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Co-Chairs

The Honourable Kelvin Kenneth Ogilvie
Mr. Robert Oliphant

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● (1635)

[*English*]

The Joint Chair (Mr. Robert Oliphant (Don Valley West, Lib.)): I'm calling our 12th meeting of the Special Joint Committee on Physician-Assisted Dying to order. It's good to see our committee members here. I believe we have quorum.

I'd like to thank the witnesses who are our guests today for joining us and for offering their wisdom and expertise.

We have four people but three witnesses coming forward today. I'm going to suggest we do the video conference witnesses first, followed by Dr. Somerville after that. I'm going to suggest that we begin in Alberta and welcome Carmela Hutchison, the president of the DisAbled Women's Network of Canada.

Welcome, Ms. Hutchison. You have 10 minutes, and after that we will go to Vancouver, and then after that to Dr. Somerville.

Thank you.

Ms. Carmela Hutchison (President, DisAbled Women's Network of Canada): Good afternoon.

I would like to acknowledge the traditional lands of the Algonquin peoples, where you are gathered, and the traditional lands of Treaty 7 first nations, from where I'm speaking with you today. Because we're televised, I also wish to acknowledge all other first nations, Inuit, and Métis peoples across Canada.

I also wish to thank the staff of the Peter Lougheed Centre, who made my appearance here today possible, but most importantly, I wish to thank them for saving my life.

DAWN-RAFH Canada has advocated on behalf of the interests of women with disabilities and deaf women as a party intervener before the Supreme Court of Canada in over a dozen cases. DAWN-RAFH Canada has presented legal arguments on both section 7 and section 15 of the Charter of Human Rights and Freedoms in cases on behalf of women with disabilities, which have brought the perspective and advanced the rights of women and people with disabilities.

The DisAbled Women's Network of Canada's mission is to end the poverty, isolation, discrimination, and violence experienced by women with disabilities and deaf women. DAWN-RAFH Canada is an organization that works toward the advancement and inclusion of women and girls with disabilities and deaf women and girls in Canada.

During the first year at DAWN-RAFH Canada of our national executive director, Bonnie Brayton and I were alarmed because we were approached by three women concerned that “do not resuscitate” orders were inappropriately applied to their family members. While I have been in hospital since December 18, 2015, I have been approached three more times by women with similar concerns while in a private room, twice in the span of five minutes.

On December 23, 2015, a friend who was visiting me in the ICU got a phone call that her uncle, for whom she is guardian, was being admitted from his nursing home to hospital. When she met him there, doctors told her that she should not consider treating him. They compared him to an old car that was not worth investing in. She insisted he be examined, and it was merely a urinary tract infection requiring rehydration and antibiotics.

Yesterday, a friend recounted that her husband had been repeatedly sent home from the emergency room while he was having a stroke. Upon being admitted to yet another hospital, he was being treated and developed heart failure because his fluid balance was upset. The doctors pressured her and her husband to not treat him. Upon summoning the cardiologist, the fluid balance was corrected and he was well within four days.

Five minutes later, I received a referral from a woman in the community who learned of a man whose wife has terminal breast cancer. This is his email that he asked me to read to you. He wrote, “What happened was that my wife, Sylvia, was rejected for getting help, as they said she was too heavy for care workers to lift. She cannot use her left leg or arm. She was visited by the nurse in charge and let know the news. I came to find her upset and crying, as well and scared.”

As part of palliative care, there must be support for family members and caregivers, as you can only imagine the toll on their mental health.

As well as a national and provincial leader in the women's disability movement, with experience in the mental health movement and the disability sector, I've been treated much like the prophetess Cassandra, whose prophecies were true but never believed. As a woman with multiple disabilities that make me ineligible for most treatment programs, and as a survivor of profound childhood abuse, my fear of physician-assisted death is visceral. The entire board of DAWN-RAFH Canada shares that fear, as do many of our colleagues across the disability sector.

When Canada ratified the Convention on the Rights of Persons with Disabilities, everyone was excited and for the first time, we hoped that things would become better for our folks, particularly with article 6 emphasizing the disadvantages faced by women and girls with disabilities. You can imagine our shock when Canada did not ratify the optional protocol. That was just the beginning.

Canada then made profound cuts to every aspect of both government and non-government women-serving organizations and agencies. Then, without building up resources to alleviate violence, economic disparity, crushing poverty, unequal opportunities for education, a lack of disability transportation, home care, palliative care, hospice care, housing, disability, and mental health care, our Supreme Court of Canada, in the name of human rights, offers us the opportunity to die at the hands of the very physicians we're supposed to be able to trust to help us.

We do not have capital punishment in this country, nor do we extradite offenders to countries who do, because we are concerned that we may inadvertently execute an innocent person and cannot devise adequate safeguards to prevent this. Yet I find it alarming that in the name of individual rights our Supreme Court believes that we can.

● (1640)

The Carter v. Canada decision has rushed to judgment, compelling governments and Canadian society as a whole to make a rapid decision on matters Canadians have not had proper time to fully understand or consider. The Government of Canada must use the notwithstanding clause to stop physician-assisted death from moving forward as it is moving too quickly. Procedures and safeguards are insufficient as are alternative resources to physician-assisted death. No aspect of Canadian society has had an opportunity to really think about what it's doing. Canada needs to rethink its direction.

In the interest of time I will begin with my recommendations. A written brief has been submitted to the clerks and will be made available to you once it's translated.

Home care and palliative care must be made part of our health care and be equivalent across our country rather than chopping people into a geographic area. It needs national standards. Mental health care must be accessible to every citizen in our country before one dollar is spent on making review panels for physician-assisted death. We do not have enough dollars to save the thousands of people who die each year from suicide to spend one cent on the industry that will seek to kill our own people. Mental health care must have professionals who are cross-trained in trauma, addiction, and disability. We need to be sensitive to the needs of other cultures beyond a western view. Within the indigenous community, life is seen as sacred and the teachings point to this sacredness. To end life before one's time is finished on Turtle Island would be viewed by many as not honouring the life journey in a good way. It is vital that those perspectives from other voices be carefully considered.

For eligibility criteria a national comprehensive regulatory system is required to protect persons who are vulnerable to being abused from committing suicide in times of weakness. This is especially true for women who are particularly vulnerable. Women with disabilities need to have had a consultation with peer support groups before being eligible for physician-assisted death. Women are particularly vulnerable as a result of social or economic circumstances that diminish their resiliency.

Women with disabilities are at a greater risk of vulnerability because there is emphasis on compliance with caregivers or similar authority figures. This is especially true of women with intellectual disabilities, women with a lived experience of mental illness, and survivors of trauma. Also, women with disabilities are at greater risk because of violence and coercion. They also worry more about being a burden to others. Women with disabilities in representative organizations have much at stake in the designed delivery of any system developed to protect persons who are vulnerable from being induced to request physician-assisted death. It must be available only to competent adults with a grievous and irremediable condition that is the cause of enduring suffering intolerable to the individual, and only in a province that has high-quality palliative care, consistently and freely available to those who reside in that province. In itself disability is not a grievous and irremediable condition.

Request for physician-assisted death must be reviewed and authorized by an independent review panel with sufficient information to determine if the necessary criteria are met. Women with disabilities are horrified that physician-assisted death would be considered an option. For anyone under 18 years of age this is especially disconcerting in the light of Tracy Latimer's murder.

The Government of Canada must use the notwithstanding clause to stop physician-assisted death from moving forward. It is moving too quickly and procedures and safeguards to physician-assisted death are insufficient as are alternative resources. No aspect of Canadian society has had an opportunity to really think about what it's doing. Canada needs to rethink its direction.

Canada must ratify the optional protocol on the Convention on the Rights of Persons with Disabilities. The Convention on the Rights of Persons with Disabilities must be upheld, particularly articles 4, 6, 10, 19, 25, 26, 28, 32, and 33. Any measures of physician-assisted death must be mindful of complying with these articles. Also, they must uphold the Convention on the Elimination of All Forms of Discrimination against Women. They must also consider the complications as well as the benefits that can occur.

● (1645)

People need to consider what happens if a person awakens after having been administered a lethal dose of medication. What happens if the dose of medication is administered and it's too late and the person changes their mind? If a person survives the lethal assisted death attempt to come out of it more disabled, what happens? Has anyone considered what policies and procedures might be brought to bear in the event the first procedure fails? How many attempts should be made to start an intravenous line and what will the process be if one cannot be established?

The Joint Chair (Mr. Robert Oliphant): Could you wind up now, please?

Ms. Carmela Hutchison: Yes.

Physician-assisted death must never be applied as it was in the Golubchuk case where physicians' values were forced on the patient and his family. The Criminal Code should be amended so that counselling a person to commit suicide, or offering assistance to commit suicide, remains a Criminal Code offence except for physician-assisted death, if it passes.

We also need to think that women with disabilities often do not have primary care physicians. In acute care settings, they're not seen by the same doctor routinely, so that's another thing that has to be brought forward.

The Joint Chair (Mr. Robert Oliphant): I'm sorry, I have to cut you off. We're quite a bit over time.

Ms. Carmela Hutchison: I thank you for that.

The Joint Chair (Mr. Robert Oliphant): We ask you to stay by because we'll have questions, I'm sure, for you.

Moving to Vancouver, we have Margaret Birrell, president, and Angus Gunn, counsel, for the Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society.

● (1650)

Mr. Angus Gunn (Counsel, Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society): Honourable senators and members of Parliament, thank you for the opportunity to appear before you this afternoon.

With me is Margaret Birrell, who is president of the Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society. My name is Angus Gunn, and I have served, since 2011, as litigation counsel for the alliance. I have been asked to provide the prepared remarks this afternoon, and Ms. Birrell will be pleased to respond to any questions the committee may have.

The members of the alliance that I represent are leading advocates for disability rights in Canada and elsewhere. The alliance sought and obtained intervener status at all three levels of court in the Carter litigation to advocate for the right that was ultimately recognized in the Supreme Court of Canada. The alliance wishes to address five themes in its prepared remarks today, and we will be providing a written copy of these remarks to the committee clerks in due course.

The first theme is on the question of the committee mandate. The alliance urges that, in recommending a framework for a federal response on physician-assisted dying, primacy be given to the values of patient autonomy and dignity that Carter described as underlying the section 7 charter rights to liberty and security of the person.

The alliance also urges a commitment to co-operative federalism, in which the federal, provincial, and territorial governments deploy both legislative and non-legislative measures in the pursuit of a patient-centric, and to the extent possible, uniform Canadian response to Carter.

The alliance considers that these aims are best pursued by implementing physician-assisted death in Canada in stages. Carter has frequently been described to your committee as a floor and not a ceiling. As a practical matter, the declaration in Carter will come into force on June 6 of this year. The floor must be implemented by that date, and legislation is needed within weeks.

The alliance urges that whatever needs to be done to implement Carter be done, and that a robust longer-term commitment be made to determine where the ceiling lies—an even more complex debate that carries no judicial deadline and deserves fuller consideration over time through a proper white paper process.

The second theme is that of divided jurisdiction. Within a coordinated response to Carter, the alliance considers the ideal structure to be a minimalist federal legislative scheme paired with uniform and comprehensive provincial and territorial regimes. Under this model, Criminal Code amendments should be limited to providing that an act of physician-assisted dying that would otherwise meet the definition of a crime shall be free from criminal liability, so long as it accords with the law of the province or territory where the act occurred. The alliance favours that model because of the unsuitability of dealing with these matters through the criminal law power, whether through the Criminal Code itself or in a stand-alone statute that relies on the federal criminal law power.

Carter expressly conceptualizes the right to physician-assisted death as an aspect of patient autonomy in decisions concerning medical care. Both palliative care and physician-assisted dying should be treated as part of best practice end-of-life medical care. They are therefore matters whose pith and substance favour the provincial and territorial legislatures' taking the lead.

The alliance recognizes the challenges in realizing this ideal, and shares the concern that a patchwork quilt of regimes across the country could result. These concerns, however, do not overcome the constitutional constraints within which we are operating.

● (1655)

A comprehensive scheme created under the federal criminal law power would inappropriately treat what is fundamentally a health care matter as a criminal law matter and would be vulnerable, we submit, to constitutional challenge.

If no statute applies in the province or territory where the act occurred, then the void does need to be filled, but a comprehensive federal regime might not be the only option. It may be that existing standards and guidelines within the medical profession for dealing with other end-of-life decision-making provide the necessary guidance. Most colleges have either promulgated such guidelines or are in the process of doing so. Alternatively, regulations under the Criminal Code could perhaps designate a provincial or territorial scheme that would apply in the absence of one in the province or territory where the act occurred.

Whether the comprehensive regime is implemented federally or provincially, the alliance favours reliance on secondary legislation for much of the detail, so that the regime can evolve dynamically and not be codified by statute.

The remaining three topics deal with questions of eligibility and process, and they apply regardless of the level at which the comprehensive regime is implemented.

The third theme is no advance panels. A central thrust of Carter was the relationship between dignity and autonomy on the one hand, and timely access to physician-assisted death on the other. Adopting an advance panel procedure for accessing physician-assisted death would create barriers and burdens, and it would erode or even extinguish the very rights recognized in Carter. To go still further and require a court order would wrongly judicialize what Carter viewed as an intensely private decision within the patient-physician relationship.

These risks are crystalized in, for example, the practice advisory issued by the Ontario Superior Court of Justice six days ago. Among other things, it requires that both the federal and provincial attorneys general be notified of an application for exemption from the Carter decision, and it also contemplates notice being given to family members.

Would all of those actors have standing to oppose the request? If so, why? Extensive affidavit evidence is required not only from the applicant and his or her attending physician but also from a consulting psychiatrist and the proposed physician who would assist death, if that person is not the attending physician.

How many weeks would this application take to be heard? How long would the court reserve judgment? Could the court's order be further appealed? Who would pay for these psychiatrists and lawyers? These hurdles are onerous, inappropriate, and antithetical to Carter. The law should not force those whose only wish is to escape grievous and irremediable suffering to spend what they hope will be their final days embroiled in litigation.

The fourth theme is that advance directives should be honoured. Carter accepted that the impugned Criminal Code provisions robbed individuals of their section 7 rights, in part by forcing them to choose between premature death or suffering until death by natural causes.

The alliance considers it essential in implementing the Carter floor to honour advance directives if the spectre of premature death is to be avoided. Advance requests for assisted death should be valid when made by a patient who, at the time of the request, was competent and had a diagnosis for a condition that was or could become grievous and irremediable, including dementia.

Fifth and final is conscientious objection. Carter recognized that nothing in its declaration would compel physicians to provide assistance in dying. The alliance submits that a comprehensive scheme should enable doctors to opt out, but only in a manner that imposes no burden on patient care and ensures continuity of care.

● (1700)

The protection of a physician's right to conscientious objection must not impair the ability of a patient eligible for physician-assisted death to access it. Conversely where a physician's conscience favours the provision of physician-assisted death, no health care institution should be able to impede that physician's ability to provide that form of health care within or outside the institution.

Thank you again for the opportunity to provide these prepared remarks and to participate in the important work of this committee.

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

Ms. Somerville.

Dr. Margaret Somerville (Professor, McGill University, As an Individual): Thank you for your invitation to appear before this committee. I'd like to put on the record, as you might already know, that I believe that euthanasia and physician-assisted suicide—what the Supreme Court calls physician-assisted death or dying—are inherently wrong and should remain criminally prohibited. That said, I'm willing to provide some recommendations for limiting the harms and risks of legalized euthanasia. Please note that in using the word “euthanasia”, I intend to refer to both euthanasia and physician-assisted suicide.

The Supreme Court recognized that the values of respect for individual autonomy and sanctity of life, especially protection of vulnerable people, were competing claims and that both had to be taken into consideration. “On the one hand”, the court wrote, “stands the autonomy and dignity of a competent adult who seeks death as a response to a grievous and irremediable medical condition. On the other stands the sanctity of life and the need to protect the vulnerable”.

In the past, in many societies, including that in Canada, religion was the main institution used to uphold the value of respect for life at a societal level. Respect for life is a preferable term to sanctity of life, because respect for life is not just a religious value; it's a foundational value in every society in which reasonable people would want to live. It must be upheld at two levels, that of the individual person and that of the society in general.

In a 21st century secular western democracy such as Canada, medicine and law are the main institutions carrying the value of respect for life for society as a whole. Both are implicated in physician-assisted death, which would damage their capacity to carry this value. It is in every Canadian's interest to make that damage as small as possible. So, to the question you asked me to address of what “framework of a federal response on physician-assisted dying...[would] respect the constitution, the charter of rights and freedoms, and the priorities of Canadians?”, I would add, “and do the least harm to the value of respect for life and to health care professions and institutions, and present the fewest risks for vulnerable people both in the present and in the future.”

I have that extended question in mind in making the proposals that are now outlined. As the court made clear in Carter, access to physician-assisted death—euthanasia—on certain conditions is an exception to the criminal prohibitions of culpable homicide and assisted suicide. Other than that very limited exception, those crimes remain in force. To avoid the future normalization of euthanasia, as has occurred in the Netherlands and Belgium, and which would have very serious consequences for future generations of Canadians, the legislation you pass must make it clear that euthanasia is such an exception, that it should be used only as a last resort, and then rarely.

If Canada had the same percentage of deaths by euthanasia as is presently the case in the Netherlands and Belgium—about 4% in the Netherlands and 4.6% in Belgium—we would have between 11,000 and 12,000 euthanasia deaths each year. I could almost not believe it when I worked out those figures, and I actually went back and tried to make sure they were correct, but I think they are correct.

To help achieve the necessary clarity of the rarity with which this should be used, I suggest that the legislation be entitled "an act to amend the Criminal Code to allow for an exception to conviction for culpable homicide and assisted suicide". This means those not complying with the law allowing euthanasia could be criminally liable and also that the person seeking euthanasia must show they fulfill the conditions for having access; that is, that they have the burden of proof. That would be consistent with what both the trial court judge and the Supreme Court proposed that the law should establish, "a stringently limited, carefully monitored system of exceptions" and a "carefully-designed system that imposes stringent limits that are scrupulously monitored and enforced." The first is the trial court, and the second is the Supreme Court respectively.

● (1705)

The committee should not be fearful of recommending exactly what the trial judge in the Supreme Court thought necessary. In short, euthanasia must be treated as an exceptional intervention, very carefully safeguarded, and rarely used. In support of this approach, I would remind you that between 1991 and 2010 Parliament rejected motions or bills promoting assisted suicide or euthanasia on no less than 12 occasions. Legalizing euthanasia is an unprecedented change of mind on Parliament's part.

You asked me to address three specific categories of considerations: eligibility criteria, processes and procedures, and roles and regulation of health care professionals.

Regarding eligibility, the first requirement is that the person requesting euthanasia has been offered high-quality palliative care, including fully adequate pain management. Apart from other reasons, this is legally required in order to obtain informed consent for euthanasia. The person must be mentally competent and must provide informed consent up to and including the point at which euthanasia is administered. This requirement acts as a protection for vulnerable, incompetent people, such as those with Alzheimer's, and means that consent from surrogate decision-makers is not allowed. Euthanasia should be restricted to people who are terminally ill—I would suggest, with a life expectancy of not more than four weeks—from physical illness, disease, or disability, and who are experiencing extreme physical suffering. Euthanasia should not be allowed for children unable to consent for themselves. Whether it should be available to mature minors is a separate question.

Regarding processes and procedures, two physicians, one of whom is a specialist in the type of disease from which the person suffers must each confirm in writing that the person fulfills the conditions for access to euthanasia and that they have been offered all reasonable alternative interventions, including palliative care and pain management. A psychiatric consultation to rule out conditions such as depression, coercion, undue influence of others, or duress is required, at least where there is any possibility of these factors affecting the request for euthanasia or consent, or where there are any doubts about the person's competency. A superior court judge shall certify that all legal requirements for access to euthanasia are fulfilled. Indeed, Chief Justice McLachlin suggested exactly that in her dissent in the Rodriguez case, and of course, the five judges of the Supreme Court required it, just about 10 days ago, when they gave the extension.

Euthanasia must not be administered earlier than 15 days after it is requested. A national research and review body should be established to collect records of all cases, investigate cases where there might have been non-compliance with the law, and issue reports at least once a year. I have a whole lot of other conditions but I'll leave those out for the moment.

Regarding roles and regulations of health care practitioners, for nearly 2,500 years physicians in the profession of medicine have recognized that assisted suicide and euthanasia are not medical treatment. This position should be maintained and these interventions kept out of medicine. My colleague Dr. Donald Boudreau and I have written a peer-reviewed published paper on that subject, for which I can provide the reference.

Consequently, a new profession should be established to carry out euthanasia. The practitioners should not be health care professionals, or if so, only ones who have permanently retired from practice. Practitioners should be specially trained and licenced, and have travel money provided to give people across Canada equal access to euthanasia. If this approach is not adopted, two publicly available lists of physicians and institutions should be established: those who will provide euthanasia and those who will not.

This is a reasonable compromise between Canadians who agree with euthanasia and those who oppose or fear it. The Supreme Court emphasized that the charter right to security of the person includes freedom from fear about what could happen to us when we're dying. This often seems to be forgotten with respect to those fearful of euthanasia.

● (1710)

This approach will also solve most freedom of conscience issues. Health care professionals must not be forced to provide or refer for euthanasia when they have ethical or conscience objections to doing so.

In conclusion, you are not just legislating for the present. You're legislating for future generations of Canadians with respect to how they will die. Whether or not we agree with physician-assisted death, legalizing physician-assisted suicide and euthanasia is a seismic shift in our most fundamental values as individuals and foundational values as the Canadian society.

I believe future generations will look back on the legalization of assisted suicide and euthanasia as the most important social-ethical-legal values decision of the 21st century; and the decisions that Parliament will make about the legislation and regulations to govern those interventions are an integral part of that decision.

Thank you.

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

[*Translation*]

Mr. Arsenault, the floor is yours.

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

My question is for Mr. Gunn.

We have often heard witnesses call Carter a floor decision, meaning that physician-assisted dying could be taken even further than it was in Carter. I imagine that argument stems from the fact that the Supreme Court stated that the circumstances of the case were the only facts it considered in coming to its decision.

In light of facts other than those examined in Carter, how would you determine the age at which a minor was deemed to be competent or have the capacity to make such a decision?

[*English*]

Mr. Angus Gunn: Thank you for the question. I will respond in English, if I may.

I'll respond in brief to the comment, and then I'll invite Ms. Birrell to supplement.

First of all, I believe the honourable member has correctly identified why Carter is the floor. The Supreme Court can only decide the case that's before it. The court was deciding what it was in the context of very well-defined factual record, so the court cannot and did not purport to pronounce more broadly than the case before it. The question is, as I mentioned in my prepared remarks, how far that Carter principle goes. I say, for the reasons I mentioned, that it is an incredibly complicated issue—the committee is well aware of this—and it's one that should be developed over time. It needn't be rushed. It's not subject to the judicial deadline, and it deserves the full consideration that a longer process would give it.

I can tell you that the alliance's position is that access to physician-assisted death should be regulated based on competency, not age. Obviously there will be some age at which an individual cannot provide competent consent to physician-assisted dying, but the alliance is not of the view that a discrete age should be adopted in that department. Again, it ultimately rests on the discretion and the judgment of treating health care professionals.

Ms. Birrell, do you wish to supplement those comments?

Ms. Margaret Birrell (President, Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society): No, that's fine. That explains our position.

[*Translation*]

Mr. René Arseneault: Mr. Gunn, how are we to interpret your alliance's position in relation to paragraph 127 of the decision, which states that one of the criteria for seeking physician-assisted death is that the person making the request must be "a competent adult person"?

How is it possible to discuss competence without regard for age?

● (1715)

[*English*]

Mr. Angus Gunn: To be clear, I'm not advocating any position before the committee on this question. My advocacy is that Carter itself is what should be implemented at the moment; namely, competent adults who have full capacity to direct health care providers.

I say the question that the honourable member has raised is something that requires further policy consideration. I've told you what the alliance's submission would be when we get to that, but that's not the gravamen of our submission to this committee today.

[*Translation*]

Mr. René Arseneault: Ms. Somerville, you said during your presentation that physician-assisted dying should be used only as a last resort. How do you reconcile that position with the Carter decision, in terms of the importance of putting yourself in the patient's shoes?

Who do you think should determine whether physician-assisted dying should apply as a last resort in a particular case, the patient or the health care professionals?

[*English*]

Dr. Margaret Somerville: To answer that, the Supreme Court makes clear that it's putting conditions on the availability of physician-assisted death, so it's a matter of what those conditions are. What I'm recommending is that it should be a last resort and very rarely used, if you don't want to normalize euthanasia. What "normalization" means is the way that most people will die—or a very large number of people. That's why I pointed out those statistics from the Netherlands and Belgium, and what that would mean in Canada.

I think most Canadians would be extremely worried, to put it in the mildest possible terms, and I believe upset if they thought there were between 11,000 and 12,000 Canadians being killed by lethal injections given by doctors every year.

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

Mr. Warawa.

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

I thank each of the witnesses for being here.

Dr. Somerville, you're a professor of law at McGill, professor of the Faculty of Medicine, and the founding director of the law faculty's Centre for Medicine, Ethics and Law, so we're quite fortunate to have you with us today testifying.

You've said you believe it's important to have quality palliative care to be able to actually obtain informed consent. Are you intimating that without dealing with the emotional or physical suffering an individual cannot give true informed consent?

Dr. Margaret Somerville: If you look at the Supreme Court of Canada cases, the two leading ones in which the original doctrine was established—Reibl v. Hughes and Hopp v. Lepp—what they require is that all reasonably indicated treatments for the patient for the condition they have must be disclosed to the patient, and the benefits, risks, and harms of each of them disclosed, including the option of having no treatment at all. If the patient chooses them, then they'll have to be made available; otherwise, the patient's consent to the treatment they're given—and let's assume we're talking here about what I would call the "non-treatment of euthanasia"—would not be validly consented to. There wouldn't be an informed consent to that if the patient hadn't been offered all reasonable alternatives.

You can't impose those other alternatives, of course, but your legal obligation and your ethical obligation is to offer them to the patient. Look at the work of Dr. Harvey Max Chochinov. There's some very good work on this. Even people who have requested euthanasia change their minds very often when offered and given good palliative care and pain management.

I've done a lot of work in this area. I've actually researched it for about 35 years. In 1993 I was asked to give the opening keynote address at the international pain conference in Paris. I proposed that access to proper, fully adequate pain management was actually a fundamental human right. That has now been encapsulated in what is called the "Declaration of Montreal", which was passed in 2010. It says that for a health care professional not to respond with reasonable alacrity to people in serious pain is a breach of human rights.

● (1720)

Mr. Mark Warawa: Thank you.

I have another question.

You've used the term "respect for life". We heard from Dying With Dignity three times. In their last presentation they used the story of someone with end-stage Alzheimer's. They said that dying in the sorry state of end-stage Alzheimer's and a year of living in a bed wearing an adult diaper was not a sensible way for people to be forced to end their lives.

Could you comment on the ethical aspects? I'm concerned that if we say people who are suffering with Alzheimer's, maybe peacefully, with palliative care.... Is this an undignified way? In calling this a nonsensical way for a person to spend their last days, what's the message?

Dr. Margaret Somerville: That brings up the very difficult and contested issue of what human dignity is.

What has happened, both in the literature and in the courts, is that the exercise of autonomy has been equated with human dignity, so that if you lose your ability to be autonomous—which by definition you do, if you're incompetent, if you have Alzheimer's disease—then you're regarded as being undignified.

The approach to it of the Dying With Dignity" people is, "We will help you by putting you out of your undignified state", and of course, that's done through a lethal injection. That's the support for euthanasia.

The other concept of dignity, the one that has underlain most of our ethics and law, is that human dignity is intrinsic to being human and that as long as you're human, you have dignity and must be respected in the way that all humans need to be respected. The danger of not taking up that concept is that then anybody who doesn't fulfill the conditions for being seen as having dignity can be disposed of.

It is then, for example, that you get euthanasia of handicapped newborn babies; you can have euthanasia of children.... Peter Singer, for example, the philosopher at Princeton, believes that parents have a right to decide whether to keep a child with disabilities, up to the age of three years. He also thinks that if they can't relate to other people, they don't deserve the protections of human dignity.

This is a bit of self-advertising, perhaps. but I just got a new book out about six weeks ago called *Bird on an Ethics Wire*, and the third chapter is about 40 pages on the concept of human dignity.

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

Mr. Rankin.

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

First, to all the witnesses, thank you so much.

Ms. Hutchison, of the DisAbled Women's Network, I want to thank you, on behalf of the committee, for the reminder you gave us of the critical importance of the social determinants of health, with your particular focus on vulnerable women. Thank you.

Joint Chairs, given the limited time I have available—five minutes —I'd like to use part of the time, if I may, to provide notice of a motion that I would like to move for the committee's consideration later in our deliberations. They all relate to the issue of palliative care, something we've heard much about and that I'm expecting will attract the support of the committee.

Here they are. If I may, I'd like to read them for the notice of the committee.

The Joint Chair (Mr. Robert Oliphant): You have four minutes left.

Mr. Murray Rankin: It is as follows:

> That, in the opinion of the Committee, the government work with the provinces and territories on a flexible integrated model of palliative care by establishing the right to universal palliative care and implementing a Pan-Canadian Palliative and End-of-life Care Strategy that is tied to dedicated funding.
>
> That, in the opinion of the Committee, the government re-establish a Secretariat on Palliative and End-of-Life Care with dedicated funding to:
>
> i. Coordinate with the Provinces, Territories and Federal health jurisdictions;
>
> ii. Set clear national standards;
>
> iii. Coordinate end of life Care research, gather consistent and ongoing data;
>
> iv. Set and monitor standards for the education of all health care providers;
>
> v. Create supports for patient and family caregivers;
>
> vi. Advise on national public education campaigns.
>
> That, in the opinion of the Committee, the government implement a National Awareness Campaign on end of life care including palliative care with a focus on end of life assistance planning.
>
> That, in the opinion of the Committee, the government improve end of life Care services within federal jurisdiction by establishing it as an essential service including culturally and spiritually appropriate palliative services for Canada's First Nation, Inuit and Métis people.

And lastly:

> That, in the opinion of the Committee, the government provide more supports for patient, family, and community caregivers including making the Compassionate Care benefits be made more flexible and available to all caregivers, not just those whose loved ones are about to die imminently.

That is the notice of motion that I'm putting on the table now, if I may.

I don't know whether I have any time left to ask a question.

● (1725)

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

I would just note that those are probably notices of several motions.

Mr. Murray Rankin: I have one motion with five parts, but I take your point. They are perhaps five motions.

The Joint Chair (Mr. Robert Oliphant): Certainly.

The floor is yours for another two minutes and 10 seconds, so you can either invite the witnesses to comment on that notice of motion, which will be brought to the committee later for voting, or you can continue your questioning.

Mr. Murray Rankin: I think I'd rather do the latter, and thank you for that.

I'd like to ask Mr. Gunn and Ms. Birrell....

Thank you very much for your participation today. Building on something you said, Mr. Gunn, how minimalist a federal response can we afford to have in the absence of provincial laws?

I'm concerned about just how minimalist it could be. You're talking about a comprehensive response, I believe. I'm wondering whether you have given thought to just how far we could presumably go, under the criminal law power, to do what we are about to try to do.

Mr. Angus Gunn: Thank you for the question.

In my prepared remarks I suggested that the implementation of Carter itself—which is, as we've discussed, restricted to its own facts—could be done with a rather minimal amendment to sections 14 and 241(b) provisions that were impugned. In the event that access to physician-assisted death was provided in a province that had not yet adopted a comprehensive scheme, and we had that minimalist of federal response, how would that void be filled?

In my prepared remarks I offered the proposal that it may be that existing guidelines and standards within the medical profession for dealing with existing end-of-life decision-making could fill the void in the absence of a provincial response. Obviously, the preferred response would be a robust provincial answer, but in its absence I say that fallback may be preferable to a rushed federal response implemented through the federal criminal law power.

I'll ask Ms. Birrell if she wishes to augment that.

Ms. Margaret Birrell: No, I'm fine.

The Joint Chair (Mr. Robert Oliphant): You have 10 seconds.

Mr. Murray Rankin: All right, then I'll pass. Thank you.

The Joint Chair (Mr. Robert Oliphant): I've been a little generous with other members. If you want to go, you can.

Mr. Murray Rankin: I have one more, if I may, then.

Mr. Gunn, if we adopt an incremental approach, as you've advocated, what do you think we should put off for later? You talked about mature minors. What other topics were you thinking should be on the later list?

Mr. Angus Gunn: Let me reverse that. I think what should be on the "now" list is that which is subject to the short fuse, and that's Carter, so adult patients with all the conditions identified in Carter. I say that is what is driving this timeline. I think everyone can agree that these are issues that deserve a full process, and for no fault of anyone it's not possible to deal with that within the constraints that we're working with. The committee could serve it by implementing that which needs implementing now and deal with everything in due course.

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

Senator Seidman.

Hon. Judith G. Seidman (Senator, Quebec (De la Durantaye), C): Thank you, Chair, and thank you very much, everyone, for being here today.

Mr. Gunn, I would like to continue with the minimalist interpretation that you have presented to us along member Rankin's line of questioning.

The Supreme Court didn't define the terms "grievous" and "irremediable" illness. We have heard from some that rigid definitions might have unintended consequences. What would be your advice on defining "grievous" and "irremediable"?

● (1730)

Mr. Angus Gunn: Thank you for the question.

I share the concern that attempting to codify a definition of either term will end up resulting in harm. There is no question that, with the advances of medical science, which conditions are grievous and which ones are irremediable will change over time. If an attempt were made to codify those definitions statutorily, over time they would become both over- and under-inclusive of the population that should be provided access to the principle in Carter.

My submission is that they should be left where they currently reside, which is in the discretion of the treating medical physicians under the applicable college guidelines.

Hon. Judith G. Seidman: Okay, thank you.

In the same mode of questioning, I'd like to ask you about the definition of “adult”. We've all talked about uniform access across the country, and we've heard from some that it's important to recommend a clear definition of the age requirement in order to ensure uniform and coherent enforcement and access across the country. How would you respond to defining “adult”?

Ms. Margaret Birrell: I think it's very important that the same criteria for accessing assisted death should be the same criteria if you have a competent underage person. Those standards should be the same. I don't think you can draw a line on age, or say this is it and that's not it. It has to be that the person requesting the right to die goes through the same procedure as an adult and the same criteria to see if they are in fact competent, knowledgeable about the options that they have, and are not persuaded by someone else. Those would be the safeguards, and those are the same safeguards you would have for an adult.

Hon. Judith G. Seidman: Even if that results in different interpretations across the country, you would not have trouble with that.

I mean, you did present to us that you would like a minimalist approach, with the provinces' ability to develop their own legislation as long as it was equal to the federal legislation. However, this might potentially result in very different accessibility across the country.

Ms. Margaret Birrell: I agree with you. That's why I think Mr. Gunn said that we need to get the floor in now. We need to be able to speak to that, and then start to work on the other issues that are coming from the whole issue of assisted dying.

I think we cannot delay, but we also can't rush with a shopping list unless we have the floor and the definitions and the safeguards.

Hon. Judith G. Seidman: Thank you very much.

Do I have a few more minutes?

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

Hon. Judith G. Seidman: Thank you very much. I think I'll end my questions there.

The Joint Chair (Mr. Robert Oliphant): Senator Cowan.

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

Thank you to the witnesses for being here. It is very helpful.

I want to pursue with Mr. Gunn the same points that Senator Seidman and Mr. Rankin were talking about, and that is the difference between your approach, a minimalist federal framework supported by what you described as a comprehensive and uniform provincial scheme, with the opinion we received from Professor Hogg that the better way to go would be to establish a robust federal scheme and leave it to the provinces to meet it. If they were able to come up with equivalent regimes at a provincial level, then the federal authority could say that it is equivalent and the provincial regulations and regimes would apply in that province.

It was his view that this is the only way in which you can ensure pan-Canadian eligibility, equality of access, and equivalent safeguards across the country. He explained that we should not assume that all provinces will step up with legislative responses to Carter, or that those legislative responses will be as you describe, comprehensive and uniform.

Why do you take a different approach than Professor Hogg, and why would your approach better meet those three roles of ensuring eligibility, quality of access, and equality or equivalency of safeguards across the country, from coast to coast to coast?

● (1735)

Mr. Angus Gunn: Thank you for the question.

The driver behind the submission presented today is the reality of the constitutional constraints in which this debate is happening. It's a premise of Professor Hogg's submission—and I have the utmost respect for Professor Hogg and his scholarship—that the federal Parliament could enact a comprehensive regulatory scheme through the exercise of its criminal law power. It is my submission that to do so would miscast the issue and would be vulnerable to constitutional challenge as an excess of the criminal law authority.

I think, architecturally, Professor Hogg's recommendation has an elegance to it, but I submit it is problematic, from a standpoint of constitutional competence, to commit to that framework. I, however, urged a framework that I say is more likely to withstand constitutional scrutiny and yet be workable. It may come at the cost of some unevenness; I think that has to be recognized. But whatever model is adopted does need to be capable of withstanding constitutional scrutiny.

Hon. James S. Cowan: I want to switch to the issue of advance directives. You're familiar with the recommendations that have been made by the provincial-territorial panel as to the various levels and different categories. Is it your view with respect to advance directives that there must be competence, not only for the initial request but at the time the request is carried out? Is that where you are on that issue?

Mr. Angus Gunn: I'll let Ms. Birrell supplement this answer, but I would say no. The example given was dementia. This is an example in which the patient would, presumably, at the end of life not have the decision-making capacity to provide informed consent. However, if an advance directive had been completed by that individual, which otherwise satisfied the criteria, it should be given effect.

Hon. James S. Cowan: You mean even if the patient had lost, as one would in that case, the capacity between the time of the original execution of the declaration and the time the assistance was administered. Is that correct?

Mr. Angus Gunn: That's correct.

Hon. James S. Cowan: Ms. Birrell, I thought you wanted to interject.

Ms. Margaret Birrell: No, I just wanted to support that.

The Joint Chair (Mr. Robert Oliphant): Ms. Shanahan.

Mrs. Brenda Shanahan (Châteauguay—Lacolle, Lib.): This is also a question for Mr. Gunn.

Ms. Hutchison mentioned in her presentation that her group is advocating for the invocation of the notwithstanding clause. Do you have an opinion on that?

Mr. Angus Gunn: It would go beyond my brief as counsel for the alliance to go there. In my submission, the government has indicated its intention to respect the spirit and letter of Carter, so to the extent that the commitment has been made, it would seem to be incompatible to invoke the notwithstanding clause.

Mrs. Brenda Shanahan: Ms. Hutchison, can you tell us a little bit more about your thinking and your group's thinking with regard to what is behind this invocation?

● (1740)

Ms. Carmela Hutchison: The implication is that people have not fully considered the full implications. Despite all its "go gently into that good night" intent, if my last breath is the one after this, then whether you are applying a biological, mechanical, or chemical means to stop the one that happens after this one, euthanasia is still a form of violence. Violence is being applied, and we need to take a very sober look at that.

What is happening with Carter is not a floor, but a toboggan down an extremely icy, slippery slope. As Canadians we have to be cognizant of that. We are a country that does not have capital punishment, yet we are going to condemn to death people who are ill, who are sick, and who are debilitated in the absence of proper disability supports and resources—

Mrs. Brenda Shanahan: May I interrupt you there to ask another question? Sorry, but I want to give you a chance to comment on this because we've heard testimony from other disability groups and witnesses who were disabled themselves and who expressed concern about patient autonomy. We're talking about how this is the individual's request and a constitutional right. The individual is asking for this.

How do you square that circle?

Ms. Carmela Hutchison: In terms of squaring that circle, we had to ask ourselves and our own organizations a lot of questions. Since Carter was a disabled woman, are we going against sister disabled women?

The reality is that the decisions they're making and the comments they're making are made because of internalized ableism. Ableism is almost like a form of racism against disability. They're looking at the situation through ableist eyes—I cannot bear to be incontinent; I cannot bear to be fat; I cannot bear to be dependent—when in reality we are all interdependent.

I would doubt very much that the people who were bringing forward litigation, the Carter case, would have changed their own oil, wired their own houses, or done their own plumbing. They had to depend on other people for certain tasks in life, as we all do.

Even to make this possible, I had to depend on technicians, on permission of the hospital, and on the head nurse to make the arrangements and the approvals that were necessary for me to speak to you today, and I had to depend on the nurses who had to help me with the bodily functions that were necessary to get me here.

Autonomy—

Mrs. Brenda Shanahan: I thank you very much, Ms. Hutchison, but isn't that what we're talking about? Isn't it a choice that you are making? Would you deny that choice to others, that choice to avail yourself of what care you're going to have?

In fact, paragraph 127 of the decision—

Ms. Carmela Hutchison: But it's a process.

Mrs. Brenda Shanahan: —states about treatment that "it should be added, [it] does not require the patient to undertake treatments that are not acceptable to the individual". Would you say that the individual has that choice?

The Joint Chair (Mr. Robert Oliphant): A very quick answer, please.

Ms. Carmela Hutchison: I think they have not explored that choice from a realistic perspective. I think that sometimes if they've not been exposed, perhaps, to situations that once they've been in them.... On the first day that I needed physical assistance with certain things, I was very upset, but then once I adapted, adjusted, and had the support of disabled peers, I was able to do many other things.

I still do many, many things, even speaking to you and speaking to issues that affect millions of people, from a hospital bed. I think that perspective needs to be brought forward. I think we need to be able to encourage people and to encourage Canadians that lives matter, even when we're talking about dementia and dignity.

● (1745)

The Joint Chair (Mr. Robert Oliphant): Thank you, Ms. Hutchison. We're a little over time now.

I need to go to Mr. Cooper.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Mr. Chair, I'll designate my time to Ms. Harder.

Ms. Rachael Harder (Lethbridge, CPC): Thank you.

Carmela, I want to thank you for being so vulnerable with us today and for giving us your time. It certainly has been a pleasure to hear you. My question is for you, and I'm wondering if you can comment.

I know that most people who have a disability go through a time of deep grief and often deep depression, and during this time there can even be suicidal ideation. There is this time before adapting to their disability, of course, and then most of them actually go on to discover that there is an ability that comes with their so-called disability, an ability that they maybe didn't have before, and this actually brings about a new sense of life, dignity, respect, and worth, if you will.

In this context, Carmela, I'm wondering if you could explain to me what safeguards you feel are appropriate in order to ensure that we are not unnecessarily euthanizing these individuals going forward.

Ms. Carmela Hutchison: We do not have such safeguards. I tried to research any kinds of measures that might measure for vulnerability, or indices, or.... For 10 years, I worked as a nurse in mental health. How could we avoid having coercion? How could we ensure...?

I'm very concerned, especially with respect to young people, because even in my own process, I had a time when I was new in my disability. I crawled around on my soft underbelly for many years thinking that I just didn't want intervention. I once walked in and said that to my doctor. I've had the same doctor since 1989. I said to him, "I don't want anything." He said to me, "Carmela, I'm not going to accept that. You're only 38."

That was my first "helmet shake" that maybe my life was worth something. I kind of let that cogitate, and I went and made a personal directive. It was sort of like, well, God made the world in seven days, okay, so maybe I'll let people gather to say goodbye and then we'll pull the plug. I have that directive. I was in the process of revising it when, ironically, I got pneumonia, ended up in urgent care, and then ended up in ICU. That's this hospitalization right now. I've been here since December 11.

As that was happening, I was terrified. I was terrified to come to ICU because of Carter, but also, as I went along in my process, I started to become involved in the peer support movement. I became involved with other people with disabilities. I also have had many medical conditions, and people have said that because I have a head injury, I can't get brain injury rehab. I can't get occupational therapy.

Ms. Rachael Harder: Carmela, may I interrupt you for a moment?

Ms. Carmela Hutchison: Yes.

Ms. Rachael Harder: I have another question for you, very quickly.

Based on what you've outlined here, could you perhaps help us understand, based on the rights that we're seeking to give other individuals in the nation of Canada, what rights are we robbing you of as an individual?

Ms. Carmela Hutchison: That's what I'm trying to get at.

Exclusion criteria, people need to be able.... This is a time when we have Google. This is a time when we have the ability to communicate electronically with health professionals, to collaborate and be able to come together to figure out solutions to problems. Instead, we complain that there's too much information and people don't bother to look it up.

I was at a point—and I want to talk about this, because this comes to the point where I talk about complications. The lab couldn't find a vein. They couldn't draw samples, so they refused to come up. What happens when somebody's requesting euthanasia? They couldn't come up. Nobody could insert a trach, because anatomically it wasn't a long enough space. I was intubated and I was awake for two weeks until there was enough air space so I could be intubated. There are many things like this. I couldn't get brain injury rehab early in my illness because I have a mental illness. There are many exclusions that happen. Those exclusion criteria have to be stopped. There are unrealistic recommendations all through this: that oh, the family doctor, you're going to have this conversation, and he's going to hold your hand all the way through, blah, blah, blah. No. I've had my family doctor since 1989. I've probably had 10 or 15 doctors, because you have an intensivist, and you have a hospitalist, and now there are rehab doctors. There have been different doctors all the way through this. So the vision—

● (1750)

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

Ms. Carmela Hutchison: I'm trying to go quickly, but I've been cut off all the way through this. I would like to finish one question at least.

The Joint Chair (Mr. Robert Oliphant): We have time limits because we have several questions and several witnesses.

I'm sorry. Thank you very much.

We'll move to Senator Nancy Ruth.

Hon. Nancy Ruth (Senator, Ontario (Cluny), C): To the Alliance of People with Disabilities, my understanding is that you want us to do the floor in Carter; you want the government to make a robust commitment to the ceiling stuff, and you want us to have a white paper. I don't know why. We've had a provincial-territorial report. We've had the external panel. We've had many, many witnesses on a whole variety of issues and ideologies: religious, legal, medical, whatever. Over 15,000 people responded to the questionnaire in the external panel.

What do you think this discussion is going to bring and add that we should not move in the direction of the ceiling now?

Mr. Angus Gunn: I accept all the observations made by the honourable member. We don't have draft legislation. The reality is that the translation of all that data—and I acknowledge it's a mountain—the translation of that mountain into operational legislation is the most critical phase of the process, and it has yet to happen. That's no criticism of anyone. I think these processes inevitably take time. The reality is that when this is reduced to a draft piece of legislation it will be appropriate and desirable, in my submission, for it to be given an opportunity for public scrutiny and comment. That's simply not possible except in a minimalist way in the timelines within which this committee is now having to work.

Hon. Nancy Ruth: That surely is the function of Parliament when a bill comes forward, both within the Commons and the Senate, to have public scrutiny of the bill.

Have you read the three bills that were proposed in the last Parliament, both within the Commons and in the Senate? If so, do you have any comment on them?

Mr. Angus Gunn: I'm sorry, but I'm not in a position to respond to that, and I think Ms. Birrell is not either.

Hon. Nancy Ruth: All right.

Do you have recommendations about specific procedural safeguards that we should build into the physician-patient relationship for physician-assisted death?

Ms. Margaret Birrell: You could look at the suggestion that someone who is going forward must have the opinion of two physicians. They have to have met with the person. If we have it in place that they have to have an in-depth discussion with two physicians, that would be the most basic safeguard. It also would allow the individual requesting it to change their mind. It also re-ensures that there be no pressure from others.

If you look at the Ontario Superior Court of Justice's position that came out six days ago, they are suggesting that some of the safeguards would be that family and friends be brought into the dialogue. Where is the individual who wants physician-assisted dying in this picture when you're pushing those kinds of structural barriers? I have never seen so much invasion, detailed invasion, on the rights of the individual as I saw in that paper that came from the Superior Court.

The safeguards should be very, very basic. They should be set up. No physician should be pushed into doing it. That system can easily be put in place. There should be no exclusion from health centres or hospitals or other facilities where the physicians want to administer the drugs. Those things can be put in place, and they are safeguards. There should be no pressure on the individual—

● (1755)

Hon. Nancy Ruth: I have a point of clarification.

Ms. Margaret Birrell: —but the system should be there.

Hon. Nancy Ruth: Nobody wants—at least, I don't want—to force anybody into doing any of this, whether they're the patient or the doctor, but after you talked about having two physicians—and I assume there'd be a consent form—that people should have the right to change their minds. Did you have a waiting period in your head when you said that? When people first consent to asking for this, did you want a delay of a few days, or whatever, before they reaffirmed their desire? What were you thinking of?

Ms. Margaret Birrell: What I was thinking of was that in the case of advance care directives, the person could change their mind, and that would be fine, but if you've gone as far as getting two physicians who are not pressured but are willing to assist and you have the consultation, the timeline is probably going to be very, very short.

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

Senator Joyal.

Hon. Serge Joyal (Senator, Quebec (Kennebec), Lib.): Mr. Chair, I apologize to the two previous witnesses, but I had to stay in the Senate for debates, so I missed the presentations. Of course, I listen carefully to each and every answer given to the questions by my colleagues. Unfortunately, Professor Somerville, I was not here when you were testifying, but I read before this meeting the op-ed that you published in *The Globe and Mail* on October 27, 2015, and I just heard the last sentence of your presentation. If I can quote the last line of that op-ed, I think it parallels your conclusion. You were promoting, of course, to protect, and I quote you:

> ...all of us as vulnerable people by upholding 'respect for life' (a preferable term to 'sanctity of life') in society as a whole.

I understand that you still maintain that fundamental position.

Dr. Margaret Somerville: Yes.

Hon. Serge Joyal: Okay, so then I feel safer to question you. I thank you for writing, because it's very challenging to read what you write.

When I try to wrestle with the concept of “respect for life”, is it not as much a code term, as with different religions filled with different beliefs or different sets of understanding? There are some religions which believe, for instance, that the death penalty for killing a policeman who is exercising their function is acceptable, and the same for a soldier. There are others who have the position, in terms of abortion, that it's okay for a short period but not after another period. Then there are other religions that would accept the concept of what is in PAD and so forth.

A respect for life is, in other words, a concept that could be filled by different content. In fact, it could have a religious substance. It could also have no religious substance. There are people who advocate respect for life even though they don't believe in any god. I would say it's difficult to follow you on that word because it is a word that opens a lot of avenues in front of us. I prefer, in a way, to follow the Supreme Court proposal, in a decision that it made almost at the same time as you published your article in mid-October, in le Mouvement laïque québécois in Quebec. I'm sure you know the decision. I want to quote just three lines of that Supreme Court decision, which illustrates my quandary about the concept of respect for life: “A neutral public space free from coercion, pressure and judgment on the part of public authorities in matters of spirituality is intended to protect every person's freedom and dignity...”.

It seems to me that's where we are wrestling with this concept of physician-assisted death. The state doesn't compel anyone to impose that. A doctor is free not to practise it; a person who feels it is not in sync with his or her belief is not compelled to have it, and so forth. Protecting the vulnerable; we all accept that. How can we reconcile your respect for life—

● (1800)

Dr. Margaret Somerville: I'll try to answer your question.

Hon. Serge Joyal: I know it's a thesis.

Dr. Margaret Somerville: If you look historically at the situations in which life could be taken, and I'm talking here about civilized societies and societies we would equate ourselves with in Canada, they were all situations where it was thought necessary to take life to save human life. Indeed, it's actually the trial judge in Carter who gives the example of self-defence: the reason you may kill without legal punishment in self-defence is that it's necessary to save innocent human life. It's the same with just war. It was the same originally with abortion; it was to save the mother's life. It's the same with capital punishment, because it was believed that if somebody had killed once, they would kill again.

Respect for life is not just a religious concept. We've used religion in the past—and this is what I said in my remarks—to uphold it, but it's not fundamentally just a religious concept.

The book that's best on this is by Jürgen Habermas, the German philosopher, who points out that it is a foundational value in every society in which you would want to live. The question becomes, does our legalization of physicians, putting it bluntly, killing their patients—because that's what they're doing—derogate from upholding the value of respect for life in society in general to such a serious degree that we shouldn't do it, even though we can understand why the person might want that and even though they're exercising their autonomy?

First of all, because I believe there are other completely set ways to deal with the suffering of the person, I've promoted that a health care professional leaving someone in serious pain is a breach of human rights. That's now recognized, for example by the WHO, by the World Medical Association, by the Canadian Pain Society, etc.

It's not that I want to leave people to suffer, but I just think that when you have the institution of medicine, which for 2,500 years has said that they will never kill, and which upholds the value of respect for life in society in general, and you've had a law, and the law of all societies like Canada says that you must not kill—that's what our Criminal Code says—and which upholds the value of respect for life, should we be derogating from that with this?

The Joint Chair (Mr. Robert Oliphant): We have to close there. I suspect you two could go on *Tout le monde en parle* and have a wonderful discussion.

That ends this section of the first part of tonight's meeting.

We will suspend now, and we will resume in this room at 7 p.m. with another panel of witnesses.

Thank you to our witnesses for joining us.

● (1800)

(Pause)

● (1900)

The Joint Chair (Mr. Robert Oliphant): I am calling the meeting back to order, after having been suspended for the last hour.

We continue with our 12th meeting of the Special Joint Committee on Physician-Assisted Dying.

We welcome witnesses who are joining us this evening. Thank you for taking the time and also for bringing your expertise to our committee's deliberations.

We have Dr. John Soles, president of the Society of Rural Physicians of Canada coming to us from Clearwater, British Columbia.

I think we're going to begin with Dr. Soles, because you never know; we could lose technical connectivity. If we start with you, that gives us a chance to get you back if we need to.

From there, we will go through the list of other witnesses, with Dr. Hartley Stern, Michael Bach, and Gerald Chipeur.

You're each given 10 minutes to speak tonight. We will begin with Dr. Soles.

Dr. John Soles (President, Society of Rural Physicians of Canada): Thank you for asking the SRPC to make a presentation to the committee.

The SRPC is a national voice for Canadian rural physicians. Our mission is to provide leadership for rural physicians and to promote sustainable conditions and equitable health care for rural communities.

I did send you a copy of the major points that I made in the fall to the external panel, and I won't repeat them in detail. Your request is for recommendations on a framework for the federal response on physician-assisted dying that respects the Constitution, the Charter of Rights and Freedoms, and the priorities of Canadians. I'm sure you're going to hear from many physician groups, and I suspect that most of them will have similar thoughts about this, as I have.

What I would like to do is give you a little background about rural Canada and a little framework of the major points that you wanted opinions on, and if we have time for further discussion about specific rural issues, then that would be what I would like to discuss more of.

As you know, Canada is 90% rural by geography, with slightly less than 20% of the population being rural. Roughly 10% of Canadian doctors work in rural areas. Canada's rural population is poorer; it's less healthy, and it has a significantly higher proportion of indigenous peoples, particularly in the north. Rural Canadians have less access to health care and may have to travel very significant distances, particularly in the north, to get such care. Canada's rural physicians are older, and they are much more likely to be international medical graduates—I'm an exception in that instance. The health care in very small rural communities may be provided by nurses and other health care workers rather than physicians. Access to specialists is limited, and most rural physicians work as generalists and include palliative care within their skill set.

That's where I'd like to start.

In designing legislation, it should be noted that good palliative care is truly physician-assisted dying. What we're really considering here is physician-assisted dying at an earlier moment in the trajectory of a life. As in all processes that are irreversible, it is vital that mistakes in assessment not be made. Patients who choose this option must be competent to make the decision, must have reasonable time to reconsider their decision, and must not have treatment options that will have a high likelihood of reversing their suffering.

Physicians are not uncommonly asked to assess competence; however, they may not have particular training or skill in this area. Legislation related to physician-assisted dying must be accompanied by clear definitions of competency, and must require patients to be assessed by two unrelated, unassociated physicians.

Although children are considered competent to make many medical decisions based on their understanding, I believe that initially they should be excluded from this process. If we do not allow adults to make decisions regarding physician-assisted dying for other adults who are incapable of consent—and I don't think we should—then we cannot allow adults to make those decisions for children.

In most other jurisdictions “adult” is defined as 18 and over, and I think Canada should use this definition as a starting point.

What is a grievous and irremediable medical condition? This is defined mostly by patients. There must be no treatment acceptable to the patient that will effectively relieve suffering and no major psychiatric condition that is treatable. If the condition that is causing enduring suffering that is intolerable to the individual is a psychiatric one, then assessment by two psychiatrists should be required prior to considering physician-assisted dying. If there is concern that there is a psychiatric condition affecting the request for physician-assisted dying, I think it would be reasonable to request a psychiatric opinion.

It's important in the evaluation of a patient who has requested physician-assisted dying that interviews be done in such a fashion that no one else can influence the patient. It's important to protect vulnerable patients from pressure from others, and it's important to ask patients about who else may have influenced their request.

The process is a challenging one, and I'm glad I'm not designing the legislation. There must be a formal process to make these requests. Patients will often talk to physicians about wanting to die, but if it came to actually requesting it, they probably would not do that. There must be some form of formal document that they sign.

There has to be an evaluation regarding competence and the presence or absence of psychiatric disease. There must be an assessment regarding other treatment options, and a discussion of what those might be and whether they are acceptable to the patient. There must be a second assessment, as I mentioned, by another physician within a reasonable period of time, and there must be an appropriate waiting time for reconsideration by the patient. All interactions and discussions must be well documented.

● (1905)

Finally, I will turn to the question of who does what. I believe that whatever the personal beliefs of a physician may be, they must be willing to discuss all legal options with their patients and make appropriate referrals if they themselves are unable to take part in that service. I think the way abortion works in Canada has some similarities. Physicians should not be obligated to be involved with a service that they have moral difficulties with, but they should be able to have such a discussion with their patients and to refer when necessary.

One of the questions that has arisen in discussions about this is death certificates and how they're filled out. I think death certificates should have physician-assisted dying as the immediate cause of death with the diagnosis that led to this as an underlying cause.

There are concerns in rural areas. The challenge in rural areas is often, as in the community where I live, that there is a group of physicians who work together, and how is it possible to arrange a second opinion about someone's suitability for this, or competence? I think it's inappropriate to do that within a group of physicians who work together. How is it possible to arrange and expedite a psychiatric consultation, if that's required, if all physicians in a group are conscientious objectors to this process? How do patients obtain a service, which is considered legal in a small community, where the physicians are not able morally to provide that service? This is a little different from the abortion discussion in that these patients are much less likely to be able to travel safely.

Where and how in a rural community where everyone knows everyone is it possible to carry out this process? What would the effect be on other members of the community? What would the effect be on the staff of a rural hospital? What would the effect be if there were radically different viewpoints within a small group of physicians?

Those are the important points of what I would like to say.

● (1910)

The Joint Chair (Mr. Robert Oliphant): Thank you. That's quite wonderful. Often people finish their important parts and continue with unimportant parts, but you didn't. That's quite good. We appreciate that.

Dr. Hartley Stern from the Canadian Medical Protective Association, executive director and CEO, thank you for joining us tonight.

Dr. Hartley Stern (Executive Director and Chief Executive Officer, The Canadian Medical Protective Association): Good evening. My name is Dr. Hartley Stern. I am the executive director and CEO of the Canadian Medical Protective Association, CMPA.

Honourable senators and members of Parliament, thank you for this opportunity to appear before you. In the time available to me I will touch upon each of the questions you have asked of us. There is greater detail in our written submission.

I have spent much of my life as a surgical oncologist and more recently as the director of the Ottawa Hospital Regional Cancer Centre, and even more recently as the director general of l'Hôpital général juif de Montréal.

In each of these positions, I bore witness to the incredible suffering that some patients nearing the end of their life suffered. I also saw the devastating impact on their families, on the physicians and on the other health care providers who were concerned with these patients.

I would teach my students about the incredible importance and impact that the relationship between the physician and the patient, built on trust and on empathy, has on that patient as he or she enters into the end-of-life decisions.

I've now joined the Canadian Medical Protective Association because as the principal provider of medical legal assistance to Canadian physicians, we can support our member physicians in their efforts to give consistent, quality care to their patients. We, the CMPA, sit at the intersection of the Canadian health care and legal systems. As such, we are already, and will continue to, receiving questions from our members and advising them on all aspects of end-of-life care, which includes palliative care and physician-assisted dying.

Today for this committee's purpose, I will focus on physician-assisted dying in my remarks.

Our principal objective in making recommendations on the legislative response to Carter is to impress upon you the overarching requirement to have federal legislation that articulates principles of clarity and consistency so that obstacles that currently exist for patients to maintain their constitutional right to access physician-assisted dying are eliminated and that protection under the law is promoted.

The obstacles that we see are created by the current gap in legislation which creates confusion in the minds of patients, in the minds of their families, physicians and other health care providers as to principally who is eligible for physician-assisted dying, what the safeguards are to protect patients, particularly the most vulnerable, and what form of physician-assisted dying should be administered.

We believe federal legislation is required. Outside Quebec, no such legislation exists and there is uncertainty. Our members have already called because of this uncertainty. In this vacuum, the courts are faced with making decisions regarding physician-assisted dying until June 6. The courts will be challenged significantly in their ability to issue orders that are consistent based only on the high principles outlined in Carter.

We are aware that in Ontario the Superior Court has already published a practice advisory to guide the court applications. The medical regulatory authorities, the colleges of physicians and surgeons, have also published guidelines for physicians. We applaud these efforts, but they are not a substitute for comprehensive legislation required to fill the social policy vacuum.

Federal legislation most importantly must address the issues of eligibility criteria and safeguards consistently applied across the country. Now we fully recognize there is jurisdictional overlap with the provincial and territorial legislatures in this regard. The committee may wish to explore the possibility of developing a framework such that federal legislation will not supplant substantially similar provincial legislation. Such an approach is not unprecedented in Canada.

I would like to focus now on the recommendations to you on the issues of eligibility criteria and safeguards—challenging issues clearly. The starting point will be amendments to the Criminal Code to confirm that physicians providing a patient with aid in dying are not in violation of the general prohibition against assisted suicide. This is a fundamental requirement to permit physicians to enter into that very trusting and empathetic relationship with the patient that is so essential to the successful implementation of this policy.

● (1915)

We are particularly concerned with the disparate interpretations of the term “adult” used in Carter. We submit that a clear definition of the age requirement is essential to remove this uncertainty. Legislation must either use an age of majority approach or define competency for a mature minor. If the approach is adopted to extend eligibility to the mature minor, we believe it will also be necessary to address how patient competence will be assessed in that context. The test to determine competency is a subjective one and is difficult to implement in the best-case scenario. In this complex situation, it will be even more complex to implement such a policy. On balance, therefore, we believe a clear age requirement is the preferable approach.

Federal legislation will also have to address the form of assisted dying and whether it includes self-administration. The legislation must include safeguards for the protection of patients. The Supreme Court did not specifically discuss the issue in their decision. In Quebec, medical aid in dying must be administered by a physician. A physician could not prescribe a lethal dose of a drug to a patient to self-administer. The College of Physicians and Surgeons of Ontario has published guidance that contemplates the possibility of self-administration.

In Carter the Supreme Court used the term “grievous and irremediable medical condition”. As you know, this is not a medical term. Legislation should provide guiding principles on this issue so that patients and their physicians have a clear understanding of when patients will be eligible, while also taking into account an individual's unique circumstances. Legislation should also clearly state whether assisted dying may be requested by way of an advance medical directive. To ensure a consistent approach and equal access, any legislation should carefully consider whether and when such directives must be respected.

I'd like to turn to the rights of conscience. The Supreme Court recognized the patient's right to physician-assisted death, but also clearly stated that its ruling was not intended to compel physicians to provide assistance in dying. Legislation is required to address the appropriate balance between these two rights. The committee might consider the model adopted under Quebec's legislation. Under that model, a physician who refuses a request for medical aid in dying for reasons of conscience must notify the designated authority, which in turn will find a physician who is willing to consider the request.

Let me reiterate the reasons for the necessity of legislative protection for physicians. Physicians engaged in physician-assisted dying play a unique role for their patients. As I mentioned, this relationship is one based on trust and empathy, and in this most complex of situations, relies on an intimate relationship between the patient and his or her physician as they work collaboratively and collectively on the best approach for that individual patient. The CMPA submits that federal legislation must provide some assurances for these physicians so that they know they will not be prosecuted if they comply with the requirements under the law for physician-assisted dying and believe in good faith that their patients meet the criteria.

In conclusion, honourable senators and members of Parliament, the task ahead of this committee is significant. We ask you to bear in mind the importance of the relationship between the patient and the physician, and the importance of ensuring that both are protected along their journey.

● (1920)

[*Translation*]

On behalf of the CMPA, I'd like to thank the joint committee for the opportunity to present our view.

We would be pleased to provide you with any further information or data that you may find useful.

Thank you very much.

The Joint Chair (Mr. Robert Oliphant): We will continue with Michael Bach.

[*English*]

He is executive vice-president of the Canadian Association for Community Living.

Mr. Bach.

Mr. Michael Bach (Executive Vice-President, Canadian Association for Community Living): Thank you, Mr. Chair, honourable senators and members of Parliament.

In order to arrive at our recommendations to this committee, the Canadian Association for Community Living asked for advice from People First of Canada, the national association of people with intellectual disabilities that advocates for themselves. They told us in no uncertain terms that they want two things. First, they want access to physician-assisted suicide without discrimination on the basis of disability. People with intellectual disabilities are three to four times more likely to die from preventable deaths than the general population, and heart disease and cancer are the leading causes. People with intellectual disabilities are dying painful and difficult deaths with intolerable and enduring suffering. They want access on the same terms as anyone else.

However, they told us just as passionately that they want absolute assurance that there will be safeguards to protect their inherent right to life and that they'll have access to those safeguards without discrimination on the basis of disability. They don't want assisted death. What they need is support and good care, because disproportionately they face poverty, lack of support, or abuse.

While much has been said in the wake of Carter about the right to choose, we believe it's equally important to give as much focus to the other half of the equation that the Supreme Court insisted must be balanced: protecting the right to life.

You know, it's odd. I feel a bit awkward as I talk about the inherent right to life, because the moment the words are out of our mouths, it's often taken, it seems, that we're trying to roll back hard-won rights to choice, like reproductive rights for women. Our motivations couldn't be further from the truth. It was in fact a small committee of people with intellectual disabilities who led their legal counsel into the Supreme Court of Canada 30 years ago this year to secure the right not to be sterilized without their consent. They won in the Eve case, which set an international standard.

We know what the right to choose is all about. We've been on the front lines of that struggle for decades. But we must also stand firmly on the vantage point of the inherent right to life, its protection forged in the dark shadow of the atrocities of World War II, in order to give it indisputable recognition and obligation by states parties: the Nuremberg Code, which set the new standard for what voluntary consent now means in medical ethics and physician behaviour, the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights.

It's true that the sanctity of human life finds a source in world religious traditions, but let us not forget that it is in the cornerstone international human rights instruments of the 20th century and in our Charter of Rights and Freedoms that the inherent right to life finds its clearest obligations on secular grounds, for Parliament and for all Canadians. So why must we design a system for physician-assisted suicide from both vantage points, not just the right to choose, but also the inherent right to life?

On Monday of this week, Flemish Radio and Television Broadcasting Organization in Belgium broadcasted a story brought to light by two sisters of a young woman who was euthanized in 2010 under the law in that country. Following the end of a romantic relationship, she was in a mental health crisis and was in treatment with a psychiatrist. Two months before her life was ended, the psychiatrist diagnosed her with autism and could then conclude that she had an irremediable medical condition and that her psychological suffering was unbearable. She was put to death. When her traumatized family later asked her physician why he had confirmed the psychiatrist's assessment, he admitted that he was not in agreement but that he had no choice, stating that he thought Tine Nys “shopped” with too many doctors.

There were two other cases reported in the medical journals. In Oregon, an 85-year-old cancer patient with worsening dementia requested physician-assisted suicide, but her psychiatrist believed she was being pressured by her family. Nevertheless, she was approved by a psychologist. In the Netherlands, a wife who no longer wished or was not able to care for her sick elderly husband gave him a choice between euthanasia or admission to a nursing home. Afraid of being left to the mercy of strangers in an unfamiliar place, he chose euthanasia, and his doctor ended his life.

● (1925)

When the Carter case was first heard at the B.C. Supreme Court, Justice Smith knew enough of such cases to very carefully examine the extensive evidence before her about the types of safeguards that could be put in place, given the obligation to protect the right to life of vulnerable persons. She concluded her analysis with the following list: mandatory psychiatric evaluation to ensure capacity for informed consent; disqualification of major depressive disorder; minimum waiting period; a second independent physician with expertise about the condition; required palliative care consultation; an advance expert review panel that must issue a decision in 48 hours; and a patient right to appeal the review panel's decision.

It was the legal counsel for the plaintiffs in Carter who presented this list to the court—the plaintiffs including Gloria Taylor and the British Columbia Civil Liberties Association—as their recommendations for effective safeguards that could justify exceptions to the Criminal Code prohibition.

Immediately following the presentation of that list, in her decision, the trial judge stated her conclusion, which was also quoted by the Supreme Court to justify its own decision:

> ...the risks inherent in permitting physician-assisted death can be identified and very substantially minimized through a carefully-designed system imposing stringent limits that are scrupulously monitored and enforced.

We stand 100% behind the recommendations of the plaintiffs, which we think can be best summarized into six core pillars of a statutory safeguard system to be embedded in the Criminal Code.

One, only adults can access. We strongly urge that mature minors not be eligible. We don't deny the suffering of children and adolescents, but we believe that palliative care is the answer in those situations. This is a decision that children and adolescents and their families should not have to make. If you have to be majority age to vote in this country, surely this is a limit that we can impose.

The second is to define “grievous and irremediable medical condition” as terminal end-of-life conditions. We urge the committee to be guided in large part by the Quebec legislation, with emphasis on incurable serious illness, and advanced state of irreversible decline in capability, and also look to the specific definitions that have been proposed in the David Baker and Gilbert Sharpe draft bill, which has been submitted to this committee, and also to the clarifications that David Baker sent by letter to this committee yesterday. If instead Parliament were to follow the recommendations of the provincial-territorial advisory group on this matter, what happened to Tine in Belgium in 2010 would happen in Canada. Moreover, the cause of her death, by the advisory group's recommendations, would be registered on her death certificate as autism. Autism would show up as a killer in Canada's vital statistics, as would Down's syndrome, bipolar disorder, cerebral palsy, and many other conditions, which it's true are serious or very serious, which is the definition proposed for defining what “grievous and irremediable” should mean, by the provincial-territorial advisory group. They turned to the Oxford dictionary for that definition. We think Parliament can and must do much better than that.

The third speaks to enduring and intolerable suffering in the circumstances—and I underline “in the circumstances”—of the patient's condition. This is a key criterion that Carter specifies: one's suffering and circumstances cannot be anticipated in advance. This criterion makes clear that advance directives should not be—we believe cannot be—on the table, and we urge Parliament to make that explicit in the Criminal Code. Capacity to consent must be a criterion right up to the moment of taking a lethal dose.

The fourth concerns review by two physicians to determine if the criteria are met—independent physicians—at least one with expertise about the condition, and the requirement that they engage other professionals as might be needed for diagnosis, prognosis, and exploration of all the causes of the person's suffering, which is the job we rely upon and vest our trust in physicians to do.

The fifth is about mandatory vulnerability assessment. This must be undertaken in response to each request, to determine if the factors that could induce the patient to commit suicide in a time of weakness are in fact motivating the request. We've outlined this in more detail in our brief to you and also in a background paper on vulnerability assessment.

The six and final point concerns an independent advance review panel to consider the request and reports on capacity and other criteria, including vulnerability, from any physicians involved. Proposals for such a panel have been presented to this committee by David Baker and Gilbert Sharpe, and also yesterday by the Canadian Council of Imams. There's also strong support among Canadians for this safeguard. In an online survey of almost 13,000 Canadians, 53% supported this mechanism, and 54% in a poll released last week by the Canadian Association of Retired Persons.

It's also important to note that the treaty body monitoring the International Covenant on Civil and Political Rights, which Canada ratified in 1976, has repeatedly called for implementation of an advance independent review mechanism for physician-assisted suicide, because of evidence like Tine's, to ensure that states parties fulfill their obligations to protect the inherent right to life under article 6 of covenant.

● (1930)

Having such a panel in place would prevent doctor shopping, guard against vulnerable persons being induced to commit suicide, and—critically important, we believe—ensure physicians do not have to play two irreconcilable and, we believe, conflicting roles: on the one hand doing everything possible to assess and remediate medical conditions and patient suffering, and then on the other approving interventions intended to bring about the death of their patients.

Thank you for the opportunity to present before the committee this evening.

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

Mr. Chipeur.

Mr. Gerald Chipeur (Lawyer, As an Individual): Thank you, honourable senators and members of Parliament.

Twenty-one years ago, in 1995, I was before a similar Senate committee on the same issue. It is a pleasure to be back with you again to talk about this important issue. I was counsel at trial and at appeal and in the Supreme Court in the Carter case, and I've spoken on this subject in Canada at our universities and Canadian bar associations.

I will go right to my most important point, Mr. Chair, and that is that if you carefully implement the exact words of Carter, you will not likely go wrong. I believe that Chief Justice Heather Smith did this, and the court's list of requirements that were published today means that my most important recommendation is there should be no assisted death unless a judge has confirmed that all the requirements of Carter have been met.

In my presentation I will go into the reason I strongly recommend judicial review in advance. I recommend that for all provinces, including Quebec. That would not be inconsistent with the Quebec legislation. With the Quebec legislation, you would have to comply with both the federal and the Quebec legislation.

I will address each of the questions that this committee sent us.

First, on age, I agree with the previous presenter that the age of 18 is the appropriate limit on access to assistance in suicide. The decision of the Supreme Court of Canada in A.C. v. Manitoba in 2009 requires Parliament to act in the best interests of children and to create a presumption that children are not competent to make life-and-death decisions, and that means anyone under the age of 18.

Second, on the question of capacity, the capacity limitations identified in Carter v. Canada are critical to protect the vulnerable. No one suffering from a mental disability that impacts capacity should have access to suicide assistance. The decision of the Supreme Court in Eve reaffirms and reinforces that principle. It prohibits consent to death on behalf of a person who is incompetent to give consent. This includes the immature, the mentally disabled, and those who have lost the ability to make competent decisions for any reason. This also means there could be no advance directives on the subject of physician-assisted suicide without conflicting with the decision of the Supreme Court of Canada in Eve.

Third, going on to conditions, all the conditions expressly identified in Carter v. Canada must be reiterated in the legislation adopted by Canada. The failure to include conditions will create unnecessary risk of abuse and will create an impression that government supports suicide. This is not a message that should be given at this time, particularly in Alberta, where the suicide rate in some first nation communities is 100 times the national average.

The fourth question was on vulnerable Canadians. The Supreme Court of Canada, in Carter, carefully balanced the right to life of those in unremitting pain with the right to life of the vulnerable who need protection from abuse under the Criminal Code. The court observed that the models in other jurisdictions were not impressive and that Canada must and could do better. The right to life in section 7 of the charter requires Parliament to take into account both perspectives on life. This issue is addressed by the European Court of Human Rights in the case of Haas v. Switzerland from 2011. In that case, the European Court of Human Rights recognized the dual responsibility of Parliament or of government, and that is you must both protect life as well as allowing individuals to make choices at the end of life.

Going on to the mechanics of the request, the legislation from Parliament should prohibit a physician or any person from raising the subject of suicide with an individual. The individual must raise the question before the subject may be addressed by a physician. There are numerous stories, and I won't take your time this evening to go through them, of psychological stress and abuse caused by government or medical staff raising the idea of suicide with the ill or the elderly. This abuse must be prohibited and prevented. Until the idea of suicide is voluntarily addressed first by the patient, the medical team must be restricted to offering only palliative care.

● (1935)

There is another reason to require that the individual raise the issue. We in Alberta know the unfortunate history of sterilization from 1929 to 1972, when health care providers used their power to abuse their patients and sterilize almost 5,000 patients against their will. Those patients were regularly noted on their chart as having consented to the process. This supports the idea of having judicial review, but it also supports the idea that hospital administrators wanting to save money or physicians wanting to raise the subject with their patients will be prevented from doing so.

Even the Canadian hero Nellie McClung got caught up in the evils of eugenics from 1929 on. In “Sterilizing the 'Feeble-minded': Eugenics in Alberta”, Grekul, Krahn, and Odynak highlight and give us a sobering reminder that all progress is not necessarily desirable. Sometimes progress takes us down a road we would not take if we knew what was at the end. Once a request is made, then all of the health status requirements of Carter v. Canada must be met and respected by the attending physician.

With regard to oversight and the question of judicial oversight, after consent has been validated, the physician should have a duty to apply to a judge for approval of death before death occurs. The physician should be required to seek the opinion of a second physician, and both should be required to swear affidavits that they are satisfied that the conditions of the law have been met. The physician should be required to serve copies of the application and affidavits upon the next of kin.

This is the minimum required when an application is made under provincial adult guardianship and trusteeship legislation in Alberta and in other jurisdictions in Canada. Surely death is more significant and more permanent than decisions regarding finances and housing. If the loss of financial control requires judicial oversight, surely loss of life deserves no less.

Courts are experienced in making decisions regarding these questions, based upon the evidence of physicians. The issue of religious objection to blood transfusions is just one area where the courts have been called upon to make such life-and-death decisions. The courts have been able to make those decisions on an emergency basis with a minimum of risk to the individual and a minimum of delay. Making these decisions is today a regular occurrence across Canada, and the initiative of Chief Justice Smith of the Ontario Superior Court today is further evidence that the courts are prepared and able to handle this responsibility.

Some have advocated leaving the entire responsibility to the physician and excluding judicial oversight. The Supreme Court of Canada has already addressed this issue and determined that there is no right to have life-and-death decisions made in secret.

In Cuthbertson v. Rasouli, a 2013 decision of the Supreme Court of Canada, the Supreme Court of Canada reviewed and affirmed the judicial oversight provided under the Ontario Health Care Consent Act. Under that act, physicians must be involved, but they should not be the ultimate arbiters of life and death. Independent judicial review prior to death is best. It will avoid much suffering and prevent the expenditure of significant funds on lawyers and court costs. Estates should go to children and beneficiaries, not to lawyers fighting over whether a physician has properly secured and documented consent.

With regard to privacy considerations, courts and physicians have effectively preserved the privacy of individuals over the last few decades when issues of life and death have come before the courts. The legislation enacted by Parliament should maintain that standard of medical ethics. All applications to a court for judicial oversight should be restricted to the parties named and served under the legislation.

● (1940)

Next, who should do what? The physician should be given the responsibility to manage the process; however, the legislation must recognize the roles of others and authorize their participation. Health care facility owners, administrators, and employees must all be given immunity once a court order is issued. Carter v. Canada only addressed the issue of physicians. If you restrict your law to physicians, you will leave 99% of the health care providers in this country at risk.

The Joint Chair (Mr. Robert Oliphant): You're at a little over 10 minutes. Could you wrap it up quickly, please?

Mr. Gerald Chipeur: Thank you very much.

In conclusion, the decisions of the Supreme Court of Canada, both on February 6 of last year and on January 15 of this year, give this committee significant guidance in terms of the kind of model to adopt. It's a model that's led by judicial review and includes an important requirement for physician participation.

Thank you very much for your time and attention.

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

Mr. Aldag.

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

I'm going to start with Dr. Soles, from the Society of Rural Physicians of Canada.

I have a couple of quick questions. The first one relates to access in rural and remote communities. We've seen that some areas have considered involving others in the medical field, such as nurses and nurse practitioners. I wonder if your group has had any discussion about that. Do you see this as being exclusively within the realm of doctors—GPs and specialists—or has there been any consideration of extending the involvement to others, such as nurses or nurse practitioners?

Dr. John Soles: I think it's an issue of determining competence. That's something that somebody with training can do, whether that training is as a physician, a nurse, or a nurse practitioner. As has been suggested by others, I think that if you're looking at judicial oversight of all this, or a legal framework for the final determination of the suitability of physician-assisted death, the health evaluation can certainly be done by others, not just physicians.

Mr. John Aldag: Thank you, and that's a great transition to a question for Dr. Stern.

I believe that in the beginning of your comments you noted that CMPA is a sort of intersection between health care and the law. I note that in the document we received, it reads, "CMPA takes no position on who should make the eligibility decision". With regard to that intersection of health care and the law, we have heard from others in the medical profession that the safeguards should come from within the medical field and that doctors are trained to assess patients and competence and those types of things, but then we have heard that from a legal perspective, perhaps we should have judicial oversight as the final say.

Do you have anything to offer from within that intersection to help us sort through what balance, what safeguards we should be looking for in the final decision, once the patient has made the determination to pursue physician-assisted dying?

● (1945)

Dr. Hartley Stern: You have asked several questions. I want to make sure that I understand them more clearly. You talked about oversight, and I assume you mean oversight at the end of the process. I think you also alluded to the issue of review prior to the decision-making. I think—if I understand your question correctly, and please correct me if I misunderstood you—you also talked about who should be involved and whether the process for determining eligibility should include other practitioners, such as nurses, or should be under the jurisdiction of the legal system. I think there are about three questions there, but maybe I didn't understand.

Mr. John Aldag: Specifically, in the lead-up to approval for someone to go ahead with physician-assisted dying, we have heard some models put forward.

One involves a physician; it could be a GP. Then there would be a waiting period for another GP, and that would be the end of it: the person could have their life terminated.

Another model would require approval from a GP and a specialist, which could include a psychiatrist.

A third model would involve some sort of medical review and discussion, but then the case would be referred to a judicial or quasi-judicial body for final approval.

In part, the question concerns protections for physicians who may decide to participate. How do we give them the necessary safeguards, to make sure that all the processes have been followed? How do we also make it clear for patients who it is who makes the final determination? Again, that has a bunch of questions in it.

Dr. Hartley Stern: I think I've narrowed it down to two questions here, and I don't mean that in anything other than a.... There's no insult intended. I really am trying to make sure I answer your questions appropriately.

With respect to the number of physicians or the specialist versus family practitioner roles, there is no physician in Canada right now who has any specific expertise. A specialist has no greater expertise than a family doctor in making this kind of decision. We are agnostic as to what type of physician should be present.

What we believe is the most critical part is that the legislation you bring forward should have great clarity around the eligibility criteria and that the legislation should be consistent across the country. If there is clarity in your language, physicians will be able to understand what eligibility is and who is eligible. Furthermore, the patient will understand better.

That is why our written submission attempted to focus this committee on the language and the words and the necessity of having clear and unequivocal language, and it is what I attempted to do in my oral submission, because then physicians can participate and, I think, protect—

The Joint Chair (Mr. Robert Oliphant): Thank you, Dr. Stern. I'm sorry to interrupt, but we're over our time limit.

Mr. Cooper.

Mr. Michael Cooper: Thank you, Mr. Chair.

My questions are directed to Mr. Chipeur.

One of the things this committee has to grapple with is the meaning of “grievous and irremediable condition”. I wonder if you might be able to comment on the meaning of a grievous and irremediable condition and whether, for instance, terminability might be implied.

Mr. Gerald Chipeur: I don't want to try to do a better job than the Supreme Court of Canada did in Carter. I think they did a very good job. I think that those words would be appropriate for your legislation. You may add a little bit more, but I think the court used those words because they believed that the right to life had both aspects to it: an important protection of life, and a protection of individuals from abuse at the end of life.

If you just say that we're going to open it up to anyone and that anyone can kill themselves with the help of the state at any time, then you effectively have the state saying, “We're in the business of death.” We fight the death penalty so hard in the criminal justice field, but then we would just open it up, wide open, in the health care field.

I believe the court wanted to say that there are very few occasions on which the state should allow this kind of very dangerous procedure to take place and that we want to have the highest standard, a standard that only deals with individuals who are in pain and cannot avoid that pain and have no other choice. I think that's what they were trying to say, and I think they said it well, and I recommend their words to you.

● (1950)

Mr. Michael Cooper: Thank you for that.

Another issue you mentioned was advance directives, which the Supreme Court, within the parameters of Carter, did not explicitly address. However, in terms of advance directives, you cited the Eve decision. You stated that in that decision, the Supreme Court explicitly ruled out advance directives.

Might you be able to elaborate on what the Supreme Court pronounced?

Mr. Gerald Chipeur: My view is that if you were to apply Carter today to a death that was with respect to an advance directive, you would be charged and convicted of murder under the Criminal Code.

The same would be the case if one were to then layer on Eve. Eve simply said that someone else cannot substitute their decision for life, meaning that if an individual is unable to make a decision about life, someone else cannot make that decision for them. That certainly counts in the case of an advance directive, because an advance directive is only applicable when you cannot make a decision and you are in a position that the individual in Eve was in.

I think both Carter and Eve expressly and explicitly rule out advance directives.

Mr. Michael Cooper: Lastly, you alluded to the A.C. v. Manitoba decision. The Supreme Court, in that decision, did recognize the common law mature minor doctrine, which, based upon the individual's level of maturity, in essence recognizes the right of minors to make health decisions.

Might you be able to comment on that and how it applies in the context of Carter?

Mr. Gerald Chipeur: I think that A.C. v. Manitoba has a very important principle. That principle is that Parliament must create a presumption under the charter that children cannot make decisions. That's the least one can find in A.C. v. Manitoba. I think that A.C. v. Manitoba does not prevent you from making that a hard cap, if you will, at least on the bottom, because in A.C. v. Manitoba the issue was not about a life-and-death decision but about whether a mature minor could make decisions with respect to health care.

Whether assisted suicide is or is not health care has not yet been decided by the Supreme Court. I'm not going to say that A.C. v. Manitoba requires you to have a firm limit of 18, but there's nothing in A.C. v. Manitoba that prevents you from choosing an absolute prohibition of any death under 18.

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

Mr. Rankin.

Mr. Murray Rankin: Thank you very much.

Thank you to all the witnesses for excellent presentations.

I would like to start with Dr. Soles. I think you said, if I'm understanding you properly, that if there were a psychiatric condition involved, there should be two psychiatrists who would be able to provide an opinion as to eligibility. Did I understand you correctly?

Dr. John Soles: Yes, I meant if this is a patient who has a psychiatric condition that is causing irremediable suffering. In cases in Europe, some caveats have already been expressed about how that has panned out for certain patients. However, I am talking about a case in which a patient is suffering specifically because of a psychiatric condition. I'm not talking about a patient who has a medical condition and a psychiatric issue at the same time.

Does that make sense?

Mr. Murray Rankin: It does. Absolutely.

Given your role with rural physicians, does that pose an obstacle in remote Canada? Do you see the use telemedicine where there's obviously a well-known lack of psychiatrists? How would that work?

Dr. John Soles: Absolutely.

Various witnesses have expressed approaches to this with legal frameworks, and so on, and all of those are challenging when we consider the circumstances in rural Canada. Seeing one psychiatrist in rural Canada is a challenge, never mind two. There was a proposal that most patients should have a psychiatric evaluation. There is very little chance of that being a practical solution in rural Canada, and I would argue there's very little chance of that being a practical solution in a great deal of this country.

● (1955)

Mr. Murray Rankin: Thank you.

Mr. Bach, thank you for your excellent presentation.

I want to give you an opportunity to elaborate on the vulnerability assessment that you suggested ought to be made mandatory. You've got more information in your brief. Can you spend a bit more time on that? Would you train physicians on vulnerability assessments? Would you seek other professionals to assist? How would it work?

Mr. Michael Bach: We see it as a three-stage process.

The physicians who are assessing and doing the diagnosis of the person who is requesting would be required to identify whether there are factors that are motivating the request other than the condition itself. The equation is that the condition causes enduring suffering that's intolerable to the individual. We need to know whether other factors are motivating the wish to die. We know, especially from vulnerable people, that situations of economic insecurity, lack of support, domestic abuse associated with the time of onset of the disability, etc., are all factors that can motivate suicidal ideation.

We're in a period where health care providers are being called upon to implement standardized protocols for suicide risk assessment. They're going to have a patient come forward to them with a wish to die. Do they invoke the suicide risk assessment protocol or do they proceed with the request? Our view is that there needs to be clear guidelines for physicians at that point. When there's a concern that it may be a factor other than the medical condition motivating the request, there would be a requirement to go to what we call a stage 2 assessment. We expect that with most people, the physicians will review the request, it will be clear that it's related to the condition, and the request will proceed. Where there's a concern that there are other factors at play, as in some of the examples that I laid out today, there would be a requirement to engage additional health professionals to inquire into what those conditions are. Is it that a family is completely burned out and stressed out?

The Joint Chair (Mr. Robert Oliphant): You can talk a bit more. You have half a minute.

Mr. Michael Bach: Okay.

The family is completely stressed out, and we need to address that situation, because that's what's motivating the request.

Then, at the third stage, if it is these other factors that predominate in motivating the wish, the person would not be eligible to proceed with the request at that point. Our recommendation is that a psychiatrist may be needed in that process to help determine whether there's a mental health issue at play.

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

Senator Nancy Ruth.

Hon. Nancy Ruth: Dr. Soles, early in your testimony you said that physician-assisted death is palliative care. Could you elaborate on that for us, please?

Dr. John Soles: Certainly. I think it's the other way around, though: palliative care is physician-assisted death. Palliative care is the assistance of someone through the last stages of life and involves symptom management, including pain management and so on. I think that whatever legislation is produced, the importance of providing palliative care needs to be emphasized.

Hon. Nancy Ruth: At the end of your presentation you gave us a whole lot of questions to which I have no answers, so I'm coming back to you with them to ask for your best guess, or something like that.

You talked about the doctors who work together. They wouldn't necessarily be independent of each other. How do you get a second opinion or a psychiatric opinion?

You talked about patients who can't travel safely. You also asked what happens when everyone knows everyone, or what happens when there are radically differing medical views in the same community.

I don't know the answers to those questions. Can you give us a bit more help, beyond just stating them?

● (2000)

Dr. John Soles: Thank you for asking that. I'm not sure I have the answers for those either.

I think the role of telemedicine was mentioned. If we're looking at a patient who has requested a physician-assisted death and is in one of these communities in which there is only one physician group, it would be most appropriate that this patient be assessed by a second physician. If that can't be done in person, then it needs to be done in some other fashion; that would presumably be via video or telephone link, preferably video.

If you had a small community in which there was no physician willing to participate in this process, other than informing a patient about the process when a patient requested the information, that would create a great challenge. I really don't think it's appropriate for these decisions to be made without actually sitting in the room with the patient.

Hon. Nancy Ruth: If the law were to allow a cocktail drug, such as is the case in Oregon, would you see that as being useful?

I don't know whether that's the word. I'm trying to figure out how nurse practitioners or other people in rural areas could deal with this, if there were a legitimate request, maybe assessed through telehealth, for physician-assisted death for someone who wants to stay in their home, whether in Grise Fiord in the high Arctic or anywhere else in Canada. A cocktail of drugs could be flown in by mail, as other drugs are sent by mail. Can you imagine that happening? What kinds of problems would there be?

Dr. John Soles: Certainly I can imagine it. As any physician who has provided palliative care does, I prescribe lethal doses of drugs to patients all the time without the expectation that they will take them.

Just to clarify that for the committee, if I have a patient who has terminal cancer, for instance, that patient will go home perhaps with a dose of medication that, if you or I had it, would be terminal. The striking thing to me is that I cannot recall, in my personal experience, any patient who has chosen to take their medication in that fashion.

I think the real challenge, if you're prescribing medications at a distance and sending them through the mail and they're being administered by the patient's family or a nurse, is to know what happens when things go wrong. I don't really want to make this comparison, but there have been cases in which death by lethal injection in the States has gone badly wrong, and those are cocktails delivered by physicians. I would hate to think of some nurse in Grise Fiord who has that kind of experience.

Hon. Nancy Ruth: The provincial-territorial report recommended that all regional health authorities have an effectively funded care coordination system in place to ensure patient access to physician-assisted dying.

How would you see this coordination system being needed, particularly in rural communities, and what do you have now?

Dr. John Soles: I'm not sure what that process is in those provinces, so it's hard for me to comment specifically. I think there are a variety of networks in different provinces related to a variety of medical conditions, and some of them work well. Some of them do not. I think that over the next years, this kind of connectivity is going to improve, but what it will look like in different jurisdictions remains to be seen.

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

Senator Joyal.

Hon. Serge Joyal: Thank you, Mr. Chair.

I would like to address my first question to Dr. Stern.

Dr. Stern, page 7 of your brief discusses rights of conscience. This issue has been discussed and raised by many witnesses. Yesterday we had the representatives of the churches, and they were wrestling with the issue of a physician or a care provider who would refuse on moral or religious grounds to be part of a physician-assisted death.

I'll read your recommendation to us, which is in the last paragraph on page 7:

> With a view to ensuring patient access to care, an appropriate approach to consider is the one adopted under Quebec's An Act Respecting End of Life Care. In Quebec, a physician who refuses a request for medical aid in dying for reasons of conscience, must notify the designated authority

—I underline “the designated authority”—

> who will then take the necessary steps to find another physician willing to consider the request.

Could you explain to us who the designated authority is and how it works in practice? The act has been implemented in Quebec, so I understand you might have the information we're seeking in relation to protecting the rights of conscience.

● (2005)

Dr. Hartley Stern: It's been three years since I left Quebec, and there are some specifics of the implementation of this that I am not current with.

When we read Quebec's act, we felt that it offered a very elegant solution to a very complex problem for physicians, and that is that for those who truly have an inability on the basis of conscience to consider referring directly to another physician who would be willing to provide this, Quebec provides for an opportunity to refer the patient to the authority. Now, I am not certain whether this refers, under the reforms that have occurred recently in Quebec in terms of the way they have reorganized the system, to the hospital in one instance, or whether it's to a regional health authority, many of which no longer exist, or which authority they're referring to, but it is something that Quebec has contemplated as an elegant solution to try to assist physicians who have significant....

We think this a solution that could be adopted in other jurisdictions.

Hon. Serge Joyal: The way I read that section of the Quebec act, section 31, in the case of a doctor practising in a hospital, it is referred to the executive director of the institution, so the institution is not neutral in that case. We had a witness last night who pleaded to us that institutions are also protected by the rights of conscience. In the case of Quebec, it's clearly in the act that the institution is not neutral; the institution has an obligation to provide the service.

In the case that there is a local authority that is not in an institution, they have to refer to the local community service centre, what we call the CLSC in Quebec. In other words, the public institutions have a responsibility to make sure that the request will be acted upon and taken care of.

Do you consider that this is safe protection in relation to the right of a physician to object to being part of physician-assisted dying?

Dr. Hartley Stern: We, like everyone else who has appeared before you, have wrestled with this most complex issue of conscience. I know very well that in the Carter decision the Supreme Court specifically said that it is improper or unacceptable to compel a physician to participate in assisted dying.

Following that inability, the issue becomes “What then?” How do we move the patient to ensure the patient has appropriate access to someone willing to do it? Again, when I left Quebec as the CEO of a hospital, we were preparing. This was before the legislation was enacted. We were preparing for a mechanism, through the director of public health, to ensure that we would be able to provide a physician in that instance.

Each province has a different governance mechanism. I can't speak to every provincial governance and I can't speak to every provincial management system, but I agree with your position that the CEO of the hospital and the board of the hospital have an obligation to participate under the law of the land.

Again, I go back to the point that we think this is the best solution, a solution similar to what Quebec is providing for their patients in need.

● (2010)

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

Ms. Dabrusin.

Ms. Julie Dabrusin (Toronto—Danforth, Lib.): I would like to thank all of the witnesses for speaking with us today and sharing their information.

I want to thank you, Mr. Chipeur, for bringing us your expertise, your having been the intervenor in the Carter decision on behalf of the Christian Legal Fellowship.

I wanted to ask you a question because you mentioned the practice advisory that the Ontario Superior Court of Justice has issued. I just wanted to confirm that you understand that this is not legislation by the Ontario legislature.

Mr. Gerald Chipeur: Yes, absolutely. It is something that the Chief Justice brought in, in light of the January 15 decision of the Supreme Court of Canada, and my suggestion is that it is a wonderful way for you go to. I am suggesting that you adopt the model that's currently followed.

Ms. Julie Dabrusin: But it isn't a legislative decision by the Ontario legislature to adopt court review for Ontario.

Mr. Gerald Chipeur: You could adopt that model. You have that jurisdiction.

Ms. Julie Dabrusin: All right.

As to my questions, I have some questions for Dr. Stern.

You mentioned in your report to us that the CMPA would like to see legislated protections against criminal charges and civil liability for doctors. I saw that you proposed one form of wording in your letter, which was from the Vermont legislation. It states, “A physician shall be immune from any civil or criminal liability or professional disciplinary action for actions performed in good faith compliance....”

Have you seen any other models? Is that the model you prefer?

Dr. Hartley Stern: Rather than focus on the model, I think I would focus on the words. For me, and in my interpretation, the issue is around good faith. Physicians who act in good faith under the law should be immune from prosecution. Whether it's bad faith, indifference, or a casual approach, that would exclude them from this protection, but I believe the vast majority of physicians will participate in good faith. They should be protected under the law under that specific wording.

Ms. Julie Dabrusin: Okay. If we were looking at that type of provision, “good faith” is what you would have us use as our governing thought?

Dr. Hartley Stern: I'm not a lawyer, but I believe that lawyers who know what good faith is could incorporate that into your legislation in a way that would be helpful to the situation.

Ms. Julie Dabrusin: I also wanted to talk to you about accessibility. You can correct me, but my understanding is that doctors pay different premium rates depending on the types of services they provide in their profession. Is that...?

Dr. Hartley Stern: With great respect, there are a number of errors in your hypothesis here.

Ms. Julie Dabrusin: All right.

Dr. Hartley Stern: Doctors don't pay premiums to us. We are not an insurance company. We are a not-for-profit mutual liability protection system. They pay fees each year, and they're not based on their individual risk. They're based on their risk as a physician. An obstetrician, who is at higher risk of getting into a civil matter, would pay a higher fee than a dermatologist or a family doctor.

Ms. Julie Dabrusin: Okay. That touches upon what I was trying to get at, but thank you for that correction.

In relation to physician-assisted dying, would there be anything you would need to see in this legislation to ensure that when doctors who perform this service were being assessed by the CMPA , the rate would not be so prohibitive to them that they would not provide that service?

Dr. Hartley Stern: Just to be very clear on the impact of this legislation, there will be no impact on what physicians pay us in the way of fees.

Ms. Julie Dabrusin: Thank you for that.

Mr. Chipeur, I wanted to talk to you quickly about this practice advisory.

Having to go through a judicial system requires legal expenses and requires paying for expert opinions. Who would cover that cost? By having a judicial system like that, don't we risk creating an access barrier so that it's only open to the wealthy?

● (2015)

Mr. Gerald Chipeur: We certainly don't create a barrier today when individuals make applications for guardianship and trusteeship or when decisions are made with respect to children when parents have refused health care. In all of those cases, either the physician or the health care facility covers the legal fees involved.

I don't think we should make a decision about life and death based upon who pays. Those issues about who pays can be addressed. Certainly the provincial governments can address that. Certainly our system is flexible enough to address the cost.

My issue is vulnerability and finding the best way to protect not just the patient but also the physician. The issue here—

Ms. Julie Dabrusin: My question was just about that particular matter.

Mr. Gerald Chipeur: Okay. I don't see that as a barrier.

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

[*Translation*]

Mr. Deltell, you may go ahead.

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

Welcome, gentlemen, to your parliament.

[*English*]

Mr. Chipeur, you said that you want to see a judicial review before any actions have been taken. I know you're a lawyer, but the point we're talking about here is health care. How can a judge know what is good or not good for someone who's going to die?

Mr. Gerald Chipeur: We do that right now in probably a dozen different cases, those in which physicians make a decision or expert determination with respect to children, with respect to the mentally incompetent, with respect to individuals who cannot make the decision for themselves, with respect to cases of guardianship and trusteeship. Right now health care decisions are reviewed by judges on a regular basis. They are well suited for it.

If we are going to protect physicians, the best way is a priori, in advance. If we are going to review what they do after the case, there will be some very big class actions. The class action bar will be there to take on the role of advocating for individuals in families who have disagreed with the decisions made by the patient and the physician.

Mr. Gérard Deltell: Take the example of Quebec: two physicians are not enough to make a good judgment in that situation?

Mr. Gerald Chipeur: I think there is a big risk of litigation and a significant risk of abuse. I say this because we have examples from Alberta up to 1972, and we have examples right now in Europe, where you have after-the-fact reviews of what physicians have done. What physicians are doing is they are not reporting, because they don't want the hassle of spending time in the review process after the fact.

I'm not saying this is theoretical; I'm saying that in fact, today, if you go with after-the-fact review, you will not catch every death, you will have abuse, and you will have negligence.

Mr. Gérard Deltell: Thank you, Mr. Chipeur.

Dr. Stern, you witnessed the Quebec experience when you were at the Montreal Jewish General Hospital. The main question we have to resolve is with regard to the mix of the criminal courts and the health care system. Health care belongs to provincial administration, and the Criminal Code belongs to federal administration. With your experience, and with what you have seen in Quebec, do you think the new law that Parliament must adopt should give a big indication to the province instead of leaving more flexibility to the province?

Dr. Hartley Stern: It's a very important question, but our perspective is really around the patient and the importance of consistency across the country so that a patient anywhere in the country has equal access, under the law, to physician-assisted dying.

We absolutely believe that federal legislation is required, and we are disturbed by the notion of different interpretations or disparate interpretations of the eligibility criteria. It is extremely important that there be consistency and clarity around the definition of eligibility criteria and consistency around the safeguards and protection, particularly for the vulnerable patients, of whom my colleagues to the left here have spoken so eloquently. This can only, in my view, in our view, be done under a federal legislative framework.

I mentioned the notion of the concept of similarity, so that if the federal legislation and the provincial legislation were sufficiently similar, it is my understanding that the federal legislation will not supplant the provincial legislation. In that sense, if all the other provinces began to look similar to what Quebec has done in a very thoughtful way, and the federal legislation also looks similar, I think we would have the consistency we're looking for.

● (2020)

Mr. Gérard Deltell: Thank you.

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

I'd like to ask Mr. Chipeur one question for clarification, and perhaps two.

You gave examples of judicial review a priori of medical practices. Can you give one where competence is not at issue? We are dealing with the idea that competence has been determined and we are saying that medical practitioners may be involved in it. You've given some examples. I think in all of them the degree of competence was at stake with judicial review of the decision. Can you give us one example of judicial review of a medical practice where competence is not at issue?

Mr. Gerald Chipeur: The decisions with respect to children are not really about competence; they are about what's in the best interest of the children, so I think those would be cases. Examples could be the blood transfusion cases, but—

The Joint Chair (Mr. Robert Oliphant): They could be.

Okay. The second question I have for you is with respect to Madam Justice Smith's operational directives. Are you aware that they're a result of the Supreme Court's decision that a judicial review would be required in the interim because an extension has been granted due to a lengthy delay due to an election? That was the reason. It has nothing to do with the Ontario court insisting they do a review. Are you aware of that?

Mr. Gerald Chipeur: Absolutely, and that was my point.

The Joint Chair (Mr. Robert Oliphant): Okay, thank you.

Mr. Gerald Chipeur: In particular—

The Joint Chair (Mr. Robert Oliphant): No, that's fine.

We need to go on now to Senator Seidman. Thank you.

Hon. Judith G. Seidman: Thank you, Chair.

Thank you all very much for being with us tonight.

I'd like to go back to an issue that we've all been struggling with. Dr. Stern, you really did say that to us. We have been struggling with rights of conscience.

We understand we have the imperative to balance the charter rights of physicians to their conscientious objection with the charter of rights of patients to access. In your response to Senator Joyal, you spoke about patients' rights to access to care, and how Quebec has done this.

I was looking at page 7 of your submission to us, at the end of the first paragraph. I'd like to try to understand how this is connected. You wrote, “we urge Parliament to ensure that physicians' freedom of conscience is protected when considering the legislation in response to *Carter.*”

I understand the “ensuring the patient access to care” component as it plays out in Quebec. Is that the answer to ensuring that physicians' freedom of conscience is protected, with which you charged Parliament? I'd like to ask you about that as well, if I may.

Dr. Hartley Stern: There really are two levels of freedom of conscience here. The first is those physicians who are uncomfortable for reasons of conscience to participate in responding to the request of the patient but who feel comfortable with referring the patient to a different physician who would be willing to perform that assistance. I believe that would be the majority of the physicians who express difficulties of conscience.

The last part, the Quebec part, which we're referring to, would involve a very small number of physicians who may feel uncomfortable referring a patient to another physician for reasons of conscience. This is our attempt to say we believe that Quebec has done an extensive review of the issues of conscience. They have been very thoughtful about this, and the solution they've come up with is, in our view, the best way of balancing the two rights, the rights of the patient and the rights of the physician. It will apply to a very small number of physicians, but that's what we think is important. We want to preserve the physician being able to participate in this in that empathetic and thoughtful way, and knowing that some of their colleagues may have difficulty with this is quite helpful in this process.

● (2025)

Hon. Judith G. Seidman: Telling us there are two different aspects to dealing with this really helps me understand, but I'd also like to go back to where you urge Parliament to ensure this. Do you think this should be addressed in federal legislation, or is it a provincial jurisdiction, or is it a regulatory body jurisdiction? How do you see this?

Dr. Hartley Stern: I think this is an absolute necessity. Our concerns are that some provinces may not entertain legislation. In the absence of legislation on this very important social policy, both physicians and patients will be left in limbo with a significant amount of uncertainty. That will be filled in a way that is insufficient and provide unequal access. It's inappropriate for a patient in one jurisdiction to have access that is different from the access available to a patient in another part of this country. Therefore, the federal legislation will guarantee that the legislative requirements are fulfilled and that patients will have a consistent approach across the country to access physician-assisted dying. We hope that the provinces' legislation, where they entertain to do it, will be sufficiently similar, so that the federal legislation will not supplant the provincial legislation in those provinces that actually do the legislation.

Hon. Judith G. Seidman: With respect to freedom of conscience of physicians, is it the responsibility of the federal Parliament to build that into the legislation, or is that something that you see the provinces or the regulatory body doing?

Dr. Hartley Stern: I absolutely believe that it is a federal legislative requirement, for the reasons I entertain. It is for consistency of access for those patients.

If we go back to my original point, the physician who feels insecure because of uncertainty is not going to be able to enter into that relationship with that patient without fear that something bad is going to happen to them. They need to be in that relationship so they can provide the empathy and trust that allows the patient to move forward with that doctor to a successful implementation of the physician-assisted death.

The Joint Chair: Thank you.

Senator Cowan.

Hon. James S. Cowan: Thank you to all the presenters. We've had very interesting and very important evidence.

Dr. Stern, I wanted to go to the issue of the decision-making process. You described it as the CMPA supporting a decision-making process that will be easily accessible to patients, respect patients' privacy, and not impose undue administrative challenges for patients or their physicians. You heard Mr. Chipeur talk about a rather more elaborate decision-making process with a prior review, including court hearings and serving of affidavits on next of kin. Can you comment on the suggestion that he's made to us this evening as it fits with the CMPA position, as I've read to you from your statement?

Dr. Hartley Stern: To be clear, we have no formal objection to a judicial review, with a couple of caveats. Our concerns are those of limiting access through a complex process that may make it more difficult for the patient to actually achieve access to physician-assisted dying.

That is provided that, one, it is not overly bureaucratic and complex and does not make it difficult for the patient to access it, and, two, that there is clarity and understanding of what this process is so that patients can understand it fully.

Patients dealing with physicians in a trusting environment get their information about the process clearly and unequivocally through a physician with whom that trust and empathy exists. The court is a remote, legal, and much more fearful environment in which to try to make these decisions. Again, we have no objection to it, but we have concerns that, one, the patients will not understand it, and, two, that it will delay the access.

● (2030)

Hon. James S. Cowan: That quality of access and availability of access are critical, as far as you're concerned.

Dr. Hartley Stern: We believe that they are. Again, we have no objection to the judicial process, but those two caveats—that it is simple and clearly understood by patients, and does not limit, slow down, or retard the access of the patients—are the critical factors in your decision-making, in our view.

Hon. James S. Cowan: The co-chair mentioned to you, Mr. Chipeur, the practice advisory that came. It's my understanding, and I just want to make sure that I understand this clearly, that you're not suggesting that the regime which Chief Justice Smith has proposed is required by the Carter decision itself; it's to comply with the interim requirements established by the Supreme Court of Canada in granting the four-month extension.

Mr. Gerald Chipeur: I think that what the Chief Justice has done is comply with the January 15 decision. There's no doubt about that.

My recommendation to this committee is that it's a great model. It's working. It was created organically by people who know about these issues and deal with them every day, so I'm suggesting that if you go to those who are already doing it today and you follow their model, I think you will not go wrong.

Hon. James S. Cowan: I'm not suggesting that we couldn't go there, but I'm also taking you as not suggesting that we would be required to go there in order to meet the Carter decision.

Mr. Gerald Chipeur: Yes.

Hon. James S. Cowan: I think that those are all the questions that I had. I did have one statement that I wanted to get on the record. It tends not to do with this, but as long as I could have a minute at the end—

The Joint Chair (Mr. Robert Oliphant): You've got it now.

Hon. James S. Cowan: If colleagues wanted to ask questions of these witnesses, I—

The Joint Chair (Mr. Robert Oliphant): No, you're the last witness, so if you would like to make a statement—

Hon. James S. Cowan: It was just a point of clarification, perhaps.

Colleagues will recall that yesterday we had pediatric specialists here, and the suggestion was made that the provincial-territorial panel did not have access to pediatric expertise, that no witnesses were called, or that the aspect of the pediatric lens, if I can put it that way, was not available to the provincial-territorial panel.

It struck me as a little odd, and I should have twigged to it at the time, but I didn't, and I went back and looked at the makeup of the provincial-territorial panel. A person whom I know very well, and I should have twigged to that last night, is Dr. Nuala Kenny, who is a pediatrician. She is a fellow of the Royal College of Physicians and Surgeons of Canada in pediatrics. She was in pediatrics at Sick Kids Hospital in Toronto, at Queen's, and then came to Dalhousie, where I knew her and where she was the head of the department of pediatrics and chief of pediatrics at the children's hospital in Halifax. She's also a past president of the Canadian Pediatric Society.

She was not a witness before the panel, but a member of the panel. I would take it that the members of the panel felt that they had that pediatric lens in their membership, so I just wanted to make that clarification.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Chair, in response to that, I just want to clarify that I was not implying that there were no pediatricians involved.

The question last night was specifically whether the Canadian Pediatric Society had been consulted. On two occasions, it was made very clear that they were not.

That's the only point that I was making.

The Joint Chair (Mr. Robert Oliphant): Very good.

That brings this meeting to a close.

I just wanted to thank our witnesses.

Just because I know your resumes are very important to you, you might want to know that you're witnesses numbers 59, 60, 61, and 62 of our hearings, and that we have had, over the last nine days, 11 meetings. We've heard from 62 witnesses and we have received over 100 written briefs to be considered. Your testimony, as well as that of 58 others, will be considered starting tomorrow morning at 9 o'clock in room 237-C in Centre Block.

We will gather again tomorrow morning at 9 o'clock. We will meet twice tomorrow to give instructions to the analysts. The end is in sight.

Thank you very much.

The meeting is adjourned.

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