



# DEBATES OF THE SENATE

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OFFICIAL REPORT  
(HANSARD)

Monday, June 13, 2016

The Honourable GEORGE J. FUREY  
Speaker

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## THE SENATE

Monday, June 13, 2016

The Senate met at 5 p.m., the Speaker in the chair.

Prayers.

### VICTIMS OF TRAGEDY

#### ORLANDO, FLORIDA—SILENT TRIBUTE

**The Hon. the Speaker:** Honourable senators, I ask that we observe a minute of silence in memory of those who lost their lives in the tragic shooting in Orlando, Florida, in the early hours of Sunday morning. Our thoughts and prayers are with the victims, their families and friends, and all those affected by this terrible act of violence.

*Honourable senators then stood in silent tribute.*

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### SENATORS' STATEMENTS

#### TRAGEDY IN FLORIDA

**Hon. Murray Sinclair:** Honourable senators, shortly after midnight on Saturday night, our openly gay daughter sat and laughed with us, as my wife and I and her sisters sang her "Happy Birthday," badly I might add, as all families do, but with huge amounts of love. She turned 33 on Sunday, June 12.

At almost the same moment, an American filled with hate for lesbians, gays, bisexuals, transgendered, queer and two-spirit people carried his legally purchased machine gun and pistol into a bar in Orlando, Florida, and started killing everyone he could.

Eventually, over a period of three hours, he hunted down all those he could find in the bar and killed 49 young men and women, whose only reason for being targeted was that they were celebrating Pride month and were openly gay.

Much has been made of the shooter's connection to Islamic terrorism and his ability to purchase, own and carry guns, despite his history of mental disturbance and violence. American politicians and others will line up in one camp or the other to denounce those who they say caused this to happen, whether close at hand or remote. The number of political footballs this event presents for use is significant. You need only look at the headlines today to get a flavour of that.

But yesterday and today, I thought only of the 49 mothers and fathers whose hearts are broken and whose lives have been torn asunder, and I think every day of the fact that I could have been and could be one of them. I think of the dozens of brothers and sisters born into the victims' families, whose anger and tears may never end, and I think of the fact that my other children could be among them also.

Society's dislike and disrespect for those who are gay and transgendered has been a part of Western thinking for many generations. The enhancement and recognition of their right to be who they are and their right to public protection of those rights does not sit well with far too many people, the shooter in this case being representative of that.

When my daughter spoke to us as a young teenager of her recognition of who she was, we stood beside her and gave her every assurance of our love and of her right to be open about what she was.

What my wife and I could not bring ourselves to discuss with her, or between ourselves, at that moment was that she had just enhanced her risk of danger. She was already living a life of enhanced danger just by being female. That danger was increased by the fact that she was in a higher at-risk group because she was an Indigenous woman.

We told her about the fact that among Indigenous people, being a two-spirit was traditionally a position of respect and honour. Ceremonies, we have been taught, are enhanced if done by or with two-spirit people present, for it is believed that they embody the strengths and spirits of both man and woman and bring a special healing power and medicine to every special event.

She has brought great respect to our family. We are said to be blessed by having her as a daughter because she is two-spirit, and we feel so. We adopted another two-spirit daughter into our family as well, whose partner just gave birth to our newest grandson. He will be raised by two-spirit parents.

As parents of two-spirits, we want to protect our children from the bullying, the offensive comments, the disparaging remarks and the physical and verbal abuses that every member of the LGBTQ2S experiences. We have learned to shield them and to heal them when our shields prove insufficient.

What we fear the most is that someone will murder them just for being gay. The belief that such an event could occur would be enough for many to discourage their children from coming out, and it would also discourage the children themselves.

So in our moment of silence, I thought of the parents. We as a society have all lost something as a civilized people in this act of mass murder, but they have lost more than we can ever know.

## THE LATE GORDON “GORDIE” HOWE, O.C.

**Hon. David Tkachuk:** Honourable senators, last week a sporting legend passed away. Gordie Howe may have belonged to the world, but those of us from Saskatchewan never let the world forget where he was from. He was one of us.

Born in 1928 in Floral, Saskatchewan, he grew up playing shinny on prairie ponds but ended his career as one of the most celebrated players in NHL history. As kids playing hockey in our province, and I'm sure on ponds all across Canada, we all wanted to be Gordie Howe.

A 23-time NHL All-Star, the NHL's leading scorer from 1950 to 1954 and again in 1957 and 1963, he won the Stanley Cup four times and was six times named the league's most valuable player. This was when there were only six teams in the NHL and the talent was as deep as you can imagine: Maurice Richard, Jean Beliveau, Bobby Hull, Stan Mikita. These are all legendary names in hockey. Gordie Howe not only played against them, many times he outplayed them. There is not one on that list who didn't respect him and not one he didn't outlast.

• (1710)

He played professional hockey for 32 years in six different decades, retiring finally at the age of 52. Nobody has seen the likes of it since. This was in the age when nutrition consisted of eating a big steak before a game and exercise consisted of bailing hay in the off-season.

But the most impressive thing about Gordie Howe was his ability to do it all: score, shoot either right or left, assist, offence, defence. “I've never played against anyone who does so many things so well,” Bobby Hull once said of him.

He had no need for an enforcer. He was his own. Nobody who knows the name Gordie Howe doesn't know about his legendary scrap with Lou Fontinato, a New York Rangers tough guy at the time. As Sportsnet described it, Fontinato had carved open Howe's face with his stick in 1959. Howe bided his time before thumping him up in a one-sided fight that left his rival bloodied with a relocated nose.

He could not only fight, he was also a very physical player. As he put it, “I played a little rough. Respect gave you more room, and if you get a little more room to manoeuvre, then you're going to be a better hockey player.”

Howe was a consummate gentleman away from the arena. As our former colleague and Howe's former teammate Frank Mahovlich put it: “He was so nice to be around. It's like two personalities. Once you got on the ice, boy, you didn't want to go in the corner with him without your eyes open because you were liable to get an elbow or something. He was a tough guy to play against.”

Honourable senators, Gordie Howe was my kind of hockey player, and with that kind of approach would have been my kind of politician. My condolences go out to his family, his friends and all those who mourn him.

## RESIDENTIAL SCHOOLS

### RECONCILIATION THROUGH EDUCATION

**Hon. Elizabeth Hubley:** Honourable senators, on Friday, May 13, it was my pleasure to attend an event called Practising Reconciliation through Education: The History and Legacy of Canada's Indian Residential Schooling System. This took place in Summerside, Prince Edward Island. The event was facilitated by the P.E.I. Human Rights Commission, in conjunction with the Summerside Intermediate School and the P.E.I. Department of Education, to showcase a newly developed curriculum that looks at the impact of residential schools on Aboriginal communities.

As the pageant unfolded, students participated in a blanket ceremony. Blankets were spread in the middle of the gymnasium, representing Turtle Island or North America. This would help the students understand what happened at residential schools. The blankets under their feet got increasingly smaller as the students were walked through the loss of land, the loss of culture, the loss of autonomy and respect. They knew first-hand and experienced what First Nations people went through. The ceremony ended with the blankets being unfolded again, signifying hope as we move forward towards reconciliation.

Students also worked with Gilbert Sark of Lennox Island First Nation to build a traditional drum and learn the traditions and stories behind it. They also had an opportunity to join a drumming circle.

Practising Reconciliation through Education is the title of the new course, which focuses on the history and the legacy of Canada's residential school system. Summerside Intermediate was the first Island school to pilot this project in two of their classes.

This course is now being taught to every Grade 9 student on Prince Edward Island. Students are being taught how those schools and the Indian Act itself left scars not only on the children who attended but on the generations that followed. The P.E.I. Human Rights Commission has partnered with the UPEI Faculty of Education and the P.E.I. Department of Education to develop and deliver curriculum to all students within the public education system.

I would like to congratulate the many organizers, stakeholders and participants on an informative and successful event. The integration of this program into the curriculum is imperative as we look towards a generation to continue the important work of reconciliation. Thank you.

### BRAIN INJURY AWARENESS MONTH

**Hon. Mobina S. B. Jaffer:** Honourable senators, I rise today to speak on Brain Injury Awareness Month, about the devastating consequences of brain injury. Brain injury is devastating not only to the survivors but also to family members, caregivers, support workers and volunteers.

Bill Hicks felt as if he had accomplished his most cherished dream at the age of 23. Bill had a keen sense of rhythm. He loved nothing more than drumming. Bill was a full member of

Vancouver's Powder Blues Band, a Juno Award-winning act. His album sales were in the hundreds of thousands. He had gigs galore. Then one day a phone call from home at an odd hour changed his life forever. His mother, her voice crackling, told Bill that his 16-year-old brother Kevin had been in a serious car crash.

Bill sat at Kevin's bedside day after day while Kevin lay in a coma in a Victoria hospital in British Columbia. Bill would talk to Kevin and gently place headphones over his brother's ears so that he could hear their favourite rock hits. Honourable senators, Kevin and his whole family's lives changed forever.

We support many Canadians suffering with brain injury. It is our responsibility to protect these people. Emergency care following a car crash or an aneurysm is often outstanding, but what happens in the years that follow is too often a slow journey into despair, poverty and hopelessness.

Honourable senators, I invite you to recognize those suffering from brain injuries. It is an issue we cannot ignore. Today I ask you to remember the people who are suffering from brain injuries and also their families as we raise awareness of brain injury in this Brain Injury Awareness Month. Thank you.

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## ROUTINE PROCEEDINGS

### STUDY ON ISSUES PERTAINING TO INTERNAL BARRIERS TO TRADE

#### FIFTH REPORT OF BANKING, TRADE AND COMMERCE COMMITTEE TABLED

**Hon. David Tkachuk:** Honourable senators, I have the honour to table, in both official languages, the fifth report of the Standing Senate Committee on Banking, Trade and Commerce, entitled: *Tear down those walls: Dismantling Canada's internal trade barriers*.

(On motion of Senator Tkachuk, report placed on the Orders of the Day for consideration at the next sitting of the Senate.)

## THE SENATE

### NOTICE OF MOTION TO EXTEND WEDNESDAY'S SITTING

**Hon. Diane Bellemare (Legislative Deputy to the Government Representative in the Senate):** Honourable senators, I give notice that, at the next sitting of the Senate, I will move:

That the provisions of the order of February 4, 2016, respecting the time of adjournment, be suspended on Wednesday, June 15, 2016; and

That the provisions of rule 3-3(1) also be suspended on Wednesday, June 15, 2016.

## INTERNAL ECONOMY, BUDGETS AND ADMINISTRATION

### NOTICE OF MOTION TO AUTHORIZE COMMITTEE TO MEET DURING ADJOURNMENT OF THE SENATE

**Hon. Leo Housakos:** Honourable senators, I give notice that, at the next sitting of the Senate, I will move:

That, pursuant to rule 12-18(2)(b)(i), for the remainder of the current session the Standing Committee on Internal Economy, Budgets and Administration be authorized to meet, even if the Senate may then be adjourned for a period exceeding one week.

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• (1720)

[Translation]

## ORDERS OF THE DAY

### BUSINESS OF THE SENATE

**Hon. Diane Bellemare (Legislative Deputy to the Government Representative in the Senate):** Honourable senators, pursuant to rule 4-13(3), I would like to inform the Senate that as we proceed with Government Business, the Senate will address the items in the following order: Motion No. 25, followed by all remaining items in the order in which they appear on the Order Paper.

[English]

## THE SENATE

### MOTION TO AFFECT QUESTION PERIOD ON JUNE 14, 2016, ADOPTED

**Hon. Diane Bellemare (Legislative Deputy to the Government Representative in the Senate):** pursuant to notice of June 10, 2016, moved:

That, in order to allow the Senate to receive a Minister of the Crown during Question Period as authorized by the Senate on December 10, 2015, and notwithstanding rule 4-7, when the Senate sits on Tuesday, June 14, 2016, Question Period shall begin at 3:30 p.m., with any proceedings then before the Senate being interrupted until the end of Question Period, which shall last a maximum of 40 minutes;

That, if a standing vote would conflict with the holding of Question Period at 3:30 p.m. on that day, the vote be postponed until immediately after the conclusion of Question Period;

That, if the bells are ringing for a vote at 3:30 p.m. on that day, they be interrupted for Question Period at that

time, and resume thereafter for the balance of any time remaining; and

That, if the Senate concludes its business before 3:30 p.m. on that day, the sitting be suspended until that time for the purpose of holding Question Period.

She said: Honourable senators, as you know, we will have Question Period with a minister tomorrow. It will be the Minister of International Trade, Minister Freeland. We are expecting her tomorrow. The motion is about making time for her.

**Hon. Art Eggleton:** I have a question. Since we're heavily into the debate on Bill C-14, is this the appropriate time to be having a minister come in? The minister is very appropriate for a number of reasons, and I would hope that we would have her, but I wonder if this is the right time, in view of all of the stuff we have before us.

**Hon. Peter Harder (Government Representative in the Senate):** If I could answer that very good question, after consultation through the usual channels, we're proceeding in the way Senator Bellemare has outlined.

**The Hon. the Speaker:** Is it your pleasure, honourable senators, to adopt the motion?

**Hon. Senators:** Agreed.

(Motion agreed to.)

## CRIMINAL CODE

### BILL TO AMEND—THIRD READING— DEBATE

On the Order:

Resuming debate on the motion of the Honourable Senator Baker, P.C., seconded by the Honourable Senator Harder, P.C., for the third reading of Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), as amended.

**Hon. Betty Unger:** Honourable senators, I rise today to move an amendment to Bill C-14 regarding the role of nurse practitioners.

Doctors and nurses have worked in a collaborative relationship for generations, but by virtue of their advanced education, doctors have been in charge.

My amendment is straightforward. It seeks to affirm the continuation of this symbiotic relationship. To be clear, my amendment does not prohibit nurse practitioners from being involved in the process. It simply makes certain that they do so under the guidance and instruction of a physician, as is the practice in many provinces and was recommended by the Special Joint Committee on Physician-Assisted Dying.

Furthermore, this amendment does not permit nurse practitioners to assess patients for competency, which must be done only by a qualified physician.

I believe this change will be appreciated by registered nurses who are entitled to practise as nurse practitioners. The amendment appears lengthy only because it impacts the legislation in 21 different places due to the frequency in which the words "nurse practitioner" appear in the bill. It makes changes to pages 3, 4, 6, 7, 8, 9 and 11. However, the Office of the Law Clerk advises me that, nonetheless, it is only one amendment and only the length of my reading makes it appear complicated.

I recognize that, for some senators, your first impulse will be to oppose this amendment, but I appeal to you to consider what I have to say. This issue has been characterized as one of access.

The Minister of Justice, when speaking to the Standing Senate Committee on Legal and Constitutional Affairs, said it this way:

In terms of nurse practitioners, Minister Philpott and I . . . recognized the need to ensure access to medical assistance in dying across the country and that . . . more remote areas communities sometimes don't have the benefit of a doctor. . . .

The minister's concern is that if we do not allow nurse practitioners to provide medical assistance in dying, then access will be restricted. In fact, the only rationale provided for granting this role to nurse practitioners is to ensure access.

In response to this, I will say two things. The fact is, we don't know how many people will ever request medical assistance in dying. Thus, this would be providing a solution to a problem that may not exist. The number of requests, due to the size of these communities, is likely to be very small and infrequent — and I'm speaking about communities in the North. Therefore, I'm surprised that this aspect of the legislation is so overbroad in comparison to what the reality is likely to be. If there is a request, surely the solution is not to provide a sweeping exemption to nurse practitioners who have less training than a physician.

I would propose that a better solution is to follow the process already utilized in health care. When a medical service is not available at a particular facility, either a doctor who specializes in that treatment is brought in or the patient is transferred to a different facility.

Consider what Carolyn Pullen, Director of Policy, Advocacy and Strategy with the Canadian Nurses Association said to the Senate Committee on Legal and Constitutional Affairs:

In both the case of abortion and in medical assistance in dying, these are not emergency situations. There is time, even in remote or rural circumstances, where if a provider needs to recuse themselves from the process, there would be policies and practices in place to bring in a substitute provider to provide that care.

Now, Ms. Pullen was actually speaking to a question on conscientious objection. However, her response provides evidence applicable to assisted dying as well.

My second point, colleagues, is with respect to adequate safeguards. Nurse practitioners provide significant and valuable services in health care. But as I previously stated, they do not have

the training that a physician does, and there is broad acceptance that more critical procedures should be left to those who are best qualified. We expect this as a safeguard not only in health care but especially in end-of-life care, because nurses will have never received training in that discipline; yet the aspect of Bill C-14 that grants nurse practitioners the same duties as physicians increases access at the expense of safeguards.

Colleagues, consider this: Aside from abortion, there is no practice in health care more deadly than the one we are legislating on, and yet we're being asked to accept that someone who does not have the training and experience of a physician should be able to assess and approve a patient for competency and consent. Furthermore, and this is no small thing, they could then carry out the act of ending that patient's life, which has never before been part of their nursing culture or experience. We are the last bastion before Canada enacts legislation for physician-hastened death.

• (1730)

Honourable senators, the Supreme Court was clear that a system of medical assistance in dying would require stringent and well-enforced safeguards. Without this amendment, we will fail to comply with this directive.

I recognize that some senators may have concerns about jurisdictional issues, so allow me to speak to this briefly. I have considered this issue of jurisdiction, and while I acknowledge that we must be cognizant of jurisdictional issues, I believe we would be making a mistake to defeat this amendment on that basis.

Allow me to explain. This bill is a federal bill which contains explicit permission granting nurse practitioners to carry out medical assistance in dying. I am simply recommending that this permission be contingent on the instruction of a physician.

Because we are amending the Criminal Code of Canada to make an exemption with respect to homicide, it is entirely appropriate for Parliament to provide clear direction regarding who has the right to approve and to administer such a practice. I believe this is a necessary amendment, and I am asking for your support today.

#### MOTION IN AMENDMENT

**Hon. Betty Unger:** Therefore, honourable senators, I move:

That Bill C-14, as amended, be not now read a third time but that it be amended

(a) in clause 2 on page 3,

(i) by replacing line 10 with the following:

“acting on the instruction of a medical practitioner commits culpable homicide if they provide that person with”,

(ii) by adding line 12 after the following:

“(1.1) No medical practitioner commits culpable homicide if they instruct a nurse practitioner to provide a person with medical assistance in dying in accordance with section 241.2.” and

(iii) by replacing line 15 with the following:

“or nurse practitioner acting on the instruction of a medical practitioner to provide a person with medical”;

(b) in clause 3,

(i) on page 4,

(A) by replacing line 4 with the following:

“(2) No medical practitioner or nurse practitioner acting on the instruction of a medical practitioner com-”,

(B) by replacing line 10 with the following:

“medical practitioner or nurse practitioner acting on the instruction of a medical practitioner to provide a”, and

(C) by replacing line 15 with the following:

“acting on the instruction of a medical practitioner commits an offence under paragraph (1)(b) if the phar-”,

(ii) on page 6,

(A) by replacing lines 2 to 24 with the following:

(3) Before a medical practitioner provides or instructs a nurse practitioner to provide a person with medical assistance in dying, the medical practitioner must”, and

(B) by replacing line 33 with the following:

“by a medical practitioner that”,

(iii) on page 7,

(A) by replacing lines 4 and 5 with the following:

“(e) ensure that another medical practitioner has provided a written opinion confirm-”,

(B) by replacing lines 8 to 10 with the following:

“(f) be satisfied that they, the other medical practitioner referred to in paragraph (e), and, if any, the nurse practitioner, are independent;”,

(C) by replacing line 15 with the following:

“other medical practitioner re-”, and

(D) by replacing lines 19 to 22 with the following:

“riod that the first medical practitioner considers appropriate in the circumstances;

(h) immediately before medical assistance is provided, give the person an opportunity to with-”,

(iv) on page 8,

(A) by replacing lines 8 to 12 with the following:

“(6) The medical practitioner providing or instructing a nurse practitioner to provide a person with medical assistance in dying, the medical practitioner who provides the opinion referred to in paragraph (3)(e) and, if any, the nurse practitioner providing medical assistance in dying are independent if they

(a) are not in a business relationship with the other practitioner or practitioners, a mentor to the other practitioner or practitioners, or re-”,

(B) by replacing line 21 with the following:

“the other practitioner or practitioners, or to the person making the re-”,

(C) by replacing line 27 with the following:

(8) The medical practitioner or nurse practitioner acting on the instruction of a medical practitioner who,” and

(D) by replacing line 35 with the following:

“241.3 A medical practitioner who,” and

(v) on page 9.

(A) by replacing line 2 with the following:

“graphs 241.2(3)(b) to (h) is guilty”, and

(B) by adding the following after line 7:

“241.301 A medical practitioner or nurse practitioner acting on the instruction of a medical practitioner who, in providing medical

assistance in dying, knowingly fails to comply with the requirement set out in subsection 241.2(8) is guilty of an offence and is liable

(a) on conviction on indictment, to a term of imprisonment of not more than five years; or

(b) on summary conviction, to a term of imprisonment of not more than 18 months.”;

(c) in clause 4, on page 9, by replacing lines 31 to 33 with the following:

“made under subsection (3), a medical practitioner who receives a written request for medical assistance in dying or a nurse practitioner who is instructed by a medical practitioner to provide medical assistance in dying must, in accordance with”; and

(d) in clause 6, on page 11,

(i) by replacing line 28 with the following:

“(a) a medical practitioner or a nurse practitioner acting on the instruction of a medical practitioner who”, and

(ii) by replacing line 32 with the following:

“ing a medical practitioner or a nurse practitioner acting on the instruction of a medical practitioner to pro-”.

Thank you.

**The Hon. the Speaker:** Honourable senators, the amendment is about to be distributed. We won't start the debate until that is done. As well, I understand that Senator Unger distributed this amendment electronically prior to the sitting, but it is being distributed in hard copy now.

If it is the wish of honourable senators to take a moment until the amendment is distributed, we will wait until all honourable senators receive it before we continue with the debate.

• (1740)

In any event, Senator Unger, your time has expired and a number of senators have risen with the intention of asking questions. Is it your intention, Senator Unger, to take questions?

**Senator Unger:** Yes.

**The Hon. the Speaker:** Are you asking for extended time of five minutes?

**Senator Unger:** Yes, please.

**The Hon. the Speaker:** Is leave granted, honourable senators?

**Hon. Senators:** Agreed.



**The Hon. the Speaker:** We have a list of senators who want to ask questions. The amendment is being distributed and we'll move to questions on debate.

**Hon. Mobina S.B. Jaffer:** Thank you very much, Senator Unger, for the amendment. I listened to you carefully and you also gave us this amendment beforehand. If I understand you well, you're saying that a nurse practitioner should not be able to help somebody when they are having challenges.

Senator Unger, we have a large country. In committee we heard that many places in our country only have nurse practitioners and that they do not have other medical practitioners. If in a large area there are only nurse practitioners, what happens to those communities? Will they be denied access to assisted dying?

**Senator Unger:** Thank you, Senator Jaffer, for your question.

I believe that the minister stated what would happen in cases like that. She stated that neither abortion, for example, nor medical assistance in dying is urgent. If a doctor could not be flown in, then the person requesting PAD, physician-assisted dying, could be moved to a location where it would be available.

**Hon. Terry M. Mercer:** Senator Unger, I was curious as you started reading because I recalled something about your background when you came here as a senator. I did a quick check to make sure I was right. You were a registered nurse.

That being the case, I thought that the country had been moving, generally across the board, more and more of our medical care to the extremely well-trained, well-qualified registered nurses, or nurse practitioners, particularly in rural areas.

Senator Jaffer asked a question of you. If your answer were to come into play, it would isolate tens of thousands, if not millions, of Canadians who would not have access. I'm not defending it; I haven't decided how I'm voting on this bill. However, I am concerned that whatever the bill is, everybody has access to it.

We've gone for 30 years with a whole province not having access to one service that was available in all the other provinces. I don't think it's fair. If you are saying that someone who is in a position where they want to access this service will have to move, that would probably be a physical and psychological burden to them. If you're talking about someone in Northern Canada, that's a long way to go, a costly way to go, and in many cases they can't get there by car, by train or bus. They can only fly. They have to fly from some remote area in the North perhaps to a place in the South or to a major centre in the North, if that's where the service is available. I think we've started to build our health delivery system around nurse practitioners in these remote communities. With this one amendment, you would start to move that backwards as opposed to putting more emphasis on the good services that nurse practitioners provide.

**Senator Unger:** Thank you for your comment, Senator Mercer.

The other suggestion is that a physician who probably routinely makes regular trips to remote communities would assist, or a video conference is possible.

I don't live in the North. Many of my colleagues who do could probably answer this question better, but I think that it's entirely possible for a person who requests this to have the assistance of a doctor who would be coming in, in any case.

There is one point of clarification with my background, honourable senators. It is true that I'm a former registered nurse; however, I was not a nurse who practised in a hospital. I worked for many years in nursing homes, and for three years I worked in a seniors' residence as a charge nurse. I have experience in that regard, and for the remainder of my time I was a nurse who started, founded, operated and ran a nursing services company.

**The Hon. the Speaker:** Senator Unger, your time has expired, but I noticed a couple of other senators who rose to ask a question. Do you wish to ask for five more minutes?

**Senator Unger:** Yes.

**The Hon. the Speaker:** Agreed colleagues?

**Hon. Senators:** Agreed.

**Hon. Frances Lankin:** Senator Unger, will you accept another question?

**Senator Unger:** Yes.

**Senator Lankin:** Thank you.

I listened carefully and I know that you thought through the issue of provincial jurisdiction. I want to come back to that because I'm not sure I have the same interpretation, and I'd like to understand how your thinking brought you to believe that this was a matter for federal jurisdiction.

Firstly, I recall that prior to the Charter, jurisdictional compliance in this Senate meant whether it was provincial or federal jurisdiction. That's what we were charged with. It still remains an important duty for us to ascertain when we're looking at the issue of constitutional compliance.

The scope of practice of a health care professional, as you would well know, is governed by regulated health professions legislation, which are provincial statutes. The scopes of practice vary slightly from province to province and jurisdiction to jurisdiction. In some jurisdictions there are separate scopes of practice for nurse practitioners, which are enhanced above the highest nursing levels, and they vary from province to province.

This bill, and this exemption that you speak to, exempts from prosecution under the Criminal Code. It does not enable someone to do something that's outside of their scope of practice. So if a nurse practitioner in a province did not have a scope of practice that would allow them to participate in medical assistance in dying, they would not be able to assist under their professional responsibility. In a province where they do, your amendments would take away part of their scope of practice and would put them under the direction of a medical practitioner.

With some parts of their scope of practice, they are currently under a medical practitioner's direction and with some they are not. I suggest to you all of that is provincial regulation, provincial legislation and provincial jurisdiction.

If your legislation would curb a nurse practitioner's scope of practice under provincial legislation by insisting that a doctor give direction before that nurse practitioner could act, is that not a matter of provincial jurisdiction?

**Senator Unger:** Thank you, senator. I'm not sure that I can answer all of your questions.

I do agree that health care — and this falls under health care — is a provincial issue. However, in dealing with this bill, physicians, medical practitioners, nurse practitioners and registered nurses are mentioned many times, and the bill legalizes homicide. So I feel that there must be some federal oversight on this matter.

• (1750)

The provinces, I know, will create their own legislation dealing with this, so I don't see that the two are necessarily in conflict. I think it needs to stay, in my opinion, the way it is.

**Hon. Donald Neil Plett:** Thank you very much for bringing this amendment forward, Senator Unger.

I'm sure you are aware that nurse practitioners in Ontario are not even allowed to order CT scans or prescribe narcotics, and yet this legislation allows them to assess a person's competency and whether or not they should require assisted suicide.

I find that to be, first of all, a little inconsistent. Of course, we heard a number of times from our colleague opposite that this is provincial jurisdiction. I'm not sure why the federal government is writing a bill if it's all provincial jurisdictions. I believe that when they craft a law, this falls under that law, and, as you say, nurse practitioners are mentioned numerous times in this.

I would ask you this: Do you find it inconsistent that a nurse practitioner cannot order a CT scan, cannot prescribe narcotics, but in fact can order or authorize assisted suicide?

While I'm up, could you give me an answer on another question? I'm not sure if you were at committee on this particular day, but I think it was the head of the nurses' association who I asked about conscientious objection. She was very adamant that assisted suicide, like abortion, is typically not an emergency surgery where somebody needs to be there at the moment.

I know Senator Patterson wants to speak and he lives up North, but I've travelled to every northern community that we have in Ontario, Manitoba and all over the Arctic. There are flights in and out of there every couple of days, if not daily. So I believe that when a person is in a life and death situation, surely they could wait a day or two for that person to fly out or a physician to fly in, which is what this nurse suggested, that physicians be able to fly in to assess this and help the nurse practitioner.

**The Hon. the Speaker:** Honourable senators, Senator Unger's extended time has now expired. Before asking leave for her to answer Senator Plett, may I suggest to other senators who wish to raise questions that they enter the debate because the time for Senator Unger has now expired twice.

Is leave granted for Senator Unger to answer the question?

**Hon. Senators:** Agreed.

**Senator Unger:** Thank you Senator Plett. You do raise some excellent points that I will try to clarify.

The role of a nurse practitioner and even registered nurses does vary from province to province, and if you Google the Canadian Nurses Association website you will see that there is more than one definition of what constitutes a nurse practitioner.

I believe that because there are many variances in this definition of nurse practitioner that it needs to be stated clearly here: nurse practitioner under the instruction of a medical practitioner.

To your second point, Senator Plett, that's where health care is really expanding. The availability of doctors to remote areas in the North is certainly much better now than it was, say, 10 years ago. That part is expanding for a very good reason. Doctors do fly in and out and patients are taken care of whatever their problems might be, especially in emergencies.

**Hon. Jane Cordy:** Thank you very much, Senator Unger, for bringing forward the amendment. As you were speaking, I was jotting down some notes, so I hope I can find everything in the right order.

As others have stated, nurse practitioners are regulated by the provinces and the territories. Newfoundland and Labrador and Manitoba brought in regulations for nurse practitioners in 1997, and Yukon was the last territory to regulate nurse practitioners. The regulations were passed in 2012 in Yukon, so every province and territory in Canada now regulates nurse practitioners.

The website of the College of Registered Nurses of Nova Scotia clarifies the role of nurse practitioners in Nova Scotia, and I'll read some of that since I'm from Nova Scotia. But before I do that, some have asked what the regulations are nationally.

The Canadian Institute for Health Information talks about the practice criteria for nurse practitioners and said:

To work/practise as a NP [nurse practitioner] in Canada, one must meet the following requirements:

- Be a registered nurse.
- Hold either a nurse practitioner post-baccalaureate certificate, a nurse practitioner post-graduate certificate and/or a nurse practitioner graduate degree.
- Pass an entry-to-practice exam that might vary depending on the area of specialty. The exam(s) to be taken are determined by the nursing regulatory body.

Lastly, what they say is this:

- Register with a provincial/territorial regulatory body as required.

This is clearly under the jurisdiction of the provinces and the territories.

In my province of Nova Scotia, to become a nurse practitioner you first have to be a registered nurse, but that's in the legislation anyway. The criteria state:

. . . must complete an approved NP education program, meet the entry-level NP competency requirements, pass the NP examination specific to their focus of practice and fulfil all other . . . registration and licensure requirements.

When you look at the Nova Scotia website, it says:

The nurse practitioner:

- Has the knowledge and skill to diagnose and treat acute and chronic illness
- Prescribe medications
- Order and interpret laboratory and diagnostic tests
- Perform procedures
- Refer to as well as accept client consultations from other health care providers.

Getting consultations from other health care providers is part of what you do. We can see that nurse practitioners are hands on with their patients and would be very knowledgeable about the health of their patients. We also can see that they are very well trained, but we do know that this is provincial/territorial jurisdiction.

Senator Unger, you said perhaps the doctor could make the decision based on a video conference. Personally, I would prefer that decision to be made by a nurse practitioner who would be at my bedside rather than a doctor who is on a video conference from Halifax or Montreal or wherever.

Like you, Senator Unger, I want to ensure that if the bill passes — and the Supreme Court has ruled that Canadians have the right to assisted dying — there are guidelines and safeguards in place to protect vulnerable Canadians. However, when we do that, we have to ensure that the guidelines are fair and that all Canadians, no matter where they live, have access to services.

Nurse practitioners are in Halifax, Ottawa, Montreal, Edmonton and Vancouver, and they can easily consult or act on the instructions of a medical practitioner or a physician to provide a person with medical assistance in dying. But I'm not sure that nurse practitioners in Pelly Crossing in Yukon or in Yellowknife or in Iqaluit or in northern British Columbia or in northern Quebec would be able to do so easily unless the

consultation was done by video conferencing, which I don't think is the optimal way to do it. Many remote areas only have nurse practitioners.

I cannot support this amendment for two reasons. First, the regulation of nurse practitioners clearly is under the jurisdiction of the provinces and the territories. As you stated in your letter and email to senators last week — and I appreciate the fact that you sent out your amendments early so that we could go over them:

This amendment may raise some concerns regarding jurisdictional issues.

For me, this does cause concern about jurisdictional issues.

Second, while I believe that we need very strong guidelines and safeguards in legislation for assisted dying, I believe that the bill as drafted provides protection while following the Supreme Court ruling, because we must not forget the Supreme Court ruling that all Canadians must have access to assisted dying. Whether we like it or not, that's the Supreme Court ruling.

Changing the bill so that nurse practitioners must only act on the instruction of a physician will cause uneven application of the law, particularly in remote areas of Canada. It would unfairly restrict access, in my mind, to those living in remote areas. Thank you.

• (1800)

**Hon. Grant Mitchell:** I won't be supporting it either. That's not to say that I don't absolutely respect the position that Senator Unger has taken. She has spoken eloquently on a number of occasions on this issue. Clearly she's passionate about it and a strong advocate for people who take her position. We should all respect that immensely.

I would like to address a point that was further emphasized by Senator Plett, namely, the question of scope of practice. Senator Unger has made that point in a number of ways, but she does point out in answer to one of the questions that in her case she wasn't involved in a medical practice that would lend her the background, experience and knowledge to act in the way that would be provided for in this bill for a nurse practitioner. Senator Plett went on to say that the way the nurse practitioner's role is defined in Ontario they wouldn't have the specific background or experience to act in that way either.

I would like to give them some comfort by reading from the bill where it specifically outlines in the definition of "nurse practitioner" the qualifications or expertise they need in order to qualify them to act in the way they would be able to under this bill. The definition says:

**nurse practitioner** means a registered nurse who, under the laws of a province, is entitled to practise as a nurse practitioner — or under an equivalent designation —

— and this is where the list is specific —

— and to autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances and treat patients.

This is a very specific class or category, if you will, of nurse practitioner. Their background, expertise and experience is very explicitly defined in this bill, and it's consistent with the background and expertise that would qualify them to act in the way they are allowed to under this bill.

While her amendment comes from a place of concern and wanting to emphasize prudence in this process, the bill meets her concern and defines “nurse practitioner” in a way that is consistent with the concern she's trying to avoid or correct. It's been corrected, accounted for and accommodated in this bill. While her amendment comes from a good place, it's not necessary. It is already covered in the bill, and so I won't be supporting the amendment.

**Hon. John D. Wallace:** Senator Mitchell, to Senator Unger's amendment, the bill, of course, is the result of the *Carter* decision. It's interesting — and I've thought of this many times myself in the context of the point raised by Senator Unger — that the Supreme Court, as I read it, spoke exclusively of physicians being involved in medical assistance in death. Nowhere is there any mention of nurses or nurse practitioners. I suspect the reason for that is because of the gravity and seriousness of the issue at hand. The Supreme Court wanted to make certain that those in the medical community that were involved were imminently qualified to provide the necessary care.

Having said that, paragraph 106 of the *Carter* decision says:

The trial judge found that it was feasible for properly qualified and experienced physicians to reliably assess patient competence and voluntariness, and that coercion, undue influence, and ambivalence could all be reliably assessed as part of that process.

It goes on to say:

She concluded that it would be possible for physicians to apply the informed consent standard to patients who seek assistance in dying, adding the caution that physicians should ensure that patients are properly informed of their diagnosis and prognosis and the range of available options . . .

Paragraph 127 states:

. . . s. 241 (b) and s. 14 of the Criminal Code are void insofar as they prohibit physician-assisted death for a competent adult person . . .

Do you believe that the bill is consistent with the intent that seems to have been clearly expressed by the Supreme Court?

**Senator Mitchell:** Senator, thank you for your question. It's clear that my position in this debate has been that while the courts are significant and powerful in their direction, there is room and

necessity for governments to govern. They have to deal with the practical problems and the day-to-day pressures of administering and managing programs such as this.

I'm not a lawyer, but I want to make the point that, on the one hand, there are those, and I think you're one of them, who argue that you can't take *Carter* explicitly with respect to foreseeable death because *Carter* goes beyond that. On the one hand, you accept that you don't take *Carter* explicitly. In this argument, you're saying I should take *Carter* explicitly because they don't talk about nurse practitioners; we shouldn't talk about them. I don't think you can have it both ways.

To give it some strength, the Supreme Court has recognized that the relationship between courts and Parliament is one of dialogue. The court explained this relationship in *R. v. Mills*, where they say:

To insist on slavish conformity would belie the mutual respect that underpins the relationship between the courts and legislature that is so essential to our constitutional democracy: . . .

That says the courts do defer to Parliament, which is responsible for governing, the chance to make adjustments from what appear to be black-and-white rulings.

In this case, given the need to consider rural and remote, as has been so well argued by others, and Senator Cordy, the nurse practitioner definition is consistent with the practice that's required and the demands of applying this program across a diverse country with very remote places.

We should be very careful selling nurses and nurse practitioners short. They work extremely hard in many remote places, under huge pressures, and they have distinguished themselves over many years and decades at operating at an extremely high level. I personally have a great deal of confidence in them and the services they provide. They are more than capable with this defined and specific list of background, experience, education and practice to fulfill the demands of *Carter* and to provide this service in a prudent, cautious and careful way.

**Senator Wallace:** Senator, I just wanted to clarify that I wasn't arguing in support of Senator Unger's amendment. I have some thoughts on it. I was asking you whether you believed that the bill was consistent with the *Carter* decision, because the wording seems to be clear in paragraph 127 that the relevant provisions of the Criminal Code were declared “void insofar as they prohibit physician-assisted death.” That seems pretty strong. I heard and thank you for your response.

• (1810)

**Senator Plett:** Senator Mitchell, I find it a little insulting that you would say that we are demeaning or belittling nurse practitioners by saying we want physicians involved. I think that's a very unfair comment. But that's a comment, not a question.

[ Senator Mitchell ]

My question is this: If in Pond Inlet somebody needs an appendectomy, needs their tonsils pulled or needs to have a hernia operation, chances are we will send in a surgeon or fly them out. That's a whole lot less serious than somebody asking for assisted suicide. Are you suggesting nurse practitioners start becoming surgeons as well? Because either these people will have to be flown out or a surgeon will have to be flown in. Again, that's not as serious as someone wanting to end their life. How do you square that box, that in that situation a nurse practitioner cannot do it, yet they're supposed to help decide on someone's last moment on this earth?

**Senator Mitchell:** Thank you, Senator Plett. I would say that there's a qualitative difference between taking somebody's appendix out and reviewing a request for their assistance in dying. You don't have to know somebody to take their appendix out, but it could be that for somebody living in an area like Pond Inlet, for example, who has been cared for by a nurse practitioner for many years, the nurse practitioner knows this person, their background, their history, their character and is probably in a far better position to assess that person's capability in requesting assisted death, over and above a doctor who would fly in for a day, never having known that person, not having known their circumstances, their life, their personality, their character, never having had a relationship with them. To say that that doctor could better assess that person's request than the nurse practitioner who has worked with them for years and knows them intimately and understands them — I would say that that nurse practitioner would be in a better position to assess that person's request than a doctor who comes from downtown somewhere in Canada and flies in for several hours to make an assessment.

**Senator Plett:** You may well be right, Senator Mitchell, but I don't think Senator Unger's amendment says that the doctor is not allowed to collaborate with that nurse practitioner. He or she is going in to assess a medical condition, not what that person's mood is and what their mood swings are, where someone who has been dealing with them regularly; he or she is going to check that person's medical history, charts, and wouldn't go in there for just 15 minutes, I'm sure.

Again, this is a final moment, and they would surely be professional enough that they would collaborate with the nurse practitioner in order to make their final decision.

**Senator Mitchell:** I simply believe that at the point at which this decision is being made, the medical condition is clearly extremely important but probably also quite evident. A nurse practitioner, with the kind of background that's been listed here, with the authority to autonomously make diagnoses, order and interpret diagnostic tests, is probably more than capable of making that assessment.

The next step in that assessment gets into the nature of the person. In order to assess that adequately and properly, I would think that having somebody who has known you and has cared for you for a long time in that medical relationship would probably be somebody who would be every bit as effective, if not more effective, than a doctor who doesn't know you at all.

**The Hon. the Speaker:** Do you want to take another question, Senator Mitchell?

**Hon. Yonah Martin (Deputy Leader of the Opposition):** I had a conversation with a lung specialist about this bill. He was talking about very specific skills and experience that would be needed to address such a medical request, such as people in palliative care and others.

I was listening to what you were saying about nurse practitioners. I also have great respect for them, but in my personal experience and observations, the people who actually would know the patient even better than nurse practitioners — who are caring for several floors and who are in and out — would be the care workers who are working very closely with the patients, sometimes 24 hours a day.

If you're looking at who knows them best, there are other individuals involved. This is a very specialized area, so would you not agree that when we talk about end-of-life care, it really does require very specialized medical professionals to be able to make such decisions?

**The Hon. the Speaker:** Senator Mitchell, your time has expired. Are you asking for leave to answer the question?

**Senator Mitchell:** Yes, please.

**The Hon. the Speaker:** Is leave granted, honourable senators?

**Hon. Senators:** Agreed.

**Senator Mitchell:** I think that you could argue that many medical professionals have a background but don't necessarily have, for example, the experience to assess that lung ailment that you've referred to in your example. I would expect that whether that was a nurse practitioner or a doctor who didn't have that experience, they would certainly be professional enough to understand that they would need to consult with somebody else to make sure that they made the proper diagnosis in that respect. I expect that that's a matter of course.

A medical doctor who needs assistance with the lung issue is just as likely to draw that conclusion as a highly professional, qualified, well-trained and provincially managed and administered practical nurse would come to. I don't think it distinguishes one from the other. In fact, it probably sustains for both equally.

**Hon. Carolyn Stewart Olsen:** I wanted to speak to this amendment because I actually do know the circumstances and have worked in these areas. I think there's a great misconception with many people.

I'm going to support the amendment for the nurse practitioners and for the nurses.

Decisions like this are of huge magnitude. They are not taken by one person or even two people. These decisions would be as a result of the team approach that is taken in hospitals, in small communities where there is just a nurse practitioner running the medical health unit, and in the North. Nothing is ever done that would be uncomfortable for nursing. Nurses are a valuable part of the health care team. Physicians, nutritionists, and psychiatrists, they're all part of a team.

When a person comes to their end of life or to what they believe is unbearable suffering, they don't just arrive there, call up the next day and say, "I'd like to die." There would be a lot of records. People have made that point.

I'll speak about the northern communities. They do everything. Their records would be sent to the main centre, to whichever physician is overseeing their work. There is always a physician overseeing their work. It would be unthinkable for me to make a decision on end of life without the backup of my colleagues.

I don't really go towards the training. I think that's irrelevant and not applicable here, in fairness, senator. All people who practise medicine in any shape or form are trained to the nth degree. They are all good and try to do the best things they can.

In this instance, we have to provide access for everyone, but in the understanding that people in remote communities — and I know of what I speak — sometimes have more access than maybe I do in Port Elgin, where I wait for my appointment. Urgent cases are dealt with urgently, and every province has those rules in place.

• (1820)

If you ask nurse practitioners to make this decision without the backup of his or her team, I don't think it's fair to them. We should put that in our thoughts as we think about this particular amendment. Thank you.

**The Hon. the Speaker:** Senator Boisvenu, on debate.

[Translation]

**Hon. Pierre-Hugues Boisvenu:** I would like to thank Senator Unger for her proposal. During the pre-study of the bill, the Standing Senate Committee on Legal and Constitutional Affairs discussed the controversial debate on the power granted to nurses.

The committee arrived at some very interesting conclusions. First, the evolution of the nursing profession toward super-nurses indicates that nurses will be taking on more and more responsibilities in the medical field.

The other important element is that in the medical field, we are seeing developments in distance medicine, via the Internet. I saw doctors in Montreal conduct surgeries on people in James Bay by giving a nurse, or a super-nurse, very specific instructions via the Internet. Wonderful things are being done through long-distance communication.

However, I am going to vote against this proposal because I think it goes against the evolution of the medical profession and could be harmful to remote regions. I come from the remote and sparsely populated region of Abitibi-Témiscamingue, where many services are provided by super-nurses.

It is important to understand that the relationship between doctors and nurses falls under the jurisdiction of the provinces and professional bodies. I cannot imagine a super-nurse in Quebec being given the responsibility of managing all of a

patient's end-of-life care. I find it inconceivable. One or two doctors or a specialist will always be providing medical supervision and diagnosing the patient, even if it is remotely.

The nurse's role will be to administer the drug if the patient wants to end his or her life. We are far from a standard practice that would give nurses all over Canada the sole responsibility for diagnosing patients, monitoring them and eventually helping them to end their life, if that's what they want. We are not even close to that.

It is therefore impossible for me to vote in favour of this amendment because it goes against the evolution of medicine, which seeks to ensure that doctors provide the same quality of care to patients in remote regions, often through a well-trained, competent and properly supervised super-nurse. That is why I am going to vote against this proposal.

[English]

**Hon. Denise Batters:** Honourable senators, I'd like to briefly speak in support of this amendment to limit the role of nurse practitioners in assisted suicide.

Further to what Senator Wallace was earlier stating, the Supreme Court of Canada's *Carter* decision made no reference whatsoever to nurse practitioners. Throughout the judgment the phrase "physician" is used in relation to assisted suicide over 100 times, including in the operative paragraph 127, but the term "nurse practitioner" was not mentioned even once. I submit it was not the Supreme Court of Canada's intention to extend the power to nurse practitioners to assess and approve patients for assisted suicide, or to administer it.

Both the Minister of Health and the Minister of Justice have asserted that they have included nurse practitioners in Bill C-14 in order to improve access to assisted suicide for Canadians living in rural and remote areas, yet they have not placed any such geographic restriction on the use of nurse practitioners in the bill. What this means essentially is that patients will not only be able to shop around for physicians who will be able to provide them with assisted suicide, now they will also be able to search for nurse practitioners to provide it for them as well. Even more disturbing, the legislation allows for approval for and administration of assisted suicide by two nurse practitioners in the absence of sign-off by any physician. This is not what the court intended, and it is not what Canadians want.

In two of Canada's most populous provinces, Ontario and B.C., nurse practitioners are not currently permitted to prescribe narcotics to patients. In some places, nurse practitioners cannot order certain tests, et cetera, without a doctor's approval.

In Ontario, for example, a nurse practitioner cannot prescribe codeine for a patient, and yet under Bill C-14, they would have the authority to decide whether or not that patient should die. I fail to see the logic in that.

I do not mean in any way to diminish the important role nurse practitioners play in our health care system. They are skilled, educated and competent. However, the fact remains that they are

[ Senator Stewart Olsen ]

not doctors. When it comes to decisions around assisted suicide, decisions of life and death, those should only be made by those with a physician's training, education, expertise and certification.

If, as the ministers state, this is a question of access, then Senator Unger's amendments are a reasonable compromise. They would leave the decision-making process around a patient's competency and informed consent in the hands of doctors, where it rightfully belongs, but would allow nurse practitioners to deliver assisted suicide to patients after the appropriate assessment and approval by a qualified medical practitioner. This could address issues of access to assisted suicide in rural and remote areas, while still ensuring that a physician ultimately reserves the decision-making authority regarding assisted suicide.

For these reasons, honourable senators, I will be supporting Senator Unger's amendments, and I encourage you to do the same. Thank you.

**The Hon. the Speaker:** Senator Patterson, on debate.

**Hon. Dennis Glen Patterson:** First, I support nurse practitioners. That's what I heard from most of our colleagues here. In Northern Canada, and I'll speak of Nunavut, which is my recent experience, nurse practitioners are the backbone of health services for the residents. Northern Canada has always been a leader in offering accessible and sometimes emergency health services in remote communities. By speaking in support of this amendment, I do not want to suggest that I don't have any confidence in nurse practitioners.

The reality, though, is that we don't have proper Internet services in most Nunavut communities, even the most populous communities. There are no fibre optics. Bandwidth is such a serious problem that you can't get Netflix, let alone consult with a medical practitioner by Internet.

The amendment talks about a nurse practitioner acting on the instruction of a medical practitioner. I understand that in rare cases that could be done over the telephone if necessary.

The reality, though, Your Honour, is that people who are seriously ill and terminally ill are being medically evacuated to three regional centres in Nunavut which do have doctors available year-round. Nunavut spends about a third of its health budget on medical travel. By the way, it was about \$65 million in 2014-15. Half of that was spent on physician travel to communities, where you might have a physician and a nurse practitioner interacting with a terminally ill patient, just like the amendment envisions.

The other \$57 million dollars was spent medically evacuating people outside the territory, including to Ottawa, Winnipeg and Edmonton, if it's Northwest Territories.

My concern about this bill is that with Senator Joyal's amendment we have opened the classes of categories to which medically assisted death could be offered. We have done so without, I'm concerned, thoroughly canvassing the issue of safeguards. To me, giving responsibility to nurse practitioners in a remote location creates a more risky situation.

• (1830)

As I say, I support the work of nurse practitioners, but I would venture to say that many of them, with such a grave decision, would welcome and, as another senator said, would probably consult with a medical practitioner so as not to have that burden on their own, if a patient was in fact in a remote location.

Because I am concerned about developing safeguards and because I think there might be a case where a nurse practitioner might — it would probably be a rare case — be in a situation where they are asked to participate in a medically assisted death, I think the amendment makes sense, and I will support it.

I do also want to say that there has been a lot of debate today about provincial or federal jurisdiction. The bill does address nurse practitioners, and therefore I think it's appropriate that we should be looking at the responsibilities of nurse practitioners in this legislation and through this amendment.

So because I'm leaning towards building safeguards in light of the broadening of classes of eligible patients in Senator Joyal's amendment, which I voted against, I am going to support this amendment.

**Hon. Murray Sinclair:** Thank you, Senator Unger, for bringing this matter to our attention and for sharing your comments ahead of time today, but I do rise to speak against the amendment.

First of all, I want to comment about the purpose that I see behind the provisions that are being sought to be changed. One is that nurse practitioners are, by and large, the sole source of medical care in most northern communities and remote communities in Canada. It causes me concern to think that we might, through an amendment like this, be putting the interests of the people of the North, particularly the indigenous people of the North, who have limited access to medical care already, in a situation where the right that the Supreme Court of Canada has acknowledged they have may not be exercisable because of lack of access to proper medical care. So, honourable senators, I encourage you to think very carefully about that before we approve an amendment such as this.

One of the comments I heard here today was that there is adequate provision of medical care to people in remote communities. That kind of caught me by surprise, because over the many years that I've been studying indigenous issues in Canada, the one constant theme when it comes to the medical services provided to indigenous people is that they receive the poorest amount of medical care in all of Canada. They access fewer doctors and medically trained physicians and less often than any other identifiable group in Canada, and the provision of medical services to them in a timely manner is sorely lacking.

For it to be suggested that they can be flown out in order to be able to talk to a doctor sort of misses the point because most of the individuals are not in a condition where they can be flown out; most of them are not in a hospital or medical facility. I would suspect that most of them would already be at home in the last stages of life, which is why this provision is part of the bill.

We are talking about people here who the Supreme Court says must firstly be suffering from a grievous medical condition that causes them intolerable suffering. For us to suggest that they should simply be flown out to Winnipeg, Montreal or Ottawa in order to consult with a doctor so that they can be allowed to die seems to me to be so illogical that it's almost reprehensible to say it. They want to be able to do this in their homes with their families in attendance in their communities, and I would think that we should be considering facilitating that and how to facilitate that rather than how to make it more difficult for them to be able to exercise medical care and their rights.

I also want to point out, as Senator Mitchell has, that if a nurse practitioner does not have the authority to prescribe narcotics, he or she is not a nurse practitioner for the purposes of this law. Nurse practitioners, as identified in the Criminal Code, are only those people who can prescribe narcotics and certain kinds of medical treatments and medical tests. And if the provincial legislation that they are governed by in Ontario says they can't do that, then they can't do it for purposes of the Criminal Code.

So there's nothing to be concerned about in terms of giving somebody licence under this law to do something they can't do in provincial law, because if you can't do it in provincial law, you can't do it under this bill.

I don't know why that issue is even before us, because the reality is it's the provinces that determine what a nurse practitioner is. The Criminal Code says if the province designates you as a nurse practitioner and you can prescribe narcotics and you can order tests, then you will not be prosecuted if you assist someone to die, provided, of course, that you comply with the bill in all other respects.

This bill is about who is going to be prosecuted and who is not going to be prosecuted and who is going to go to jail and who is not going to go to jail. I want to point out that the Government of Canada could, in response to *Carter*, have simply said anybody can assist someone to die and not be prosecuted. That's not an unreasonable response to a court decision that says you have the right under the Charter to be assisted to die.

It refers to physician assistance, there's no question of that, but that was the evidence before the court. I don't think for a moment that the court ultimately would say, "Government, you have to impose some physician assistance here in order for the right to be a right." You have the right; it's an absolute right, unless you prescribe some limitations to it. They may have suggested some by saying "physician assistance is what we're thinking about," but that doesn't mean that if the government decides not to require physician assistance and decides not to prosecute people who assist other people to die, it's illegal. It's not.

So the legislation, this particular bill, needn't even be here; if the government chose not to legislate, there would still be a right to die. In the absence of this bill, nurse practitioners, and any other person in Canada probably, could assist someone to die. Those are the potential implications of *Carter*, because *Carter* does talk about physician assistance, but what it ultimately says is that everyone under section 7 of the Charter has the right to medical assistance in dying. It doesn't say that it has to be only those who are licensed medical practitioners, for example. That might be what they intended to say, but who knows what the future holds.

I do point out that for purposes of this particular bill, to take out all references to "nurse practitioners" is going to result in a denial of access to care to a large potential area of the population, and that is those who cannot get proper medical care now and who are not getting medical care now. All of the studies point to that.

I just wanted to respond to some of the comments that I've heard here and indicate that while I appreciate there are communities that have limited medical care where doctors can fly in and do fly in, there are a large number of communities in this country where doctors are never seen and people have to move. I've been to many of them, and I've spoken to people from those communities. I know there are some people who go almost their entire life — until the very end of their life, in fact — without ever seeing a doctor. They still rely upon, in many indigenous communities, traditional healers to help them with medical care.

And now this bill provides an opportunity for them to be able to get assistance from nurse practitioners, whose ability to do that is going to be governed by legislation imposed by each of the provincial jurisdictions. So it's not like we're creating a pool of unqualified people here. We are saying: Provinces, you create the qualifications. If they are qualified to do it, and you say they are qualified to do it, and if they do it, they will not be prosecuted. That's all that this bill says.

• (1840)

I don't think we should try to extend it any further than that, or try to lessen from that, because to do that is going to deny medical care to most of the indigenous people of this country who live in remote parts of Canada.

**The Hon. the Speaker:** Are senators ready for the question?

All those in favour of the motion in amendment will please say "yea."

**Some Hon. Senators:** Yea.

**The Hon. the Speaker:** All those opposed will please say "nay".

**Some Hon. Senators:** Nay.

**The Hon. the Speaker:** In my opinion, the nays have it.

*And two honourable senators having risen:*

**The Hon. the Speaker:** I see two senators rising.

**Senator Mitchell:** Thirty minutes, please.

**The Hon. the Speaker:** It is a 30-minute bell.

The vote will take place at ten minutes after seven.

Call in the senators.



• (1910)

Motion in amendment negatived on the following division:

YEAS  
THE HONOURABLE SENATORS

Ataullahjan  
Batters  
Beyak  
Carignan  
Dagenais  
Doyle  
Eaton  
Enverga  
Frum  
Housakos  
Lang  
MacDonald  
Maltais  
Manning  
Marshall  
Martin  
McInnis  
McIntyre

Mockler  
Ngo  
Oh  
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Nil

BUDGET IMPLEMENTATION BILL, 2016, NO. 1

FIRST READING

**The Hon. the Speaker** informed the Senate that a message had been received from the House of Commons with Bill C-15, An Act to implement certain provisions of the budget tabled in Parliament on March 22, 2016 and other measures.

(Bill read first time.)

**The Hon. the Speaker:** Honourable senators, when shall this bill be read the second time?

(On motion of Senator Harder, bill placed on the Orders of the Day for second reading two days hence.)

• (1920)

CRIMINAL CODE

BILL TO AMEND—THIRD READING—  
DEBATE CONTINUED

On the Order:

Resuming debate on the motion of the Honourable Senator Baker, P.C., seconded by the Honourable Senator Harder, P.C., for the third reading of Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), as amended.

**Hon. James S. Cowan (Leader of the Senate Liberals):** Honourable senators, on two occasions I have circulated a proposed amendment dealing with advance requests. Last week I did it electronically and today I did the same. I would ask the pages to circulate the amendment, which I will be moving at the end of my speech, so that senators who care to listen and care to follow can do so. The document which the pages are circulating now will be the amendment that I will move at the conclusion of my remarks, if that's in order, Your Honour.

Honourable senators, when I spoke at second reading of Bill C-14, I said that the Supreme Court of Canada's decision in the *Carter* case provided the "floor" for legislation on medically assisted dying. That is, it set out the minimum that Bill C-14 must provide. That is what we've been told repeatedly by many legal and constitutional authorities.

Of course, it was to bring this bill into conformity with that minimal standard that this chamber passed Senator Joyal's amendment last Wednesday. Since then, we've spent long days and some nights grappling with proposed safeguards, examining ways to make sure that the right protections are in place for the vulnerable, especially now that we've returned the eligibility standard to that established by the Supreme Court of Canada.

But colleagues, I believe that our responsibility does not end there. As many witnesses before the Special Joint Committee on Physician-Assisted Dying and then before our Legal and

Constitutional Affairs Committee have said, the *Carter* decision is the floor, but it is not the ceiling. We have a responsibility to pass a law that not only meets the minimum standards set out in *Carter*, but also anticipates future challenges under the Charter and, even more importantly, addresses the real needs of Canadians facing almost unimaginable difficulties in their lives.

Last December, both Houses of Parliament joined to establish the Special Joint Committee on Physician-Assisted Dying, tasking the committee with making: “recommendations on the framework of a federal response on physician-assisted dying that respects the Constitution, the Charter of Rights and Freedoms and the priorities of Canadians.” Parliament got the mandate exactly right. I believe that describes our task as legislators working to address this issue appropriately. Unfortunately, a major priority of many Canadians was left out of Bill C-14 altogether, namely advance requests or advance directives, as they are also known.

Advance directives were not before the Supreme Court of Canada in the *Carter* case. But we heard from several constitutional experts that, in their opinion, there is a constitutional right to medical assistance in dying under an advance directive. We were urged, in the words of Joseph Arvay, lead counsel in the *Carter* case, to “get ahead of the courts” and provide in this legislation for advance requests.

When Minister Philpott appeared in this Chamber during Committee of the Whole on June 1, she confirmed my impression that this is one of the aspects of greatest concern to Canadians around the issue of medical assistance in dying. She told this chamber that “one of the topics we . . .” that is, the government, “. . . heard about most was the matter of advance directives.” She went on to talk about the challenges of drafting appropriate legislation, particularly given the timeline that her government felt they had within which to address this bill.

Colleagues, I can appreciate that it is not easy to draft appropriate language, but I do not accept that as an excuse not to try.

We have all received hundreds, if not thousands of emails from Canadians pleading with us to include in this bill a provision recognizing advance requests for medical aid in dying. They speak of their right to individual autonomy and dignity — exactly the concerns that the Supreme Court of Canada said in *Carter* underlie the section 7 Charter rights to liberty and security of the person.

Furthermore, by failing to provide for advance requests, the bill in effect discriminates between people on the basis of disease. It excludes individuals whose disease will inevitably result in the loss of their capacity to consent. Instead of a patient-centred approach, we have been asked to help impose a disease-centred approach.

I am, of course, concerned that this will result in either people suffering intolerably, or placing them in a situation whereby they may choose to end their lives prematurely — precisely the situation that the *Carter* decision sought to avoid. Without advance directives, individuals with diseases such as Alzheimer’s will be denied their right to end their life in a dignified manner.

It is for this reason that both the special joint committee and the majority of the members of our Legal and Constitutional Affairs Committee recommended that advance directives be permitted in medical assistance in dying.

Here is the recommendation of the special joint committee, recommendation 7:

That the permission to use advance requests for medical assistance in dying be allowed any time after one is diagnosed with a condition that is reasonably likely to cause a loss of competence or after a diagnosis of a grievous or irremediable condition but before the suffering becomes intolerable. An advance request may not, however, be made prior to being diagnosed with such a condition. The advance request is subject to the same procedural safeguards as those in place for contemporaneous requests.

Regrettably, colleagues, this recommendation was not reflected in Bill C-14, something that concerned our Legal and Constitutional Affairs Committee during its pre-study of the bill. Our committee, by a majority, called for the acceptance of recommendation 7.

To this end, I have prepared and circulated an amendment which I will move shortly. I’d like to describe briefly what it would do.

The amendment provides that an advance request may be made by a capable person who is at least 18 years old.

It could not be made prior to the diagnosis of a grievous illness. This was the recommendation of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying in its report of November 30, 2015, and that was also the recommendation of the special joint committee in Parliament. As the special joint committee explained on page 24 of the report:

Limiting the option of advance directives to individuals who already have a diagnosis makes it easier to ascertain that there was informed consent. At that point, the person knows more about what he or she may expect in the future to provide relevant direction in the request. The same safeguards to ensure competence and consent must be in place for advance requests and consideration could be given to additional safeguards. Thought should be given to encouraging and possibly requiring health care practitioners to communicate regularly with their patients while they are competent to ensure that their advance requests continue to reflect their wishes.

The committee’s recommendations are reflected in my proposal. The advance request under my proposal may be prepared — that is, signed and dated — only after the person has been informed by a medical practitioner or a nurse practitioner of a grievous medical condition that is reasonably likely to cause enduring suffering or loss of the capacity to make, or the ability to communicate decisions with respect to their health. For those senators who are looking at the draft that’s been circulated, it’s on page 2 of my amendment, which would replace lines 34 and 35 on page 6 of the bill.

By the way, colleagues, last week I circulated to all senators an earlier version of this proposal. The one before you contains a few changes from that draft, made in response to comments I received from colleagues and to take into account amendments we have already adopted here. One of those changes is to recognize specifically and provide for a situation identified by the special joint committee, namely, where a person has made a request and been approved for medical aid in dying, but then loses capacity prior to MAID being administered. For example, the request is made and approved on a Friday, and the procedure is scheduled to take place on the Monday, but over the weekend the patient falls into a coma or otherwise loses capacity.

This was an issue highlighted by various witnesses who appeared before our Legal and Constitutional Affairs Committee on the pre-study. For example, Dr. Douglas Grant of the Federation of Medical and Regulatory Authorities of Canada raised this, saying that Bill C-14 provides no contemplation for what he described as the “arc of the competence declining patient.” He was concerned that “Physicians of such declining patients will be faced with the precarious task of making death-bed determinations of competence and feeling an urgency, perhaps, to provide the service their patients want before it becomes too late, before the patient slips into incompetence.”

• (1930)

Another change that I made to the version before you now was to change the requirement that the person must have a “serious” medical condition to a “grievous” medical condition. It was suggested that this would bring the language into line with the *Carter* language, and I agree. I did not include “irremediable” because an advance request may well be prepared at a time when the person is still trying treatments. But in any case, MAID cannot be administered, including under an advance request, until the medical condition is both grievous and irremediable.

We stipulated in the definition of “advance request” that it must specify the conditions — including the existence or development of particular symptoms, mental or physical incapacities or other circumstances — that the person believes would, for them — and this is about the patient — constitute intolerable suffering and the types of treatments that are not acceptable to them.

I want to stress that any individual may receive medical assistance in dying pursuant to an advance request only if they meet all of the conditions for MAID set out in clause 241.2(1) — that is the general eligibility provision in the bill; and if they then subsequently lose the capacity to make or the ability to communicate decisions with respect to their health; and, finally, if all the conditions in the advance request have actually been met.

All of the usual safeguards apply: The request has to have been signed before two independent witnesses; there must be two medical practitioners or nurse practitioners agreeing that the person meets the criteria for MAID. The amendment then goes further and adds an additional set of safeguards that before MAID may be administered pursuant to an advance request, the medical practitioner or nurse practitioner must, in addition to complying with the safeguards set out in subclause (3), satisfy the following: first, be of the opinion that the person has lost the

capacity to make or the ability to communicate decisions with respect to their health, and that it is not reasonably foreseeable that the person will regain the capacity to make, or the ability to communicate, decisions with respect to their health; second, be of the opinion that the conditions specified in the advance request have been met; and third, ensure that the other medical practitioner or nurse practitioner has provided a written opinion confirming both of these criteria are met.

Colleagues, that is my proposal to provide for advance directives. As I said at the beginning of these remarks, I believe this is a priority of Canadians. Senator Bellemare referred in her speech on June 3 to public opinion polls. In particular, she quoted an Ipsos Reid survey conducted on behalf of Dying With Dignity. She noted that this poll found that 84 per cent of Canadians believe a doctor should be able to assist someone who is terminally ill and suffering unbearably to end their life. She drew our attention to this survey to support her argument that Canadians would not find it socially acceptable to go beyond providing MAID to those who are terminally ill.

In fact, colleagues, the survey quoted by Senator Bellemare was from 2014 — before the Supreme Court of Canada’s decision in *Carter*. Ipsos Reid conducted another survey in February of 2016. That survey found that 85 per cent of all Canadians support the Supreme Court of Canada decision in *Carter*. That may give some comfort to Senator Bellemare that by the Senate passing Senator Joyal’s amendment last week we were in fact not going beyond Canadians’ wishes.

Furthermore, the poll also asked about advance requests. Eighty per cent of Canadians surveyed support assisted death for patients who are competent at the time they make the request but not competent when the request is carried out, provided the person already has the diagnosis when the request is made.

Colleagues, Canadians are looking to us to fill what they see as a gaping hole in this bill and provide for advance requests. They see it is a matter of personal autonomy and dignity. I agree. As the special joint committee said, medical aid in dying is an issue that should be focused squarely on the patient; his or her needs and wishes, properly protected with safeguards, must come first. Advance requests are a critical part of this patient-centred approach.

I look forward to your comments and questions, and of course welcome suggestions for improvements. So, colleagues, for the reasons I have described, I now move, but perhaps I should ask for a further five minutes.

**The Hon. the Speaker:** Your time has expired, Senator Cowan. Are you asking for five more minutes?

**Senator Cowan:** If I may.

**The Hon. the Speaker:** Leave granted, colleagues?

**Hon. Senators:** Agreed.

**Senator Cowan:** Thank you, colleagues.

I move:

That Bill C-14, as amended, be not now read a third time, but that it be amended in

(a) clause 3

(i) on page 5,

(A) by adding after line 6 the following:

“**advance request** means a request for medical assistance in dying, within the meaning of paragraph (a) of the definition *medical assistance in dying*, made by a capable person who is at least 18 years of age that

(a) specifies the conditions — including the existence or development of particular symptoms, mental or physical incapacities or other circumstances — that the person believes would, for them, constitute intolerable suffering and the types of treatments that are not acceptable to them; and

(b) provides their consent to receive medical assistance in dying in the event that, at some time in the future, the specified conditions are met and the person has lost the capacity to make or the ability to communicate decisions with respect to their health. (*demande anticipée*)”, and

(B) by replacing line 33 with the following:

“(b) they are at least 18 years of age and are — or, in the case of a person who is to receive medical assistance in dying pursuant to an advance request, were at the time they made the request — cable of”,

(ii) on page 6,

(A) by replacing line 4 and line 5 (as replaced by the decision of the Senate on June 9, 2016) with the following:

“(e) they have given informed consent do receive medical assistance in dying and, except in the case of a person who is to receive medical assistance in dying pursuant to an advance request, they have done so after having had a palliative care consultation and having been informed of treatment, technology or support options available to relieve their suffering.

(1.1) A person may receive medical assistance in dying pursuant to an advance request only if, in

addition to their meeting the criteria set out in subsection (1), the following criteria are met:

(a) they have lost the capacity to make or the ability to communicate decisions with respect to their health; and

(b) the conditions specified in the advance request have been met.”, and

(B) by replacing lines 32 to 34 and line 35 (as replaced by the decision of the Senate on June 8, 2016) with the following:

“(ii) signed and dated

(A) in the case of an advance request, after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous medical condition that is reasonably likely to cause enduring suffering or loss of the capacity to make, or the ability to communicate, decisions with respect to their health, or

(B) in any other case, after

(I) the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition, and

(II) the condition has begun to cause enduring suffering that is intolerable to the person;”,

(iii) on page 7,

(A) by replacing line 17 with the following:

“the person’s death, or, if the assistance is not being provided pursuant to an advance request, the loss of their capacity to pro-”, and

(B) by adding after line 30 the following:

“(3.1) Paragraph (3)(h) does not apply if

(a) the medical assistance in dying is provided to the person pursuant to an advance request; or.

(b) the person,

(i) in the opinion of the medical practitioner or nurse practitioner, meets all of the criteria set out in subsection (1), as confirmed in the written opinion provided by the other medical practitioner or nurse practitioner referred to in

paragraph (3)(e), but, after having met the criteria, loses the capacity to give the express consent referred to in paragraph (3)(h), and

(ii) before having lost that capacity, gave consent for the medical assistance in dying to be provided after that loss.

(3.2) Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying pursuant to an advance request, the medical practitioner or nurse practitioner must, in addition to complying with subsection (3),

(a) be of the opinion that the criterion set out in paragraph (1.1)(a) is met and that it is not reasonably foreseeable that the person will regain the capacity to make, or the ability to communicate, decisions respecting their health;

(b) be of the opinion that the criterion set out in paragraph (1.1)(b) is met; and

(c) ensure that the other medical practitioner or nurse practitioner referred to in paragraph (3)(e) has provided a written opinion confirming that

(i) the criterion set out in paragraph (1.1)(a) is met and that it is not reasonably foreseeable that the person will regain the capacity to make, or the ability to communicate, decisions respecting their health, and

(ii) the criterion set out in paragraph (1.1)(b) is met.

(3.3) A person who is to receive medical assistance in dying pursuant to an advance request is considered to be in a state of suffering that is intolerable to them in the circumstances of their condition if the requirements set out in paragraph (3.2)(b) and subparagraph (3.2)(c)(ii) are met.”, and

(iv) on page 9, by adding after line 7 the following:

“**241.301** A medical practitioner or nurse practitioner who, in providing medical assistance in dying pursuant to an advance request, knowingly fails to comply with the requirement set out in paragraph 241.2(3.2)(c) is guilty of an offence and is liable

(a) on conviction on indictment, to a term of imprisonment of not more than five years; or

(b) on summary conviction, to a term of imprisonment of not more than 18 months.”;

(b) in clause 7, on page 12, by replacing line 22 with the following:

“241.2(3)(a) of the *Criminal Code* and, if applicable, paragraphs 241.2(3.2)(a) and (b) of that Act.”;

(c) in clause 9, on page 13, by replacing line 20 with the following:

“paragraph 241.2(3)(a) of the *Criminal Code* and, if applicable, paragraphs 241.2(3.2)(a) and (b) of that Act.”; and

(d) in clause 9.1, on page 13, by replacing line 26 with the following:

“sistance in dying and to re-”.

Thank you, colleagues.

• (1940)

**The Hon. the Speaker:** Senator Cowan, are you asking for more time for a question?

**Senator Cowan:** I would be happy to.

**The Hon. the Speaker:** Is leave granted?

**Hon. Senators:** Agreed.

**Hon. Art Eggleton:** Thank you very much, Senator Cowan, for your presentation.

I want to ask you a question on a possible scenario that a lot of people would consider to be something that might happen quite frequently in terms of advance requests.

Let us say somebody is diagnosed with dementia, decides at that point in time, while they're still competent, that they want to make an advance request, determines a stage where they think that request should be carried out — perhaps the stage where they say they don't have the intellectual capacity they had or don't know their family or immediate friends — and then somewhere down the line, say 10 years, that circumstance comes about. But the person, at that point, is able to function to a considerable degree, may not know a lot of people or their family, but is not experiencing unbearable suffering or pain.

What happens in that circumstance? The person wouldn't be competent, but it's not as if they're in the same state as many other people who are undergoing physical challenges. How would you see that unfolding?

**Senator Cowan:** Thank you, Senator Eggleton. That's a very good question. We've all struggled with that and what would happen when you say that you would never want to be in that circumstance and then how do you know because you've lost competence?

My response would simply be that this is a matter of choice and autonomy. The fact that you or I might say that that person appears happy and not to be suffering, it is respecting the right of the person who has made that choice.

In none of this debate are we talking about somebody making a decision for somebody else. We're not talking about substitute decision makers; we're talking about the right of an individual who meets the criteria set forth in the amended bill, making a choice with respect to her or his future and how and when they would decide they want to leave.

At the end of it, while we're competent, if we're saying we're not asking somebody to make judgment for somebody else, to say that we're now going to substitute our judgment for that judgment when that person has lost competence, we'd be arguing against ourselves. It's a question of the rights of the patient.

Obviously, this is not a decision that would be taken lightly. As Senator Baker has often pointed out, it is at the provincial level that much of the work is done and the regulations are made with respect to the content of advance directives and how they are managed and reviewed. The College of Physicians and Surgeons will obviously be very much involved in developing guidelines should this proposal be adopted.

At the end of the day, Senator Eggleton, for me it comes down to the fact that the patient has made an informed consent and decision and has received all of the input they need before they make the decision and give the direction. They describe the circumstances in which they would want this action to be taken, and that is the decision that ought to be respected.

**Senator Eggleton:** What if that time comes and the person, although not considered competent, does have some sense of the difference between life and death and says they do not want to die?

**Senator Cowan:** My sense is that in those circumstances medical assistance in dying would not be provided. I just do not think that would happen. But I think it would be a matter that would be regulated at the provincial level. However, what we're trying to do is permit this to be done and permit this freedom, choice and autonomy to be provided.

In the circumstances that you describe, it's hard for me to imagine that physicians and nurse practitioners would administer medical assistance in dying against the express wish, even if it was not a competent wish at the time.

**The Hon. the Speaker:** Honourable senators, we're out of time again. Is Senator Cowan going to ask for five more minutes?

**Senator Cowan:** Five more minutes.

**Hon. Senators:** Agreed.

**Hon. Carolyn Stewart Olsen:** Senator Cowan, I listened with a great deal of interest and sympathy. The proposed amendment refers to "assistance in dying, made by a capable person who is at

least 18 years of age." Is that a legal term meaning "competent," or what is the difference between "capable" and "competent"?

• (1950)

**Senator Cowan:** It really is "competent." It is a question of competence. I don't believe "capable" is a broader term than "competent." It's a person who meets the tests that are in the bill now with respect to consenting or requesting.

I'd like to consider that. Perhaps I could get back to you. To me, the two words are the same, but that said, I'm not sure why we wouldn't use the same terms in both.

If you'll allow me, Senator Stewart Olsen, I will think about it overnight and return to it.

I know the time is going on. This is a very serious matter, and I would encourage as many senators as possible to participate in the discussion, because this is not an easy issue.

**Senator Stewart Olsen:** I would appreciate that.

**Senator Cowan:** Thank you. It's a good point.

**Hon. Murray Sinclair:** I have a question for Senator Cowan and an observation.

"Competent" and "capable" do not mean the same thing. You can be capable of doing something but not competent to do it. Let's start with that, and you can continue to think about it.

Inherent in your presentation was a suggestion that if we don't do this now, we're not going to do it or it ain't going to get done. I want to know what is wrong with the proposal that I see in the bill now to put this under further study and to come back with an appropriate set of criteria for advance directives.

I see some problems with the wording that you have put together. For example, the penalty provisions appear to talk only about people who have knowledge as opposed to people who act negligently. I want to know how one measures intolerable suffering in advance, because "intolerable" means intolerable at a particular point in time, and it's a very subjective phrase.

I'm a little concerned about us rushing through to amend a bill when something as important as this requires a very significant degree of public input and study. I don't disagree with the need for advance directives. I just don't know that we can do it with this particular amendment in this particular period of time.

Would you tell me why you think we need to do this now?

**Senator Cowan:** Senator, thank you for the question. In my view, we are only having this discussion because of the decision in *Carter*. If it was not against the backdrop of the *Carter* decision, we would not be having this discussion. This is not an issue that Canadian politicians would choose from a suite of public policy available for debate and say, "Let's take this one on."

I don't draw many parallels with the abortion debate, but it's only because of decisions that are made that we deal with these difficult issues. I'm suspicious of promises to conduct studies and to return to a topic at some point in the future unless the timelines are very tight, because we've all seen many occasions when people have said, "Well, this is good enough for now and we'll come back to it," and we never do.

I'm not criticizing this government or any other government; I'm criticizing all of us. I think this is not a debate that most Canadian politicians, including in this chamber, embark on willingly and are anxious to come back to before they are forced to.

There have certainly been some opinions given that this is a Charter right as well and that it won't be long before someone will challenge this under the Charter. You may not agree, Senator Sinclair, but there are others who hold a different view. I believe you made the comment that 50 per cent of lawyers before you are wrong, and in this country we have appeal courts that from time to time disagree with trial judges.

Lawyers, judges and legal scholars are not always right — and I don't profess to be an expert in this area — but there is a body of opinion that this is a Charter right. I think we have a responsibility to at least address anticipated Charter challenges. That's the reason why I think we ought to deal with it now.

**The Hon. the Speaker:** Colleagues, Senator Cowan's time has expired.

I would remind senators that because time expires for questions, it doesn't preclude senators from making a point on the debate. Senators can always join the debate at any time before debate is closed.

I would just caution senators, when asking a question, to try and get in as many senators as possible. Try and make your questions as pithy and terse as possible, please.

[Translation]

**Hon. Pierrette Ringuette:** Honourable senators, many of you did not seem to understand why, last Wednesday evening, all I had to say to the amendment proposed by Senator Joyal was, "it's 2016."

Obviously, successive governments have turned a blind eye to the issue of medical assistance in dying. Even in this chamber, when Senator Nancy Ruth and Senator Campbell introduced a bill on this issue, the majority of senators did not want to discuss it. Furthermore, no political party addressed this issue in its election platform last year, in spite of the Supreme Court's decision in February 2015. Not February 2016, February 2015.

When Senator Baker or journalist Andrew Coyne says that the Senate cannot speak out against a bill introduced by the elected majority, we need to remember that Canadians have been discussing this for decades, and that—

[English]

— because of politics and parliament inaction on the subject, Canadians had to move the subject before the courts, and some had to reach out to other countries for dignity.

[Translation]

Furthermore, honourable senators, on Wednesday evening we also heard the argument that before the *Carter* decision in February 2015, providing medical assistance in dying was prohibited and illegal under the Criminal Code.

Once again, to show you that we're at least 20 years behind on this, the provinces have issued directives that indirectly allow medical assistance in dying. More than 12 years ago, I signed a directive at the Edmundston hospital instructing that I not be provided with medical assistance in a specific situation.

For a long time — at the request of the public, I should point out — the provinces and territories have essentially ignored the Criminal Code and health care professionals' oaths in their directives. Once again, I believe that the legal authorities are turning a blind eye to avoid having to discuss such a sensitive issue.

[English]

Honourable senators, if it had not been for the determination of Kay Carter and the seasoned decision of the Supreme Court, with criteria and a legislative deadline, we and the other place would not be discussing the issue. We would not have Bill C-14.

It is human nature to push discussion on sensitive issues as far as we can. From my perspective, it is important that we address Bill C-14 in the 2016 context of long overdue discussion among Canadians.

• (2000)

[Translation]

I have known many people who realized that they would suffer at the end of life and chose to commit suicide, with all the negative implications for themselves and their loved ones. Some expressed the opinion, which is probably based on religious considerations, that it would be preferable to keep a person in a state of sleep. We have to ask ourselves where the dignity and the choice are in such a scenario.

I wonder why we accept and even recommend that Canadians make a will to dispose of their material assets, yet we are not prepared to accept a living will or a legal directive about quality of life or a directive concerning dying with dignity. Isn't a living will more important than a will about the disposal of material and financial assets? We really have to consider and determine where our societal values lie.

I recognize that here again, we are moving slowly on giving Canadians what they want. Let's hope that we can soon legislate

and recognize Canadians' right to issue an exhaustive directive allowing them to die with dignity.

I would like to give the example of two people who were close to me. I will call them Mr. and Ms. Martin to protect their identity. Ms. Martin, the mother of 12 children, was 63 years old and had suffered for several years from rheumatoid arthritis. She was also aware that she was predisposed to Alzheimer's disease because of family genetics. Unfortunately, Ms. Martin could not give an advance directive. She went into a seniors' home at the age of 65. She weighed about 150 pounds and was my height.

She passed away last year. At the time of her death, she weighed only 60 pounds and was about three feet, six inches tall, as a result of physical deformities due to her illness. How can anyone accept that someone who is suffering such intense pain, caused by this kind of deformity, cannot use an advance directive?

I would now like to talk about Mr. Martin, whom Senator Mockler knew very well. A veteran of the Second World War, he was injured during the war when a grenade exploded nearby and he lost his right arm and part of his right leg. He was only 20 years old at the time. Around the age of 70, he began suffering from dementia. For 50 years, Mr. Martin never talked about what happened to him, what he suffered or his war injuries. Then, for 15 years, every day, down to the last possible detail, this man relived the pain of what happened after the grenade exploded and he lost his right arm and part of his right leg. For 15 years, he experienced terrible pain — mental pain, yes, but mental pain that was terrible for him, to say nothing of the impact it had on his family.

[English]

Honourable senators, ten years ago, the controversial bill allowing same-sex marriage was the end of the world. It was the end of Canadian families. It took some senators ten years to finally accept that it is a reality. There's nothing wrong; it's reality. Surely we can be more in tune with the discussion Canadians have been having for a very long time.

[Translation]

Honourable senators, Bill C-14 must give Canadians a choice, and not just an exception like the one the bill contained when it first came before the Senate. I strongly support the idea that Canadians should be allowed to give advance directives with peace of mind. The provinces have been giving Canadians this option indirectly for nearly 20 years. It is simply a question of going one step further in 2016. The principle of advance directives should be debated and, I sincerely hope, accepted by this chamber. Thank you very much.

[English]

**The Hon. the Speaker:** On debate, Senator Harder.

**Hon. Peter Harder (Government Representative in the Senate):** Colleagues, I will be brief, but I do want to take the opportunity to speak to the amendment as proposed by Senator Cowan.

[ Senator Ringuette ]

As you all know, this amendment is based on the premise that an individual's "reasonable foreseeable" is being removed from the legislation as we dealt with that amendment last week, and due to the nature of expanding the legislation to include those whose natural death is not reasonably foreseeable, I find it very difficult, impossible indeed, to support this amendment.

However, I do want to make several points for consideration in this chamber. First, this amendment aims to develop specific policy that is hugely important, as it deals with life-and-death consequences for both patients and practitioners. This is not a policy we should consider on the fly as a Senate, and this is why the government has already had in the bill an amendment made in the legislative committee of the other place that required meaningful study on advance directives within 180 days of Royal Assent. As we will discuss in a later amendment, we may want to give additional precision to that study, but it is wrong to say that we have only this opportunity to develop and deal with this issue.

A further point is that I am afraid we are developing amendments in this chamber that not only are significant but really have not benefited from involvement of key stakeholders and Canadians at large. In drafting this amendment, I haven't seen any particular references to organizations representing nurses or doctors who have embraced the concepts, although they are obscure concepts in this amendment. What medical practitioners have spoken about on this issue and have been consulted about in the course of developing this amendment would be interesting.

• (2010)

Jeff Blackmer of the Canadian Medical Association has stated that advance directives are:

... incredibly complex and difficult, because it's very hard to capture all of the nuances and the specifics of a very complicated medical condition and intervention.

Dr. Douglas Grant, who has often been quoted here and indeed was quoted earlier tonight, without taking a position on advance directives, he noted that "a myriad of new issues" would need to be addressed if such requests were to be permitted.

I dare say, senators, the "myriad of new issues" that have yet to be addressed ought to wait being addressed before we move with a legislative framework.

I do not believe that senators have been given the full consideration in the matter of this expansion of advance directives, and I cast caution in providing assisted death to a patient being given the authority for a doctor or nurse to determine if someone will not again have the ability to communicate.

This is a highly complex area in which we have very little international experience. The international experience that we can draw on is from the Netherlands, as I mentioned in my speech on second reading, where physicians are generally unwilling to follow through on these advance requests. Parliamentarians have heard



from Canadian physicians that it is already extremely difficult to implement advance directives, and it would be even more complex to do so in a case of medical assistance in dying. We have no other information about the willingness of Canadian physicians to engage in this practice.

I would also add that provincial regulatory bodies across the country have put in place guidelines for medical assistance in dying, and every single provincial regulatory body in the country has said “no advance requests.” There seems to be a consensus that this is an area we need to discuss carefully, moving forward perhaps, but one in which government ministers have committed to advance in a study. We need to get it right rather than simply, as a last resort of dealing with this legislation before us, make an amendment of this significance.

**Hon. Terry M. Mercer:** Would Senator Harder take a question?

**Senator Harder:** Sure.

**Senator Mercer:** Senator Harder, we have had for a long time in this country organ donor cards on our drivers’ licences. Senator McInnis, who was the Minister of Transportation in Nova Scotia, permitted that and I congratulate him for that.

The issue is, if you sign your organ donor card, basically you’ve pre-authorized and given an advance directive for organ donation in the situation of your death. However, if at the time of your death your spouse or your next of kin is consulted by the surgeon who is about to do the surgery to remove whatever organ it might be to transplant into someone else and they say, “I don’t want it to happen,” do you know what the normal response of that surgeon is? Oh, I can tell you. You were looking questioningly at me.

It may have changed, but in my experience, when I was Executive Director of the Kidney Foundation, no surgeon would do it if a family member objected. They would obviously emphasize the story that the husband, the wife, the son or the daughter wanted to do this, so they are now objecting to it. They would explain the situation, but normally no surgeon would do it over the objection of a loved one, even though I think the organ donor card would stand up legally.

**Senator Harder:** Senator, if I understand the import of your question, we’re here dealing with the Criminal Code, and I can’t imagine that without the appropriate consultation and engagement with the very people who would have to be involved in medical assistance in dying, that they would be confident of moving forward with advance directives without a greater understanding of how to deal with and secure the knowledge that Senator Eggleton — the medical community would be very hesitant, to say the least, and I tried to reference that in my comments, to engage in advance directive implementation without knowing and being assured that the person who gave the advance directive is still of the mind and would wish that to be conducted, which is why we should be very cautious in adopting this, particularly when we have been so exuberant in eligibility.

**Hon. Mobina S. B. Jaffer:** Senator Harder, I have a question for you. I listened to you very carefully, and if I understood you, you were saying that you’re not rejecting advance directives. What

you are saying is that in the bill there are 180 days to start the study. You’re not rejecting the idea of advance directives. You’re just saying, “Give us time to study.”

**Senator Harder:** Thank you for the comment because it gives me the opportunity to make very clear that I am not, nor is the government, saying we should never look at this. In fact, in clause 9, you’ll see we are very much committed to looking at this as an issue, consulting with the care-providing community and all of the stakeholders that would have a role and a view on this. But this is not something that we should rush into the legislation at this time as a result of an amendment before us today.

I am quite open, as were the ministers when they were here and as I will propose when we get to clause 9, of having very assured parameters around those studies, which we might want to establish in this chamber. But this is one of the issues, along with several others, that would merit further consideration, experience, data and engagement of the caregiving community.

**Senator Jaffer:** Many people here have heard throughout our discussion and even in committee that the Netherlands and other countries have had issues. I have to tell you that it surprises me that this has been a barrier. I love this country because we are leaders, so there would be no harm in us looking at this advance directive issue and saying, “We are leaders and these are the safeguards we have set up.” Wouldn’t you agree there’s no harm in being the leader on this issue?

**Senator Harder:** There’s absolutely no harm in being a leader on this issue or any other issue that has merit, of course not. Even today, I would argue Canada is a leader in dealing with this issue, as there are only seven jurisdictions at the national level that legislate in this area.

I do think we would want to benefit from the experience of those jurisdictions. We know from the article that I cited, which is in the geriatrics studies journal, that this has been a more difficult issue in the Netherlands than they thought it would be. In meeting with, as the Minister of Health referred to, counterparts from the Netherlands, they very much cautioned doing this in one step and that we should take our time to get it right with due experience and a broader understanding from all of the stakeholders.

**Hon. Jane Cordy:** On page 13 of the bill, clause 9.1, under “Independent Review,” both ministers “. . . must” — not “shall,” not “may” — “no later than 180 days after the day on which this Act receives royal assent, initiate one or more independent reviews . . . .” They mention independent reviews on mature minors, which I think needs a lot of study, as do advance requests and mental health issues, as I spoke about the other day with Senator Batters in relation to her amendments.

Do you not agree that this particular aspect of the bill would indeed provide further study and more in-depth knowledge for those of us trying to make these decisions, and that this study would go a long way in alleviating some of the concerns that have been raised?

**Senator Harder:** I thank the honourable senator for her question and can give assurance to her that that is indeed how the government views the clause that the senator referred to.

• (2020)

While the government obviously would reserve how it dealt with the policy issues enumerated in that clause, they certainly would have to table before this house and the other house those studies, and we would have a clearer sense of engagement on those issues in a timely fashion and have the opportunity to actually get it right.

**Hon. Percy Mockler:** I have a question to the Leader of the Government in the Senate. I agree with you when you say we need to get it right. Then you said in your comments, Mr. Leader, that there are obscure concepts in this amendment. Would you please explain what you mean by obscure concepts in the amendment that is before the house?

**Senator Harder:** Given the engagement by the question by the Honourable Senator Stewart Olsen and by the comments made by the Honourable Senator Sinclair, there are issues being probed with respect to the wording of the amendment and that we've had, at least to my mind, an unclear and unsettled answer.

**Senator Eggleton:** We've just been talking about and you've described the study under clause 9.1, but a study doesn't necessarily lead to legislation. You answered that yourself in a question that I asked you the other day. I realize that this clause refers to 180 days, and there may well be an amendment coming that will put parameters on the back end of that and require some report, but that still doesn't require legislation. So if at the end of this we don't get legislation, then are we not discriminating against people who have a mental illness, because we're saying that unless they're competent at the time, they are not going to be considered?

**Senator Harder:** That's the trouble with information. You can change your mind. Obviously, the studies that are being anticipated would have broad stakeholder engagement and lay out the issues. Were a government willing to go forward with one or all of the study areas, they would have to legislate and this house would become involved yet again. But without making a commitment to legislation, you are making a commitment to the study of the issues that are widely debated in this house, in the other house and amongst the Canadian public, and we owe it to the public to address this important issue of advance directives in a fashion that is workable, understandable and viewed as having appropriate safeguards.

**The Hon. the Speaker:** Senator Harder, are you asking for five more minutes for questions?

**Senator Harder:** Sure, if there are questions.

**The Hon. the Speaker:** Is leave granted, colleagues?

**Hon. Senators:** Agreed.

**Hon. Joan Fraser (Deputy Leader of the Senate Liberals):** This is not actually about advance directives, but now that our attention has been drawn again to clause 9.1, I wonder if it would be

possible to get some elucidation on what seems to me to be some contradiction between the English and French versions. I could be wrong, but I would like to be sure.

The English version refers to requests for MAID where "mental illness is the sole underlying medical condition," and the French version refers to "les demandes où la maladie mentale est la seule condition médicale invoquée."

Subject to correction on my linguistic skills, it doesn't seem to me that "invoquée" is the same as "underlying." It brought to my mind the Alberta case, where you could argue that mental illness was the underlying condition, that this poor woman suffering from what I believe is called "conversion disorder" had, as a result of that medical condition, unbearable physical suffering. As I understand it, what was cited in the court, was the combination, not just the initial precipitating underlying medical condition. I wonder if you could have some of your minions examine this for us.

**Senator Harder:** Thank you for the question. As the senator will know, I have many minions on my budget and I would be happy to inquire, but I'd prefer that we address it when we get to that clause.

While we're speaking about my ability to discern different English and French texts, I simply want to draw attention that we've experienced this even with amendments that we passed as recently as last week.

**The Hon. the Speaker:** On debate, Senator Wallin.

**Hon. Pamela Wallin:** I want to thank Senator Cowan and Senator Ringuette particularly for comments this evening on the profound need for advance directives, and Senator Eggleton and Senator Jaffer, who talked about the importance of choice in this question.

This is, as so many of us have already acknowledged, the most important bill we'll probably ever debate, and for all of us it is extremely personal.

As I suggested to some of our colleagues in the House of Commons, perhaps if the average age of their house was the same as ours, they might see the urgency surrounding this debate a little more clearly, because I think for some of us this is very personal; we're dealing with mothers, fathers, siblings, husbands, wives, not grandparents and people who may be a little more distant.

This debate goes to the core of who we are and the values we hold dear. It's about the ones we love and doing our best to make those lives matter, to honour those who want to choose how they live. I do feel very strongly that no other generation should be robbed of choice and dignity in both life and death.

The Supreme Court of Canada has ruled, the legislation has been presented and we are now tasked with ensuring that people are treated with fairness. We have so many issues in this country — and we've heard it discussed tonight already — surrounding accessibility to health care and to care. I have a niece who was on

[ Senator Harder ]

an emergency list in my home province, and the emergency wait is between two to six months — not optional surgery but emergency. So this notion that we have access and easy access to care and fairness in that care is just not my experience.

This legislation is a step and a start, but I really in my heart of hearts do not believe it's good enough. While I support much of what Senator Cowan's amendment says, I believe it still disqualifies an important group, which is why I intend to move a subamendment. Please indulge me for a few more remarks before I do that.

Many colleagues in this chamber have spoken eloquently, pointing out that the legislation cannot and should not discriminate between those who are suffering and are at death's door, and those for whom death is not imminent but for whom life has become intolerable.

There is, however, another category of people who have been denied their rights in this bill, and we could change that, with a simple act of giving all adult Canadians the option of simply preparing an advance directive. Let me explain.

Consider those with conditions like dementia or Alzheimer's. Under this bill, they would be denied the right to make a choice. This legislation asks that they be diagnosed before they could hope to gain the right to ask for assistance. But once you are diagnosed, then you may well be considered to have lost the capacity for consent, so then they can no longer choose to ask for medically assisted death. It is the ultimate Catch-22.

And what about the person who has had a stroke or was in an accident — completely unpredictable. There can be no diagnosis before or after the fact.

• (2030)

An advance directive would give guidance for family and medical professionals should that person be unable to communicate their pain or their wish to end a life destined to be one of intolerable suffering.

My amendment is about fairness and choice. Why can't we prepare for our own futures, plan for the worst but hope always for the best? That is why we need the option of an advance directive, so that we can make our voice heard, even if we are silenced by illness.

It simply doesn't make any sense to forbid a competent and clear-headed person from stating in writing, in advance, their reasoned and desired decision that when a certain point of incapacity has been reached, they be allowed to die with dignity and free from pain.

Why do we discriminate between those who are suffering and those who are dying? This is the basis for my amendment. The need for a diagnosis excludes a whole group, a group of people for whom a diagnosis would equal a denial of their right, or that group of people who are struck down, perhaps in the prime of their life.

It begs the question: Why is the end of life so much more important in this debate than the end of any quality of life? In other words, for those who choose a quality of life, why can they not have a voice in how they live their life or end it? This is not mandatory but it should be an option. No one is compelled to have an advance directive, but they should have an opportunity to make their views known, to speak for themselves while they still can. As the court said, the way we live and die is a matter critical to a person's dignity and autonomy. Let our legislation reflect that.

Honourable senators, let us show respect for all of those who wish to end their lives at a time and in a manner they know to be right for themselves and for their loved ones.

My amendment is straightforward. I want all consenting adults to have the choice to seek medical assistance in dying, not just those who are aged or those who are on the verge of death or those who have been diagnosed as terminal.

I am proposing a choice for people who are suffering, people who want the right not to live in pain or to suffer needlessly. Simply put, my amendment would allow competent adults to make an advance request for medical assistance in dying in anticipation of losing, by illness or accident, their capacity to provide informed consent.

#### MOTION IN SUBAMENDMENT

**Hon. Pamela Wallin:** Therefore, honourable senators, I move:

That the motion in amendment moved by the Honourable Senator Cowan be amended by replacing clause (a)(ii)(B) with the following:

This is a very technical question and it does not spell out exactly what I have tried to say in my remarks.

“(B) by replacing lines 32 to 34 and line 35 (as replaced by the decision of the Senate on June 8, 2016) with the following:

“(ii) except in the case of an advance request, signed and dated after

(A) the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition, and

(B) the condition has begun to cause enduring suffering that is intolerable to the person;”,.”.

This is a subamendment moved to Senator Cowan's amendment on advance directives because I want to protect those two categories of people who are left on the sideline if they are diagnosed and therefore lose their right to consent or if they have no option to even be diagnosed in the case of an accident or a stroke. Thank you.

**The Hon. the Speaker:** Senator Wallin, will you take a question?

**Senator Wallin:** Yes.

**Hon. David Tkachuk:** Thank you for that, Senator Wallin. We both have some experience in these matters, but the advance directive thing is bothersome, and I'm not sure exactly how you get around the situation of a dementia patient or even one in the early stages of Alzheimer's.

Once the advance directive is signed, at what stage does it take effect? In the case of my father, who had dementia for three years, there were times when he didn't know who I was, was confused, but at the same time functioned rather normally.

How do you even approach this topic? How do you say, "Well, dad, is it time?" It's way too early for this whole amendment, as well as the subamendment. I agree with Senator Harder; it is way too early for this. There are so many complicated questions.

How would you deal with a situation where the person, in the end, even though they are confused, says, "I don't want to do that; to heck with the advance directive"?

**Senator Wallin:** I think the point of the subamendment is to clarify, to make this really simple, that at any age and stage in our life we can sit down and go through this process. As Senator Ringuette alluded to, we sit down, write our will and decide who gets the money or the car or the house or the home quarter. We make those decisions when we are of sound mind. We write it down on a piece of paper, and subsequently those things sometimes get changed. Circumstances change, there's no question about that; but, again, you have to sit down with a lawyer, with people who are experts in this field, and indicate in that case that you want to make changes.

I'm saying this is the same kind of thing. You may want to make an advance directive to say there are circumstances in which I do not want to carry on. If I do not know my family, am in pain or disconnected from the world as I have always known it, those are circumstances people will be able to define, as they will. They will write this down. They will try and indicate what they are saying to their families, to the powers that be, what they are directing people to do, including medical professionals and their family, that there are circumstances they don't want to live through, suffering and pain and no knowledge of my family and being incapable of experiencing love or hurt or any number of things.

I think many of us have had conversations with our parents and family members about the circumstances in which they no longer want to go on. I sat in a hospital room with my father just before he had heart surgery. He said, "If I come out of this unable to function either mentally or physically, or some combination of the both, then life has no meaning for me. Life has no quality. I'm a guy who needs to be out there able to do things, relating and connecting with people." He said, "That would be no life for me."

It was guidance for me; it was helpful. We didn't, at that time, fortunately, have to deal with his passing, but it was very helpful to have the discussion, to bring it forward so that you know what

your family members want and what they consider important in their lives.

I think that's what this amendment and notion of an advance directive gives us all. It gives us some sense of having some say over our life, some sense of choice and, most importantly, I think, some sense of control.

**Hon. Peter Harder (Government Representative in the Senate):** Would the senator take another a question?

**Senator Wallin:** Yes.

**Senator Harder:** Senator, thank you for your comments and indeed for the provocation of your subamendment. In your comments you referred to a certain point of incapacity. Am I correct in that presumably the amendments you're proposing would kick in at a certain point which would oblige medical practitioners or a nurse practitioner to make the assessments you are suggesting?

• (2040)

I wonder whether and to what extent there has been consultation for this amendment with the very people you are now giving a responsibility and a power to implement and what their reaction has been, because, as I cited in my comments on the main amendment, the practitioner community has been highly cautious about moving this fast in this regard without proper thought about how you balance the patient's desire — at least at the point of the request — with the circumstance of actually delivering the assistance in dying.

**Senator Wallin:** I think the advance directive is what it says. It's a directive given in advance when you are still able to speak, when you still are able to give consent and when you are of sound mind. That would be there for guidance.

I think the practitioner community has formally said that they have questions and issues about this. There is no reason that we couldn't continue to discuss, debate and define. As other colleagues have suggested, these matters are going to go to court most surely anyway. When you talk to doctors one-on-one, or to other forms of practitioners, this is their life on a daily basis. They deal with this every single day. An advance directive would give them a bit of guidance and direction as opposed to what the original bill would say, and even what the amendment would say, namely that you must have a diagnosis at that point before you can even start the discussion.

This would offer some clarity for family and for practitioners and some sense of control for the individual at the heart of it.

**The Hon. the Speaker:** Your time has expired, Senator Wallin, but Senator Day was looking to ask a question. Do you want to ask for more time?

**Senator Wallin:** Certainly, I would ask for a few more minutes.

**The Hon. the Speaker:** One more question, then.

**Hon. Joseph A. Day:** Senator Wallin, I heard your comments with respect to the diagnosis aspect, but I read your amendment and it seems to require that the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition.

Isn't that a diagnosis and isn't that what you were trying to avoid with your amendment?

**Senator Wallin:** It is what I'm trying to avoid. As it was explained to me by the drafters, I would be using much simpler language. I think I tried to say that "competent adults should be able to make an advance request for medical assistance in dying in anticipation of losing, by illness or accident, their capacity to provide informed consent."

The language in the amendment is such because of Senator Cowan's amendment and because of Senator Joyal's earlier amendment. This is how the language has to be changed technically to accomplish what I have set out in my comments.

**Senator Day:** I like your comments better than your amendment.

I received more letters and emails from individuals with respect to this issue than I have with respect to all of the other aspects that we've had under debate here. People want to be able to leave a living will. When they lose capacity and can't carry on the life that they have traditionally been carrying on, they want to be able to say that they don't want extraordinary resuscitation; they don't want tube feeding; they don't want a tube to remove their waste from their bowels; they don't want any of that type of activity to take place. They have had a good life. They'd like the family to be brought in and they'd like to be able to say goodbye.

That's what I'm hearing from the people who are contacting me. That's what I was hoping to see in your amendment because I don't think what we're talking about in an advance directive is after you've been told that you're in trouble here. We're all in trouble from the day we're born. We're all going to die at some time and it would be nice to be able to die in dignity.

**Senator Wallin:** Regarding the language here, I couldn't agree more. Believe me, the table officers will attest to this. I have asked that things be put in the simplest form that we could so that the message is clear. But because I am proposing a subamendment to an amendment, and the bill has already been amended, this is the language that they have studied and put forward to accomplish what I have said to you. They have assured me — and I've asked them repeatedly — that's what it would accomplish. It's because of the technical nature of a subamendment to an amendment to a bill that's been amended. That's the best I can do, but I agree totally.

On the question of living wills and the kinds of responses that we've had from people, I'm assuming your emails are like mine. We've had some email blasts and you get all of the standard letters. I've had dozens and dozens of well-crafted, thought-out, personal letters where people have laid out the case for this, much as I am trying to do tonight.

[Translation]

**Hon. Claude Carignan (Leader of the Opposition):** Would Senator Wallin take a question?

[English]

**Senator Wallin:** Absolutely.

[Translation]

**Senator Carignan:** Thank you, Senator Wallin. I am reading Senator Cowan's proposed amendment and I am looking at your subamendment, and I get the impression that we are creeping ever more into provincial jurisdiction when it comes to health management and property as they relate to civil law. Everything to do with how, when, why and in what form directives might be given falls under civil law. Essentially, directives could be given in the form of a will.

Are we not veering away from federal jurisdiction over criminal law, which in this case consists in determining what is not criminal? As soon as we go beyond the notion of what is not criminal, everything else — the how and the when — falls under provincial jurisdiction.

[English]

**The Hon. the Speaker:** Senator Wallin, your time has expired again. Are you asking for time to answer Senator Carignan's question?

**Senator Wallin:** I would ask for a moment to answer.

**The Hon. the Speaker:** Granted, honourable senators?

**Hon. Senators:** Agreed.

**Senator Wallin:** I've looked at this, as I tried to tell Senator Day and others, in a straightforward way. I still believe the bill, the amended bill and the amendment proposed tonight denies a basic right, a Charter right, to at least these two categories of people that I've described.

We have said that we will allow people who are aged and terminal and we've laid out the circumstances in which they would be allowed to ask for medical assistance in dying. My concern is that we have denied these two groups their basic Charter rights. It doesn't really have anything to do with provincial jurisdiction or any of those things. I'm merely asking that everybody have the same right as some.

**The Hon. the Speaker:** Are senators ready for the question on the subamendment?

**Some Hon. Senators:** Question.

**The Hon. the Speaker:** All those in favour of the subamendment please say “yea.”

**Some Hon. Senators:** Yea.

**The Hon. the Speaker:** All those as opposed, please say “nay.”

**Some Hon. Senators:** Nay.

**The Hon. the Speaker:** In my opinion the “nays” have it. The subamendment is rejected.

On debate, Senator Enverga.

**Hon. Tobias C. Enverga:** Honourable senators, I rise to speak to Senator Cowan’s amendment to expand the access to assisted death by allowing for so-called “advance directives.” I am quite concerned about the effects that this will have and the different treatment patients with such an advance directive will receive from a legal perspective compared to those who do not have an advance directive in place, but wish to seek assistance to die.

• (2050)

Honourable senators, one of the safeguards that the Trudeau government put in place to ensure that there would be no hasty decisions from patients to die was the 10-day waiting period between the time of the request and the procedure to end that person’s life. That would be subsection (g) on page 7. Another safeguard is found in the following subsection (h), which made sure that a person, immediately before receiving the assistance to die, is given a final chance to withdraw the request. Should we pass Senator Cowan’s amendment there would be several consequences.

The first and most important consequence is that, once an advance directive has been signed, there is no real way of regretting that decision after a person is not able to communicate such a change of heart. This may not only occur in a slow and orderly manner, and we are risking those persons who do not get the opportunity to make the necessary changes. I suspect that many will start to rethink the way they see death once it is upon them. I repeat: I suspect that I will see them start rethinking the way they see death once it is upon them.

Another consequence, honourable senators, is that there will all of a sudden be two tiers of patients that this exemption of the Criminal Code will apply to. One is those who will seek assisted dying through the framework we currently see in the bill. The other tier will not have to endure these safeguards and can, at the moment they cease to communicate, be put to death. Once we have two tiers, we are not equal before the law, which is one concern. What I am more fearful of, though, is that we will see a rise in advance directives for assisted dying so that patients will not have to endure the waiting time put in place to ensure that they are indeed sure they wish to die.

If the government drafted this bill, especially these two subsections based on the prediction that some will in fact change their minds at that very moment when they are about to die, we, by allowing for advance directives, will increase the number of people who access assisted death.

Honourable senators, our esteemed colleague Senator Baker has, on several occasions, talked about advance directives in the Legal and Constitutional Affairs Committee. He has made the point that they already exist. However, it is a very big difference between refusing intervention at some stage in one’s treatment and having a doctor or nurse practitioner actively end that life.

Honourable senators, I cannot see this as anything but a subtle push to increase the accessibility to assisted dying by taking away that last moment to make a change of mind. That is why I cannot support this amendment. We are taking away a person’s right to be consulted one last time — to be asked: Are you sure you want to go ahead with this?

As I said earlier, our opinion of our death is often changed as it becomes more imminent, not to mention when a person knows that time of death is now.

#### MOTION IN SUBAMENDMENT

**Hon. Mobina S.B. Jaffer:** Honourable senators, in subamendment to Senator Cowan’s amendment, I move:

That the motion in amendment moved by the Honourable Senator Cowan be amended by adding after subparagraph (a)(iii) the following:

“(iii.1) on page 8, by adding after line 34 the following:

“(10) Despite anything in this section, no person may receive and no medical practitioner or nurse practitioner may provide medical assistance in dying pursuant to an advance request before the day that is two years after the day on which this section comes into force.”, and”.

**The Hon. the Speaker:** Honourable senators, as a subamendment, it is moved by the Honourable Senator Jaffer, seconded by the Honourable Senator Cordy, that Bill C-14, in subamendment:

That the motion in amendment moved by the Honourable Senator Cowan be amended by adding after subparagraph (a) —

May I dispense?

**Hon. Senators:** Dispense.

**The Hon. the Speaker:** Senator Jaffer, on debate.

**Senator Jaffer:** Thank you, Your Honour.

Senator Cowan has asked that we move an amendment on advance requests and I am suggesting another amendment saying this is a good idea but we should wait two years. I will explain why I think we should wait two years.

Honourable senators, for many years I have drawn up different things for people who are looking at the end of their life or they’re doing succession planning. And the three things that we do is

Powers of Attorney to look at how, if you're not able to look after your immediate affairs, like banking, you have someone look after that for you; then you have wills; and the last thing in the last few years, probably in the last three, four years or even longer, we have looked at what we used to call a living will, which my friend Senator Day has mentioned many times, but now, at least in British Columbia, we call them representation agreements. These representation agreements are really agreements of omission. You say do not make extraordinary efforts, do not forcefully feed me, do not do this and do not do that.

A provincial government can have a law that a representation agreement that says the doctor should not take extraordinary steps and my family should not do this. This is now within our system. Honourable senators, when that was being set up there was lots of education around the representation agreements. In our office we have all kinds of videos, all kinds of material to tell people that this is what you have to do, why you should do it, and many times clients will tell me, "We don't want to do it, we'll leave it to our families." And I say to them that's their choice, but if you leave it to your family, you may have three, four children, three agree with it, one doesn't, and it causes a rift in the family. It's better if you make the decision. Then no sibling can say, "You are the one who wanted mom to die. I didn't." It would be a decision you make.

That is within the provincial arena and at the moment that already exists. So omission exists, you can tell your doctor you don't want this done, you don't want that done, and that is already in place.

What we are asking for here is a commission; we are asking the doctor to go further, to provide a substance to help you on your journey, which sort of goes along with the Criminal Code. And that's a more serious thing, that's a further thing in the evolution of our society.

I listened to the minister very carefully and I listened to the stakeholders. Even this weekend I listened to a number of people, I had a number of phone calls, and I listened to people who said, "We need to put safeguards in."

I agree we need to put safeguards in and we need to consult more with stakeholders. The minister has already, after listening, I believe, after coming to our Senate committee, she listened to us and she said she will institute a study within 180 days and I salute her for that.

Now I'm saying to you, honourable senators, the only thing I'm asking is that I want her to work with her officials and have something in place within two years. I heard her, I've heard others who have said that, yes, they want advance requests but they want it to be studied, they want a regime in place, they want an educational program in place, and to make sure that there are safeguards.

I agree with that, but I want to make sure — and Senator Harder said that as well — that there is time to study. So I'm saying let us give the minister time to study, let us give her two years, but make sure that it's in the bill so that after two years we have a regime.

Thank you very much.

• (2100)

**Hon. Peter Harder (Government Representative in the Senate):** Would the honourable senator take a question?

**Senator Jaffer:** Yes.

**Senator Harder:** Senator, I heard you very explicitly urge caution, and I agree with that. Wouldn't caution suggest that we take the two years that you would wish in your subamendment to ensure that we got the amendment right, rather than inscribing an amendment that we admit is incautious in law?

**Senator Jaffer:** Senator, you know that nothing in this world is permanent. If the government wants to change the amendment that we pass here today, Parliament is supreme. Two years later, the government could come back and say, "This amendment you passed is not quite correct; we want it this way."

As far as Parliament is concerned, we can change anything. If this was not the right amendment, there is nothing to stop us in the future from getting the right amendment.

**Hon. Lillian Eva Dyck:** I'm curious about this amendment and why you have put it in as amending Senator Cowan's amendment, rather than amending clause 9.1 of the bill and then putting in that section which is talking about the independent review and 180 days. Why would you not have included in that clause the idea of the two-year limit?

**Senator Jaffer:** That's a very good question. That is another way that I will proceed, depending on what happens this evening. I believe that Senator Cowan's amendment and what he said are very important. We've heard about advance directives. I respect what he said. I wanted him to lay the groundwork, and then I would piggyback on his amendment to say, "Yes, that's great, but let's wait two years."

[Translation]

**Hon. Claude Carignan (Leader of the Opposition):** Senator Jaffer, would you take a question?

I have some issues with advance directives related to the fact that people consent when they are competent, but cannot revoke that consent. With medical assistance in dying, people can change their minds at the last minute. In these cases, though, people cannot change their minds even if they want to because they have no way to communicate that they have changed their minds. If I agreed to your amendment and waited two years for it to come into force, how would that change the substance of the problem I have with this issue?

**Senator Jaffer:** I have a lot of problems with this issue too. However, I have given it a lot of thought because I work in this domain almost every week.

[English]

Senator, I have thought about this a lot, and not just now when we've had this bill, but even before. The reason I want the two years in the bill, if my honourable colleagues see fit, is that this is a

very difficult issue. It has turned each one of us inside out. One of the reasons I humbly believe we are looking at this is because the Supreme Court of Canada has said we are going to look at it.

My concern is that as government gets very busy and things happen, all this bill says is that there will be a study within 180 days, but it doesn't say when it will be implemented or what will happen with that study. As I've already said, I absolutely respect the idea of a study and a regime, but we must have something to make sure that advance directives are later on, that after two years of study a regime is in place.

Because my greatest concern is that, yes, we've passed Senator Joyal's amendment, but we still haven't looked at the issues of people with requests. The reason I have gone along with Senator Cowan's amendment is his request only comes into place if there is a diagnosis and something triggers it. It's not when you are 20 and you don't know and you set advance requests. His is at the beginning of your sickness when you say, "This is what I want done."

In my other profession, I've seen so many people who have this request and nowhere to go because there is nothing in place. When you plan your life, you look after your money and assets. You tell the doctor not to do this or that, but you have no rights to tell the doctor, "Let me die with dignity." What this is about is dying with dignity.

[Translation]

**Senator Carignan:** Everything you just said about what I choose to do with my furniture, my future, my care, is all under provincial jurisdiction. Why would it be in the Criminal Code?

[English]

**Senator Jaffer:** We are not. You are right; I said that earlier. You may have missed that. Those are all things in the provincial jurisdiction, but advance requests are not. Because, in my humble opinion, it touches the Criminal Code.

An advance request is something the doctor has to do, and until recently the doctor was not allowed to do that; it was a criminal act. For me, advance requests are more. The representation agreement is within the provincial jurisdiction, and that's why it's already in place. But advance requests are not within provincial jurisdiction, and we need to put something in place to make sure a person can decide how they want the last days of their life to be spent.

**Hon. Daniel Lang:** I'd like to follow up on Senator Carignan and the question of provincial responsibility. If the authorization for a medical assistance directive is not the responsibility of the province or territory, in their terms of reference now for purposes of a medical assisted death protocol, why do they specifically refer to no request?

**Senator Jaffer:** Senator Lang, can you explain that? I did not understand it. I'm sorry.

[ Senator Jaffer ]

**Senator Lang:** This is one of the concerns I have, as I listened to the debate over the last number of days. The provincial and territorial responsibilities versus those of the federal government. We are now talking about the advance medical directive.

Senator Carignan made the point that now are we starting to talk about provincial responsibility. Because when you take a look at the guidelines that have been set down by the provinces and the territories, without exception they talk about no requests.

I'm assuming they're talking about no requests because, as a province, at this stage they do not feel they want to deal with the question of requests, although it lies within their responsibility. Following that logic, why are we discussing this particular amendment, in view of the fact that it's a provincial responsibility?

**Senator Jaffer:** Thank you very much for that clarification, Senator Lang. That's exactly my point. The province cannot ask for requests; that's not within their jurisdiction. This is a Criminal Code request, so it can only be regulated by the federal government. That's why the provinces are saying no request, because it is not within their jurisdiction.

**The Hon. the Speaker:** Senator Fraser, do you have a question?

**Hon. Joan Fraser (Deputy Leader of the Senate Liberals):** I want to participate in the debate on the subamendment.

Colleagues, I strongly support Senator Cowan's amendment, and I do not believe that Senator Jaffer's subamendment is, strictly speaking, necessary, but it may be advisable, for many reasons; therefore, I am going to support it.

• (2110)

Senator Cowan's amendment addresses an issue that we're all aware of. We've all come across these cases in our own lives, of people who, having been diagnosed with a serious condition that is likely to cause them intolerable suffering, want to be able to set the terms and conditions of their death when they get to that.

In light of the Supreme Court's decision, in light of the work of the joint committee which recommended advance directives after diagnosis, I think the amendment is entirely in order.

If I may just echo Senator Jaffer a little bit, because concerns have been expressed here about provincial jurisdiction. The fact is that assisted death is a matter for the Criminal Code. The provinces can't do anything with it unless the Criminal Code is amended to permit it. Of course, they will then, as they always do in medical matters, set up their own rules and procedures, varying from province to province, to some extent. That's fine; that's the way our system works. But they can't lift a finger until we adjust the Criminal Code.

I would also suggest that the amendment was anything but hastily drafted. It grew directly out of the work of the joint committee, and I happen to know that long hours were spent drafting it. I believe it is a well-conceived and well-drafted motion in amendment.



However, I also take very seriously the remarks of colleagues who say, “This really is territory that I don’t feel quite as comfortable with. I would like to be certain that we are going to get right.” I think Senator Jaffer has come up with a fairly creative way to tackle that, to say it won’t come into force for two years.

It has been suggested that we just shouldn’t look at this at all, if we’re willing to wait for two years. Here I am back deciding with Senator Cowan. If we don’t put it in the bill, it will never see the light of day, or not for many years.

**Some Hon. Senators:** Hear, hear.

**Senator Fraser:** Nothing else in this bill would compel the government to act on the wonderful studies — and I’m sure they will be wonderful — that it is engaged to commit. The bill doesn’t even contain a deadline for those studies.

Think about how wrenching this debate has been. Do we really think that parliamentarians, particularly elected parliamentarians who have to worry about getting re-elected, are going to want to reopen this issue?

**Senator Mockler:** No.

**Senator Fraser:** The way to solve this conundrum is to put it in the bill and have it come into force. Two years hence is, to me, a fine period. That way, if the government or the majority in the House of Commons or, for that matter, the majority here, discover, after study and reflection, that there are elements that could be improved in our provision for advance directives, they had better do it before the two years is up.

If we do not find grounds for improvement after reflection, careful thought and study, then the provision will come into force, whether or not an election is imminent or people feel uncomfortable about raising the issue again.

I believe, colleagues, if we don’t put a fundamental provision in the law now, we will be failing in our duty to all those people who need it, who know — and we know — that they are going to be facing intolerable suffering and who want the right, after they have their diagnosis, to control what lies ahead to the extent that any human can.

I strongly suggest that we adopt both Senator Jaffer’s subamendment and Senator Cowan’s amendment. That way, we will have made a significant contribution to the well-being of the people of Canada.

**The Hon. the Speaker:** Senator Dyck, on debate on the subamendment?

**Senator Dyck:** Yes.

This has been an interesting discussion this evening. I think I’ve got everything straight.

Senator Jaffer, you’ve come up with, as Senator Fraser said, a very creative method of satisfying the requests of people that we don’t move too hastily but, at the same time, put within the bill the suggestions that we have at this point in time. It seems to me that, after hearing that, I’m leaning towards, yes, I support your subamendment.

As has been said by other senators, we all want to find the balance between giving people choice and protecting those who are vulnerable. It seems to me that your subamendment does do that.

We want to allow people in those conditions, such as dementia or Alzheimer’s, to be able to make the choice to end their life with assistance before they reach the stage of intolerable suffering and before they reach the stage where they’re no longer capable of giving informed consent. So it seems to me to be proper.

I would just say, on a technical matter, it was brought up that perhaps the amendment that Senator Cowan proposed hadn’t been completely carefully thought out, and there was a question posed by Senator Stewart Olsen about the word “capable.”

That amendment to the bill is actually retaining the same words that were in the original bill. It’s really just inserting in the phrase “dealing with advance requests.” If you go to the original version of the bill, on page 5, you will see that, at line 33, it says “they are at least 18 years of age and capable of making decisions . . . .” That word “capable” is actually in the original bill.

If you flip over to the next page, under subsection (e) it says “they give informed consent . . . .”

The words “capable” and “informed consent” are in the original bill. The word “capable,” in Senator Cowan’s amendment, is from the original bill. The “consent” would still stay in his amendment because that part has not been changed. So it’s “capable” and “giving consent.” It has been thought out carefully.

Of course, when you’re asked a question on the spur of the moment about every single word, sometimes you can’t get to that answer immediately, but I had the time to look through and noticed that that was the case.

Senator Cowan’s amendments have been carefully thought out. The only question I had was one that I wasn’t able to ask on clause (B)(ii)(A) in the case of advance requests, talking about “. . . a grievous medical condition that is reasonably likely to cause enduring suffering . . . .”

The only thing I noticed there was that the phrase to do with “intolerable suffering” was not included, but it is mentioned earlier on. That was my only question with regard to that.

In the medical diagnosis, it does clearly say earlier on, in clause 3 — (a)(i)(A)(a) — that the medical condition is such “. . . that the person believes would, for them, constitute intolerable suffering . . . .” So it is covered in the earlier clause of the amendments.

Therefore, I am supporting both amendments.

**The Hon. the Speaker:** Senator Sinclair, on debate.

**Hon. Murray Sinclair:** With respect to the subamendment, Your Honour.

The two-year proposal that's been suggested causes me a bit of concern because it appears to suggest that the provision has got some validity to it, that the amendment proposed by Senator Cowan has some validity to it that's going to have a positive legal consequence at the end of the two-year period that we're all going to be prepared to support. I suppose we could vote against the amendment proposed by Senator Cowan and allow this amendment to go through, but I would discourage us from doing that.

• (2120)

This particular suggestion of having a two-year limitation period proposed for this particular amendment seems misplaced. It is probably an amendment which should go with respect to clause 9.1 of the proposed bill. So I'm not prepared to support it with respect to this amendment, but I might be prepared to reconsider it with respect to looking at the limitation or tightening up the timelines with respect to the studies and reviews that are called for in clause 9.1 of the actual bill. The matter that's always been of concern to me is the openness or the possible openness with regard to the reviews.

I do want senators to know that I don't intend on supporting this particular amendment, but I would like to consider the possibility of looking at tightening up the timelines with respect to article 9. Thank you.

**The Hon. the Speaker:** Are honourable senators ready for the question?

**Hon. Senators:** Question.

**The Hon. the Speaker:** The question on the subamendment of Senator Jaffer. All those in favour will please say "yea."

**Some Hon. Senators:** Yea.

**The Hon. the Speaker:** All those against will please say "nay."

**Some Hon. Senators:** No.

**The Hon. the Speaker:** In my opinion, the "nays" have it.

*And two honourable senators having risen.*

**The Hon. the Speaker:** I see two senators rising. Do we have an agreement from the government liaison and the whip?

**Senator Mitchell:** Fifteen minutes.

**Some Hon. Senators:** Now.

**Senator Mitchell:** Fifteen minutes.

**The Hon. the Speaker:** The default position is one hour. Do we have an agreement? Fifteen-minute bell. The vote will take place at 9:36.

Call in the senators.

• (2140)

Motion in subamendment negated on the following division:

#### YEAS THE HONOURABLE SENATORS

Campbell  
Cowan  
Day  
Downe  
Dyck  
Eggleton  
Fraser  
Hubley  
Jaffer  
Joyal

Kenny  
Lankin  
Lovelace Nicholas  
Mercer  
Moore  
Munson  
Oh  
Ringuette  
Tardif—19

#### NAYS THE HONOURABLE SENATORS

Ataullahjan  
Batters  
Bellemare  
Beyak  
Boisvenu  
Carignan  
Cools  
Cordy  
Dagenais  
Doyle  
Duffy  
Eaton  
Enverga  
Frum  
Gagné  
Greene  
Harder  
Housakos  
Lang  
MacDonald  
Maltais  
Manning  
Marshall  
Martin  
Massicotte  
McCoy

McInnis  
McIntyre  
Mitchell  
Mockler  
Nancy Ruth  
Ngo  
Ogilvie  
Omidvar  
Patterson  
Plett  
Poirier  
Pratte  
Raine  
Rivard  
Runciman  
Seidman  
Sinclair  
Smith  
Stewart Olsen  
Tannas  
Tkachuk  
Unger  
Wallace  
Wells  
White—51

#### ABSTENTIONS THE HONOURABLE SENATORS

Meredith

Wallin —2

**The Hon. the Speaker:** Resuming debate on the amendment of Senator Cowan.

[Translation]

**Hon. Claudette Tardif:** Honourable senators, I would like to speak briefly about the amendment moved by Senator Cowan. First, I would like to say that I agree with his amendment, which proposes that Bill C-14 be amended to allow advance requests for medical assistance in dying.

[English]

I know that critics have said that medically assisted dying is too complex, context-specific and absolute to use advance directives as a tool to provide consent. However, the government itself has acknowledged that not allowing advance directives could force those with competence-eroding conditions to take their lives prematurely, and perhaps violently, or risk permanently losing access to medically assisted death once they no longer have capacity to consent.

Honourable colleagues, this would be discriminatory against a group of Canadians. This would violate equality rights and the right to life, liberty and security of the person, according to section 7 of the Charter.

I would further like to stress that a strong majority of Canadians want the option of advance consent in medically assisted dying.

Honourable colleagues, a Forum Research survey of Canadians on June 7 indicated that 74 per cent of Canadians interviewed were in favour of advance consent in assisted dying. Senator Cowan and his colleagues indicated that according to an Ipsos Reid poll, 80 per cent of Canadians supported advance consent.

Forum Research President Lorne Bozinoff, said:

It is clear from these findings that [Canadians] don't want to deny this right to those who can't, in the end, speak for themselves.

I would like to share with you an excerpt from a message that I received from an Albertan, one of many messages — in fact, I would say hundreds — that I have received, as you have, from Canadians across this land. She states:

I am a retired nurse who has worked in many health care settings, including pediatrics, public health, a geriatric assessment unit and finishing my career as a case manager for AHS. I continue to volunteer in areas including health care. We have three grown children and four grandchildren.

As a couple, my husband and I, we share the belief that we would like to end our lives with dignity and may possibly need the assistance of a physician. The proposed legislation falls short for us in several areas. It does not allow for advance consent for patients with degenerative disorders like dementia. We are strong advocates of people being able to make their wishes known on requesting physician or nurse practitioner assisted death.

My mother died of vascular dementia, and she had no quality of life at the end. She was like a bird, with the reflex of opening her mouth when presented with puréed food, but no longer knew her loved ones or could be involved in any meaningful conversations.

I've heard the comment made by physicians quoted often that some of these patients with dementia seem happy. I wonder if he has spent 24 hours per day for a week with that person, and if he would say that if he experienced that reality.

[Translation]

Honourable senators, the excerpt that I read to you echoes the messages that I received from many Canadians.

The Special Joint Committee on Physician-Assisted Dying and the Standing Senate Committee on Legal and Constitutional Affairs examined this issue in depth and made fair and informed recommendations. According to those recommendations, an advance request could not be signed until after the person is diagnosed with a grievous health condition that is reasonably likely to cause that person enduring suffering or the loss of the ability to make and share his or her health decisions. According to the recommendations, the person would have to be competent and at least 15 years old. In my opinion, the safeguards added in this amendment are sufficient.

The proposed amendment is consistent with *Carter*, which indicates that everyone has the right to dignity and individual autonomy. It also reflects the wishes of most Canadians.

Honourable senators, we are talking about a matter of rights and human dignity, and I am going to support this amendment.

• (2150)

[English]

**The Hon. the Speaker:** Would you take a question, Senator Tardif?

**Hon. Jim Munson:** Senator Tardif, for many of us, tonight and the last few days have been tough. It's been a struggle to come to a decision. Many have spoken about their own individual cases. Of course, I have mine, but I won't be speaking about that issue and my family. But it really has been tough. I always have a great deal of empathy for others.

We discussed this as individuals tonight, even just before this vote. June 6 was a date that the government had laid down as imperative, and I'm looking at tonight as another one of those nights where we have to make a decision. We seem to be moving at a rapid pace, and I was hoping we could at least have a night to think about this.

I go back to Senator Eggleton's conversation about a person who gives an advance directive, and then the person later on is in a state of dementia and has no way of expressing himself or herself.

You talked about the issue of how peaceful a person would look. I know it's going to be difficult for you to even answer this question, but where is that moment with two independent physicians? Where is that moment in a person's life when a decision has to be made or should be made to end that life? We both know of others who don't seem to be struggling in any sort of pain; they are diagnosed at 84, and at 94 they are sitting in a seniors' home and feeling very comfortable about their lives.

I just can't figure it out, in my own mind, that moment of people sitting down in a home where that decision has to be made to end somebody's life.

**Senator Tardif:** Thank you, Senator Munson, for that question. It's one that I've certainly struggled with and I know that many of us have. I don't have a definitive answer. I think each of us has to answer for ourselves. It's a matter of coming to terms with the personal realities we've had in the past and as we situate it in the context of the information before us.

I have been convinced by the arguments that have been put forward, by reading the judgments of the people who have dealt with not necessarily advance directives but, certainly, in looking at the decisions rendered by the courts of appeal in Alberta and in Ontario, the Supreme Court, as well as by the eloquence of our colleagues in their statements.

To answer your question — and I know I'm not answering it directly, Senator Munson, but it is a difficult issue — I think, once again, it is a matter of when a person decides and having that right to make that personal decision for oneself.

**Senator Munson:** A point of edification: When a person gives an advance directive or a request, at that particular time would, in that advance directive — and I'm putting these things out here because we were not on the Legal and Constitutional Affairs Committee. We were doing a lot of other things that senators do that I think are extremely important, so when we get into this kind of debate, the minutiae of it gets a bit more difficult.

Are there specifics in the advance directive where a person could say, "If I go into a coma or have a major heart attack," that kind of thing, can that be part of an advance directive of a specific nature of your illness? That would be helpful for me.

**Senator Tardif:** I believe that is so, Senator Munson. From my understanding of what's before us, that would be possible.

I know that certainly now one can give an advance directive. If you're in a coma and something is already in your will, those advance directives are already present when you pass away.

**The Hon. the Speaker:** On debate.

**Hon. Dennis Glen Patterson:** Honourable senators, with the greatest of respect, I think we are getting carried away with our exuberance to go way beyond what was contemplated by the duly elected government in Bill C-14. We should not do this lightly, honourable senators.

[ Senator Munson ]

The new Parliament has a clear majority. Some of us have said this is the Senate's finest hour. I'd say if this debate is to be described as an hour, it's a rushed hour with Parliament scheduled to go on a summer break within weeks. And dare I say, again, with all respect to the thought that's gone into this amendment, we are risking with a plethora of amendments losing credibility in the other place.

I have maintained we've been rushed by the circumstances of the Supreme Court judgment coming towards the end of the previous government's mandate, and then followed by the Supreme Court's unwillingness to grant Parliament the full time that had been requested by the government.

I hear Senator Eggleton today expressing his concern about classes of people being deprived of their rights, but let us venture on to this new ground with caution and with full knowledge of all the implications and nuances of such a complex issue as advance directives.

We've seen these complexities touched on and probed even in a short few hours of thoughtful debate tonight. Even Senator Cowan, who has clearly thought deeply about this, wants to think about one question overnight.

So I want to say that I support studying further expansion of the right to physician-assisted death in a careful and thoughtful way, exploring carefully and crafting safeguards, examining experiences and lessons learned in other jurisdictions, and allowing Canadians the opportunity to be consulted, which I don't think they've had.

Again, I want to commend the senators who put their significant time, energy and experiences into the study of the joint committee to date, and the study of this bill. But I do say that there is more good work for a special committee of the Senate, or another joint committee, not one that is rushed to do its work on either side of the Christmas holidays.

I took careful note of Senator Harder's suggestion in this debate tonight that we should take more time to study these profound and complex issues. That's the way we should proceed: thoughtfully, carefully and taking the time to try to understand as best we can the full implications of rights we establish, because once given, they are hard to take away.

This amendment, I say with respect, will rush to a conclusion on a very complex issue. I cannot support proceeding now. Let us go ahead with this, if we decide to do so, with our eyes wide open, following more careful study than we've had time to do so far.

I will not support the amendment.

**The Hon. the Speaker:** Are senators ready for the question?

On debate, Senator Sinclair.

**Senator Sinclair:** Given the comments with respect to the amendment proposed by Senator Cowan, my comments will be relatively brief. I, too, am opposed to the amendment, but I do want to go on record and make it very clear that I think we do need an advance directive principle in the legislation.

I think Canadians have certainly spoken about it. I received the same emails and messages that you all have, and I know that there's broad support for it, but this bill, I think, is an example of how doing the right thing in haste can end up causing us to do the wrong thing.

• (2200)

Despite all of the effort, and I'm sure many hours have gone into the drafting of this particular amendment, there are provisions within it that cause me significant concern.

I've alluded to a couple of them. One is the question of how in an advance directive you can identify what intolerable suffering is in the future is a matter of some concern to me. I've heard allusions here to a heart attack or entering into a coma, and that's clear. If we just delineated those kinds of things, we would probably be quite fine.

However, the issue of intolerable suffering goes far beyond that. It also includes the inability or lack of willingness to continue to tolerate the situation that you are facing, including mental suffering. I don't know how you measure mental suffering today for what you will experience in the future, and that requires us to come to some determination. I can say today I do not want to remain alive if I am suffering intolerably mentally in five years from now if I continue to have a grievous condition that I've been told I now have. But if someone were to ask me at that point in time and say to me, "How are you feeling?" I might say, "I'm feeling good." Then they say, "No, no, because of your condition, you must be suffering intolerably." They would have the authority under the directive to end my life, I guess. And we can't have that.

We can't have legislation that is so vague that it puts power into the hands of somebody who is not you. You have to be able to retain as much power as late as possible. At this point in time, this legislation doesn't give us that kind of protection.

I'd like us to consider the fact that we are, as I said in my very first comments on second reading of this legislation, breaking new ground here. We are setting the tone for what this country will be known for in the future, and we have to get it right. We have to do it right. I don't disagree with the need for us to have an advance directive. I'm just concerned that we're not doing it right at this point in time, and I think we need more information.

I'd like to hear from medical experts about how we create an advance directive that allows a competent person today to give instructions for a period of time when they are not competent. If somebody were to say, in fact, as Senator Eggleton says, "No, I don't want to die now," somebody could say, "But you're not competent to make that determination; therefore, you're going to die because you have a condition which renders you mentally incompetent."

All of that causes me huge concern here. This bill doesn't have the proper safeguards for those people for whom we say it is intended to benefit.

Many people can benefit from an advance directive today based upon this kind of a situation in this kind of bill in this day and age because they can identify specific conditions, such as being in a

coma, such as having a heart attack, such as having your legs cut off or losing your limbs, specific things that you can name. But let's name those kinds of situations that people can identify instead of leaving it so vague that it's conceivable that a court in fact could strike this down. I want to be careful about doing that.

I'm cognizant of my earlier remarks. Senator Cowan reminded me that in my courtroom half the lawyers were always wrong, and Courts of Appeal have often said that trial judges are sometimes wrong, too. But I always remind people it takes two in the Court of Appeal to get me, and it doesn't mean that they're right just because they say that.

I also want to, as I mentioned in a question I put to Senator Cowan earlier, draw to senators' attention that the penalty provisions for this particular amendment cause me some concern as well because it uses the phrase of "knowingly" doing something. If somebody in fact negligently causes the death by not averting to all of the information that the patient has provided and acts in a negligent way to cause the person to die pursuant to what he thinks is an advance directive, then why would that person not be subject to prosecution? It's the fact that we're exempting, apparently, those who are acting negligently, and I'm concerned about that, when in fact we could, through a properly worded penalty provision, deal with that as well.

Again, it's not that we can't do it. We can do it perhaps relatively easily by simply saying that advance directives that are enacted pursuant to provincial legislation would protect anybody from prosecution, and that might end up being the answer. Perhaps by the time the studies are done, provinces will have lined up to determine what the advance directives for this kind of situation would be.

My point now is we are trying to do too quickly something which requires more time, and I want to encourage senators not to support this amendment but to again consider the question of what I raised earlier, and that is perhaps we should be putting tighter timelines on those reviews that are called for in this bill. Thank you.

**Senator Fraser:** Would Senator Sinclair accept a question?

**Senator Sinclair:** Yes.

**Senator Fraser:** Thank you very much, senator. I'm not in the habit of taking on former judges, but I guess I'd just like you to clarify a couple of points of your reasoning.

The first one would be in connection with the amendments provisions about offences and punishment, where you, as I understand it, were particularly concerned about the insertion of the word "knowingly."

But if I turn to page 11 of the bill, "knowingly" is right there on line 5, line 12 or 13. It seems to me that the amendment simply mimics the language in the bill. Have I missed something? And again on page 8, line 36. Can you explain this to me?

**Senator Sinclair:** I'm not sure what you're asking me to explain to you. I can explain to you what my comments were intended to cover, and that is that if an advance directive is worded pursuant

to a vaguely worded amendment in the bill now, or if it is drafted in a way that discourages further analysis or in fact allows someone to proceed further without further analysis, then all of those “knowingly” provisions which you’ve averted to are not there to protect the patient. They can simply rely upon the advance directive. And if the advance directive is inadequate in and of itself, they will not have done their due diligence to ensure that the person is and was at the time properly competent and capable of giving that consent because they can say they rely upon it when they should have more information and should, I think, pursue more information about that.

But the word “knowingly” in the provision that’s been proposed is intended to capture those people who, in the face of information to the contrary — I think is intended — still go ahead and do what they shouldn’t do. My point is we should also be considering the question of what about those who don’t do their due diligence and don’t do what they should be doing.

**Senator Fraser:** Would the senator accept another question?

**Senator Sinclair:** Yes, of course.

**Senator Fraser:** With some trepidation, but never you mind.

**Senator Munson:** He’s not a judge anymore.

**Senator Fraser:** But I never was a judge.

So now I’m going back to the introductory paragraphs of the amendment and the definition of “advance request,” which says, in subparagraph (a), that an advance request specifies the conditions including the existence or development of particular symptoms, mental or physical incapacities or other circumstances and the types of treatments that are not acceptable to the person.

• (2210)

How could one, in law, reasonably expect to be more specific than that in an amendment to the Criminal Code on the assumption that every individual would have their own set of specific conditions? They would have to specify the conditions, would they not?

**Senator Sinclair:** I would think that’s what a review would tell us.

**The Hon. the Speaker:** Are honourable senators ready for the question?

**Hon. Senators:** Question.

**The Hon. the Speaker:** Senator Sinclair, do you wish to take another question?

**Senator Sinclair:** Yes, quickly.

**Hon. Art Eggleton:** The amendment that we have before us deals with the legal question of the Criminal Code and the exemptions that would be provided in the case of advance

requests. Senator Carignan has mentioned that a lot of this would appear to be in provincial jurisdiction. Wouldn’t it be perhaps the responsibility, then, of the colleges of physicians and surgeons of each of the provinces to determine, in terms of the guidelines to the people of their profession, exactly where you would draw the line here? That is, where a person of mental incapacity would be in a position where it could be considered intolerable suffering and reasonable to end a life, as opposed to some grey area. Wouldn’t they have to remove that grey area? Isn’t that a responsibility, would you say, of the colleges of physicians and surgeons?

**Senator Sinclair:** That is true. The honourable senator has hit the nail on the head here. This is an area of both provincial and federal jurisdiction. The most the federal government can do is exempt individuals from criminal liability for doing something that the legislation allows them to do, but they cannot create an exemption under provincial law or permission under provincial law. The provinces have to create that medical authority, through amendments to medical legislation or licensing legislation, to authorize doctors to do the procedure that the legislation calls for, particularly in the area of “advance directive,” because advance requests or advance directives are covered by provincial legislation at this point in time. We can’t create an advance directive regime federally, in my view, that is going to be inconsistent with or is going to end up being inconsistent with provincial advance directive legislation in place now, and we shouldn’t do that.

**Senator Eggleton:** I see this as sort of permissive in that regard in that it deals with a Criminal Code issue, but it leaves it then to the provinces to work out these matters that are of concern to us — that is, the different scenarios that we’ve been talking about in the course of this debate. Isn’t that the case? Isn’t it really saying: “Okay, we’ll make sure we cover you under the Criminal Code so you’re not prosecuted. You now, provinces, as the deliverers of the health care system; you, the colleges of physicians and surgeons of each province, as the regulators of the profession, will now have to pull all that together and make sure it works within this framework.” Isn’t that really where we’re at with this motion?

**Senator Sinclair:** It’s where we’re at with respect to the debate about this amendment. It’s also where we’re at with respect to the bill overall, because the bill overall requires there to be federal-provincial cooperation. We could authorize legislation federally which says that people will not be prosecuted for providing medical assistance to someone who wishes to die, but provincial legislation still needs to be in place to authorize them, pursuant to their medical legislation or their medical licensing legislation, to be able to do that. That may be part of the review process about how that all gets put into place.

**The Hon. the Speaker:** Are honourable senators ready for the question?

**Hon. Senators:** Question.

**The Hon. the Speaker:** In amendment, it is moved by the Honourable Senator Cowan, seconded by the honourable senator Fraser:

That Bill C-14, as amended, be not now read a third time, but that it be amended in —

Shall I dispense?

**Hon. Senators:** Dispense.

**The Hon. the Speaker:** All those in favour of the motion will please say “yea.”

**Some Hon. Senators:** Yea.

**The Hon. the Speaker:** All those opposed, please say “nay.”

**Some Hon. Senators:** Nay.

**The Hon. the Speaker:** In my opinion, the “nays” have it.

*And two honourable senators having risen:*

**The Hon. the Speaker:** Do we have an agreement on time?

**Senator Mitchell:** There are several senators —

**The Hon. the Speaker:** A five-minute bell?

**Senator Mitchell:** I’d go 10.

**The Hon. the Speaker:** A 10-minute bell?

**Senator Plett:** Your Honour, we had an arrangement that we would vote now.

**An Hon. Senator:** No, we didn’t.

**Senator Plett:** Yes, we did. Senator Mitchell and I had an arrangement that we would vote now, but we will yield, again, to the fact that he couldn’t get his people over here and we’ll have a five-minute bell.

**The Hon. the Speaker:** Honourable senators, if there is not unanimous agreement as to a time, the default position is a one-hour bell. Do we have agreement on time?

**Senator Mitchell:** Ten minutes.

**The Hon. the Speaker:** Ten minutes, agreed?

**Hon. Senators:** Agreed.

**The Hon. the Speaker:** The vote will take place at 10:26.

Call in the senators.

• (2220)

Motion in amendment negated on the following division:

YEAS  
THE HONOURABLE SENATORS

Boisvenu  
Cowan  
Day  
Downe  
Dyck  
Eggleton  
Fraser  
Hubley  
Jaffer  
Joyal  
Kenny  
Lang

Lankin  
Lovelace Nicholas  
Massicotte  
Nancy Ruth  
Ngo  
Ogilvie  
Stewart Olsen  
Tardif  
Wallin  
Wells  
White—23

NAYS  
THE HONOURABLE SENATORS

Ataullahjan  
Batters  
Bellemare  
Beyak  
Campbell  
Carignan  
Cools  
Cordy  
Dagenais  
Doyle  
Duffy  
Eaton  
Enverga  
Frum  
Gagné  
Greene  
Harder  
Housakos  
MacDonald  
Maltais  
Manning  
Marshall  
Martin  
McCoy

McInnis  
McIntyre  
Mercer  
Meredith  
Mitchell  
Mockler  
Moore  
Oh  
Omidvar  
Patterson  
Plett  
Poirier  
Pratte  
Raine  
Rivard  
Runciman  
Seidman  
Sinclair  
Smith  
Tannas  
Tkachuk  
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ABSTENTIONS  
THE HONOURABLE SENATORS

Munson

Ringuette—2

(The Senate adjourned until tomorrow at 2 p.m.)

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