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—
Co-Chairs

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

Special Joint Committee on Physician-Assisted Dying

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• (1700)

[English]

The Joint Chair (Hon. Kelvin Kenneth Ogilvie (Senator, Nova Scotia (Annapolis Valley - Hants), C)): We have a quorum and I'm calling the meeting to order.

[Translation]

Welcome to the 11th meeting of the Special Joint Committee on Physician-Assisted Dying.

[English]

I'm Kelvin Ogilvie, a senator from Nova Scotia and co-chair of this committee. I'm chairing it today along with my co-chair colleague, Rob Oliphant, the member of Parliament for Don Valley West.

In this session, which will go from 5 to 6 p.m., we have two groups presenting. First of all, we have His Eminence Cardinal Thomas Collins, Archbishop of Toronto, and with him Laurence Worthen, executive director of the Christian Medical and Dental Society of Canada and the Coalition for HealthCARE and Conscience.

We welcome you. I will remind you that together you have a total of 10 minutes for your presentation.

Appearing by video conference we have Vyda Ng, executive director of the Canadian Unitarian Council.

Ms. Ng, you have 10 minutes as well. Because it's technology, and we already know you've been shunted around Toronto a bit with something happening at the first site, we're going to invite you to present first.

Just before you start, I want to remind the witnesses and everybody that the committee members, when called, have five minutes in total for their question and the response, so the questioners should be efficient with language, and to the responders, if you could be direct in your answers, it would be much appreciated.

With that, I invite Ms. Ng to present.

Mrs. Vyda Ng (Executive Director, Canadian Unitarian Council): Thank you for the opportunity to present before this joint committee.

As far back as the early 1970s, the Canadian Unitarian Council has advocated for the right of a terminally ill patient to make decisions about the time and manner of their death. We were involved as intervenor in the Taylor and Carter cases in 2012 and 2014. In this presentation I wish to emphasize the following.

First, around eligibility criteria and competency, we are of the belief that the competency requirement should apply at the time of the initial request for physician-assisted dying, and at the provision of the requested treatment. However, we do recognize that patients with an irremediable condition may deteriorate at any time. Therefore, we think that once informed consent has been fully attained, this should stand, and that decisions around the manner and time of death should be made on an individual basis, for example, where an individual suffers from dementia or lapses into a coma after providing the initial informed consent.

We also believe the consent to the termination of life must be made freely, without coercion or pressure, and after the patient has had a chance to consider all treatment options.

In terms of the grievous and irremediable condition, we believe there are a number of illnesses, disabilities, and conditions that cover this range of description, and we believe the condition that causes the suffering that is intolerable to the individual should be defined by the individual and not by any outside body. We believe very strongly that there should not be a predetermined list of illnesses, conditions, or symptoms, as the experience varies from person to person.

On the matter of equitable access, we believe that publicly funded institutions should be required to provide physician-assisted dying on their premises. Other health care professionals may provide assisted-dying medication, especially in situations where there is no physician available or willing, or in the more remote regions.

In areas that are remote, ways must be found to allow patients equitable access so that there are no delays and the same level of compassionate care may be provided.

In circumstances where the physician is unwilling to provide assisted dying, mechanisms must be in place for individuals to access this without undue stress.

We also believe physicians and health care practitioners should be able to make their own decisions based on their conscience. They should be able to refuse the provision of assisted dying if this is their personal belief. They should be able to make these decisions without fear of reprisals or consequences; the institutions for which they work should not be able to levy any kinds of consequences upon them.

When it is the case that a physician decides not to provide assisted dying, the patient must be given full access to other means. There should be no impediments to the individuals requesting assisted dying, and institutions should not prevent patients from accessing this care.

There needs to be a carefully thought-out system for transfer of care so that patients are not denied compassionate treatment and to make sure this is done without additional stress or trauma to the individual. Patients' needs need to come before doctors' wishes, and provincial, territorial, or municipal governments should not allow any roadblocks or barriers to exist for patients to access assisted dying.

Why does the Canadian Unitarian Council feel so strongly about this? As a religious institution, we realize different faiths have different beliefs, but we do not think the views of any one faith can be used to restrict the freedoms of other individuals. As a religious body, we have had a history of supporting choice in all manner of things, even when it hasn't been popular to do so, things such as choice in abortion, the rights of the lesbian-gay-bisexual community, or the call of women to be ordained. We've often taken the path that hasn't been popular, but we feel that this is the right thing to do.

• (1705)

It's very much in keeping with Canadian values to put the needs and wishes of Canadians ahead of the values of individual doctors and institutions, and to respect each person's dignity at the most traumatic period of their life.

We also think that in order to safeguard good processes, reviews should take place after each instance of physician-assisted death. These are necessary, but we do not think that having a review before the medication is in the best interests of the patient in case doing so leads to delays.

That is the end of our presentation.

Thank you.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you very much.

Now, Your Eminence, I will turn to you and your colleague. Please make your presentation.

His Eminence Thomas Cardinal Collins (Archbishop, Archdiocese of Toronto, Coalition for HealthCARE and Conscience): Good evening, and thank you for allowing us this opportunity to provide input on such a profoundly important subject.

I appear today on behalf of the Coalition for HealthCARE and Conscience. Joining me is Larry Worthen, the executive director of the Christian Medical and Dental Society of Canada.

We are like-minded organizations committed to protecting conscience rights for health practitioners and facilities. In addition to the Catholic Archdiocese of Toronto and the Christian Medical and Dental Society of Canada, our members also include the Catholic Organization for Life and Family, the Canadian Federation of Catholic Physicians' Societies, the Canadian Catholic Bioethics Institute, and Canadian Physicians for Life.

I will address two issues: conscience protection for health care workers, and palliative care and support services for the vulnerable.

For centuries faith-based organizations and communities have cared for the most vulnerable in our country, and they do so to this day. We know what it is to journey with those who are facing great suffering in mind and body, and we are committed to serving them

with a compassionate love that is rooted in faith and is expressed through the best medical care available.

We were brought together by a common mission: to respect the sanctity of human life, which is a gift of God; to protect the vulnerable; and to promote the ability of individuals and institutions to provide health care without being forced to compromise their moral convictions. It is because of this mission that we cannot support or condone assisted suicide or euthanasia.

Death is the natural conclusion of the journey of life in this world. As the author of the Book of Ecclesiastes wisely observed long ago, the dust returns to the earth as it once was and the life breath returns to the God who gave it. Death comes to us all, so patients are fully justified in refusing burdensome and disproportionate treatment that only prolongs the inevitable process of dying, but there is an absolute difference between dying and being killed. It is our moral conviction that it is never justified for a physician to help take a patient's life under any circumstances.

We urge you to consider carefully the drastic, negative effects that physician-assisted suicide will have in our country. Killing a person will no longer be seen as a crime but instead will be treated as a form of health care. According to the Supreme Court, adults at any age—not just those who are near death—may request assisted suicide.

Following the lead of some European countries, whose experience with assisted suicide and euthanasia we disregard at our peril, the provincial-territorial expert advisory group has already gone beyond the restriction of assisted suicide to adults and has proposed that children be included.

The right to be put to death will, in practice, become in some cases the duty to be put to death as subtle pressure is brought to bear on the vulnerable.

Those called to the noble vocation of healing will, instead, be engaged in killing, with a grievous effect upon both the integrity of the medical profession committed to doing no harm, and the trust of patients and those from whom they seek healing. Even those doctors who support this legalization in principle may be uneasy when they experience its far-reaching implications.

The strong message from the Supreme Court is unmistakable: some lives are just not worth living. We passionately disagree.

In light of all this, it is clear that reasonable people, with or without religious faith, can have a well-founded moral conviction in their conscience that prevents them from becoming engaged in any way in the provision of assisted suicide and euthanasia. They deserve to be respected. It is essential that the government ensure that effective conscience protection be given to health care providers, both institutions and individuals. They should not be forced to perform actions that go against their conscience or to refer the action to others, since that is the moral equivalent of participating in the act itself. It's simply not right or just to say, "You do not have to do what is against your conscience, but you have to be sure it happens".

Our worth as a society will be measured by the support we give to the vulnerable. People facing illness may choose to end their lives for reasons of isolation, discouragement, loneliness, or poverty, even though they may have many years yet to live. What does it say about us as a society when the ill and the vulnerable in our midst feel like burdens? Often a plea for suicide is a cry for help. Society should respond with care and a compassionate response to these vulnerable people, and not with death.

- (1710)

Proper palliative care to date is not available to the majority of Canadians. It is a moral imperative for all levels of government in our country to focus attention and resources on providing that care, which offers effective medical control of pain, and even more importantly, loving accompaniment of those who are approaching the inevitable end of life on earth.

Larry Worthen will now provide more detail about some specific recommendations.

Mr. Laurence Worthen (Executive Director, Christian Medical and Dental Society of Canada, Coalition for HealthCARE and Conscience): Thank you, Cardinal Collins.

Ladies and gentlemen of the committee, His Eminence has provided you with some insight into our concerns about how legalizing physician-assisted suicide or euthanasia will impact vulnerable patients.

Provided they can consent, people with disabilities such as rheumatoid arthritis and paraplegia, or those with mental health difficulties could qualify for assisted death according to the criteria set down by the courts. Often people who have these challenges are struggling in a world with many barriers. The danger is that they will choose assisted death because of the failure of our society to provide the necessary support.

Through increased access to palliative care, disability, chronic disease, and mental health services, Canada can significantly reduce the number of people who see death as the only viable option to end their isolation, their feeling of being a burden, and their sense of worthlessness.

Our concern for our patients extends to our concern for conscience protection. Recently the College of Physicians and Surgeons of Ontario passed a policy requiring referral for assisted death. A referral is the recommendation or a handing over of care to another doctor on the advice of the referring physician. The requirement to refer forces our members to act against their moral conviction that

assisted suicide or euthanasia will, in fact, harm their patients. If they refuse to refer, they'll risk disciplinary action by the Ontario college.

When a proposed practice calls into question such a foundational value of the common good of society and the foundational value of the very meaning of our profession, a health care worker has the right to object. Health care workers do not lose their right to moral integrity just because they choose a particular profession.

In the landmark Carter case, the Supreme Court of Canada said that no physician could be forced to participate in assisted death. It also said this was a matter that engaged the charter freedoms of conscience and religion. It is not in the public interest to discriminate against a category of people based upon their moral convictions and religious beliefs. This does not create a more tolerant, inclusive, or pluralistic society, and it is ironic that this is being done all in the name of choice.

Fortunately, six other colleges have not required referral. We have enumerated several possible options for the federal government to ensure these charter rights are respected all across the country. We have a legal opinion, which we will make available to the committee, that lists five ways the federal government could protect conscience rights.

If the federal government does not act, then we risk a patchwork quilt of regulatory practices and a serious injustice being done to some very conscientious, committed, and capable doctors.

Despite our concerns, members of our coalition will not obstruct the patient's decision should this legislation be put in place. The federal government could establish a mechanism allowing patients direct access to a third party information and referral service that would provide them with an assessment once they have discussed assisted death with their own doctor and clearly decided they wish to seek it.

Our members do not wish to abandon their patients in their most challenging moments of vulnerability and illness. When we get a request for assisted death, should this legislation go ahead, we'll probe to determine the underlying reason for the request to see if there are alternatives for management. We'll provide complete information about all available medical options, including assisted death. However, our members must step away from the process, allowing the patient to seek the assessment directly once they have a firm commitment to take that path.

Like our coalition, the Canadian Medical Association has stated that doctors should not be required to do referrals for assisted suicide or euthanasia. It's important to remind the committee that no other foreign jurisdiction requires physician compliance in assisted death through a referral.

In closing, we highlight four areas of serious concern, the need for the following: improved patient services, including palliative, mental health care, and support for people with disabilities; protection of the vulnerable; provisions that physicians, nurses, and other health care professionals not be required to refer for or perform assisted death or be discriminated against because of their moral convictions; and finally, protection for health care facilities, such as hospitals, nursing homes, and hospices, that are unable to provide assisted death on their premises because of their organizational values.

• (1715)

Thank you for your time and consideration.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you very much.

I'll now turn to our colleagues, and Madam Shanahan.

Mrs. Brenda Shanahan (Châteauguay—Lacolle, Lib.): Thank you very much, Mr. Chair.

My question is addressed to Monseigneur Collins and Mr. Worthen.

I just want it on the record that I am a practising Catholic, although I say "practising" because I'm not very good yet. You can be assured that I have reflected and prayed on this matter greatly, both before and now during this time that I am a member of Parliament, and I have had to make my peace with my own personal beliefs. I know what I believe and I know that if I'm ever faced with the choice, I'd like to think that I will be able to make the choice that my faith requires of me. But that being said, I'm here as a parliamentarian and I cannot impose my beliefs on others and I am very conscious of the fact that we have to make recommendations for legislation that is going to address the beliefs and values of all Canadians.

I am relieved to hear that you acknowledge the Carter decision, as indeed we must. How do you reconcile, then, your approach given that so many Canadians, and Catholic Canadians, look to faith-based care for that end-of-life care? How do you reconcile the process of delivering end-of-life care to Canadians in the event that they ask for physician-assisted dying?

• (1720)

Cardinal Thomas Collins: Larry will give some of the details.

I would say first of all that we do not agree, obviously, with assisted suicide and euthanasia. We think this is a direction that leads all kinds of people into tremendous suffering and is not good for our whole community. It is really a thing that causes great ultimate suffering for all of the most vulnerable, including those who are considering suicide and things of that nature. We know, though, that obviously, as you say, people are proceeding along this path in response to the Supreme Court judgment, but individuals.... And I would not presume to say that I'm going to, by my words, stop that from proceeding. This is the parliamentary process that's in place. It is not for me to engage in it. But I would simply say that there are many, many Canadians, especially those most deeply intimately involved in caring for people, who are profoundly troubled by our country moving in this direction, and that in whatever procedures you are in the course of setting up for those who have that profound conviction I think their conscience needs to be protected. I'm glad

the Unitarian Church also agrees with that. I think it's not only individuals, but also institutions.

There are ways of providing protection for conscience and dealing with this issue. I think Larry has mentioned that, and might want to give more detail on it.

Mr. Laurence Worthen: Yes, the proposal which we will leave behind was one that we discussed at length with the Canadian Medical Association, and which they have approved. It basically shows the physicians articulating their conscience issue around assisted suicide and euthanasia with the patient, having the dialogue and discussion with the patient, giving the patient information about all viable options, but then simply stepping back from the process and allowing the patient to have direct access to an assessment for assisted death. Our hope would be that either the federal government or the provincial governments would create an information referral service so that after patients have had the discussion with their own doctor, they are able to access that directly. We've checked that out with moral theologians, both on the evangelical and Roman Catholic side, and they find it morally acceptable. This seems to us to be a way for our physicians to continue to care for the patient, not affect the physician-patient relationship, and also allow the patient to make their decisions without there being any obstruction from the physician.

Mrs. Brenda Shanahan: So would you be open to this duty to inform, then, if not an active referral, but to inform another body that the patient has requested physician-assisted suicide?

Mr. Laurence Worthen: We differ slightly from the recommendations of the provincial-territorial expert advisory group. They suggested that it would be the physician's responsibility to inform the third party. Our feeling is that it would be unacceptable for us to have to take that responsibility and that the actual patient could be the one to contact. In the situation where the patient is unable to contact, which would normally happen in an institution, then we could look to a patient transfer that would be the opportunity, then, for another physician in the facility to be able to respond to the patient's concerns.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you.

Mr. Warawa.

Mr. Mark Warawa (Langley—Aldergrove, CPC): Thank you to the witnesses for being here. It's very interesting.

I researched the Unitarian Council and I didn't see any hospitals that had been established by the Unitarian Church, but I did find many that are faith-based Catholic hospitals.

I appreciate the question from MP Shanahan and her sharing that we should not impose our beliefs on other Canadians. However, there's this balance of faith and doing what's right in our own hearts too. Also there's been comment around this table that a doctor's conscience should be protected, and maybe not to do it themselves, but to refer.

I've heard from most physicians.... Actually, I think it was 70% of physicians who do not want to have to be required to refer, so 30%, which is 24,000 physicians, are willing to practise this. Focusing on the 70%, I think that most Canadians believe they should not be forced to perform assisted suicide or euthanasia and they should not be forced to refer.

There's been a question, I think from one of our senators, that institutions, bricks, do not have a conscience. If you could comment, do institutions have a value system that would say yes or no? Should they have the right to say no as an institution?

Is there a possibility of having a harmonizing system? You could have institutions, hospitals, like a Catholic hospital, that are not bound because they're providing health care. They could be known as a hospital that provides health and natural death, and there could be some hospitals that provide that other choice. Could you comment on that?

• (1725)

Cardinal Thomas Collins: I think it's very true to say that institutions are not bricks and mortar. You don't look around and say this is.... Institutions are made of people. Institutions are like the Sisters of St. Joseph, the Grey Nuns, all of the various groups who have brought loving health care to this place. They're not things; they're communities of people. They have values, and that's why people come to them. That's why they seek them out.

They know when they go, for example, to a hospital—and I can think of St. Michael's Hospital, St. Joseph's Hospital, Providence centre which has a wonderful palliative care place.... They know they can trust when they come to the sisters or to the church. It's true, as well, for Jewish and Protestant institutions, similar institutions, of which there are many. In my own diocese, there are very many. They can trust that we have certain values that we hold to. Those values are important for our whole society. Political parties have values; other institutions have values. They're not objective things. They're not material things. That's a great value for our whole community.

These institutions are funded by the government because they do immensely good work. They provide a variety, diversity, choice, I might say, to people, and that's very, very important.

I would say that institutions provide the spirit. I think of the one next to where I live, the Urban Angels, St. Michael's. It's a sign of hope for people. If you undermine the institution for what it is, our society will be very much harmed. Our whole community would be a lot harsher, colder, crueller, without the witness given by communities of faith who are on the ground, on the street, day by day, caring for the most needy. I don't think they should be undermined or attacked.

Mr. Mark Warawa: Thank you, Cardinal Collins.

I'm wondering about the safeguards to ensure the conscience. You said you had some ideas on physicians who do not want to participate within a federal regime. I had heard that one of the suggestions was that it could be a criminal offence to force someone—a physician or an institution—to be involved with this.

Is this one of the suggestions that you were considering?

Mr. Laurence Worthen: Yes.

Our legal brief has five different options in all. Just as in some of the provincial college documents, doctors who choose to do euthanasia are protected against discrimination on the part of faith-based institutions, so also we would ask that doctors who do not want to do euthanasia be also protected. That could be by way of criminal statute that would make it unlawful for someone to be coerced into participating in this.

Mr. Mark Warawa: [*Inaudible—Editor*] institution.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you.

Mr. Rankin.

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

Thank you to all of our witnesses. I particularly appreciate, Cardinal Collins, your strong assertion of the need for our committee to address palliative care. I really appreciate your putting that on the table.

I want to explore a little bit of what Mr. Warawa was just saying in his question, presumably to Mr. Worthen. I'm going to read to you from the the "Interim Guidance" of the College of Physicians and Surgeons of Ontario. They talk about how physicians must provide an "effective referral...to a non-objecting, available, and accessible physician or agency...in a timely manner". In my province of British Columbia, the similar body says that physicians must ensure "an effective transfer of care for their patients". This is in the context of conscience protection for health care providers.

Now, you have stated that this obligation to refer patients would violate the conscience rights of certain physicians and that instead there should be a mechanism to provide patients with third party information, assessment, and services. I'm a little concerned, though, because other witnesses have told us that simply providing a person who wishes to exercise their constitutional right can't be limited by a Yellow Pages reference, an 800 number, or a website.

I'm trying to get my head around what you're suggesting and, in particular, how that would affect "effective" right of access for Canadians in remote communities if one were to accede to your recommendation.

• (1730)

Mr. Laurence Worthen: Thank you for the question. It's a very good one.

I think there needs to be more.... Our proposal is not to simply send someone to the Yellow Pages, far from it. Our doctors are committed to the life and well-being of their patients, so they would want to maintain the physician-patient relationship. They would want to discuss this important decision with their patients. They would want to spend time determining what the reason for the request is. They would also want to ensure that the patient was able to get the assessment if they so desired it. They would not want to stand in the way of that.

We should not be talking in this country about simply having an operator at the end of the phone who is going to give someone a number. In my view, we should be responding compassionately to these people, because many of these people will need services, support, and help. This service that is anticipated by the Canadian Medical Association, and similarly, I think, in the provincial-territorial expert advisory group recommendations, would be for support services to be made available and for this person to get an appropriate assessment in a thorough way. We're not talking about sending someone to the Yellow Pages; this is in a thorough way.

I think something like this is really important in a more remote community, because even in a remote community you might have one doctor or two doctors. Both might be people who are not prepared to participate in assisted death. This means that it would be important for that individual to be able to get access to this service, and I think the responsibility is on government to ensure that service is available and provided.

Mr. Murray Rankin: In the time that's available—it's so short—I want to go to the institutional side. We've talked about the conscience of the health care provider. I'd like to turn again to the institutional argument and to quite boldly put forward the point that if an institution of which the cardinal has spoken receives public funding, shouldn't they be required to provide all Canadians with the constitutional rights they now have?

I understand about the professional, and you've put some good arguments forward, but I'm still at a loss to understand why a body that receives public funding shouldn't be required to be providing constitutional rights that all Canadians now enjoy.

Mr. Laurence Worthen: To answer that quickly, I would say that it's misreading the Carter decision to say that it requires individual physicians or facilities to provide the service. What it says is that Canadians have the right to this, but it doesn't say that they have a right to it from every individual institution or individual doctor.

Mr. Murray Rankin: But what if there's only one such institution in a remote northern Ontario community, for example?

Mr. Laurence Worthen: This happens all the time in medical care. There are certain procedures that are only provided in certain places. It's up to government. The departments of health cannot shirk their responsibilities here.

If this is something that the Supreme Court has mandated, then the departments of health have to find ways to provide these services. If that means they have to send a physician out to that individual or bring that physician in.... That commonly happens.

Mr. Murray Rankin: If there's a hospital in a particular community, they shouldn't be providing that service even though it's—

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Senator Nancy Ruth.

Hon. Nancy Ruth (Senator, Ontario (Cluny), C): Ms. Ng, you have said that access should be evenly available and that doctors must transfer patients if they have a conscientious objection. What is the opinion of the Unitarian Council if the hospital is a faith-based hospital that objects to doing physician-assisted death, not just the doctor? Or does the Unitarian—

• (1735)

Mrs. Vyda Ng: We understand that there are many faith-based institutions that provide hospice and palliative care. It's even more important in those situations that a good, effective process of transfer of care does happen, as we've been talking about, especially in the more remote communities. It is the constitutional right of every Canadian to receive this care, and it is a fine balance between protecting the rights of conscience of the physician and making sure that the rights of the individual patient have not been violated. A good mechanism needs to exist. Whether it's a direct doctor referral care or a third party referral system, it needs to flow smoothly. I would think that if someone checks into an institution or a hospice facility that is faith-based, they would know ahead of time that certain moral values apply.

To go back to the previous question about institutions if they're publicly funded, we believe that publicly funded institutions should provide this kind of assisted dying.

We also believe in the sanctity of life, but we don't think that life should be extended and preserved at all costs. We believe that quality of life is really important as well. There is no dignity, there is no compassion when someone is terminally ill. They're at the end of their life. They can't take care of themselves. Their bodies have let them down. They are in pain and they can't look after themselves. There is no dignity in that.

My partner died a little over two years ago. He was diagnosed with a condition early in 2000 and lived beyond his original prognosis. He was fortunate enough to receive very good care in a hospice. It was excellent palliative care. But would he have wanted access to physician-assisted dying? Yes, he would have. He was in pain. He was uncomfortable. He was not the person that he knew himself to be. If we force someone to prolong their life because a physician isn't willing to provide that kind of care, then we're violating their constitutional rights.

Hon. Nancy Ruth: Thank you.

You did say that there should be a review after death. Could you explain that a bit more?

Mrs. Vyda Ng: I think a review process serves to make sure that effective mechanisms are in play. As this practice and this legislation rolls out, we're not going to know what it looks like. So in terms of helping both the institution and the physician make better choices down the road, I think a thorough review of what request was made, how the request was handled, how the institution handled it, and how the physician handled it will help both the institution and the physician.

Hon. Nancy Ruth: Who should do this review?

Mrs. Vyda Ng: I think it should be an objective party, whether it's a committee put together by various stakeholders.... It should not be the institution that provided the care and it shouldn't be the physician who provided the care, but someone objective. And I think the review is even more—

Hon. Nancy Ruth: Can you see this coming under the coroner's office in the provinces?

Mrs. Vyda Ng: I'm sorry, can you—

Hon. Nancy Ruth: Can you see the coroner's offices being expanded to include this kind of thing? What I'm getting at is, is there a need to create a new institution or can we use what already exists in every province and territory across Canada?

Mrs. Vyda Ng: I think the options are there, as long as no biases are built in, as long as there's a process to make sure that the reviews are objective and that there are no preconceived agendas.

Hon. Nancy Ruth: Thank you.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you.

Senator Cowan.

Hon. James S. Cowan (Senator, Nova Scotia, Lib.): Welcome to the witnesses, and thank you for your evidence.

Your Eminence, I appreciate your faith-based opposition to physician-assisted dying, but that's not the issue before us. The court has made a decision and we're bound by that decision, and physician-assisted dying is a constitutional right for those eligible to access it. I appreciate the concerns that you've expressed about conscientious objectors and nobody being forced to participate. But it seems to me, and I'd ask for your comments, that what we're really looking at here is, we ought to be looking at it through the eyes of the affected patient. The rights and beliefs we might have have to be accommodated to meet those rights that the patient has.

Perhaps you would wish that there is not going to be physician-assisted death in this country, but there is, so what particular, specific precautions should we be recommending be put in place to protect from abuse and protect the vulnerable? I think all of us would want to afford every protection to the vulnerable, but what specifically should we be recommending that would allow physician-assisted death to proceed, but at the same time provide appropriate protections for the vulnerable?

• (1740)

Cardinal Thomas Collins: I'm certainly sure there are people—many around this table and around the country—who are very much committed to ensuring that physician-assisted suicide takes place. Obviously, after the Carter decision, this is the project of this committee.

As I have made clear, I don't believe this is the direction the country should be going in. Far be it from me to suggest making it about should we have three doctors, two doctors, should we have one, should we do...? I don't believe it should happen, so I can't convince—

Hon. James S. Cowan: I understand that, Your Eminence, but that's not where we are.

Cardinal Thomas Collins: I'm sure other people will be doing that, but I don't believe in the thing itself. What I do believe is that the rights of conscience, of people who are constantly involved with compassionately caring for those most in need, need to be protected. I also believe that alternatives should be presented, funded very directly, and that would be palliative care.

Hon. James S. Cowan: Again, you're preaching to the choir here, because all of us would believe there ought to be more readily accessible, better palliative care available to more Canadians, but again that's not our issue. Our issue is, and maybe Mr. Worthen can address this issue of precisely what are these...? You spoke about

protection of the vulnerable as being a concern. What can we do to protect the vulnerable within a regime which permits the constitutional right of eligible persons to access physician-assisted dying?

Mr. Laurence Worthen: I'm with the cardinal on this. I spent some time a year and a half ago with Dr. Theo Boer, who is the medical ethicist in the Netherlands. He was on a euthanasia commission there, and their job was to review cases. He indicated that they went through every one of the so-called safeguards that were available in the Dutch statute, and he explained to me about cases that he had where doctors had circumvented them. One study has shown that in about 20% of cases doctors were performing euthanasia when they thought they were doing palliative sedation.

In my discussion with Dr. Boer, I said that it appears to me that the so-called safeguards are just there to sell the concept of assisted suicide.

Hon. James S. Cowan: Surely if there are safeguards in place, and physicians or other health professionals disregard or circumvent those precautions, then that's a disciplinary matter for the College of Physicians and Surgeons or the nurses' association.

Mr. Laurence Worthen: Unfortunately, if you look at what's happening in these countries, doctors just get a slap on the wrist.

Hon. James S. Cowan: We're talking about Canada.

Mr. Laurence Worthen: They get a letter telling them.

What I'm trying to say is that once you accept the idea that state-sanctioned killing of patients is morally acceptable and you open it a crack, it becomes almost impossible to find a place to stop that process.

Hon. James S. Cowan: I don't mean to be—

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Mr. Aldag.

Mr. John Aldag (Cloverdale—Langley City, Lib.): I'd like to thank you all for the comments you've shared. They're giving me much more to think about once again.

Cardinal Collins, you mentioned that you may not want to be involved in forming...or shaping, so I'll put this to the other two panellists.

Continuing on with the question of safeguards, we've heard from some presenters here that we should look at safeguards being medical. If somebody decides that they may be interested, there is a one-physician, perhaps two-physician, process with a wait time to be determined. We've heard from other witnesses that this should be taken away from the medical community and moved into a legal or quasi-legal kind of piece.

I'm wondering if you have thoughts on either of those options, or if there is another option on safeguards that we should be contemplating as we mull over how this may actually work out in terms of looking at protections for the vulnerable. How do we create the appropriate amount of time for reflection by both the patient and the care providers, and within what field? Is there something missing that we haven't considered in that legal or medical realm?

I throw that out to both of you for thoughts or comments.

• (1745)

Mr. Laurence Worthen: We've done studies looking at the various countries that have legalized this. Generally speaking, the problem you have is that when a patient comes to a doctor and they say that they want to die, many different factors could be contributing to that. Many of those could be dealt with. The problem is that if you are expecting a physician to be able to do the full evaluation required to ensure that the person is not being coerced, no other jurisdiction is willing to put the funding in place to be able to do that properly.

When you say that it's a safeguard to have two physicians... In other jurisdictions, there is something called "doctor shopping", where, if they don't get the answer they want from the first two physicians, they'll go on to a third, fourth, or fifth physician. Eventually they will find somebody in the jurisdiction who believes in patient autonomy to the extreme, where they will decide that because the person wants to die, they should be able to die.

The reality is that we have concerns even with the use of the term "safeguard". It normally means that it's whatever we can put in place to be able to salve our conscience about how these vulnerable people will end up being put to death. The Carter criteria put together include disabled people.

It's so common for our physicians—it happens on a weekly basis—that patients will say they want to die: they've had a traumatic, emotional incident; they've just been diagnosed with a serious illness, or they've just become a paraplegic or a quadriplegic. Any number of factors can generate in a person's mind the desire to end their life. The question is, do we as a society have the compassion and concern to be able to put the resources in place to assist those people, or will we end up just euthanizing them and basically wash our hands of our responsibility for our fellow people?

Mr. John Aldag: I want to hear from our other panellist as well.

Ms. Ng, I'm wondering if you have any thoughts on this idea of safeguards.

Mrs. Vyda Ng: The protection of vulnerable peoples is really important, and I think the assessment of competency is vital to this.

We're talking about two different things here: the protection of the vulnerable people and making sure the person seeking assisted dying is really sure this is what they want. That's where the careful assessment process comes in.

I think you made a good point that maybe someone doesn't want to die, that they just want to be out of the situation they're in. That's where the suicide assessment might come in. If there are other options to help someone deal with mental health issues in a more healthy way, then those should be available.

However, the difference is that when you're talking about someone with an irremediable illness, the road is bleak, right? So the careful and thorough assessment is really important. The assessment by two physicians is really important. The patient needs to completely understand the consequences of this decision on both themselves and their family. They need to know all the treatment options that are available. I think the key to this is that the patient must freely choose this option after considering all the treatment options, and the request for the physician-assisted death must be

made by the patient and not another party. When you're talking about protecting the vulnerable, there is a fear here that someone else might request the death of this patient, and we want to make sure that doesn't happen, so the request for the medication must come from the patient and not another party.

• (1750)

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you, Ms. Ng.

Mr. Cooper.

Mr. Michael Cooper: Mr. Chair, I will provide the balance of my time to Mr. Genuis.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Thank you very much, and thank you to the witnesses for being here today.

Cardinal Collins and Mr. Worthen, you bring a refreshing perspective. I would say respectfully that it's a perspective I wish we could have had an opportunity to hear more of at this committee.

I have two specific issues I'd like to raise. I'll raise them both at the same time, if that's okay, and then leave the balance of my time to you gentlemen to respond to them as you wish.

My understanding is that the idea of dignity, a word we hear often in this committee, is very important in the Catholic tradition as well, but I think sometimes we use words like "dignity" and "compassion" without a certain precision to them.

Cardinal Collins, could you talk to us a little bit about the understanding of dignity in the Catholic tradition, and give us a bit of a definition? Of course, we would all like to see people have dignity at the point of their death. Perhaps, then, we need to think a little bit about what dignity really means.

The second issue I want to hear more about is palliative care. I think all of us agree that palliative care is good, and we would like to see more palliative care. I think we need to go further than that and recognize that it is not just desirable but necessary to provide people with palliative care.

This was made clear by the report of the expert panel—and I'm quoting here—that a request for physician-assisted death cannot be truly voluntary if the option of proper palliative care is not available to alleviate a person's suffering. In other words, it isn't a genuinely autonomous choice at all if we continue to provide palliative care to such a tiny fraction of Canadians. In fact, if we proceed with this and don't respect conscience for institutions, I fear we'll see the closure of more faith-based palliative care services that aren't willing to provide this.

I wonder if you could comment both on the issue of what dignity means and also on the centrality of palliative care.

Cardinal Thomas Collins: Okay. Maybe I'll start with the very important point you raise concerning dignity. Everyone may have different opinions or different views on that.

I would say dignity comes from within the person himself or herself. I would think even a person without faith would see that in a purely human way, the dignity of the human person. It doesn't come from the circumstances around them. From the point of view of faith, it comes from the idea that we see a person as a child of God, as someone who has inherent dignity. Every person must be treated with reverence.

Did Jean Paul II have dignity? When he was a 58-year-old pope skiing down mountains, he had dignity. Did he have dignity when he was in the last years of his life when his body was breaking down? I would say he had dignity then and he had dignity at the other times as well. Dignity comes from within the human person. I would say dignity comes with a reverence we give to a person, and that's why we should surround them and care for them. Think of Mother Teresa. The people she served, did they have dignity? Yes, they did, and she tried to help them in their suffering and care. Dignity comes from within. Dignity, I would say, comes from God. What we are doing, and have been doing for hundreds, a couple of thousand, years is surrounding a person, reverencing their dignity. That's why we don't believe it's right to kill them. We think that's just not right. That is not the way to dignity.

On palliative care, I think not only do we need to talk about it but that it needs to be dealt with at the federal, provincial, and municipal levels, and certainly at the private level. I can tell you that in my own diocese—I can't speak for other religious groups—we have various initiatives. Just this afternoon I got a proposal for another palliative care place that we're thinking of putting in the centre of Toronto. We do this. We're on the ground. We're doing it. We're caring. But I do think it would help a lot if this was funded. I mean, what are we spending on in our country? I would think it should be on caring for those who have dignity inherent within them from the first moment of their life to the end of this life at the end of their earthly journey. I think we need to not just talk about it, but to do something about it.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you very much.

Senator Seidman.

Hon. Judith G. Seidman (Senator, Quebec (De la Durantaye), C): Thank you, Chair.

Ms. Ng, I'd like to ask you a little more about the point you made about a review after a death. We have heard, for example, that the review is very important. Data collection and oversight could then lead to a review of the legislation in an ongoing way to update or change it over time. We have heard that this could be a joint federal, provincial and territorial kind of oversight. You mentioned the importance of review. Would you be able to comment on this, please?

• (1755)

Mrs. Vyda Ng: I think we learn from mistakes. Going out, we know very little about how it's going to play out in Canadian society. Opinions are very dichotomized around this. I think a review would serve all sides in this situation. If we proceed without a review, we won't know what we've done well and we won't know what can be improved. We won't know if palliative care actually may take care of a lot of the issues that people who are irremediably ill face. A review process, if it's a joint federal, provincial, and municipal venture, will

provide answers to a lot of the questions we're asking now in this situation and will help us make sure that, one, processes that are working well will be improved upon and shared, and two, processes that aren't working so well will be improved upon, especially in the cases where areas are more remote, in cases where physicians are acting on their conscience, and in cases where maybe not enough education or information is being shared with health care practitioners. We cannot afford to assume that the rollout of this will be smooth.

Hon. Judith G. Seidman: What kind of information could you see being collected under this approach, in terms of monitoring oversight and then having a feedback loop into the legislative process?

Mrs. Vyda Ng: Some examples are: how assessment of competency is done; how physicians have the conversation with their patients; whether or not the patients feel comfortable enough to broach the subject knowing that there are going to be physicians who are not comfortable providing that kind of care; whether the institution has enough resources to support both the patient and its own medical personnel when these conversations are going on; whether two physicians are present, if that makes a difference in terms of the request from the patient; what kind of medication is used; and whether there are requests from the patient to self-terminate or whether the medication is going to be administered by a physician. Whether or not the family members are involved I think is important. That also speaks to matters of coercion and protecting the vulnerable. Patients might feel subtle pressure from family members to act either one way or another way. I think these intangibles are also important for the review process to pick up on.

One of the important things—I've talked about the equitable access—is how patients in the remote areas access this care. His Eminence has talked about having a third party referral process. In principle we don't object to that, but if it puts more barriers and roadblocks in the way of the patients requesting this care, and if it doesn't work very well, then a better mechanism needs to be produced.

Hon. Judith G. Seidman: We have heard that nurse practitioners and other medical professionals could be involved in actually administering the process, the death for the patient. Could you see that as well?

Mrs. Vyda Ng: We could see that happening as long as the proper information, education, training, and support were provided to the health care professionals involved in administering that. We don't say that physicians should be the only ones, because we know that circumstances are different around the country, especially in more remote areas. So yes, we are open to the option of other health care professionals being involved both in administering the medication and in support.

• (1800)

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you, witnesses, for being here with us today, and colleagues, for your questions.

We need to turn this around in two or three minutes for the next session.

With that, I suspend the meeting.

•(1800) _____ (Pause) _____

•(1805)

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): I'm calling the meeting back into session.

In this session we have three panels.

We have, from the Canadian Council of Imams, Sikander Hashmi, who will be speaking on their behalf.

We have two panels appearing by video conference. The Centre for Addiction and Mental Health is represented by Dr. Tarek Rajji, chief, geriatric psychiatry; and Kristin Taylor, vice-president of legal services. From the Canadian Paediatric Society, we have Dr. Dawn Davies, chair, bioethics committee, and Mary Shariff, associate professor of law and associate dean academic at the University of Manitoba.

Once again, for the benefit of the witness groups, I will indicate that each group has 10 minutes in total and our committee members have five minutes for questions and answers.

Mr. Genuis.

Mr. Garnett Genuis: I have a very brief point of order.

Another member and I were timing during my speaking time and I think I was about 45 seconds short in terms of when you stopped the time. I'm sure there was no ill intention there, but I just wonder if maybe that time could be applied to another member on our side.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): According to the clerk, I said 20 seconds to Mark, but it was 22 seconds, and on mine it was 25. I have been routinely cutting them off at that point. If it's 30 seconds or more and they don't get the answer in, I ask the witness to provide a written answer afterwards.

Thank you very much.

With that I will also continue the process that we invite the groups by video conference to appear first, just in case there is a technological glitch. I will go in the order they're listed on the paper in front of me. That means I'm going to invite the Centre for Addiction and Mental Health to present first, please.

Dr. Tarek Rajji (Chief, Geriatric Psychiatry, Centre for Addiction and Mental Health): Thank you.

Members of the Special Joint Committee on Physician-Assisted Dying, thank you for the opportunity to appear before you today to share our perspectives on this extremely important topic.

My name is Tarek Rajji. I'm the chief of geriatric psychiatry at the Centre for Addiction and Mental Health, CAMH, and I am joined by my colleague, Kristin Taylor, vice-president of legal services.

CAMH is one of Canada's largest mental health and addictions academic health science centres. We combine clinical care, research, and education to transform the lives of people affected by mental illness or addiction. We have over 500 in-patient beds, 3,000 staff, over 300 physicians, and over 100 scientists. We treat over 30,000 patients each year.

PAD, physician-assisted dying, as it relates to mental illness is an extremely complex topic. The Supreme Court did not explicitly define specific medical conditions that would be eligible for PAD, but ruled that the "competent adult person" must have "a grievous and irremediable medical condition (including an illness, disease, or disability), that causes enduring" physical or psychological "suffering that is intolerable to the individual in the circumstances of his or her condition". This means that mental illness may be eligible for PAD.

But should mental illness be eligible for PAD? If so, how should we address it within a therapeutic clinical relationship? How do we ensure that safeguards are in place to protect those whose mental illnesses make them vulnerable to suicidal ideation?

We do not have the answers to these questions yet. These are issues that we continue to struggle with at CAMH. We have convened a working group of clinical, legal, ethics, and policy experts from across our organization, who are attempting to answer these questions and determine the impact that PAD will have on our patients, clinicians, and organization. Kristin joins me today as the co-chair of this committee.

What we would like to share with the special joint committee today are two key insights from our expert working group that we hope will assist in developing a federal framework on physician-assisted dying.

Our first insight is, should mental illness be considered irremediable? Mental illness is typically chronic and episodic. Following the natural history of mental illness, some individuals have persistent symptoms, some experience worsening symptoms, and some even recover from illnesses, even illnesses like schizophrenia. To date, we cannot predict who will be on what trajectory. Further, we have some effective treatments for mental illness and some knowledge to guide us with respect to personalizing treatments; however, we are still far from predicting what treatments would work for a particular person.

The symptoms of mental illness that persist, worsen, or remit include thoughts of suicide. However, a minority of patients with mental illness die from suicide. Again, while we have good knowledge about risk factors for suicide and some interventions that have been shown to reduce suicidality, we still cannot predict when a suicide will happen. This natural history is in contrast with terminal illnesses and some chronic physical illnesses, which are irremediable in that a proximal death is an eventual outcome.

Thus, mental illness may be grievous to an individual. Symptoms can cause enduring psychological and sometimes physical suffering. However, suffering should not be equated with irremediableness, and the lack of an inevitable or predictable death by natural history provides us with an opportunity to deliver recovery-based treatment.

A recovery-based approach to mental health care, which we provide at CAMH, focuses on hope and on developing the skills that are needed to live with a mental illness and its symptoms. We do not just focus on treating or curing the illness. Similarly, people with mental illness may be vulnerable to the impact of the social determinants of health. They may live in poverty, have poor housing, and lack social support. These circumstances may exacerbate suffering and a person's perception that their illness is irremediable.

Again, part of recovery-based care is for mental health professionals to work with people to help them cope and address these reversible causes of suffering. Therefore, within a clinical recovery-based environment, there is always the potential for mental illness to be remediable.

● (1810)

I would like to use a clinical example to illustrate the points I've talked about: a 73-year-old woman with a lifelong history of bipolar disorder, recurrent, and a persistent desire to die driven by a sense of futility and of being limited by her illness and the cognitive deficits, the attention problems, and the planning deficits that are due to this illness. The patient was married once and now she has an adult daughter and a granddaughter. She also has a neighbour with whom she has limited contact. Her bipolar illness is responsive to medications. However, despite good response, she has a persistent wish to die.

During her treatment, my discussions with her around death were focused on acknowledging her wish, respecting it, but also confining it. I focused on exploring with her the possibility of strengthening her relationship with her daughter through regular visits and meals together. This evolved to regular babysitting that her daughter and her son-in-law depended on. This new form of her relationship provided her with an unexpected sense of satisfaction and meaningfulness. These new feelings and experiences did not eliminate her wish to die, but ran in parallel and competed with it during her daily life.

We also explored her ability to consolidate her relationship with her neighbour who ended up having a stroke, and the patient became part of his network of caregivers.

This therapeutic work with her took about three years. The lack of inevitable and proximal death allowed this work to happen. Further, throughout the three years, what deterred her from committing suicide was the possibility of pain or a medical sequel if suicide was not successful and the shame she would have left her daughter with.

Would the availability of a painless death option and the sanction by a physician have eliminated the obstacles of pain and shame and interfered with the completion of this therapeutic work?

The second point I want to present to you is there must be safeguards in place to ensure people with mental illness truly have the capacity to consent to PAD.

In addition to the points I made previously about the natural course of the mental illness and its social determinants, individuals with mental illness experience distorted perceptions due to the illness and its consequences.

When a person is experiencing an acute episode of their illness such as a major depressive episode, or an acute psychotic episode, or a manic episode, it's not uncommon for them to have severely distorted beliefs about themselves, the world, and their future. Sometimes the sense of helplessness, and worthlessness, and hopelessness continues even when the symptoms of the mental illness are better controlled.

Thus these distortions raise questions about the capacity to make PAD requests during both the acute and less acute phases of the illness. In addition it is during the phases of relative wellness that recovery-based approaches to care are critical to change these distorted beliefs that have often been reinforced by lifelong experiences with a recurrent mental illness, associated stigma, and sometimes abuse or neglect due to this illness.

Again, I would like to use a clinical example to illustrate these points: a 55-year-old man with a long history of chronic schizophrenia with onset that occurred when he was 18 years old. Even before the full manifestation of the illness, this man was considered as awkward and bizarre at school, bullied by classmates, and was unable to excel in several academic or social activities. He continued to experience some failures since the full break of his first episode, including failure to maintain a job, failure to have a romantic relationship, and a failure to maintain the relationships he had before the illness.

It is not hard to see the lack of capacity when this person is experiencing an acute psychotic episode, but what about when he is not experiencing an acute episode? Wouldn't these repeated failures and maltreatment be contributing to a sense of worthlessness and hopelessness?

This distorted and learned view of self can potentially change in response to a recovery-based treatment and not only treatment that addresses the acute psychosis.

In both examples we recognize there will be some individuals with mental illness who will persistently perceive that they have suffering from an irremediable illness. These individuals may also argue that they are capable of making this decision. We believe that in these situations an objective decision of the irremediable nature of a person's illness must be made by a board versed in these issues, such as the Consent and Capacity Board in Ontario.

Members of the special joint committee, thank you again for the opportunity to speak with you today. There are no easy answers when looking at PAD and mental illness.

● (1815)

Today I have attempted to lay out the very real challenges and concerns that affect us at CAMH as a recovery-based organization that aims to transform the lives of people with mental illness. We hope that sharing our thoughts and recommendations will assist you as you move forward with your work.

Kristin and I would be happy to take any questions.

Thank you.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you very much.

I will now turn to the Canadian Paediatric Society and invite them to make their presentation.

• (1820)

Dr. Mary Shariff (Associate Professor of Law and Associate Dean Academic, University of Manitoba, Canadian Paediatric Society): Thank you for inviting us to speak with you today. I am very grateful for this opportunity.

I am a law professor who has been researching issues around physician-assisted suicide and palliative care since approximately 2008, and I was an expert witness on comparative laws for jurisdictions at past termination-of-life legislation for the Carter case.

In terms of legislative response, one possibility would be to construe Carter, of course, as narrowly as possible, which would be to construe it to the specific facts of the case. But of course you could always use Carter as a legislative entry point to include individuals and medical conditions not deliberated or decided upon by the Supreme Court.

Today I am here to speak to the matter of children, and with respect to children, I would argue that you should not go beyond the Supreme Court's pronouncement.

In termination-of-life legislation there are two main organizing streams when it comes to deciding whose request for physician-assisted dying can be legally granted.

First there are the substantive criteria, which we understand are the patient qualifiers, what criteria qualify a patient's request to be entertained by a physician. Then there are also the procedural due-care criteria, meaning what procedures you put in place to make sure that the patient has actually met the substantive criteria.

As we know, in cracking open the Criminal Code to allow willing physicians to provide termination-of-life services without prosecution, the Supreme Court only expressly identified the substantive criteria, namely, competent adult, grievous and irremediable condition, enduring suffering that is intolerable to the individual, and clear consent to termination of life. The court did not expressly articulate procedural due-care criteria, meaning that it didn't articulate the safeguards to be implemented to make sure the patient satisfies those four to six qualifying criteria.

As we know, the Supreme Court provided the substantive criteria of "adult" but did not define "adult", but again, if we go back to the facts of the case, the court was making and could only make a pronouncement on those facts. Non-adults were simply not part of the equation.

First, I would argue that it's not arbitrary to exclude non-adults from qualifying criteria in any first iteration of Canadian termination-of-life legislation. Again, there is no evidence before the court on the issue of children or adolescents. But also note the evidentiary finding by the trial judge, as articulated by the Supreme Court, that while there is no clear societal consensus on physician-assisted dying, there is a strong consensus that it would be ethical only with respect to adults who are competent, informed, and grievously and irremediably ill who voluntarily chose it.

Second, there is a massive ethical question as to whether children and adolescents should be able to qualify in the first instance for

lethal injection. This ethical question was not considered in Carter, and to the best of my knowledge, it has not been fully considered by Canadians. There is no ethical data on minors to inform the Canadian legal analysis. Dr. Davies will speak more to the issue of data.

Third, the argument is being made that the law has already allowed mature minors to make medical decisions even if doing so would result in their death. But let's think about that a little more closely. In those death cases, the decision is about rejection of treatment whereby if the child rejects treatment, the child runs the risk of dying. This is an entirely different consideration for children than is children being expected to consent to lethal injection.

Fourth, we also see from those cases in the Canadian case law that if the odds of survival are good with treatment, the court will override a minor's refusal. We know that Carter does not use the criteria of terminal illness, so how does one figure out the odds of survival for a child whose medical condition is a mental health issue or other form of disability?

This leads me to my fifth and final point, and then I'll turn it over to Dr. Davies.

• (1825)

Yes, we absolutely have processes that help us to discern a child's capacity and maturity for a particular decision, but the process for determining a minor's capacity does not answer the substantive question. It was more than just an acknowledgement of adults' capacity that actually drove the Carter result.

Dr. Dawn Davies (Chair, Bioethics Committee, Canadian Paediatric Society): Hi, I'm Dawn Davies. I'm a palliative care physician at the Stollery Children's Hospital in Alberta. I'm here today as a representative of the Canadian Paediatric Society, where I'm the current chair of the bioethics committee.

Thanks for giving the CPS an opportunity to address you. The legislation you are to consider is of particular importance to physicians who care for children and youth as the issues of eligibility and consent are complex. I'll highlight the relevant clinical dimensions of caring for seriously ill children, and how these intersect with the legislation about physician-assisted dying, which I will abbreviate to PAD for the sake of time.

The CPS recommends that the complex matter of assessing a minor's capacity be left to the minor's parents and immediate clinical team. Physicians are able to make this assessment as stated in Carter.

As has always been the case with mature minors, the greater the risk of serious harm or death, the more vigilant health care providers must be in their assessment of one's capacity to make the decision, and to ensure that it is free from duress from parents and other authority figures. It's also important to understand that these assessments are sometimes difficult to make, and that referral to the courts for life-and-death cases is not uncommon.

While the provincial and territorial panel suggests that capacity is more relevant than age, they did not consult with pediatric health care providers, parents, or minors. The CPS strongly recommends that comprehensive consultation must occur with the following groups prior to further legislation that would include children and adolescents: parents of children who are severely disabled or have terminal illness, and those parents who are bereaved after losing children with similar illnesses; relevant pediatric health care professionals; and representatives of major religious and child advocacy groups.

The Belgian law on euthanasia for adults came into force in 2002, and was extended to include children in 2014, but this has been widely criticized for lack of appropriate broad consultation prior to the inclusion of children.

There is also no Canadian pediatric data regarding either requests for a physician-assisted dying for minors, the opinion of Canadian pediatricians about PAD, nor their willingness to participate in assisting death of children specifically.

We must anticipate the source of requests for PAD, and parents of never-competent children deserve special mention. While we understand that proxy decision-makers will not be able to request PAD on behalf of any other person, requests from parents for euthanasia of their terminally ill children are neither new nor exceedingly rare. Decision-making for treatment of never-competent children is based on a best interest standard. It is possible that parents will challenge the courts on the basis that continued life, as experienced by their dying or profoundly disabled child, is not in their child's best interest.

Studies have shown that such requests are more likely if the child has uncontrolled pain. However, palliative care for Canadian children is greatly underserved, with many community-based health professionals having little to no training in the provision of palliative care to this group. The CPS therefore recommends enhanced pediatric-specific palliative care funded and equipped to care for children and their families in the setting of their choosing, especially their homes. Given the rapid societal shifts since the Carter decision and the short timeline to enact legislation, the CPS strongly enshrines the physician's right to conscientiously object to providing PAD, especially in the case of children and youth.

Thank you.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you very much.

I will now turn to our guest in the room.

Mr. Hashmi, would you please present to us.

Imam Sikander Hashmi (Spokesperson, Canadian Council of Imams): Thank you very much, sir.

Good evening, everyone. My name is Sikander Hashmi. I serve as an imam at the Kanata Muslim Association in Ottawa. I'm also a member of the Council of Imams of Ottawa-Gatineau. This evening I'm here with you as a spokesperson for the Canadian Council of Imams.

In the Islamic faith tradition, neither euthanasia nor assisted suicide are supported or encouraged. However, since that matter has

already been decided by the Supreme Court, our concerns regarding the legalization of physician-assisted dying centre around the preservation and the sanctity of life as well as the vulnerability of patients.

Most Canadians would agree that life is sacred and that an effort should be made in most, if not all, circumstances to preserve it. The Quran highlights the importance of saving a life in verse 5:32, that whoever saves a life, it is as if they have saved humanity entirely. We understand that in some cases patients experiencing extreme levels of pain and suffering, and those expecting the same in the future, may desire an end to their life. We empathize with them. As we draw from our faith, we are instructed to pray for them to gain relief from their suffering and to try our best to make them comfortable by providing the best possible care.

Our concern is that the availability of the option to die with the assistance of another individual may, in some cases, be subject to the interests of others rather than the patient, leading to direct or indirect encouragement and promotion of physician-assisted dying. We believe there must be robust safeguards in place to ensure that this option is exercised only by those who voluntarily and independently choose physician-assisted dying after going through an informed decision-making process.

We propose that any such requests be considered and evaluated by an end-of-life team of four members: first, a physician, ideally one who is familiar with the medical history of the patient and is involved in treating the patient; second, a psychiatrist or a psychologist who is able to understand the mental state of the patient and the reasons for their decision; third, a social worker who can inform the patient of the care options available to them and discuss potential impacts of their choices on themselves and on their family members; and finally, a spiritual care provider, representing the faith tradition of the patient, who can offer spiritual counsel and advice if the patient desires their services.

This team shall ensure that all care options available to the patient have been clearly explained without bias; that the patient has made the decision voluntarily and without duress or encouragement from another party; that the patient understands the impact of their decision; and that the patient's immediate family members are informed, if possible, about this process, and counselling is offered to them unless explicitly requested otherwise by the patient.

Furthermore, we recommend that paragraph 241(a) of the Criminal Code of Canada be amended to ensure that encouragement to commit suicide, including physician-assisted death, remains a criminal offence. In our view, a patient should be able to seek the assistance of a physician to end their life only if they meet all of the following criteria: they're above the age of majority in their jurisdiction; they're capable for personal care; they're suffering from a grievous and irremediable medical condition; they're in an advanced state of irreversible decline and capability; and they experience regular and unbearable physical suffering that cannot be relieved in a manner the patient deems tolerable.

The patient should be required to sign a request form, or in the case of a disability, express their wish clearly in unambiguous terms through any other means. The process and procedures could be as follows:

The patient would inform the care provider of their request or their desire for care or for physician-assisted death. The end-of-life care team would visit the patient to assess eligibility and inform them about available choices. The team would contact family members, inform them about the request, and offer them support, unless requested otherwise by the patient. The team would make a follow-up visit to the patient. If the patient chooses physician-assisted dying, the team would have them sign appropriate forms. The request would be submitted to the health care provider. The health care provider would arrange for the time and location and for the physician who is willing to assist the patient in dying. Details of this would be shared with immediate family members, unless requested otherwise by the patient. Before the procedure, the end-of-life care team would once again confirm the decision with the patient if the patient is still able to communicate. If the response is in the affirmative, the physician would assist the patient in ending their life and the death would be reported to a central federal registry.

• (1830)

Physicians and faith-based care facilities should not be compelled, in our view, to perform this procedure if their conscience, faith, and personal values do not allow for the taking of life.

We would like to highlight the statement of the College of Family Physicians of Canada on issues related to end-of-life care, which says:

As a matter of social justice, all Canadians...should have access to palliative care that meets national standards. Palliative care must be available in all health care settings. In addition, a variety of settings must be available for end-of-life care.

We also echo their call for sufficient funding to ensure that all Canadians have access to palliative care that meets national standards and the needs of each community.

The teachings of our faith lead us to believe that every disease has a cure. We just have to work to find it. Therefore, we recommend placing a greater emphasis on medical research towards finding cures and better pain management methods, particularly through increased funding and reversal of cuts to programs such as the combined MD/Ph.D. program for which funding was withdrawn in June 2015.

In conclusion, we would like to reiterate that neither euthanasia nor assisted suicide are supported or encouraged in the Islamic faith tradition. We believe there is a need and an opportunity to improve quality of life for patients and to protect the vulnerable. We hope our suggestions are useful in developing legislation that is balanced and compassionate.

Thank you very much.

• (1835)

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you very much.

Committee members, we have three panels, so would you be very clear in to whom you're directing your question.

Monsieur Arseneault.

Mr. René Arseneault (Madawaska—Restigouche, Lib.): I have a question for Dr. Davies. It's about age.

[Translation]

My question will be short. It has to do with minors.

How does the determination of a child's capacity to make a decision about their treatment differ from the determination of an adult's capacity to make the same decision?

[English]

Dr. Dawn Davies: Basically, in assessing the capacity of a minor person, we are trying to establish that they can have a full understanding of the information, and that they can process all the different alternatives available to them and make a decision that is reproducible if we have the same conversation with them again. What we're trying to establish is that they have an adult level of maturity and reasoning.

I think the difficulty is that the younger the child is, the more there are issues that may be at play in terms of trying to please others, including their parents and sometimes their religious and spiritual advisers, and they may even have beliefs about what is good for their family or what will be good for their siblings, for example. I think this is the reason that when it comes down to a life-and-death decision it's very often referred to the court, because those sorts of things are not clear. I think health care teams often want to refer to a higher authority for that decision to be made if the child is at risk of losing their life.

[Translation]

Mr. René Arseneault: Thank you.

I was very glad to see that, in your brief, you mentioned the fact that, in the Carter decision, the court responded to the factual circumstances in the case and that the decision leaves the door open, as other witnesses have told us, to other possibilities.

I'd like to come back to the issue of age. In your profession of pediatrics, is there any consensus, at least in terms of a minimum age at which there is no doubt in determining that a child cannot give free and informed consent?

[English]

Dr. Dawn Davies: I don't think there is any consensus. Even across provincial jurisdictions, the age of consent varies greatly, from 14 to 18. I think capacity really comes down to the individual patient, with the individual question that's being asked of them.

In general, the less weighty the outcome of the decision, the more we allow the minor to play a role in that decision. For example, for a very young child, it may be asking which arm they would like their intravenous started in because the risk of harm is so low. However, a child not wanting potentially life-saving chemotherapy if they have a good prognosis or not wanting any further treatment if they have just suffered from a terrible car accident, for example, are the cases that are much more difficult to assess.

• (1840)

[Translation]

Mr. René Arseneault: I'd like to stay on the same subject.

During your career, have you ever had to deal with a case where a very young child was in a serious accident and, as a result, sustained major injuries and had to decide whether or not to accept medical treatment? Have you ever had to consider or assess such a child's free and informed consent? If so, how old were they?

[English]

Dr. Dawn Davies: We had a case where it was a catastrophic accident. The teen in question was 17 years of age, so he qualified as a child at the beginning of the illness. Without saying too much more for the sake of confidentiality, a decision was made to treat that child in the immediate time after his accident despite his opposition.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Mr. Cooper.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): My question is directed to Dr. Rajji.

Dr. Rajji, from your experience, do all GPs have the training necessary to diagnose psychiatric conditions?

Dr. Tarek Rajji: By training, yes. That's part of the training for all GPs; they can make a diagnosis of a psychiatric condition. Sometimes when it's not a straightforward psychiatric condition, they may refer the individual for a consultation.

Mr. Michael Cooper: How do you know if it's straightforward or not straightforward? Could you explain that?

Dr. Tarek Rajji: By straightforward, I mean following the way that we make a diagnosis. Clinically, there is a textbook where there's very clear criteria about how to make a diagnosis of a major depressive disorder or schizophrenia. When the presentation is not consistent with one of the criteria or the set of criteria, what we call the differential diagnosis is complex. When it's not clear that this was a depressive episode with psychosis or schizophrenia, then a referral is typically made for diagnostic clarification. That's when the clinical presentation does not fit in one category, a simple category.

Mr. Michael Cooper: The College of Physicians and Surgeons of Nova Scotia recently issued a standard of practice, and it provides that where the grievous and irremediable condition is a mental illness, either the first or second physician must be a psychiatrist.

My question for you would be in terms of dealing with a situation where, for example, there may be a grievous and irremediable condition that isn't a mental condition, but the person suffers from some sort of psychiatric condition which goes to the question of capacity. In those situations, is a psychiatric opinion necessary? Also, would a GP, for example, have the ability to, I guess, tease out the issue of a grievous and irremediable condition from that of a psychiatric condition, which may be the underlying motivation for the request?

Dr. Tarek Rajji: That's a great question. We also discussed that at our panel at CAMH.

I think it's critical to have a comprehensive capacity assessment for someone who has a mental illness but is suffering from a non-mental illness which could be the grievous and irremediable condition. As you are suggesting, I think it would be critical to evaluate whether the request for PAD, for example, is being driven by the mental illness itself or the view of their physical illness as influenced by the mental illness.

That's something, as psychiatrists, we engage in even now with different types of decisions. For example, when one of my patients has a chronic mental illness and they develop cancer, let's say, the oncologist would consult me to see if the decisions being made around the cancer treatment are influenced by the comorbid mental illness of schizophrenia, and how much the refusal or acceptance of a treatment is influenced by the cognitive distortions or beliefs that are driven by the mental illness.

• (1845)

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Mr. Rankin.

[Translation]

Mr. Murray Rankin: Ms. Sansoucy will ask the first question.

Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP): Mr. Chair, I'm going to share my time with Mr. Rankin.

I'd like to thank the witnesses for their presentations. My question is for the Centre for Addiction and Mental Health representatives.

Mr. Lemmens told us that, in his view, the request should be considered by a committee made up of four members. Other witnesses told us—

[English]

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Could I ask you to stop for a second, please. Apparently the translation is not working. I have paused the time.

[Translation]

Ms. Brigitte Sansoucy: Thank you, Mr. Chair.

My question is for the Centre for Addiction and Mental Health representatives.

Mr. Lemmens told us that, in his view, the patient's request should be considered by a committee made up of four people. Other witnesses told us that a physician should be involved, some said two physicians, others said one physician and one psychiatrist, and others still said that a judge should be involved.

You told us that the request should be considered by a panel. I'd like you to tell us who should sit on that panel, as well as whether that component should, instead, come under the provincial and territorial legislation that will flow from our decision at the federal level.

[English]

Dr. Tarek Rajji: Thank you for the question. I will address the issue of the participation of a psychiatrist in these committees, and maybe Kristin can also talk about other potential members of such committees. It's also something we discussed in our panel at CAMH.

For individuals who don't have a mental illness before they develop a physical one that is an irremediable and grievous illness, I don't think it is always necessary to have a psychiatrist as part of the panel. However, many of the individuals who develop a terminal illness will develop a new mental illness, in the form of major depression or sometimes in the form of a psychosis. If there is a suspicion by the primary treatment team that there is a psychiatric condition that either happened before the physical illness or after the physical illness, I think engaging a psychiatrist at that level and as part of the panel would be important. Again, this is related to my previous answer about assessing extensively and in depth the issue of capacity.

Ms. Kristin Taylor (Vice-President, Legal Services, Centre for Addiction and Mental Health): With respect to the team that would be involved in the decision-making along with the patient to see whether or not the criteria were met, I think my friend has addressed that.

Where we would consider a panel or a board, such as the Consent and Capacity Board here in Ontario, would be where decision-making was required to be appealed, where the patient who was making the request was refused by the clinical team, the advisory team that was in place. It would be a place to go where the issues or the point of contention could be heard and properly addressed. As to the make-up of that committee, here in Ontario we have a psychiatrist or a medical practitioner, a layperson, as well as a lawyer. The combination seems to make sense. The competencies of that tribunal could certainly address these types of issues, although they are extremely complex and certainly new to that board.

The other aspects...perhaps if it's not an appeal, but there are certainly issues that come up in the context of the process itself, we would look to that board or that tribunal as well.

Mr. Murray Rankin: Thank you.

I would like to build on what my colleague asked you in regard to the Centre for Addiction and Mental Health. It's the same question, I suppose, but in a different way.

Ontario has the Consent and Capacity Board, as you referenced, as a review mechanism, but the only other province or territory that has a similar one is Yukon. I'm just wondering what you would suggest, what alternatives might provide similar safeguards elsewhere in Canada.

Also, are you suggesting that we create a board federally so that we have consistency, or leave this to the provinces and territories?

• (1850)

Ms. Kristin Taylor: To answer the first part of your question, I believe all provinces and territories do have health profession appeal boards of some sort. Whether or not it's a consent and capacity board, there are health appeal boards where decisions or issues that come up in the clinical setting or health care setting would go. I don't have my jurisdictional chart on that, but that's where I would look if there isn't a tribunal or a board specific to the mental health in the consent and capacity aspects.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Could you sum up quickly, please.

Ms. Kristin Taylor: I missed the second part of the question.

Mr. Murray Rankin: Perhaps you could provide it later.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Could you provide the answer in writing later?

Ms. Kristin Taylor: Yes, we would be happy to do that. I apologize.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Senator Seidman.

Hon. Judith G. Seidman: I would like to address my question to Dr. Rajji with the Centre for Addiction and Mental Health. Dr. Rajji, my understanding from my documentation here is that you're chief of geriatric psychiatry.

Dr. Tarek Rajji: Yes.

Hon. Judith G. Seidman: In that case you may be well placed to answer an issue, or at least give us your opinion on a question that has recurred.

With regard to advance directives in countries that permit PAD, individuals with mental health issues, including dementia, are treated differently with regard to advance directives. In the Netherlands, patients are permitted the use of advance directives to outline their wishes while they're competent. In the U.S., they're not. Quebec originally included advance directives, but then removed it from the final version of their bill.

Should our committee consider advance directives to ensure the will of individuals who lack capacity so they are able to access PAD?

Dr. Tarek Rajji: This is a question that I think we are also starting to discuss at our panel at CAMH. I don't think we have clear, specific recommendations at this point. The complexity of the issue is that the capacity changes, and that's why the advance directives are important. When individuals may wish to have PAD at that time they may not have the capacity to execute it. However, the wish itself also could change.

From a clinical perspective, again, while dementia has probably a more predictable degenerative course in terms of the natural history compared to what I presented, it's also hard to predict the mental state the individual would experience. When they are incapable of making these decisions is not black or white.

I've seen individuals in the late stage of dementia who are quite content just to sit in a chair and smile. In some sense the neurodegeneration didn't result in severe anxiety or pain and they are dependent in their functions, but they seem to be content versus other individuals who have a different course and exhibit severe suffering at the later stage of the illness.

I'm sharing the complexities of the issue rather than sharing a specific recommendation. The wish may change the mental state of the individual even though they may be lacking in capacity, but the suffering itself may be different between one individual who is capable and projecting and imagining what it would be like for them when they are in that advance stage based on what they know of other individuals versus what could happen 10 years down the road from when the diagnosis was made.

Hon. Judith G. Seidman: We had quite a stark presentation the other day about the last year of life of someone with dementia. It's probably in all our minds.

We were asked to think about how we would feel with a family who had dementia, or even ourselves, and would we want to ensure that we wouldn't have to endure this terribly stark picture of the last year of life with the privilege of being able to say in advance with an advance directive while we were still competent that we wouldn't want to and that in fact, someone might end their life far earlier while they were still competent if they didn't have the assurance that they'd be able to provide an advance directive.

• (1855)

Dr. Tarek Rajji: I understand the complexity of it and I think there needs to be a more in-depth discussion about the advance directive in such individuals. It is not black or white.

Hon. Judith G. Seidman: Thank you very much. I didn't mean to put you on the spot.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you, Senator.

Senator Joyal.

Hon. Serge Joyal (Senator, Quebec (Kennebec), Lib.): Mr. Chair, I would like to address my question to the Canadian Paediatric Society, and in particular to Ms. Mary Shariff. My question deals with the status of Canadian law in relation to minors in reference to health services. It might be easier for you to comment.

I would like to refer you to a decision of the Supreme Court in 2009. It's a majority Supreme Court decision that you probably know of, *A.C. v. Manitoba (Director of Child and Family Services)*, whereby the Attorney General of Manitoba and the ones in British Columbia and Alberta intervened in the case. I would like to quote paragraph 46 of the decision, wherein the court stated the following:

...common law has more recently abandoned the assumption that all minors lack decisional capacity and replaced it with a general recognition that children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding.

In other words, they have the right to make those decisions. It continues:

...the right to make those decisions varies in accordance with the young person's level of maturity, with the degree to which maturity is scrutinized intensifying in accordance with the severity of the potential consequences of the treatment or of its refusal.

In other words, it's not a blanket exclusion. They say that as much importance as the decision has for the young person making it, so much more demanding is the scrutinizing of the various sets of criteria that the court has stated at paragraph 96. There are seven of them.

It seems to me that we cannot exclude this, as you suggested, and have a blanket decision that all youngsters below 18 would not be competent. I think they would be competent, but the test of analyzing their competency would be more stringent, because for the decision and the impact of the decision, of course, we know it's about life, and life especially is one of the seven criteria that the court established in that decision.

It seems to me that if we are to legislate in relation to age—or I should say generally the criteria of accessibility—I think we have to take into account that decision of the Supreme Court, which is very recent. It was in 2009.

Dr. Mary Shariff: I absolutely would agree with you. One of the things that I'm trying to point out is that there's a distinction between the procedure for assessing capacity and the substantive criteria, right? So yes, we have a procedure in place that can assess the decision-making capacity with children, but that doesn't actually answer the question of whether or not minor children or non-adults—children and teenagers or adolescents—should be able to be given access to physician-assisted death in the first place.

There's a huge ethical component, and ethical data that was not available at the Supreme Court with respect to children was available with respect to adults. The Supreme Court decision didn't just rest on an adult's capacity to choose physician-assisted death. It actually rested on a number of different evidentiary bases to determine, when the arguments were made under section 7—life, liberty, and security—the issues around dignity, the burden on other people, and so on and so forth. We haven't heard any data with respect to what a child's feelings are in terms of when they have a particular type of illness.

I think what I'm trying to say is, yes, absolutely, we have processes to assess a child's capacity, but we have not looked from that ethical data perspective at the substantive question of whether or not they should be given that access in the first place, which would involve consultation with pediatricians, families, and children, and then taking the next step in looking at the issue of process and determining whether or not they do indeed have the capacity to make that decision.

Does that make sense?

• (1900)

Hon. Serge Joyal: Well, I have a different opinion, but I don't think I have the time to express it.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): You're out of time.

Ms. Dabrusin.

Ms. Julie Dabrusin (Toronto—Danforth, Lib.): I would like to address my question to Dr. Rajji of CAMH.

Tonight we've talked about a couple of different scenarios involving mental health, and I would like your clarification as to how you see the difference between them and particularly on how that applies for eligibility.

We have a scenario perhaps where there is a person who has a mental health issue—I think schizophrenia was used as an example tonight. The person considers the situation to be grievous and irremediable, and the enduring suffering is intolerable, and that person is requesting physician-assisted dying.

Another scenario would be a request from a person who has some type of a terminal illness as well as a mental health issue such as schizophrenia. Can you perhaps tell us if you see a difference in what that might mean for eligibility, and what impact that might have?

Dr. Tarek Rajji: To give a completely hypothetical example, if someone has an illness like schizophrenia and they are having an acute episode of psychosis and they are thinking of death or requesting suicide or requesting PAD, it's because of a hypothetical belief that if they don't die, then the whole planet is going to turn into dust. There is a delusional belief that's driving the suicidal ideation or the request in that case. This is where the capacity assessment is important, to differentiate whether or not that request is driven by delusion or by a distortion that's driven by the mental illness.

A similar scenario could happen with someone—and I will change this example for privacy—who has schizophrenia but then develops a treatable cancer and is refusing the treatment because they believe that if they get the treatment, their sibling will get the cancer. In this case, the decision to receive a treatment or to request PAD because of the cancer is driven by the delusion that if they don't die, then their sibling will get the cancer. I think this is where it's important to engage a psychiatrist to assess the capacity and to determine how much of the request for PAD is driven by delusional thinking. I hope this answers your question.

Ms. Julie Dabrusin: Thank you.

Assuming that the person does pass a capacity assessment, so that the person does have capacity, and you have those two scenarios again, what would be the impact on eligibility?

Dr. Tarek Rajji: In the case where someone is requesting PAD because of schizophrenia, this is where the irremediable nature of the illness is not clear. We can't define it clearly. In the example I gave, some individuals are not acutely psychotic, but they believe there is no hope that they will recover from the illness they are suffering from. This belief about themselves, their view of themselves, is not psychotic according to medical terminology, but it is driven by social factors that have contributed to it, maybe because they've been abused since they were kids. Maybe they were bullied and then they lost their jobs because the person who was hiring them couldn't understand how to deal with someone with a mental illness. Over time, a person with mental illness builds up all of these beliefs of worthlessness or helplessness or hopelessness, but these beliefs are malleable. That's the recovery-based approach I referred to that could be used as an intervention.

●(1905)

Ms. Julie Dabrusin: I just want to jump in though, because there are two parts. You're discussing vulnerabilities, and we must absolutely investigate how to protect vulnerable people, but there was the initial question of simple eligibility, which was whether, to your mind, a person who has capacity but in these two different situations could be eligible under the Carter test.

Dr. Tarek Rajji: In the first example, it's hard to make a case for eligibility just because of the mental illness, because the belief will probably still be driven by the mental illness, or the implications of the mental illness, that they are subjected to. In the second example, they could be eligible if clearly the illness is not contributing to the capacity and they are suffering from a terminal physical illness considered by a board, by a consensus, or by the physicians to be irremediable. The difference is that in mental illness it's hard for us to see if just because of a mental illness the condition could be irremediable.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you.

Mr. Albrecht.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Thank you, Mr. Chair, and I want to thank all of our witnesses.

My first question is directed to Mr. Hashmi. Thank you, Mr. Hashmi, for drawing attention to what I believe is the foundational concept that all of us, as committee members, need to have, which is the basic intrinsic dignity of all human beings, regardless of deformity or disability.

We are blessed to have many Canadian doctors of many faiths and I'm sure many in your community are medical physicians. Would you care to comment on what degree of conscience protection you would like to see in the legislation, given the fact that we have the Carter decision? We would rather it wasn't there, but it's there.

What kinds of conscience protections would you like to see this committee include in the recommendations to our government?

Imam Sikander Hashmi: We would say that there should definitely be protection for individual physicians who want to avoid any type of participation in this type of procedure. I would also extend that to health care facilities that are faith-based to ensure that.... Again, it's a balance of rights. Those who want to stay away to whatever degree they feel is important for them, their faith, and their conscience, should have the ability to do so.

Mr. Harold Albrecht: Thank you very much.

My next question is for the Canadian Paediatric Society. I want to be sure that I heard you correctly. I thought I heard you say that the provincial-territorial expert advisory group did not consult with the Canadian Paediatric Society before it made its recommendations. Did I hear you correctly?

Dr. Dawn Davies: Yes, that's my understanding.

Mr. Harold Albrecht: Are you aware of any other stakeholder groups, and I believe that the Canadian Paediatric Society is certainly an important stakeholder group, that may have been excluded from consultation in the formulation of the recommendations by the provincial-territorial expert advisory panel?

Dr. Dawn Davies: As far as it concerns children, I'm not aware of any consultation with any child advocacy group, any child protective service, or the Canadian Paediatric Society.

Mary, is there anything that you can add?

Dr. Mary Shariff: I'm not aware.

Dr. Dawn Davies: No.

Mr. Harold Albrecht: Thank you.

I guess it's concerning for me as a committee member to realize that, especially when many times during these consultations we have heard the phrase, "Carter is a floor, not a ceiling", you as a pediatric society are recommending that we not go beyond Carter. I think that's very informative.

My last question is for the Centre for Addiction and Mental Health.

You indicated that you provide care for up to 30,000 patients who are dealing with various mental health challenges. You also indicated that it's difficult to say conclusively whether or not these conditions may or may not be irremediable. You commented on chronic and episodic features of mental illness, and even talked about how schizophrenia could in some cases be overcome to the extent that it may not be cured but that there are strong coping mechanisms.

I was so encouraged to hear you say in your testimony that you focus on hope, because I think that one of the conditions of what this committee is charged with is providing that hope. Part of providing that hope, in my opinion, is being sure that we are not opening the door for those who may be vulnerable, especially those with mental health challenges.

Because of the episodic nature and the potential for changing minds, and so on, can you assure us that we can put adequate safeguards in place to be sure that even 1% of that 30,000 is not allowed to end their life prematurely, unintentionally, because of an episodic issue with depression?

We were informed earlier by some of our witnesses that the concept of safeguards might actually be an illusion. I just wonder if you could comment as to whether or not we can be sure, as committee members, that we can, in fact, put adequate safeguards in place.

• (1910)

Ms. Kristin Taylor: That is a big ask.

This is one of the areas that we talked about in our working group, the concept of vulnerability for our patient population, and as we talked about earlier, the social determinants being part of that sense of hopelessness in patients suffering from mental illness, particularly depression.

The safeguards that I think you're being asked to craft need to take into account that there will be people who are seeking this type of assistance as part of their illness to end their lives prematurely. I think one of the safeguards that we are considering is that clinicians here have the ability to conscientiously object, based solely on our focus on hope and recovery. As we've gone through our discussions, the clinicians are struggling with when our conversations with our patients in our treatment take a 180-degree turn and start to talk about how they could end their lives today—

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): I'm going to have to ask you to wrap it up.

Could you sum up your answer quickly, please.

Ms. Kristin Taylor: Yes, sorry.

To sum it up, you have a very large task ahead of you, and anything we can do to assist, we are happy to do.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you.

Thank you, Mr. Albrecht.

Senator Nancy Ruth.

Hon. Nancy Ruth: Senator Seidman, do you have a question?

Hon. Judith G. Seidman: Yes.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Are you deferring your time to her?

Hon. Nancy Ruth: Yes.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Senator Seidman.

Hon. Judith G. Seidman: Thank you.

I believe it was the Canadian Paediatric Society, so perhaps it was Mary Shariff who spoke about the first iteration of Canadian physician-assisted death legislation.

In light of our discussion here about data, oversight, monitoring, and input to a legislative process, I was interested that you used the concept of the first iteration, because I had a feeling that you were thinking about a second iteration or a third iteration.

Might you please explain why you used that language, and what it implies?

Dr. Mary Shariff: I used that language because Carter can be construed very narrowly. It seems to me there is a pre-emptive discussion for including other individuals, such as children and minors, and other types of conditions, for example, through the advance directive, all at this time pre-emptively, in anticipation that there might be a charter challenge.

We know there could be a charter challenge simply because of the nature of the arguments that were made in Carter. Many arguments can be made on the section 7 right-to-life argument that unless they have this down the road, they will take their lives sooner. Many things can fall into that.

Because there wasn't any data in the Carter case with respect to minors, for example, and there was no discussion on advance directives.... I know there's this idea floating around about the floor and ceiling. I'm not particularly fond of that analogy, metaphor, or whatever you would call it. I think that we need data. We need to understand.

Even with Belgium there's controversy, but we're looking at something similar to a Belgian scheme. I think right from the beginning of the trial decision we were looking at a Dutch-Belgian scheme in Canada. There's no secret to that.

In Belgium when they looked, for example, at children, they put their law in place in 2002 and didn't start thinking about minors, other than emancipated minors, until 12 years later, so they had time to actually gather data and look at the evidence. That data around minors is simply not before the Supreme Court.

The decisions and the arguments around sections 7 and 15 are based on experiences with respect to adults who are requesting a particular service, a termination-of-life service, and we don't know how the essence of those arguments is transferrable to minor children. It's as simple as that.

When I say "first iteration", I'm not sure.... If the argument is that we can move forward with this because there's only a handful of people that it involves, let's be prudent and not rush to put it all in. Let's gather some information. We're Canada. We're not the Netherlands. We're not Belgium.

• (1915)

Hon. Judith G. Seidman: So you're saying the strictest interpretation of Carter to begin with perhaps.... In the first round of legislation: data, monitoring, and input into maybe an update to the legislation. Is that what you're suggesting?

Dr. Mary Shariff: Something to that effect.

Hon. Judith G. Seidman: Thank you. I appreciate that.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Senator Cowan.

Hon. James S. Cowan: My questions are for the Canadian Paediatric Society as well.

In your presentation, you talked about the first iteration and the need to be very careful if we are to go beyond the adult capacity to younger persons. I was reading the bioethics committee's practice point document, which was originally posted in April 2011 and was reaffirmed on February 1 of this year. It deals with withholding and withdrawing artificial nutrition and hydration. I look at point 7, which says, "Medically provided fluids and nutrition can be withdrawn from children when such measures only prolong and add morbidity to the process of dying."

[Technical difficulty—Editor]

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Keep talking.

Hon. James S. Cowan: Okay.

How do you square that circle? How do you reconcile the presentation that you're making here tonight, urging us to be very careful and not to go beyond...above the floor, if you like, with the document that was originally posted in 2011 and then reaffirmed just the other day?

Dr. Mary Shariff: It's a simple answer. Carter doesn't limit to terminal illness, to a terminal phase of a terminal illness. So those are cases, with respect to withdrawal of nutrition and hydration, in a child who is terminally ill. It's simple. Carter is not just about terminal illness.

Hon. James S. Cowan: So is that the basis for your distinction, on whether or not the illness is terminal?

Dr. Mary Shariff: One.

Hon. James S. Cowan: Okay. What else?

Dr. Mary Shariff: Well, with respect to what you're specifically....

Dr. Dawn Davies: I think that would be an hour-long lecture unto itself. The difference between euthanasia and assisted dying is

completely different from withdrawing treatments, medically provided treatments, that can confer no benefit to a child.

All I can say is that ethically and legally, that's very clear. I just don't think we have time to get into the particulars, but I feel very well versed in both of those, if we need to have further communication.

Hon. James S. Cowan: Thank you.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you, Senator.

Ms. Dabrusin.

Ms. Julie Dabrusin: Imam Hashmi, I thank you for outlining for us what you would see as a process under Carter. One issue that we've seen come up is the issue of effective referrals. If you saw a doctor who might conscientiously object because of faith issues, or any others, we had a suggestion from the BC Civil Liberties Association that one option would be for the doctor to not refer to someone else but to report to someone within the hospital setting, "I have objected to a treatment". That's all they do, and then someone steps in.

Does that seem like a system that would be agreeable to you?

• (1920)

Imam Sikander Hashmi: I think so. We have to respect the rights of the doctors or the health care providers with regard to their beliefs and their conscience, but at the same time we have to respect the Carter decision as well and the individual rights of the patients.

In that case, yes, if a physician went to their supervisor or whomever within the organization and told them, "This is the request that has come to me, now you take care of it", I think that should be fine.

With regard to the proposed end-of-life team that you're talking about, if a request was made, then this team could go and present options. I think for many doctors, at least from the Muslim faith, it perhaps would not present a problem, because they're talking about the options available and they're not talking about just one option, which is physician-assisted death.

I don't really foresee any issues with regard to that.

Ms. Julie Dabrusin: Thank you.

My other questions were in fact for the person who has now been cut off.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): For the benefit of everyone here, it was at the other end that the conference ended.

Ms. Julie Dabrusin: Is he coming back?

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): We're trying to make a connection, but there is no return on the contact.

The Joint Chair (Mr. Robert Oliphant (Don Valley West, Lib.)): You could ask the question and get it on the record. Then we could get a written response from them.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Exactly.

Ms. Julie Dabrusin: I appreciate that. Thank you.

My question, then, is for Dr. Rajji.

In describing the scenarios and the assessment of whether an illness is irremediable, I'm not sure it's been taken into account that Carter does not require a patient to accept treatment. I would like to have his assessment on the eligibility question for mental health issues, somebody who has purely a mental health issue or an overlying mental health issue with a terminal illness, in the scenario where a patient under Carter does have the right to say that they do not want to pursue any further treatment for their mental health issue.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): The clerks will be in touch. We'll see if we can get an answer for you on that.

Thank you very much.

The co-chair has been granted the next Liberal turn in the cycle. I will turn the questions over to him.

The Joint Chair (Mr. Robert Oliphant): I would like to ask CAMH officials, Dr. Rajji in particular, a few questions as well.

How do they engage patients in the working group they have established on physician-assisted dying? How many patients are on their committee? What has the patient response been to the questions raised?

I would similarly ask the Canadian Paediatric Society how you involve and engage children in the discussion of their health issues. You have referred to something called ethics data. Having studied ethics post-secondary in a number of courses, I have no idea what ethics data is. Perhaps you could explain ethics data, not ethical data, or ethic data—I wasn't sure what you said—and what that actually means. I even googled it and couldn't find an answer.

As well, in terms of how you engage children, Manitoba has a very robust plan for the way they engage children in some health research. I'm wondering how you have done it to get specifically the position you've presented tonight.

Dr. Dawn Davies: I'll start. I don't think it was my piece of the submission, and we didn't mean to be misleading or confusing in any way. Suffice to say that the Canadian Paediatric Society has not had any discussion about this as a group yet in that the provincial and territorial findings were only released at the end of November.

In terms of how we include children and families in decision-making, many hospitals have—

The Joint Chair (Mr. Robert Oliphant): It was specifically referring to children who have rights, specifically children, not families. It was children.

Dr. Dawn Davies: Okay, I'll give you the example of chemotherapy. Explaining the chemotherapy, what's entailed, what will be happening to the child, is proportional to how much the child wants to hear, how much the child wants to give over to the parents —

The Joint Chair (Mr. Robert Oliphant): I'm sorry, I wasn't clear. You've presented a position tonight and I'm wondering how you've involved children in developing your policy position, which both of you have articulated. I understand children's involvement in their care decisions, but in your policy decision.... You've spent quite a bit of time articulating a policy decision tonight. Maybe they are personal opinions. I thought they were actually from your

organization, so I might be confused. Are they personal or are they organizational?

•(1925)

Dr. Dawn Davies: They're organizational in that we had six days to pull this together. It has been to the executive of the CPS. We decided to stick to the overarching themes that we wanted to get across, about which we thought there would be consensus, and what we want to be clear about is there has been absolutely no discussion with health care professionals, children, families across the country about this issue, and for that reason we think it would be absolutely premature to include it as it's not prescribed by Carter that we do so.

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

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you.

Dr. Rajji, can you hear us?

A voice: Yes, we can.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): While you were offline in inner space we had two questions that were directed to you. The clerks will be in touch with you with the written questions, and we would appreciate your getting back to us with the briefest possible delay. Is that fine with you?

Dr. Tarek Rajji: That's very fine, thank you.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you very much.

The last question will go to Mr. Albrecht.

Mr. Harold Albrecht: Thank you again, Mr. Chair.

I just have another question for the Canadian Paediatric Society.

You pointed out that quality palliative care must be accessible for children and youth, and you extrapolate from some British Columbia data that indicated 10 out of every 10,000 children are in need of palliative care services, and yet with that very low number, 10 out of 10,000, you indicate that only 5% to 12% would have benefited from palliative care services in terms of what was available to them. I think you're pointing out to this committee again the extremely low level of palliative care options that are available, especially in terms of palliative care for children. We know in a general sense from the expert advisory panel that only 55 out of 77,000 Canadian physicians are specialists in palliative care. These two very concerning issues point out that we need to do better.

My question would be this. Are you saying in your submission that for physician-assisted death to be offered, before that happens we at least have to be able to offer extensive palliative care options to children who may, in the future, be requesting this procedure?

Dr. Dawn Davies: That's a personal opinion, but I think I can also speak on behalf of the CPS. That is exactly what we're saying. It's absolutely premature that we would expect that children should be able to ask to end their lives when we have completely inadequate national palliative care services available for children. Just for the record, there are fewer than 20 full-time physicians in Canada who are providing specialized palliative care services to children, and very many front-line community health professionals, be it family doctors or home care nurses, are completely devoid of any training or experience in caring for children with life-limiting illnesses.

Mr. Harold Albrecht: Thank you.

I may have missed it in your earlier presentation or your response to a question, but what is your current definition of an adult? Is it 18, or something other than that?

Dr. Dawn Davies: I think for the purposes of your legislation, I would say 18 is an adult. I would be as conservative as you can possibly be.

Mr. Harold Albrecht: I like your being conservative.

I'm going to share the rest of my time with Mr. Warawa.

Mr. Mark Warawa: Thank you.

I want to thank Imam Hashmi for being with us.

Do you have a handout?

Apparently, it's not in both official languages, but we could come back and meet with you after the meeting. Would you have a handout that is your testimony?

Imam Sikander Hashmi: We can absolutely make that available.

Mr. Mark Warawa: Thank you.

Just for clarification, on the conscience issue, you said that physicians of faith and institutions of faith should not have to be involved. Are you saying in participating and not having to refer?

Imam Sikander Hashmi: No, they would refer, but we're talking about participation in the practice.

Mr. Mark Warawa: Thank you very much.

Mr. John Aldag: Mr. Chair, I don't know if this is a point of order or not, but we were able to overcome the technical difficulty. Although I agree with sharing and we moved to share, I just wonder, since we have the others back online, if we could get the two questions that were asked to be answered really quickly. I think it would help all of us to hear the answers, instead of waiting for a written deliberation.

• (1930)

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): I'll put it to the committee.

Is it agreed?

Some hon. members: Agreed.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you, committee.

Dr. Rajji, you're going to be back on. Let's see, the first one was from Ms. Dabrusin, and the second one was from the co-chair.

Ms. Dabrusin.

Ms. Julie Dabrusin: Let me see if I can do this.

The Joint Chair (Mr. Robert Oliphant): Do you want time to think? I can ask my question.

Ms. Julie Dabrusin: No, it will just be a slight variation on how it was said.

When you were talking about "irremediable" earlier, Dr. Rajji, you were talking about the availability of treatments and about not being able to assess how treatments are going to succeed or not, but the Carter decision doesn't actually require a patient to accept treatment. A patient can decide that they do not want to pursue further treatment. Taking that into account, I was wondering how you would see that affecting eligibility for a person with mental health issues.

Dr. Tarek Rajji: When I was talking about the irremediable nature of the illness, I was thinking of three concepts. The first is the natural history of the illness itself. There is no proximity of death or inevitable death associated with mental illness the way there is with some other medical disorders. By natural history, for example, 25% or more of individuals with schizophrenia may recover if they wait long enough, and they may recover completely from schizophrenia.

The second point is that—

Ms. Julie Dabrusin: To clarify, is that spontaneously or with treatment?

Dr. Tarek Rajji: We don't know. We don't have enough knowledge about this. Most people would have had some form of treatment. Whether it's because of the treatment or natural history, it's hard to tell what is causing that. These are longitudinal studies that would take 10 years, 20 years, 40 years sometimes to get that knowledge.

The other issue is the issue of suicide. It does happen, but again, we don't know when it's going to happen or if it's going to happen. We have good knowledge about the factors that increase the risk.

The third point is related to medication and whether someone would respond or not and even without responding to a treatment, whether they would recover naturally. We know, for example, with depression that people who do not have any treatment for depression or depressive episodes will eventually recover from it. We don't know exactly when.

The other part of the issue, the second big concept related to the irremediable nature of the illness, is that even for individuals who have the symptoms and still experience the episodic nature of the illness, there is a recovery approach that we take on to help individuals live with the illness. Because of that lack of inevitable and progressive course towards death, in some sense, we have the luxury and the hope of working with someone, even if they are refusing treatment. I can think of specific examples of individuals and patients I have seen in the last week or so who are refusing treatment but are still coming to see me, because my point to them is that I will be there if they come back to see me. We will keep working on talking about the issues related to treatment or recovery, and about how to live with the illness, so that the illness doesn't become—

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): I think we understand the overall answer to your question. This could go on for some time, so I'm going to ask Mr. Oliphant.

The Joint Chair (Mr. Robert Oliphant): I think mine is quicker. I think you said earlier that you have a working group established on physician-assisted dying, and that it is in process.

Dr. Tarek Rajji: Yes.

The Joint Chair (Mr. Robert Oliphant): How are you engaging your patient population in that? How many patients are on the working group? You have 30,000 patients you treat every year. How many of them are engaged in your process, and how are they engaged?

Ms. Kristin Taylor: Our working group committee is a subcommittee of our medical advisory committee in the hospital. As we indicated, it's an interprofessional group, with legal as well as ethics. We have a representative with our empowerment council, which is a patient advocacy group that works within CAMH but is actually separate from it. Their role on our committee, as well as many other committees within our organization and externally, is to be the patient's voice.

The Joint Chair (Mr. Robert Oliphant): Is that one patient?

Ms. Kristin Taylor: Sorry, it's one patient representative, but she is undertaking, as part of the empowerment council work, consultations external to this committee. So although it's one person who sits on the committee of, I think, seven or eight of us on the

working group, the patient's voice is being brought to us through this representative.

● (1935)

The Joint Chair (Mr. Robert Oliphant): Would you call it a patient-centric process? Your minister who funds you, Mr. Hoskins, has suggested that every process in every hospital should be patient-centric. Would you describe that as patient-centric?

Ms. Kristin Taylor: Yes, I think so.

We have the clinicians at the table as well as the patient voice. I can assure you that if she didn't feel we were doing a good enough job, she would let us know.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie): Thank you very much.

Witnesses, thank you very much for your testimony here. You've all been very articulate, and we thank you very much for that.

Committee, I thank you for your patience.

I need to remind you that in this room, tomorrow afternoon at 4:30, the committee meeting will begin. How it proceeds depends on your House of Commons fellows' decisions tomorrow with regard to their votes.

With that, I declare the meeting adjourned.

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