



PARLIAMENT | PARLEMENT
CANADA

Special Joint Committee on Physician-Assisted Dying

PDAM • NUMBER 003 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Monday, January 25, 2016

Co-Chairs

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

Special Joint Committee on Physician-Assisted Dying

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• (1105)

[English]

The Joint Chair (Hon. Kelvin Kenneth Ogilvie (Senator, Nova Scotia (Annapolis Valley—Hants), C): Colleagues, we have a quorum. I call the meeting to order.

[Translation]

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

[English]

You obviously do not want to listen to this voice all during the session today, so my co-chair has kindly agreed to chair today's meetings. I thank Rob very much.

Over to you, Rob.

The Joint Chair (Mr. Robert Oliphant (Don Valley West, Lib.)): Thank you, Senator.

If there's a doctor in the room, keep an eye on the senator.

Voices: Oh, oh!

The Joint Chair (Mr. Robert Oliphant): Welcome to the third meeting of this committee. We welcome our witnesses.

I recognize Senator Joyal.

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

I just want to remind the honourable members of this committee that the Senate is an independent chamber of Parliament and that we are constitutionally entitled to exercise sober second thought. On that basis, we don't feel bound by the conclusions of this committee or the report of this committee in the exercise of our constitutional duty, as reminded by the Supreme Court of Canada in April of 2014.

Thank you, Mr. Chair.

The Joint Chair (Hon. Robert Oliphant): *Merci*, monsieur.

That's well noted by the committee. I think we have already been establishing a great working relationship on this committee, the first joint committee in some 20 years as a special parliamentary committee. I look forward to your first thought and your second thought in our work.

We welcome witnesses today. Our first witnesses are from the Department of Health. We have two officials: the assistant deputy minister, Ms. Hoffman; and the manager of the chronic and continuing care division, Ms. Harper.

We welcome you and thank you for coming on relatively short notice to our committee. We are up and running quickly. We know you have work that you do every day, so thank you for attending to us in this meeting.

You have about 10 minutes for your opening presentation, and then 35 minutes for committee witnesses.

Ms. Abby Hoffman (Assistant Deputy Minister, Strategic Policy, Department of Health): Thank you very much.

Good morning, all, and thank you for the opportunity to be here today to discuss this important issue.

[Translation]

Last week, my colleagues at the Department of Justice provided a summary of the Carter ruling and an overview of the core issues, particularly as they relate to the Criminal Code.

[English]

Today I'd like to address some key considerations from a health sector perspective, touching on issues that the committee may wish to keep in mind as you move forward with the development of your recommendations. My remarks cover issues that will need to be addressed by three levels of responsibility: by the federal government, by provincial and territorial governments, and by medical regulatory bodies that operate under mandates from their respective provincial and territorial governments. I will comment on each of these.

Let me start with the federal government. In general terms, in health the federal government has the following responsibilities: establishing and monitoring compliance with national principles for Canada's health care system, as set out in the Canada Health Act; providing block funding support for health care to provinces and territories through the Canada health transfer; regulating market access for drugs and medical devices, and regulating patented drug prices; funding or delivering certain health care services for specific groups; and providing leadership and developing programs and funding in a range of other health-related areas, including public health, health research, statistics, and health care innovation.

In the federal health portfolio, we are already considering the implications of physician-assisted dying in several of the areas I've mentioned. For example, if there turned out to be significant differences in access to physician-assisted dying among provinces and territories, there could be challenges related to the Canada Health Act principles of comprehensiveness and accessibility. There may also be questions for federal drug regulatory regimes under the Food and Drugs Act—specifically, for example, whether the drugs used in physician-assisted dying must be approved by regulatory authorities for that specific purpose, and how to ensure that those drugs are used appropriately. In the case of controlled drugs, regulatory changes under the Controlled Drugs and Substances Act may be required if controlled drugs are used to help end a life as opposed to treating a health condition.

[*Translation*]

The federal government also has some responsibilities for the direct delivery or coverage of health services for particular federal populations, such as First Nations and Inuit, members of the Canadian Forces, veterans, the RCMP, prisoners in federal institutions and certain classes of immigrants and refugees. There will be a need to align federal and provincial-territorial frameworks for physician-assisted dying to support access to this service for these groups.

[*English*]

The federal government is also responsible for rolling up data from the central vital statistics registry in each province and territory into a national database and for publishing annual summaries of deaths as part of Canada's vital statistics. This function has the potential to support the collection and publication of national data on physician-assisted dying.

In the course of your work, the committee can expect to hear views on palliative care. The Carter decision has led to widespread calls for improvement in palliative care in Canada, both from those who view it as an alternative to physician-assisted dying and from those who see it as an integral part of the spectrum of care options at the end of life. The need for improved palliative care has been emphasized in the reports of the federal external panel, as well as the provincial-territorial expert advisory group.

In its role of contributing to the overall quality and sustainability of the health care system, the federal government has funded a number of initiatives, in partnership with provinces, territories, and health NGOs, to advance palliative care education, awareness, national standards, and research. These activities, together with those of provinces and territories, are helping to improve the availability of palliative care. Still, however, it is estimated that about 70% of Canadians do not have access to palliative care, particularly those residing in rural and remote areas. Beyond that, many providers are not trained to provide palliative care services.

Through the new health accord process, the federal government plans to invest \$3 billion over the next four years to help deliver more and better-quality home care services for Canadians. We expect that support to include palliative care in a variety of settings and we expect that this will be one of the initiatives and priorities in the new accord.

●(1110)

When federal-provincial-territorial health ministers met in Vancouver last week, the ministers acknowledged the desirability of a consistent approach to physician-assisted dying. Provinces and territories are looking to the federal government for clarity on issues such as the types of physician-assisted dying that will be permitted, and eligibility. These are subjects that could presumably be addressed through amendments to the Criminal Code.

Provinces and territories are also looking for common ground on issues such as appropriate wait times between a request for and the provision of physician-assisted dying; how to protect the conscience rights of providers in ways that avoid limiting access for patients who may seek a physician's aid in dying; data collection, monitoring, and reporting; and research. These are issues that may best be addressed through pan-Canadian approaches led or coordinated by the federal government in conjunction with other partners.

Depending on the scope of the federal response, provinces and territories will need to consider a broad range of issues with respect to the implementation of physician-assisted dying. A relatively narrow federal approach, such as minimal amendments to the Criminal Code, would offer more flexibility to provinces and territories to make their own decisions on significant legislative, regulatory, and policy matters. On the other hand, a more extensive federal approach would help achieve greater consistency across the country. In either scenario, provinces and territories, medical regulatory bodies, and health care institutions will have considerable work to do.

Provinces and territories, in connection with their areas of responsibility for the delivery of health care, will need to consider, among other topics, the following: the processes to request, approve, and deliver assistance in dying; where the service will be offered, whether in institutions, at home, in hospices, or in long-term care facilities; and any safeguards to protect vulnerable populations that are not already outlined in a federal framework. Putting in place transparent processes for data collection, monitoring and reporting, and compliance will be important, as will be defining offences and penalties for non-compliance.

Provinces and territories may also pursue initiatives to improve the availability and public awareness of advance care planning, palliative care, and other end-of-life options. In the case of advance care planning, whether such directives could be used by individuals to express their preferences with respect to a physician-assisted death long before they are diagnosed with a condition that meets the criteria for physician-assisted dying is a complex issue provinces and territories may tackle, ideally, in a manner consistent across all jurisdictions.

Other issues that fall squarely under provincial-territorial jurisdiction include the following: whether physician-assisted dying should be treated as a publicly insured health service eligible for coverage under provincial and territorial health insurance programs; how health professionals should be reimbursed for their involvement in physician-assisted dying; liability protection for health care professionals; whether existing legislation for consent, capacity, and age of majority are appropriate for physician-assisted dying or need modification; regulation of the investigation, reporting, and tracking of deaths, which is normally dealt with under provincial coroners legislation; and any necessary amendments to life insurance legislation.

The work that Quebec has done can help inform implementation plans for physician-assisted dying in the rest of the country. Quebec's act respecting end-of-life care established a right to end-of-life care, including medical aid in dying in the form of voluntary euthanasia, a regime for advance medical directives, and a provincial commission on end-of-life care for oversight and reporting. Quebec also released a strategy to increase access to quality end-of-life care and develop guidelines, training, and tools on medical aid in dying for health care providers.

While provinces and territories are ultimately responsible for the delivery of health care, they have delegated authority for medical practice and discipline of health care providers to self-governing professional bodies, such as those for physicians, pharmacists, and nurses. These regulatory bodies will need to consider how to guide, train, regulate, and discipline their members in relation to any regime of end-of-life care that includes physician-assisted dying.

• (1115)

While some practices, such as assessing competency and ensuring informed consent, are already routine in medical practice, the particular requirements for physician-assisted dying will likely require new protocols and training.

I'll just say a further word on the roles of medical regulatory bodies.

Most provincial colleges of physicians and surgeons have either published guidance documents for members on physician-assisted dying or are in the process of preparing them. These guidelines indicate that provinces and territories are working towards a consistent approach, but also that there are important areas where they may diverge. Points of possible divergence include age of consent, different approaches for defining and determining whether a condition is "grievous and irremediable" and "causes enduring suffering", responsibilities arising from provider exercise of conscience rights, residency as an eligibility requirement, and so on.

Both the federal external panel report and the expert advisory group report support the idea of avoiding a patchwork approach to physician-assisted dying across the country. From the federal perspective, a reasonable degree of consistency across provinces and territories would support the underlying values of the Canada Health Act—that is, that all Canadians should have comparable access to needed health care services without barriers associated with financial means or geography.

A uniform regime would also provide greater certainty for providers and help to avoid people seeking physician-assisted dying in another jurisdiction because it is not available or only available under more restrictive conditions in their own home province or territory. More importantly, it would provide reassurance to eligible Canadians that no matter what their means or where they live, the option of physician-assisted dying would be available to them.

[*Translation*]

I hope these remarks have been helpful in understanding the various levels of responsibility within the health sector for physician-assisted dying. While Criminal Code amendments could lay the ground for a consistent approach to the provision of physician-assisted dying in Canada, collaboration among federal-provincial-territorial governments and medical regulatory authorities will be critical to achieving reasonable uniformity.

[*English*]

I welcome your questions. I will do my best, along with my colleague, to respond or to refer you to experts who can address them when we cannot.

Thank you.

The Joint Chair (Hon. Robert Oliphant): Thank you, Madam Hoffman.

Go ahead, Madam Shanahan.

[*Translation*]

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

Ms. Hoffman, thank you very much for your testimony.

Could you talk to us about the terminology, and the difference in the terms that are used to refer to broad categories in connection with physician-assisted dying? Could you also discuss the difference between the French and English terms?

[*English*]

Ms. Abby Hoffman: Thank you for the question.

Are you asking for the distinction as to how these are defined in each of the two languages, or are you simply asking for the distinction between euthanasia and assisted suicide?

Mrs. Brenda Shanahan: Yes, euthanasia. We've seen different terms being used in the reports, so just talk to us a little about that in terms of how your department would be working with this issue.

Ms. Abby Hoffman: I guess the first thing I would say is that our general understanding—I know that colleagues from the Department of Justice spoke in some detail about this the other day—is that we would regard the Supreme Court decision as having addressed both euthanasia and assisted suicide.

I think probably one of the most important considerations is simply that euthanasia, in effect, involves an act taken directly by, in this case, a legitimate authorized medical provider who is personally and directly responsible for taking steps to hasten the death of an individual. Assisted suicide engages the provider in a significant way, but at the end of the day, it's actually the individual who wishes to bring their life to an end who actually administers the medication that will hasten their death, so in effect the most important distinction is who provides advice and who administers medication that hastens a death.

Within those categories, you will find in various of these reports descriptions of voluntary euthanasia, involuntary euthanasia, and so on, but those are subcategories of those two essential distinctions.

• (1120)

Mrs. Brenda Shanahan: Okay.

[*Translation*]

I have a second question.

Could you tell us a bit about the work your department is doing with the Province of Quebec on Bill 52?

[*English*]

Ms. Abby Hoffman: Well, I think it's relatively straightforward. Up to this point, in respect of a federal-provincial-territorial working group that's been established to assist with collaboration between the two officials in the health and justice sectors in the two orders of government, Quebec has been very willing to share information and provide a lot of documentation because it is very well advanced, obviously, in this issue compared to the rest of the country. I would say that up to this point Quebec, quite appropriately, has made it clear that they have their own legislation and their own regime in place. They are not an official member of this working group, but they have provided a lot of support, particularly to officials in other provinces and territories.

[*Translation*]

Mrs. Brenda Shanahan: I'd like to go back to the first question.

Have you noted important differences between the French and English terms?

[*English*]

Can you speak to that?

Ms. Abby Hoffman: I'm not sure, frankly, that I can actually speak to that. I'm not aware of that issue, and I would not say, just based on a reading of the Quebec act or the commentary in either the provincial-territorial or the federal panel report, that it has been identified as a concern. I don't want to say absolutely that it is not a concern, but I would not say that it is something that has come to our attention up to this point.

Mrs. Brenda Shanahan: So we're very comfortable with physician-assisted dying.

[*Translation*]

So "l'aide médicale à mourir" is the equivalent.

[*English*]

Ms. Abby Hoffman: I think so.

Ms. Sharon Harper (Manager, Chronic and Continuing Care Division, Department of Health): Perhaps I can add something to that.

In the federal panel's report, there is quite a discussion about terminology, and that would be a very good place to start to read about the various people who have come before the federal panel to discuss the distinctions in terminology. A lot of them come down to how people feel they are going to impact on the medical profession or how they feel they might impact on the relationship between the patient and the doctor. They do a very nice job of laying that out.

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

Mr. Cooper is next.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you very much, Ms. Hoffman, for your presentation. I want to follow up on the issue of palliative care, which you briefly addressed in your presentation.

The president of the CMA has said that in light of the Carter decision, accessible palliative care is absolutely essential, and in the subject expert reports that have been prepared, it has indeed been a consistent recommendation.

The House of Commons did pass motion 456 in September 2014, which was introduced by the member for Timmins—James Bay, Mr. Angus, respecting the establishment of a pan-Canadian palliative strategy. I wonder if you might be able to elaborate on what steps have been taken, if any, toward that pan-Canadian palliative strategy.

Ms. Abby Hoffman: Thank you.

The first thing I would say, just to reiterate the comments I made in my remarks, is that there is no question that discussions following the Supreme Court's decision in Carter have really shone quite a bright light on the area of palliative care, but well before that there was a lot of interest in our department in doing work in this area. We have undertaken a number of initiatives with the Canadian Hospice Palliative Care Association, for example, in some of the areas that I mentioned in my remarks.

Has that, to this point, led to what one could really call a comprehensive national strategy? The answer to that is "not yet", but, as I also mentioned in my remarks, because of the elevated interest, we fully expect that in our upcoming discussions with provinces and territories about the home and community care piece that's intended to be a part of this new health accord, there will be a major focus on palliative care.

I don't know, Sharon, if you want to say anything further about initiatives the department has pursued to this point.

• (1125)

Ms. Sharon Harper: I think I can offer a little bit on two particular initiatives that were funded over the past few years.

One was with the Canadian Hospice Palliative Care Association. It was called "The Way Forward". It provided a framework for different levels of governments to work together to build an integrated palliative approach into all areas of health care provision. That is currently available on the Internet. We'd be happy to provide the site information if that would be helpful.

Another one is currently ongoing with Pallium Canada. They are providing the training of trainers and supporting training for front-line health care providers in providing palliative care in a number of health care settings. We can provide more information if that would be useful.

Thank you.

Mr. Michael Cooper: Thank you for that information.

Following up on that, I think a lot of issues respecting palliative care fall under provincial jurisdiction. However, I think there has been a broad recognition that the federal government does have a role to play in setting policy expectations and establishing guidelines and in issues respecting standards of care. Would you be able to comment on what steps have been taken to engage with provincial and territorial governments on those issues?

The Joint Chair (Hon. Robert Oliphant): You have one minute.

Ms. Abby Hoffman: I'm not in a position to document a lot of past activity in this area, because it hasn't happened, but I think that for the future this is absolutely an area that will be part of this agenda connected to the health accord.

The Joint Chair (Hon. Robert Oliphant): Go ahead, Mr. Rankin.

Mr. Murray Rankin (Victoria, NDP): Thank you, Chair, and thank you to the witnesses.

Ms. Hoffman, I'd like to ask you further about your point that under the Canada Health Act there are principles of comprehensiveness and accessibility. We'd been advised by the Library of Parliament that the accepted view now is that Parliament may contribute its revenues to matters that legislatively are within provincial jurisdiction.

With reference to the block transfers, the conditional grants you've talked about, I'm wondering whether the federal government, as a matter of policy, would contemplate requirements for the provinces to make sure this service is accessible and, if not, to withhold federal funds.

Ms. Abby Hoffman: I doubt that we would arrive at a situation in which we would dictate specifically, as a condition of federal funding, what forms of care are required to be provided by any individual or by provinces and territories collectively. Medical necessity, generally speaking, although it's referenced in the Canada Health Act, is left to provinces to define. Provinces and territories, as a condition of receipt of federal funding through the Canada health transfer, are obligated to provide "medically necessary" services, but, as I say, the act does not define those.

What tends to happen is that as certain forms of service provision come into vogue and are widely practised in most jurisdictions, if there is a circumstance whereby a jurisdiction has chosen not to provide that service, that issue then becomes or could become a topic of conversation between the federal government and that province. The comprehensiveness principle is really about the provision of services at what is the generally accepted standard of care in the country.

• (1130)

Mr. Murray Rankin: If it were to happen with this service, as we've seen with other services, that a particular province did not make it available, then you would or would not exercise your power to withhold funds?

Ms. Abby Hoffman: Let me just say that the last line of defence is the withholding of funds. There would be interaction with that jurisdiction and a lot of conversation long before the point of withholding funds.

Without getting into a lot of detail on the Canada Health Act, normally funds are withheld and deductions made from Canada health transfers in cases where user fees occur or extra billing occurs, where there is a so-called violation of one of the principles. If over time there was a failure to provide access to physician-assisted dying in an environment where it was permitted by law and provided in most other jurisdictions, one could arguably say that would be a violation of one of the Canada Health Act principles, theoretically, but it is a very long process to turn a violation or an alleged violation of a principle into a situation in which financial penalties are levied.

There is also stipulated, by convention, a process for interaction and mediation with a province or territory when there's a dispute about respect for the Canada Health Act principles.

Mr. Murray Rankin: You alluded to offences and penalties for non-compliance. Is this an example of a province or a particular provider that did not provide this service?

Ms. Abby Hoffman: I suppose that over time, that could be the case. As I've indicated, one could argue that if the standard of care and the standard of approach to end-of-life care in the country is the provision of physician-assisted dying and a jurisdiction chose not to put an appropriate regime in place, an individual would have recourse. They could argue that their charter rights are being infringed. They might also make an argument that their particular government at the territorial or provincial level is not fully respecting the principles of the Canada Health Act.

Mr. Murray Rankin: The reason I ask is that it's difficult for an individual to stand in the courts. I'm suggesting that the federal government has responsibilities, just as you said, to ensure comprehensiveness and accessibility. The act provides penalties and it provides the ability to withhold funds, so I would expect that would happen.

Ms. Abby Hoffman: I guess I'm just noting that there is a long process when it comes to issues related to Canada Health Act principles, as opposed to user fees and extra billing. There's a long process that would ensue before we got to the point of financial penalties—but yes, at the the end of the day, they are provided for.

Mr. Murray Rankin: Just quickly—I only have half a minute—you alluded at the end of your remarks to liability protection for health care professionals and life insurance issues. Are you suggesting that the federal government would have a role in that sphere as well, or is that simply limited to the provinces?

Ms. Abby Hoffman: No, I'm not. I would say that we would regard those as areas of provincial responsibility. I think the issue here is simply whether there's a role for governments collectively to look at those issues, to benefit from each other's intelligence, and to have common approaches.

Mr. Murray Rankin: Thank you very much.

The Joint Chair (Hon. Robert Oliphant): Senator Seidman is next.

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

The external panel, in its report, suggested that Canada has an opportunity to be a world leader in developing an oversight system for physician-assisted dying. Data collection, effective monitoring, and reporting with scientific rigour is one form of safeguarding the integrity of the process. The panel also said that serious consideration and time should be devoted to this objective. It points out that to avoid duplication, there should be collaboration among provinces, territories, and the federal government.

Ms. Hoffman, you suggested in your presentation that Health Canada might have some role to play in this. I'd like to know how you see this kind of oversight in terms of powers and responsibilities. What kind of governance structure should there be?

Ms. Abby Hoffman: The first thing I would say is that this would only come about, I believe, if there were agreement among provinces and territories and the federal government that this was desirable. Each province and territory—as is the case in other jurisdictions in the United States and internationally where physician-assisted dying is provided for—would have its own machinery for collecting data and looking back at cases of physician-assisted dying when those have occurred. In any event, in various jurisdictions deaths already need to be recorded, and they are the subject, at least, of statistical reports.

What would be of interest here, and I expect that we will talk about this at the federal-provincial-territorial working group table, is whether there is interest in an aggregated oversight function. While it is possible that Health Canada could take on that function, I think it would likely make more sense for some sort of arm's-length capacity to pursue it and for it to be done in conjunction with the existing health data and statistics agencies, such as Statistics Canada, the Canadian Institute for Health Information, and so on.

I think that at this point it is certainly not a proposition that Health Canada has imagined we would pursue unilaterally. However, it seems that in the report there is some very strong interest in having what I'll call an oversight mechanism, but it would also be a body that would collect information about cases of physician-assisted dying that have taken place in the country with a view to examining the circumstances and helping to get at some of these issues, such as how one defines an “irremediable” condition, whether or not there is guidance for practitioners that could be elaborated upon, and so on.

I think we would see it as something that could be useful, particularly in the early days of a physician-assisted dying regime being in place in Canada.

•(1135)

Hon. Judith G. Seidman: Would you see this also providing some kind of built-in mechanism to evaluate, in an ongoing way, how the system is working and to perhaps make changes?

Ms. Abby Hoffman: If it did more than collect statistics—and I think some experts have argued for that—then in effect its reports on

what has transpired would lead to recommendations about improving the regime, yes.

Hon. Judith G. Seidman: If I have time, I might move to another question that is somewhat related.

When the justice officials were here last week, they said that Canada is in a rather unique jurisdictional situation because issues in our Criminal Code are federal and health is provincial-territorial. They said that this creates serious challenges in designing the legislation and operationalizing it.

If you could, give us some idea of what the challenges might be. In your presentation you referred especially to uniform access across the country.

Ms. Abby Hoffman: First of all, health, as I think the justice folks said, is an area of concurrent responsibility. The Criminal Code could lay out ground on some issues. I think other issues where one might want to see consistency will be the product of consultation and dialogue between the two levels of government and with stakeholder organizations. In that case, the consistency will be achieved more through interaction, dialogue, and agreement on a possible direction, not through legislative fiat.

The Joint Chair (Hon. Robert Oliphant): Senator Cowan is next.

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

Thank you to the witnesses for your evidence today. I wanted to follow up on the same point.

We're all conscious of the jurisdictional turf issues here with the federal government, the provincial governments, the territorial governments, and the medical professional regulatory agencies. Can you tell us a bit about the mechanisms that are in place now for discussions?

I assume that these organizations and these entities are not operating in silos and that there are continuing discussions. We know of federal-provincial ministerial meetings, but you mentioned a working group. Can you tell us a little more about that and what progress is being made towards identifying things that are clearly either federal responsibilities, looking at it from our point of view as a committee, or areas where the provinces and territories are looking for some leadership at the federal level from a coordination or facilitation partner? Can you elaborate a bit on that?

Ms. Abby Hoffman: I'll underscore one point initially here, which is that there is in general, I think, a desire for consistency. That's one starting point.

With regard to the machinery that exists, you mentioned the federal-provincial-territorial ministers of health. They meet annually, and in certain circumstances more often. They in turn have a group of federal-provincial-territorial deputy ministers who meet very regularly, in person and by teleconference. At certain times they may have interactions weekly or every few weeks. They are the ones who authorized the creation of this federal-provincial-territorial working group, which brings together individuals who wish to participate from all jurisdictions and from both the health and justice sectors.

That group has had some interaction up to this point, but I'll be candid in saying that its work has been somewhat impaired by the fact that there has been no clarity to this point about what the scope of the federal legislative backdrop will be, assuming there is one, for physician-assisted dying. It's very difficult for that group of individuals, well qualified as they are, to discuss the implications for the actual implementation and delivery of physician-assisted dying without knowing what the legally sanctioned regime will be.

Nonetheless, and particularly taking into account the very tight timelines that exist, our work is about to resume. On the health side, I represent the federal government on this group. Our work is about to resume with some degree of speculation about what we think the regime will ultimately look like, and then we will be dealing with the implications of that for provinces and territories.

On the medical regulatory side, there are all the individual self-regulating professional bodies for nurses, pharmacists, physicians, and so on at the provincial level. There is also a national body, the Federation of Medical Regulatory Authorities of Canada. I expect they are likely to be witnesses who will appear before this committee. They can tell you about the work they have been doing with their members across the country, trying to work towards harmonized approaches even while not knowing, as I say, what the legislative regime will look like in the final analysis. The Canadian Medical Association and others are doing something similar. A lot of players out there are involved in consultations and discussions and are preparing guidelines and so on with this hope of achieving consistency.

I'm not sure I'm answering your question specifically about what it is that is uniquely the federal government's responsibility. It's obviously elements related to the Criminal Code. Beyond that, it's a matter of judgment and willingness to collaborate.

• (1140)

Hon. James S. Cowan: I guess I was looking at the fact that it's a huge issue. It has interjurisdictional issues within issues.

As a result of the ongoing discussions, can you help us by identifying two or three or four issues for which you think there would be a clear expectation of federal leadership?

Ms. Abby Hoffman: I would say it's first of all a question of whether it is euthanasia and assisted suicide or one or the other. There are issues around conscience rights and how those should be respected, and the implications of respecting them with regard to access. There are eligibility issues, issues around age, and any further elaboration or further detail on the criteria that the Supreme Court set out around suffering, irremediable illness, grievous condition, and all of that. There's been a lot of controversy about whether mental illnesses should be included, so that's connected to it as well.

The Joint Chair (Hon. Robert Oliphant): Thank you. If you have another list, I'm sure the senator would be happy to have it.

We have about a minute or two left in this round. As opposed to going to another questioner, I would like to ask one question.

From Health Canada's perspective, what is the difference between voluntary euthanasia and physician-assisted dying? I wasn't quite sure from your definitional answer. I understand involuntary

euthanasia, but the difference between voluntary euthanasia and physician-assisted dying, because both have a volitional...

Would you have an answer?

• (1145)

Ms. Abby Hoffman: I suppose the most obvious dimension of it is that physician-assisted dying, providing an individual has gone through all the appropriate steps to demonstrate competence and informed consent and so on, could include advising an individual how to actually accelerate their own death, whereas euthanasia is actually the authorized medical personnel administering the medication, generally speaking, that would cause death.

The Joint Chair (Hon. Robert Oliphant): But one death could be the same. It could be both.

Ms. Abby Hoffman: Well, I would say that voluntary euthanasia is one form of physician-assisted dying.

The Joint Chair (Hon. Robert Oliphant): Okay. Thank you.

All right. Thank you very much. Thank you, witnesses.

We'll have a brief suspension of three minutes as we get the video conference prepared. Because we have an overflow crowd, I want to let you know that you have the option to stand. We hope to bring in some extra chairs, but the meeting is televised and is available in room C-160 if you'd like to sit and watch. However, you're also welcome to be here. Thank you.

We'll take three minutes to suspend, and we thank the witnesses.

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_____ (Pause) _____

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• (1150)

The Joint Chair (Hon. Robert Oliphant): I'd like to call the meeting back to order, please.

Thank you, Mr. Hogg, for joining us today.

In this second round we have Peter Hogg, who will be given 10 minutes to present to the committee, and then, by teleconference, we will have Monsieur Marc Sauvé and Monsieur Jean-Pierre Ménard, who will be sharing 10 minutes.

We'll begin with Mr. Hogg's presentation. After we have the two presentations, we'll begin our questioning.

Mr. Peter Hogg (Scholar in Residence, Blake, Cassels, and Graydon LLP, As an Individual): Thank you, Mr. Chair.

The committee has a written presentation from me. I think there is also a French translation, although I didn't deliver the text until Friday, as I had short notice. My presentation will follow that written piece, and of course I look forward to questions later.

With regard to my credentials, I am a constitutional lawyer and I have no expertise in physician-assisted dying, so I'm only going to be able to help the committee on constitutional issues. I've set out in the presentation the exact order of the court. I won't read it to you again because I expect you're sick of hearing it—or perhaps it would be a good idea to read exactly what the court said.

The court said that it was issuing “a declaration that s. 241(b)”, which is the aiding and abetting suicide one, “and s. 14”, which is the consent provision in the Criminal Code, “are void insofar as they prohibit physician-assisted death”—that is what the court said, and they didn't distinguish between euthanasia and physician-assisted suicide—“for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.”

Under a previous Canadian government, Canada argued against this order on the ground that it was impossible to design effective safeguards to prevent error or abuse. There was a general agreement that if there was no way of preventing error or abuse, then clearly you couldn't have physician-assisted suicide. However, what the Supreme Court did was accept the finding of the trial judge, which was based on the experience of other jurisdictions that effective safeguards could be designed. Now, the trial judge didn't design the safeguards, but she said there was good evidence that they could be designed.

That's why the declaration of invalidity was postponed for one year. Of course, as you all know, it's been extended for a further four months. The idea is to allow Parliament or the provinces to design and enact appropriate safeguards. The role of this committee, of course, is to recommend the necessary legislation to Parliament.

You're all very much aware of the division of powers over health. Canada has the power over criminal law, and of course any regime of safeguards that you were to recommend would be a valid criminal law, because it would be added to the Criminal Code. It would be necessary in order to make provisions for physician-assisted dying effective.

However, physician-assisted death is one of the matters that is also within provincial jurisdiction, and already today I could hear a lot of questions about what the limits are. I would just say this about the provincial jurisdiction: although Quebec has already enacted an act respecting end-of-life care—and I'm sure it will be a very useful act when you design the federal act—it's very important to recognize that there's no guarantee that all provinces will enact statutes; therefore, you have to design a law that can be effective throughout the country, even on the assumption that there is no provincial law or no territorial law in part of the country.

In other words, you have to produce a self-sufficient act that could be operated even if the province in question did nothing. In a way, then, agonizing over the exact boundaries between provincial and federal power is not really necessary. What you have to do is design a set of safeguards that could work even in a province that did nothing. I think that's very important, because if Parliament does not enact a law that could be operated in a province where there is no law, the people of that province would be denied the right to physician-assisted dying, which the Supreme Court has said they have. That's one rather obvious point of view.

The next point I make in my paper is that although it would be very nice if the provinces all came out with uniform legislation, you have to recognize that it may not happen. One thing you can do is recommend a provision in the federal law that in effect provides

what I call an “equivalence provision”, which in effect would say that if the federal Minister of Health or the Governor in Council—you could use any framework—is satisfied that a province or a territory has enacted safeguards that are substantially equivalent to the federal safeguards, then the federal law would not apply in that province.

The advantage of doing that is that it would avoid overlapping legislation. Also, if you don't do something like that, issues of conflict between the federal and provincial law will be quite complicated, and they will be resolved by the rule of federal paramountcy. That would be a bad situation. I think it can be resolved by a so-called equivalence provision.

In my paper, I give you two precedents for an equivalence provision. One is in the federal privacy legislation, which provides that the Governor General, if satisfied that the legislation of a province is substantially similar to part of the federal privacy legislation, can exempt the province from that part of the federal act. Orders in council have been published with respect to Alberta, B.C., and Quebec, so it's perfectly plain and obvious and publicly open that the federal privacy legislation is supplanted by the provincial privacy legislation in those three provinces.

I thought there was a similar one in the Canadian Environmental Protection Act. There is, and there are references to it. The reference to it is in my paper. It's a more limited one. It says that the minister and a provincial government can agree in writing that a province has a law that is “equivalent” to the federal environmental law. Then the Governor in Council can make an order declaring that the province is exempt from the federal regulation.

• (1200)

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

• (1205)

Mr. Peter Hogg: Yes.

That's the only point I want to make, except to say that I think there are other precedents out there. It's a very wise way of dealing with overlapping laws, and the committee should be aware that it can be done and it has been done.

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

Now, we have the Quebec Bar, *le Barreau du Québec*.

Monsieur Sauvé.

[*Translation*]

Mr. Marc Sauvé (Director, Research and Legislation Services, Barreau du Québec): Thank you and good morning, Mr. Chair.

My name is Marc Sauvé. I am the director of research and legislation services at the Quebec Bar. I'm accompanied by Mr. Jean-Pierre Ménard, a lawyer recognized in Quebec for his expertise in health law. Counsellor Ménard was a member of the Quebec Bar working group on dying with dignity in 2010. He also chaired the committee of expert jurists created by the Government of Quebec to study the implementation of the recommendations of the Select Committee on Dying with Dignity of the National Assembly. The report of that expert panel was tabled on January 15, 2013.

The Bar has not taken a position on the amendments the federal legislator may make to the Criminal Code in the wake of the Supreme Court ruling in the Carter case. The Bar has thus kept all of its options open to respond to any future bill on this topic.

I will now yield the floor to Mr. Ménard, who will give the members of the committee an overview of the legal issues involved in the various options related to this legislation.

Mr. Jean-Pierre Ménard (Lawyer, Barreau du Québec): Thank you.

Mr. Chair, ladies and gentlemen members of the committee, we have in fact been working since 2009 on the issue of physician-assisted dying in the Canadian constitutional context. The Quebec Bar thanks the committee for its invitation.

This morning we simply want to convey to you a certain number of ideas on how the committee could approach these issues. First of all, there is a time constraint that is important. In addition, this matter is extremely complex and very broad.

We have to have a clear understanding of what the Supreme Court decided in the Carter ruling. It simply decided that two sections of the Criminal Code contravene the charter, and gave the federal government one year—plus four months, now—to amend the Criminal Code to make it comply with the charter. The priority in the short term is thus to amend the Criminal Code.

It is clear that the issue of physician-assisted dying goes beyond the strict limits of the Criminal Code. In that context, I agree with Professor Hogg's analysis, which is that this touches on many other matters that are for the most part issues of provincial jurisdiction.

When we examined how the recommendations of the Select Committee on Dying with Dignity of the National Assembly could best be implemented, we attempted to see whether, within Quebec's constitutional areas of jurisdiction, the province had sufficient powers to draft a law that could meet its citizens' wishes. We concluded that the province did have those powers.

Despite the fact of that there is no perfect demarcation between federal and provincial jurisdictions, in light of established jurisprudence we believed that there was room for the provinces to act, and even considerable room. In that context, it is clear that the federal government wanted to legislate and go further than the Criminal Code. This could be interesting, because it is important that Canadian citizens have comparable, though perhaps not equal, access from one end of the country to the other. Clearly, we have to find a process to achieve that.

The problem a federal law on this question may pose is that this legislation may be very close to matters the committee formed by the previous government had established. For instance, if the federal government drafts legislation that concerns palliative care, monitoring, the training of physicians and that type of thing, it would clearly be acting in provincial areas of jurisdiction. It is clear that any federal law on these matters could easily be subject to constitutional challenge by people who are opposed to forward movement in this area.

We believe that the important thing in the short term is that the federal government amend the Criminal Code. This could be done

very quickly and simply by amending sections 14 and 241, stating that those sections do not apply when someone asks for physician-assisted dying and meets the criteria set out by the Supreme Court. In the short term, that could be sufficient.

If we want to go further, I think that the first step should be a federal-provincial discussion, since the provinces have primary jurisdiction over all of the issues I just referred to. I believe that this might be the safest process to consider.

You could also consider a statutory exception. That could certainly be justified constitutionally, but I think it may open the door to debate, and perhaps make things easier for those who wish to challenge this.

Quebec's experience has shown that a law on physician-assisted dying can contain sufficient safeguards. These are not the provinces' sole prerogative. Safeguards also come from the Canadian Parliament, for instance through the Criminal Code. That would be a first series of safeguards, but another set would fall under provincial jurisdiction. There are the rules on consent, monitoring, and so on.

Essentially, since the physician is the one who acts, the simplest process to monitor quality is to monitor physicians' activities. In every province there is a college of physicians that is very sensitive to these matters and fully qualified to take on that responsibility. In addition, provinces may also create other organizations on their territory to monitor and control the process.

I do not think it is relevant for the federal government to create a Canadian monitoring mechanism, because proximity is important. And of course, this raises the issue of monitoring all medical practice. Obviously, it could be difficult for the Parliament of Canada to legislate on that.

•(1210)

The right to physician-assisted dying has now become a constitutional right for all Canadian citizens. The debate is no longer about whether this is a good thing or not. Nor is this right subject to other conditions aside from the ones set out by the Supreme Court. The provinces, colleges of physicians and the Canadian Parliament may add other conditions, but the effect of that should not be to empty these things of their content.

In the short term what is important is amending the Criminal Code. If we want to go further it would be useful to divide the process up. First, we have to respond to the Supreme Court ruling through the Criminal Code. Then we have to take the time to establish a more general framework to consult Canadians. A second legislative process could then be established that would not be subject to the deadline set by the Supreme Court. The objective of this process would be to complete what the Criminal Code already contains. This would give us more time to hold a broader debate.

As to the conditions, when the federal government asked the Supreme Court for an extension, the reasoning was that it was important to establish rules to regulate behaviour and determine which acts are authorized or not. The Supreme Court has already answered these questions in large measure. As to knowing who has access to physician-assisted dying and under what conditions, the Supreme Court has already answered that too. Then there is the regulation governing those who act. Reference was made to physicians and the institutions where people would die.

The Supreme Court has established a primary, basic regime. For the moment, we can be satisfied with that framework. Should it be improved, and extended to minors? What about adults who are not mentally competent? Should we allow people to have access to physician-assisted dying only in hospitals, or also outside of their walls? Could other people aside from physicians provide that assistance? These are broader debates, and in my opinion it is not necessary to settle these matters or make those decisions now.

In the short term, let us deal with the Criminal Code. It could be changed very simply and quickly without modifying fundamental things, and we must ensure that we negotiate with the provinces. If we fail, the general legislation could be relevant. It is clear that if we adopt a general law without involving the provinces, we will be opening the door to some serious constitutional challenges. That is why I believe that in the short term it would be preferable to narrow our scope.

As to safeguards, we could take inspiration from the Quebec law, since it offers an excellent process in that regard. It is not perfect and it is not the only possibility, but it represents the results of six years of analysis, study, and public and legal debates. It could thus be a source of inspiration. Several provinces are now looking at what Quebec did, and it would be appropriate to take advantage of that.

This concludes my remarks. I will be pleased to answer the questions of the members of the committee.

The Joint Chair (Hon. Robert Oliphant) : Mr. Ménard and Mr. Sauvé, thank you.

[English]

We will continue questioning with Mr. Arseneault.

• (1215)

[Translation]

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

Mr. Ménard and Mr. Sauvé, thank you for the precious time you have shared with our committee.

I have a very simple question and I would like to hear what you have to say on this topic.

In the near term, we must respond to the Carter ruling. In short, we have to amend the Criminal Code, which can be done simply. How do you see this being done, in terms of the drafting of the legal text or amendments?

Mr. Jean-Pierre Ménard: Sections 14 and 241 were not totally invalidated. They were invalidated to the extent that they relate to

physician-assisted dying. So, we can quite easily add a paragraph. I am giving you the simplest answer, but the analysis could be refined.

If you were in a hurry and simply wanted to align yourselves on the Supreme Court decision and the Charter, you could enact similar exceptions to sections 14 and 241. I have not done any final drafting exercises yet, but you could say that those provisions do not apply to a competent adult who asks for physician-assisted dying and whose state meets the conditions set out by the Supreme Court.

That would be the easiest common denominator to achieve something in the very short term. That exception could then be refined, among other things, to have it apply on condition that the physician's action be compatible with the provincial act or what have you. You can always add other elements to it. That is what you need to do if you want to deal with the most pressing matters and take your time to debate things afterwards. At this stage, you may want to avoid biting off more than you can chew, as the French proverb says.

In minimal terms, you could do that. You could also add regulations regarding access to assisted dying. For instance, should you limit that assistance to Canadian citizens in order to avoid "euthanasia tourism"? Are there other rules you can think of? Basically, you can at this time set limits.

Mr. René Arseneault: Would there be risks, in your opinion, if we decided to limit ourselves to amending the Criminal Code provisions referred to in the Carter ruling? In attempting to respect that ruling, do we run the risk of including too much and interfering with provincial and territorial jurisdictions?

Mr. Jean-Pierre Ménard: It is clear to me that an exception to the Criminal Code is a matter of federal jurisdiction. That is why the exception does not need to be described extensively, nor include too many details.

The fact of saying that the Criminal Code may to some degree in this case obtrude on the provincial legislation is not heresy, and Mr. Hogg can confirm that. This could be done in the short term, which does not prevent the federal government from discussing things with the provinces, with regard for instance to having uniform legislation. This has been done in other health-related areas concerning organ donation, for instance. It was agreed to attempt to standardize laws throughout the country and that was done to a certain extent. So this would certainly not be the first time that we discuss standardizing legislation. That possibility exists if we want to respond to the Supreme Court's legislative requirement.

Aside from that, you could resort to a legislative exception, or negotiate with the provinces to agree on a broader regime that would develop the notion of safeguards, accessibility rules, monitoring and so on. I think both can be done. Must everything be included in a single bill? You must also consider managing your time and the content.

Mr. René Arseneault: Thank you, Mr. Ménard.

I have one minute left.

Professor Hogg, thank you for being with us today.

[English]

Mr. Peter Hogg: I don't agree with that idea. I think that simply amending the Criminal Code in a way that basically just captured the order of the court would not respect the Supreme Court decision, because, remember, the argument against this was that there would not be safeguards against error or abuse.

I think this committee has to design and enact an amendment to the Criminal Code. I agree with Monsieur Ménard on that. However, the Criminal Code has a number of sections that are highly detailed, particularly where there is an exemption from prohibition of gambling or whatever it may be, so I think it's your duty to come up with something not unlike the Quebec act as an amendment to the Criminal Code.

I repeat: let's not be confident that the provinces will all faithfully enact legislation. Some of them won't; therefore, I think you have to provide something, not just in the short term, but something that can last and that would enable people in every part of the country to take advantage safely, with appropriate safeguards, of physician-assisted death.

• (1220)

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

Mr. Warawa is next.

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

Professor Hogg, on your comments about equivalency provisions and your point that not all provinces may adopt this, for those provinces that do not, there would have to be a federal regime to fill that gap. You are suggesting that for those provinces that do adopt a regime, it would then be up to the provinces, providing it was equivalent to the federal regime.

Mr. Peter Hogg: Yes, it would be something that was substantially equivalent. It would not be exactly the same. It would be respectful of provincial jurisdiction, but it would have to have an adequate set of safeguards.

Mr. Mark Warawa: Thank you.

One of the challenges that we see is availability of health care. I asked the Library of Parliament to provide a percentage of availability of a family physician, province by province. In a number of areas it's extremely high in terms of Canadians not having access even to a family doctor. There was a previous discussion that in a physician-assisted death, a person should be referred by their family doctor to be considered, but many Canadians do not have access.

We also heard from the CMA. One of the physicians said in the CMA report that "My greatest fear is that people end up having easier access to lethal injection than palliative care...." We heard that it's only 30%, and that 70% of Canadians do not have access to palliative care. Access to palliative care will be different from province to province.

Highlighting on access to palliative care, one of the physicians said that "Negative self-perception and concerns about being a burden to others can often lead patients to consider physician-

assisted suicide and euthanasia." If one of the possible causes for people to consider physician-assisted death is that they do not have access to good palliative care—and it's different throughout Canada, and you're suggesting a federal regime—would you envision a federal regime whereby a euthanologist or a specialist who would assist or guide a person through suicide, or provide voluntary euthanasia, would be licensed federally within that regime?

Mr. Peter Hogg: No, I don't think you could construct something like that to be consistent with the Supreme Court decision. The Supreme Court talks about physician-assisted dying. You can't cure all of the faults and the inconsistencies in the health care systems across the country, and I think you have to respect the basic scheme that the Supreme Court has set out, such as the use, for example, of persons who are not physicians. Obviously there will be some role for pharmacists and other people, but the consent will have to be certified by a physician. That's what the court says.

Those are things that are not really.... The court was completely unaware of the circumstances in all the various provinces and territories too.

• (1225)

Mr. Mark Warawa: Thank you, Mr. Hogg.

How much time do I have, Mr. Chair?

The Joint Chair (Hon. Robert Oliphant): You have one more minute.

Mr. Mark Warawa: Thank you.

What do you see this federal regime looking like if you do not have the provinces involved? If a province is not involved, specialist physicians would not be made available to provide the services to end a life.

Mr. Peter Hogg: I didn't say the provinces wouldn't be involved, but if a province doesn't have a physician-assisted dying regime, then your legislation will be the only game in town. It will have to operate and it will have to include adequate safeguards against error or abuse.

Mr. Mark Warawa: I think it leaves it very vague. For provinces that are not involved, then, there is no regime unless there's a federal regime, yet that federal regime does not include a specialist to administer the lethal drugs.

Mr. Peter Hogg: Do you mean a federal official to authorize the administration of lethal drugs?

Mr. Mark Warawa: I'm just trying to grasp what you're suggesting.

Mr. Peter Hogg: A doctor in a province that does not have a regime of physician-assisted dying will follow the federal law that applies in his or her province.

Mr. Mark Warawa: Thank you.

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

Next is Mr. Rankin, and then and Madam Sansoucy.

Mr. Murray Rankin: Professor Hogg, I'm very grateful to you for coming today.

I think it was really valuable that you drew our attention to the practical problem, the pragmatic problem, of a situation in which some province does not have jurisdiction in place and the federal government has to essentially fill the void. You talked about equivalence and gave two federal examples of how that's been done in other circumstances.

I'm just wondering how far Parliament could go, under the Constitution, in creating the kind of comprehensive regime that deals with protections for the vulnerable and the like without going into provincial jurisdiction in doing so. I recognize your point that this is a constitutional right that has to be available coast to coast to coast, but I'm thinking of practical things like liability for health care professionals, life insurance, and some of those things.

Would the federal government, as an amendment to the criminal law, be able to go as far as required to provide that comprehensive regime?

Mr. Peter Hogg: When you speak of things like insurance and liability, I'm not sure that the federal government could legislate those things as part of the Criminal Code. I think the committee is really limited to designing the safeguards that would make the system work, even in a province that had no legislation, and I think that does exclude some health care matters.

For example, I don't think your committee could make recommendations for legislation on palliative care. That seems to me to be beyond your mandate. It may well be possible that the feds could do that through the Canada Health Act or something.

Mr. Murray Rankin: All right.

I'm going to share my time with Madame Sansoucy.

[*Translation*]

Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP): Thank you.

My question is for Mr. Ménard.

Mr. Hogg told us that our committee's role was to ensure that all Canadians will be able to access physician-assisted dying. In its recommendation 8, the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying recommends that another health professional acting under the guidance of a physician or nurse practitioner be authorized to provide assistance in dying.

In your opinion, are there any barriers to allowing registered nurses or other health care professionals to provide physician-assisted death, especially as concerns our perspective? We were saying this morning that all Canadian men and women wherever they reside should have access to physician-assisted death. However, we know that the availability of health care personnel varies from region to region.

What barriers would prevent other health care professionals from assisting physicians in this?

• (1230)

Mr. Jean-Pierre Ménard: In Quebec we asked ourselves that question, because this practice was exclusive to doctors. We wondered whether other health care professionals could do it. The conditions for obtaining physician-assisted death absolutely imply

the participation of a doctor, for instance for the diagnosis of a grave and incurable disease. We have to ensure that the suffering is intolerable and cannot be relieved by means that are tolerable to the person. This necessarily implies a medical assessment. Physicians are the ones who know the criteria.

This would already considerably limit asking other health professionals to make the decision. As for the act, we wanted to avoid a situation where the physician would simply write a prescription and then leave things to others. And so we decided that the physician would be personally engaged and would himself or herself administer the medical assistance, and would be with the patient in order to manage complications should any arise. Indeed certain complications can quite clearly go beyond the competence of a nurse or a pharmacist to intervene. Physicians are the ones who have the required knowledge to cope with those situations.

As for the purely medical management of the action, conditions relating to whether that solution is indicated or not, obtaining informed consent and assessing the patient's ability to consent, these are in Quebec necessary conditions to obtain physician-assisted dying. In addition, Quebec's criterion is based on the concept of end-of-life care, which is not the case for the Supreme Court.

All of these concepts require a medical assessment. The physician is the one who has been trained the best to shoulder these responsibilities. Nurse practitioners or pharmacists do not necessarily have the necessary level of knowledge to do so. Given the gravity of the decision, we preferred to limit those responsibilities to physicians. That is the legislator's choice, but I think it can easily be substantiated.

From that perspective, the provincial act provides a good framework for these issues. In Quebec it was decided that a second doctor would validate the first one's decision. We also included a monitoring by medical authorities such as the Quebec College of Physicians and the Council of Physicians, Dentists and Pharmacists, as well as external oversight exercised by a specialized organization.

Clearly this is first and foremost a medical act, to be monitored by medical organizations and to be executed in keeping with a medical protocol. These safeguards aim to ensure that the treatment will be executed properly.

I'd like to make a clarification. Earlier, when I spoke of minimal content...

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

Videoconference communication is not easy.

[*English*]

Senator Nancy Ruth is next.

Hon. Nancy Ruth (Senator, Ontario (Cluny), C): In some states in the United States, assisted suicide is allowed, but not euthanasia. In contrast, in the Benelux countries, both assisted suicide and euthanasia are allowed. Quebec has chosen to permit euthanasia but not assisted suicide.

Can you explain what the debate was and how Quebec came to the decision it did?

[*Translation*]

Mr. Jean-Pierre Ménard: Basically, Quebec's journey was the following. The act regarding physician-assisted dying is the Act Respecting End-of-Life Care. It contains a general framework for all end-of-life care, including palliative care, continuous palliative sedation and physician-assisted dying. It provides a framework for organizing the whole process of providing end-of-life care and the monitoring of that.

In that context we did not choose to go with what is designated by the term “euthanasia” because it is pejorative and implies that this could possibly happen without consent. That is not at all what we are dealing with. And so we came back to the concept of physician-assisted dying, provided by a physician.

In Quebec, the debate was launched in the main by the College of Physicians. It wondered whether it was possible in certain exceptional circumstances for a physician to legitimately offer to help his patient to die if he has nothing left to offer to keep him alive. We chose to have the physician administer the medication himself rather than giving it to the patient, giving him a means to commit suicide. In that case, the patient could do this without medical supervision, at home, in his or her basement, or at some other time, when his condition might have changed. We felt it was important that this be associated with a health care process.

When the law was discussed and passed the Carter ruling had not come down yet. So we were working in the context of the Canadian criminal law before that ruling.

We also thought that “assistance to suicide” could have changed the true nature of the law, what we refer to in English as the pith and substance of that law which was in our opinion a health-related law. Assistance to commit suicide seemed to us to be outside of medical processes. The College of Physicians did not subscribe to that approach either. In Quebec there was no real call for opening the door to have physicians assist suicide. That was a choice that is related to the rest of the act, a health-related act, an end-of-care act. Assisting suicide was not perceived as being part of the end-of-life care continuum.

• (1235)

[*English*]

Hon. Nancy Ruth: In the parts of northern Quebec or in very rural areas where there may only be a nurse or even a nurse practitioner, do you allow teleconferencing? How is instruction given and how is consent given?

[*Translation*]

Mr. Jean-Pierre Ménard: Consent can be given in various ways. The physician has to ensure a whole series of things. First he or she must ensure that his staff meets medical requirements. Afterwards, he must inform his patient about how the procedure will unfold. He must make sure that free consent is being given, and particularly that there is no external influence. That is why, for instance, if the patient is perceived as a burden by his family, the physician must ensure that no external influence is being brought to bear. Otherwise, physician-assisted death will not be granted.

The consent must also be informed consent. On that topic the law refers to the information the physician must provide to his or her

patient. The jurisprudence is well established here. The physician must ensure that the patient has not only received the information, but also that he has understood it. This has to be well-documented in the file, and repeated a few days later, by the patient.

So, there are a series of processes. Ideally this can be done in a face-to-face conversation between two people, but it is also conceivable that it could be done through Telehealth. Other means may be used when they exist. The physician clearly has to ensure that the request is coming, quite personally, from the patient, that he or she is not being influenced at all, and that he is well-informed. The physician's role is to ensure that all of those conditions are met. That is a part of the safeguards. This has to be recorded, documented, and verified by the organizations that monitor the procedure.

[*English*]

Hon. Nancy Ruth: There's no prior consent in the Quebec law—prior to, say, getting dementia.

[*Translation*]

Mr. Jean-Pierre Ménard: We had a very long debate on that, to decide whether that should be permitted in advance directives. In Europe, for instance in Belgium, this is allowed as long as the patient's wishes were expressed in the five previous years.

In Quebec we decided not to allow this for several reasons. First, how is it possible to know whether the patient changed his mind or not and if this truly reflects his or her wishes?

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

I now give the floor to Senator Joyal.

[*English*]

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

My first question will be for Professor Hogg. Welcome, professor.

My first question is in relation to what you proposed to us: to stick to coming forward with a template of essential elements that Parliament would consider safeguards within the confines of the Criminal Code.

You mentioned that some provinces might decide to do nothing, while some others might do something that would be restrictive vis-à-vis what the Supreme Court has stated in Carter. Therefore, in my opinion, we have to envisage that if we want to maintain similarity of rights all through Canada, we have no other choice but to legislate.

That's my first question to you. Then I'll come back to Monsieur Ménard.

Mr. Peter Hogg: I agree with that completely, Senator Joyal.

Hon. Serge Joyal: In other words, we want to address ourselves to the minimum definition of what we consider essential safeguards. Let's take the age of consent, for instance: an average citizen might believe that the age of consent for a decision should be 21, but the Criminal Code contains a variety of ages of consent in relation to different offences. I don't need to expand on the sexual offences. There are offences for which you are guilty at 14, at 16, at 18. In other words, we're not bound by the idea that you have to be 21 years old to give consent and agree to the administration of the drug. It's up to us to determine what the age of consent is in relation to a specific offence.

• (1240)

Mr. Peter Hogg: Yes, I think that's right. The Supreme Court, in its order, spoke of a "competent adult person". I don't think it would be open to you, for example, to have 16 as an age of consent for this purpose, because that would not be a competent adult person. Between 18 and 21, I would think you would have some leeway within the word "adult" to decide that.

Hon. Serge Joyal: Okay.

The other thing that preoccupied me, Monsieur Ménard, is this.

[Translation]

The Quebec law was developed on the basis of Quebec's jurisdiction in health care. At this time we are talking about Parliament's jurisdiction with regard to the Criminal Code. Consequently our approach could be much broader than the one adopted by Quebec, which was determined by jurisdiction over health care matters. That is why I believe that the Quebec law in some of its provisions may be used as inspiration, but with regard to the definition in the Quebec act of

[English]

"terminally ill", it doesn't exist in the Supreme Court decision that "terminally ill" has to be a safeguard. In my opinion, it's not what the Supreme Court decision provides.

[Translation]

So I think that by reviewing the Quebec act in connection with our role in defining

[English]

what "grievous and intolerable suffering" is, those are the two criteria. It doesn't mean that you also have to be terminally ill or that you have to understand that intolerable suffering needs to lead you to terminally ill.

[Translation]

I think that the Quebec law is good as such, with regard to the province's jurisdiction regarding health care, but it is restrictive with regard to the criteria contained in the Carter ruling.

Do you share that interpretation or analysis of the Quebec legislation?

Mr. Jean-Pierre Ménard: Absolutely. The Quebec act is more restrictive than what the Supreme Court allows in its Carter ruling. The law was passed before that decision was handed down. At the end of the legislative process Parliament is undertaking now, clearly Quebec is going to have to review its law to have it perfectly align

with the Canadian Charter of Rights and Freedoms, as well as with the principles of the decision embodied in the Carter ruling.

The Quebec act contains certain criteria that make physician-assisted death an exceptional process and a last resort, that is to say when medicine has nothing left to offer and is in fact only prolonging suffering and indignity. That is essentially why the law is so restrictive.

The end-of-life care concept also was a part of the debate. If I remember correctly, the opposition put that concept forward. Those who were opposed to the law really wanted to limit its scope more. This was part of the political negotiations that took place in order to bring about support for the adoption of the act. That criterion is clearly not a part of the Supreme Court ruling. In my opinion this should certainly be reviewed if needed. I think that Quebec should wait for the Canadian government to make its position known, as well as the criteria that position will be based on, before it does its review.

You are right to say that your position is broader than what Quebec determined or defined. The Supreme Court did in fact give you more room to maneuver.

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

I now give the floor to Ms. Dabrusin.

Ms. Julie Dabrusin (Toronto—Danforth, Lib.): Thank you, Mr. Ménard and Mr. Sauvé.

[English]

Thank you, Professor Hogg, for coming today.

You've suggested creating a comprehensive piece of legislation that can occupy the field when a province hasn't legislated. However, in the assisted reproduction case, the Supreme Court of Canada found that the pith and substance of legislation was deemed to be the regulation of the medical health profession.

How can we create such all-encompassing legislation while avoiding that type of finding?

• (1245)

Mr. Peter Hogg: The Criminal Code at the moment prohibits the aiding and abetting of suicide and prohibits consent of the victim as defence against murder. Those provisions will remain in place, so if we are going to have exemptions from those provisions, they will also have to be in the Criminal Code. That would be the criminal law power legislating the safeguards suggested by the Supreme Court and never departing from the criminal law. That's the difference.

In the assisted human reproduction case, I argued that case and I thought that the court was wrong in saying that it wasn't criminal law. In that case, they were not legislating an existing Criminal Code provision, but even in that case, some of the prohibitions were accepted, even if they had exceptions and exemptions.

I don't think that's a useful precedent. I think that the useful idea is that you are amending the Criminal Code.

Ms. Julie Dabrusin: When we're looking at creating safeguards and we look at other jurisdictions, we see that they've had waiting periods as a part of their safeguards. If we were drafting legislation, would we, federally, be able to also create waiting periods?

Mr. Peter Hogg: Yes.

Ms. Julie Dabrusin: Going to another part of the constitutional aspect, is there a risk? If we created waiting periods, would that potentially pose a violation of section 7 of the charter?

Mr. Peter Hogg: No, I don't think so, because the court has mandated you to construct safeguards, and I think every reasonable person would agree that some waiting period is a desirable safeguard.

Ms. Julie Dabrusin: In terms of our powers, if we were trying to create comprehensive legislation, would the ability fall to us to create a board or a commission to collect data and have some type of universal oversight across the country?

Mr. Peter Hogg: It would certainly be within Parliament's power to create an oversight and data collection body. I'm just a bit worried about what happens if quite a number of provinces have legislated and have been exempted from the federal legislation.

You would need the agreement of the provinces to have a comprehensive national data collection body and a monitoring body. You could certainly do that as part of the federal legislation, but if the federal legislation exempts a number of provinces, then that would be more....

Perhaps what one could do is exempt provinces from everything but the monitoring and data collection, but that would be very controversial in the provinces. It's a difficult issue, and I don't have a clear answer to it.

[*Translation*]

Ms. Julie Dabrusin: Mr. Ménard, if you don't mind I'm going to put my question in English.

I think there are only 20 seconds left?

[*English*]

Would you in Quebec have any ideas about provision of data to a federal body? Would there be consent for that?

[*Translation*]

There are only five seconds left.

Mr. Jean-Pierre Ménard: Unfortunately, I cannot speak on behalf of Quebec. I can say however that under the provincial law, each health care institution is going to report on a yearly basis on all of the physician-assisted death cases. That report will be sent to the Commission on End-of-Life Care. Every year, it will report the number of cases, the number of denials, and so on. So there will be a lot of data in the public space in connection with the application of this law.

I think that an array of data will automatically be accessible to the public across the country. I cannot unfortunately speak for the Government of Quebec, but let us say that this will already be in the public domain.

• (1250)

[*English*]

Mr. Peter Hogg: That's a very interesting point. Even without provincial consent, there may be publicly available data, as Mr. Ménard is suggesting, that a federal agency could obviously take advantage of, so there may be ways to handle it.

The Joint Chair (Hon. Robert Oliphant): Mr. Albrecht is next.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Thank you, Mr. Chair, and thanks to our witnesses for your presentations today.

Since 1991 there have been at least 15 initiatives in Parliament regarding implementing physician-assisted suicide, and in all of those cases members of Parliament have chosen to reject them. Some of the recent initiatives involved work on motion M-388 and Bill C-300, which calls on the federal government to implement a federal framework for suicide prevention, so I find it somewhat ironic that we're here talking about physician-assisted suicide at the same time that our federal government, the health department, and the Public Health Agency of Canada are actively working on implementing a federal framework for suicide prevention.

It's quite clear that physician-assisted suicide and euthanasia are irreversible actions, yet studies have shown that many patients who were interested in assisted suicide or euthanasia often change their minds. Certainly one of my primary concerns in the work that I've done on suicide prevention over the last number of years has been exactly that: protecting the most vulnerable Canadians at the most vulnerable points in their lives. We all know that depression is, by and large, a treatable condition, and it's questionable whether anyone in that condition is capable of making a rational request to have his or her life ended.

I want to refer to some of the jurisdictions that currently permit some form of assisted dying. Individuals who have mental health issues that affect their decision-making capacity are treated differently. For example, in the Netherlands individuals can use an advance directive to outline their wishes while they are still competent, but all of the U.S. states that allow physician-assisted suicide do not allow that, and I understand from Mr. Ménard today that Quebec is also in that group.

Mr. Hogg, in terms of access and in terms of protecting vulnerable people, from a legal perspective, what are some of the dangers of allowing individuals who do not have decision-making capacity to access physician-assisted suicide, and what protections could be put in place? You mentioned the waiting period. That is one possible protection, but I'd like you to outline others.

Then, are advance directives an appropriate way to ensure that individuals who lack this capacity are able to access physician-assisted suicide?

Mr. Peter Hogg: The court said that it had to be a competent adult person who clearly consents, and the waiting period, as you rightly say, is a help in being sure that we have a competent adult person and—something like the Quebec act—having a second physician interview the patient and form his or her view as to their competence.

I think part of your task is to figure out safeguards that would prevent a transient bout of depression from turning into a physician-assisted death.

Mr. Harold Albrecht: That would be my primary concern exactly. Every one of us in this room has gone through difficult periods in life, some of them extremely difficult, when such a decision could be made.

Obviously suicide is not a criminal act—

Mr. Peter Hogg: No.

Mr. Harold Albrecht: —or at least it's no longer called “committing” suicide. However, when you're asking someone else to act on your behalf, I think there are many more dangers involved. That's my primary concern.

Mr. Peter Hogg: Yes.

Mr. Harold Albrecht: Thank you very much for your response.

I will share the rest of my time with Mr. Cooper.

Mr. Michael Cooper: Thank you, Professor Hogg, for your presentation.

One of the tasks that Parliament will have to grapple with is this definition, provided in the Carter decision, of a grievous and irremediable condition.

I'm wondering about your opinion on the flexibility that Parliament has, for example, to impose a terminability limitation or criterion in legislation, having regard to the Whatcott decision, wherein the Supreme Court of Canada held that a high degree of deference would be afforded to Parliament in passing a complex regulatory response to a social problem or matter.

• (1255)

Mr. Peter Hogg: There will be some deference by the court to Parliament's choices in this matter—that is to say, your choices—but I do think there is a difference between procedural safeguards such as the time delay, the second physician, the signature in writing, and those kinds of things, which are all clearly within your mandate, and what one could describe as substantive safeguards, meaning that it has to be somebody who's already dying. Many of us would think that was a perfectly sensible safeguard, but that is not part of the court's elements.

If you put in some substantive requirements, such as requiring that it be terminal, you will certainly get challenges from people who want to avail themselves of the assisted-dying option. It would require a fair bit of tolerance by the court as to whether that kind of restriction would be acceptable. I don't rule that sort of thing out, but I think it would be better not to do that—not as a matter of policy, because I have nothing to say on policy, but just because it will make your law more vulnerable if it's a substantive safeguard as opposed to a procedural one.

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

Senator Seidman, we have just a few minutes.

Hon. Judith G. Seidman: If I may, I would ask Monsieur Ménard about the advance directives issue.

The National Assembly's Select Committee on Dying with Dignity report recommended, in recommendation 19, that advance directives be taken into consideration. It even requested that “necessary measures to ensure the advance directive for medical aid in dying appears in a person's medical file and is recorded in a register”. This was included in the original draft of Bill 52. However, after study of the legislation, it was exempted from the actual bill.

Could you explain to us what the issue was in this case?

[*Translation*]

Mr. Jean-Pierre Ménard: It is comparable to all advance directives. We at the Expert Jurists Committee had recommended that this be allowed. It was withdrawn in the course of the debate, for several reasons. Regarding wishes expressed previously by a patient, there are several difficulties. Was the patient capable of giving those directives when he or she gave them? How can that be verified? Did he have a proper understanding of the decisions that he was making at that time? Has he changed his mind since? When it becomes possible, will that still be his wish?

Questions of that type were submitted in the course of our work and we preferred to adopt a much more prudent and conservative approach. We decided in a way to apply the “here and now rule”. This means that when the time comes for the person to make that choice, his wishes will prevail. We did not want to allow a person in good health to make that decision at home, in his basement, 10 years before he knows what the situation will be like when he or she is actually in it.

We also wanted to avoid that third parties authorized to make that decision for someone could make a decision based on criteria other than the best interest of the person concerned. Take the example of a third party authorized to make decisions who is also the heir, or for whom the elderly person has become a burden. We really wanted it to be an independent decision taken by the person concerned and only that person. That was the choice we made as we went along. There was a lot of debate on this. Really, in the final analysis, it was a political choice, because there were some solid arguments on both sides. We wanted to place greater weight on protecting the person, especially vulnerable persons. The Quebec act contains a whole host of safeguards intended to protect vulnerable people.

• (1300)

[*English*]

The Joint Chair (Hon. Robert Oliphant): Thank you very much to the witnesses.

The meeting will adjourn. We will commence again at 5:30 p.m. in camera.

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