (Mr. Robert Oliphant (Don Valley West, Lib.)):** I call to order this tenth meeting of the Special Joint Committee on Physician-Assisted Dying.

I welcome our guests, our witnesses.

What we have done in the last couple of meetings when we've had a teleconference is that we have chosen to go to the teleconference first, so we will hear first from Derryck Smith, the co-chair of the physicians advisory committee of Dying With Dignity.

You will have 10 minutes, Dr. Smith, and then we will go to Sharon Baxter and Carolyn Ells. Our process is to have that 30 minutes of input from our witnesses. Then committee members will be asking all of you questions and they may direct questions to any of you or all of you as they choose.

Dr. Smith, thank you for joining us. The floor is yours.

**Dr. Derryck Smith (Chair, Physicians Advisory Council, Dying With Dignity Canada):** Thank you.

My name is Derryck Smith. I'm a practising psychiatrist in Vancouver. I was head of psychiatry at BC Children's Hospital for 30 years, but currently I work mostly with adults. I'm a board member of Dying With Dignity Canada and the chair of the physician advisory committee. I'm also a board member of the World Federation of Right to Die Societies, which is meeting in Amsterdam this year in May. Your committee may wish to attend.

I became committed to this issue not because of anything to do with my patients but from watching my father and mother-in-law die horrible deaths, mostly from dementia.

In terms of the issues you wanted me to address, on the issue of eligibility I have no argument with the words and language used by the Supreme Court. Incidentally, I was an expert witness on the Carter case as well. The one concern I have with the Supreme Court language is limiting this measure to “competent adults”. I would much prefer that it be limited to “competent individuals”, because many teenagers are quite competent to make medical decisions. That of course leaves us with the conundrum of what to do about children suffering from terminal illnesses, in pain. Typically we let children's parents make decisions on all other medical matters. I know it's hard to lobby for extending physician-assisted dying to children, but I think we need to wrap our minds around how to deal with suffering children at some point as well.

The last question, which is of particular interest to me given my history with my two relatives, is what to do with individuals who at one time were competent and now are not because they are either in a coma or demented. I know there is legislation in British Columbia to link advance directives to medical intervention at the end of life. I think we need to give some thought to how we will allow people to make decisions when they're competent about what's going to happen to them when they are not competent. I don't have advice for the committee on that, but I think you need to wrap your heads around what to do with that, if anything.

In terms of the next issue, the processes and procedures, I don't have much argument with the general ideas that are out there currently involving requests to two different physicians, with a reasonable time period. For someone who is close to death, “reasonable” may be a matter of days. For someone who is not that close to death, it may be a month. I think making sure that people have had time to understand the decision they're making, reflect on it, discuss it with their friends and relatives, and then reaffirm their decision is an important safeguard.

In terms of the oversight, I would suggest that for the best oversight there is a good model in Oregon. They have an annual report about all things concerning physician-assisted dying. This would give us a tracking mechanism over time. I'm hoping that this would be done federally rather than provincially.

The last one has to do with privacy considerations. I think what has happened in Quebec is maybe an ideal model. I've been given to understand that at least one patient, and maybe more, has had physician-assisted dying, and yet I've seen nothing in the press about it. That's good, because we do not want the privacy of individuals compromised. The privacy of patients and doctors needs to be protected, with one exception: I think I'm compelled by the argument that the certificate of death for people who die from physician-assisted dying should state both the diagnosis of the illness that they were suffering from and the fact that it was physician-assisted dying in order to make statistical reference to these easier.

In terms of the roles and regulations of health care practitioners, I think most of the discussions to date have focused on the doctors, on the two licensed physicians, making decisions on this. I wonder what we're going to do for people in remote communities. I know in B.C. there is some thought being given to using telemedicine for at least one of the opinions. Thought needs to be given to the role, if any, of the nurse practitioners and the pharmacists who have to be involved with providing the medications that will be prescribed by physicians.

To my way of thinking, the way we conduct physician-assisted dying should be built around the needs of the patient. Some patients are incapable of swallowing medication. In that situation, administering medication intravenously, such as in Quebec, seems to me to be the way to go, but I suspect that the vast majority of patients—and probably doctors—would prefer to have oral medications prescribed, which is the model that is used in Oregon.

In terms of the rights of conscience, I don't think any physician should be forced into performing a medical act that they do not believe in. In fact, doctors already have a wide range of flexibility in their practice. In theory, I could be out doing surgery, according to my license, but I'm obviously choosing not to do that. You don't even have to evoke conscience to have doctors refusing to participate in certain medical acts, including this. If doctors, because of religious or other beliefs, don't want to participate, I think we should allow them not to have to be involved, but they should have to make an effective referral, because it's the rights of the patient, the autonomy of the patient, that's of primary concern with these issues.

I have a grave concern, however, about discussions allowing institutions, health authorities, or hospitals to opt out based on a so-called objection of conscience. If we allow health authorities to opt out, for example, it may be that the entire north of British Columbia would be without these services, or the entire province of Alberta, or Prince Edward Island. There is a history with this, in that abortion services are still not available on Prince Edward Island; women have to go off-island.

I think this is a national program. It should be available nationally. I do not believe that institutions that receive public funding, such as hospitals or palliative care facilities, should be able to opt out. If they are private, that is one thing, but public funding should allow the institution to provide this service.

I know that battles are already forming up in B.C. between Catholic-based institutions and the medical staff. I'm told by a medical colleague that at St. Joseph's hospital in Comox, the medical staff have voted in favour of providing physician-assisted dying, but I suspect that the institution, the hospital, may not be in favour of it.

That's an issue I would like to see addressed to make sure that this is widely available to all members of the Canadian public.

In terms of the roles and regulations for health care practitioners, I think it's fairly straightforward. The role for doctors is evident in the discussions that have been forwarded to your committee from the various medical associations and licensing bodies. I don't have anything much more to say about that.

In terms of discipline and penalties, the easiest way would be to leave that to the licensing bodies and each of the provincial jurisdictions, because that's what they do now. I can't see a federal body looking after the disciplining of physicians when there's already a mechanism in place in the provinces to do that. I would leave discipline and penalties to the licensing authorities.

I believe I'm going to finish my comments there. I again thank you for inviting me to testify in front of your committee. I look forward to hearing my fellow witnesses and dealing with any questions as they arise.

● (1740)

**The Joint Chair (Mr. Robert Oliphant):** Thank you very much, Dr. Smith.

I'm going to suggest that we move to Carolyn Ells, associate professor of medicine at McGill and, I believe, also at the Jewish General Hospital.

**Dr. Carolyn Ells (Associate Professor, Medicine, Biomedical Ethics Unit, McGill University, As an Individual):** I was there until recently. I'm full time at McGill now.

Thank you. The committee asked us to provide very concrete recommendations, specifically on the areas, as Derryck Smith mentioned, of eligibility criteria, processes, and rules and regulations for health care professionals, so that's how I've structured what I have to say.

As a bit of a preamble and so you understand where I'm coming from, the analysis and recommendations that I'm going to present in this statement take into account the current legal context, including that in Canada, of course, and in particular the Supreme Court Carter decision; the context of health care delivery in Canada; the experience of Quebec in addressing physician-assisted dying, which I have followed closely and, to various degrees, have been involved with; the important and competing values and voices of Canadians, which I've heard and read through academic, public, and other media reports, such as that of the External Panel on Options for a Legislative Response to Carter v. Canada and similar types of reports that have come before this group and in Quebec; and the philosophy, bioethics, and medical literatures and debates on these topics.

Regarding my experience as a health care professional, I was a respiratory therapist for about 10 years. After I studied philosophy and focused my career as an academic on bioethics, I was a hospital ethics consultant for about 10 years. Both of these areas required me to be involved in many different ways regarding end-of-life care, and they informed my views.

For the purposes of this statement, I'm going to understand physician-assisted dying as encompassing both physician-assisted suicide and voluntary euthanasia. I'm referring to assistance in dying whereby the physician or a designated, regulated health professional administers the means of death under certain circumstances and with the voluntary consent of the patient. That would be voluntary euthanasia. In physician-assisted suicide, a physician or delegated, regulated health professional prescribes the means of death under certain circumstances and with the voluntary consent of the patient, and the patient self-administers the means of death.

From a bioethics perspective and often in the literature, we don't see a great distinction as far as the values are concerned, but as you know, some jurisdictions allow one or the other, and some allow both. Certainly, they feel different for the people involved.

To the extent that the recommendations and rationales of the provincial-territorial expert advisory group on physician-assisted dying in its final report of November, 2015, bear on the federal-level collaboration and legislation, I recommend that those recommendations be followed in the response of the committee. Many of the recommendations that I'll mention now actually come from that report and are informed by it.

Regarding eligibility, according to the court in the Carter decision, a person who meets the following eligibility criteria is eligible for physician-assisted dying: a competent adult who clearly consents to termination of life and who has a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. That's how the Carter decision characterized eligibility.

I understand that the Carter case was a specific case responding to the specific situation of those who initiated it. It seems to me, from my experience, that we should allow a broader range of criteria, and consider Carter to be the minimum criteria, so in my opinion additional scope consistent with, but not considered in, Carter should be included in the response of the committee.

That said, the federal government, I believe, should amend the Criminal Code such that physician-assisted dying is limited only to those people who are eligible for publicly funded health care services in the province or territory where the request is made.

The federal government should amend the Criminal Code such that the eligibility for physician-assisted suicide is based on the person's capacity to make a decision, rather than on the person's age.

● (1745)

Current legal and professional standards and processes with respect to determining capacity to consent to care, and what consent to care is to consist of, should be followed.

The federal government should amend the Criminal Code such that the eligibility for physician-assisted dying is limited to only those persons who clearly consent to termination of life.

The federal government should amend the Criminal Code such that the eligibility for physician-assisted dying is limited to only those persons who have a “grievous and irremediable” illness, disease, or disability that cannot be alleviated by a means that is acceptable to that individual. In this case, “grievous and irremediable” should be defined as “very severe or serious”. I note that this criterion provides a more objective criterion for eligibility than the Carter decision.

Mental illness should not preclude eligibility for physician-assisted suicide. Legislative or regulatory safeguards will be warranted, though, where grievous and irremediable illness, disease, or disability is primarily of a mental nature, as opposed to a physical nature. Respectfully, I don't feel that I have expertise to go further in my recommendation there, but of course I realize that safeguards will be a concern in expanding the scope to mental illness or persons with mental illness.

Regarding processes and procedures, I believe the federal government should amend the Criminal Code to allow that at any time following the diagnosis of a grievous or irremediable condition, an eligible request for physician-assisted dying, made through a valid patient declaration form, may be fulfilled when suffering becomes intolerable. This speaks a little bit to the issue of someone who is no longer competent but does make a competent decision before losing competence.

The federal government should encourage the development and implementation of a pan-Canadian strategy for physician-assisted dying. No doubt this is a challenge, but I feel strongly that we need continuity of care and continuity of procedures and access across the country. The federal government should encourage that and also should collaborate with the other governments, health professions, and others towards that end.

Regarding roles and regulations of health professionals, I'm uncertain, to be honest, where the federal government jurisdiction over rules and regulations of health care practitioners lies. My assumption is that a lot of these matters should be addressed at either the provincial level or the health professions' own regulations bodies. However, to the extent that the federal government does have a role in setting high-level parameters regarding roles and regulations of health professionals, I offer the recommendations that follow.

The federal government should amend the Criminal Code to explicitly protect properly regulated health professionals who provide supporting services during the provision of physician-assisted dying. That's not just for the physicians, but for all those health professionals who are providing supporting services.

The federal government should amend the Criminal Code to allow the provision of physician-assisted dying by a regulated health professional, such as a registered nurse, who is acting under the direction of a physician. In selecting the regulated health professions to qualify for this role, consideration should be given to enabling access to physician-assisted dying in communities where Canadians live or receive health care services.

I will move to the issue of conscientious objection, which was a huge concern in Quebec and no doubt still is. For the last few years when Bill 52 was in the pipe, and then after it was passed by the National Assembly, both the health professionals and the institutions were very concerned about conscientious objection and what they were allowed and not allowed to do. I coordinate activities with ethics consultants at McGill-affiliated institutions, and this was for sure an abiding concern.

My view on this issue is similar to that of our colleague: an individual health professional should be allowed to make a conscientious objection to providing physician-assisted suicide; however, the duty to care for the patient and the duty to inform the patient of all end-of-life options continue.

● (1750)

Some institutions, notably some faith-based institutions, may also make a conscientious objection to providing end-of-life care. This is natural when the core values of the institution are in conflict with providing such services. However, like health professionals, institutions in the public sector also have social contracts. To some extent, we should require non-faith-based institutions to allow physician-assisted dying or to at least not prevent it from taking place in their institution. Those who are objecting should transfer, or offer transfer, or provide people to come in and provide those services there.

To the extent possible, I think the provision of physician-assisted dying should be required of certain health care institutions, probably the regional hospitals and the big referral hospitals, as a matter of providing access to Canadians.

● (1755)

**The Joint Chair (Mr. Robert Oliphant):** I'm afraid you'll have to end it there. Thank you very much.

Ms. Baxter.

**Ms. Sharon Baxter (Executive Director, Canadian Hospice Palliative Care Association):** Good afternoon, everyone. I have a terrible cold, and I'm hoping I can get through this without coughing fits.

I'll be speaking mostly to hospice palliative care, the care that Canadians get at the end of life, and how it intersects with physician-hastened death, but not as much about the criteria for physician-hastened death. I'm the executive director of the Canadian Hospice Palliative Care Association. We work in and represent the hospice palliative care settings across the country, with over 600 registered programs and services and over 3,000 members.

We've just completed a three-year initiative, “The Way Forward”, around expanding what we think about as the specialist palliative care that about 35% of Canadians would need to use. About 65% of Canadians actually die in primary care and don't actually need the specialist palliative care teams and programs that we offer in hospitals. We talked about the palliative approach in primary care, so I can talk a little bit about that. That's to reach those Canadians who have dementia diagnoses and die over seven or eight years, as opposed to those who maybe have cancer and die in a profound dying stage. We can talk a little bit more about that.

While the recent Supreme Court decision on the issue of physician-hastened death has captured media attention, a relatively small number of Canadians are likely to meet the criteria for those services. Based on what we see in other jurisdictions around the world, we expect it to be about 2,500 to 3,000 Canadians in any given year, so it's not a huge number. However, of the 260,000 Canadians who will die this year, only 10% will die suddenly. The other 90% could use better hospice palliative care or a palliative approach to care.

We know that everyone has the potential to benefit from the growing willingness to acknowledge that dying is a part of living and that people deserve and should receive the integrated palliative approach to care at all stages of their illness trajectory and in all settings of care. It would be a shame if a Canadian chose physician-hastened death because their pain and symptoms were out of control and not managed well or because they had never been referred to hospice palliative care. I think we can all agree that we want to provide the best end-of-life care possible for all Canadians. We need to make sure that our government is focused on the delivery of quality hospice palliative care services along a full spectrum. All patients deserve access to information about options at the end of their lives, including physician-hastened death. It's something we all need to provide.

I am aware that this committee has asked us to keep our comments around eligibility, criteria, processes, and procedures. I'll say less about the physician-hastened death and more about the interface between the two. For further details, I refer the committee to the larger submission we made in the fall, which I believe you've all seen.

There is a dire need to educate Canadians around hospice palliative care options available to them at the end of their lives. I think Canadians don't want to talk about death and dying and don't necessarily understand what's available for them at the end of their lives until such time as they interface with the health care system in a moment of crisis. Comprehensive hospice palliative care can help alleviate many of the factors that may cause people to consider physician-hastened death, particularly the burden on their loved ones, depression, and inadequate pain and symptom management.

There's still a lack of understanding and conversation taking place between physicians and patients around options at the end of life. Doctors are often not well trained to engage in end-of-life conversations, resulting in unclear goals of care, the burden of stress and anxiety being placed upon caregivers, and an overall lack in fulfilling the wishes of how patients would like to live in their final days.

The Canadian Hospice Palliative Care Association believes we need national leadership and coordination of a fully funded national strategy to ensure universal access to hospice palliative care. That includes an awareness campaign around hospice palliative care generally, including advance care planning. We now have resources and tools for advance care planning, but we're not using them to the maximum. They're just coming out now.

Over the last few years, our initiative, “The Way Forward”, developed practical and implementable tools and resources to help policy-makers, health planners, and service providers across the country. Some of the provinces are taking on this new national framework now, but we're in early days. This initiative is now over, but the information needs to be pushed out further across all of the provinces and territories.

● (1800)

The federal government is responsible for health care provisions for certain groups of people, including veterans, military personnel, prisoners, and our indigenous peoples. All of these groups should be afforded the same coverage in hospice palliative care, but that is currently not the case. Access to hospice palliative care is not an essential service for our first nations people on reserve. Home care is an essential service, but palliative care isn't. This must be rectified. This is a clear opportunity for the federal government to improve the treatment of first nations people.

We must engage Canadians and patient groups to be champions, to talk about death and dying. We must also disseminate information to the hospice palliative care community to educate both patients and physicians. It's time to normalize this conversation.

Palliative care and physician-hastened and physician-assisted death are philosophically and clinically separate. Conflating them could result in confusion, making people who are already frightened of palliative care even more reticent to avail themselves of this vital and effective means of addressing suffering. We'll need to be careful with that.

We must educate and support health care providers to help them overcome their own fear of loss, dying, and death. An integrated palliative approach to care should be part of all health care providers' education. We must ensure that our future physicians and allied health providers are well versed in these conversations and are ready to have them with their patients. Only when conversations about death and dying are fully transparent and when options at the end of one's life are fully understood and discussed will we be able to properly manage requests for physician-hastened death.

The Canadian Hospice Palliative Care Association believes hospice palliative care does not include physician-hastened death. Hospice palliative care does not hasten or prolong death. Hospice palliative care strives to end suffering, not life. Canadians need universal access to hospice palliative care, including good pain symptom management. All patients deserve access to information around end-of-life options, including physician-hastened death. We need to be part of that.

The separation between palliative care and physician-hastened death must not impede a smooth, compassionate, and effective transition between both, and we need to work on that. How do patients go from one area to the other, and who will be doing that?

Physician-hastened death will greatly impact the illness trajectory of elderly and sick Canadians and their caregivers. We must ensure that this new development is introduced in an appropriate way that does not impinge on the programs and services already available. Moreover, a structured and unified action plan must be presented to the Canadian public, including those working within the hospice palliative care field, explicitly establishing norms of practice and standards of care that should be followed when carrying out physician-hastened death.

The following factors should be considered. Allied health care professionals, including physicians and nurses and other allied professionals, must be protected in such a way that their decisions are respected and alternative options presented should they choose not to administer a physician-assisted death. All institutions and physicians should be given the option to opt out of providing physician-hastened death, granted they are willing to provide a referral to this service. I echo some of the comments that Carolyn made about the transfer or transition to another setting.

In the palliative care units in hospitals, there will be physician-hastened death. They may not have those people do it; maybe somebody else will come in to do it. In home-based programs, I can see it happening quite easily. The process in our residential hospices, of which there are 80 in this country, is not around hastening death. They're asking for a site exemption.

Keep in mind that most of them don't receive much government funding. They are charitably funded, for the most part, and they want to make sure that they are actually following the wishes of the community that raises the money for residential hospices. We'll see where that all goes.

**The Joint Chair (Mr. Robert Oliphant):** You have one minute left.

**Ms. Sharon Baxter:** Legislation must be put in place to ensure that the specific requirements are met for a patient to be granted physician-hastened death. More than one person should be conducting the competency assessment. We must ensure that trained professionals are used during these consultations and that they are able to adeptly analyze a patient's illness trajectory and make sure this is the only option to alleviate a patient's suffering.

The federal government will need to be responsible for developing universal legislation with regard to physician-hastened death that provincial governments can follow. There needs to be one set of regulations and norms of practice that should be followed nationwide.

Clear information and readily available guidelines must be available to all Canadians in order for them to be informed about their options. These resources should be led by an awareness campaign funded by the federal government and distributed among the provinces.

In closing, I have a few bullets.

The CHPCA is calling on the federal government to consider a national federal strategy or framework for hospice palliative care that would work toward the following: ensuring universal access for all Canadians; a national awareness campaign for hospice palliative care, including advance care planning, which would inform Canadians on the options available to them at the end of their lives, including physician-hastened death; the protection of Canadian health care workers in the hospice palliative care field, including the option for them to opt out of providing physician-hastened death should they choose to, although they would then refer a patient to the appropriate place; clear and informed legislation regarding physician-hastened death, developed federally, to be enacted provincially and through institutions; and readily available information and resources for physicians, families, caregivers, and patients regarding their end-of-life options and physician-hastened death.

● (1805)

**The Joint Chair (Mr. Robert Oliphant):** For questioning, we begin with Mr. Lemieux.

[*Translation*]

Ms. Shanahan will also be speaking.

**Mr. Denis Lemieux (Chicoutimi—Le Fjord, Lib.):** Thank you, Mr. Chair.

My question is for Ms. Ells, from McGill University.

Witnesses representing palliative care physicians told us that they regularly engaged in physician-assisted dying, since one of the final steps in palliative care is palliative or continuous sedation. It consists of rendering a suffering patient unconscious such that death occurs naturally without causing any conscious distress.

In your view, ethically speaking, how does the practice of palliative sedation differ from the practice of physician-assisted dying?

[*English*]

**Dr. Carolyn Ells:** Of course, in some ways they seem equivalent in principle; however, no, they're different.

Palliative sedation or continuous sedation till death—there are various terms that talk about it—is an accepted practice within the standard of care in certain circumstances.

Basically, it's the idea of sedating someone deeply—almost like you would during surgery—until death. Death doesn't happen quickly in those cases; Sharon might speak well about that too. It takes a long time to accompany someone through that, and one needs to titrate that very carefully, but yet it is an option out there. In Quebec law, they allow that for people who cannot consent on their own behalf. In a sense, they're allowing for something that's already allowed within medical practice. To be honest, I saw it more as political, you know, that we'd still allow for something.

The greater issue, I think, is the importance of consent. In regard to giving a substance that ends one's life very quickly, health professionals, health institutions, and, I believe, many patients, families, and individuals prefer someone to consent to that for themselves. I think that palliative sedation, or continuous palliative sedation, is a very good treatment modality among the varieties of treatment modalities that would not be used as a first or second line of treatment, but only when the suffering was really quite terrible. Some pain is really awful to see and very, very difficult to manage. I can imagine that it would be much easier for some people simply to be asleep, in a sense, rather than conscious.

I don't see a huge ethical difference. I see it more of an emotional difference. However, it requires resources.

● (1810)

**The Joint Chair (Mr. Robert Oliphant):** Madam Shanahan.

**Mrs. Brenda Shanahan (Châteauguay—Lacolle, Lib.):** In fact, I'd like to continue on that line and explore either with you, Professor Ells, or with Dr. Smith, what the criteria are to access palliative care as we have it now. Just so we can understand, what are the actual medical interventions that take place, or what is given and what is withdrawn? Then you could talk a little more about the continuous sedation.

**The Joint Chair (Mr. Robert Oliphant):** There's just one minute.

**Dr. Derryck Smith:** Maybe I could lead off that discussion. I'm very much in agreement. We need better palliative care in Canada. The biggest problem now is accessing it, because mostly it's available only in the major centres.

However, I think that if you look at the experience in Oregon, you will see that there are more people accessing palliative care who want to have physician-assisted dying than there are people who die from natural causes, so it's not one or the other. In spite of the best palliative care, we are all going to die, so it's probably not one or the other. It's both.

I think the other model we have to keep in mind, particularly with the model of continuous sedation, is that the vast majority of Canadians want to die at home, surrounded by their friends and family. If you look at the statistics from Oregon, you see that more than 70% of people who have physician-assisted dying die at home. That's one of the great advantages. Because no one is going to get continuous sedation in their home, we should make options available for Canadians to die at home where they wish to, at a time of their choosing, and surrounded by their friends and family.

**The Joint Chair (Mr. Robert Oliphant):** Thank you, Dr. Smith.

Mr. Warawa.

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

Thank you to the witnesses.

Dr. Ells, are you representing and bringing recommendations from McGill, or are these your personal recommendations?

**Dr. Carolyn Ells:** These are my personal recommendations.

**Mr. Mark Warawa:** Thank you.

Dr. Smith in beautiful British Columbia, I love your tie. My question for you is whether the positions you've shared tonight are the same as those of Dying With Dignity or whether they are your own.

**Dr. Derryck Smith:** In large part, my positions represent the views of Dying With Dignity Canada and the physician council. The one position I outlined that has not been fully debated or adopted by Dying With Dignity Canada is the issue of what to do with the children who are suffering irremediable illnesses, but who are obviously never going to be competent to give consent themselves. That position I brought forward, because I've spent most of my life working with children and teenagers, and I think we really need to give more thought to that.

**Mr. Mark Warawa:** Thank you, Dr. Smith.

We have heard from Dying With Dignity, last week from Linda Jarrett, last night from Wanda Morris, and now from you. We have had lots of opportunities to hear from Dying With Dignity, and what you've shared is very consistent with what we heard the previous two times.

I have a question for the Canadian Hospice Palliative Care Association.

Ms. Baxter, do you represent the position of your association, or are these your own views?

**Ms. Sharon Baxter:** These views are from our association. Since last summer we've gone through a long process to develop our statement. In the fall we had a large conference of 650 hospice palliative care professionals and caregivers, and we came to a consensus on our key messages. I didn't get into all of the key messages, but they'll be in the bigger submission.

● (1815)

**Mr. Mark Warawa:** Right. Thank you.

You've used the term “physician-hastened death”. Member of Parliament John Aldag and I hosted a town hall meeting last Saturday, and that was the term that people seemed to like using. In your brief, which we have here, you suggested that a consenting adult should be somebody over 21 years of age.

Just for interest, for members of the committee, with regard to asking about the age, 96.6% of the people who responded to this survey said that it should be 18 or over. That's right in line with what you're saying. Could you comment on that?

**Ms. Sharon Baxter:** When I presented to the panel in the fall, I actually told them that when we talked about when we leap over and become an adult and that sort of thing, that wasn't based on any great science. Our pediatric palliative community said that you can drive at 16, you can drink at 19, you can join the military, and 21 was that last point across the threshold of adulthood. It wasn't based on anything other than feeling that it was the age of consent.

There's a lot of debate and discussion about the younger terms. I do think that we would have a problem with young teenagers grappling with what they have to grapple with, but that's what we put in our submission. It's not based on any huge science.

With regard to the term “physician-hastened death”, one of our colleagues, the Canadian Society of Palliative Care Physicians, which is one of our partner organizations, as well as most of their members and my members, felt that the term “physician-hastened death” played into the idea that palliative care does not hasten death. It sort of signifies that. People who work in palliative care do assist in death and dying, but they're not actively ending somebody's life, so they felt that the term was interesting.

We've been very hesitant. You may notice that our submission said “physician-assisted” death and we're using the term “hastened” right now. We're waiting to see what the legislation says, because I think whatever the legislation decides in June will be what we all have to call it. Right now we're in this period of transition, but the hastened death piece resonated with the palliative care community.

**Mr. Mark Warawa:** Do I have any time left, Chair?

**The Joint Chair (Mr. Robert Oliphant):** You have 20 seconds.

**Mr. Mark Warawa:** I'll get a quick answer. In the polling, 95% of people who responded said that there should be a requirement for palliative care to be offered to someone so that they actually have informed consent. Would you agree?

**Ms. Sharon Baxter:** Absolutely. I just need to say that the jurisdictions that have moved toward physician-hastened death and physician-assisted death have all made investments in palliative care, as we've seen in Quebec in the last six months to a year. I think it needs to happen, because you get yourself caught up in being challenged that you haven't provided the best care possible and then people are choosing to end their lives because we haven't done the best that we could.

**The Joint Chair (Mr. Robert Oliphant):** Thank you, Ms. Baxter. It's hard to call you Ms. Baxter, Sharon.

**Ms. Sharon Baxter:** We know each other.

**The Joint Chair (Mr. Robert Oliphant):** We have Mr. Rankin and then Madam Sansoucy.

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

Just for the committee's benefit, I know, Dr. Smith, that you are a very prominent child psychiatrist in British Columbia and former head of the BCMA, so I was taken with your comments, sir, about the problem of dealing with competent adults and your recommendation that we expand it to children, which I know is a very difficult issue.

I'd like to ask you to expand a little on that. I notice that the interim guidance from the College of Physicians and Surgeons of B. C. limits the service of physician-assisted dying to adults, so I'd like to give you an opportunity to say how you personally see that this might work.

**Dr. Derryck Smith:** I think that in the first instance, we should leave it to persons who are competent legally, and there are many people who are competent legally who are not over 21. I know there is legislation in British Columbia that specifically allows young teenagers to consent to medical care without consulting their parents, and that was specifically around the provision of birth control pills for young women. I have worked with many teenagers over the years and I have worked with a number who have been facing death, and I think they would be competent in the legal sense to consent to physician-assisted dying as they would be legally competent to agree to other kinds of medical care.

From a practical point of view, if you're dealing with a teenager, you ideally like to get the teenager and the parent to agree, because then you know you have the individual who has authority to agree to it, but I don't think that limiting this to adults.... Why would we want teenagers to suffer, but we're prepared to relieve adults of suffering? It makes no sense to me, and that's why I'm saying that the most controversial area—and this is certainly a controversy in Europe—is what to do with children who are suffering irremediable pain at the end of their lives. I'm not expecting your committee to deal with that other than to give it some thought, but I think limiting it to competent individuals would solve the concerns that I have around teenagers who may be legally competent.

● (1820)

**Mr. Murray Rankin:** Thank you, sir.

Another difficult problem that you put your finger on is the issue of someone who is no longer competent. You spoke about dementia, for example. Again, the college in B.C. seems to be saying that the patient must maintain mental capacity for physician-assisted death to proceed, and if at any time they lose that capacity to rescind their decision, physician-assisted death ceases to be an option, yet those are very much the people you talked about who motivated you. They are the people for whom one would want to allow this service to be provided. You spoke of your relatives, for example.

I'd like you to spend a little bit longer on that topic.

**Dr. Derryck Smith:** I'd be happy to do that.

I have visited a number of people who were in the latter stages of dying from dementia. They are typically in bed, incontinent of feces and urine, in adult diapers 24-7. They do not know who they are or where they are. They cannot speak. This is not a condition most Canadians would want to be in at the end of their life. I certainly do not want to end my life that way. I witnessed both my father and mother-in-law dying in that state. We need to find a way to allow people who are competent currently to ensure that they do not end up in that condition toward the end of their lives if they choose not to. People are perfectly at liberty to choose to die how they wish, so I think we need to give some more careful thought to that.

I know what the College of Physicians and Surgeons has said here, but I disagree with them on that, and I would challenge members of your committee to reflect on how they would like to die and what they would think about a relative of theirs dying in the sorry state of end-stage Alzheimer's and a year of living in a bed wearing an adult diaper. It's not sensible for people to be in that state at the end of their life.

**Mr. Murray Rankin:** I have one minute left.

I would like to know if you think that any process we come up with ought to contain an appeal or whether that is necessary. Let us suppose that a particular physician or group of physicians refuse the service a patient seeks. What happens then? Should there be an appeal for that patient? Is there a danger of "doctor shopping" under those circumstances?

**Dr. Derryck Smith:** Generally, I am in favour of appeals on any important decision that happens in our lives. The court system has many levels of appeal. The only instance that I know of where appeal systems are in place is in the European countries, where a person who is denied physician-assisted dying by their physician can appeal. In Belgium, the appeal rate I'm familiar with is about 30%. In other words, 30% of people who were denied by their physicians are allowed by this panel to have physician-assisted dying. I think you'd have to look at the legislation in those countries to get a better sense of how to make that operational, but, in general, I think most important decisions in our lives should be able to be appealed.

**The Joint Chair (Mr. Robert Oliphant):** Thank you, Dr. Smith.

Senator Nancy Ruth.

**Hon. Nancy Ruth (Senator, Ontario (Cluny), C):** Dr. Smith, in your experience, are doctors familiar with the social determinants of health? If they are, will doctors be able to distinguish between a grievous and irremediable medical condition and a patient's wish to die because of inequalities in health care, societal neglect, and social prejudices about life, whether they have a disability or a mental health condition?

**Dr. Derryck Smith:** That's a very difficult and probing question. I think doctors are aware of the social determinants of health, of such things as access to quality health care and access to clean water, good food, and so on. Maybe we're not as sensitive as we should be to some of the inequalities we see in our society, particularly with first nations communities and other disadvantaged individuals. I live in Vancouver, and the streets of downtown Vancouver are inhabited by people who have chronic mental illness and substance abuse problems.

I don't pretend to give you an easy answer on that one, because I don't think there is one. I certainly believe, however, that people whose primary suffering comes from mental illness should not necessarily be denied access to physician-assisted dying, although the numbers in Oregon and the European countries are very small for people who simply have a mental illness that makes their life intolerable.

Having known many patients with severe mental illness, though, I can tell you that many of them end up with a life that is intolerable. Could it be made better by the provision of better services? Probably the answer is yes.

● (1825)

**Hon. Nancy Ruth:** We had testimony from some psychiatric association that if a person had colon cancer, say, and requested physician-assisted death, and they had a history of mental illness, a psychiatrist should be called in to assess competence before that was given. Do you agree with that?

**Dr. Derryck Smith:** I think there is a role for psychiatry, particularly where mental illness is one of the issues. Some people have called for psychiatrists to be involved with every decision. I think that's really neither practical nor necessary. General practitioners, family doctors, are the ones who usually determine whether someone is competent or not, but there may be a role specifically for psychiatry to play where there is an issue of mental illness.

I'm hoping that my colleagues at the Canadian Psychiatric Association are going to address that. I spoke with the Canadian Psychiatric Association at their annual meeting this year, and I think they are attuned to the issues and hopefully will come up with some policy directive on that.

**Hon. Nancy Ruth:** Thank you.

Professor, I note your professional work on feminist approaches to bioethics. Could I ask you for a gender-based analysis of physician-assisted death? Are there particular matters in physician-assisted death relating to women, or to men, of which this committee should take particular notice or that we should address in our recommendations?

**Dr. Carolyn Ells:** The reporting of those who request and complete death via physician-assisted dying should include statistics about gender, for sure. We're certainly aware that the population is aging, and women tend to live longer than men and tend to live poorer than men in terms of their resources. Some women who are at that age now are from generations that were trained and socialized to not think highly of themselves, to defer, and things like that.

So yes, we should be careful; however, I think we should consider that health professionals have accompanied patients through very difficult situations for a long time and have a lot of experience with carefully building a relationship, a rapport, and going through a consent process in planning how one's dying and one's care at the end of life should be. I think we should allow that we are already pretty good at a lot of that. I don't think we need to learn a lot of extra new things, but of course we should take great care—

**Hon. Nancy Ruth:** Thank you.

Ms. Baxter—

**The Joint Chair (Mr. Robert Oliphant):** I'm sorry, Senator, but I'm afraid I have to move from you and turn to Senator Cowan.

**Hon. James S. Cowan (Senator, Nova Scotia, Lib.):** Thank you.

My questions are for Dr. Smith.

All of us are concerned about suggestions that vulnerable Canadians would be at risk in this regime that is to be established in response to Carter. Would you agree with me that the concepts of capacity, competence, and informed consent are well understood by physicians and in the legal system and that there's no need to further define them?

**Dr. Derryck Smith:** Yes. Doctors cannot perform any medical services for any patient without someone consenting to it. Many times it's implied. If a patient just shows up in my office to see me, I don't get them to sign a consent. I presume they are consenting because they are there. However, the ante has to be upped once you get into serious matters. For example, no Canadian going for surgery is going to have it without a written consent.

I think this is maybe one of the ultimate decisions in life, so I think we need to keep the bar very high on the fully informed consent that one has to think about for a while.

Are doctors attuned to those issues? I believe the average doctor is. Family doctors make these decisions on a daily basis when they're assessing patients. That's not to say that we couldn't improve. I think there needs to be a general education program for physicians, not only to help them deal with the mechanics of physician-assisted dying but also to help with the philosophical issues, the ethical issues, and the issues of informed consent.

We need to learn more, but I think we're pretty okay with informed consent currently.

● (1830)

**Hon. James S. Cowan:** That also applies to assessment of capacity and competence.

**Dr. Derryck Smith:** Yes. There are manuals—

**Hon. James S. Cowan:** Sure. That's right. If a physician in our current system is in any doubt about capacity or competence—and I agree with you that it depends on the severity of the procedure that's involved—they might ask for a second opinion, or indeed the opinion of a specialist. The nature of the doubt would inform their decision as to the kind of second opinion that would be required.

**Dr. Derryck Smith:** Absolutely. I'm asked to do capacity assessments by lawyers for various individuals. There are people like me who have expertise in that area.

I think that having a panel of experts available to assist our colleagues on difficult questions of competence and capacity is very sensible. It probably could be done informally, in the same way that medical consultations are arranged now.

**Hon. James S. Cowan:** Could I shift for a moment to the issue of access? Again, I think we have to make sure that the system that is designed and the service that is available will be available, as best as it can be accomplished, for Canadians from coast to coast to coast, regardless of where they live. I'd like you to comment on the need for the involvement in that of non-physicians, of other health professionals, in order to guarantee the kind of access that is so necessary.

**Dr. Derryck Smith:** I think doctors are fairly well distributed across the country. It would be ideal if all Canadians had a family doctor, which is not the case now, unfortunately. I'm concerned about rural and remote communities, where there may not be a doctor living in the community. We may have to look at the role for nurse practitioners or telemedicine. A good deal of medical services, at least in my province, are done over a telemedicine link. I think the recommendation I've read that makes the most sense is that one of the two doctors must assess the patient in person, but the other one could be done by a telehealth link.

Finally, I think we have to recall that doctors, whether administering intravenous medications or prescribing medications, have these medications supplied by pharmacists. I think we need to give some thought as to whether there is a particular role for pharmacy here. What about pharmacists who don't want to dispense medication that they know is going to be used to hasten death? We need more thought in those areas.

**Hon. James S. Cowan:** Thank you.

**The Joint Chair (Mr. Robert Oliphant):** Thank you.

We're going to go to round two. Just before we do, I want to use the chair's prerogative to ask Dr. Ells a question.

From your past life as a practising ethicist, can you tell us if you see a role for a hospital ethics committee? The Supreme Court has said that we are going to have physician-assisted death and we're going to have it in a variety of places and a variety of venues. The venues that have the most developed ethics programs are hospitals.

You have been a practising ethicist, not just a theoretical one. Can you give us any comment that could help us in understanding what that role could be and what it should be?

**Dr. Carolyn Ells:** I don't think there should be a requirement for an ethics consult by a single consultant or a committee on every occasion. These resources ought to be available, to be sought when things are particularly difficult, but I would not want it to gum up the process by being added in.

● (1835)

**The Joint Chair (Mr. Robert Oliphant):** Would it have a role at the beginning, as a policy body, and then on availability later, on an unusual case?

**Dr. Carolyn Ells:** Yes. Absolutely.

**The Joint Chair (Mr. Robert Oliphant):** Thank you.

We'll begin our second round with Monsieur Arseneault.

[*Translation*]

**Mr. René Arseneault (Madawaska—Restigouche, Lib.):** Thank you, Mr. Joint Chair.

Thank you, Dr. Smith, Professor Ells and Ms. Baxter. I know your time is valuable, but this evening, you're really helping to shed light on issues that the members of this committee need to consider in order to come up with a bill.

My first questions are for Ms. Baxter.

I read the briefing note your association submitted. Your association acknowledges the need to respond to the Carter decision through a bill that amends the Criminal Code, while ensuring the promotion of palliative care. I understand the dynamic behind your association's position.

I also appreciate the fact that your association suggested responses to the criteria or parameters set out by the Supreme Court of Canada, in keeping with the Carter decision. I am assuming, then, Ms. Baxter, that you read the Carter decision.

Paragraph 127 of the decision summarizes the court's thinking, if you will, or decision. Without quoting the entire paragraph, I'll cite some of it as a reminder for you. The Carter decision states that “a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition... that causes enduring suffering that is intolerable to the individual” may seek physician-assisted dying.

In Carter, that suffering is perceived by the patient. I'm trying to figure out how to reconcile the court's position in Carter with your or, rather, your association's position. Specifically, I'm referring to your stance whereby a request for physician-assisted dying should be granted only when the health care professionals are in agreement that no other options are available to ease the patient's suffering. Then, and only then, should access to physician-assisted dying be provided.

How do you reconcile that with the Carter decision?

[*English*]

**Ms. Sharon Baxter:** We know that there will be Canadians who want physician-hastened death. We know that Canadians need physician-hastened death in some situations. I'm not sure this will answer your question in the way you worded it, but one thing we want is for Canadians to have the best options and the best care possible up to the point where they decide on physician-hastened death.

You know, even within the hospice palliative care community, a small number of palliative care physicians have said they'd be interested in performing physician-hastened death. Most of them aren't interested, but what all of them are saying is that they want to give the best care possible and see if we can manage the pain and symptoms. Then we will refer them on to find the best person or the best program to provide physician-hastened death.

There's not a conflict between the two. We just want to make sure that the best care is offered and the best options are offered at the start, before they go to physician-hastened death. I think there are some concerns about having somebody who has had uncontrolled pain, because a lot of Canadians aren't getting the right care they need at the end of their lives. They're living in isolation, they're showing up in hospital emergency rooms without having the proper care or ever being referred to palliative care programs. These people arrive in drastic circumstances. We're saying we want to get them the best care possible, and then if they want to have a physician-hastened death, we will refer them and they will get that.

[*Translation*]

**Mr. René Arseneault:** Very well. I see what you're saying.

I have a question about age. I was listening to what you said earlier in response to the question—

**The Joint Chair (Mr. Robert Oliphant):** You have a minute left.

**Mr. René Arseneault:** Okay.

In your brief, it says that the patient should be 21 in order to make such a request but that careful precautions need to be taken with those in young adulthood. Do you mean those who are 21 years of age or those who are younger than 21?

● (1840)

[*English*]

**Ms. Sharon Baxter:** As I said earlier, it's not based on a whole pile of science. We hadn't even referred a lot with our pediatric palliative care community. They are coming here tomorrow. I was speaking to their lawyer, who's presenting tomorrow. I'm sure the Canadian Paediatric Society will give you a better reflection.

The pediatric palliative care community is a small percentage of our community. There are seven residential pediatric hospices in this country. They are concerned about where they lie. We picked the age of 21 for no other reason than it is that last barrier to add on. If people have a better sense of that, I'm sure you'll hear it tomorrow.

**The Joint Chair (Mr. Robert Oliphant):** I need to move on to Monsieur Deltell.

[*Translation*]

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

Welcome to your Parliament, ladies and gentlemen.

My question is very simple. We are here not to determine whether we support allowing people to die with dignity through physician-assisted dying but, rather, to decide how to go about it.

The Supreme Court was quite clear in telling us that we needed to amend the Criminal Code. Given, however, that the Criminal Code is the responsibility of the federal government while health care falls in the provincial domain, we need to figure out how to harmonize the two.

In the committee's recommendations to the government, should we suggest that the legislation set out very clear direction for the provinces or give them free reign, in your view? I'd like to hear what all three of you think. For the sake of comprehension, I'll ask Mr. Smith, from Vancouver, to go first.

[*English*]

**Dr. Derryck Smith:** I'm happy to address that, but again, you won't get a lot of wisdom from me out of this. I'm well aware of the balance of powers between the federal government and the provinces. Hopefully working together in the best interest of Canadians will result in a national program, but we may have to end up with a patchwork of regulations.

I think it's important that we have a national reporting mechanism, even if the provinces go their separate ways on some of the specifics. For example, I cannot imagine that Quebec will move its current legislation to allow for the prescribing of oral medications without a great deal of thought. I don't think we'll get national agreement on some things, but I've not heard anyone argue against a national reporting system so that Canadians, on an annual basis, will get some idea of how the system is working and be assured that the vulnerable are protected, that there's ready access, and that things are being done properly.

[*Translation*]

**Mr. Gérard Deltell:** Ms. Baxter?

[*English*]

**Ms. Sharon Baxter:** I agree with the idea of national reporting, and we've come out and said that we would prefer national legislation as a guiding principle. I know Quebec does its own thing and has already done its own thing, but in regard to the rest of the provinces, we understand that implementation of the process will depend on where the community is at and what the needs of the population are. We've already been talking to rural Manitoba, and they're talking about a mobile unit. There are all sorts of different ideas coming out of the provinces on how they would try to satisfy their needs, particularly rural needs.

I think we need national legislation and national reporting. Within those guidelines, implementation will fall to the provinces to figure out what meets the needs of their population and their own health systems. No two provinces' health systems are set up the same way. We're not starting from the same point every time.

[*Translation*]

**Mr. Gérard Deltell:** Ms. Ells?

[*English*]

**Dr. Carolyn Ells:** The system ought to provide it. If it's the right of Canadians to receive access to physician-assisted dying, then I would like the federal legislation to require provinces and territories to make it available where people live in each province and territory. I think we have to compromise in the struggle of competing values so that some institutions are responsible to provide it. Whether others can opt out, particularly if a conscience-based deep core value is the reason to opt out, the system nonetheless ought to provide it.

**Mr. Gérard Deltell:** I think we all recognize that it will be a very difficult task. We're talking about provincial power and a federal obligation, but if we let all the provinces decide by themselves, don't you think we'll see tourism in Canada? People from Alberta will want to go to Quebec, and what else?

● (1845)

**Dr. Carolyn Ells:** Exactly. That's why I think we shouldn't allow that. This helps to justify the federal government taking a stand to help ensure access all the way across. Canadians who are eligible in the public health care system ought to be able to receive it where they live.

**The Joint Chair (Mr. Robert Oliphant):** Senator Seidman.

**Hon. Judith G. Seidman (Senator, Quebec (De la Durantaye), C):** Thank you very much for your testimony today.

Ms. Baxter, if I might ask, you mentioned that there are 600 hospices across the country.

**Ms. Sharon Baxter:** There are 600 hospice or palliative care programs, either home-based, hospital-based, or hospices, and of those, only 80 are residential hospices.

**Hon. Judith G. Seidman:** Thank you. That's very helpful.

With that in mind, thinking specifically now about Bill 52 in Quebec, I'm wondering if there is anything you could share with us in terms of how the hospices are reacting to Bill 52, and if there is something we might learn from that right now.

**Ms. Sharon Baxter:** Thanks for asking that question, because I didn't fit that in.

The 29 residential hospices or residences in Quebec formed an alliance and went to the provincial government and were given an exemption, so that's something for you to think about if you're looking at site exemptions for hospices. That was granted in Quebec. Interestingly, the medical adviser of one of the hospices has ALS and pleaded with them to let her die in her own organization, and they have agreed that when the time comes, they will perform physician-hastened death in that one hospice. That sort of throws everything out when you have all the hospices standing together and then you have this one exception, but it was the right decision for them.

Generally, the hospice programs in Quebec raise $2 million to $3 million of their money from their communities, and they are not government funded. They do get some government funding, but we're talking half a million dollars out of a $3 million budget. They have to be connected to their communities, since that's where they get their money.

I think over time we'll see how this all goes. Right now they are standing firm in Quebec. The rest of the provinces are challenging themselves. The boards of directors are meeting now without knowing what the legislation is going to tell them. They're trying to figure out whether they'll generally say that they would prefer to transfer out, but we'll see where that all goes. That's just for the residential hospices.

The rest of the hospice and palliative care programs are really quite.... If they give the best care possible and a person wants physician-hastened death, they will refer to the right people.

**Hon. Judith G. Seidman:** That actually leads me to my next question, to which Professor Ells and Ms. Baxter and perhaps even Dr. Smith might respond, and that has to do with the referral process itself and the transfer that everybody has talked about.

I'd like to have some explanation of how you see that working. For example, when the British Columbia Civil Liberties Association was here yesterday, the solution they proposed was that physicians should have to notify some third-party body, whether it's the hospital or the health authority, of their refusal. It would not be to provide an effective referral but simply to notify, with the permission of a patient, about their desire not to carry out this service. In that way there can be a transfer of care for the patient, which is what happens in Quebec right now.

How would that work? Is it left to the provinces? Will professional regulatory bodies make some kind of systematized approach to this process? Is this something that should be in the federal framework? How do you see that happening?

Maybe I could start with Dr. Smith.

**Dr. Derryck Smith:** If you look at how referrals are made now, you will see that they do not involve any formalized bodies in any of the provinces. Family doctors make referrals to surgeons, psychiatrists, and so on, and doing so is all pretty informal, so if you want a system put in place, there is nothing to build on currently.

I suspect what is going to happen is that consumer groups will spring up. I know my organization is interested in helping doctors who are interested in this to form organizations so that it may become well known which doctors are going to be involved and which ones aren't. That is the model used for most abortion services in Canada currently. I would be reluctant to institutionalize a referral system, but, on the other hand, we have to make sure that the patients' autonomy and needs are put at the forefront, rather than what institutions and doctors may wish to do.

We need to have some public way of getting referrals from doctors who do not wish to participate so that a patient's care is continuous and people don't get dropped, because this is a critical stage in someone's life. This is not a stage in your life when you want to be digging around trying to find a new family doctor. There needs to be some thought given to how that's going to be made operational, and I don't have a ready solution for you, I'm afraid, at this point.

● (1850)

**Hon. Judith G. Seidman:** Thank you. I appreciate that, because that's exactly the reason for the question. It's the point you just made, which is that we need to think about the patient. It needs to be patient-centred, so we need to ensure access when a physician decides he can't do it.

If I might ask Professor Ells—

**The Joint Chair (Mr. Robert Oliphant):** I'm sorry, but I have to end it there. It's a fast five minutes. Maybe you can nudge Senator Cowan and he can help you with a question.

**Hon. James S. Cowan:** I'm always happy to help Senator Seidman.

I was just going to follow up with Dr. Smith first, and then perhaps invite our other guests to comment as well. It's about this whole business of access and making sure that Canadians, at this critical stage in their lives, at the end of their lives, have equality of access. They're not, generally speaking, as mobile as they would have been at earlier stages in their lives.

Do you see any way that this can be accomplished other than having a general framework established at the federal level and then leaving it up to the provinces, in their own ways, to come up with an equivalent regime that meets the guidelines and the standards set at the federal level? At the end of the day, isn't that the only way in which we can guarantee the kind of access that the court says we must have for all Canadians?

**Dr. Derryck Smith:** I'm not an expert in federal or provincial regulation. What I would not like to see is some kind of very bureaucratic process involved, because that's likely to get bogged down.

I can tell you that in British Columbia I'm aware of three and possibly four family doctors who have expressed an interest in providing these services. If someone called me up, I would recommend that they go to see them. My organization, Dying With Dignity, is likely to establish informal rosters of doctors who are prepared to assist patients in accessing this service.

I don't know if that's going to be good enough, though, but the risk of doing it federally or provincially is setting up a cumbersome bureaucracy. I don't know—

**Hon. James S. Cowan:** Excuse me. I was speaking about a sort of overall framework rather than a detailed bureaucratic regime, but with standards that are available—

**Dr. Derryck Smith:** I'm very much in favour of standards. I think there should be rules such that there must be a smooth transfer of service from doctors who do not wish to participate to those who will. That's a heavy burden to put on doctors who object, but it's important, because these are vulnerable people at the end of their lives who must not be left dangling because their doctor does not want to provide this service to them.

So principles, yes, but as to specific regulations, I don't know.

**Ms. Sharon Baxter:** I want to respond to that.

We have issues about transferring from one setting of care. In this country, it's terrible. It's terrible getting from acute care into long-term care or home care or getting out of hospital and into home care.

We don't want that to happen at this stage, so what we need to do is make sure that the onus to refer is on that person, the physician or whomever, and make sure that they follow through, and follow through in a timely manner.

I've talked to the woman who runs the hospice program in Oregon. They're 16 years in, so they've worked out a lot of their issues. Even though the medication is administered by the patient and the family, there is a physician there, and there is a pharmacist who has to prescribe and whatnot. What they do there is that the hospice program says their goodbyes to the patient and the family, and then a group like Dying With Dignity that's a state-run organization comes in and actually does the thing.

I'm listening to what Derryck is talking about. I think we need to make sure that we have some safeguards or some organization that we can quickly go to and count on to be able to help us with the referrals.

**Hon. James S. Cowan:** Can I ask Professor Ells to comment briefly on that?

**Dr. Carolyn Ells:** Referrals or transfers take place at two different levels. One is between the attending physicians for the patient, and another may take place between institutions. The one between physicians is not so problematic, other than firmly requiring a timely transfer. These requirements are already in their codes of ethics. They're already in place.

However, institutions should be required to know who is available in their institution to provide these things. Institutions that make conscientious objections should—

● (1855)

**Hon. James S. Cowan:** But I don't understand how.... I can understand how an individual can have a conscientious objection, but how does a building have a conscientious objection? How does it have an ethical—

**Dr. Carolyn Ells:** It's not quite as comfortable, but hospital institutions, like many institutions, have missions, visions, values, and statements. If they're an ethical, robust organization, their values ought to drive their strategic plan and how they roll out their policies and provide their services.

I'm aware, for instance, of a particular small Catholic hospital that opened up a large palliative care unit in Quebec—poor timing—and then had to struggle with whether or not it would eliminate this important service for the people in their community because of their own conscientious view.

**The Joint Chair (Mr. Robert Oliphant):** Thank you, Dr. Ells.

Mr. Aldag.

**Mr. John Aldag (Cloverdale—Langley City, Lib.):** Thank you.

Just before we get into a question, I wanted to clarify a point that my colleague from Langley—Aldergrove made on the session that we had this past weekend with our respective communities. Some really good information was shared, but I would be hesitant to throw out any numbers or statistics, because it wasn't a statistically accurate poll. It wasn't a representative sample. On things like age, I wouldn't want to mislead our committee members on that being a definite piece. I just want to share that with the committee as a piece of context for what was done.

**Mr. Mark Warawa:** On a point of order, MP Aldag has made reference to this document. It was submitted in a timely fashion, as required by the committee. Because of the overwhelming amount of material that's being presented to the committee, I would ask that this document, which is very accurate, be provided to every member of the committee. There would need to be unanimous consent to do so. It will be provided, hopefully in the next day or two, because it hasn't been translated yet, but I could pass this out, and then MP Aldag could actually refer to it. He does not have this yet.

**Mr. John Aldag:** At this point I simply wanted to clarify that it wasn't a statistically accurate poll or representative sample. It was a point in time when a group of people from our constituencies came out and gave us feedback, which is very useful to us. I was just concerned that perhaps it was misunderstood as being something other than what it was, and I just wanted the committee to realize that when there were numbers of—

**The Joint Chair (Mr. Robert Oliphant):** I don't think that's a point of order. I think we'll take under advisement your concern about getting the report to all of the committee. We'll get it when it's translated.

**Mr. John Aldag:** I'll move to my question. The question is for Ms. Baxter.

You mentioned, and I have read about it as well, that in Oregon we've seen one example of how palliative care can increase once physician-assisted dying comes in. I'm wondering if you have a comment on what the trend is, either in Canada or even internationally, in terms of palliative care. Are we seeing growth just as a result of whatever is happening, or are investment levels fairly stagnant? We see the Oregon example of how physician-assisted dying is actually bringing about increased palliative care investment. I'm wondering what's happening in the palliative care fields and how this relates.

**Ms. Sharon Baxter:** The number of Canadians who are aging out and dying and having diseases and needing good end-of-life care is increasing. Just look around the table; there are a lot of people with gray hair in the room. I just happen to dye mine.

Therefore, we need to provide those services. CIHI, the Canadian Institute for Health Information, puts out a terrific little chart that shows how Canadians die. There are four trajectories. They are sudden death, disease, frailty, and organ failure. Organ failure means heart attack and Parkinson's and the long dementias and stuff.

We need to think about how Canadians die and what kinds of services they need. They don't all need the care of a specialist, palliative care by a full team, or intervention of the type needed by somebody who has cancer and drastic pain and symptoms at the end of their life. We need to look at what services and what kind of palliative approach Canadians need.

We've struggled with this issue in the last three or four years. If 65% of Canadians never see a palliative care specialist, how do we ensure them a better end-of-life experience in which their needs are met and they won't be showing up in hospitals? Right now $35,000 per year per patient in the last year of life is spent on unplanned hospitalizations because we don't do a very good job of supporting those people who are living in their communities and in their homes. We can do a much better job of that. We need to consider all that.

I think it's our responsibility to do a much better job with all that, particularly in light of physician-hastened death. We've said to our community that this is an opportunity. We see it in other jurisdictions, and other jurisdictions have said they have to do the best they can if they're going to offer hastened death. I think that we have to call ourselves on that. We're not talking about millions and millions of dollars for specialist care or palliative care programs, but about pushing out this primary-care approach. That means every physician and every nurse talks to patients and their families about their needs. It means that we have checklists and that we look at frailty indicators. We have 85-year-old patients coming into a doctor's office and nobody asks them any questions about how they are doing, whether they are isolated, whether they have enough food, or whether they have fallen. There are lots of things we can do and there are lots of ideas, including this national framework that we put out.

We're all in favour of doing a better job across the board. If a patient chooses physician-hastened death, so be it. We need to do a better job of not deferring and not delaying, on working together in these systems, and on not prolonging people in the wrong place at the wrong time. There are way too many senior citizens lying on hospital gurneys in corridors. We really need to do a better job.

● (1900)

**Mr. John Aldag:** Thank you.

**Mrs. Brenda Shanahan:** You mentioned that the hospices in Quebec had gathered together to opt out of Bill 52, but that when push came to shove, one of their own members wanted to die in hospice. I mean, we love hospices. That's the ideal place instead of dying at home unsupervised or on an emergency room gurney. People in a hospice are already receiving palliative care. Why wouldn't people have access to physician-hastened death in a hospice? It's a choice that they may not take, but if they want it, why wouldn't they have access to it in a hospice?

**Ms. Sharon Baxter:** It's a case that the hospice people believe in a philosophy of not hastening death, and this is something different. They do believe that their patient and patient-centred care have to be prominent. They're not saying they won't refer someone.

It is a difficult question. Every one of the hospice programs in this country is struggling right now with their boards of directors, their staff, and their volunteers. The one in Ottawa, the May Court hospice, has 400 volunteers. These people volunteer their time, their money, and their energy because they believe in the philosophy of hospice. Now they are saying, “You're going to allow somebody to die here?” They think they could send those patients to the Civic Hospital or whatever.

I'm not sure what the answer is. I don't have the answer. You guys are going to have to come up with some answers somewhere.

**The Joint Chair (Mr. Robert Oliphant):** Thank you.

We're going to suspend for about three or four minutes as we prepare the next video conference.

I thank the witnesses, both in person and via video conference.

Thank you very much for your time with us today.

● (1900)

(Pause)

● (1910)

**The Joint Chair (Mr. Robert Oliphant):** I will call us back to order for the second part of our evening.

Thank you to our witnesses for joining us. From the College of Physicians and Surgeons of Nova Scotia, we have Dr. Douglas Grant and Marjorie Hickey. From the Criminal Lawyers' Association, we have Leo Russomanno.

Joining us via video conference is Dr. Alika Lafontaine, in Grande Prairie tonight. I used to spend a lot of time in Grande Prairie.

We'll begin with you, Dr. Lafontaine, because of the video conferencing. If we have technical problems, it gives us a second chance to get you back if we need to.

You can hear and see us, and we can see and hear you as well. You have 10 minutes for your presentation.

**Dr. Alika Lafontaine (President, Indigenous Physicians Association of Canada):** Thank you very much.

My name is Alika Lafontaine, and I am an Oji-Cree anaesthesiologist practising in northern Alberta. I would like to acknowledge the Western Cree of Treaty 8, from where I'm video conferencing, as well as the Algonquin people, on whose territory these hearings are being held.

My thanks to the committee for the invitation to speak. I'd also like to extend thanks to the board members of the Indigenous Physicians Association of Canada, our past presidents, and IPAC membership for their input into this testimony, as well as the indigenous health advisory committee of the Royal College of Physicians and Surgeons and the staff of the college. In particular, I'd like to thank Dr. Tom Dignan, who has guided many indigenous physicians like me over the past few decades.

Senator Ted Quewezance, chair of the senate of the Federation of Saskatchewan Indian Nations, and Mr. Mike Cachagee, executive director of the National Residential School Survivors' Society, have both been extremely helpful. Senator Quewezance and Mr. Cachagee, also residential school survivors, are people who have helped me remember the responsibility of being Oji-Cree and that we should move forward with this work in a good way.

I am president of the Indigenous Physicians Association of Canada, the only national voice of first nations, Métis, and Inuit physicians. For almost two decades, national indigenous physician advocacy organizations have lobbied for improvements in indigenous health. Our organization has current and past members who represent every province and territory in our great Canadian federation. As one of the three founding nations of Canada, indigenous peoples have a critical perspective to add to all Canadian issues.

The Indigenous Physicians Association of Canada does not have an official position on medically assisted dying. It has not been identified, by our members or by the indigenous patients we serve, as a high priority. They are focused on other pressing issues within indigenous health. The comments I share are a reflection of the ongoing discussion we have on this issue and how it fits more broadly into indigenous heath. Some of these perspectives are my own.

In reviewing these hearings, I feel obliged to identify the absence of the major national indigenous organizations. I believe there has not been meaningful consultations with indigenous peoples, although meaningful mainstream Canadian consultations have been carried out by many other organizations that have presented here. You are all aware of the widening health disparities among indigenous peoples and the rest of Canada. When considering the overrepresentation of indigenous peoples in nearly every category who may qualify and pursue medically assisted dying, it should be strongly considered that you may be ignoring the largest proportional demographic that is eligible to pursue this service. I hope the apparent absence of indigenous consultation is remedied prior to any final decisions regarding indigenous patients and medically assisted dying.

As a physician, I recognize that medically assisted dying must be provided in a thoughtful and patient-centred manner. I applaud the members of this committee for their commitment to explore an issue that could be divisive and emotionally exhausting. I am thankful that so many organizations have taken the time to provide meaningful advice to the committee, and preface my comments as specifically pertaining to indigenous patients. Whether the issues I raise are dealt with, they will remain issues nonetheless.

My personal experience with indigenous patients and their concerns regarding medically assisted dying are very different from my experience with mainstream Canadian patients. One reason is that medically assisted dying has existed in our communities for more than a century.

When residential schools exposed children to nutritional deprivation and medical experimentation, that was medically assisted dying. When traditional medicines and cultural practices were made illegal, driving traditional healing underground, that was medically assisted dying. When traditional medicine is appropriated, depleted, and patented by private industry, so-called discoveries that have been known by indigenous peoples for generations, thereby removing access to our own ways of healing, that is medically assisted dying. When traditional medicine is treated with hostility by mainstream health professionals, despite being requested specifically by patients, that is medically assisted dying.

● (1915)

When child and family services apprehend indigenous children at an alarmingly high rate—if not the highest rate of all demographics—with medical decisions made by the crown, and an inconsistent quality of standards that contribute to children dying in care or going missing, that is medically assisted dying. When the trauma of residential schools is perpetuated intergenerationally and we do nothing to stem the tide of abuse, addiction, and suicide that overwhelms our indigenous communities through insufficient mental health intervention, except in crisis, that is medically assisted dying.

When indigenous peoples have programs designed without their input, then are chastised for poor engagement in mainstream health care, that is medically assisted dying. When Health Canada provides 40 programs that do not provide comprehensive primary health care on reserve and neglects to provide a seamless transition between federal and provincial health jurisdictions, that is medically assisted dying.

When the health system prescribes benzodiazepines, opioids, stimulants, and other prescription substances without considering the high risk of addiction and overdose, that is medically assisted dying. When health professionals request services for indigenous patients and their requests are denied by bureaucrats at Health Canada who ignore clinical recommendations, that is medically assisted dying.

When nursing stations employ health professionals that lack a skill set to provide emergency and urgent care or when nursing stations lack basic life-saving equipment and medication that does not meet the minimum standard of every other health facility, that is medically assisted dying.

When there is no monitoring, tracking, or enforcement of standard practice that every other Canadian can expect when receiving medical care, that is medically assisted dying. If an indigenous person dies and no one tracks it, does anyone care?

What we are pleading for in indigenous communities is not medically assisted dying. That already exists in more ways that can be counted. What we are pleading for is medically assisted life.

It is in this background that I make the following nine recommendations.

One, consult indigenous peoples regarding their opinions on medically assisted dying and whether it is a priority. You can do this during the submission of each first nation's health strategy, a requirement of funding for health programs on reserve, and through national consultations with those off-reserve, first nations, Métis, and Inuit. Continue to engage the national indigenous organizations and weigh their opinion with the same weight as those who testify through this current process.

Two, implement the truth and reconciliation recommendations for health. Change the culture of medically assisted dying towards indigenous peoples by the health care system. Confront bias, discrimination, and racism in indigenous health.

Three, reprofile existing funding with Health Canada towards primary care services, with a lower focus on public health programming. You do not build a health system around public health. You build it around primary care services. Public health cannot exist in isolation and should not exist to the detriment of primary care services.

Four, implement the recommendations of the Naylor report on health care transformation, including the creation of an indigenous health quality council so we can independently track indigenous health outcomes and provide support to indigenous communities. Health quality councils are a central support of provincial health systems. The Naylor report goes into more detail about this.

Five, create a national indigenous health strategy that seamlessly integrates medically assisted dying. This deserves to be a stand-alone national priority in health, not a subcategory below other health priorities. Dealing with the crisis should be at the same level as pharmacare, the opioid crisis, and medically assisted dying.

Six, pass an indigenous patient bill of rights that ensures seamless transitions in care between federal and provincial systems and puts patient need before policy and procedure within Health Canada. Design it to minimize jurisdictional ambiguity and emphasize jurisdictional responsibility.

Seven, do not create a program for medically assisted dying unless you speak directly to the community who may access it. In a system where everyone is already dying, the effects of creating a literal program where patients intentionally die within the medical system will further disengage and disenfranchise indigenous patients and families.

Eight, provide access to a culturally safe educational organization that will provide education on a patient's right to live, a patient's right to die, and the legal mechanisms that protect each. Empower patients with information.

Finally, nine, ensure that complaints from patients and patients' families about bias, discrimination, and racism of health care providers and/or administrators that push patients or patients' families to choose medically assisted death in a way that is not patient- and family-centred are transparently addressed. The complaint process should outline the various ways that complaints can be pursued, including through health regions, regulatory bodies, and civil actions.

● (1920)

I want to emphasize that I believe no individual in our health care system deliberately causes harm to indigenous patients. Through historical trauma, mainstream attitudes, and system design, however, we do cause ongoing harm, whether intentional or not.

Thank you for the opportunity to participate in these hearings. Medically assisted dying is an important issue for Canadian and indigenous patients. *Meegwetch*.

**The Joint Chair (Mr. Robert Oliphant):** Thank you very much, Dr. Lafontaine.

I think we'll keep in that medical vein before we switch to the legal vein again, so we'll turn to Dr. Grant and Ms. Hickey.

**Dr. Douglas Grant (Registrar and Chief Executive Officer, College of Physicians and Surgeons of Nova Scotia):** Thank you, honourable Chairs and committee members.

My name is Dr. Gus Grant. I am the president of the Federation of Medical Regulatory Authorities of Canada, but speak today in my role as registrar of the College of Physicians and Surgeons of Nova Scotia. I'm accompanied by our legal counsel, Marjorie Hickey.

Our college has jurisdiction over the regulation of the medical profession in Nova Scotia. The college's objects, which are defined by a provincial statute, are to serve and protect the public interest in the practice of medicine, preserve the integrity of the medical profession, and maintain the confidence of the public and the profession in the regulation of medicine. I would respectfully submit that any legislation regarding physician-assisted death, PAD, be directed to complement the work of the colleges toward these objects.

The legislative component of the framework must provide clarity and certainty for patients and physicians without confining the medical judgment of physicians or limiting access for the patients. Those aspects of PAD that are fundamentally medical and touch on the exercise of professional judgment, the delivery of clinical skill, or the essence of the patient-doctor relationship should remain regulated by the colleges. As with any aspects of medicine, the clinical means by which PAD is delivered will change over time. Legislation cannot confine progress of this sort, and the college is mindful of the adage that to define is to limit.

The ultimate combination of legislation and regulation must result in a framework that is seen with confidence to appropriately protect vulnerable patients; promote a patient's right to life, liberty, and security of the person; and give consideration to the physician's freedom of conscience. To that end, the college makes the following submissions regarding certain discreet aspects of PAD that are already before the committee.

With respect to eligibility criteria and the question of mature minors, the college asks that legislative amendments specifically address whether PAD is available only to competent adults or also to competent mature minors. The college takes no position on this issue, apart from encouraging explicit legislative direction. The college supports the definition tabled to this committee by Professor Downie earlier this week.

Another item is the place for the now famous language in Carter of “grievous and irremediable medical condition”. These famous words and the interpretation of these words will evolve. The college does not feel that this evolution should be limited by legislation, but if legislation does address these words, the college urges that the spirit of Carter be maintained. The primary lens through which to assess eligibility must remain that of the patient's illness experience. Eligibility is to be determined primarily based on the subject of experience of the patient.

However, protection of vulnerable patients, together with the public's confidence in the framework, will be served if the assessment of eligibility includes an objective component. The college supports an interpretation of the word “grievous” to mean a very serious condition and, thus, requires an objective assessment of severity by physicians.

On this, I'd say one more thing. Please avoid lists. With advances in medicine, that which is grievous today may be imminently curable tomorrow.

I'd like to talk about the timing of the eligibility criteria for Carter. To effectively regulate our college and colleges, we need specific legislative direction on the question of when each of the eligibility criteria must be met. The Carter decision, unfortunately, does not give clear guidance on these questions, and the colleges, our college, would prefer to have direction from legislation, rather than to be left to extrapolate from Carter.

We must consider the arc of the deteriorating patient. If all criteria are to apply at the point of either prescription of medication or administration of medication, patients who lose their competence or who become unable to express their experience of intolerable suffering will be unable to avail themselves of the physician-assisted death they may have requested earlier while competent.

● (1925)

To avoid this dilemma, legislation may also be needed to address the role of advance directives. On this, the college makes no submission beyond recognizing that a myriad of new issues are associated with the expansion of PAD to include patients who are no longer competent.

With respect to the clinical process, I make the following submissions. Most provinces have developed professional standards that have been informed by the work of FMRAC and by the Canadian Medical Association, and have been built through extensive consultation. Contrary to the submission of Professor Downie earlier this week, these standards are largely harmonious.

I submit that the clinical process is best left to the regulator. There are issues specifically addressed in these standards that are before your committee. Specifically, should there be legislated and defined waiting periods? The college does not support legislated waiting periods. The goal should be for physicians to make a determination of eligibility free from ambivalence, and to take whatever time is needed and reasonably required to do so without unduly limiting patient access. Prescribed time limits would encroach on this critical exercise of professional judgment.

How many physicians should be involved in the process and who should they be? This is a question that our college does not feel requires legislative address. The college currently takes the position that eligibility should be provided by two physicians, or determined by two. In these early days, I think public confidence will be served by the involvement of more than one physician.

We also take the position that when the grievous and irremediable condition is primarily a mental illness, the determination of eligibility should be informed by a psychiatric opinion. In the course of our consultations, there has been concern that mental health patients who seek PAD are among the most vulnerable. The public, in my submission, will be comforted by the involvement of a psychiatrist.

Medicine is increasingly delivered through a team-based approach. The allied health professionals, working with or under the direction of physicians—think nurses, counsellors, dispensing pharmacists—require clear legislative comfort that their involvement with PAD will not be considered illegal or criminal.

The next question is perhaps the most contentious: what are the responsibilities of physicians conflicted by conscience, and by whom should these responsibilities be mandated? We have a history to confront. I refer to our country's experience with abortion and access to contraception, where conscientiously objecting physicians faced, and continue to face, the same question. On many occasions, whether through silence or obfuscation, physicians chose, and continue to choose, not to assist women to access a legal and medical service that runs counter to their personal beliefs.

I respectfully disagree with the submission of Dr. Jeffrey Blackmer of the CMA to this committee. As a regulator, I submit that it is naive to think that access to physician-assisted death will not be an issue, whether for reasons of conscience or geography. The provincial colleges are not in unanimous agreement on the question of conscience. Whereas it's unfortunate there is not a unified pan-Canadian approach, this alone should not invite federal legislation. The professional and ethical obligations of a physician in this difficult situation are clearly within the objects of provincial legislation. The colleges, through FMRAC, should work toward consistency, both to establish the physician's obligations and to establish the disciplinary consequences that might flow from a breach of those obligations.

With respect to oversight and program structure, I make the following and final two submissions. Should there be a formalized oversight process? Medicine is driven by data. A formal oversight process will allow medicine to develop evidence as to which conditions give rise to the request for assistance in death. Track the timelines of the request and the death, and in so doing identify opportunities for research and for intervention.

Most importantly, I submit that the process must be retrospective. The medical profession is well capable of assessing eligibility and delivering care. This inherently medical process should not be interrupted. We cannot place an administrative panel between a physician and a suffering patient.

● (1930)

My final submission pertains to the oversight of the medication itself. The experience in permissive jurisdictions is clear. The majority of patients prescribed medication to end life do not take the medication.

According to *The New England Journal of Medicine*, we are in an epidemic of deaths from opioid overdoses, and I appreciate the reference to this by Dr. Lafontaine. We now face the situation where our family medicine cabinets will contain medications for the purpose of ending life. These medicine cabinets are the targets of addicts and of experimenting teenagers. There needs to be a robust system for the return of unused medication. The college would welcome that this system be mandated through legislation.

I thank you for the great privilege of making these submissions and welcome your questions.

**The Joint Chair (Mr. Robert Oliphant):** Thank you very much, Dr. Grant.

Mr. Russomanno, you have 10 minutes.

**Mr. Leo Russomanno (Member and Criminal Defence Counsel, Criminal Lawyers' Association):** Good evening. On behalf of the Criminal Lawyers' Association, I thank you for inviting our organization to give you our thoughts on this very important topic. Having seen the transcript of the remarks of previous witnesses, I truly feel honoured to be a member of this group of individuals and part of this debate.

The Criminal Lawyers' Association represents more than 1,500 members, primarily criminal defence lawyers in the province of Ontario. A large portion of our efforts relates to ensuring access to justice in criminal law and protecting the civil liberties of Canadians.

The majority of our members' clients are part of vulnerable groups in one way or another. Our organization's members routinely assist individuals with mental health issues, marginalized groups, the impoverished, and the uneducated. Our position here really reflects what is the constitutionally minimal standard that's set out in Carter, and what the role is of Parliament and the federal sphere in how to deal with the issue of section 7 compliance.

The Criminal Lawyers' Association is against the duplication or the addition of unnecessary complications into an already unwieldy Criminal Code. We're skeptical of any attempt to import what is essentially a medical regulation into the Criminal Code. We're also skeptical about the federal government's jurisdictional competence to regulate assisted suicide comprehensively within the Criminal Code. The Criminal Code, as we know, is a very blunt tool, and it ought to be used sparingly. You have to ask yourself if the federal role will be a criminal one, because that's the anchor for the jurisdictional authority. What does that look like?

What is the continued relevance of criminal law and the regulation of physician-assisted death post-Carter? That is the question I'm here to address on behalf of the Criminal Lawyers' Association.

Having gone through some of the testimony in earlier hearings and having gone through Carter several times now, I must say that Carter sets out fairly clearly what is the constitutionally minimum standard. It starts at paragraph 1 of the decision. Paragraph 1 of the decision couldn't be more clear as to what the issue is with section 7 compliance.

The prohibition in the Criminal Code with respect to counselling suicide created a net that was cast too wide and went beyond the legislative objective. That's what section 7 principles of fundamental justice are about—looking at the legislative objective and then looking at the effects of trying to meet that legislative objective. Overbreadth is really about casting a net that's too wide.

What Carter was about and what the Supreme Court was saying is that there are individuals who unfortunately are faced with a “cruel” choice as a result of this blanket prohibition. Those were the words of the Supreme Court in paragraph 1 of Carter. A person who is able to consent and has a grievous and irremediable illness or medical condition and intolerable suffering faces this cruel choice of ending their life early, before the onset of this intolerable suffering or pain, or waiting for a natural death. The Supreme Court found this to be an unconstitutional choice that individuals were faced with.

If we're going to accept that this counselling suicide provision is going to remain in the Criminal Code—and for the purposes of these hearings, I take it as a given that we are leaving it in place—the role of the federal government in terms of a constitutionally minimal standard is to really create an exception that meets those constitutionally minimum standards. Outside of that, subject to the comments I made earlier, getting into comprehensive regulation would just be encroaching upon the powers of the provincial governments to regulate health care.

Subject to questions, of course, those are my comments at this time.

● (1935)

**The Joint Chair (Mr. Robert Oliphant):** Thank you very much for a very clear presentation.

Ms. Dabrusin.

**Ms. Julie Dabrusin (Toronto—Danforth, Lib.):** Thank you to everyone for coming tonight and for speaking with us.

Dr. Lafontaine, you mentioned, as number two in your list of recommendations, that we take into account the application of the Truth and Reconciliation Commission recommendations. I'm wondering if you might be able to give us some guidance on those.

In particular, I was looking at the health section. Recommendation 22 calls upon the Canadian health care system “to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.” When we're looking at the application of Carter, which is what we're tasked to do, can you give us some guidance on how that might look and what we should be considering?

**Dr. Alika Lafontaine:** Thank you for your question.

I'll touch on a couple of comments from Dr. Grant and Mr. Russomanno. Dr. Grant mentioned that you should not put administrative oversight between the patient and the physician. As I mentioned in my preamble, we've created a system design that absolutely does this. When we're looking at the application of physician-assisted dying in particular, and we're looking at it through the context of the Truth and Reconciliation Commission's calls to action for health, the goal is to become patient-centred. It's to make sure that the objective of the law is achieved, just as Mr. Russomanno mentioned.

When you're looking at objective 22, it's not just respect for traditional healing practices; the outcome is to ensure that patients receive access to those services in a way that's patient- and family-centred, keeping in consideration the realities of our health care system. I think with the application of physician-assisted dying in the framework of the provinces, indigenous patients will fall between the cracks, because they exist in federal jurisdictions. Health Canada is supposed to provide those programs to ensure that we have primary care on reserve and for our off-reserve indigenous peoples, but time and time again you get this jurisdictional ambiguity going back and forth.

When we're writing up the rules of physician-assisted dying in the context of indigenous patients, it's important to always go back to what those outcomes are: ensuring that the patient-physician relationship is respected, ensuring that there's transparency, and ensuring that the outcome of the law is achieved regardless of what policy and procedure might currently be in place.

● (1940)

**Ms. Julie Dabrusin:** Thank you for that.

There are two parts I want to jump into. You raised the jurisdictional question. That's something I have been wondering about quite a bit. What we see as a possibility, if the provinces choose to draft inclusion regulations or legislation that says you must be provincially insured to access care, then.... I don't know and maybe you can clarify this for me. If indigenous people living on reserves are federally insured, is there a possibility that they then would be carved out of provincial legislation?

**Dr. Alika Lafontaine:** I think that possibility does exist. Dr. Grant can probably speak to the ability of any of the regulatory colleges to actually enforce their standards on reserve.

A good example would be any of the multiple news stories you've seen of patients who have died in northern communities that existed under federally provided Health Canada clinics. We know that they don't meet standards. When you look at a family medicine clinic that exists in, let's say, northern Alberta—Fort Vermilion is under Alberta Health Services—they're required to have certain things available. If they don't have those things available, that clinic gets shut down and all the patients get re-streamed to another place where they can receive care until those standards are met again. When the same thing happens in a federal jurisdiction, that does not happen.

Now, as to whether or not that's legal, I don't think we've actually had a court case that outlines it. We talk about jurisdictional ambiguity, but in the case of child and family welfare services, where we found there was discrimination between children under federal care and children under provincial care, it took a lawsuit for people to actually say whether or not this was the right thing to do.

There are two ways in which this whole system is sustained. The first is by maintaining ambiguity and encouraging patients that, you know, this is just how it is; there's nothing you can do about it. But I think there will be a court case coming, whether it's with physician-assisted dying or something else in health, in order to clarify that responsibility and the responsibility for seamless transition of care, which has already been outlined in Jordan's principle. Second is ensuring that the programs are uniform across the provinces.

Do they have to be carved out? I don't think they do. Are they currently carved out? Absolutely.

**The Joint Chair (Mr. Robert Oliphant):** That's time.

Mr. Cooper.

**Mr. Michael Cooper (St. Albert—Edmonton, CPC):** Dr. Grant, is my understanding of your testimony correct such that the College of Physicians and Surgeons of Nova Scotia takes no position with respect to whether euthanasia should be available simply to adults or whether it should be extended to, for instance, mature minors?

**Dr. Douglas Grant:** Our position is simply that explicit direction is required on this question.

**Mr. Michael Cooper:** I have before me “Standard of Practice: Physician-Assisted Death” from the College of Physicians and Surgeons of Nova Scotia. At section 5, which contains the eligibility criteria, it says the patient must be an adult. When I turn to section 11, which contains definitions, it defines adult as “a person who is 19 years or older”.

It would seem that the College of Physicians and Surgeons of Nova Scotia does have a position. Could you explain that?

**Dr. Douglas Grant:** Certainly. In the absence of a response from Carter, the position of our college, and of most colleges, was that standards that most loyally adopted that which was expressed in Carter should be developed . However, we as a college did not feel that it was up to us to extrapolate from Carter. We felt from the specific language of Carter that an adult patient meant just that. We, however, recognized that there are legal precedents and the legal question of a mature minor, so we come making the submission today that this is a question that requires addressing.

● (1945)

**Mr. Michael Cooper:** Thanks for that clarification.

Moving on to just the issue of medical practitioners, as a physician, could you perhaps comment on what the ability, for example, of a family physician would be to identify and diagnose a psychiatric condition?

**Dr. Douglas Grant:** In my experience of over 15 years as a practising family physician, I would say that the majority of cases presenting to my office had a component, if not a dominant component, of mental illness. It is, sadly, a very common presentation to family physicians, and I would think that it's very much within the scope of practice of almost all general practitioners to deal with mental illness.

Of course, family physicians, when they get into a spot where it feels as though the presentation of the patient is beyond their scope, turn to consultants for further assistance.

**Mr. Michael Cooper:** That's why, for example, in the standards that have been set out, it is recommended that for a mental condition, a psychiatrist conduct the second evaluation. Why would that be necessary if a family physician could diagnose?

**Dr. Douglas Grant:** There are a number of questions within that. The standard puts forward the requirement that when a grievous and irremediable condition is primarily that of mental health, the opinion of eligibility should be informed by a psychiatrist, so that the physician making the determination of eligibility can rely on the opinion of a psychiatrist who may already be present. I believe it was in the last session—and the physician's name escapes me now—that the witness who was video conferencing pointed out that involving psychiatrists for all such cases may create a problem of access.

I think we also have to recognize that in these early days of this new medical service and this new right of patients, as the profession itself grows increasingly accustomed to making decisions on questions of this sort, all would be comforted by the presence of a psychiatric opinion.

**Mr. Michael Cooper:** You're suggesting then that a psychiatric opinion in these sorts of matters would be appropriate in all instances, at least as a good safeguard, or, as you said, a comfort.

**Dr. Douglas Grant:** The psychiatric opinion that we think should be relied on is not one that makes the determination of eligibility for physician-assisted death. We're simply suggesting that when the condition is primarily a mental health condition, the determination of eligibility for PAD should be informed by a psychiatric opinion.

**The Joint Chair (Mr. Robert Oliphant):** Thank you, Dr. Grant.

Mr. Rankin.

**Mr. Murray Rankin:** Thank you.

I guess this is a question for Dr. Grant. We understand that other end-of-life care decisions, like the withdrawal of life support, for example, engage some of the same issues that we're wrestling with here. I'm thinking of capacity assessment, informed consent, and so on.

Could you describe the most rigorous process of checks that might be followed before a complex or contentious request for the withdrawal of life support is fulfilled? How does it work?

**Dr. Douglas Grant:** It all flows from the patient-doctor relationship. The essence of practising medicine is understanding your patient's condition, seeing it through your patient's eyes, and physicians make determinations of decisional capacity or competence every day. The backbone of the Carter decision supports that, that this is the foundational brick upon which our system is built.

This is new territory. Whereas making a determination of competence to achieve an informed consent is fundamental to medicine, I would anticipate that physicians in this situation will often get another opinion, as we always do. Ours is a collaborative profession. When faced with complex, novel questions like the one you describe, it's second nature for physicians to get collaborative opinions, whether that be from a psychiatrist or, in certain settings, as I think was referred to by Chair Oliphant's question, from ethics boards and health authorities. It's natural for physicians to seek comfort with opinions from others.

● (1950)

**Mr. Murray Rankin:** Thank you.

My next question is for you, Mr. Russomanno, and thank you.

It's about criminal liability for physicians. What degree of misconduct would expose a physician to criminal prosecution as opposed to discipline by their professional body? We have a job here to look after the vulnerable. There will be some problems, no doubt, where a physician assisting crosses the line. We've been urged to put a lot of our eggs in the basket of the disciplinary powers of the college, but there's still this criminal liability in certain circumstances.

I'd love it if you would talk a little bit about that boundary.

**Mr. Leo Russomanno:** Yes, and as I mentioned, the criminal law is a heavy hammer. One might question whether it ought to be used at all.

The question of counselling suicide is really a subset of homicide law. In many cases, if not most, counselling suicide is just another category of murder, without the mandatory minimum sentence of life imprisonment.

Using the Criminal Code to criminalize the conduct of physicians who might run afoul of the exception, which is to be created and was seen in essence in Carter, might be seen as a fairly heavy-handed way of dealing with those physicians. The question you pose is a very good one. The answer might lie more in the use of crown discretion, because crown attorneys exercise discretion every day. In fact, even in laying a counselling suicide charge as opposed to a murder charge, there's an exercise of discretion that creates a massive difference.

**Mr. Murray Rankin:** Just to build on that, then, presumably the charge in the worst case of misconduct would be either unlawfully assisting a suicide or homicide.

**Mr. Leo Russomanno:** Murder, yes.

**Mr. Murray Rankin:** One carries a maximum sentence of 14 years, I believe, and the other a life sentence. If that's true, wouldn't that create an incentive for physicians to prefer assisted suicide over voluntary euthanasia?

**Mr. Leo Russomanno:** I'm not sure I understand how that—

**Mr. Murray Rankin:** Maybe there are two sections of the Criminal Code that we have to deal with in these circumstances. One could be a charge of homicide, and one could be a charge of assisting suicide in an inappropriate way.

**Mr. Leo Russomanno:** The premise of your question I think might be based on answers given by the counsel at the Department of Justice—I apologize, but I don't remember her name—who seems to equate counselling suicide with physician-assisted death, whereas euthanasia would be more tantamount to murder. I don't agree with that characterization.

Physician-assisted suicide, if it runs afoul of the exception in Carter, is, in every conceivable way that I can think of, murder. It's a matter of crown discretion that a person is charged not with murder but rather with counselling suicide. In regard to aiding and abetting a murder, for example, to take it out of the physician-assisted suicide context, if a person provides the getaway car to someone knowing that they're specifically intending to kill somebody and they do then go on to commit that murder, the person who provides the getaway car is equally guilty of murder.

**The Joint Chair (Mr. Robert Oliphant):** Thank you.

I'm going to give Mr. Rankin one more minute if Ms. Hickey wants to comment, because you were implicated in there on that boundary between criminal and regulatory discipline. I don't know whether you have anything you want to add.

**Ms. Marjorie Hickey (Legal Counsel, College of Physicians and Surgeons of Nova Scotia):** I would just reinforce what Mr. Russomanno said in terms of the bluntness of the instrument of the Criminal Code and urge that professional standards be developed on the more nuanced areas involving the clinical judgment of physicians that can address individual circumstances so that the provisions of the Criminal Code deal only with those provisions that require clarity on the eligibility criteria. That will then give physicians the appropriate discretion to exercise their judgment, which would then fall within the realm of the medical regulatory authorities provincially to address it in the type of nuanced way that can better be accomplished through that mechanism than through the blunt instrument of the Criminal Code.

● (1955)

**The Joint Chair (Mr. Robert Oliphant):** Thank you. It is a joy to be surrounded by physicians and lawyers.

**Voices:** Oh, oh!

**The Joint Chair (Mr. Robert Oliphant):** Senator Seidman.

**Hon. Judith G. Seidman:** Thank you very much for your testimony.

I will start with Dr. Grant.

When Peter Hogg appeared before the committee at the end of January, he proposed that federal legislation should be drafted to provide a fairly extensive framework for physician-assisted dying in Canada, with the provision that this federal legislation would not apply to provinces or territories that have enacted substantially similar physician-assisted dying regimes.

We've had other witnesses who have said that the federal framework should be much less extensive.

Do you have an opinion with respect to Mr. Hogg's proposal? He is, of course, a supreme constitutional expert, and we do have a lot of respect for what he said, but I think someone from the provincial college might have a perspective. He had no perspective, no experience at all with the medical aspects of this, which he readily admitted.

**Dr. Douglas Grant:** I think what I fear most is legislation that is overly prescriptive. As I said in my submission, so much of this touches on the fundamental essence of medicine, which is understanding your patient, achieving informed consent. I worry that federal legislation that is too ambitious, too prescriptive, might intrude on that relationship, and moreover, it might not have the flexibility required to evolve as medicine evolves.

Make no mistake; our college and the colleges in general will welcome direction on areas in Carter that are unclear, or perhaps even more important, that are beyond our jurisdiction to do anything about. I would say there are some clearer areas where federal legislation and amendments to the Criminal Code will help, but I would urge that the medical nuance, the medical relationship that's at the centre of this not be subject to legislative confines.

**Hon. Judith G. Seidman:** In fact, you said when you began your presentation that what was fundamentally medical and clinical should be the right of the colleges, so I ask you about the process and procedures with which we have been somewhat preoccupied; process and procedures meaning the steps that should be involved in making a request for physician-assisted dying, and the steps that should be involved in the physician providing physician-assisted dying.

Is it your intent to tell us that those are issues that are between the physician and the patient?

**Dr. Douglas Grant:** I would say so. Thank you for the question. Yes.

I would say this. The colleges and the medical profession need some clarity about things, and in my submissions I discuss the arc of the deteriorating patient. We need that direction. Physicians need to know they are on solid legal footing. Moreover, so too do the patients and their families. This is an incredibly stressful time for families and I think they deserve the comfort of knowing that this is proceeding in an orderly and clear way.

Federal legislation that addresses those areas that are still unclear, like the timing of the criteria, would be welcome, but leave to the profession of medicine the essentially medical things.

**Hon. Judith G. Seidman:** Thank you.

Dr. Lafontaine, thank you very much for your presentation to us this evening. It was extremely revealing and important for us to listen to.

I would like to ask you a rather pragmatic question, if I might. It has to do with some testimony we've heard before this committee about how regulated health professionals, including registered nurses or physician assistants, should be able to provide physician-assisted dying under the direction of a physician or a nurse practitioner. This was with special reference to access of citizens and others, and this might apply to aboriginal communities and first nations in the north that don't have the same kind of access in a regular way to physician-assisted dying that this legislation may refer to.

● (2000)

**Dr. Alika Lafontaine:** That's an excellent point and thank you for the question. I'll go back to a comment that was raised earlier about the Supreme Court saying that this is a cruel choice. I think when Carter came down the way that it did, it was an effort by the Supreme Court to ensure that patients were empowered to make a choice that affected them in an unconstitutional way.

Dr. Grant has gone back over and over again to getting to the essence of the patient-physician relationship, and I think that sort of relationship is developed with any type of health care professional, physician or otherwise.

One of the realities in medicine is that when you come into my OR and I am your anaesthesiologist, you have no power. You have only the power that I give you. If you start being combative, and I decide that you've already provided your informed consent, I can start giving you medication that will change the way you think and take away your ability to resist. I think that's something we need to consider strongly when it comes to remote communities, including those indigenous communities that you mentioned.

The goal of any of this legislation should be to democratize the power differential that exists between physicians and their patients, or between any other health care provider and their patients. We have the incredible responsibility as health care providers to allocate resources, and we do this deliberately through policies that we follow, but we also do it based on our decisions. When you were talked to earlier by Mr. Russomanno about the crown having the latitude to decide what types of charters are laid, that actually takes the power out of the hands of the patient. As we develop more and more policy that strengthens the physician position or the nurse position, or other legislation that might be passed, we have to keep in mind that the goal of Carter was to empower the patient. It was not to create additional jurisdictional barriers or to enhance the power differential that already exists between the patient and other bodies.

Whether it's a nurse or it's any other individual who provides it, we need to consider that we're really focused on making sure that the patient has the choice.

Another quick point is that it's not straightforward to do physician-assisted death. As someone who has skill in providing different pharmaceutical medications in order to achieve certain outcomes, I can say that it is not straightforward, so you have to consider, as well, whether or not the subsequent training will be provided to do this in a way that is actually comfortable.

**The Joint Chair (Mr. Robert Oliphant):** Thank you.

Just before we move to Senator Joyal, I want to give Mr. Russomanno a chance to clarify for the record something that our analysts are questioning. It refers to section 241 of the Criminal Code, which has an (a) and a (b). Paragraph (a) refers to counselling a person to commit suicide. Paragraph (b) is aiding and abetting a person to commit suicide.

Carter is dealing with paragraph 241(a), and you kept referring to paragraph 241(b) but we're blending them. We just want to make sure we can clarify this so we can use it for our testimony.

**Mr. Leo Russomanno:** Thank you. I appreciate that opportunity. We're talking about different kinds of party liability, so under section, I believe, 21—

**The Joint Chair (Mr. Robert Oliphant):** It was (b) and (a) I mixed up, but you get my point.

**Mr. Leo Russomanno:** I'll take your word for it either way.

Party liability is generally dealt with under section 21 of the Criminal Code for most offences, for example, for aiding, abetting, or encouraging an offence. There are different kinds of party liability. You can actively, just through words, encourage someone to commit a criminal offence, which seems to be parallel to paragraph 241(b), whereas the actual act of aiding, which is perhaps providing the life-ending medication to someone, goes beyond mere words of encouragement and actually plays a different role in bringing about the end of that person's life.

Either way, you get to that end result, which is liability under the Criminal Code, so those are just different expressions of party liability through different means.

I'm not sure if that helped clarify things.

● (2005)

**The Joint Chair (Mr. Robert Oliphant):** Let me turn to our analysts.

Does that help to clarify this? I know you're shy....

Okay, we'll get this clarified afterwards. Perhaps you could stay for a few minutes while we make sure we have it clear.

**Mr. Leo Russomanno:** Certainly.

**The Joint Chair (Mr. Robert Oliphant):** Thank you.

I'll turn now to yet another lawyer, Senator Joyal.

**Hon. Serge Joyal (Senator, Quebec (Kennebec), Lib.):** Thank you.

You won't be surprised if I want to stay on the legal aspect of the issue. To go back to your answer on what we should be considering if a physician or a health care provider does not comply with the law that Parliament may adopt in relation to physician-assisted death or euthanasia, should we stick to the penalties of the code as they are now, or should we take into consideration that, looking into the decision of the court, there could be mitigating circumstances in relation to either counselling suicide or being part of it? As you know, those are two different offences.

In relation to the doctor, per se, should it not be a way to find a middle ground, considering that we are in a different context—there is a special relationship here, as both the doctor and Ms. Hickey recognized—and considering that this is a profession ruled by a professional order? In other words, there is an element in there that would not exist in non-physician-assisted death; I mean in the regular lives of citizens. If somebody like me advised somebody to commit suicide, I am not a doctor, I am not there to provide any kind of professional advice in terms of health.

Should we not consider that there is a middle ground, and propose in our report to Parliament that in cases of breaches of the law that we are drafting there should be some elements to consider in terms of the penalties, either as mitigating factors or as different scales of penalty?

**Mr. Leo Russomanno:** It sounds like an issue of sentencing, if I understand correctly. As it stands, section 241 provides a maximum sentence of 14 years. It would seem there's wide latitude in terms of the sentence available.

To clarify as well with respect to using the criminal law to render physicians liable, we have the added protection in criminal law of *mens rea*, of the mental element of the criminal offence. A standard of negligence, for example, would not be high enough, presumably, to meet the *mens rea*, which is more often than not in the Criminal Code a subjective component. There would have to be a specific knowledge on the part of a physician, presumably, that the person is not consenting in a competent way. That may address some of the concerns with physicians being liable for acts that may run afoul of the Carter exception.

In terms of a penalty, yes, I think generally speaking the Criminal Lawyers' Association thinks that the Criminal Code should be used sparingly, and that very often there might be other regimes in place to deal adequately with these kinds of “misconduct”, if I can call them that. I'm not trying to take away from the seriousness of the situation, of course, but there are regulatory bodies that do handle physicians who are negligent or who do have acts of misconduct in this regard.

I'm not sure how else you might build in discretion in sentencing to the Criminal Code. With the maximum as it exists, it would seem that there already is in place quite a significant latitude. I believe it is a straight indictable offence. Perhaps there would be additional latitude by making it a hybrid offence. That would give additional discretion on the part of the crown attorney.

● (2010)

**Hon. Serge Joyal:** That's what I was contemplating, and in fact that was to be my next question. It would be a way for the crown to exercise discretion on the nature of the circumstances in which the breach happened, and would give an opportunity to mitigate, as you said, the strength of the Criminal Code as it is now in relation to that offence.

**Mr. Leo Russomanno:** Yes. Generally speaking, the summary conviction offences carry a maximum penalty of only six months' imprisonment. In some other cases, it's 18 months, but as a maximum. That's one of the major differences. It also just generally represents a less serious offence when the crown elects to proceed by way of summary conviction. That might be a way to include greater latitude in the Criminal Code.

**Hon. Serge Joyal:** Since you are also a lawyer, Dr. Grant—and of course Madam Hickey could certainly have an idea about this—what's your view of that?

**Dr. Douglas Grant:** There are two types of potential breaches. Perhaps that's overly broad, but one of the two potential breaches I foresee is the inappropriate provision of physician-assisted death. If that's accompanied by a *mens rea*, that is inherently criminal. If it's not, then it's the inappropriate exercise of professional judgment, and that's regulatory. The regulatory colleges are familiar with these overlapping spheres. Sadly, we face those cases all too often.

The other type of breach would be the inappropriate blockage of access. I made the point in my submissions. I worry about that. If a physician, through obfuscation or what have you, inappropriately blocks access to an otherwise eligible patient, I know of nothing that would call that criminal as yet—that would be before your committee to consider—but I would say that it would be something that a regulatory body would deal with quite severely.

**The Joint Chair (Mr. Robert Oliphant):** Thank you, Dr. Grant.

Mr. Aldag.

**Mr. John Aldag:** Thank you.

I'd like to continue along with what we were just talking about a bit in regard to the idea of blockages as well as access. It's about looking at the power of the colleges across the country to influence where things go.

I'll go back a step. I've had a number of doctors speak to me about the use of medicinal marijuana as an example of where we have something that's legal, but it's only somewhat clear in the profession about what's allowed or what's not allowed. I've had some physicians say that they won't prescribe because it's unclear with the CMPA what the liabilities are. Some feel that the colleges of various jurisdictions will single them out if they're participating too much in prescribing.

I'm hoping you can put my mind at ease and say that the colleges will be enablers as opposed to setting up barriers to access. We've heard a lot about conscientious objection. There will be a body of physicians who simply don't want to participate and I'm hoping that won't influence the professional bodies that oversee this to create disincentives for participation. That could come through any number of ways. It can be sanctions. It can be the threat of sanctions. It can be threatening, or reducing the scope of licences because of over-prescribing whatever, or over-participation, or not doing a full range of things. We've had some discussions about whether people specialize in this. Does it limit their ability to practice the full range of medicine?

I would like to hear from your perspective, from the colleges' perspectives, about how we ensure that we don't end up with arbitrary restrictions or limitations to access and actually are able to enable those physicians. We've heard that upwards of 30% are showing support for participating. How do we ensure they are able to participate in physician-assisted dying initiatives and not have the colleges hanging over them?

**Dr. Douglas Grant:** “Ensure” is a powerful word. Carter makes it abundantly clear that no physician can be compelled to participate in this. It's the anticipation of all the colleges—and I think it's reasonable to anticipate—that there will be a coalition of willing physicians who embrace this service. It's certainly happened in other permissive jurisdictions. In the course of our consultations I think it's reasonable to expect that physicians will step to the front for this. Some of course won't.

As for the colleges, in the aftermath of Carter and in the vacuum that existed, I can tell you as president of FMRAC that all of the colleges wanted to put together rough frameworks of how this can be provided. The unanimous view of all of the colleges was that the highest court in the land has created a right, so how do we enable it?

● (2015)

**Mr. John Aldag:** Okay, that works. I wanted to hear that from the college perspective. We heard it somewhat from the CMA, but we hadn't heard the college perspective on that.

Continuing along are things like CMPA concerns. I don't know who speaks for them, but it's an interesting one. Does that become a disincentive? How do physicians know that their actions in physician-assisted death aren't going to affect their eligibility for insurance, or is that not worthy of discussion?

**Dr. Douglas Grant:** I would say first of all that I certainly don't speak for CMPA—

**Mr. John Aldag:** Right, but as a physician, you would know the risks.

**Dr. Douglas Grant:** Having said that, I can absolutely assure you that they've been nothing but co-operative along the same lines as the colleges have been. The highest court in the land has recognized that this is a right. They would like clarity and direction as to how the right can be accessed.

Again, I don't speak for CMPA, but I speak with CMPA frequently, and I know that is their view.

**Mr. John Aldag:** Okay.

The document we received from the Nova Scotia college was well thought out. There are sections in it on duties of first and second physicians. Were there any discussions...or is it beyond the scope of your group to look at the role of other health practitioners? We've had lots of discussions about nurses and nurse practitioners, and none of those others are referenced in this document. I am just wondering if there is any—

**Dr. Douglas Grant:** That's largely because they are beyond our jurisdiction. We were looking to fill a void to the extent we could, and we developed what we thought was the most complete document we could within our jurisdiction and we shared it on a consultative basis with other health professionals. There can be no doubt, as I stated in my submission, that health care workers and professionals with whom doctors work need comfort, and the comfort has to be legislative or this service can't be delivered.

**The Joint Chair (Mr. Robert Oliphant):** Thank you very much.

I will just note that CMPA, the Canadian Medical Protective Association, will be joining us later in the week, so we'll be able to get into that.

Mr. Warawa.

**Mr. Mark Warawa:** Thank you, Chair. I'll be sharing my time with Mr. Albrecht.

This is a question for Dr. Lafontaine.

Thank you for being with us by video conference. Both you and the witness we heard yesterday, a professor, shared with us a concern about the lack of consultation with indigenous communities. As you are aware, the Supreme Court has required Parliament to create a carefully designed system that imposes strict limits that are scrupulously monitored and enforced. To create a carefully designed system requires consultation, yet we have an extremely tight time frame. Parliament needs to have legislation in place by June 6. This process we're going through right now is eating up approximately a month of that extension, leaving three months to build legislation, which takes approximately another month, and then two months to pass it through the House and the Senate.

How would you suggest that indigenous communities be consulted and be part of the process so that we are respecting and showing that input of and consultation with indigenous communities is important?

**Dr. Alika Lafontaine:** That answer has two parts. The first part is that with any law that has this type of complexity, I'd expect it to evolve, so although you are obliged to create a law that is thoughtfully put together, there should be thought on how it will grow over the years. Dr. Grant commented that what is a grievous and irremediable condition that is incurable today may not be that tomorrow. There needs to be room for growth in that way.

The second part is that consultation needs to happen over a period of time, and as you rightly state, the three or four months that you currently have, no matter how you do it, won't be adequate for consultation. That time won't allow people to reflect on the magnitude and weight of what is happening.

How do you do that in a measured way? I think you already have a network of indigenous organizations that could weigh in, so first reach out to them and ask them to put together a position paper on it that discusses some of the issues that I brought up, and they will have others that they will bring up.

Ensure that there is a transparent oversight process specifically for indigenous people, which includes jurisdictional ambiguities that often exist through federally administered programs. Most important to me in my experience with indigenous patients is to ensure that there is a feedback mechanism to hear from patients, so once the law ends up being passed, that there is a component of the law that allows patients to report back to some type of centralized body. Whether you invest that responsibility within the regulatory colleges in provinces or wherever, ensure that you actually assign someone to deal with complaints about the process. As the law evolves, that consultation will be an important part of how that law ends up growing and changing.

● (2020)

**Mr. Mark Warawa:** In this process where you see legislation evolving, would you see a need to have an annual or semi-annual review of the existing legislation to assist in the adjustments and the evolving process? Would you see it beginning as more stringent and then becoming less stringent? Will the evolution process become more stringent or less stringent?

**Dr. Alika Lafontaine:** I think the most important aspect of this law is that you have a clear outcome. Is the goal to empower the crown prosecutors to have leniency in how they prosecute? Is it to ensure that the power lies within the regulatory colleges? Or is it patient-centred, whereby the patient defines what is an important situation in order to intervene in this way? That's the first part. Having that clear outcome is important, as well as really defining how you distribute that power structure. The second part of it is ensuring that there's a monitoring mechanism, that you're achieving that outcome.

I think that with this sort of law, with the complexity of it and the multiple stakeholders involved, you could quickly get lost in the process. What I think is being measured for indigenous patients is “are indigenous patients empowered?”, full stop. Regardless of who you have to do that, that's the outcome you should be measuring.

**The Joint Chair (Mr. Robert Oliphant):** Senator Seidman.

**Hon. Judith G. Seidman:** Thank you, Chair. I will defer my time to Senator Joyal, if I may.

**The Joint Chair (Mr. Robert Oliphant):** Yes. We have time for both of you, actually, for about four minutes each, if you'd like.

**Hon. Judith G. Seidman:** I'll still defer my time to Senator Joyal.

**Hon. Serge Joyal:** Thank you, Chair. This an example of how we are independent in the Senate and non-partisan.

Mr. Russomanno, I would like to come back to the definition of a hybrid offence. The Criminal Code contains a certain number of hybrid offences. Could you explain to us, to the members of the committee, the principles that preside over a hybrid offence versus an indictable offence? In other words, what are the substantial elements that define a hybrid offence in comparison to an indictable offence?

**Mr. Leo Russomanno:** For an indictable offence, there is no time limitation as to when the alleged offence occurred. It could have been historically years earlier. For a summary conviction, or a hybrid offence that allows for the possibility of a summary election, it would have to be six months since the date of the alleged offence. I should back up and say that, for a hybrid offence, the crown has the power to decide whether to prosecute by way of summary conviction or by indictment. A straight indictable offence is just simply that; it's indictable. The other limitation on a summary conviction offence is that the maximum sentence is 18 months, and that's only for a prescribed few offences.

Procedurally, there are other limitations with summary conviction offences, in that they are tried in the provincial court. In Ontario, it would be the Ontario Court of Justice, and there's no right to elect a judge and jury trial.

With some exceptions, for indictable offences there is a right to elect the mode of trial with a preliminary inquiry or a trial by judge and jury. Of course, there are exceptions in the law, but those are the broad differences between a hybrid offence, which allows a choice, and a straight indictable offence.

● (2025)

**Hon. Serge Joyal:** You don't see any circumstances in relation to physician-assisted death for which a offence can be created that is different from the one that the courts provide now in relation to section 241?

**Mr. Leo Russomanno:** Do you mean a different offence that does not have the same elements? I don't see what a different offence would look like.

I would say that given the legislative objective of protecting the vulnerable from being in a state of weakness, as the Supreme Court puts it in Carter, in regard to being coerced to commit suicide, that's a very serious offence. With the commensurate *mens rea*, that's a very serious offence, of course, because a physician in that context would be bringing about that person's death without their consent.

Again, I go back to my earlier comment that this is not really different from the offence of murder. It carries the same elements: the causation, substantial contributing cause of death, and the specific intent to bring about that person's death. I'm not sure if there would be room for another criminal offence and I'm not sure that the CLA would really be in favour of creating more criminal offences to criminalize the conduct of individuals in this context.

**Hon. Serge Joyal:** In relation to the role of the College of Physicians and Surgeons of Nova Scotia, when you conduct inquiries in relation to professional negligence, what makes the distinction between professional negligence, which in some cases might be very important in terms of consequences for the bodily integrity of the person, and a Criminal Code offence?

**Dr. Douglas Grant:** With respect to the discussion you were having with Mr. Russomanno, I would worry that the contemplation of a hybrid-type offence, a watered-down criminal charge would have the effect of chilling physicians from providing this service. It might act as a deterrent to consider getting into this realm of practice.

The colleges often deal with complaints and conduct investigations that may overlap with the criminal sphere. There are times when there are positively articulated obligations of the college. For instance, if we see anything that involves sexual abuse of a minor, we immediately, perforce of statute, involve law enforcement. We would need clear direction about the Criminal Code provisions and we would adhere to them.

I can't speak for most of the colleges but I can tell you that in Nova Scotia we have an effective, close working relationship with law enforcement. If there's a matter that seems on its face potentially criminal, if we have reasonable grounds to suspect there's criminal activity, we make a determination based on the immediate public safety, which may involve suspending a doctor's licence on an interim basis, informing the crown, and then waiting for the crown to conduct a criminal investigation. The parts work fairly smoothly.

**Hon. Serge Joyal:** So you have the experience of that kind of co-operation—

**Dr. Douglas Grant:** Sadly, sir, yes.

**Hon. Serge Joyal:** Of course, nobody would want to see that happening.

You realize, and I'm sure that you do, we are here in uncharted waters and we want to be sure that the legal system, as it is now, and the professional system provide for the safeguards that would be needed in the case of the implementation of what we are seized to legislate on at this stage.

● (2030)

**Dr. Douglas Grant:** I couldn't agree with you more, sir.

**Hon. Serge Joyal:** Those are the four minutes that Senator Seidman gave me.

**The Joint Chair (Mr. Robert Oliphant):** There were six and a half minutes, senator. Seven minutes.

**Hon. Serge Joyal:** Okay. Thank you.

Did you say, Dr. Grant, that you are a family doctor?

**Dr. Douglas Grant:** I was, yes.

**Hon. Serge Joyal:** We had on Monday a representative from the College of Family Physicians of Canada, Dr. Francine Lemire. You might know her.

She answered very specific questions about the obligation of a doctor to provide for a referee when the doctor has a conscientious objection to providing the services, the right that we now have to satisfy according to the Supreme Court decision.

What is the position of the college in relation to that? Do you share the views of Dr. Lemire that a doctor cannot abandon his or her patient and say to look in the Yellow Pages or search online on their computer to find a doctor? What would be the position of a physician, according to you, who will want to exercise his or her right of conscientious objection in relation to informing the patient where to find that service?

**Dr. Douglas Grant:** I would first say that there's absolute unanimity across the country that physicians cannot abandon their patient. The conscientious-objecting physician cannot simply abandon the patient. They must continue to provide care to that patient. All colleges agree with that.

The difference amongst the colleges is on whether there exists a positive obligation to make an effective referral or whether they contemplate indirect referrals through another agency, whether it be the physician making the indirect referral or providing information to the patient and ensuring that the patient has the necessary knowledge. That's the range of options.

I think we can learn from the Benelux countries' experience that over time, as a network of willing physicians becomes known, the issue of access goes down. Our college's view—this dovetails with the question from honourable member Cooper—is that we saw it in our standard simply to operationalize what we thought Carter was saying. We weren't trying to make new law or expand on it. We just wanted to operate.

Carter doesn't give us clear direction there. I think this is essentially a medical thing, and I think the colleges need to get a harmonized approach to it. Our approach in Nova Scotia, as we were essentially treading water after Carter, was that we recommended an effective referral, but we mandated, for the physician who could not see his or her way clear to making an effective referral, that an indirect referral be achieved by providing the patient information.

There's some variety across the country amongst the colleges.

**The Joint Chair (Mr. Robert Oliphant):** Thank you, Dr. Grant and Senator.

Because I'm feeling generous and it's Groundhog Day, I'm going to allow Mr. Albrecht a couple of minutes for a short question.

**Mr. Harold Albrecht (Kitchener—Conestoga, CPC):** I hope I'm not being equated with Groundhog Day, Mr. Chair.

**Voices:** Oh, oh!

**The Joint Chair (Mr. Robert Oliphant):** It's just a national fete.

**Mr. Harold Albrecht:** Thank you.

I'll try to be brief and be respectful of your time.

There's just a little confusion on the issue of conscience protection. You did reference Carter. It's quite clear in paragraph 132, “In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying.” I think there would be disagreement among professionals, legal and otherwise, as to what that actually means. Does it include active referral? Does it even include passive referral? I don't want to get into that argument right now, but I think there is room for debate around the definition.

One of my concerns is that as we approach the issues of conscience, it's paramount and I think this committee is charged with the very simple obligation to ensure that physicians have conscience protection, including, I would go so far as to say, not to refer. No other jurisdiction that has legalized physician-assisted suicide or euthanasia imposes any compelling of medical doctors to refer.

I want to ensure that our world view, as doctors or whatever other practice we're in, is not compromised by a set of external forces that forces us to go against our conscience. In fact, I would be concerned that in the issue and the situation with medical doctors who are compelled to go against their conscience, could there not be a serious implication of possible post-traumatic stress syndrome or other psychiatric issues with which those physicians might have to deal?

That's a very existential question. A more practical one is that if the regulations are allowed to be developed on a province-by-province case, is it not possible that a physician practising in Nova Scotia, where the regime is more mandatory, could move to New Brunswick, for example, or some other province where there's a more lenient and what I would call a more “open” regime in terms of allowing physicians to actually practise according to their conscience in all spheres of medicine?

● (2035)

**Dr. Douglas Grant:** I think I followed most of the questions there.

All would agree that it's an open question. Clearly the tidiest mechanism to close the question is for legislation to define what “assistance” means. The inconsistency among the colleges was generated by the colleges all independently waiting for federal direction, trying to figure out how best to interpret Carter without specific direction, and quite frankly, without terribly clear legal authority. I think it remains entirely available for the colleges to come up with a harmonized approach that would follow the lead of whatever legislation is directed.

I'll repeat, I worry terribly about two things: that legislation will intrude on the nature of the patient-doctor relationship, and that, again—I say this with sadness—we have to confront, as a profession, the manner by which we dealt with access to abortion and contraception when it was established as a legal right.

**The Joint Chair (Mr. Robert Oliphant):** Thank you, Dr. Grant.

Thank you to all our witnesses. It has been a long evening, and you have added much that has been very helpful to our debate and our discussion.

Just before we close, I remind you that the committee will be meeting tomorrow night at five o'clock, but watch your inbox, because the votes in the House of Commons are going to be at three now. They have been moved and we have taken that break for the vote. We're seeing if we can move the witnesses up, but we're not sure if we're able to move the witnesses without being rude, etc., so we may have half a meeting and break for dinner and then have a second meeting, or we may have them all combined if we can.

Again, thank you.

The meeting is adjourned.

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