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# Special Joint Committee on Physician-Assisted Dying

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EVIDENCE

**Tuesday, January 26, 2016**

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**Co-Chairs**

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



## Special Joint Committee on Physician-Assisted Dying

Tuesday, January 26, 2016

•(1730)

[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]

I want to welcome you to the fifth meeting of the Special Joint Committee on Physician-Assisted Dying.

[English]

Tonight we have two panels. In the first panel we will hear from two individuals who were involved in the External Panel on Options for a Legislative Response to Carter v. Canada. We have Mr. Benoît Pelletier, who is a member of the external panel, and we have Mr. Stephen Mihorean, who is the executive director of the secretariat.

This session will end no later than 6:30 p.m. You have 10 minutes for your presentation.

[Translation]

**Prof. Benoît Pelletier (Member, External Panel, External Panel on Options for a Legislative Response to Carter v. Canada):** Thank you, Mr. Chair.

Honourable members, thank you for the invitation to appear before you to discuss this extremely important topic.

[English]

Thank you, Mr. Chair and honourable members of this committee, for the invitation to appear before you on this most important issue. I will be speaking mainly in English, but there will be paragraphs that I will repeat in French. These are paragraphs I have chosen for their significance.

[Translation]

So I will be speaking in both official languages, but mostly in English.

[English]

My name is Benoît Pelletier. I am a full professor at the Faculty of Law at the University of Ottawa and a member of the bar of Quebec.

I appear before you this evening as the representative of the three-member External Panel on Options for a Legislative Response to Carter v. Canada. The chair of the external panel is Dr. Harvey Max Chochinov, Canada research chair in palliative care, and the third member is Catherine Frazee, a professor emerita at Ryerson University. They are out of the country but are following these

proceedings closely and will be available to assist this committee going forward. I am pleased to appear on their behalf and with their full support, and I will do my best to represent our work.

I am also assisted this evening by Mr. Stephen Mihorean, the executive director of the panel's secretariat. For the record, my co-panellists and I would like to recognize the substantial contribution we received from the extraordinary group of professionals in the small secretariat who supported our work.

I would also like to take this opportunity to thank the government, past and present, for the confidence placed in us to do this work. The external panel report is detailed and complex because the issues related to physician-assisted dying are detailed and complex. These issues require consideration and thought to determine sound social policy. This committee has been provided with copies of our report, which I will not have time to review in detail. I will instead highlight some of what we heard in a series of long meetings with intervenors, medical practitioners and regulators, academics, government representatives, and civil society organizations, as well as with two of the individual claimants, Ms. Lee Carter and Mr. Hollis Johnson, and another claimant, the British Columbia Civil Liberties Association. The complete list of those we met with in Canada, the United States, the Netherlands, Belgium, and Switzerland is found in annexes C and D of our report. As well, abstracts of transcripts from these in-person consultations are found in annex E. The panel also reviewed a total of 321 formal document submissions, which are summarized in annex F and chronicled with brief individual abstracts in annex G.

I would like to say a little about what we learned in Europe. There appears to be general satisfaction with the law in the countries we visited. We were told that assisted dying works well in the context of a robust social safety net, well-founded health care services, and high levels of trust in physicians. At the same time, there is intense controversy about cases that push the boundaries or test the limits of the law, cases that challenge the age requirement, cases involving advance directives, and cases that arise from psychological, existential, or psychiatric suffering or from suffering related to chronic conditions that are not life-threatening.

•(1735)

For many people one of the most important safeguards is transparency. Mistakes and abuses must be detected and acted upon. The same applies to non-compliance with reporting requirements.

The panel's online questionnaire was completed by almost 15,000 Canadians. I would like to draw your attention to our analysis and the results of this public consultation, which provides a rich source of information and insight, and which can be found in annex A of our report. For example, participants demonstrated strong levels of approval for palliative care education for all health care providers; for better supports for disabled people; for better home care, palliative care, and end-of-life care in the whole country; and for an efficient oversight of physician-assisted dying.

The questionnaire also revealed that respondents were more likely to agree that physician-assisted death should be allowed when a person faces significant life-threatening and/or progressive conditions. The questionnaire demonstrated that participants were generally very concerned about the risks that existed for people who are mentally ill, especially those with episodic conditions, and for people who are isolated or lonely.

[*Translation*]

Here are the results of the questionnaire we posted online that was completed by more than 15,000 Canadians.

For example, participants demonstrated strong levels of approval for palliative care education for all health care providers, for better support for disabled people, for better home care, palliative care and end-of-life care in the whole country, and for an efficient oversight of physician-assisted dying.

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[*English*]

On some issues we found high levels of agreement among Canadians from diverse perspectives. For example, there was agreement with the idea that all Canadians who suffer should have access to the supports and services that are within our capacity as a nation to provide, wherever they are in their lives and whatever their personal circumstances. There was agreement with the idea that Canadians should invest trust and respect in an assisted dying regime that features transparent, accurate, reliable, and objective oversight through data monitoring, research, and public reporting.

Honourable members of this committee, we reported on the points of view that were expressed to us, but our report is not just an account of those exchanges. Our report contains much information and analysis on the issues.

We heard clearly that there is a need to balance individual autonomy and the protection of vulnerable people. This being said, I would like to say a little more about autonomy and vulnerability.

With respect to autonomy there are a number of what I would characterize as core values that informed the Carter decision. Among them are the integrity of a person, dignity, self-esteem, and the right

of an individual to make important decisions regarding the end of his or her life.

**The Chair:** You have one minute.

**Prof. Benoît Pelletier:** I will do my best to summarize the rest of my presentation, Mr. Chair.

• (1740)

[*Translation*]

I want to point out that autonomy is one of the core values outlined in the Carter decision.

[*English*]

As for vulnerability, it is, of course, a complex and subtle concept. Although the term “vulnerable populations” has been used to describe certain identifiable groups in society, the panel heard from many sources that vulnerability is not simply a characteristic of an individual or group, but rather is a state that any one of us could be in under certain circumstances. We heard that sometimes people are made vulnerable in particular contexts and situations when personal autonomy, status, wealth, and well-being are compromised in any significant way.

What this means in the context of physician-assisted dying is that all persons are potentially vulnerable. Being vulnerable does not disqualify a person who is suffering intolerably from seeking an assisted death, but it does put that person at risk of being induced to request a death that he or she does not desire. This is the risk that the Supreme Court called upon Parliament and provincial legislatures to address in a complex regulatory scheme.

Concerns were raised about access to physician-assisted dying, particularly for people living in Canada's remote communities. Concerns were also raised about how indigenous people will respond to physician-assisted dying.

There were, of course, many questions about which there were competing visions. For example, do the terms “grievous” and “irremediable” need further definition in legislation, or should physicians and their regulatory bodies have the discretion to interpret these terms? Should the decision to provide an assisted death be subject to review, and if so, should that review take place before or after a request has been granted? Are protections for vulnerable persons required beyond those routinely in place for patients wishing to refuse or withdraw life-sustaining treatment? How should the overlapping jurisdictions of provinces and the federal order of government be addressed?

The establishment of eligibility criteria, possible definitions of key terms, and the implementation of appropriate safeguards to protect vulnerable individuals are theoretically the responsibility of the various governments and legislative assemblies. In this regard, the Canadian population expects collaboration between the federal government and the provinces and territories so that the division of responsibilities and the implementation of physician-assisted dying and its oversight are managed in a consistent and effective manner.

While most attention has been given to physicians as our country is in the process of making particularly important decisions on this incitive and challenging topic, our extensive consultations and work, including the report before you, were completed and delivered to the government within five months. Our panel wanted to advance the debate and to make sure that everyone—from citizens to members of Parliament to federal ministers to provincial and territorial elected officials or representatives—had access to all relevant perspectives and information.

Above all, Mr. Chair, we wanted to assist this Parliament in making informed decisions. I hope the report of our panel and my testimony today will facilitate this committee's work.

• (1745)

In conclusion, I would like to signal for you, members of this committee, that as I am appearing on behalf of my co-panellists, there will be occasions today when I will respond on behalf of the panel and there will be times when I will be giving my personal opinion. When those latter situations arise, I will say so.

Those are my opening remarks. Thank you. I would be happy to take any questions you may have in the official language of your choice.

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

Monsieur Lemieux.

[*Translation*]

**Mr. Denis Lemieux (Chicoutimi—Le Fjord, Lib.):** Mr. Pelletier, if I may, I would like to begin by congratulating you on the excellent work you did last year, free of charge.

I know that the Liberal government has removed from the committee's mandate the requirement to present legislative options to the Carter decision.

Yesterday morning, we heard from Jean-Pierre Ménard, who suggested that we respond to the Supreme Court's request in two steps.

The first step would consist in amending sections 241 and 14 of the Criminal Code to make them consistent with the new requirements related to physician-assisted dying.

The second step would consist in implementing a detailed Canada-wide process to give the provinces and territories the time to legislate on all other aspects of physician-assisted dying. Mr. Ménard also said that those other issues often come under provincial and territorial jurisdiction.

What do you think about Jean-Pierre Ménard's suggestion?

**Prof. Benoît Pelletier:** Thank you for the question.

You are right to point out that physician-assisted dying may require a number of interventions from the Government of Canada. I want to emphasize that, whatever the Government of Canada's interventions may be, it is obviously desirable for the provinces and territories to collaborate. I would go as far as to say that the principle of cooperative federalism—which is found in many Supreme Court decisions and is an extremely healthy principle for applying

Canadian federalism—must be at the core of this Parliament's intervention.

The most urgent step without a doubt would be to amend the Criminal Code of Canada in order to comply with the Carter decision. However, I have to say that, even if Parliament failed to do so, the Carter decision would prevail as soon as the stay of the application of decision expired. That means the ruling would apply as of June 6 of this year. On that date, the Carter decision will be applicable in Canada. The provisions of the Criminal Code, even if they were not amended by this Parliament based on the Carter decision, will have to be interpreted as inoperative given that they prohibit physician-assisted death, while the conditions set out by the Supreme Court of Canada are, of course, respected.

That being said, I would say the big question is what kind of leadership the federal government will want or have to show when it comes to physician-assisted dying. Many Canadians are calling for the federal government to play that role. Some Canadians even want consistency in terms of physician-assisted dying measures.

However, as you pointed out, provincial jurisdiction is important in this case. Of course, I think that any kind of federal leadership will have to take into account the provincial presence and will even have to be reconciled with the presence and involvement of the provinces.

• (1750)

**Mr. Denis Lemieux:** Thank you.

[*English*]

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

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

Thank you to the witnesses and to the panel in its entirety for the work you have done, the hours of consultation, and for the report and its timely release.

I was particularly interested in and appreciated the amount of involvement that we saw from Canadians—15,000 Canadians participated in this—and the key findings in your document that you've shared with us. Could share with us what those key findings were, in particular with regard to what Canadians were saying? What was the strong support that you heard in relation to people who were suffering a mental or psychological illness?

My understanding of the report was that there was much greater support if it was a physical, not mental, issue regarding the suffering. I also believe the report was showing stronger support if the illness, the suffering, dealt with a life-threatening, progressive condition that was terminal—again, not a mental and not a temporary suffering, but a definite prognosis that it was a progressive, terminal illness.

Could you elaborate on that, on the mental issue and on whether the majority of Canadians are saying, or the stronger support seems to be, that it be a physical, terminal, progressive illness?

**Prof. Benoît Pelletier:** Yes. Thank you very much.

What I will say comes from the 15,000 people who answered the questionnaire and also from the consultations we had all over Canada. As you know, we met many experts, groups, associations, and so on.

There is a concern, expressed by many people, about the application of physician-assisted dying to people who suffer from psychological illnesses. It is clear that support is stronger among the population for the application of physician-assisted dying in cases of physical illness or physical disability, for example, than in cases of psychological illness.

At the same time, I should say that, a priori, the Carter decision does apply to psychological situations, maybe as well as to physical situations. I say “as well as to physical situations”, but this still has to be determined through an interpretation of the decision. I would say that, *prima facie*, the Carter decision applies to both psychological and physical illnesses. Respondents were more likely to agree that physician-assisted death should be allowed when a person faces a significant, life-threatening, or progressive condition. If someone suffers a significant, life-threatening, or progressive condition, then the support generally of the population is stronger than in the case where a person is not in such a situation and has many years to live.

I'd say that this is the challenge that this Parliament should face. This is the challenge that flows from the Carter decision. The Carter decision does apply to assisted suicide and voluntary euthanasia, it does apply to psychological and physical illnesses, it does apply to situations where someone is not confronted by the end of his life, so that decision is quite large. That decision is quite wide in its scope. The challenge for this Parliament and the provincial legislatures is not to see if there should be limits to that decision. Again, if there are limits to that decision, those limits should not go against the spirit of the decision—

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

**Prof. Benoît Pelletier:** —because of course due respect for the decision of the Supreme Court of Canada is necessary in this case.

• (1755)

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** Thank you, Mr. Pelletier.

I'm going to remind everyone that we have a five-minute time limit for the question and the answer.

Mr. Rankin is next.

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

Thank you, Professor Pelletier, for your remarks.

I note that in chapter 2 of your report, you spent a great deal of time on federal-provincial issues, and today you've also spoken about the fact that the population expects collaboration between the federal and provincial governments. Yesterday Professor Hogg testified before us, and he was reminding us that the federal government must establish its own regime. It cannot count on the provinces to step in. They may not. We have a constitutional duty, he said, to remember that it's from coast to coast to coast that we're doing this work.

He had a suggestion, and I would like your reaction to it. It was that we have a system in which the federal government—the cabinet, or the Minister of Health—might declare that provincial regimes, in the event that they pass muster, were substantially similar, like that of Quebec. He told us of two other federal examples in which that process had been used.

I'd like your reaction to that way of squaring the circle. I also would like to know whether you agree with his analysis that we must assume there may not be provincial legislation and must therefore go it alone, as it were.

**Prof. Benoît Pelletier:** I don't think it should be assumed that there shouldn't be provincial legislation. Medical aid in dying, or physician-assisted death, is related to both criminal law and health. With regard to health, a certain part of Canada has said that it is a matter that is under co-shared jurisdiction. It's a matter that belongs to the provinces, and it belongs to the federal Parliament. It all depends on your perspective on the subject. It all depends on the nature of the intervention of the legislative assembly that is concerned.

I would say that you cannot assume there will not be provincial legislation or that there should not be provincial legislation. What you could do, though, is to just talk with the provinces, discuss with the provinces, and enter into a dialogue and see how there could be concerted action with regard to physician-assisted death in order to give more harmony and coherence to both the federal and the provincial interventions.

As for the Quebec law, I would say very briefly that the Quebec law could be a very good model across Canada, but it doesn't go as far as the Supreme Court of Canada appears to have gone in the Carter decision.

**Mr. Murray Rankin:** That reminds me that on page 57 of the report, you make it clear that the court didn't limit its decision, as Quebec did, to terminal illness but went beyond that. I wonder if you could tell us more about the boundaries you might suggest for the terms that are used in the Carter decision.

For example, do you see a need to define the terms “grievous” and “irremediable”, or would it be preferable simply to leave it to the courts to pour meaning into those terms over time?

• (1800)

**Prof. Benoît Pelletier:** Of course some people argue for these terms to be defined, and some people argue for the opposite.

Those who argue for the terms to be defined say that in fact these terms could be interpreted in different ways and that the physicians who will be facing the physician-assisted death situations won't necessarily know how to define the terms “grievous” and “irremediable”. They say that it would be good to define these terms in the law.

At the same time, these terms are very difficult to define. We consulted many people, as you know, and when we asked people to give us or propose to us a definition of these words, frankly, no one really came up with a definition that could be put into a law. Most people said they thought it would be a good idea to define these terms but that they still had to think about how the terms should be defined. Of course the dictionaries give the definitions, but these definitions do not help us very much.

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

Senator Nancy Ruth.

**Hon. Nancy Ruth (Senator, Ontario (Cluny), C):** Thank you for your work and for being here tonight.

In your issues book in eligibility scenario number 3, you asked Canadians whether they should be able to receive physician-assisted death based on an advance directive. Sixty-two per cent of the balanced representative sample agreed or strongly agreed. Am I correct that this scenario for an advance directive received the highest level of support of any that you proposed?

**Prof. Benoît Pelletier:** Well, the fact is that this question of advance directive is not a question that we have examined as closely as other questions. I think it would be good for this committee, or eventually other institutions, to pay more attention to the specific question of advance directives.

**Hon. Nancy Ruth:** I'm happy to do so, but my question was on your report, in which 62% strongly agreed or agreed that this was a good thing and that it received the most support. Is that correct?

While the secretariat is finding the answer to that question, I'll go on.

One of the things that amazes me when we talk about the other jurisdictions is that all the Benelux countries, Switzerland, and the states in America that have physician-assisted death could all fit within Canada and we'd still have space, so I think the geographical framework in which we are making these decisions is very important, although we might not have the population that all of those countries combined have.

My question is around wait periods. It's been suggested in other testimony that waiting periods may be a safeguard to consider. There is no way for Parliament to choose a waiting time or periods that will be fair to all, in my opinion. Given the size of this country and the lack of complete medical facilities in many places, is there any reason why timing cannot be decided on a case-by-case basis between an attending physician and the patient, or between the physician and those who hold powers of attorney for the patient with prior directives?

**Prof. Benoît Pelletier:** Yes, geography is a challenge for Canada, of course, because many people live in very remote communities.

Some people expressed concerns that these people living in remote communities would not have fair access to physician-assisted death. This is what brought some experts to suggest to us that there could be an itinerant group of physicians, an itinerant group formed by medical personnel, that could travel and make sure there is access to physician-assisted death all across the country, even in the very remote areas.

•(1805)

**Hon. Nancy Ruth:** So does that mean that a patient and the doctor

—

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** Senator Ruth, you have to let him finish and get your first question answered, because you're running out of time.

**Hon. Nancy Ruth:** Yes. It was on the 62%.

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** Mr. Pelletier, do you have an answer, or would you like to respond after the meeting?

**Prof. Benoît Pelletier:** Concerning the representative sample for the question “To what extent do you agree or disagree that you... should be able to receive a physician's assistance to die” if you “have advanced dementia and cannot make decisions on your own”, what I see in the report is that 42% of people strongly agreed with that.

**Hon. Nancy Ruth:** And how many agreed? There were two answers, “strongly agree” and “agree”. What were they combined? My understanding is that they made 62% combined.

**Prof. Benoît Pelletier:** Combined, it's 62%: 20% agreed, and 42% strongly agreed.

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

Senator Joyal is next.

[Translation]

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

Welcome, Mr. Pelletier.

I would like to talk to you about item 2, which is titled “Mature Minors.” That is on page 54 of your report.

As you know, the Carter decision refers to competent adults. Yesterday, your colleague, Professor Hogg, said that there can be different ages of majority in the Criminal Code. In other words, people can reach the age of majority at 21, 18 or 16 years of age.

The Carter decision established that a competent adult had the right to physician-assisted death. I think that Parliament is not limited by that decision or by a strict interpretation of the definition of an adult. It is Parliament's duty to define what the mental capacity of an individual to express their decision and intention should be.

Setting aside what you noted in your report—especially when it comes to Ontario's Health Care Consent Act, 1996, which does not specify the age at which a minor can express their agreement or disagreement with a treatment—as a law professor, can you suggest what approach the committee should use to define the age of accessibility?

**Prof. Benoît Pelletier:** I first want to say that you are correct. The Parliament of Canada can go beyond the Carter decision, which adopts the principle that physician-assisted dying is accessible to an adult. Of course, that raises the question on who is an adult and at what age adulthood is reached. Nevertheless, Parliament can go beyond that decision and look to provide physician-assisted dying to minors who are capable of making decisions. For many people, the big question has nothing to do with age, but rather with decision-making capacity.

Parliament has the option to go further than the Carter decision. However, the Criminal Code of Canada currently sets that age at 18 years. In the provinces, the age of majority is 18 or 19, depending on the province. So it could be possible for Parliament to determine at what age someone is an adult and to apply physician-assisted dying only to adults, but it could also be possible for Parliament to open up access to physician-assisted dying even further by making it available to minors who possess, and I repeat, a decision-making capacity, but who are not adults, strictly speaking.

•(1810)

**Hon. Serge Joyal:** So should we not follow the same procedure as Ontario's Health Care Consent Act, 1996, which has been in practice for 20 years and which basically leaves practitioners—the professionals—the role or responsibility to decide on the individual's mental capacity in the case of those referred to as “below the adult age of 18 or 21”?

**Prof. Benoît Pelletier:** That is clearly a possibility Parliament should look into.

From a strictly personal perspective—and I am not engaging other members of the committee here—I would say that the debates before the courts will eventually be based on the principle of equality. In the Carter decision, the Supreme Court of Canada settled the debate based on the person's right to life, security and liberty. It did not want to respond to the question based on the right to equality set out in section 15 of the Canadian Charter of Rights and Freedoms. There could be litigations before the courts where people will demand access to physician-assisted dying in the interest of equality. Those who advocated the most strongly for the application of physician-assisted dying basically told us that suffering is suffering, regardless of the age of the person suffering. That is clearly a powerful argument.

[*English*]

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

Ms. Dabrusin is next.

**Ms. Julie Dabrusin (Toronto—Danforth, Lib.):** Thank you.

You noted from your experience in investigating the European jurisdictions that when you visited them, there was general satisfaction with the laws. I would note that several of them do actually have permission for mental disorders or psychiatric disorders as a basis for physician-assisted dying.

You noted certain things that were requisites, and one of them was the safeguard of transparency. I wanted to ask you a little bit about oversight. How would you describe effective oversight for a physician-assisted dying system?

**Prof. Benoît Pelletier:** That idea of oversight is quite reassuring for the population. The population likes to know that there might be a body or different bodies collecting data and analyzing how physician-assisted dying is provided all across Canada, and maybe doing some study on the impact it has on human rights in general.

Many points of view were expressed concerning the mission of an oversight body that would be created. Some thought that it should only collect data, that the data should stay confidential, and that there should be a public reporting, or perhaps a reporting to Parliament. Other people went beyond that and said that the oversight body should really do a social analysis of the impact of physician-assisted death, and maybe have money in order to give subsidies to scholars to do research on different questions related to that issue.

It's not clear, either, that there should only be one federal body. There could be a federal body and different provincial bodies, or there could be only provincial bodies working co-operatively, working together, as in fact an interprovincial organization, which is possible. When we hear the word “oversight”, we should not necessarily think federal only. It may be federal, provincial, and territorial. In any case, it certainly reassures people.

Let me say this. In my view, there are four cardinal points, four fundamental points, that are reassuring people or that are important in that issue. The first one, of course, is access to physician-assisted death, as least as the Supreme Court of Canada has defined it in the Carter decision. The second is efficient oversight. The third is better palliative care. The fourth is robust safeguards for vulnerable people.

If you talk to anyone and you tell them that these are the four components of what the federal or provincial intervention with regard to physician-assisted death will be, people will be reassured, because there will not only be access to physician-assisted dying but also a commitment for oversight, a commitment for better palliative care, and a commitment for the protection of the vulnerable.

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

Go ahead, Mr. Deltell.

•(1815)

[*Translation*]

**Mr. Gérard Deltell (Louis-Saint-Laurent, CPC):** Welcome to your Parliament, Mr. Pelletier.

Mr. Joint Chair, I don't want to tell you our life story, but I am happy to see Mr. Pelletier again, as I knew him when he was an MP and minister in Quebec City, where I worked as a journalist. Later on, when I became an MP in Quebec City, he was a professor and commentator. I will not repeat what he had to say about my work right now, but we will talk about it later.

Mr. Pelletier, thank you so much. I want to thank your committee and thank you for doing such thorough and careful work. In less than five months, you produced a document filled with relevant information. Congratulations. I commend and thank you for that.

I would like to discuss two issues with you, one of which concerns the most vulnerable individuals. I would first like to talk about something that's right up your alley, cooperative federalism. Earlier, you talked about Canadian leadership. That is actually why we are here today.



Health care comes under provincial jurisdiction, but we have to know how much it will be affected by the Criminal Code. You are talking about Canadian leadership and cooperative federalism. So I would like to hear what you have to say about the following two hypotheses.

The Canadian government can set a specific limit to how far health care can go or it can instead leave it up to the provinces to define health care by limiting, in a way, the Criminal Code to allow the provinces to adjust. However, since we are basically talking about health care, which is entirely under provincial jurisdiction, that initiative should be the responsibility of each province. So every province will have the time to hold this debate, as Quebec has been doing for six years.

Do you think the legislation the federal government will introduce should be more specific, or should it instead give leeway to provincial legislative assemblies?

**Prof. Benoît Pelletier:** I think that the federal government should give the provinces considerable leeway to act on this issue, while perhaps legislating on matters such as age, which we discussed earlier. For instance, it could perhaps also legislate on the issue of residence requirements. In fact, if residence requirements varied from one province to another, there would be a risk of interprovincial tourism and perhaps even international tourism should a province lack residence requirements.

I feel that age and residence requirements are probably the two most obvious areas in which the federal government could potentially intervene. When we consider federal leadership or federal involvement, we can see a number of possibilities and scenarios.

In the first scenario, the federal government's involvement would be limited to the Criminal Code of Canada. So it would be fairly limited.

In the second scenario, an amendment would be made to the Criminal Code of Canada and to decisions of the Canadian Parliament, which would adopt measures on the eligibility and protection of vulnerable individuals. That would take matters much further.

In the third scenario, the federal government would adopt framework legislation in the hope that the provinces would support it. Another option would be to strongly encourage them to support it, or leave a lot of room for provinces and territories, since this is really about providing health care in physician-assisted dying, which basically comes under provincial jurisdiction.

I would like the federal government to leave a lot of room for the provinces. In matters like this one, I would hate to see the federal government becoming too involved because physician-assisted dying basically takes place in hospices, hospitals and palliative care hospices, which fundamentally come under provincial jurisdiction.

The vision Mr. Hogg has put forward is clearly that we can have a Canadian federalism. However, the vision I have been promoting for years is based on the existence of two levels of government in Canada, each with its own constitutional responsibilities, and not a single government.

• (1820)

[English]

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

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

Thank you very much, Mr. Pelletier.

There have been suggestions—and you alluded to these in your presentation—that the federal government should amend the Criminal Code to allow provisions for physician-assisted death by a regulated health care professional, such as a registered nurse or nurse practitioner acting under the direction of physicians. Might we have the benefit of your view on this?

**Prof. Benoît Pelletier:** Yes, you've noticed that the Supreme Court of Canada talked about “physician-assisted death”, and in French we sometimes say “*aide médicale à mourir*”, which is of course larger, but the Supreme Court really talks about physicians.

Although the Supreme Court says that medical personnel should be protected, those medical personnel who participate in the treatment should be protected as well as physicians are.

To be frank, I don't have any specific idea about whether we should open the door for nurses or other medical personnel to give the treatment or to provide aid in dying, but I'll give you what is, again, my personal point of view. I realize how difficult it is for me tonight to at the same time represent my co-panellists and answer your questions as you probably are expecting me to do.

I would say that this is the first time that Canada is facing the challenge of physician-assisted death. I personally think Canada should proceed with very great prudence on that subject, acknowledging the decision of the Supreme Court of Canada, respecting the decision, but at the same time understanding that this is new for our country, and we as Canadians will have to adapt to it. When the adaptation has been done, then maybe there will be other steps that will be desired by the population itself. I would say that at first we should be extremely careful not to go too much beyond the Carter decision.

The Carter decision has indicated the destination. I think that for now, it's sufficient for the destination to be respected. I wouldn't suggest that this Parliament go far beyond that.

Again, this is a personal point of view.

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** Senator Cowan, you will have the last question. We'll have to turn it around quickly, because the next panel has to be out of here at exactly 7:30.

• (1825)

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

Thank you for being here, and thank you for the work you've done.

I want to return briefly to the question that Mr. Rankin asked you earlier with regard to the proposition that Professor Hogg put to us yesterday. I want to get your view as a lawyer and constitutional scholar as well about the authority that the Canada Health Act gives to the Parliament of Canada to act and to move in areas if the provinces or territories do not act.

I think what Professor Hogg was saying was not that we should assume that the provinces wouldn't act, but that we cannot assume that all of them will act and that all of them will act in a way that is consistent with Carter.

Does the Canada Health Act give this Parliament the authority to act in that situation?

**Prof. Benoît Pelletier:** I think the Constitution in general gives this Parliament such jurisdiction or such an authority. Again, the Supreme Court said that health is a shared jurisdiction and did not give any description or definition of what would be the respective jurisdictions of the provinces and of the federal Parliament. It could be through the Canada Health Act. It could be in an independent act, a stand-alone act, a new act on physician-assisted dying, for example, that would be adopted by the federal Parliament in addition to changing the Criminal Code.

I think what is important—and again, it is a personal point of view—is that, first of all, if the federal Parliament intervenes with regard to safeguards, it should also intervene in order to make sure that there is access all over the country.

**Hon. James S. Cowan:** To assure equality of access and opportunity, if that's the proper term—

**Prof. Benoît Pelletier:** Exactly.

**Hon. James S. Cowan:**—there is a responsibility on the part of the federal Parliament.

**Prof. Benoît Pelletier:** You're right. I wouldn't see the federal intervention to be on just some aspects of the question. That would be unjust, in my view. If there has to be an intervention, it should be on all aspects, including first assuring that there is access all over Canada.

My second point is that I personally would like what Quebec did to be respected. In other words, I would like the Quebec law, the Quebec act, to be respected and not jeopardized by any federal intervention. I'm sure that most—

**Hon. James S. Cowan:** We're both going to be cut off here in a minute, but if I could just say this, I think Professor Hogg's answer to that was equivalency, meaning that there could be a declaration of equivalency if a province came up to a certain standard, even if they did it in a slightly different way. Would you agree with that?

**Prof. Benoît Pelletier:** Yes, under the reservation that the Quebec act does not go as far as the Carter decision itself.

**Hon. James S. Cowan:** It initially has to be amended accordingly.

**Prof. Benoît Pelletier:** That's right. That's a big problem.

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

**Prof. Benoît Pelletier:** The fact that it does not fit the Carter decision absolutely well is a big problem in this case.

I would like to see what Quebec did fully respected. To be frank, I would prefer co-operation and collaboration among the governments. If there is one issue, Mr. Chair, where such co-operation is possible and desirable, it is precisely this one.

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** Thank you. I think that's a very important point to close on in this regard.

Thank you very much for appearing before us.

We are going to temporarily suspend the meeting for one minute. We have to turn this around quickly.

• (1825)

(Pause)

• (1830)

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** Colleagues, we have the second panel before us.

We have with us the two co-chairs of the provincial-territorial expert advisory group on physician-assisted dying, Jennifer Gibson and Maureen Taylor.

Witnesses, you have a total of 10 minutes for your presentation. We will be very efficient because we know you have to leave at precisely 7:30 to get out of here.

Please proceed.

**Dr. Jennifer Gibson (Co-Chair, Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying):** Thank you so much for the invitation to join you.

This has been what I would say was quite a journey—I'm sure you're on the same journey right now—to get our heads into some of these issues and to be able to come forward with a set of recommendations, which I believe you've had an opportunity to review in the report we have drafted, as well as the set of slides that were prepared.

What we'd like to do, though, is draw out a few highlights from that report and then turn it over to you to engage with us with your questions in the hope that we might be able to put some flesh on the bones of some of the questions you may have. We may not take the full 10 minutes, but we're really looking forward to the conversation that we might have.

In regard to when we started off on this work as the expert advisory group, I should note by way of a bit of background that 11 of the 13 provinces came together to create this expert advisory group. One of the key messages we received from them was that they were seeking to avoid a patchwork approach. Hence, one of the reasons why we created the expert advisory group was so that we could provide recommendations that would reflect the continuity of the Canadian context across the board.

In addition to that emphasis on avoiding a patchwork, we certainly heard from the stakeholders we met with, through written submissions and in-person consultations, about the importance of collaboration across jurisdictions, which includes federal, provincial and territorial, and also regulatory bodies, and we heard that there could be more alignment and clarity across those roles, but also a real effort to work together to clarify these issues. That was an important message that we heard along the way.

One of the things we also heard about consistently was the importance of having a strong legislative response, both at the provincial-territorial level and at the federal level. Particularly, in our case, in thinking about where we'd like to spend some of our time with you, there are some reflections on where there might be some clarity within the Criminal Code, which we heard about consistently from the provinces and territories as being particularly helpful for the work they need to do within their own jurisdictional settings.

Just to reinforce, the third piece that we also consistently heard about, and as you've also heard from the federal panel, is that physician-assisted death shouldn't be treated as some sort of parallel set of activities isolated from a comprehensive set of end-of-life services for Canadians. Hence, there was a strong message that we heard, and also reinforced in our own report, in regard to seeing physician-assisted death as part of an integrated end-of-life care strategy that would engage all levels of government, including the regulatory bodies, in a very effective way.

Thus, one of the encouraging things in looking at some of the federal findings, as well as our report, is that there is some nice consistency. I'm going to pass this over to Maureen, who will pick up on some of the pieces that we thought we'd highlight to you in relation to some possible clarifications within the Criminal Code.

• (1835)

**Ms. Maureen Taylor (Co-Chair, Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying):** Thank you, Jennifer.

Again, thank you very much for asking us to be here.

I think all of you have the slide deck that was just handed out. The nub of it is on page 6, really, with regard to priorities to raise with the federal government. Jennifer and I will address a couple of these for you.

The first one is about something you just raised with Mr. Pelletier in regard to other health professionals who may need to be involved in physician-assisted death. We take a different view. We very strongly think that the Supreme Court decision, although it mentioned physician-assisted death, did not mean to exclude other health care professionals.

Anyone who understands how health care is delivered in this country knows that it is delivered not solely by physicians. We heard very strongly from the territories, which said that they have fly-in communities where there is no physician. There is a nurse in a nursing station. If we're going to guarantee access across the country, we have to give a mechanism for them to be able to assess patients using telemedicine in conjunction with physicians in other areas, as well as to deliver it.

I also want to say that nurse practitioners, if you're not familiar with them, have a stand-alone scope of practice that absolutely should encompass end-of-life care, so we're asking that when you redraft the Criminal Code to carve out the Carter decision, you make it clear that other health care professionals, such as nurses and pharmacists—I'm a physician assistant, by the way—will be protected, but also especially that nurse practitioners and health care professionals acting under the directive of a physician will be

able to assess patients for their eligibility and carry this out. That's an access issue.

I also wanted to talk about one of the later points on the definition of "grievous and irremediable". Although Mr. Pelletier said they heard from people who think it should be defined but no one was sure how, we have a very strong opinion that it should be defined in what is the common usage. It should be "very severe or serious". As someone who works in front-line health care, I think we understand, as health care professionals, what "very severe or serious" looks like. Obviously, acne is not very severe or serious.

I wanted to address those, and now Jennifer is going to address a couple.

**Dr. Jennifer Gibson:** The other area is definition, and again, we are focusing on definitional issues because they were highlighted, through our consultation, as an area where clarity within the Criminal Code would be an enabler of some consistency across the provinces. One topic is the definition of "adult". As was noted a little bit earlier this evening, there are different ages of majority across the country—18 and 19. In the area of health care decision-making, there is no age of consent in most of the provinces. This means that a number of provinces do actively recognize a mature minor rule, which allows for the mature person under the age of 18, who is competent, to make decisions at the end of life.

Our position on this is that whatever definition of "adult" we might use, it should be a competency-based definition, not one that is based on age.

There are a couple of reasons for that. Again, current practice over a number of years has been that capacity has been the driver of whether or not somebody is able to or should be able to consent to a treatment at the end of life. That would involve a very significant practice change for which there is no justification in other end-of-life situations. Also, we believe that competency really gets at the heart of what the Supreme Court of Canada was going for here: somebody who can voluntarily choose to take a direction, for either self-administered or physician-administered death, according to these criteria, because they are competent to make such decisions, because they believe a decision is in their own interest, or because it is consistent with their values. Competency is the key to being able to do that, not someone's age.

Was there anything else you wanted to put forward?

• (1840)

**Ms. Maureen Taylor:** Those are the highlights, but obviously, we're here to answer your questions on anything else as well. Thank you.

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** Thank you very much. It was very effective.

Monsieur Arseneault.

[*Translation*]

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

Ms. Gibson and Ms. Taylor, thank you for your work and for joining us today.

You set out a series of recommendations, the first of which says the following: “Provinces and territories, preferably in collaboration with the federal government, should develop and implement a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying.”

Yesterday, we heard from Professor Hogg and Mr. Ménard. Today, we are hearing from Mr. Pelletier. In one way or another, they have been telling us that a pan-Canadian strategy is necessary.

Could you tell us in more detail why you felt the need to make this your first recommendation?

[English]

**Ms. Maureen Taylor:** Thank you for the question.

I'll be very blunt. Of course there needs to be better palliative care. There needs to be better access to palliative care.

I sometimes think we overstate the lack of palliative care. I was watching some of your panellists from earlier in the week, and I think sometimes the statistics that are used, if you check, are very outdated. My husband had excellent palliative care; so did my mother. The provinces have been working hard to improve this.

What we were seeing before our panel convened was that those who were opposed to the Supreme Court decision were saying we should not bring in physician-assisted dying in Canada until every Canadian has access to good quality palliative care. Of course, in our country, with a universal health care system, we will never have “Cadillac quality” access to anything. That's just the nature of the system. I personally didn't want that issue to get in the way of us moving forward.

I very strongly believe in a pan-Canadian approach to palliative care, but I also believe strongly that as we move toward that, we should not let people suffer in the meantime if they want to end their lives, end their suffering, when they meet the eligibility criteria in the Carter decision.

[Translation]

**Mr. René Arseneault:** Are you implying that Canada lacks that kind of strategy, from coast to coast to coast?

[English]

**Ms. Maureen Taylor:** Yes, there's a lack of strategy. There's a lack of resources, no question.

[Translation]

**Mr. René Arseneault:** I have another question for you.

In recommendation 3, you say the following: “All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying.”

That goes a bit further than the Quebec legislation, which is brand new.

Can you tell us more about recommendation 3 and explain why you are putting it forward?

[English]

**Dr. Jennifer Gibson:** In our analysis of this issue, the Carter decision left room for both self-administered and physician-administered death. We looked at a number of jurisdictions. Some jurisdictions provided self-administered death. One of the limitations of this approach, of a self-administered death only, is that for those who might not be physically able to self-administer, then that actually creates a barrier to access. On the other hand, a physician-assisted death—that is, a physician-administered death—was very clearly identified in other jurisdictions as desirable. We certainly saw that they were quite successful in introducing both.

There will be some Canadians who will say, “I would really like to take ownership of this particular decision. I would like to be able to determine the time of my own death, and I would like to be able to administer it.” Others will say, “If I am suffering intolerably and I'm unable to administer, I would like someone to help me. I would like to be competent. I would like it to be at the time of my choosing. I need help in order to be able to do that.”

I think we owe it to Canadians to be able to offer both of those options to them.

• (1845)

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

Mr. Cooper.

**Mr. Michael Cooper (St. Albert—Edmonton, CPC):** Thank you.

My question relates to recommendation 29 of your report, wherein it is recommended that physicians file a report with a review committee to ensure compliance. I note that this regime exists in every Benelux country. Notwithstanding that in the Benelux countries we've had euthanasia for about a decade or longer, depending on the country, in only one instance has there been a public prosecution, and that was not the result of any report. It was not the result of the work of a committee or a review board. It was the result of a physician who'd spoken too much and too openly in the media.

In that context, what reasonable assurance can we have that the reports submitted to such a committee will be accurate?

**Dr. Jennifer Gibson:** This is an issue that we've heard crop up a number of times, on whether or not there should be a retrospective review or pre-review of all cases. We've spent a lot of time thinking about this, and we've heard testimony about it as well.

One of the concerns often raised was that, look, unless we have pre-review, then we're going to see physician abuses happening. Our concern with raising such a concern is that this would actually apply to almost every end-of-life decision we currently have in Canada today. We do not pre-review end-of-life decisions on a regular basis in hospitals and hospices all across Canada now, so there would need to be a strong justification for diverging from this practice in the case of physician-assisted death.

We are also concerned that by introducing a pre-review process it would actually create an undue burden on Canadians, many of whom will be entirely competent to make these decisions, will be very settled in their views, will have gone through the process, and will be very clear that this is the choice they would like to make. There will be no controversy about whether or not they are competent. Again, many of our health professionals are very skilled at being able to assess that level of competency. To introduce a pre-review would actually create an undue burden in many of those cases.

We have gone in the direction of retrospective review, and that's an important step. The retrospective review is extremely important because it gives us an opportunity to be able to learn from the experience within our system. We need to be able to monitor. We do need to be able to track data. We also need to understand where we are seeing certain patterns emerge. It will enable us to continue to evolve and improve the policies that support this work.

In our recommendations, we were trying to find the right balance, not unduly burdening patients but ensuring that there were sufficient safeguards through the process, up to the point of that individual finally having self-administered or physician-assisted death, and not adding an additional judicial review, tribunal or otherwise.

**Mr. Michael Cooper:** As a result, it is your recommendation that this decision be left entirely with physicians. In my opinion, this would seem to be putting physicians in a very tough position, having regard for...on the one hand applying, in many instances, a complex factual matrix to a complex legal regime. How are physicians equipped to do that?

**Ms. Maureen Taylor:** I'm sorry, but what are we leaving in the hands of physicians?

**Mr. Michael Cooper:** You are leaving in the hands of physicians the ability to make a determination as to whether or not this procedure can go forward without more, without any further authorization to physicians.

**Ms. Maureen Taylor:** Two physicians is what we said, and the eligibility is the Carter decision: a patient has to be diagnosed with a "grievous and irremediable" condition. Physicians make these decisions with their patients every day. Yes, every day physicians are talking to their patients about when it is time to withdraw chemotherapy, or when it is time for terminal sedation, which is basically how my husband died.

Those are discussions that... Physicians are assessing their competency to make these decisions every day. There are physicians who will not be comfortable with this, and we say very clearly that they shouldn't have to participate. It's for physicians who have that relationship with their patient, feel that the patient meets the criteria, and want to move ahead with it.

• (1850)

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

Mr. Rankin.

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

Thank you very much for your excellent work.

I want to step back from the specific recommendations. A colleague was pointing out to me that if we look at your long list of

recommendations, we see that very few are federal. Most of them are provincial. Some of them simply confirm practices with the colleges and so forth.

What kind of role do you envisage the federal government playing in this legislation? We were reminded that a province may not do anything, that it may choose not to do this, so I'm trying to square that with your approach on the recommendations.

**Dr. Jennifer Gibson:** That's an excellent point. Indeed, most of our recommendations were focusing on the provinces and territories, in part because they were wondering what their scope or role ought to be.

But you're right, and one of our key messages is embedded in there, but it's probably worth unpacking a bit. What we were seeking was clarity, as we've noted, in the Criminal Code carve-out related to health professionals and related to eligibility criteria so that those would apply in a pan-Canadian way.

We've also underscored an important role federally for there to be federal oversight. We heard earlier from the expert panel. We are actually envisioning two levels of oversight. The federal level of oversight primarily would be more like a commission that would provide overall policy recommendations. There would be a gathering of data. We'd gather data from across the country and then be able to report back to the public on the state of end of life in Canada, particularly as related to physician-assisted death. Then, within the provinces, there would be a level of overview as well.

One of the worries, of course, is that we do live in a system that has a federal government with a narrow scope of jurisdiction related to health care, and we have provinces and territories where most of the jurisdictional work is. That's the system we've inherited. That's what we're working in. One of the key messages we took away from our work with the provinces and territories is that they were the ones underscoring that they did not want to see a patchwork. Many of them were saying that they need to have clarity on the Criminal Code issues and then they will follow from there. They were really looking for direction from the clarification on the Criminal Code by the federal government in order to be able to proceed.

**Mr. Murray Rankin:** Time is so limited here, but in recommendation 18, you call for—and you did it in your oral remarks—a definition of some of the key terms such as "grievous and irremediable". Why? Just to push a bit, why can't we leave it to the courts? We put all these words in the Criminal Code, some of them very general, and over time we have meaning for those words. Why would we want to perhaps narrow ourselves by putting words in a definition?

**Ms. Maureen Taylor:** We don't want you to narrow it. "Irremediable" has already been defined in Carter, because they said the patient does not have to try therapies that are not acceptable to the patient. That's done.

For "grievous", we're saying "very severe or serious".

**Mr. Murray Rankin:** The Criminal Code probably means already.... That word already appears in the Criminal Code, so why put it down?

**Dr. Jennifer Gibson:** One of the reasons why we reinforced this is that there were a few voices that were starting to say, “If you could just tell us what it means, we’d know how to apply it”, but most clinicians say that doesn’t work for them, that they don’t know.

One of the key messages we heard consistently was that they want to know when we’re talking about “grievous and irremediable” that they as clinicians are operating without incurring liability in what they do. They say they want to make sure they’re following the rules, but to please not have it so narrowly stipulated that if the following conditions cross that bar, that’s the level of—

**Mr. Murray Rankin:** Okay. That’s helpful. Of course, we all expect there to be protections provided. I think everyone is on common ground with that.

Is the word “competent” something on which we can leave the decision of whether a person is “competent” to the doctors and also to the nurse practitioners? I think you made a powerful point about the role of nurse practitioners in this piece. Do we need that definition in our work or not?

**Ms. Maureen Taylor:** We say in our report that there are provinces that already have ways of evaluating. When a physician is worried about a patient’s competency, they seek other expert opinion. They send the patient on. Where there is a disagreement between the patient and the physician, Ontario has the Consent and Capacity Board.

We’re saying to let those things that are already in place take this over, so no, we don’t think you need to address competence.

•(1855)

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

**Hon. Judith G. Seidman:** If I might, I’d like to ask about recommendations 12 and 13, on the timing of the completion of the declaration of competence, and specifically about advance directives.

You say on page 32 that you “recognize that rules about advance directives vary across the country and, therefore, where a patient wishes to consent to physician-assisted dying in advance”, you recommend “a standardized patient declaration form”.

Could you help us understand your process of thought on this issue?

**Ms. Maureen Taylor:** Depending on the province you’re from... I’m from Ontario, so I use advance directive. You’re going to hear in a couple of days from Jocelyn Downie, who is a health law expert, and we’ll defer some of the legalese to her.

She felt very strongly that this is not a consistently applied term across the country. She believed that we needed to come up with a new way of letting everyone know legally what our wishes would be if we lost competence. She came up with the phrase “patient declaration form”, so we’re adopting that.

But if you’re more comfortable thinking about this in terms of advance directive, we think, unlike some of your previous guests, that if you’ve been diagnosed with a grievous and irremediable condition and you’re competent at the time of the diagnosis, you should be able to use some kind of advance directive to lay out your

wishes in case you lose competence before physician-assisted dying can be administered. I think we go through three scenarios. You can read the report.

There’s a fourth scenario where we couldn’t reach a consensus. It’s trickier. Let’s say you’re me, healthy, with no diagnosis. I know that under certain conditions I would want a physician-assisted death, but some people on the panel felt that you can’t know what your wishes will be before you have the diagnosis. You can’t speculate. So we say that the federal government and the provinces should get together and discuss this very serious issue over the next year and come up with some sort of resolution on that.

**Hon. Judith G. Seidman:** Could you give us some idea of the argumentation you went through? You said that the panel itself had difficulty with this issue, and certainly Quebec had difficulty with this issue, because they ultimately took it out of Bill 52. Could you give us some of the input you had when you discussed it in provinces and territories in your committee?

**Ms. Maureen Taylor:** I’ll let the bioethicist take that.

**Dr. Jennifer Gibson:** There are a couple of factors here. The most obvious example is a case of somebody who is competent, has a grievous and irremediable condition, and is suffering intolerably. In that case, it’s very clear they would be eligible. They meet the criteria, no question.

We have a very engaged Canadian citizenry. Canadians are starting to talk about death. We have a number of initiatives focusing on advance care planning across the country. We’re encouraging Canadians to talk to their families. We’re encouraging Canadians to articulate their values. We’re encouraging Canadians to think about how they would like to die, in other respects.

It is an evolving area of practice. It’s an evolving area where, on the one hand, we’re starting to see a much more engaged country. Canadians are willing to do this, but it’s still moving.

One thing we’re thinking about is, within that particular context of how this applies to physician-assisted death, I might be very clear that I might wish to end my life, under certain circumstances, if I already knew that I had a grievous and irremediable diagnosis. I may not be suffering intolerably, but I might want to have the opportunity to speak with my family and articulate my wishes. Then if I subsequently lost competency but all of the other criteria were met, I would want my family to be able to exercise my wishes in that particular case. There has been consistency in some of the conversations we’ve had about advance care planning and the situation in which someone might lose competency after having met the criteria.

The more complex situation, though, is a situation where I might have gone through a number of those steps but I'm not suffering intolerably yet. In that particular case, I might have articulated what intolerable suffering would mean to me. I might be able to spell that out in an advance directive of some kind. In that particular case, we have said that it would be the expression of wishes that might be able to inform a decision to proceed with my wishes, which would be to end my life.

I think we're seeing a convergence of conversations. They're converging around physician-assisted death right now. There's still more work to do, but I think we're moving.

• (1900)

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

Senator Cowan.

**Hon. James S. Cowan:** Thank you for being here, and thank you for your work.

In Carter, the terminology used was “grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual”. Do you see any reason to distinguish between mental illness and physical illness?

**Ms. Maureen Taylor:** We do not, for the purposes being considered for this. Where I think we felt there could be leeway—you've talked about waiting periods, cooling-off periods, and whether patients should require a psychiatric evaluation. We definitely don't feel every patient who asks for this needs to have a psychiatric evaluation, but I would think that where the baseline condition is mental illness—and here we're talking about refractory depression most of the time—most physicians would want that patient to have a psychiatric evaluation. I think that's just going to be good practice.

No, a mental illness shouldn't exclude you under Carter, but will it require other thought processes? Probably, and I can see where those people would probably need to convince the physician over an extended period of time.

Then there's the whole competency issue. Interestingly, we reached out to psychiatry associations. We should not assume, just because someone has a mental illness, that they are not competent.

**Hon. James S. Cowan:** The courts have been very clear on that.

**Ms. Maureen Taylor:** Yes.

**Hon. James S. Cowan:** I have one more question.

There's the business of conscientious objection. Nobody is trying to force anybody to participate in this process. That protects the practitioner, whether they're a physician or another medical professional. The corollary of that, in looking at it from the point of view of the patient, is how we ensure that there is what I would call an effective referral. That means something more than simply saying, “I can't be involved in this. You're on your own. Go and look it up on the Internet. Go call the medical society, and they may be able to help you”. Don't you agree that we need to design a regime that ensures there is a more effective referral than that?

**Dr. Jennifer Gibson:** Yes.

**Hon. James S. Cowan:** What would that look like?

**Dr. Jennifer Gibson:** This became clear to us through the consultation. We heard from many physicians who initially felt as though this was a burden and it was falling only on physicians' shoulders.

However, on the issue of access, very clearly, there are multiple actors who need to be operating together in order to ensure access. In here, we've defined roles for different levels and institutions, including regional health authorities, to facilitate access.

Quite apart from the issue of conscientious objection, access itself is going to be a challenge for many in Canada. There will need to be system coordination, which will be at the provincial and regional level within provinces—

**Hon. James S. Cowan:** That's the role of the regulatory authorities, the colleges of physicians and such?

**Dr. Jennifer Gibson:** It is of regulatory authorities, indeed. I think this is where the Supreme Court of Canada invited us to balance rights.

We do acknowledge in clinical practice—not just physicians but other health professionals as well—that they have a right of conscience. In fact, one of our members on the expert advisory group, Dr. Sister Nuala Kenny, reminded us that conscience also applies to those who are proponents and are willing to practise physician-assisted death. Their conscience tells them that this is the right thing to do.

We need to be able to ensure that we have a regime that calls on physicians and clinicians to stay closely anchored to what they're called to do in terms of public service. Colleges do have a key role in making very clear the expectations of their members in terms of facilitating access.

It's been very clear in our recommendations, and we're hearing this especially from physicians in palliative care, that an effective transfer of care would be important, but that all physicians and clinicians ought to be able to provide information about all of the options. That doesn't mean that the physician needs to participate in the act of physician-assisted death, but they must be able to provide information on the options and, if necessary, on the basis of conscience, they must facilitate an effective transfer. To do that well, they're going to need others in the system facilitating it.

• (1905)

**Hon. James S. Cowan:** Exactly. Can I just make sure that your comments would also apply to institutions?

**Dr. Jennifer Gibson:** Yes.

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

**Mr. John Aldag (Cloverdale—Langley City, Lib.):** Thank you. Before I get started, I do want to take a moment and share something very personal. I'll be very quick.

When I shared with my wife, who's a physician, that I was being put on this committee, she immediately sent me a YouTube link to the story of Dr. Donald Low. I simply wanted to thank you, Maureen, for being here, and to share, acknowledge, and honour the impact of your husband's life and death.

**Ms. Maureen Taylor:** Thank you.

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

I'm going to share my time really quickly with my colleague Brenda. I have two really quick questions.

In the report, you talk about physicians refraining from participating in physician-assisted dying. That was in recommendation 36. I'm just really curious about your discussions on how big an issue that is. Do you see that it's a large issue we need to pay a lot of attention to with regard to conscientious objection?

Do you have any quick thoughts on that?

**Ms. Maureen Taylor:** I'm not a legal expert, but I have a feeling that this is going to be seen as something that the provinces will say they have jurisdiction over. That's what we were told by the Attorney General.

I will say that I love that you're thinking along those lines, because, again, we don't want a patchwork approach to this. As we know, right now in Prince Edward Island, women cannot get an abortion. We do not want that to happen with physician-assisted dying. Anything your group can do to ensure... One worry—I'll be blunt—is that some provinces will do nothing after next June and they won't bring in legislation. I think you were talking about that yesterday.

If you can have something in place so that those Canadians who live in a province that wants to bury its head in the sand won't be left without this option.... I don't know what those things are, I'm not the expert, but I love that you're thinking about it.

This is an issue that seems uniquely Canadian. Of course, there are physicians who conscientiously object in the other jurisdictions, but as far as we know from our research, it has never been such a mountain to climb as it seems to be in Canada, and I have no insight as to why that is.

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

I have a very quick one and then I'll pass it to Brenda.

There's a struggle I've had, and I don't know if you've come up with it in dealing with provinces and territories, and that is simply the terminology. As I go back and talk to constituents about physician-assisted dying, "physician" doesn't capture it and "dying" doesn't, nor does "death". I wonder if that came up and if you have tight terminology that we could be considering.

Then I'll pass this on to Brenda.

**Dr. Jennifer Gibson:** We eventually just went with the language that was in the Supreme Court of Canada's ruling, of course, but we did hear some.... Each of these terms could be unpacked and has its own associated controversies.

Consistency would be great. I don't know how to land on that to provide any strong recommendation one way or the other, except to say that we like the language we've been using.

**Ms. Maureen Taylor:** My personal opinion is that I don't like "suicide" with this. Yesterday, I think, you were talking about how Health Canada has a campaign to prevent suicide. That is precisely

why I don't think suicide belongs in this discussion. I think that's a different issue.

As for "euthanasia", yes, this is technically euthanasia, but we know that has a pejorative connotation. I like to use "physician-assisted dying" or "medically assisted dying".

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** Ms. Shanahan.

• (1910)

**Mrs. Brenda Shanahan (Châteauguay—Lacolle, Lib.):** Since we need to act on the federal Criminal Code provision, our responsibility is to ensure that there is not a worse public evil. In your opinion, what is the worst public evil, having physician-assisted dying legislation or not having it?

**Ms. Maureen Taylor:** I think that public evil thing was in there. That was how it was being explained in regard to how a federal law could trump provincial health care law. Again, these are questions better put to someone like Jocelyn Downie, who will be here on Thursday.

The federal government can get involved in health care, which seems to be a provincial purview, when it's to correct a potential public evil. I would think vaccinations might be an example. If a province weren't going to make it mandatory for children to get certain vaccines, the federal government might be able to step in there and say that's bad for public health. If you're asking me—

**Mrs. Brenda Shanahan:** I guess what I'm seeing is that this report came from something. Something is going on across the country, and it seems that this report is trying to address it.

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** Okay. We can't explore this if she doesn't have it figured out.

Monsieur Deltell.

[Translation]

**Mr. Gérard Deltell:** Thank you, Mr. Chair.

Ladies, welcome to your Canadian Parliament.

I would like to discuss two issues with you, including terminology, but I would first like to discuss the distribution of power between the federal government and the provinces.

Earlier, Mr. Pelletier was asked a very specific question—whether he wanted the proposed legislation to be open for provincial authorities or more restrictive. In other words, we wanted to know whether to give more powers to the provinces so that they could decide what direction to take, or give them specific instructions instead.

Do you think that the legislation the Government of Canada intends to propose should be very specific so as to leave the provinces little leeway, or should it instead give the provinces the leeway they need in this area?

[English]

**Dr. Jennifer Gibson:** I think our recommendations were quite clear that it's really around definition and the scope, particularly as related to health professional roles. That will be an issue that cuts across all provinces.



In terms of more prescription than that, I think there will likely be some push-back from the provinces. The provinces do have jurisdiction over health. They actually have active legislation in place. I think it would make a bit of a legal quagmire for them, because each province is going to need to look at its own jurisdiction and figure out, given its current acts of legislation and current legal framework, what is the best way to introduce physician-assisted death in the province's particular setting.

Earlier somebody mentioned the idea of equivalency and said that this was something that was surfacing for us to ensure that Canadians have effective access wherever they happen to be. Ensuring that there is a legal framework to do that may mean that some provinces might have a single act of legislation that captures the whole, while others might actually have omnibus legislation that makes revisions to what they have. But the effective result would be that all Canadians in all provinces and territories would have access.

**Mr. Gérard Deltell:** Do you think the provinces and territories will welcome that kind of attitude that lets them decide where they want to go, instead of the federal government telling them where they have to go, period?

Let me remind you that it took six full years in the legislature of Quebec, under six different governments, six different premiers, to achieve that goal. Do you think the provinces will welcome the fact that they will be able to decide for themselves?

**Ms. Maureen Taylor:** Yes.

One statement in our report says that we advocate for moving forward on this at whatever level will achieve consistency across the country and prevent a patchwork. We thought we were talking to the provinces. That was our mandate: provinces and territories. If you think that you can, without encroaching on something purely provincial, come up with something that will achieve that consistency—of course, it would depend on how much it mirrors what we've recommended, and I am speaking personally—then that would be great.

You'll have lots of constitutional lawyers to advise you on what you can get away with, as far as the provinces go, and what you can't. From our point of view, we want consistency across the country.

**Mr. Gérard Deltell:** I'll be quick, and this will not be a question but just a remark. It's quite important to define the wording. Let me tell you that in Quebec, we started the debate under the title *l'aide médicale à mourir*, and we finished with *soins de fin de vie*. This is the same situation but not exactly the same words. It's quite important to define exactly what the words mean in that situation.

•(1915)

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

**Hon. Nancy Ruth:** Yes. Thank you for being here.

I want to take your minds to vulnerable persons. What does "vulnerability" mean? Who are vulnerable persons? How will we recognize them? What specific measures do you propose to protect vulnerable persons from being induced to commit suicide at a time of weakness?

**Dr. Jennifer Gibson:** One thing that was pretty clear to us throughout our deliberation was that almost every patient we'd be talking about in this particular conversation would be vulnerable in one way or another. Vulnerability was something that would apply to all patients, as a whole, who might be candidates for this.

There might be some unique types of vulnerability we need to be attentive to. We heard earlier about persons with mental health issues. Some concerns were raised as to whether they deserve more protection. You know what? Indeed, we want to ensure that everyone who's making these decisions is competent to do so. We've also heard there may be certain social conditions that may impede someone's ability to make autonomous decisions.

In thinking this through, we suggested a number of things. First of all—and I believe this was reinforced also by the federal panel—this is not a single decision. This is a process. That process, as we've mapped out in the report, allows any patient who might wish to even start a conversation about physician-assisted death to have the opportunity to do so. That process might, if required given the circumstances of a particular patient, invite the opportunity for a competency assessment, which is common practice in medical care as it is. It might also involve an assessment or a conversation with a psychiatrist if there are concerns about whether or not an underlying mental health issue might actually or potentially be having an impact on someone's competency.

We heard consistently that there could be an opportunity for better training for health professionals in the area of assessing social vulnerability. One could say that until we have all of those social vulnerabilities resolved, we ought not to be implementing this. We weren't willing to go down that road.

We thought, actually, that with having two physicians sign off, the eligibility criteria, and the time through which somebody might be able to have these conversations, we would provide a sufficient level of protection for all Canadians, regardless of one's level of vulnerability. We also thought more work could be done to strengthen the skills and capacities of physicians and other health professionals to be attuned to other types of vulnerability that might not be immediately obvious.

**Ms. Maureen Taylor:** I think we should be satisfied, too, that in Oregon, where they track this, the vast majority of patients who ask for physician-assisted dying and get it are the three Ws: white, wealthy, and well-educated. It is not the socially vulnerable who get there.

In fact, I think we should wonder whether the poor and undereducated will even know this exists in Canada and that it's an option, and we should be worried about them accessing it.

**Hon. Nancy Ruth:** On the side, you referred to the social determinants of health, in that there may be other issues that could perhaps help move someone away. That certainly is the position of the last panel, although they didn't talk about it.

Do you want to say more about that, whatever you think about it?

**Ms. Maureen Taylor:** Do you mean poverty, homelessness, and things like that?

**Hon. Nancy Ruth:** Yes, poverty, lack of access, bad food, no housing, and homelessness.

**Ms. Maureen Taylor:** We did hear from some stakeholders who said that until every homeless person has a home, they can't make a competent decision to choose between physician-assisted dying and palliative care. Again, we're not going to be able to solve the homelessness problem—and I wish we could—before June. We have to move forward.

Every day, physicians see patients who fight with their families about what they want at the end of life. Are you wanting mom to stay on that machine just because you can't let her go? I've seen families who don't want to let them go because there is a disability cheque coming into the house. How sad is that? Every day, physicians see these situations and have to make decisions, and we think they can do it in this case too.

•(1920)

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

Senator Joyal.

**Hon. Serge Joyal:** I'd like to come back to your recommendation 17, where you propose that competence should be substituted for age as a criteria to have access to physician-assisted dying. Could you explain why you removed the age factor? It could apply below 21 years of age, but it would apply over 21 years of age also. If there's no age factor and no more adult status, then, of course, everything becomes a matter of evaluating the competence.

Could you explain why you proposed that approach to the issue of age as a criteria of eligibility?

**Dr. Jennifer Gibson:** Yes, and you're absolutely right, in that a 21-year-old who is not competent would not meet the eligibility criteria for the purposes of physician-assisted death. Age by itself would not be sufficient. That would apply on the north side of 18 or on the south side of 18.

Also, when we looked at current practice within health care—this is not just in Canada, this is broadly—what we saw is an increasing recognition, particularly in pediatric settings, that some children, but especially adolescents, have the competence and the capacity to make end-of-life decisions, and in fact are empowered and encouraged to be able to be active participants in that.

We wanted to be able to acknowledge this, to acknowledge that what this turns on is not their age—it's not what their birth certificate says—but really their ability to appreciate and understand the diagnosis and their options. Many of these children, these adolescents, would have had a period of time when they may have been sick for a great deal of time. They may reach a point where they say, "I know this better than anyone else does, and my life experience is far richer because of this experience." One of the concerns is that a 16-year-old hasn't had the life experience to make such decisions. Well, many of us haven't had the life experience to make an end-of-life decision until we're faced with it, but many of these young people actually have the competency to do so.

We're not saying to let us liberalize to the point that any child who says, "I want physician-assisted death" should have access. The stringency of this criterion related to competence is essential.

**Hon. Serge Joyal:** If I may, I would like to come back to the issue of initial consent given by persons who become incompetent later in life. I would like to understand clearly the distinction between this

and a will, whereby a person provides that in a case where the person is suffering from an accident or another disease and loses his autonomy, the person can decide to opt for somebody to consent that they not be maintained artificially in life. It is suicide, in a way, to decide that in such a condition you prefer to die.

What you've proposed, if I understand well, would mean that when a person is diagnosed with a disease or a physical or mental condition that is irremediable, that person could opt at some point in time to have somebody express consent to terminate their life. Do I understand well these conditions through which you would add to the capacity of a person to decide when that person would be dying at a point in life because her physical or mental condition would be totally irremediable?

**Ms. Maureen Taylor:** Regarding the first one you talked about with the will, where you say, "I wouldn't want my life maintained artificially", sometimes you're not on a ventilator and you don't need resuscitation but unfortunately you linger in that near vegetative state, for want of a better phrase. That's what some people are saying. My father says that's fine with him, that he doesn't mind because he's not going to know any better then.

My dad would say that's fine. For me, I would say no, so the only way I'm going to get that death hastened is with a physician-assisted death. We're saying that's going to be allowed for me if I make it clear in an advance directive what, for me, would qualify as "intolerable suffering". But again, our committee has said that we've made a decision, and it's only if you already have the diagnosis. Here's a good example. If I have an advance will and I have a stroke tomorrow, I'll survive the stroke, and I might not have any capacity to speak or recognize my family, but I'm not dying either. That's too bad, but I can't get a physician-assisted death because I didn't have the diagnosis before I lost competency.

Do you see?

•(1925)

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

Madam Shanahan.

**Mrs. Brenda Shanahan:** I didn't want to go too far down this road because I really believe that the procedural and health administration aspect of it is in the provincial competency, but we're here and that's really where your work was.

I have two things. What are the minimum safeguards that you would envisage? That's sort of on the federal side. Also, did you consider options such as multidisciplinary teams working in this area? If so, how does that fit in with safeguards and the physician-assisted part?

**Dr. Jennifer Gibson:** It's an interesting question, because what we've laid out in the protocol is a series of steps here, including an assessment of whether or not the patient meets the eligibility.

First of all, the patient makes a request. Their competency and all of the eligibility criteria are assessed. The first physician confirms that. A second physician must also confirm that the eligibility criteria are met. At either of those stages, if necessary, if there's concern about competence, there might be a consultation with a psychiatrist or a social worker or someone.

All of those steps are there, but what you've introduced is really interesting, and that's the multidisciplinary team. This is where some of these recommendations actually speak to each other.

It's not nearly as explicit, but it was in the back of our minds, and for some of the ways in which a physician—or a nurse practitioner, if this were to be extended to nurse practitioners—might get to know his or her patient, very often they operate within a multidisciplinary team, where knowing the patient is actually about speaking with the members of your team and getting to know them through the multidisciplinary team. The physician is not the only person who speaks to the patient. It's the social worker, the nutritionist, the physio person, and all of those folks in the circle of care. They collectively get to know the patient in order to be able to provide insight and to say, “Yes, this individual is competent.” Somebody has to make the determination of competence, but those other members do have a relationship with that patient and might be able to inform it.

What we've tried to do here is acknowledge that this is in fact the way in which health care is currently delivered. It's also being established as a standard of care that we ought to aspire to: to see interdisciplinary teams circling around a patient in a way that actually meets the comprehensiveness of their needs. What we're trying to do is align some of what we're recommending here with what is emerging as best clinical practice from a patient-centred perspective.

I'm not sure if that answers your question.

**Mrs. Brenda Shanahan:** Thank you. Yes, I think that gives us some reassurance on the safeguard part.

You said right at the top that the patient makes the request, and I think that's a key concern, too, in that it's not something that's suggested to them, that it's the patient who activates that request. In my work with living wills and *mandats en cas d'inaptitude* in

Quebec—mandates in case of incapacity—as a former social worker and financial planner, I asked a lot of the questions about “What happens if you die today?” or “What happens if you're in a state where you can't make a decision?”

One thing we were always careful to say was that the key element is talking to your family, because you can't predict every situation. That's a concern I have about advance directives. Do you want to speak to that and about talking to the family? What about family reactions?

**Ms. Maureen Taylor:** We do not believe the family should be able to overturn a patient's request if they don't agree, when the patient wants this and is competent. At the same time, we don't believe the family should be able to initiate this for a patient, whether the patient is competent or not. A substitute decision-maker cannot request physician-assisted dying in our opinion.

• (1930)

**Mrs. Brenda Shanahan:** Okay.

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

Thank you very much for being here. I think we're going to get you out exactly on time. I need to inform the committee that for tomorrow there's been a slight change in time. The first panel will be from 5:15 to 6:15 and then we will take a suspension and begin the second panel, which will go from 7 until 8 p.m. Does everybody have that? It's due to a vote in the House, so I have to get your agreement on this.

**Some hon. members:** Agreed.

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** We're at Wellington.

**Hon. James S. Cowan:** It's from 5:15 to 8 p.m.

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** It is 5:15 to 8 p.m. in total, but there will be a break between 6:15 and 7.

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

**The Joint Chair (Hon. Kelvin Kenneth Ogilvie):** Notices will be sent to confirm it.

The meeting is adjourned.





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