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The Honourable PIERRETTE RINGUETTE,
Speaker pro tempore

CONTENTS

(Daily index of proceedings appears at back of this issue).

Debates Services: Josée Boisvert, National Press Building, Room 831, Tel. 613-219-3775
Publications Centre: Kim Laughren, National Press Building, Room 926, Tel. 343-550-5002

THE SENATE

Wednesday, February 10, 2021

The Senate met at 2 p.m., the Speaker pro tempore in the chair.

Prayers.

SENATORS' STATEMENTS

LUNAR NEW YEAR

Hon. Victor Oh: Honourable senators, I would like to take this opportunity to wish everyone a happy Lunar New Year.

It is my pleasure to be here with you, sharing part of my culture. Also called Spring Festival, many people from my home country of Singapore, along with China, Vietnam, Korea and other Asian countries, will be celebrating this holiday on February 12, welcoming the Year of the Ox.

As the Lunar New Year is one of the most important festivals in traditional Asian culture, it provides a time for families and friends to unite, reflect on the past and think about the future.

The fact that we take the time to acknowledge important cultural occasions such as these in the Senate is emblematic of Canada's commitment to multiculturalism.

As this new year begins, the ox gives us hope for a new start. The ox represents hard work and honesty, and I believe these two traits will serve us well on the road ahead. The year 2020 was an unprecedented year for us all. The COVID-19 pandemic has brought us many challenges, but also hope that together we can overcome the obstacles ahead of us.

While we are celebrating the Lunar New Year with our loved ones, I would like to remind everyone to continue to follow guidelines from health officials.

Once again, I wish you all a happy Lunar New Year. *Xin Nian Kuai Le. Xing Fu Ji Xiang. Xie xie.* Thank you.

THE LATE CHIEF RON MICHEL

Hon. Mary Jane McCallum: Honourable senators, I rise in tribute to Senator Ron Michel of the Prince Albert Grand Council, December 6, 1951, to Monday, January 25, 2021.

Senator Michel was born in 1951 in a log cabin on the Churchill River, what he called the lifeblood of the Peter Ballantyne Woodland Cree in northern Saskatchewan. His mother and father lived and passed on to their children a rich and spiritual traditional lifestyle of hunting, fishing, trapping and gathering. His father encouraged him to get an education, saying that it was the future of First Nations people, but his father refused to allow Ron to attend residential school.

Ron and his wife — my sister Nancy — were married in 1972, and both graduated as teachers from the University of Regina in 1981. Together they built their family, their careers and worked as educators on the reserve.

Ron realized that First Nations people needed advocacy and a voice and entered politics. He was elected a band councillor in 1983 — a position he served for two years. He ran for chief in 1985 and held that position for 20 years, with a hiatus of 2 years.

The Peter Ballantyne Cree Nation is comprised of seven distinct communities geographically separated by great distances. With his expertise and position as chief, he was able to negotiate new schools and health centres for many of the Peter Ballantyne communities and turned it into one of the most progressive First Nations in Saskatchewan.

He helped to establish the Prince Albert Grand Council, which is comprised of 12 First Nations Treaty 5 and Treaty 6 signatories in northern Saskatchewan. He was chief when Peter Ballantyne negotiated the Treaty Land Entitlement Act in 1993. This agreement was critical, as it would serve as the socioeconomic engine for Peter Ballantyne's future, and remains the most important factor in their continuing success. Ron was chief when the Northern Lights Casino became a reality and built on the urban reserve of Peter Ballantyne in Prince Albert, Saskatchewan.

Ron ran for the position of Grand Chief of the Prince Albert Grand Council in 1985. He served as Grand Chief from 2005 until he retired in 2017. As Grand Chief, he worked with the 12 First Nations to create more capital, work, services and programs. Thank you.

INSULIN—ONE-HUNDREDTH ANNIVERSARY

Hon. Jim Munson: Honourable senators, my statement today celebrates a century of health. If you can believe it, 2021 marks the one-hundredth anniversary of the discovery of insulin in Canada.

The well-being of children continues to be a driving force in my role as a senator, so I'd like to dedicate this statement to the 33,000 brave school-aged children in Canada who rely on the self-sustaining liquid every day. Insulin makes life possible for all these young people, so I think you'll agree that's a real reason to celebrate.

In fact, 75% of persons diagnosed with insulin-dependent Type 1 diabetes are under the age of 18. The Canadian Paediatric Society estimates that there are an additional several thousand insulin-dependent children under the age of 5.

However, you know as well as I do that the road to discovering insulin was a long one. Frederick Banting and Charles Best began researching pancreatic extracts at the University of Toronto in May of 1921. By the end of summer later that year,

their extracts were finally bringing down blood sugar levels, and at the end of the year, the extracts were ready to proceed to human trials.

The first person to receive a dose of the finalized insulin extract was also a child, Leonard Thompson, a 14-year-old Toronto boy. Banting and Best knew the discovery of insulin was an immense opportunity to save lives, and that it belonged to the world. Subsequently, they sold the patent for insulin in 1923 for \$1.

While we know that insulin injections allow a person with Type 1 diabetes to stay alive, they do not cure the disease or prevent its long-term complications. Thankfully, strides in technology, such as a continuous glucose monitoring system, or CGM, enable patients to live longer, healthier lives. When I think of these strides, I'm reminded of a great Neil Young quote, "One new feature or fresh take can change everything."

• (1410)

Canada has the researchers, the skills and the heart to be the ones that turn Type 1 into "Type None." Every day is a step closer to a cure.

There is research coming out of the University of Alberta from a team led by Dr. James Shapiro for an injection of insulin-producing cells derived from the patient's very own already-existing cells — no need for immunosuppressants or organ donations.

Honourable senators, in closing, this means that Canadian medicine is once again well positioned for another diabetes breakthrough. Colleagues, please join me in celebrating 100 years of insulin in the spirit of looking forward to a cure.

Thank you.

PLAY ON! STREET HOCKEY CHAMPIONSHIPS

Hon. Douglas Black: Honourable senators, I rise today in support of Play On!, Canada's national street hockey tournament.

As perhaps you know, Play On! is a respected non-profit sports organization that has sponsored cross-Canada street hockey tournaments in previous years. They are proposing to again hold a Canada-wide tournament later this year that will involve approximately 40 communities, including First Nations communities, and thousands of participants.

So why am I actively supporting this initiative, and why am I asking you to consider supporting this nation-building tournament? As we all know, COVID is crushing community spirit, and we just can't continue to allow that. This project will bring kids, teens and young and old Canadians into the street, competing, exercising and laughing again. For me, this is more than a tournament; this is part of a revival.

In our role as senators, which allows us to connect with Canadians from all walks of life and all sizes of communities, I know we see the need now to support events that allow communities to open and reconnect. In my recent virtual tour of

Alberta, I have seen an alarming rise in all forms of mental illness and its impacts because of anxiety, isolation and inactivity. This project can help address these issues.

That alone is reason to support it, but there are also economic reasons to support this project. It's estimated that the economic impacts will be between \$50 and \$100 million for Canadian cities and towns, and that can make a meaningful difference for communities that are trying to get back on their feet after this devastating year.

Colleagues, this project is backed by an experienced management team, many of whom have operated at the highest level of global sports organizations, including the Olympics, the Invictus Games and the World Junior Championships for hockey. I have seen firsthand their ability to organize and inspire.

I believe in this event and this vision of a unifying, post-COVID national street hockey event.

I hope you will consider the positive events that this project can bring to your community and join with me in supporting this project.

Thank you very much, senators.

[Translation]

BLACK HISTORY MONTH

Hon. Marie-Françoise Mégie: Dear colleagues, I am pleased to rise today to commemorate Black History Month. On Thursday, February 18, I will be participating in a panel discussion for youth to discuss racism and its effects on the mental health of Black people. Many taboos still need to be broken on these issues. I would like to thank Mosaïque interculturelle and the Fondation des médecins canado-haïtiens for their support.

As you know, the burden of the pandemic is weighing very heavily on the shoulders of Black women who work in difficult conditions in our hospitals and seniors' homes. They are experiencing anxiety every day. This is a time to pay tribute to them. It is also a time to share with you the requests made by the Parliamentary Black Caucus in their 2020 statement. Here is an excerpt:

1. Measure the pervasiveness of systemic discrimination through the collection of race-based data; . . .

3. Eliminate the barriers to access to justice and public security for Black Canadians and Indigenous people;

We must:

Focus on effective policing with an emphasis on de-escalation techniques and mental health programming.

Many Black people are calling for the reallocation of certain budgets to:

... social service and mental health care experts trained in nonviolent intervention and de-escalation.

We don't often hear about microaggressions against Black people in Canada, but their effect on mental health is insidious. The whole community feels the shame of being constantly targeted by the media and police, and that can lead to depression that is often hidden and under-diagnosed. The humiliation of being arrested near one's workplace or in front of one's family can also lead to depression.

Those are just a few examples. It is a perpetual source of anxiety, and it is passed on from generation to generation. We have to keep talking about these problems until they are recognized and resolved, and not just for one month a year.

Thank you.

[English]

THE LATE CHRISTOPHER PLUMMER, C.C.

Hon. Pamela Wallin: Honourable senators, he was the great-grandson of Canada's third prime minister, Sir John Abbott. He was a concert pianist, and although he loved his music he loved words more. So he set off to New York City in 1949, and just five years later he made his Broadway debut in *The Starcross Story*. For him, there would be seven decades of compelling, powerful, poignant portrayals of humanity at its best and worst.

Christopher Plummer was the greatest actor of his time, still doing what he loved until the age of 91, still giving voice and meaning to characters great and small — all this with his wife, Elaine Taylor, his wife of more than 50 years and an actress herself — at his side. She was his best friend, a calm companion and she was with him at the end.

When I served in New York City as Consul General, Chris and Elaine were always willing, witty and wonderful ambassadors for our country, and they always impressed our American friends with the quality and contributions of Canadians. One late evening, after a Stratford Festival production of *King Lear* at the Lincoln Center — starring Stratford alum Christopher Plummer — he joined us all back at the residence.

As the evening unfolded and after a drink or two, Chris made his way to the piano, sat down and began to play the now-omnipresent soundtrack of the 1965 hit movie *The Sound of Music*. We gathered around, and it took us a moment to realize he was improvising his own lyrics to those now-ubiquitous tunes. His versions were funny and rude, and evidence that, while the movie truly launched his stellar career, it was a role he detested.

It was the stage that he truly loved, and throughout his life he often returned to it, with a one-man show or a two-hander with Barrymore or *Inherit the Wind* with Brian Dennehy. He played Cyrano, Iago, Hamlet, Macbeth and King Lear. On screens large and small, he played lovers and villains, spies and heartless billionaires. He is one of the few — certainly the only —

Canadian to ever win the triple crown of acting: an Academy Award, an Emmy and a Tony. But it took until 2012 for that Oscar win for his role in *Beginners*.

The irony was not lost upon him. Chris was self-deprecating but had a great ego. He commanded a stage or screen, and always a room, but he never felt his performance was quite good enough. Of course, it always was. He made the impossible seem effortless.

He often joked about choosing his roles if it meant a big paycheck or an exotic shooting location, but that wasn't true either. He did it for the love of the game.

You are immortalized for those of us in the audience, so go on, Christopher, to command the next stage, as you always have.

• (1420)

ROUTINE PROCEEDINGS

KINDNESS WEEK BILL

FIRST READING

Hon. Jim Munson introduced Bill S-223, An Act respecting Kindness Week.

(Bill read first time.)

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

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

QUESTION PERIOD

FINANCE

COVID-19 ECONOMIC RESPONSE PLAN

Hon. Yonah Martin (Deputy Leader of the Opposition): Honourable senators, if time permits, I may have three questions for the leader, but here is my first one.

There was something in the news this morning regarding Vancouver's historic Chinatown, and it concerns me greatly. The region, including many others, has been impacted by COVID-19 and the small businesses that are there. Chinatown in Vancouver currently has a retail vacancy rate of over 17%. The federal government's decision to ban cruise ships, which has been extended to the end of February 2022, has had a devastating impact on local business sales as well. The store closures and

vandalism being faced by Chinatown is heartbreaking to witness as this has long been a vibrant cultural centre in the city for over 125 years. And, of course, there is the opioid crisis and the Downtown Eastside, which is almost neighbouring the area.

Leader, what specific action is your government taking to help owners of small businesses in Vancouver's Chinatown weather these tough economic times, and can this community expect further measures to be taken, especially in light of the upcoming federal budget?

Hon. Marc Gold (Government Representative in the Senate): Senator, thank you for your question. I spent four very happy years in Vancouver, know the area well and I remember it very fondly. Everyone in this chamber and across the country is concerned about the impact the pandemic has had generally and, in particular, as you outlined, in that important area in Vancouver.

The government has done a lot to try to help small businesses through this crisis and continues to listen to businesses, to understand their needs and try to respond as best as it can.

I won't give you the long list. All senators are aware of the rent subsidy program, the adjustments the government made in response to input from tenants, and the other measures to provide support — whether it's support for employees so that they can stay on the payroll or, at the very least, still be able to put food on the table as businesses try to figure out how they are going to get through this period — the extension of the wage subsidy, the business credits available and the like.

None of that takes away from the anxiety that small businesses feel as the pandemic seems to be continuing with every bit as serious implications. I am confident that the government remains in close contact with its provincial counterparts and is getting the input that they're getting from the municipalities, and I certainly will make inquiries as to what particular asks may have been made in the various networks and report back.

Senator Martin: As a supplementary question, it is a very historic part of our province, so I'm curious about Heritage Canada and, with the upcoming federal budget, whether certain considerations are made for very important regions in our country.

Senator Gold, is your government currently monitoring the uptake of federal support programs by ethnocultural communities, like Vancouver's Chinatown, or by region? What kind of outreach is your government doing to ensure these business owners are aware of and can apply for federal programs available to them, especially in consideration of language barriers that may exist?

Senator Gold: Thank you, senator. These are very important questions. I don't have the specific answers. I'll make inquiries and be happy to report back.

[Senator Martin]

FOREIGN AFFAIRS

ISLAMIC REVOLUTIONARY GUARD CORPS

Hon. Linda Frum: Honourable senators, my question is for the Leader of the Government in the Senate. Senator Gold, two months ago I asked you whether your government would commit to listing the Islamic Revolutionary Guard Corps as a terrorist organization as it had agreed to do immediately when it voted to support a motion in the House more than two years ago.

You said two months ago, in response to my question, that you would make inquiries, so my question today is a follow up. With whom did you make inquiries and what have been the results of those inquiries so far?

Hon. Marc Gold (Government Representative in the Senate): Thank you for your question, senator. I made inquiries of the responsible ministers and departments and have not yet received any updates, and therefore I am not able to report anything further.

This is an ongoing preoccupation and concern for the government. The government has taken steps to target certain groups within Iran and the matter of the Revolutionary Guard remains a matter that is under consideration by the government.

Senator Frum: The Government of Canada listed 13 organizations as terrorist entities last week. One of them was listed less than a month after it was involved in violent protests in Washington, D.C. Yet we are still waiting for the IRGC to be listed, even though it is the prime organ responsible for exporting terrorism around the globe, and it comes from the country known as the world's leading sponsor of terrorism.

Senator Gold, why, if this government was able to act so quickly on the 13 other listed entities, is it so slow to list the IRGC? What is it about those 13 entities that distinguishes them from the IRGC?

Senator Gold: The government takes seriously the legal requirements that the law imposes upon determining that an entity or organization is to be listed. That information comes from investigations that are made and evidence that's gathered — evidence that is sometimes easier to gather in some jurisdictions than in others.

The government remains committed to following the proper procedures to determine when and which groups fall within the categories to be so listed and will continue to do so.

[Translation]

JUSTICE

MEDICAL ASSISTANCE IN DYING

Hon. Éric Forest: My question is for the Leader of the Government in the Senate. By removing the reasonably foreseeable natural death criterion, adding more safeguards for people whose death isn't reasonably foreseeable, and removing the requirement for final consent in some situations, Bill C-7 provides greater dignity and certainty for Canadians who want to put an end to their enduring and intolerable suffering caused by a grievous and irremediable medical condition.

That said, I think that, like us, the government will realize that Bill C-7 doesn't provide a satisfactory answer to Canadians suffering from mental disorders. We realize that the government needs more time to study the matter. Canadians who are suffering cannot wait for the next legislative review. It is a question of dignity and fundamental rights. That leads me to my question.

• (1430)

Does the government recognize that access to medical assistance in dying is a fundamental right and that it must commit to swiftly delivering a legal framework allowing Canadians suffering from mental disorders to have the right to the same services and same state protection as other Canadians?

Hon. Marc Gold (Government Representative in the Senate): Thank you, senator, for your question — a question that is top of mind these days as we debate Bill C-7.

As you can see in following the debate, the exclusion of those suffering solely from a mental illness is at the heart of our deliberations. This issue was the subject of an amendment that was adopted yesterday by the majority of senators, and it was also considered during a parliamentary review of Bill C-14. Bill C-7 and the government's position were very clear: The right to access medical assistance in dying is a fundamental right recognized by the Supreme Court in several cases, including in *Carter* and more recently in *Truchon*. We will work earnestly to find a solution to ensure that this issue can move forward. However, as yesterday's debate showed, the subject is complex. I am pleased, if that is the right word, with the quality of the debate in the Senate, which has greatly contributed to our understanding of this difficult issue.

Senator Forest: Thank you. As you just pointed out, leader, yesterday the Senate adopted Senator Kutcher's amendment, which would, after 18 months, remove the provisions that prevent individuals who suffer from mental disorders from accessing MAID. The purpose of the amendment, as we know, is to protect the constitutional rights of persons with mental disorders and, in a sense, it sets a deadline for the development of a framework to protect persons with mental disorders.

Here is my question for the Government Representative, who has actually dedicated his career to defending the basic rights of Canadians as well as our Constitution: Will the Government Representative try to convince the government to accept the

amendment adopted by the Senate yesterday evening to make medical assistance in dying available to people whose only underlying condition is a mental disorder?

Senator Gold: Thank you for the question. As you will understand, my opinions and viewpoints must remain confidential, considering my role as the Government Representative. I can assure you, as I have said several times in this chamber, that the Government of Canada is open to any amendments that seek to improve the bill and are consistent with the objectives of the law. I therefore hope the government will give serious consideration to all the amendments proposed by the Senate, and that is what I expect the government to do.

[English]

HEALTH

COVID-19 PANDEMIC—RAPID TESTING

Hon. Bev Busson: Honourable senators, my question is for the Government Representative in the Senate. Senator Gold, I believe that every government across Canada is trying their best in these unprecedented times to find the elusive balance between the protection of public health and the economic recovery. We will not be able to restore vibrancy to the economy while this pandemic rages. We all know the role of vaccines for a longer-term protection and have no doubt that they will be effective. But in the interim, I have long been curious about why we have not more vigorously used testing and aggressive contact tracing in Canada.

On February 2, Perrin Beatty, CEO of the Canadian Chamber of Commerce, joined experts to co-author an open letter urging adoption of a rapid testing program combined with rigorous contact tracing. Twenty-eight other leading public health and business advocates from across the country signed on to the appeal, including four from British Columbia. Bottom line, this group estimated that at a price tag of \$2 billion, we could be testing 200,000 people per day almost immediately, and testing 5 million people daily by April.

The imagery of a country on the war footing against this virus comes to mind.

I'm aware that all government spending on the COVID response must be repaid and that there are always federal-provincial considerations, but given the stakes, could you tell me whether the Government of Canada is seriously considering the rollout of this kind of large-scale national rapid testing program?

Hon. Marc Gold (Government Representative in the Senate): You're entirely correct to note how important testing and contact tracing will be for us to be able to continue forward to open up the economy in a safe and sustained way.

As I've reported earlier in this chamber, the federal government and its officials are in the ongoing process of approving new testing technologies as they come on stream. The government has authorized six of these tests; expect more as the technology develops. At this date, I'm advised the government

has deployed almost 17.7 million rapid tests to provinces and territories, and shared guidance on how they can be used effectively. The provinces then decide as to how to use them.

I'm not aware of the situation in British Columbia, senator, but I know that in both Quebec and Ontario there have been pilot projects to determine how best to use them to assess the reliability and so on.

Very importantly and promisingly, the Government of Canada is partnering with the Creative Destruction Lab Rapid Screening Consortium to launch a workplace pilot project — actually a series of pilot projects — in several provinces and territories, in various sizes of businesses and industries, to see how rapid testing can be done quickly and effectively in those workplace settings. We await with interest the results of those projects.

Senator Busson: Senator Gold, Australia has apparently used rapid testing and contact-tracing programs at the national level with great success. Canada and Australia are comparable as federal states. Has the government assessed whether there is anything unique about Canada that would preclude us from adopting the kind of program implemented by the Australian government?

Senator Gold: The Government of Canada is in contact with its counterparts and allies around the world, and especially those with whom we share similar constitutional frameworks. But there are federations and there are federations; some are more centralized and some are more decentralized. And there are limits to how easily one can incorporate the actual practices of one to another.

The federal government of Canada is working carefully, closely and properly with its provinces and territories. We're working together to find appropriate ways to meet the needs of Canadians and the particularities of those needs as they are expressed throughout this very large country.

INTERNAL ECONOMY, BUDGETS AND ADMINISTRATION

BUSINESS OF THE COMMITTEE

Hon. Diane F. Griffin: Honourable senators, my question is to Senator Marwah in his capacity as Chair of the Standing Senate Committee on Internal Economy, Budgets and Administration.

Senator Marwah, could you tell us approximately how much money has been saved on travel and accommodations for senators who would otherwise have travelled to Ottawa since the implementation of hybrid sittings?

Hon. Sabi Marwah: You are absolutely correct, senator. There have been savings as a result of the pandemic and its resulting impact on items such as senators' travel, accommodation, committees, office budgets and administration. To the end of January of this year, the savings are approximately \$5.5 million. I should also mention that there have been incremental costs associated with the pandemic as well that are roughly \$500,000.

• (1440)

Senator Griffin: I have a follow-up question for Senator Marwah. As a fellow committee chair, I'm very interested in augmenting the capacity of our administration to conduct committee meetings. Is there any possibility that the surplus money saved because of our hybrid sittings could be reallocated to facilitate more committee meetings?

Senator Marwah: That is a fair question, senator. The answer to that is a bit more complicated. I should point out that there are two elements of the Senate's budget. The first element is what is called the statutory portion. This consists of senators' salaries, travel, accommodations and so on. These savings, unfortunately, cannot be reallocated.

The second part of the budget is voted, which consists of items such as office budgets and administration expenses. These savings, in fact, can be reallocated.

To the end of January, the savings are roughly divided evenly between the statutory and the voted, so yes, some savings can be reallocated. However, I should also point out that aside from the equipment, buying and reusing the reallocation, there is an impact on staffing because staffing does need to be ramped up to accommodate additional sittings. That could take some lead time if we decide to proceed with additional sittings.

[Translation]

CANADIAN HERITAGE

OFFICIAL LANGUAGES—APPOINTMENT OF GOVERNOR GENERAL

Hon. Jean-Guy Dagenais: Honourable senators, my question is for the Leader of the Government in the Senate.

Leader, the government that you represent is preparing to table an update on the official languages in Canada. Although it is a necessary exercise, it may very well prove to be a disappointment. I won't deny that we are very eager to look into this at the Standing Senate Committee on Official Languages. In the meantime, your Prime Minister will have to fix one of his mistakes and soon appoint another Governor General of Canada to replace the one who had to resign amid a scandal.

Can you assure us, leader, that Prime Minister Trudeau will appoint a person who is fluent in both of Canada's official languages to this important position?

Hon. Marc Gold (Government Representative in the Senate): Thank you for your question and for highlighting the importance of Canada's two official languages. I have no information about this aspect of the process that will be used to submit a list of candidates to the Prime Minister or what criteria he will use in making his decision. We look forward to his decision.

Senator Dagenais: As leader of this chamber, a bilingual government entity, do you personally think that this position should be filled only by a candidate who speaks Canada's two official languages, or do you not consider French to necessarily be a requirement?

Senator Gold: As representative of the government, I assure this chamber that the government takes our two official languages very seriously and considers them an essential part of our identity as Canadians. As I said, dear colleague, I cannot make any promises about the Prime Minister's upcoming decision on our next Governor General.

[English]

HEALTH

COVID-19 VACCINE PROCUREMENT

Hon. Leo Housakos: Honourable senators, my question is for the government leader in the Senate.

This afternoon, the Indian government released a readout of a telephone call that took place at some point today between Prime Minister Trudeau and Prime Minister Modi of India. The readout states:

... Prime Minister Trudeau informed Prime Minister Modi about Canada's requirements of COVID-19 vaccines from India.

Prime Minister assured the Canadian PM that India would do its best to support Canada's vaccination efforts, just as it had done for many other countries already.

Government leader, we see the damaging effects on vaccine procurement thanks to Justin Trudeau waiting so long after the CanSino deal fell apart before finally turning to others. We have no written exemption from Europe on their vaccine export controls. We have no domestic vaccine production as this government chose to rely on foreign governments and foreign countries. Now when Prime Minister Trudeau finally turns to India for help, his relationship with India has deteriorated to the point that the only assurance given to Canada is that India will do its best.

Government leader, why did Prime Minister Trudeau wait so long to make this call? What exactly did the Prime Minister ask from the Indian government in terms of help? Was it for a million doses of AstraZeneca vaccines, which are not even approved yet in Canada?

Hon. Marc Gold (Government Representative in the Senate): Thank you for your question. I don't have details of the conversation, but I don't accept the premise of your question at its core.

The government has taken steps to secure a variety of sources of vaccines from multiple sources internationally, as I've said many times in this chamber. It is to reduce the risk to Canadians that one particular supplier, in one particular jurisdiction, may

not be able to deliver the goods, or that the vaccines, indeed, may not be effective against the virus or its variations and mutations that we're seeing spread with alarming frequency.

The government continues to work diligently — the Minister of Public Services and Procurement, primarily — to secure both vaccines and related equipment for the benefit of Canadians. This is a constant daily preoccupation. It falls to the Minister of Public Services and Procurement primarily, and secondarily to other officials including other ministers, notably the Prime Minister. The Government of Canada remains confident that it will deliver on its promise that every Canadian who wishes to have a vaccine will have one by September, if not earlier.

Senator Housakos: Senator Gold, that is precisely the problem. The problem is you don't have information, and as government leader, if you don't have information, imagine the problem for Canadians.

I find it curious that the Prime Minister's daily itinerary made absolutely no mention of his call to Prime Minister Modi. When I checked a little while ago, there was no readout release from Prime Minister Trudeau's office in regard to this call. Will Canadians ever get to hear Prime Minister Trudeau's version of this call? When will this government start being transparent with information?

Senator Gold: If I remember the first part of your question, senator, the call took place today. I think that it is fair to expect that Canadians will continue to be advised by this government, as they have been, as to how things are unfolding. This government has shared information with Canadians — good, bad and indifferent — on a regular basis since the beginning of this pandemic. It has tried its best to keep Canadians informed, and it is doing its best to keep Canadians protected.

FINANCE

COVID-19 ECONOMIC RESPONSE PLAN

Hon. Yonah Martin (Deputy Leader of the Opposition): Honourable senators, my question for the government leader in the Senate concerns small businesses, including those that have been impacted in historic Chinatown in Vancouver.

According to CFIB, one in six small businesses across Canada — about 181,000 of them — are considering closing permanently. As we know, many have already closed.

As of January 21, in my province of British Columbia, less than a third of small businesses are making normal revenue and only 39% are fully staffed.

Leader, I have previously raised with you the fact that small businesses that opened in 2020, just before the start of the pandemic, do not qualify for any of the programs brought forward by your government. When will your government fix this gap and allow new small businesses that started operations in 2020 to apply for federal support?

• (1450)

Hon. Marc Gold (Government Representative in the Senate): Thank you for your question. As this chamber well knows, the government is constantly re-evaluating the success, impact and efficacy of its programs. It has, on more than one occasion, come back to Parliament, from the House of Commons to this house of Parliament, the chamber, with revisions to the programs based upon experience. The government continues to listen and seek ways to improve the situation. If any new programs are to be introduced or adjustments to programs to be made, as soon as they are made public, I will report the details in the chamber.

Senator Martin: At the start of 2020, these new businesses began. Now, it is 2021, a year later. The finance minister herself, in this chamber as well as at Finance Committee, said she's aware of this issue and is looking at it closely. As you know, for small businesses, even one day, one week, can make that difference, and we see the evidence of it with so many closing.

The new program your government announced on January 26 of this year, the Highly Affected Sectors Credit Availability Program is also not available to these new businesses that started in 2020.

Leader, why is your government continuing to exclude new businesses and choosing to ignore their requests for help, a year later?

Senator Gold: The challenge for this government or any government faced with a pandemic of this duration and depth is to make sure that the assistance is both broad enough to benefit all Canadians and targeted enough to hit those especially in need. There's no doubt the government has been transparent and open with this, that when moving things quickly through the policy development process, certain things will not necessarily hit the mark as they would if more time had been taken.

Time, as you correctly point out, is not the friend of small businesses that are struggling or families that are struggling. I would only repeat what the Minister of Finance said. This is seriously under consideration. We are anticipating a budget at some point — and I'm afraid I don't know the date, so can't share it. I think Canadians can expect that the budget will contain measures that will continue to help Canadians and businesses get through this difficult time.

[Senator Martin]

DELAYED ANSWER TO ORAL QUESTION

(For text of Delayed Answer, see Appendix, p. 926.)

POINT OF ORDER

Hon. Yonah Martin (Deputy Leader of the Opposition): I'm not asking for a ruling because I think not it's in the rules, but during Question Period, we, by tradition, do not raise questions about items that are on the Order Paper because we can deal with them, especially if they relate to government legislation.

In the case of the question from Senator Forest regarding Bill C-7, I was wondering whether, in terms of what we have done in the past, that we would reserve such questions for the debate of that bill rather than taking up limited time during Question Period.

That was just a point of order I wish to raise and whether you wish to comment on that or not. Thank you.

The Hon. the Speaker pro tempore: Thank you, Senator Martin, for raising that issue.

It is true tradition dictates that during Question Period we don't ask questions that are related to an issue that's on the Order Paper, especially at this time when the discussion is quite focused on Bill C-7.

However, it is against the rules to make a statement pertaining to an issue during Senators' Statements and not during Question Period. But I do respect your point of order, and I hope that senators will keep the tradition alive and keep their questions regarding issues on the Order Paper for debate during that particular issue.

ORDERS OF THE DAY

BUSINESS OF THE SENATE

The Hon. the Speaker pro tempore: Honourable senators, before we resume debate on Bill C-7, let me remind you that we are dealing with the bill by theme. Yesterday we dealt with the theme of mental illness and degenerative illness. I understand that that debate is concluded, so we can proceed with the next theme.

Today we will therefore start debating issues relating to safeguards and advance requests. As you know, speeches and amendments are to only deal with that theme. A senator can speak only once to the third reading motion during debate on this theme, but can also speak once to any amendment or subamendment moved.

A speech on the main motion for third reading is limited to 10 minutes, but if the senator provided an amendment before 5 p.m. yesterday and intends to move it, the speaking time is extended to 15 minutes. The speaking time for amendments and subamendments is 6 minutes.

If there is a request for a standing vote the bells will ring for 15 minutes, and the vote cannot be deferred. Any whip or liaison may, however, extend the time for the bells to 30 minutes.

Once debate on the theme concludes — either today or at a subsequent sitting — debate on the next theme can begin. It is not possible to revert to an earlier theme.

Let me thank you once again, senators, for your cooperation.

CRIMINAL CODE

BILL TO AMEND—THIRD READING—DEBATE

On the Order:

Resuming debate on the motion of the Honourable Senator Petitcher, seconded by the Honourable Senator Gold, P.C., for the third reading of Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), as amended.

Hon. Donald Neil Plett (Leader of the Opposition): I do have an amendment at the end of my speech.

Honourable senators, I rise today to bring forward an amendment that I hope will alleviate some of the concerns raised by the disability community, specifically about the coercion of vulnerable patients to accept physician induced death.

Given the well-established power imbalance in the doctor-patient relationship and the intensification of that imbalance when the patient is vulnerable, patients have often felt pressured to accept assisted suicide when it has been suggested to them.

Dr. Ramona Coelho testified at committee, as a family doctor with many vulnerable and impoverished patients. She asserted that Bill C-7 must include a provision that MAID conversations be patient-led. She told the committee:

When you're faced with loss of function, denied essential supports, living in poverty, things can be overwhelming for all of us. There is a subtle kind of coercion that can take advantage of such a patient's state, signalling to them that they are better off dead.

Dr. Ramona Coelho gave poignant examples of the sacred and unquestioning trust vulnerable patients can have in their physicians, and cautioned against exposing this vulnerability to an end-of-life situation.

She asked us, out of respect for these patients, for clarity in the bill in terms of bringing up MAID.

Dr. Catherine Ferrier raised a similar concern when she testified at committee, stating:

I would also make it illegal to suggest it to anybody ever, and that includes just listing it as one of the options. Because, as health professionals, we have a power differential. What we raise as an option is often understood as a recommendation, even if we don't intend it that way.

Dr. Leonie Herx, in response to the notion that MAID should be introduced alongside other medical options, stated:

But MAID is not just another option. It is irreversible. It has significant ethical and professional implications. If a doctor introduces MAID, this may be all the push that is needed to nudge a person to pursue it.

This amendment was also a direct request from the Council of Canadians with Disabilities, the Canadian Society of Palliative Care Physicians, Siksika Nation and many other physicians and organizations.

• (1500)

What is the problem, one might ask, with a patient being presented with all the options? In many cases, probably nothing. However, this fear is not a hypothetical one. We know this has happened with extremely vulnerable patients. We know that many have been offered death repeatedly when they have demonstrated absolutely no interest.

When the result of this pressure could be death, we must act. By now I am sure we have all heard the story of Roger Foley, a man from London, Ontario, who has been diagnosed with a neurological disorder that limits his ability to move his arms and legs. While in the hospital for years, he repeatedly asked for help in finding adequate assisted home care. Instead, he was offered assisted suicide on at least four occasions by medical practitioners, although he demonstrated no interest in dying. He recorded one such incident, which received widespread media attention. This incident even caught the attention of the UN Special Rapporteur on the rights of persons with disabilities, who ultimately wrote a strongly worded letter expressing great concern and strong recommendations for Canada. We now know that the concern of the UN on this issue has only grown.

When I raised this with the Honourable Carla Qualtrough, the minister for disability inclusion, she acknowledged the power imbalance and agreed that it is problematic for a physician to raise the option of an assisted suicide with a patient who has demonstrated no interest. When I asked her specifically about Roger Foley, she said:

I have grave concerns with the particular circumstances of the individual that you spoke of. Quite frankly, I can tell you, he is not alone. I regularly hear from families who are appalled by the fact that they take their child, potentially their older child and are offered unprovoked MAID. I think that has to stop.

She also expressed a willingness to consider the amendment I am proposing today, which I consider a win for the disability community.

The minister is correct: Roger Foley is not alone. At committee, Krista Carr from Inclusion Canada referenced many examples of documented MAID coercion. Last week, when Jonathan Marchand testified at the committee, he explained that after he ended up in intensive care and was given an emergency procedure to help him breathe with the assistance of a ventilator, he was told that he would require 24-hour-a-day care. He said:

Unable to speak, several doctors pressured me to accept euthanasia, "comfort care" as they called it, to end my life. I never asked for this.

Colleagues, this is heartbreaking and disturbing, and I hope we are all taking note.

Senator Dalphond pointed out earlier this week that Jonathan Marchand was finally given home care after his Senate committee appearance, and that he was no longer committed to a hospital room for the rest of his life. I truly could not be happier for Mr. Marchand. However, I frankly think it is a tragedy that it took an appearance before a federal parliamentary committee for Mr. Marchand to be heard and seen. He was occupying a space, honourable senators, in front of the National Assembly in Quebec for five days and nights a week to protest what he deemed to be his incarceration. It provides me no comfort that his life became a public relations issue and that action was finally taken. What happens to every other Canadian living with disability or chronic illness who does not have the opportunity to appear before a televised parliamentary committee? I think Mr. Marchand's letter to Senator Dalphond after he raised this question should put to rest any idea that his concerns have been alleviated or that his life has become any easier.

Honourable senators, the fact that several doctors offered Mr. Marchand death when he was in the depths of despair is something that should cause us all great discomfort. Other jurisdictions have acknowledged this power imbalance and the risk of coercion that exists when physicians are offering assisted suicide to a vulnerable patient who has made no such request. Victoria, Australia, for example, enshrined the requirement I am proposing today into their legislation. That discussion around assisted suicide must be patient-led.

I want to thank the many Indigenous groups and leaders for their important advocacy on this issue. I want to quote one part of their letter we received today stating:

Our population is vulnerable to discrimination and coercion in the health care system and should be protected against unsolicited council regarding MAID. These civil measures should extend to all Canadians.

Colleagues, the rationale is clear. However, let me explain the particular wording drafted by the law clerk's office and agreed to by stakeholders, physicians and medical doctors we have been working with, as I will not have a final reply to any technical concerns raised given the format of our debate.

The first clause can seem far too broad if read on its own, and I had questions about this myself when I first received the draft. However, the law clerk's office assured me that in federal legislation, the rule and the exception are traditionally separated as they have been here. The clauses will be read together by anyone responsible for interpreting them. The first clause prohibits a medical practitioner from providing information to a patient who has a grievous, irremediable medical condition. The second clause nullifies this first clause if the patient requests any information about MAID. Colleagues, this will achieve the desired effect, which is that a physician cannot offer MAID to a patient who has not requested it while remaining consistent with federal law.

A similar amendment was proposed in the House of Commons. However, that amendment was punishable by indictment, which was concerning to some, and, perhaps, justifiably so. We have ensured with this proposal that any physician who violates this prohibition would only face a summary conviction.

Why impose a penalty at all? Without a penalty there is no enforceability. There are no teeth, no real protection. One only needs to look at the "for greater certainty" clause with respect to conscience rights in Bill C-14. It may have indicated Parliament's wishes, however, provinces can and have legislated around this clause. Unfortunately, it was not enforceable. We want to avoid the same pitfall here. The effect of this clause is that vulnerable patients will be protected from coercion, whether subtle or overt, real or perceived, from a physician or practitioner.

We already know the message that Bill C-7 is sending to the disability community, as David Shannon, an Ontario lawyer living with a disability, said in an article:

I want equality in my world and in my place in Canada. How will I ever be equal if people think I should be dead? Over 6.2 million Canadians (22 per cent of the population) have a disability. Should the shining beacon of their lives and the love they give be snuffed out? Life stories lost like tears in the rain.

I know none of us, not even the strongest proponents of this legislation, want to send this message to those living with a disability. However, this is the message that is being heard loud and clear. Let's make sure this is not the message they hear in their doctors' offices. If we protect vulnerable patients from undue pressure or coercion, we can prevent unnecessary death. Let's not let the gravity of that be lost on us. It's my hope that we can all support this balanced approach to ensure access is not impeded for those who request it, and that we can avoid the horrific pressure experienced by vulnerable Canadians, especially as this regime is radically expanded. With this amendment we will ensure that never again when a patient asks for help, a lifeline or a chance at a hopeful future, will a physician respond by offering them death instead.

MOTION IN AMENDMENT NEGATIVED

Hon. Donald Neil Plett: Therefore, honourable senators, in amendment, I move:

That Bill C-7, as amended, be not now read a third time, but that it be further amended on page 7 by adding the following after line 30:

“1.1 The Act is amended by adding the following after section 241.2:

241.21 (1) A medical practitioner or nurse practitioner who provides information on medical assistance in dying to a person who has a grievous and irremediable medical condition is guilty of an offence punishable on summary conviction.

(2) Subsection (1) does not apply if the information provided on medical assistance in dying was requested by that person.”.

Thank you, honourable senators.

• (1510)

The Hon. the Speaker pro tempore: Senator Plett, we have some senators who have some questions for you.

Hon. Frances Lankin: Senator Plett, would you accept a question?

Senator Plett: Yes. I will.

Senator Lankin: Thank you very much. I am pleased with the changes that you have brought forward to what was considered in the House of Commons. I'm not completely convinced of how I will vote at this point in time. There are a couple of things, and these are technical and I would like a technical response to it.

I think you know from previous interventions in this debate that I have a lot of questions about federal-provincial jurisdiction and how these two approaches interact with each other, or two jurisdictional responsibilities interact with each other. In this case, it seems to me that the requirements of the ethical codes of the colleges for health care professionals that are involved in the MAID teams — the ethics that are set out, the guidelines that are set out, the implementation by the provinces — all of this that you're suggesting really falls within that provincial jurisdiction, although I understand completely why you're looking for a pan-Canadian response.

The other question I want to pose to you, and it was an interesting one — and a conversation I was in with some others in the chamber or on our hybrid chamber as well — are you not suggesting that physicians or nurses or others who are involved in this process are unable to communicate options, which in this case, as a result of Supreme Court rulings are, in fact, individual rights, and the bill and the changes in the Criminal Code are about individual autonomy? These two things worry me. First, the federal-provincial jurisdiction, if you could comment on that. Second, I understand that we don't want coercion, but how do people get information if they are unaware of this option? Thank you, I'm done.

The Hon. the Speaker pro tempore: Unfortunately, the 15 minutes have expired.

Hon. Marc Gold (Government Representative in the Senate): Thank you, honourable senators. I'm not going to be voting for this amendment. I'd like to take a few minutes to explain why. I do understand the very legitimate concerns expressed by Senator Plett's amendment. I recognize and, indeed, the committee heard accounts of persons with disabilities being offered MAID despite wanting to be treated and to continue living. I recognize further that offering MAID to a person who wants all available treatments pursued may cause that person to lose confidence in their practitioner, or may harm their own perception of themselves, and may even influence them to seek a death they might not otherwise have wanted.

But this amendment is neither necessary to protect the patient, nor in the judgment of the government desirable as a matter of law or policy. First of all, it's not necessary. The eligibility criteria in our law offers protection against persons receiving MAID if that is not, in fact, their genuine desire. A person must give their informed consent under section 241.2(1)(e), and the medical staff or nurse practitioner must inform the person that they may withdraw their consent at any time. And indeed, it remains a crime to encourage a person to die by suicide or by MAID even for practitioners. A practitioner who provides MAID to a person while knowing that they were pressured into it would face criminal prosecution under the current law.

Second, as noted by Senator Lankin in her question, the oversight of the conduct of health care providers — including whether there has been an inappropriate exercise of their clinical judgment or their treatment towards patients — is within the exclusive legislative jurisdiction of the provinces and is the responsibility of the professional regulatory bodies under provincial jurisdiction.

To quote just one witness that we heard, Fleur-Ange Lefebvre, the Executive Director and CEO of the Federation of Medical Regulatory Authorities of Canada:

FMRAC maintains that issues related to physician conscience remain matters of provincial and territorial jurisdiction. We submit that the responsibility to direct physicians as to their responsibilities vis-à-vis patients requesting MAID, when conflicted by conscience, should remain with the physician's respective medical regulatory authority.

Not only is it not necessary, honourable colleagues, it's not desirable in terms of law or policy. First, let us not forget that access to MAID is a constitutional right that's recognized by our courts, grounded in our rights to personal autonomy, and all legislative responses, whether federal or provincial, must keep that clearly in mind. And in this regard, we must also keep in mind the duty of health care professionals. They have a professional obligation to inform patients of all options available to them. Here is what we heard from some witnesses during our committee study.

[Translation]

I will start with Sylvain Le May, from the welcoming and support services for students with disabilities at the Université du Québec à Montréal, who said, and I quote:

People with disabilities who are living with intolerable suffering will not be better served if the government were to criminalize the option to receive MAID from a health care professional. If the government were to prohibit this assistance, these people would not have the opportunity to have their desire to die taken seriously. Listen, different options should be discussed and considered, including medical assistance in dying.

End-of-life care, including MAID, is part of the continuum of care.

[English]

Dr. Chantal Perrot, a MAID assessor and provider in Toronto who testified at committee, added in her written brief to the committee:

The legality of and right to MAiD is still not well-known by many Canadians. Requiring people to raise a subject they do not know about is ludicrous and punitive, effectively denying MAiD to many people. Medical practitioners should be not only able, but required to inform their patients of the existence of legal MAiD in Canada and their right to an assessment, without fear of being accused of a criminal act.

Furthermore, honourable colleagues, the proposed amendment would have a negative and chilling effect on health care professionals. The effect of exposing them to the risk of potential criminal liability for giving information might inhibit them from doing what their professional obligation and professional codes require them to do. In this respect, putting some of these considerations together, colleagues, the amendment is an inappropriate and, indeed, possibly even an unconstitutional overreach in use of Parliament's criminal law power under the Constitution. It reaches to the core of exclusive provincial jurisdiction with no clear compelling criminal law purpose to ground it in Parliament's criminal law power under section 91.27 of the Constitution Act, 1867.

Now, I try to be modest when I talk about the Constitution. I take very seriously what many senators have said in this chamber about not using it as a club to stifle debate, and I've tried to do that throughout my whole career in the Senate. So if it's not clearly unconstitutional — and I'm not saying that it is — it is most certainly, in my judgment, an inappropriate use of the criminal law power, given that this falls so closely within provincial legislative power.

To conclude, it is neither necessary nor desirable. I will be voting against it. Thank you.

The Hon. the Speaker pro tempore: Before we move on to the next senator, I would like to state that for senators who are with us by video conference, many of you have your hand raised. If it's on the issue of a previous question to a senator, then please remove your raised hand.

[Senator Gold]

• (1520)

Hon. Mohamed-Iqbal Ravalia: Honourable senators, I rise today to speak to this amendment from the perspective of my experience as a rural family physician.

As we're aware, Canada's MAID regime was developed as a direct result of the Supreme Court of Canada's 2015 decision in *Carter*. Prior to this ruling, any medical and nurse practitioners who provided or assisted with what we now classify as MAID were guilty of an indictable offence punishable by up to 14 years' imprisonment.

The bill that is before us today is a result of a second court decision that struck down the reasonable foreseeability of natural death as an eligibility criterion in the Criminal Code, as well as an eligibility criterion in Quebec's Act Respecting End-of-Life Care providing that the person must be at the end of life. Once again, the court found these criteria violated section 7 of the Charter.

The Charter is intended to protect the most fundamental and essential rights of all Canadians. Our courts have consistently ruled that because of the Charter, Canadians may not be prohibited from accessing medical assistance in dying. It is important to remember that our debate today takes place in that context.

Honourable colleagues, in my experience as a family physician, the free flow of information was critical to the relationships I developed over time with my patients. Patients rely on their medical practitioners, as my patients relied on me, to be the ones with the training, professional judgment and integrity to provide them with all the information that was available. They trusted me to offer the best possible ranges of treatment options to suit their unique circumstances. Patient centredness was the core of my practice.

The simple and devastating reality is that there are circumstances in which a patient is in such pain and suffering that accessing care to peacefully end the patient's life, on the patient's own terms, may well be the only option out of a range of agonizing choices. It is not about coercion or cajoling. The availability of medical assistance in dying is a crucial part of my daily practice.

From a clinical perspective, patients seeking access to MAID likely have a range of factors that would interfere with their ability to become properly informed. That person is likely elderly, and certainly suffering from a grievous and irremediable condition that is likely causing them considerable and frequent pain. That person's condition is likely interfering, at least to a degree, with their ability to carry out day-to-day activities; and they are on some medications that may bring with them side effects.

In such circumstances, asking a patient to locate their own informational resources regarding MAID and sort the reliable from unreliable sources may well be beyond the abilities of many of these individuals.

Canadians living in rural communities and remote areas are likely to face even greater obstacles than their urban counterparts, as rural communities tend to have less reliable internet access, resources, support services and consistency of care.

If this amendment is adopted, the patient's medical providers would not be able to maintain a relationship based on the free flow of information and reliance on professional judgment. The patient's medical or nurse practitioner would face imprisonment simply for providing information about a procedure that the Supreme Court of Canada has ruled Canadians must be given access to.

As I mentioned in my third reading speech, we must ensure that physicians and nurse practitioners have a practical and feasible pathway to ensure that they are fully able to address their patients' suffering or intolerable pain, with medical assistance in dying being one — one — of a range of options.

In Newfoundland and Labrador, our regional health authorities play a central role in the coordination of MAID, including supporting patients and providers who need assistance in navigating the service. For medical practitioners who do not support MAID, they are required to refer them appropriately.

Honourable senators, providing information to a patient is an essential component of any medical treatment sanctioned by medical regulation and is critical to ensuring that Canadians can access the care that they deserve. Medical and nurse practitioners must be free to ensure that they can provide appropriate, reliable information without fear of penalty.

On this basis, I oppose this amendment. Thank you.
Meegwetich.

Hon. Pierre J. Dalphond: Honourable senators, I will speak in opposition to the motion, but from a slightly different perspective. Senator Ravalia is a doctor; I'm going to speak based on my previous life experience where I was called to read and interpret many provisions of the Criminal Code. Thank you to Senator Plett for providing me an opportunity to go back to my old job.

I have the wording in my hands. What is before us will be a new section 241.21, which is made of two paragraphs. One outlines the principle, and the second paragraph provides the exception to the offence which is created in the first paragraph.

Let's read the first paragraph: "A medical practitioner or nurse practitioner who provides information . . . is guilty of an offence punishable on summary conviction."

What are the elements of the offence? First, you have to be a medical practitioner or a nurse practitioner. Both expressions are defined in the Criminal Code in the sections dealing with MAID in section 241.1. Who is a medical practitioner? Well, it is a doctor ". . . entitled to practise medicine under the laws of a province." Who is a nurse practitioner? Well, it is:

" . . . a registered nurse who, under the laws of a province, is entitled to practise as a nurse practitioner . . . make diagnoses . . . prescribe substances . . . "

These provisions target two groups of people, those I have just mentioned. These provisions will not target psychologists, assistant nurses or all the staff working in the hospitals providing the daily care like helping you go to the washroom, helping you to have a bath or shower, providing you a meal or something else. So it's very narrow in scope.

When I look at the story that Senator Plett referred to, that of Roger Foley, and I read the reports in the paper that he recorded the conversations with two men, neither of them is a nurse or doctor. One is most likely an accountant in the hospital, because he told Mr. Foley that if he continued staying at the hospital, he would be charged \$1,800 a day. That doesn't sound like a nurse talking. I assume that was someone in charge of the administration. That person said if Mr. Foley didn't want to pay this, maybe he should consider options, including MAID. That person would not be covered by this provision. That person is an administrative staffer at the hospital.

That's the first part of the principles that are being proposed to us.

The second part of the principle is that if you are found guilty, you will be punishable on summary conviction. You will remember that about a year and a half ago we amended the Criminal Code to change the penalty of what summary conviction means unless there is something specific. Here, nothing specific is provided, therefore the general rule will apply: two years maximum in jail, a \$5,000 fine, or both.

If one of the persons targeted, a medical practitioner or a nurse practitioner, is found guilty, that person would be found guilty of a criminal charge. As you know, a doctor found guilty of a criminal charge will have to face disciplinary proceedings and most likely would be expelled from the profession.

What is being proposed here is more or less capital punishment for doctors.

Now let's look at the second paragraph, the principle: "Subsection (1) does not apply if the information provided . . . was requested by that person." It says "person," but it must be a patient because it's in a medical relationship. The exception to the infraction, then, is when the information is provided because it was requested by the patient.

• (1530)

Take the following example: we have a patient in a palliative care centre who knows that he's nearing death. He's in the palliative centre because, unfortunately, his death is imminent. Imagine that this patient is suffering unbearably. He can't take it anymore. One of these days, maybe once a day, once a week, the doctor comes to his room to talk with him. He says to the doctor, "I can't bear it anymore. I've already been here for a week or two. I know I'm near death. I can't take it anymore. Is there something you can do until God takes me away?"

The doctor can only answer that question by saying, "Well, one of the options, Mr. Dalphond, because you are suffering unbearably, is to offer you continuous palliative sedation. That will put you in a kind of coma. You will no longer suffer because you will no longer feel the suffering." But he cannot say more.

He cannot say, “Well, there’s another option. Continuous palliative sedation will put you in a coma, but MAID could put an end to it while you are conscious.”

The Hon. the Speaker pro tempore: I am sorry, Senator Dalphond. Your time has expired.

Hon. Salma Ataullahjan: Honourable senators, I rise today to speak on Bill C-7 and to Senator Plett’s amendment that ensures that every conversation regarding medical assistance in dying is always patient-initiated.

The reason for my support is simple: nobody should be recommending medical assistance in dying to anybody. This amendment ensures that only the patient can start the conversation on MAID, and only then can this life-ending procedure be discussed.

The Senate’s Legal Committee heard considerable testimony from witnesses who supported patient-led conversations. Colleagues, we’ve heard from Roger Foley, and we just heard Senator Dalphond speak of him. Unfortunately and sadly, we heard so many similar stories that highlight the inadequacy of our medical care system. If not addressed, I fear MAID may become a convenient alternative to inadequate care.

In addition to our lagging medical care system, a disturbing reality was brought to our attention at the Legal Committee — ableism. A growing trend of ableist thinking has contributed to the expansion of MAID. Ableism has become so pervasive in society that many do not recognize it or acknowledge it as a concern. Thus, ableism is still embedded in our social structure. We need to identify it and work systematically to eliminate it.

If we are determined to go down the road of making medical assistance in dying readily accessible to those whose death is not reasonably foreseeable, then the least we can do is to prevent primary caregivers and medical professionals from initiating this conversation.

The will to live is inherently built within all of us. In our moment of weakness, we rely on our loved ones and primary care providers for guidance. We also trust medical professionals to improve our quality of life and longevity.

Despite the limited amount of time spent with a doctor discussing one’s medical condition, a significant power differential exists. The impact of this relationship can induce involuntary decisions, especially during moments of weakness.

[Senator Dalphond]

The power imbalance between a doctor and a patient diminishes the autonomy of the patient. Additionally, not all medical professionals are equal. We have heard stories from patients who were coerced into MAID before alternative medical measures were exhausted.

Also, we should not rely on the assumption that every health professional abides by the ethical and moral standards that are expected of them. If we are aiming to prevent, or at the very least minimize error and abuse while protecting the autonomy of our most vulnerable, then this amendment serves this purpose. Thank you.

Some Hon. Senators: Hear, hear.

[Translation]

Hon. Marie-Françoise Mégie: Honourable senators, today I rise to oppose the amendment proposed by the Honourable Senator Plett. If this amendment passes, it will be a major step back for our society. Why criminalize health professionals when their practices are already regulated by federal and provincial law? Each of these professions has a code of ethics enshrined in provincial law. Section 14 of the code of ethics of the Collège des médecins du Québec clearly states, and I quote:

A physician must promote measures of education and information in the field in which he practises.

Section 40 of the code of ethics of the Ordre des infirmières et infirmiers du Québec states, and I quote:

A nurse shall provide her or his client with all the explanations necessary for the client’s comprehension of the care, treatment or other professional services being provided to him or her by the nurse.

MAID isn’t something that is offered. It is a request made by the patient, which means that the patient must be well informed. I want to stress the point that the patient’s right to make a free and informed decision includes the right to receive accurate, understandable information about their health.

I hope to make senators understand that we need to carefully consider the consequences of making something that doctors and nurse practitioners do as part of their practice a criminal offence under the law. Doctors and nurses are already under a fair bit of stress, and there is no reason for us to also hang the sword of Damocles over their heads. That is unnecessary and harmful to the free practice of medicine in our country.

We must preserve the sacred trust between caregivers and patients, particularly when it comes to obtaining free and informed consent on something as irrevocable as medical assistance in dying. This amendment could undermine that essential trust and place undue stress on eligible individuals and their loved ones. Section 18 of the code of ethics of the Collège des médecins du Québec states, and I quote:

A physician must seek to establish and maintain with his patient a relationship of mutual trust and refrain from practising his profession in an impersonal manner.

Section 28 of the code of ethics of the Ordre des infirmières et infirmiers du Québec states, and I quote:

A nurse shall seek to establish and maintain a relationship of trust with her or his client.

Professionals must always perform their duties honourably. I respect my honourable colleague's choice to oppose any practice involving MAID for his own personal reasons. However, I cannot support his efforts to unfairly criminalize our health care professionals. In closing, I want to share a story that I found very interesting entitled "Pastor uses medical assistance to die." You can find it on the *Canadian Mennonite* website. When the pastor requested MAID, medical staff at the hospital suggested that he stop eating. The pastor was later informed that he qualified for MAID, that it was a legal option for him. He therefore asked to be transferred to another hospital that had agreed to administer it.

Which do you think is better: a doctor who suggests patients starve themselves to death, or one who provides patients with information about medical assistance in dying? Which of those two professionals should be convicted of an offence? I ask you to reflect on that question. Honourable colleagues, I hope you will vote against this amendment. Thank you.

[English]

Hon. Mary Jane McCallum: Honourable senators, I rise today to speak on Senator Plett's amendment to Bill C-7. I, too, am concerned about where this debate is going. It is not going in the direction that First Nations and the disability community want it to go.

I've worked on reserve as a health professional for over 30 years. In January 2021, I went to my home reserve to provide service at a dental clinic. On my travel there, I spoke to many nurses and doctors regarding MAID. Many were unaware of this bill, just as they were unaware of Bill C-14.

How, then, can senators evaluate the level of capacity assessment work that will be required? How can they assess it on behalf of medical professionals? It's not for senators to determine and decide this for themselves. This is a determination to be made by the medical professionals. Moreover, it's not only the medical professionals from whom people seek advice. They access information from the internet and other questionable sources. We are placing health professionals in a very precarious position without their informed consent, and patients likewise.

• (1540)

It has been stated that there exists the issue of ensuring an appropriate number of health professionals who provide care, namely, the doctors and nurses. When you look at safeguards, there is difficulty with ensuring that First Nations in remote communities have a single medical doctor, let alone two. The medical doctors and nurse practitioners come into the communities for two days every other week and they rotate. The nurses are the main health professionals and they are rotated through the communities from different areas of Canada and through different contracts.

To be able to have a conversation with patients regarding MAID, you need to have trust in your health care provider who understands the historical context of oppression. This takes years to establish and is especially true in First Nations communities. The health professional has to understand the language of the patient, and many don't. Under the current system, this is impossible. Many patients are unable to write, let alone fully understand the nuances on concepts of MAID.

Ethics is an area that cannot be regulated by law. You either have it or you don't. It's not something you bring to the table and say: We're going to practice ethics now. In my previous management position, I saw health professionals flying under the radar with their codes of conduct. The problem of oversight by regulatory bodies on self-regulating groups is inadequate and there is research with this.

Professional obligation is not always practiced, especially when many doctors are told to give 10-minute appointments and only four appointments per year. This is the reality in First Nations communities today. I know because I have raised that with hospitals. Once again, we hit the gap that is created by the interjurisdictional problem that First Nations have experienced through other laws passed by the Senate. In this situation, it places patients and health professionals in a gap that sees no resolution.

We have heard from people whose voices need to be heard. As a medical doctor wrote to me this week:

We spend a lot of time and energy working toward suicide prevention. However, now it seems we are sending a message to disabled and dying Canadians that says we agree with you, your life isn't worth living. So we won't try to stop you from killing yourself. Instead, we will help you end your life. Why is access to MAID a right that every Canadian should have to the point that doctors are being threatened against their consciences to provide access to it? However, we don't put that same energy into ensuring everyone has access to palliative care or mental health services. Most people don't actually choose MAID because of inadequate pain control. Most choose MAID due to fear of losing autonomy and because they aren't able to engage in activities they find enjoyable due to loss of dignity and feeling like a burden on family.

These are primarily mental health issues that shouldn't be solved by helping someone commit suicide. These burdensome fears can be lightened by coming alongside patients to support them, advocate for them, encourage them and help them to shift their focus. I encourage you to look at the research on dignity therapy by Harvey Chochinov, which speaks to this.

Generally, a desire to die is a cry for help and is transient. If we loosen the safeguards on criteria, we will be losing too many people who, with a little support, could have gone on to enjoy fulfilling lives. MAID unfortunately does not just impact the person who chooses it but also has wide-reaching effects for the person's family, friends and their community.

I know that this is not an easy issue but I implore you, please do not continue to expand criteria for MAID or loosen the safeguards already in place. I know I speak on behalf of many of my patients, family friends who feel the same way. Thank you.

Hon. Stan Kutcher: Honourable senators, I rise today to speak to the proposed amendment as a physician and teacher of physicians. Let me begin by saying that I respectfully oppose.

In my opinion, it attacks the most fundamental aspect of the delivery of health care — that inviolate and confidential space that is the communication between the person who suffers and seeks care and the person who provides that care. This is a space of respect, compassion and trust. We interfere with that space not only at our peril by criminalizing it, but with the possibility of violating it for every Canadian who finds themselves in a position of intolerable suffering. This space should not be invaded by an amendment to the Criminal Code that threatens clinicians with jail time of two years less a day if they do not comply.

The meaning of the word “patient” in the English language is “one who suffers.” The role of the health care provider vis-à-vis the suffering has included and continues to include one which promotes comfort and shares with the patient what remedies might be available to them while respecting the autonomy of the patient.

This does not mean that the clinician should impose their own values. This does not mean that the clinician should bully or otherwise induce a patient to accept a remedy that the patient does not wish. This does mean, however, that the clinician should not hide, conceal or neglect to inform the patient about the range of remedies that they could consider as a potential intervention to alleviate suffering.

It is incumbent on a clinician to discuss the pros and cons of each potential remedy with their patient. The clinician must acknowledge and accept the patient’s suffering, realizing it isn’t a personal experience and it is not for them to judge, invalidate or negate.

When the patient’s suffering is intolerable and the patient has made this known to the clinician, it is then incumbent on the clinician to respectfully inform their patient of the options available that could be considered for relief of that suffering. In Canada, in 2021, this may include MAID. This is the principle of patient-centred care. Patient-centred care runs in direct contradiction to historic practices founded on paternalism, where the clinician knows what is best for the patient and where the clinician’s values define what is best, even if the patient does not share those values.

On a practical level, this amendment will harm patients who are experiencing intolerable suffering and do not know that MAID is available. Let me be clear: This does not mean that they will choose or receive MAID, it means that they will get information about MAID.

We know that the clinician-patient relationship is characterized by a power imbalance. A clinician should never attempt to coerce a patient to accept an intervention that is not acceptable, but

neither should they hide information from their patient just because they disagree with that intervention. It is not for the clinician to choose which intervention the patient could consider. It is incumbent on the clinician not to deny information that the patient needs to have in order to make that choice.

This power imbalance can be far-reaching. In addition to patients who experience intolerable suffering but do not know about MAID, there are those who may feel they will be abandoned, stigmatized or shamed by their clinician if they ask about something that they think their clinician objects to. This will effectively deny them the exercise of their right to consider MAID as an option.

This amendment would make punishable by a summary offence a clinician respecting the patient’s constitutional right to receive information from their trusted health care provider that they could consider in terms of their own decision making. We’re not talking about a clinician providing MAID here. This is the issue of a clinician respecting the right of a patient to information.

This amendment can put an onerous and unnecessary burden on the clinician. What counts as requested? Does the exception to criminal liability only apply if the patient says explicitly, “Give me information on MAID?” What if the patient says, “I’m suffering intolerably. Is there anything we have not yet discussed that I could consider as a means to alleviate this terrible situation?”

• (1550)

In short, this amendment raises the spectre of jail time for ethically practising providers and turns the contemporary practice of patient-centred care on its historical head. It promotes a paternalistic “I know what is best for you” perspective. In doing so, it denies persons with intolerable suffering equality of access to legitimate and legally recognized interventions that they could consider should they wish to do so.

Please let us not force patients to accept what we think they should know about or what we think they should be kept in the dark about. Please vote against this amendment.

Thank you, *meegwetch*.

[*Translation*]

Hon. Renée Dupuis: Honourable senators, I would like to share my reasons for voting against this amendment. I believe that the way the amendment is drafted is too broad. “Provides information” is far too vague. When it says, “provides information on medical assistance in dying to a person who has a grievous and irremediable medical condition” or “provides information . . . to a person,” it does not specify the context in which that information would be provided. For example, in a seniors’ residence, there is a community group of residents that organizes information sessions on medical assistance in dying. Could there be people in attendance who suffer from grievous and irremediable medical conditions? Maybe they are not experiencing intolerable suffering. I think the amendment is far too vague. Let’s not forget the criminal law context. This

amendment runs the risk of short-circuiting the real effort being made by the physicians' colleges in each province to enforce ethical standards.

I will conclude by saying that the power dynamic between patient and physician does exist; there really is a power dynamic. It has evolved, and let's hope it continues to evolve. However, as patients, our expectation today is that a physician who can't heal us will inform us of all existing reasonable means to ease our suffering. I don't think we can presume that patients know the full range or details of these means. Thank you.

The Hon. the Speaker pro tempore: Senator Miville-Dechêne, I see that your virtual hand is raised. Do you wish to debate the amendment?

Hon. Julie Miville-Dechêne: I wanted to come back to one part of the amendment presented in Senator Plett's speech. I believe he referred to the law passed by Victoria, Australia, on medical assistance in dying. He stated that this law prohibits a physician from starting the conversation on MAID, and he is right on that point.

However, like Senator Dupuis, I want to look at the details of what the law says. I will therefore quote part of the Victoria law. For a physician to initiate discussion about medical assistance in dying with their patient:

[*English*]

. . . is to be regarded as unprofessional conduct within the meaning and for the purposes of the Health Practitioner Regulation National Law.

[*Translation*]

However, this law is certainly not in the Criminal Code. It is the equivalent of a professional regulation that would be found in provincial legislation here in Canada.

I would like to close by saying that, like others, I find it very difficult to imagine that a doctor could start this conversation. I understand that circumstances can vary, and I think it is difficult to shed light on these kinds of private conversations and, especially, to criminalize this kind of conduct. However, I have a hard time grasping that a doctor could start this conversation. This must happen only in very, very rare cases. Thank you.

[*English*]

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

Hon. Senators: Question.

The Hon. the Speaker pro tempore: All those opposed to the motion in amendment will please say "nay."

Some Hon. Senators: Nay.

The Hon. the Speaker pro tempore: All those in favour of the motion who are in the Senate Chamber will please say, "yea."

Some Hon. Senators: Yea.

The Hon. the Speaker pro tempore: All those opposed to the motion who are in the Senate Chamber will please say, "nay."

Some Hon. Senators: Nay.

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

And two honourable senators having risen:

The Hon. the Speaker pro tempore: We will have a 15-minute bell. The vote will take place at 4:11.

Call in the senators.

• (1610)

Motion in amendment of the Honourable Senator Plett negated on the following division:

YEAS THE HONOURABLE SENATORS

Ataullahjan	Martin
Batters	McCallum
Boisvenu	Mockler
Christmas	Ngo
Griffin	Oh
Housakos	Plett
Jaffer	Poirier
MacDonald	Smith
Marshall	Wells—18

NAYS THE HONOURABLE SENATORS

Anderson	Greene
Bellemare	Harder
Bernard	Hartling
Black (<i>Alberta</i>)	Keating
Black (<i>Ontario</i>)	Klyne
Boehm	Kutcher
Boniface	LaBoucane-Benson
Bovey	Lankin
Boyer	Loffreda
Brazeau	Lovelace Nicholas
Busson	Marwah
Carignan	McPhedran
Cordy	Mégie
Cormier	Mercer
Cotter	Miville-Dechêne
Coyle	Moncion
Dagenais	Moodie
Dalphond	Munson
Dawson	Omidvar

Deacon (<i>Nova Scotia</i>)	Pate
Deacon (<i>Ontario</i>)	Patterson
Dean	Petitsclerc
Downe	Ravalia
Duffy	Saint-Germain
Duncan	Seidman
Dupuis	Simons
Forest	Stewart Olsen
Forest-Niesing	Tannas
Francis	Verner
Frum	Wallin
Gagné	Wetston
Galvez	White
Gold	Woo—66

ABSTENTION THE HONOURABLE SENATOR

Manning—1

• (1620)

Hon. Fabian Manning: Your Honour, I would like a moment to explain my vote.

The Hon. the Speaker pro tempore: Go ahead, Senator Manning.

Senator Manning: I decided to abstain from the vote as I have done in previous votes. I don't believe in medical assistance in dying, period. I have some serious concerns with it, and that's why I voted the way I did. Thank you.

The Hon. the Speaker pro tempore: Thank you. Resuming debate.

Hon. Pamela Wallin: I do have an amendment, and it was presented in advance.

Honourable senators, as most of you know by now, I believe the issue of MAID is profoundly personal, that each of us has the right to make our own decisions when it comes to the end of our own life — a right that can only be realized with the guidance and direction of a legally respected advance request.

As someone with a history of dementia in my family, I seek the peace of mind that an advance request — and consent to it — will provide. I am certainly not alone in this belief. The majority of Canadians have come to the same conclusion.

During my own ongoing consultation regarding this bill, I have heard from so many people who have shared their experiences in either providing MAID or who are looking at MAID as an option to end their life.

I spoke with Dr. Stefanie Green of the Canadian Association of MAiD Assessors and Providers, who said that allowing for advance requests is the most important change we can make to improve the law, a sentiment echoed across the medical

community, especially by practitioners who bear the burden of criminal liability in determining and performing medical assistance in dying.

I also spoke with Ron Posno, an 81-year-old former RCAF test pilot and beloved teacher for students with special needs, who shared with me his current experiences with mild cognitive impairment, MCI, a precursor to dementia. He explained his frustration with accepting the law as it now stands, that his loss of memories, experiences, context, and certainly dignity, will be something both he and his wife will be forced to accept, unless we can make this bill better.

It's a sad truth that our current MAID laws create these gaps in accessibility. Ron shared stories of others he has met along the way, who chose to take their own life through suicide, rather than suffer alone and afraid through an end of life over which they would have no control.

That's why I'm introducing these amendments today, because of people like Ron or my late mother or my grandmother or the thousands of Canadians diagnosed with Alzheimer's each year — that silver tsunami so quickly approaching — and for all of those who do or did not want to leave this life in pain, or live on without knowledge or awareness of family, friends or even oneself. And I do it for the loved ones and caregivers and doctors and assessors on whom so much responsibility has fallen because we have delayed our responsibility as legislators to make this law clear.

• (1630)

My amendment will allow anyone to make a signed written declaration to consent to MAID before being diagnosed with the grievous and irremediable medical condition. It will give those who are fearful of losing their conscious capacity the certainty that they can access MAID before they reach a place where consent may not be possible.

Right now, the safeguards in clause 3 of Bill C-14 and subclause (3.1) of Bill C-7 require a signed agreement to MAID after someone is diagnosed with a grievous and irremediable medical condition. This has created that Catch-22 for some who can no longer consciously agree to MAID because they have been diagnosed with a cognitive impairment condition. This amendment will fix that and allow anyone to declare their consent to receive MAID while still of sound mind and with conscious decision-making capability.

This change in approach should also give one the option to waive the final consent waiver for MAID for those whose death is not reasonably foreseeable — when it's inevitable, but not imminent. Currently, Bill C-7 only allows an advance request when death is reasonably foreseeable. This is Audrey's amendment, and it makes sure that those who have a naturally foreseeable death and who are approved for MAID do not have to end their life early before losing their capacity to consent.

It's an essential step in the right direction, but that right also needs to be extended to those whose death is not reasonably foreseeable. If you are approved for MAID due to MCI, dementia or Alzheimer's, and your death is not imminent, you should still be allowed to make an advance request.

I spoke of this the other night here in the Senate — of people who get trapped in the perverse illness lottery. A foreseeable death, one that comes with a serious cancer diagnosis, would allow a request for MAID, but if the lottery deals you the Alzheimer's card, then you may not be allowed to make an advance request because the diagnosis alone may be considered disqualifying.

There are some who believe that more committees, more time, more academic scholarship, more consultation with the public or more bureaucratic review is required. I fully support any motion to ensure that the required parliamentary review of Bill C-14 takes place immediately, and I have for more than five years. But it has been stalled. There's always a reason — maybe an election or the need for more COVID-related legislation or whatever. Enough. The consensus on advance requests is clear and overwhelming. The government's own public consultation on MAID from March last year found that almost 80% of Canadians support advance requests for MAID and a growing number, over 75%, support advance requests for MAID for cases of dementia or Alzheimer's.

It has taken five years to include Audrey's amendment, found here in Bill C-7, in the law. The government now believes we should give the right to an advance request to those whose natural death is foreseeable. Why not do so for those whose death is not imminent but whose life is hell? And why not give us the right to prior consent before being diagnosed? Why let this bill create more even more accessibility gaps?

Some believe that allowing advance requests means running the risk of administering MAID to the unwilling, but I believe that the current safeguards in this bill prevent this from happening. Of course, no one should be forced against their will to undergo MAID. In fact, it would be very difficult to make that happen.

Dr. Chantal Perrot said the following in committee just last week — and I received a very long email from her today reinforcing these notions:

Vulnerable people need to be protected, and this includes people who want MAiD, who would be denied MAiD under severely restrictive criteria and safeguards. Part of the assessors' and providers' responsibility is to assess for the

vulnerability of the patient, while also respecting the individual's right to make decisions with which others may not agree. . . .

I believe it is important to listen to the vast majority of Canadians who support advance requests to help ensure people's wishes are respected. This is what autonomy means. It is what our constitutional right to choice means.

The changes I propose are designed to give the option to sign and date an advance request for MAID before a diagnosis is given by a medical practitioner — a diagnosis that may be disqualifying. They will also make the text of this bill consistent and will ensure that the option to waive final consent applies to both those with a reasonably foreseeable death and those for whom their death is not foreseeable.

MOTION IN AMENDMENT ADOPTED

Hon. Pamela Wallin: Therefore, honourable senators, in amendment, I move:

That Bill C-7, as amended, be not now read a third time, but that it be further amended in clause 1,

- (a) on page 3, by adding the following after line 18:

“(3.1) Subparagraph 241.2(3)(b)(ii) of the Act is replaced by the following:

(ii) signed and dated before or after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;”;

- (b) on page 4, by replacing line 13 with the following:

“(ii) signed and dated before or after the person was informed”;

- (c) on page 5,

- (i) by replacing line 30 with the following:

“(3.2) For the purposes of subsections (3) and (3.1), the medical”;

- (ii) by replacing line 33 with the following:

“the requirement set out in paragraph (3)(h) or (3.1)(k), as the case may be, if”;

- (iii) by replacing line 37 with the following:

“(1) and all other safeguards set out in subsection (3) or (3.1), as the case may be,”.

Thank you, colleagues.

Some Hon. Senators: Hear, hear.

The Hon. the Speaker pro tempore: On debate.

Hon. Paula Simons: Honourable senators, my mother was a brilliant, beautiful woman — a woman with a passion for great literature, high fashion and duplicate bridge. She was a woman who disliked sentimentality of any kind, so I hope somewhere she'll forgive me if I say I'm still haunted by the memory of the day I took her for that fateful neurocognitive exam, the day the specialist delivered the bleak diagnosis: Alzheimer's disease.

My mother's response was straightforward. She asked for medical assistance in dying, but she was, of course, both too early and too late. Her death was not imminent. Her sufferings would eventually be grievous and irremediable, but they weren't yet. And at the same time, she had already lost much of her capacity to be her own medical decision maker.

Her tragic story demonstrates why advance directives must be part of our understanding of medical aid in dying. We cannot properly exercise our autonomy or protect our dignity if we cannot choose for ourselves when and while we still have the capacity to do so. We must give Canadians the opportunity to exercise free and informed prior consent when it comes to end-of-life decisions.

Such a concept is neither new nor radical. Advance directives, or personal directives as they're known in Alberta, are well established in provincial health law. Back in 1991, the Ontario Court of Appeal in a case known as *Fleming v. Reid* stated:

• (1640)

A patient, in anticipation of circumstances wherein he or she may be unconscious or otherwise incapacitated and thus unable to contemporaneously express his or her wishes about a particular form of medical treatment, may specify in advance his or her refusal to consent to the proposed treatment. A doctor is not free to disregard such advance instructions, even in an emergency. The patient's right to forgo treatment, in the absence of some overriding societal interest, is paramount to the doctor's obligation to provide medical care.

The legal framework, then — the paradigm — is already in place. Expanding it to encompass degenerative dementias is both logical and humane and would give people facing dementia diagnoses, or the future prospect of dementia diagnoses, badly needed peace of mind. It would protect their charter rights, too, to equal treatment under the law regardless of physical or mental disability.

I can tell you that as the years ground on, it was terrible to see my proud, elegant mother lose her ability to read and write, her ability to dress herself and her ability to recognize her oldest, dearest friends.

Last July, after months of pandemic isolation where we could only visit with her at a distance, which confused her horribly, my mom suffered a broken hip. In the emergency room, the doctor was blunt. There was no way she would recover from her injury. The doctor therefore offered me two terrible choices. We could

leave her shattered hip untreated, pump her full of morphine and send her to a palliative care centre to die. I asked if she would be given anything to ease her death. No, I was told. She was still ineligible for anything as humane as MAID.

Instead, the doctor told me their only option would be to withhold all food and fluids and leave her to die of dehydration and starvation. Oh, and because of COVID, I would not be allowed to be with her. I would need to say goodbye to her right there and then in the ER and send her off to die alone in pain and terror.

The alternative was little better: the physical stress and trauma of major surgery and the painful aftermath of a hip replacement with no real prospect she'd ever walk again. Still, in the moment it seemed the least bad choice. Was it the right decision? I just don't know.

I do know that my mother suffered in hospital for more than a month in agony, fear and raging, violent fury, unable to understand why she was there and why I wouldn't bring her home. Every long day, I bore witness to her torture and torment. I listened to her scream and scream. She was so utterly vulnerable.

It was my job to protect her. I failed.

Eventually, she stopped eating and drinking, and I can't tell you whether that was out of instinct or some conscious choice. We chose not to have her force fed with a feeding tube. The hospital moved her to a quiet, private room and brought in a bed so I could sleep beside her.

My brother and I were both with her as she died, over the course of hours, her way finally, belatedly, smoothed by generous doses of hydromorphone.

My mother, she would have hated this speech. She would have found it sentimental, manipulative, mawkish and a grotesque invasion of her privacy. Still, if her story can, in any way, help you and help the government to see the wisdom of Senator Wallin's compassionate, common sense idea, then I shan't apologize, not even to her.

I failed my mother when she needed me most. We mustn't fail Canadians now. For mercy's sake, and in the name of mercy, can we not give Canadians better choices and the right to speak for themselves while and when they still can? Thank you. *Hiy hiy*.

Some Hon. Senators: Hear, hear.

Hon. Jane Cordy: Thank you very much to Senators Wallin and Simons, who have already spoken on what is a very emotional and passionate issue for people who are looking at the whole issue of dementia. Dementia is, indeed, a difficult and emotional disease that many families face every single day. To see a loved one not knowing those who care for and love them is heartbreaking. I think that many of us in this chamber or on Zoom today have watched as loved ones lose touch with reality.

Honourable senators, Bill C-7 deals with cases like the Audrey Parker case. Ms. Parker had advanced breast cancer with brain metastases. She was eligible for MAID. There was a good chance that the brain cancer would affect her cognitive capacity to consent before the date that she wanted for MAID.

So Audrey Parker had MAID months before she would have chosen it. Bill C-7 allows for an advance request when you already qualify for MAID. This is a change from Bill C-14.

However, honourable senators, what this amendment does is allow for advance directives after the diagnosis of an illness but before the person would be eligible for MAID — so the person would not be eligible for MAID at that point.

Honourable senators, Jennifer Gibson, a professor of bioethics at the University of Toronto, worries that most of the public debate about advance directives has been simplified and focused on Alzheimer's dementia. Dementia forms are varied and have many stages that affect suffering and the ability to consent. Professor Gibson believes that there are significant differences in the issues, and there are uncertainties around dementia and consent that should be considered.

Honourable senators, I would ask: What are the significant issues that should be looked at? What are the significant uncertainties that should be considered? I don't know the answer to those questions. Also, what criteria should be used to allow advance directives? What safeguards would have to be put in place if we allow advance directives?

Honourable senators, I don't know the answers to those questions either.

Honourable senators, the Legal Committee did not study advance directives in their review of Bill C-7, nor did the committee evaluate advance directives in their study of the bill. There were no witnesses at the Legal Committee to talk about advance directives. There were no witnesses at the committee to answer questions or offer opinions on advance directives. Honourable senators, I cannot vote in favour of an amendment that changes Bill C-7 so drastically. I cannot vote in favour of an amendment that brings forward changes that have not been debated in the committee and for which the subject matter was not discussed before today in relation to this bill.

We as senators have a responsibility to hear all sides of an issue. It is a very emotional issue, but especially when this issue is a life-or-death issue, we have a responsibility to have witnesses at committee hearings who will agree or disagree on legislation such as Bill C-7.

The legalizing of advance directives is a complex issue and needs lengthy consideration at the committee level. We have not done that.

Honourable senators, we have not gathered evidence on this amendment to guide us, or at least to guide me. We have a responsibility for sober second thought when we study legislation and when we look at amendments. I will not be supporting this amendment. Thank you.

Some Hon. Senators: Hear, hear.

Hon. Kim Pate: Honourable senators, like Senators Wallin and Simons, and so many others in this chamber and elsewhere, I speak as a family member — a daughter and a granddaughter — of loved ones who died after years of living with dementia. I would personally like to be able to have access to an advance directive. I recognize that this is, in part, a function of the privilege which I currently enjoy.

• (1650)

A witness at the Legal Committee characterized Bill C-7 as legislation created for those who are “well, but worried, well off, and White.” The proposed amendment expands non-end-of-life medical assistance in dying in ways that will likely create more rights and more choices for those who are most privileged — those also most likely to have the financial and other resources necessary to put in place advance directives. I am concerned that it would do so at the expense of entrenching and reinforcing ableism, in particular for those who are most marginalized, including as a result of class and race.

Bill C-7 permits advance consent to medical assistance in dying as an alternative to a painful death in the event of a loss of capacity. This amendment would extend the bill to permit consent in advance to medical assistance in dying as an alternative to a painful life; a life with disabling health issues.

When Minister Qualtrough appeared at the Legal Committee last fall, she spoke not only about her ministerial responsibilities with respect to Bill C-7, but she also reminded us of her lived experience:

Daily, we — Canadians with disabilities — hear comments like, “I could never live like that.” “If I had to live like that, I would rather be dead.” “How can you live like that?” We face stigma, stereotypes and ignorance. This is the backdrop for these conversations.

Disability organizations have challenged us to reflect on how much of our understanding of others' suffering is shaped by ableism, systemic discrimination and exclusion.

I have spent nearly four decades working with and on behalf of some of those most marginalized, victimized, criminalized and institutionalized. Today, one in four federal prisoners are seniors. Many are suffering from chronic health conditions, pose no risk to public safety, yet have been kept in prison instead of being allowed to receive the health care that they need in the community.

Many are living with dementia and live in conditions of isolation that amount to segregation and solitary confinement. Imagine for a moment the situation of someone facing the prospect of cognitive decline in prison, fearing that the rest of their life may be spent in conditions that amount to torture, alone and likely terrified.

Too often, visiting loved ones with dementia in long-term care homes, I found myself horrified by the parallels with the conditions of social and psychological isolation.

Surely, the COVID-19 pandemic has destroyed any possible illusion about the adequacy of the current long-term care system, and particularly for-profit homes, as a regime to be entrusted with our loved ones at the moments they are most vulnerable and most in need of care.

Given the current cost barriers and unavailability of home and community-based care for many considering non-end-of-life medical assistance in dying under Bill C-7, the alternative is life in this thoroughly inadequate system of long-term care institutions.

Canada continues to lag behind on long-term, health and social care, spending significantly less than the average among OECD countries as a percentage of GDP. Not surprisingly, the Netherlands, which leads the way in terms of spending, has also pioneered programs like dementia villages that have put in place more humane, community-driven options for those with dementia and other neurodegenerative conditions.

How can we justify prioritizing expanding rights to advance directives for some without a similarly clear focus on the need to ensure that health, social, housing and income support systems uphold standards of adequate and dignified care for all?

Yet another of my dilemmas, honourable colleagues. *Meegweich*, thank you.

[Translation]

Hon. Chantal Petitclerc: Senator Wallin, thank you for the amendment that you presented today, which is an extension of your hope that people be allowed to make an advance request for medical assistance in dying before they have a grievous and irremediable medical condition. If I remember correctly, you have addressed the House on this essential issue twice already. Today, I would like to point out how consistent your work on this issue has been and how important it is.

[English]

I would like to take my time today to underline the significant complexity of this area as a matter of federal legislation.

We are talking about a situation where a person with decision-making capacity writes a document setting out that they would want to receive MAID in the future if they lose decision-making capacity, and if the specific circumstances arise that causes them unbearable suffering when they no longer have capacity.

This matter is complex and would require safeguards for at least two distinct periods. First, the time when the person prepares the document setting out their wishes to receive MAID in the future; and, second, the time when a practitioner would administer MAID to end the person's life because the conditions specified in their document are fulfilled.

This amendment does not speak to any safeguards around the written consent provided before an eligible diagnosis.

This amendment is also silent on the complexities that may arise from harmonizing provincial and territorial laws to account for advance requests. For instance, advance requests require the participation of substitute decision makers, such as family members.

[Translation]

Since the person would no longer have the capacity to make health-related decisions for themselves, it would be up to others to determine when and how the advance request would be implemented and to contact the practitioner administering MAID. Provincial laws may also require that advance requests be kept in a registry so that practitioners can access them and make sure they are up to date. The practicalities are regulated by the provinces and territories. Of course, those are just a few examples of the complexities and details that I believe must be carefully considered before moving forward. As you know, the committee's in-depth study and pre-study of Bill C-7 did not address advance requests because they are not part of the bill.

[English]

Yes, it is true, a few witnesses did comment on advance requests. Professor Raphael Cohen-Almagor, the University of Hull in the United Kingdom, said to the committee about advance directives:

They should be taken care of seriously and carefully. I've seen at least 60 different versions of advance directives, from fluid to general ones, like, "I would like to die when I don't know my children," to very detailed ones.

Professor Cohen-Almagor noted another practical problem:

... we have to be cognizant of changes that happen in the minds of patients as they progress with the disease.

Because a patient who is diagnosed with dementia may say they want one thing at one stage of the disease but change their mind as they progress to another stage, should the practitioner abide by the advance directive if the patient wants something very different now? These are very important and legitimate questions.

The Council of Canadian Academies report on advance requests also noted many complexities with advance requests for MAID. The majority of experts, practitioners and stakeholders consulted on this specific issue during the government's round table in February 2020 recommended that this type of advance request be studied further as part of the parliamentary review of the MAID regime that is required by former Bill C-14.

• (1700)

[Translation]

Honourable senators, like many of you, I look forward to this parliamentary review.

[English]

I believe policy decisions surrounding advance requests must be based on that kind of thorough, comprehensive study that takes into account the multitude of details that ensure Canadians are protected and well cared for. That is why, Senator Wallin, that while I sincerely support your intention, I cannot support the amendment.

[Translation]

Hon. Diane Bellemare: I have a question for Senator Petitclerc.

Hon. Lucie Moncion (The Hon. the Acting Speaker): There's no time left. We have to move on to Senator Gold.

[English]

Hon. Marc Gold (Government Representative in the Senate): Honourable senators, I want to begin by expressing my admiration for Senator Wallin and for everything that she's bringing to this debate. Senator, you're passionate and reasoned. You're reasonable in your advocacy on behalf of this issue. Your arguments and your presentations are deeply rooted in the core values that define us, define our Charter, our right to live, to control our own lives and our own passage through life, to be treated with equal respect and concern. So your story and many others touch me personally. Thank you. But I have to agree with Senator Petitclerc, and I'm not able to support this amendment.

As others have explained, this issue is very complex, and introducing such an amendment would require far more study, so that all the proper safeguards to protect those most vulnerable would be in place. Changes of this magnitude to medical assistance in dying require a cautious approach so that we might have confidence that legislation will ensure the protection of Canadians at the end of their lives.

But beyond the issues of policy that the amendment would introduce and attempts to introduce, I have serious reservations on process grounds, and not just as Government Representative but as a senator. At committee and during debate, we've heard time and time again that even minor modifications to MAID cannot and should not be rushed. That's why we collectively insisted on doing our work responsibly, even in the face of the original December court deadline. That's why I have spent months reminding government colleagues in the other place that

the Senate will insist on studying Bill C-7 in an appropriately thorough fashion. That is our job. That's what we're doing, and we take it seriously.

In my view, adopting Senator Wallin's amendment would simply be inconsistent with the attention to detail and seriousness that we, as a chamber, have given to the study of Bill C-7 thus far. We simply have not properly considered the ramifications and effect of this proposal. It would be — and I say this respectfully because I am touched and moved by it — it would be irresponsible to introduce this as an amendment to Bill C-7.

As an analogy, imagine for a moment a scenario where I, as Government Representative, introduced a government bill expanding access to medical assistance in dying on the issue of advance requests. I had not put into place a transparent process of consultation, discussion or information requests of experts. Neither had I referred the bill to committee for study. I was simply asking the Senate to pass these changes in one day, without any study, without any review or scrutiny.

Now, we all know what your answer would be — a hard no — and with good reason. The Senate would insist on conducting sober second thought. This amendment, the weight of its importance and the consequences of its passage surely are significant enough for the study and review that it deserves.

Honourable senators, our Standing Senate Committee on Legal and Constitutional Affairs spent countless hours on the language and content of Bill C-7, hearing from well over 100 witnesses. It did so because, when it comes to MAID, every word in the legislation matters. It's a matter of life and death. There was no focus or attention given to advance requests during committee study because the subject is simply not addressed in the proposed legislation. In fact, the committee's 36-page pre-study report does not even address the issue.

Senator Wallin's proposal would introduce a new, major component to MAID on the fly — changes that have not been researched, scrutinized or studied by any parliamentary committee in either house. In that context, I submit to you that adopting this amendment would simply be — and again, respectfully — imprudent, and I ask you to vote against it.

Hon. Frances Lankin: Senator Wallin, may I thank you for your continued work on this. I do support your amendment. I'm struck by how many of us have family experiences that help shape our understanding or view of this. I am struck by how closely my family's experience mirrors Senator Simons', and I don't have the courage of Senator Simons today to speak about this without bringing forward tears that I won't be able to speak through.

What I do want to say about my family experience — but I want to speak mostly about the technical issues in this amendment — is that my mom suffered for nearly 30 years with dementia and with a serious progression of dementia which rendered her incapable, just a few years into the 30 years, of making any such request like this. She died long before MAID was a reality in Canada. She had a major stroke, and the diagnosis was that she could never recover from that and that she would only be able to be kept alive with a feeding tube.

The family had done everything right. I had worked with my mom when she still had capacity to consent to treatment; to provide an advance directive on a living will, for personal care; on being sure that my brother and I were well aware of her wishes; and ensuring that whenever she had an interaction with the health care system that her wishes were provided to the physician attending and the other health care professionals. That advance directive did not want heroic efforts to keep her alive should her condition — and there were a number of requirements — which she met, at the time that she did pass.

Every province and territory has legislative and regulatory regimes in place to allow for advance directives on personal care, to allow for living wills that set out the expectation. There is legislation for consent to treatment and how that is to be judged and treated, long before MAID came to our national dialogue, and for capacity to consent, adjudication where there is a dispute around that.

This amendment from Senator Wallin builds on top of all that exists in our country. This is a form of saying that those advance directives, which can say — and I will speak on behalf of my brother and I who, every time we talk, check in to see how our cognitive abilities are because we fear the genetic heritage — that I don't want any intervention under these conditions. I want to die.

• (1710)

But the dilemma is, in MAID, to be able to appreciate using medical assistance in dying as opposed to my mom, who had the saline drip removed as per her own request, and whom I sat beside for 14 days while she died of hunger and thirst. No one would agree that's appropriate, and we all would want to figure out how to get to a better place. But why is it that I can insist on the conditions that would lead to my death through pain and anguish but not through medical assistance in dying? This does not make sense to me.

Senator Wallin has brought this issue forward over and over, and we all have heard these debates. I am sorry that the committee didn't explore these issues when some witnesses brought them forward. That's true.

To Senator Cordy and Senator Gold, I understand the point that you are making, but the intransigence on the part of this government not to hold the reviews that we had requested — we discussed this thoroughly in Bill C-14 as well, as we did mental illness, as we did mature minors. Those studies, for all the reasons we've heard, have not taken place, and we are asking people to wait another two, three or four years, when the system to allow for advance directives that would lead to a person's death already exists. Senator Wallin's amendments simply provide safeguards around when this must be signed; before a diagnosis of lack of cognitive impairment or dementia comes about.

I appreciate that people would like to spend more time on this. We have had many opportunities to discuss this over the last five years, and it has been brought forward by Senator Wallin. There have been debates. Quite frankly, a lot of us have reached out

and done research on this, because it's of particular interest to us, to hear from professionals, regulators and various provincial jurisdictions —

The Hon. the Speaker pro tempore: Senator Lankin, I'm sorry. Your time has expired.

Hon. Pierre J. Dalphond: I agree with Senator Wallin that, and 80% of Canadians that using advance directives is the direction in which the law should go. My issue with the amendment is that to accomplish that, it adds two words, which are "before/or," which I'm afraid are not enough to achieve that goal.

The three countries, so far, that have allowed advance directives — Belgium, the Netherlands and Luxembourg — highlight many different policy considerations and options that are at stake.

In the Netherlands, the system is currently before the courts, which are dealing with the issue of whether advance directives can be used to provide MAID to people with Alzheimer's.

In Belgium, unlike in the Netherlands, an advance directive is valid only for persons who are unconscious at the time of the provision of MAID. This means that individuals with conditions affecting decision-making capacity, such as dementia, are not able to use an advance directive to request euthanasia for a future date, when they are no longer capable of making decisions. Also, the directive is valid for only five years, but it can be renewed.

In Luxembourg, the advance directive is only for unconscious persons. Unlike in Belgium, there is no time limit, but every five years, a central body of government verifies that the person who signed the advance directive still wants to keep it in the system.

Under Bill C-7, if this amendment is accepted and the other requirements of Bill C-7 are not changed, a person will need to be conscious to receive MAID. There are a few issues with this that I can think of now. Do we allow advance directives if a person is unconscious at the time MAID is provided? Is there a form to be used? Will that be the same form across the country, or would that decision be left up to the provinces? Will advance directives be time restricted, like in Belgium and Luxembourg? Should a national or provincial authority be in charge of confirming a person's wishes every five years, like in Luxembourg?

We did not hear answers to these questions during the study of Bill C-7. Unlike the mental illness question, which arose in nearly every panel, advance directives were generally not addressed by witnesses.

[Translation]

In answer to a question from Senator Boisvenu about advance directives and the possibility of using Bill C-7 to make that an option, Danielle Chalifoux, a lawyer with the Institut de planification des soins du Québec, said this:

In Quebec, our group of experts submitted a report to the government that included a comprehensive advance request regime. We studied all aspects of such requests. Federal lawmakers might find it very useful as well.

... in Quebec, the group of experts that studied this issue proposed a comprehensive advance request regime. The group went into great detail. This can't be done by a province alone, so the group hopes that the federal government will include it in the bill.

Ms. Chalifoux added:

... it's an extremely complex problem. It requires a whole system of forms and applications, the assurance of free and informed consent; when will it happen? Can MAID be administered when individuals are totally incapacitated? What exactly does that mean? Will the family's views be taken into account? How will this be articulated? We examined a great deal of data in our report, data that could hardly be reflected in one short clause outlining waiver of final consent. In my view, it would actually do a disservice to the public to do so without guarantees or safeguards, because that's also an extremely delicate subject.

Unfortunately for us today, these questions were not debated in committee, and I have to conclude that it would be premature, as Senator Gold pointed out, and perhaps even ill-advised to adopt these two small but meaningful words. However, I do hope that Senator Gold will press the government to ensure that the committee, which should have been created a year ago to do a complete review of Bill C-14, is actually struck in the coming weeks so that the work can finally begin.

Thank you.

Hon. Pierre-Hugues Boisvenu: Honourable senators, I support the amendment proposed by my colleague. Yesterday I presented a somewhat similar amendment, but it was defeated.

Bill C-7 has a rather hypocritical perspective when it comes to persons suffering from degenerative disease. They are told that they are eligible for medical assistance in dying, but that they cannot make advance requests. How can a person suffering from a degenerative disease make a request for medical assistance in dying and exercise their rights without making an advance request? That is like telling that person that they are being given a driver's licence, but they do not have permission to board their vehicle. That pretty much sums up Bill C-7.

Dozens of people contacted me this morning, people who received a diagnosis. They get the impression that the Senate has forgotten about them, that it has turned a deaf ear to their plight and the pain they experience every day.

By making an advance request, these people would be able to live with peace of mind until they reached level 5 of their disease, the stage where they would lose full contact with reality and where the family or the physician, by virtue of the authority given by the patient in advance, would proceed to ending their days.

As I said yesterday, we have the key that will ensure those people are not imprisoned by their inevitable suffering. When we force these patients to continue to suffer, we do the same to their family. The patient's pain and suffering also affect the people supporting them and the entire family.

We failed to help these people in 2016 and we are about to fail them again in 2021.

• (1720)

I do not believe that the government will complete its work on mental illness in two years, given that this matter is too complex. However, it is not that complex to those suffering from degenerative diseases, because the law states that they have this right. What the law does not mention is how this right will be exercised.

I believe that Senator Wallin's amendment shows how this right will be exercised. I want to reiterate that we do not have the right to fail the people who want to exercise this right a second time in 2021. Thank you.

Hon. Claude Carignan: I'd like to begin by saying that I lean towards supporting advance medical directives. That is why yesterday I voted in favour of Senator Boisvenu's amendment seeking to compel the government to study this issue quickly. I wanted to help nudge it that direction.

A number of senators have mentioned that when Bill C-14 was adopted, we called for a study on advance medical directives, emancipated minors and the issue of mental illness. However, the government failed to do its job. This was also recommended by a joint committee of the Senate and the House of Commons, which studied this issue and recommended a more in-depth study.

That unfortunately did not happen. It was also unfortunate that, when we studied Bill C-7, we didn't look into how to proceed with advance medical directives. This topic wasn't studied, aside from the testimony quoted by Senator Dalphond, perhaps. I think that's the only mention specifically about advance medical directives, in addition to a few questions from my colleague, Senator Boisvenu, but we didn't really address the issue.

That got me thinking about this issue. We all have our own personal story. Part of my story is that my mother has Alzheimer's. I have often heard my mother pray for death to take her. Every time I visit her, I can tell the light in her eyes has grown a little dimmer. Last time, she barely recognized me. Even so, I have a hard time imagining what my always-smiling mother would think of a doctor showing up all of a sudden to administer MAID.

We really need to think about this issue because, when a person is unable to consent at the end of life, that raises some serious ethical issues. Even though I tend to be in favour of

advance medical directives, I encourage people to vote against this amendment. We might have to push this government and practically beg it to keep its promise to put a process in place as soon as possible, in collaboration with the provinces.

Quebec is already fairly advanced in this area, so it could share its experience with the provinces and the federal government to help set up an advance directive system for those who have indicated when and how they want to leave this world. Thank you.

Senator Bellemare: The issue of advance directives is quite upsetting and makes me emotional too, because, like you and your friends of a certain age, I think it would be good to be able to make such requests.

However, Bill C-7 does not address that issue, and we were not given the mandate to study it. Even though I strongly support advance directives, I would prefer that we continue to consider this matter.

I have also had personal experiences that made me think about the issue of advance medical directives. My late father had dementia. When he began suffering a great deal in his long-term care facility, they gave him sedatives, such as morphine, and, in the end, he passed quickly and quietly.

At that time, when I went to visit him, I saw something disconcerting: two people with Alzheimer's whose smiles lit up the whole care unit. While living in the care facility, they fell in love. Even though their respective spouses still came to visit, those two did not remember them at all. They seemed so happy in their little bubble. When one of them died, the other followed just two weeks later.

I know these individuals weren't suffering, and perhaps that's the key, but the fact remains that this is a complex issue that requires careful reflection. We could always argue that this is just an amendment to the Criminal Code and leave it up to the provinces to reflect on it. Nevertheless, it seems very clear to me that this aspect was left out of Bill C-7 and, because of this, the scope of the bill is greatly expanded.

For these reasons, I will not be supporting Senator Wallin's amendment, even though I agree that it should be studied and I would be inclined to support it. Thank you.

[English]

Hon. Jim Munson: I wasn't going to speak on this particular amendment, but sometimes debate does matter. Every once in a while, after being here for 17 years, sometimes I think the Senate has to take the initiative and has to force the debate.

I was thinking this afternoon, at the beginning of the debate, that I would abstain because of the arguments that are being made with this particular initiative of an advance directive. Everybody tells their own story, and I, too, have a story, but I don't have to get into that story about my own mother and father today. I was moved by Senator Simons' debate and how she spoke about this.

[Senator Carignan]

I know the issue is not in this particular bill, Bill C-7, but there has been enough discussion that has gone on here and on the other side that we sometimes have to be brave. If we pass this amendment it has to go back to the other side, and who knows what they will say in the other place? With that, and without getting into the complexities of it all, sometimes we use the words "I have empathy, but," or "I really feel for you, but"; but in this case, I am rising to say that I will support this amendment. Thank you.

[Translation]

Hon. Renée Dupuis: I wanted to ask Senator Wallin a question, but since we're running out of time, I will put it another way.

It seems to me that the discussions that took place during the deliberations on Bill C-7 focused on the clause providing for a waiver of final consent, subclause 3.2 of amending clause 1, which provides that the waiver of final consent is reserved for situations where death is reasonably foreseeable. This means that a deliberate decision was made to ensure that individuals whose death is not reasonably foreseeable would not be allowed to waive final consent if, prior to their losing their capacity to consent, they had signed an agreement with the doctor who would administer MAID. This was neither by chance nor by mistake.

• (1730)

The Standing Senate Committee on Legal and Constitutional Affairs discussed this proposed addition in Bill C-7. I believe that the dilemma we are in is related to the fact that . . . I also want to reference the more than 150-page report entitled *L'aide médicale à mourir pour les personnes en situation d'incapacité : le juste équilibre entre le droit à l'autodétermination, la compassion et la prudence*, written by a group of experts in Quebec. That is why I insisted that Ms. Chalifoux appear before our committee. As Senator Dalphond alluded to earlier, she shared with us the recommendations made by the group of experts. This is an extremely complex issue, and Senator Wallin's amendment, which we are debating now, addresses two things, in my opinion. The amendment could have addressed just the notion of giving individuals the opportunity to waive final consent, regardless of whether their death is foreseeable, in cases where the individual is experiencing serious, intolerable and irremediable suffering. Thank you.

[English]

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

Hon. Senators: Question.

The Hon. the Speaker pro tempore: Honourable senators, all those opposed to adopting the motion in amendment, please say "nay."

Some Hon. Senators: Nay.

The Hon. the Speaker pro tempore: All those in favour of the motion and who are in the Senate Chamber, please say "yea."

Some Hon. Senators: Yea.

The Hon. the Speaker pro tempore: All those opposed to the motion who are in the Senate Chamber, please say “nay.”

Some Hon. Senators: Nay.

The Hon. the Speaker pro tempore: In my opinion, the “nays” have it. I see two senators rising.

And two honourable senators having risen:

The Hon. the Speaker pro tempore: We will have a 15-minute bell. The vote will be at 5:48 p.m. Call in the senators.

• (1740)

Motion in amendment of the Honourable Senator Wallin agreed to on the following division:

YEAS THE HONOURABLE SENATORS

Black (<i>Alberta</i>)	Lankin
Black (<i>Ontario</i>)	Marshall
Boisvenu	Marwah
Brazeau	McPhedran
Busson	Mercer
Cormier	Mockler
Cotter	Moodie
Coyle	Munson
Dagenais	Ngo
Dasko	Oh
Deacon (<i>Ontario</i>)	Omidvar
Dean	Patterson
Downe	Ravalia
Duffy	Saint-Germain
Duncan	Simons
Forest	Smith
Forest-Niesing	Stewart Olsen
Galvez	Tannas
Greene	Verner
Griffin	Wallin
Hartling	Wells
Jaffer	Wetston
Keating	White—47
Kutcher	

NAYS THE HONOURABLE SENATORS

Anderson	Klyne
Batters	LaBoucane-Benson
Bellemare	Loffreda
Boniface	Lovelace Nicholas

Boyer	MacDonald
Carignan	Martin
Cordy	McCallum
Dalphond	Mégie
Dawson	Moncion
Francis	Petitclerc
Frum	Plett
Gagné	Poirier
Gold	Seidman
Harder	Woo—28

ABSTENTIONS THE HONOURABLE SENATORS

Ataullahjan	Dupuis
Boehm	Manning
Bovey	Miville-Dechêne
Deacon (<i>Nova Scotia</i>)	Pate—8

• (1800)

Senator Pate: I would like to explain my abstention, Your Honour.

Honourable senators, I’ve abstained despite my personal view because I believe it is irresponsible to prioritize legislation to expand choices for those most privileged without first or also ensuring that measures are in place in the form of standards and funding of adequate health, social, housing and economic supports to ensure that all — in particular those who are poor, racialized and those with disabilities — also have access to meaningful choice.

The Hon. the Speaker pro tempore: Thank you, Senator Pate.

Hon. Colin Deacon: Honourable senators, I am in favour of advance directives, but I really believe that the need for greater study to manage risks and put up guardrails is essential. I look forward to supporting it in the future. Thank you.

Hon. Patricia Bovey: Honourable senators, I too want to explain my abstention, and it’s for exactly the same reason as Senator Deacon (*Nova Scotia*). Thank you.

[*Translation*]

Senator Dupuis: I abstained because I did not want to prevent the proposal from being adopted. I am in favour of advanced directives before a diagnosis is made, but I do not want to give the government the opportunity to reject the amendment on the mental illness exclusion in the response we will receive from the House of Commons. Thank you.

[English]

The Hon. the Speaker pro tempore: Honourable senators, pursuant to the order adopted on February 8, 2021, the sitting must now be suspended for an hour. We will resume at 7:08 p.m.

(The sitting of the Senate was suspended.)

(The sitting of the Senate was resumed.)

• (1910)

CRIMINAL CODE

BILL TO AMEND—THIRD READING—DEBATE

On the Order:

Resuming debate on the motion of the Honourable Senator Petitclerc, seconded by the Honourable Senator Gold, P.C., for the third reading of Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), as amended.

Hon. Denise Batters: Honourable senators, I will be making an amendment with this particular speech.

Assisted suicide is final. There is absolutely no room for error or innocent lives will be lost. That is why any consideration of expanding the regime to those for whom death is not reasonably foreseeable must be subject to the most stringent safeguards. The courts have also said this. And yet in Bill C-7, the federal government has started to roll back even the safeguards that were put into the legislation less than five years ago.

Bill C-7 would eliminate the 10-day waiting period between a request for and the delivery of assisted dying where death is reasonably foreseeable. It allows for the waiver of final consent, opening the door to advanced directives, and it removes the requirement that a request for assisted death must be signed before two independent witnesses. Now only one will do.

We are treading on dangerous and shifting ground here, and it is moving too fast. It was only five years ago, during our pre-study on the issue of assisted dying, that our Legal Committee voted unanimously to ensure at least 15 clear days between signing a request for MAID and providing the death. We sent that recommendation back to the Trudeau government but they refused to accept it, instead opting for 10 days. Even at that, it could be shortened if necessary in order to preserve consent. Now, here we are and they're removing it altogether.

Even the creator of the original assisted-dying legislation, former justice minister Jody Wilson-Raybould, has expressed concern about the removal of safeguards in Bill C-7. Last fall in Question Period she asked the current Minister of Justice David Lametti why this new legislation abandoned safeguards from Bill C-14, especially when neither the lower Quebec court's *Truchon* decision nor the Supreme Court's *Carter* decision required it. The minister's response was to refer to his so-called intensive consultations the government supposedly conducted on this bill.

Perhaps those are the same intensive consultations one Indigenous witness at committee called "inadequate" and of which another said: "I don't believe there has been any engagement in a proper way." Or perhaps it was what disability rights group Inclusion Canada has called the hasty and completely inadequate process for round-table discussions with persons with disabilities; or maybe Minister Lametti was referring to the government's online consultation, which I can assure you was minimal because I filled it out myself. The questions were written in a prescribed way, with only limited answers to steer responses in one direction, and the only way to provide additional information was in long form comments that are more difficult to quantify.

Media reported that some people had taken the online questionnaire multiple times, some even dozens of times. It's ridiculous. Canadians didn't get adequate consultations. We didn't have a parliamentary review. All this Trudeau government has given us on this is SurveyMonkey. That's not consultation, honourable senators, and it is not a sufficient basis for rolling back protections that are meant to safeguard people's lives. There is no return policy with assisted suicide.

Dr. Harvey Schipper warned the Legal Committee about the need to retain safeguards in Bill C-7 because of the lack of any evidence to the contrary. He said:

... I don't think we have the evidence to remove any safeguards. In fairness, I don't think we have the evidence to add new ones. We just don't know. You have got trivial data from 13,000 cases.

Dr. Schipper was referring to cases in which MAID was administered in Canada.

Certainly taking out the waiting period is really, really foolish. It's un-biological.

The courts have understood the necessity for strong safeguards in the establishment of any assisted dying regime. In its *Carter* decision, the Supreme Court of Canada agreed with the trial judge that the risks associated with physician-assisted death can be limited through a carefully designed and monitored system of safeguards. The lower Quebec court decision in *Truchon* stated:

The Court instead accepts that the other eligibility criteria and safeguards already in place in the legislation are sufficient to ensure that the system can provide medical assistance in dying to individuals who are entitled to it.

Neither court ruling called for the revocation of existing safeguards.

The Trudeau government asserts that removing the 10-day waiting period between the day the request for MAID is signed and the day it occurs causes increased suffering. Of course, this does not take into account the risk of shortening a life

prematurely in the event that a patient might change his or her mind. Law professor Trudo Lemmens spoke to this balance at our Legal Committee.

The argument for removal —

— of the reflection period —

— is that it cruelly imposes suffering on people who made up their mind already, but that ignores that it protects people who may have weeks, months or even years of further meaningful life. There is, to my knowledge, no legal, ethical or medical expertise that permits us to confidently conclude that the suffering of some associated with the delay outweighs the risk that others are prematurely deprived of their life. . . . nothing can undo a person's death. It seems perfectly reasonable in public policy to err on the side of prudence.

Proponents of assisted suicide maintain that people who wish to access assisted dying have already made up their minds by the time they are within 10 days of completing MAID. We heard significant testimony at our Legal Committee pre-study that suicidality can fluctuate greatly. Dr. Harvey Chochinov testified:

Our research group reported that will to live can fluctuate highly over intervals as short as 12 to 24 hours. In fact, 40% of patients who were prescribed lethal drugs in Oregon decided not to take a lethal overdose, preferring to let their underlying disease take its natural course.

Dr. Leonie Herx, from the Canadian Society of Palliative Care Physicians, expressed her concern about the removal of the 10-day waiting period, saying:

If you remove the 10-day waiting period, we will be in a situation in Canada where people can request MAID and get it on the same day, when we've just heard that up to 40% of people have not even had palliative care involvement prior to requesting MAID. And now, with this legislation, we're possibly going to be ending someone's life on the same day when they've not had proper information or proper experience of how their suffering could be addressed in other ways.

Clearly, a decision of this magnitude requires additional reflection.

Honourable senators, this period of reflection is only 10 days. That's shorter than a long-range weather forecast or a COVID self-quarantine period. You get more time than that to return a small purchase from most stores. Senators, we in the Senate of Canada are a body of sober second thought. Shouldn't Canadians have the ability for sober second thought about ending their own lives?

The government seems to be throwing out safeguards without even understanding what it is they're doing. Take, for example, the provision in Bill C-7 which will reduce the required number of independent witnesses for a request for MAID from two down to one. When Minister Patty Hajdu appeared before our Legal Committee she told us:

The only role of a witness is to confirm the identity of the person signing and dating their requests. Witnesses play no role in determining whether someone is eligible for MAID or whether their decision is voluntary and informed. . . .

The minister said this during here pre-planned and prepared opening remarks, so this comment obviously was not off the cuff. Yet when I asked Department of Justice officials to verify that last week, they told me:

Our view would be that the role of the witness to the written request is both to confirm that the person signing the request is the person the request is about, and to confirm that that person understands what it is they are signing and is signing it voluntarily.

It seems that the Trudeau government is in such a rush to push this legislation through that their ministers are failing to read the fine print. Does Minister Hajdu even know what's going on? We know she doesn't know what's going on with vaccine contracts, but she doesn't even know the process for people to die — the process she is helping to expand. There is no excuse for that kind of negligence by a minister in life-or-death matters as important as these.

It is this Trudeau government's haste to make these changes so quickly — too quickly — that concerns me the most. During a pandemic, where people are suffering and everything else seems to be delayed or moving slowly, this government can't seem to get this assisted-suicide legislation passed fast enough. It is ready to abandon whatever safeguards it can, like a boat taking on water. Why this bill? Why now? We haven't even had a parliamentary review. We don't even know yet what we don't know. And the courts haven't asked the government to roll back significant safeguards. That is why I am proposing an amendment today that will restore the 10-day reflection period and the requirement for two witnesses to the way those safeguards were originally instituted under Bill C-14.

Honourable senators, one of our primary responsibilities as senators is to protect the vulnerable and represent their views in this chamber. We need to look out for those vulnerable people now. Let us retain those crucial safeguards to at least try to ensure that Canadians are properly protected under this legislation.

MOTION IN AMENDMENT NEGATIVED

Hon. Denise Batters: Therefore, honourable senators, in amendment, I move:

That Bill C-7, as amended, be not now read a third time, but that it be further amended, in clause 1,

(a) on page 3, by deleting lines 19 to 34;

(b) on page 4, by replacing line 19 with the following:

“tion (4) — before two independent witnesses who then al—”.

• (1920)

The Hon. the Speaker pro tempore: Senator Marty Deacon has a question.

Hon. Marty Deacon: Thank you, Senator Batters. I certainly understand your passion and leadership in this area, and I think I understand the integrity of the concern around making sure that we're as diligent as possible with safeguards and due process.

My question tonight is around the 10-day waiting period, if you don't mind. I've read that many feel that this 10-day waiting period is cruel and unnecessary given that it extends patients' suffering, and in some cases, they will even stop taking medication to ensure they're of sound mind when the day comes to accept medical assistance in dying.

Through the work that you've done, I'm wondering if there are any numbers on the people who have used this 10-day period to change their mind. What I'm trying to get at tonight is this: I'm wondering if the risks — with respect to everybody — of extending suffering for patients outweighs the risks that some will change their mind in this 10-day period. Thank you.

Senator Batters: Thank you for that question, Senator Deacon.

First of all, it's important to note that there already is the provision in that particular 10-day waiting period subsection, and this would be retained with my amendment, that if there is any possibility of capacity or the ability to have informed consent lost during that time frame, they can already reduce that all the way down to zero. So that provision is already there and would remain under this particular amendment that I've proposed here.

As far as the number of people who have been asked or potentially already received MAID in Canada — or requested it — we just have received so little data from the government. First, as we've heard throughout our legal studies, there is the problem in the type of data — there are just minimal data that are really available to us to know very much about it.

We've found so far; there's a desire to have increased data so we know more about these types of cases. A lot of times, as I did my speech, I quoted from Oregon or witnesses who have seen the more international experience, and for whom it has happened over a longer period of time. But that's something I know others are trying to encourage the federal government to do — to have better data collection so that we can know more about these types of cases. But the ability to waive that period, that's already in there. It would be retained.

For some, there might be a slightly longer — like a few days — period of suffering. However, I think the risk of somebody being put to death and potentially changing their mind if they were to have that reflection period, as opposed to; it's already quite a short period of time. As I said, we were going to have a longer period of time. Some of us wanted to have a much longer period of time.

[Senator Batters]

But it's only 10 days. It's a short period of time, and that's why I think this is a reasonable safeguard. It was something Jody Wilson-Raybould thought was a reasonable safeguard, as did Jane Philpott, health minister at the time. They thought it was crucial to have those safeguards in place and make sure the most vulnerable people were protected, because that's what we have to do. We have to look at that small — maybe small — certain number of people who might be affected in the worst possible dire consequences, that they may have been put to death but might instead have changed their mind.

The Hon. the Speaker pro tempore: On debate.

[Translation]

Hon. Chantal Petitclerc: Honourable senators, I am opposed to this amendment that offers no additional protection to patients and could potentially add to their suffering.

[English]

The first part of the proposed amendment would aim to retain the current reflection period of 10 days for persons whose death is reasonably foreseeable, following the signing of their MAID request. In Bill C-7, the removal of the 10-day reflection period is based on the lived experiences of clinicians, caregivers, practitioners and family members over the past four years, who have told us time and time again that forcing someone to wait 10 more days — whose death is reasonably foreseeable and who has already been assessed and approved — only brings additional suffering.

[Translation]

I want to note that this is not an evaluation period. The current system already includes a mandatory reflection period between the approval of a request and the administration of MAID.

As Minister Hajdu told the Standing Senate Committee on Legal and Constitutional Affairs, it turned out that this reflection period was not fulfilling the original intent of giving the person time to reflect on their decision before receiving MAID. The experience of the past four years and the consultations showed us that, rather, the reflection period served only to prolong suffering for individuals who had already considered their circumstances very carefully and who had already taken significant time to reflect on their decision before requesting MAID. This was confirmed by several witnesses who appeared before the committee, including Dr. Alain Naud from Université Laval, who said, and I quote:

Patients who request medical assistance in dying don't do so hastily, as an impulsive move. It's a deliberate request, the result of a long-term decision-making process, and I would say that virtually 100% of patients who make a request have already discussed it with their circle, their attending physicians and their nurses. All of them are already aware of the decision.

[English]

During the consultation period to prepare the legislative response to the *Truchon* decision, experts and practitioners have consistently indicated that the mandatory reflection period causes patients to suffer unnecessarily while waiting for the procedure.

[Translation]

They have even noted that some patients chose to stop taking their medications to avoid the risk of losing their capacity to consent to MAID before they could receive the procedure.

[English]

The change proposed by Bill C-7 would only affect persons whose death is foreseeable. As I already mentioned, these persons seek MAID after careful consideration, and they are firm in their wishes.

Several witnesses to the Legal and Constitutional Affairs Committee during the study welcomed this measure.

The same reasoning applies to the reduction in the number of witnesses; the other part of the amendment. During the round table consultations held in January 2020, there was overwhelming support for removing the requirement for two witnesses. MAID providers and assessors have consistently reported that finding two witnesses who are not subject to the exclusions in the Criminal Code constitutes an access barrier for many individuals seeking MAID.

[Translation]

That is especially true for people living in care homes or other residences where their family or social networks may be very limited. When I agreed to sponsor this bill, this was one of the first things I asked the department's representatives about. I wondered why the requirement for two witnesses was being removed and why it was so difficult to find two witnesses. I was surprised by this, perhaps because I am at a point in my life where I am very well supported. However, I was shocked that for many seniors living in rural areas, and also for all kinds of reasons, finding the required two witnesses can be a very significant barrier.

• (1930)

Furthermore, it is false to say that reducing the required number of witnesses to just one would weaken the protection of vulnerable people. That is very important, and I want to remind senators that the one and only role of the witness is to attest to the signing and dating of the MAID request. The witness plays no role in assessing the eligibility —

The Hon. the Speaker pro tempore: Thank you very much, Senator Petitclerc.

Hon. Pierre J. Dalphond: The amendment regarding the number of witnesses is supported by many individuals and groups who testified before the Standing Senate Committee on Legal and Constitutional Affairs. Dr. Yves Robert, secretary of the order at the Collège des médecins du Québec, said, and I quote:

We also support the amendment to the Criminal Code that would require the signature of a single witness only on a request for medical assistance in dying. This will greatly facilitate the request process.

In addition, Dr. Alain Naud, a clinical professor at Université Laval, said, and I quote:

The following aspects of Bill C-7 should be retained: the requirement that a request be signed before only one witness, who may be a caregiver, which is extremely important

In its brief, the Barreau du Québec said, and I quote:

What is more, under the bill, from now on, only one witness will be needed to sign the MAID request, as opposed to the two witnesses the law currently requires. In our opinion, these changes solve a significant problem encountered on the ground, namely the difficulty of finding witnesses who meet the criteria to act as such, particularly for more isolated individuals or those living alone.

[English]

Professor Jocelyn Downie from Dalhousie University said, “. . . reducing the witness requirement removes a burden on access that did not provide a compensatory benefit of protection.”

Dr. Joshua Wales, palliative care physician at Sinai Health said:

. . . I strongly agree that reducing the number of independent witnesses for the patient's written request from two to one and allowing that witness to be a health care or personal care provider removes a barrier to access that many individuals experience, especially those who are more socially isolated. This change will result in more equitable access to MAID.

It is critical to understand that the only role of the witness is, as Senator Petitclerc just said, to confirm the identity of the person signing and dating their request. Witnesses play no role in determining whether someone is eligible for MAID or whether their decision is voluntary or informed.

For example, the Ontario MAID request form asks the witness to confirm the following, and only the following, before signing:

I am at least 18 years of age; I understand the nature of the person's request for medical assistance in dying; the patient . . . signed the request for medical assistance in dying in my presence and in the presence of the other independent witness —

— when there are two —

I am signing under the person's direction.

And that the witness is independent from the requestor and will not financially benefit from the requestor's death.

That confirms, of course, the independence.

In short, the witness does not assess or confirm the requestor's capacity to consent. That's not providing any security whatsoever.

As for the removal of the 10-day reflection period, suffice to say that we have heard from many witnesses that this additional period often prolongs the suffering. For example, Dr. Stefanie Green, President of the Canadian Association of MAiD Assessors and Providers said:

In four and a half years, there has been no evidence this reflection period has safeguarded anyone from anything, but there is both subjective and objective evidence to suggest it has mandated substantial suffering.

Colleagues, there's no need to prolong suffering, and there's no justification for it. Thank you. I don't support this amendment, of course, you understand. I invite you to vote against it. Thank you.

The Hon. the Speaker pro tempore: Do you have a question, Senator Batters?

Senator Batters: I do. Would Senator Dalphond take a question?

The Hon. the Speaker pro tempore: You have a minute and a half.

Senator Batters: I have a couple of questions for Senator Dalphond. First, you referenced what Senator Petittelerc said and what you repeated as the role of the witness. However, in my speech I indicated what the Department of Justice officials, whom I questioned when they were there to help us with the bill — and these are the people who draft the bill — said:

Our view would be that the role of the witness to the written request is both to confirm that the person signing the request is the person the request is about and to confirm that that person understands what it is they are signing and is signing it voluntarily.

That was something that Minister Hajdu did not seem to know when she testified, and both of you have indicated what she said. However, the Justice officials indicate something very different: voluntariness is something that the witnesses assess.

As well, would you agree that, with the increased number of people who are now allowed to be witnesses — including people who care for the patients in those care homes — under Bill C-7, it is much easier to find those two witnesses? Would you concede that? Thank you.

Senator Dalphond: I refer to the form used by the witnesses in Ontario. I respect that the minister may have a different view, but the practice is in the field, and these forms are subject to the rules that have been adopted in Ontario for the witnesses.

Hon. Donald Neil Plett (Leader of the Opposition): Honourable senators, I rise today to speak in favour of Senator Batters' proposed amendment to restore safeguards that have been unjustifiably removed from this legislation.

I am very concerned about the dilution of safeguards from our existing regime and the consequences of diluting those safeguards, particularly because we have been told by experts that we do not have any evidence to justify their removal.

Bill C-14 put in place a waiting period of at least 10 clear days after signing a request for medical assistance in dying. This request must also be signed and dated by two independent witnesses before MAiD is provided. The purpose of that clear 10-day period has been to provide a period of time where the full implications of that decision should be considered, both by the patient and by the patient's practitioners. This is to ensure confidence in the patient's desire to receive physician-induced death.

Bill C-14 was focused on individuals who have a grievous and irremediable medical condition. Exceptions were incorporated into the legislation to waive the 10-day reflection period if the medical practitioners agreed that death was fast approaching or if, alternatively, an individual might soon lose the capacity to provide informed consent.

We know that, according to the *Canadian Medical Association Journal*, this waiting period has, in fact, been waived. On its website, the Government of Canada indicates that the purpose of the waiting period is to:

Provide patients ample time to reconsider their request and allow health practitioners to feel confident about the sustainability of the individual's decision.

I believe that safeguards were very appropriate in that, while flexible, they reinforced the exceptional nature of what was being enshrined in legislation. Namely, that medical assistance in dying should be provided but that every effort would be made to ensure the patient fully understood the implications of his or her decision. The waiting period also enables a patient to be fully aware of the potential health care alternatives to assisted death.

The principle was that a person's worst day should not automatically transition into being their last day due to a decision largely made in an atmosphere of pain and suffering. The 10-day reflection period that exists in our current legislation comes from the published work of Dr. Harvey Chochinov, who found that desire to die in the terminally ill fluctuates and often dissipates in two weeks. When Minister Hajdu was asked about removing the safeguard, she stated that often, when the formal request is made, this is after long, difficult conversations with families and physicians, and that when this decision is finally reached, waiting an additional 10 days is unnecessarily cruel. However, the minister is missing the point entirely. We all know that safeguards are not put in place for what is often the case. Safeguards are put in place for the exact opposite reason: to

prevent unnecessary and wrongful death in situations that are less obvious, where an individual does not have such a support system or is experiencing fleeting suicidal ideations.

• (1940)

Honourable senators, we would like to believe that adequate and equal care is provided to all patients in such circumstances. But we know from experience that this is not the case. Over 1,000 practising Canadian doctors recently signed an open letter in relation to noting that up to 70% of citizens nearing the end of life still have no access to basic palliative care services. Colleagues, I find it most disturbing that our answer to this problem now is that we will make medical assistance in dying easier to obtain, and that we will do them a favour by reducing the safeguards around any request that they make for that service.

As Dr. Leonie Herx of the Canadian Society of Palliative Care Physicians wrote recently:

Almost all of the patients I work with in palliative care have a reasonably foreseeable death, and so with the new law, the removal of the 10 day waiting period from time of request to receiving MAiD (medical assistance in dying) means that my patients, almost all of them, if they were to express a desire to die, could be offered MAiD, or request MAiD, and die that day.

So, in essence their worst day becomes their last day without any opportunity for healing.

This is extremely unsettling, honourable senators. Let's not lose sight of the importance of safeguards in this legislation dealing with life and death. I hope you will join me in voting in favour of this amendment so the safeguards that have undoubtedly prevented unnecessary death can continue to serve this function under this revised regime. Thank you.

Some Hon. Senators: Hear, hear.

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

Hon. Senators: Question.

The Hon. the Speaker pro tempore: If you are opposed to the motion in amendment, please say "no."

Some Hon. Senators: No.

The Hon. the Speaker pro tempore: Those in favour of the motion and who are in the Senate Chamber, please say "yea."

Some Hon. Senators: Yea.

The Hon. the Speaker pro tempore: Those opposed to the motion and who are in the Senate Chamber, please say "nay."

Some Hon. Senators: Nay.

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

I see two senators rising.

And two honourable senators having risen:

The Hon. the Speaker pro tempore: We have a 15-minute bell, so the vote will take place at 7:58. Call in the senators.

• (1950)

Motion in amendment of the Honourable Senator Batters negated on the following division:

YEAS THE HONOURABLE SENATORS

Anderson	McCallum
Ataullahjan	McPhedran
Batters	Miville-Dechêne
Black (<i>Ontario</i>)	Mockler
Boisvenu	Ngo
Brazeau	Oh
Deacon (<i>Ontario</i>)	Plett
Downe	Poirier
Lankin	Stewart Olsen
MacDonald	White
Marshall	Woo—23
Martin	

NAYS THE HONOURABLE SENATORS

Bellemare	Griffin
Bernard	Harder
Black (<i>Alberta</i>)	Hartling
Boehm	Jaffer
Boniface	Keating
Bovey	Kutcher
Boyer	LaBoucane-Benson
Busson	Loffreda
Carignan	Lovelace Nicholas
Cordy	Marwah
Cormier	Mégie
Cotter	Mercer
Coyle	Moncion
Dalphond	Munson
Dasko	Omidvar
Dawson	Pate
Deacon (<i>Nova Scotia</i>)	Patterson
Dean	Petitclerc
Duffy	Ravalia
Duncan	Saint-Germain

Dupuis	Seidman
Forest-Niesing	Simons
Francis	Smith
Frum	Tannas
Gagné	Wallin
Gold	Wetston—52

ABSTENTIONS
THE HONOURABLE SENATORS

Manning	Wells—2
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• (2010)

Hon. Yonah Martin (Deputy Leader of the Opposition):
Honourable senators, I rise today to speak on Bill C-7. I will be bringing forward an amendment.

I know that every senator in this chamber has deeply held views on this legislation. I respect those divergent opinions. But what we share in common, I believe, is a desire to ensure that we do the best for patients and families who are at the most difficult time in their lives — the end of one's life or the death of a loved one.

Without the five-year review that was promised after the enactment of Bill C-14 and with only a limited number of witnesses and testimonies, albeit far more than during the House of Commons study of Bill C-7, most of us have not witnessed the full MAID regime from start to the last stage. None of us have received MAID — obviously — to truly understand medical assistance in dying itself, or fully comprehend the immense complexities, strains and pressures around the end-of-life experience involving MAID.

In that context, I'm very concerned that, while we are now seeking to expand the applicability of medical assistance in dying, we are removing safeguards and are failing to provide sufficient protections to ensure that the will of the patient is always respected throughout the entire process, even at the last possible moment. After all, unlike being able to change one's medication due to an adverse reaction or overcoming an error in a medical procedure, receiving MAID is fatal.

If we examine the principles inherent both in this bill and in Bill C-14, passed during the previous Parliament, we note that these principles stress the fact that medical assistance in dying is always to be initiated by the patients themselves. Bill C-14 noted the robust safeguards, reflecting

... the irrevocable nature of ending a life, are essential to prevent error and abuse in the provision of medical assistance in dying.

The preamble to the bill we have before us, Bill C-7, also reiterates this principle by stating that, among the interests and societal values that must be balanced is "the protection of vulnerable persons from being induced to end their lives . . ."

Colleagues, it is my view that these principles are even more important now, given the scope of the legislation we have before us, because of the amendments that have been adopted thus far.

Honourable senators, some of you have spoken about personal experiences with end-of-life circumstances involving loved ones, and I have been moved to tears. I have several of my own as well. The atmosphere is highly emotional. Patients may not be fully present or be aware of their surroundings. They may be partially present but their statements may be imprecise, their gestures not perfectly understood. Persons in the room, whether family or medical practitioners, may have differing interpretations as to a patient's desires and reactions.

While in a palliative setting for my father, I clearly recall the moments before, and that moment of my father's final breath, and the intensity of those minutes. This is why I believe we must ensure that the legislation which governs medical assistance in dying must give every benefit of doubt to respecting the clear will of the patient during the process itself, to the very last possible moment.

Again, I remind colleagues that what we are talking about is irreversible. Given that stark reality, it is vital that we at least try to ensure that the will of the patient remains paramount. I believe that the legislation must err on the side of caution in interpreting the will of the patient during the MAID process. It is in this context that the "greater certainty" clause currently found in the bill causes me to pause every time I read it.

Clause (3.3) states:

For greater certainty, involuntary words, sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance for the purposes of paragraph (3.2)(c).

What concerns me about this clause is the highly subjective nature of what is being articulated. Even persons who have known an individual for their whole lives will have different interpretations of what may be a substantive statement by an individual versus involuntary words. The last thing we want to do is to contribute to confusion, and dispute as to whether an irreversible decision was properly and legally taken.

What further concerns me about this clause is that it makes a presumption. It states that

... sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance for the purposes of paragraph (3.2)(c).

Surely every circumstance will be different, just as every patient is different. It is completely wrong to write only one interpretation into legislation.

When Professor Trudo Lemmens testified before the Standing Senate Committee on Legal and Constitutional Affairs, he referenced this issue of advance consent versus the patient's reaction when MAID is actually being administered. He made reference to a very disturbing case in the Netherlands where a person with dementia had given an advance directive for MAID, but on the day it was administered, the patient resisted. Despite

that, the person was given MAID. The movements of that patient were believed by some to have been involuntary, but others had a very different interpretation. It resulted in legal proceedings against the doctor in question.

An article in the *Journal of Medical Ethics* describes this dispute over the will of the patient as the “then-self versus the now-self” dilemma. How does one interpret gestures and movements as a patient is being impacted by their illness, by medical procedures and by the very lethal circumstances of the MAID process?

Included among these medical circumstances is the impact that medications may have on different patients. In this regard, there is so much that we do not know, but what we do know is that patients’ experiences with drugs will not be uniform.

My father, for instance, was one such outlier of every single medication or procedure he was given while hospitalized over an 18-month period. He was the daily subject of the team of medical professionals who were part of his complex care at several institutions. He experienced severe reactions and was captured in the 1% to 5% of patients who are at risk of experiencing a dangerous side effect of a procedure without fail.

I am my father’s daughter. I, too, am such an outlier. A normal dose of a drug that relaxes most people is sure to elicit an adverse reaction in me.

• (2020)

In British Columbia, the *Medical Assistance in Dying Protocols and Procedures Handbook* of Comox Valley references several possible scenarios. It acknowledges that sedatives can “cause restlessness.” It states that on very rare occasions the drugs may not place the patient in a medically induced coma. The protocol incorporates a backup plan in case of failure of MAID.

What is clear to me from the testimony I heard at committee is that medical professionals do not always agree on many of the issues concerning the administration of drugs and the impact those same drugs will have on different patients. In fact, interpretations and analyses can be starkly different.

On the one hand, we heard medical witnesses tell our committee that the drugs used in MAID essentially induce a peaceful death. Some witnesses even described the MAID process as “elegant,” while other witnesses presented a very different picture.

Dr. Joel Zivot, a professor at Emory University and practising anaesthesiologist and intensive care medicine specialist, explained that what one sees on the surface can be deceiving:

Let me also be clear, though, that the way a person would die with medical assistance in dying is going to be with a combination of the propofol but mostly the paralytic. The propofol is given in a very large quantity, 10 times what I would give in the operating room.

To state that the death that the person experiences is peaceful, this is unknowable or false. To say that it outwardly appears to be peaceful, I suppose that would be true. But that is a chemical myth put in place. . . .

Professor Zivot has provided anaesthetics and sedation to over 50,000 people, so his testimony should not be discounted.

As previously stated, we haven’t conducted a thorough review of the MAID regime, nor of the protocols in place. I know that different provinces have different protocols and experiences, and perhaps even cooperation going forward, but a thorough review has yet to be done across the country. Currently there are no national or consistent provincial standards. There is a lack of clear understanding and there are discrepancies about the pharmacology involved in the MAID protocol. In addition to all of these complexities, expansion of the regime is taking place during a pandemic that is stressing an already stressed medical system.

Originally, when Bill C-14 was enacted, we were told that Parliament would conduct a thorough review of the impact of the legislation five years after enactment. Now we are told that we must approve and enact a major expansion of MAID even before that review is conducted. The government has said that we must do this to respond to a lower court’s decision in *Truchon*. Instead of conducting a careful assessment, based on evidence, about how MAID has been implemented to date, the timeline of a lower court is driving this headlong expansion of MAID. If this is the way the government is determined to proceed, then at a minimum we should seek to ensure that we err on the side of caution in protecting patients.

Given all that we do not know, and in the absence of the five-year review we were promised, the process of administering MAID must minimize the possibility of error when it comes to respecting the will of the patient at the time of death by assisted suicide. To do otherwise will create extreme moral distress for both family members and health care providers.

We have heard conflicting evidence, which is both confusing and concerning. The United Nations Convention on the Rights of Persons with Disabilities states that all persons are equal before and under the law and are entitled, without any discrimination, to the equal protection and equal benefit of the law. Where an individual has lost capacity, those fundamental rights remain unaffected and must be protected. In my view, this means we must ensure that we do not deliberately and unambiguously discount gestures or signals that may indicate that a person has changed his or her mind.

Colleagues, there are still many unknowns regarding the MAID process, and we are all learning what a person at this stage of MAID truly wants or is truly experiencing. Until we are convinced beyond a reasonable doubt, we should not have such a sweeping clause.

MOTION IN AMENDMENT NEGATIVED

Hon. Yonah Martin (Deputy Leader of the Opposition): Therefore, honourable senators, in amendment, I move:

That Bill C-7, as amended, be not now read a third time, but that it be further amended in clause 1, on page 6, by deleting lines 16 to 19.

Unless you can say with absolute certainty that all words, sounds or gestures are involuntary, I urge you, honourable senators, to also err on the side of caution and support this amendment. Thank you.

Hon. Chantal Petitclerc: Honourable senators, Senator Martin, as you well know, I do hear and respect your concerns, but I do not agree and I will oppose this amendment.

[Translation]

To put this in context, Bill C-7 would allow MAID for someone whose natural death is reasonably foreseeable without requiring final consent, which is commonly referred to as the Audrey Parker amendment.

In this scenario, an individual must be at risk of losing their decision-making capacity before the date chosen to receive MAID, and the individual must have already entered into an arrangement in writing with their practitioner, providing advance consent.

Pursuant to the proposed amendments, advance consent would be nullified if the individual indicates, through words, sounds or gestures — such as an involuntary reflex — that they are refusing or resisting MAID. In that case, naturally, the practitioner would not be able to proceed.

The amendments also very clearly state that reflexes or involuntary movements — emphasis on “involuntary,” such as twitching when touched — would not constitute refusal or resistance. Some of our colleagues who are far more qualified than I am know that medications can affect a person’s behaviour in such circumstances. For example, medication could render an individual incapable of demonstrating refusal or resistance or could cause them to become agitated.

If a person whose prior consent was no longer valid because they showed signs of resistance or refusal subsequently regains their decision-making capacity, they can take the necessary steps with their practitioner to receive MAID once they have that capacity.

[English]

In short, honourable senators, this justifies the inclusion in the bill of the paragraph on the waiver of final consent and that of the clarification that involuntary bodily reactions to contact do not constitute resistance or refusal.

In the government’s view, both the clause on resistance or refusal and the clarification are clear and appropriate.

With or without the “for greater certainty” clause, practitioners, as we know, will always use their expertise, competence and judgment to determine whether the patient is demonstrating refusal or resistance, or merely reacting involuntarily to contact. But by removing the “for greater certainty” clause, the proposed amendment may generate confusion for practitioners, who may no longer have a clear sense of what the law requires or permits.

I think the clarification is important, and for the reasons I have expressed I will not vote in favour of this proposed amendment.

Hon. Pierre J. Dalfond: Honourable senators, I won’t have much to add to what Senator Petitclerc said, because she said it clearly and I agree with everything she said.

I would like to add a quote from Dr. Stefanie Green, President of the Canadian Association of MAID Assessors and Providers:

The issues of consent, and capacity even, are essential in everything we do. And that is why we take so much time to assess patient support even before that decision to proceed happens. I think you’re asking me specifically about the moment that MAID is being provided. In that context right now, of course, we need to obtain final consent immediately. In the context of this amendment, we would be looking at a patient who has been deemed to have lost capacity to make that decision but has made an advanced request to proceed. There is certainly a difference that we all can recognize in the flinch of an arm when a needle is going in to start an IV, versus someone who looks at you and says, “Who are you?” or, “Why are you here?” or, “Please stop.”

There is a very obvious manner to make those distinctions. And I think that our clinicians have proven themselves to be very, very careful in this past four and a half years and will be especially more so in such a condition.

• (2030)

In summary, a patient can, when death is foreseeable, waive the right to provide the final consent at the time of administration of MAID. Why does he or she do that? Because they fear that they will lose the ability to consent. So they waive that. So the doctor or the medical practitioner walks into the room to administer, and they will face a person who is no longer able to consent. However, despite that, the government said if this person has shown signs that they are resisting — opposing — MAID, then the doctor should not provide MAID. So this is the principle.

This is only a clarification to say that a reflex, or some kind of thing when they see a needle or you place the needle in the arm and there may be some movement, is not a sign that the person is saying, “No, stop.” This is really better protection for the patient, who has already waived his consent and is no longer able to consent.

Hon. Michael L. MacDonald: Honourable senators, I won’t speak for long as I intend to enter the debate again in a few days. I do want to say a few words about this amendment. In my view, the amendment provides needed caution and clarity in an area of law and ethics that is entirely new.

As Senator Martin noted, we currently have two clauses in the bill which will, inevitably, result in added confusion and contribute to *ex post facto* disputes about whether consent was properly given.

This legislation is, in essence, compounding the conditions where families, practitioners, lawyers and judges will argue about whether a patient may have changed their mind, notwithstanding the advance directives that have been given by that patient perhaps years, even decades, before.

I think it is worth restating what clause 3.4 states:

Once a person demonstrates, by words, sounds or gestures, in accordance with subsection (3.2), refusal to have the substance administered or resistance to its administration, medical assistance in dying can no longer be provided to them on the basis of the consent given by them under subparagraph (3.2)(a)(iv).

But then clause 3.3 states:

For greater certainty, involuntary words, sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance for the purposes of paragraph (3.2)(c).

While it may often be clear what was an involuntary word, sound or gesture, it is absolutely certain that this will not always be clear, particularly after the fact.

What is to be done if there is a difference of opinion about whether a particular sound, gesture or word was involuntary?

What if one person in the room, perhaps someone who may have known the patient for years, regards a particular gesture that others consider “involuntary” as, in fact, actually constituting a substantive objection?

I agree with Senator Martin that, as a minimum, we should ensure in this legislation that we try to err on the side of caution in interpreting the will of the patient during the MAID process.

This issue is all the more important because, under the legislation, there is no limit to how long in advance a person can arrange in writing for MAID to be provided if they lose capacity. Theoretically, the arrangement could be made for years into the future, calling into even greater question the gestures and words a person utters during the MAID process.

Thomas McMorrow is an Associate Professor of Legal Studies in the Faculty of Social Science and Humanities at Ontario Tech University. He has stated the following in relation to this issue:

Having the capacity to give or withdraw consent at the moment of provision is the lynchpin of the system of safeguards governing MAiD in this country. In other words, receiving MAiD requires contemporaneous, not advance or implied, consent. This protects people from having their lives ended against their will.

Surely, the protection of people from having their lives ended against their will should remain an overarching principle for every senator in this chamber.

Professor McMorrow raises additional questions about what happens even when there is agreement that a particular sound or gesture may not have been involuntary and the MAID process is stopped.

So it begs the questions: Can different potential dates for death be established as part of advance consent?

In those circumstances, could MAID be attempted again later, even if dissent stopped the process in an initial attempt?

There is already incredible uncertainty in this legislation without compounding it further as a result of disputes over what constitutes a voluntary versus potentially involuntary objection.

The uncertainties built into this legislation are unfortunately inevitable, given the somewhat artificial — and I would suggest somewhat irresponsible — way in which the government has rushed this legislation in an entirely new area of Canadian law.

Yet, we do have to have underlying principles in Canadian law around advance consent that we should still seek to apply.

In 2018, The Expert Panel Working Group on Advance Requests for MAID, formed by the Council of Canadian Academies, noted that consent includes the following principles:

Healthcare consent must be informed. . . . Informed consent must be voluntary

Physical dissent on the part of the incapacitated person precludes participation, regardless of any written directive.

In my view, the proposed amendment is consistent with these principles.

This amendment reinforces the clarity and caution that one should expect to accompany such critical matters. I’m going to support this amendment and I encourage all honourable senators to support it as well.

Some Hon. Senators: Hear, hear.

Hon. Stan Kutcher: I will speak against this amendment. I will use this time to encourage us to think critically about information that we hear, the validity of evidence and the reliability of those who provide it to us, and that we do not cherry pick outlier opinions and ignore the weight of other experts.

We have seen the impact of the chaos this can cause with the hydroxychloroquine story in COVID-19, and we don’t need to repeat this with MAID.

In fact, in response to misinformation that was presented to our body about the use of midazolam, four physician senators took the extraordinary step of consulting with experts from across this country to clarify the issue of how midazolam is actually used, and the brief was submitted to the committee by Senator Mégie and shared with all our colleagues.

• (2040)

It is important that we get our information, not from Professor Google, but from those experts who actually are expert in the area that they are opining on.

We've also seen this kind of intervention with our witnesses. Senator Martin raised the testimony of Dr. Zivot. Dr. Zivot opined about a drug that is not used in MAID protocols in Canada. He has never provided MAID. He has not even observed a MAID procedure.

Let me share with you a letter I received earlier today from someone who does provide MAID and who understands the protocols because he specifically wrote to me about Dr. Zivot's testimony.

I have had multiple letters, and I just happened to save this one. I've had comments such as "I nearly fell off my chair when I listened to what was said," and "bizarre."

I will read:

I am so and so. I've been a MAID assessor and provider since August 2016. I have personally performed 137 MAID procedures and attended others.

I would like —

I'm cutting this.

— I would like to express specifically points made by Dr. Zivot. As you recall, he forwarded the notion that people who receive MAID die an unpleasant death because of drowning by pulmonary edema. He cites autopsies conducted by Americans who received execution from lethal injection —

By the way, we've never seen those reports and been able to evaluate them.

Well, he stated that autopsies are not done on MAID patients in Canada. That's not entirely true.

He goes on to talk about a case of his that had a MAID procedure. He conducted an autopsy through the Ontario coroner's office and had a post-mortem examination done. The request was endorsed by the husband and family. Then, he talks about some of the autopsy and the findings of Lewy body dementia. The entire body was examined. She did not have pulmonary edema.

For the 137 MAID procedures I have personally conducted and in the cases I have witnessed, I have seen a peaceful and dignified death 100% of the time. There has

never been an outlier to this observation. I have never seen respiratory distress or even symptoms, other than the cessation of breathing.

I have also done two MAID procedures where the patient went on to donate organs, including lungs. There was no pulmonary edema or lung damage. These lungs went on to save a life in Ontario.

In my extensive experience, I would state without reservation that anyone who passionately claims that people suffer during a MAID procedure is forwarding a conspiracy theory.

And he goes on.

Honourable senators, it is important that when we debate these challenging and fiercely important topics, we stick to the facts, we don't indulge in conspiracy theories, that we don't look at outliers that are way off the page, and that when we ask people to be experts in MAID, that they actually are experts in MAID.

Honourable senators, I cannot support this amendment, and I hope you don't either. Thank you.

Some Hon. Senators: Hear, hear.

Hon. Mary Jane McCallum: I would like to ask a question.

The Hon. the Speaker pro tempore: You have 35 seconds.

Senator McCallum: Doctors who have been working with MAID are in a privileged and unique situation. Do you know how long it takes doctors to gain expertise in the interpretation of such a unique type of communication that patients have, when it's not oral or verbal and instead you're looking at sounds and body movements? Will other doctors or medical people gain this expertise?

The Hon. the Speaker pro tempore: Senator McCallum, I'm sorry, the time has expired.

Hon. Rosemary Moodie: Honourable senators, I wanted to start by sharing a few thoughts around the question of the validity of MAID procedures and some of the information that we have received from witnesses that seeks to shed some light on the comparison between, completely frankly, an unrelated set of procedures; that of lethal injection.

My office started to look at the experience of MAID providers some months ago, and we conducted a survey of 17 clinicians throughout the country in various settings; clinicians who work within urban settings and within large groups, some who have conducted hundreds of cases of MAID procedures. We also spoke to physicians who worked in the more geographically isolated areas, sole practitioners who were conducting MAID procedures as well.

We learned certain key things from them. What we learned was, in fact, these witnesses, these people who are all only medical experts in this area, have each conducted hundreds of MAID procedures. All of them described their experiences as

they witnessed these procedures, bar none, as peaceful, restful, to the point of happiness in some cases, and undisturbed individuals who passed through a MAID procedure.

They described no instances where people struggled, fought, had violent reactions or some of the descriptions that we have heard from witnesses who attempt to compare lethal injection to MAID procedures.

What we heard from witnesses who have had some experience on a topic — lethal injection — but who are not medical experts on MAID, was a description of a very different procedure from the protocols and the oversight that we provide here in Canada. A scan of what the protocols look like, and what they are, reveals that there's consistency across the country.

There are five drugs, in some cases six drugs, used when required. There is a similarity in the drugs that are being used, and there is a consistency of approach used by all practitioners. There is clear documentation of the procedure, and the storage and availability of the information that is collected are transparent. It's retrievable, colleagues. It's something that can be examined. It doesn't disappear into nothing. It's there.

In fact, this is very different to what happens in lethal injection, where there may or may not be a clinician of any sort present, whether it be a nurse or a physician; where, in fact, there may not be as carefully controlled circumstances. Where, in fact, the exercise of that procedure may be quite different and have different outcomes.

Much of the intervention of MAID has focused on this irrelevant comparison, and while interesting, we cannot verify the expertise of the witness that we heard. He has never, by his own admission, had peer-reviewed research publications or any other contributions to the literature in this area that we can examine and that we can verify as to whether it is, in fact, credible information.

• (2050)

Secondly, there was a paper published. The details are a lung transplant done from a home in Ontario. You heard about that from Senator Kutcher just now. If you'd like, we can share that information with you. Dr. Eric Thomas provided that information. He talks about the experiences he has had in many cases. He talks about the patient he had with the MAID procedure in November, the one you just heard about, and the fact that she did not have pulmonary edema when her lungs were removed for transplant.

We have also learned that there are a number of patients who allow their organs to be transplanted, patients who opt for the MAID procedure and donate their organs. In general, what we know about organ transplantation —

The Hon. the Speaker pro tempore: I'm sorry, Senator Moodie, your time has passed and we have to move on to debate with Senator Mégie.

[Translation]

Hon. Marie-Françoise Mégie: Honourable senators, I second everything that my colleagues, Senator Kutcher and Senator Moodie, said. However, I'd like to raise one small point that is often problematic. Sometimes, patients move their arms, and people might interpret that as a sign of refusal or unwillingness. Most of the time, when that happens, the patient has already begun to receive the first dose or one of the first doses of sedative. They should be relaxed, and they are. However, a phenomenon called fasciculation may occur. These are small, involuntary muscle movements. To the uninitiated, the patient pulling their arm away may appear to signal refusal. Doctors are aware of this phenomenon and know when they can continue, because these movements aren't evidence of refusal on the part of the patient. Often, the patient's loved ones can say if the patient expressed that desire. The doctor can also stop and ask the question again if the patient isn't already in a coma.

That's the nuance I wanted to point out to complement what my colleagues have said. With regard to medication, you received a document that provides all the details, and we were able to have it confirmed by colleagues from all the provinces. If you read it carefully, I think you should have grasped the difference between the dosages that are used for medical treatment and the much higher dosages used for lethal injections, which are given in the United States, but not in Canada. Thank you.

[English]

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

Some Hon. Senators: Question.

The Hon. the Speaker pro tempore: In amendment, it was moved by the Honourable Senator Martin and seconded by the Honourable Senator Plett:

That Bill C-7, as amended, be not now read a third time, but that it be further amended in clause 1, on page 6, by deleting lines 16 to 19.

The Hon. the Speaker pro tempore: Those in favour of the motion who are in the Senate Chamber will please say "yea."

Some Hon. Senators: Yea.

The Hon. the Speaker pro tempore: Those opposed to the motion who are in the Senate Chamber will please say "nay."

Some Hon. Senators: Nay.

The Hon. the Speaker pro tempore: I believe the “nays” have it. I see two senators rising.

And two honourable senators having risen:

The Hon. the Speaker pro tempore: We'll have a vote at 9:09 p.m. Call in the senators.

• (2110)

Motion in amendment of the Honourable Senator Martin negatived on the following division:

YEAS

THE HONOURABLE SENATORS

Anderson	McCallum
Ataullahjan	Mockler
Batters	Ngo
Boisvenu	Oh
Carignan	Plett
MacDonald	Poirier
Marshall	Smith—15
Martin	

NAYS

THE HONOURABLE SENATORS

Bellemare	Jaffer
Bernard	Keating
Black (<i>Alberta</i>)	Kutcher
Black (<i>Ontario</i>)	LaBoucane-Benson
Boehm	Lankin
Boniface	Loffreda
Bovey	Lovelace Nicholas
Boyer	Marwah
Brazeau	McPhedran
Busson	Mégie
Cordy	Mercer
Cormier	Miville-Dechêne
Cotter	Moncion
Coyle	Moodie
Dalphond	Munson
Dasko	Omidvar
Dawson	Pate
Deacon (<i>Nova Scotia</i>)	Patterson
Deacon (<i>Ontario</i>)	Petitsclerc
Dean	Ravalia
Downe	Saint-Germain
Duffy	Seidman
Dupuis	Simons
Forest-Niesing	Stewart Olsen
Francis	Tannas

Frum
Gagné
Gold
Griffin
Harder
Hartling

Wallin
Wells
Wetston
White
Woo—61

ABSTENTION

THE HONOURABLE SENATOR

Manning—1

The Hon. the Speaker pro tempore: Senator Manning.

Hon. Fabian Manning: Honourable senators, I'd just like the opportunity once again to explain my vote. I do not agree with the origin of MAID, therefore, I cannot agree to any of the amendments to the legislation. Thank you.

The Hon. the Speaker pro tempore: Thank you.

(At 9:22 p.m., pursuant to the order adopted by the Senate on February 8, 2021, the Senate adjourned until 2 p.m., tomorrow.)

APPENDIX

DELAYED ANSWER TO ORAL QUESTION

AGRICULTURE AND AGRI-FOOD

AGRISTABILITY

(Response to question raised by the Honourable Donald Neil Plett on November 3, 2020)

Agriculture and Agri-Food Canada (including the Canadian Pari-Mutuel Agency)

The Government recognizes agriculture as an essential service and is committed to supporting producers and businesses.

Federal, provincial, and territorial (FPT) governments implemented changes to AgriStability to respond to the impacts of COVID-19, including extending the enrollment deadline for 2020, as well as increasing advances on AgriStability payments, with interim payments rising from

50% to 75%. These changes will help farmers manage impacts of market disruptions, increased expenses, and production challenges.

On average, FPT governments have spent \$1.6 billion annually on Business Risk Management (BRM) programs over the last 5 years. BRM programs are cost-shared at 60 percent federally, 40 percent provincially-territorially.

Last November, during the two-day virtual conference with its FPT counterparts, Agriculture and Agri-Food Canada made a concrete offer to make immediate enhancements to AgriStability, including removal of the Reference Margin Limit and increasing the compensation rate. Several provinces and territories are currently seeking authority to increase their provincial-territorial 40 percent share of the changes, and the Government hopes to move forward with changes in the near future.

CONTENTS

Wednesday, February 10, 2021

PAGE		PAGE		
SENATORS' STATEMENTS		Health		
Lunar New Year		COVID-19 Vaccine Procurement		
Hon. Victor Oh	887	Hon. Leo Housakos	893	
The Late Chief Ron Michel		Hon. Marc Gold	893	
Hon. Mary Jane McCallum	887	Finance		
Insulin—One-Hundredth Anniversary		COVID-19 Economic Response Plan		
Hon. Jim Munson	887	Hon. Yonah Martin	893	
Play On! Street Hockey Championships		Hon. Marc Gold	894	
Hon. Douglas Black	888	Delayed Answer to Oral Question		
Black History Month				894
Hon. Marie-Françoise Mégie	888	Point of Order		
The Late Christopher Plummer, C.C.		Hon. Yonah Martin		
Hon. Pamela Wallin	889			
ROUTINE PROCEEDINGS		<hr/> ORDERS OF THE DAY		
Kindness Week Bill (Bill S-223)		Business of the Senate		
First Reading				
Hon. Jim Munson	889			
<hr/> QUESTION PERIOD		Criminal Code (Bill C-7)		
Finance		Bill to Amend—Third Reading—Debate		
COVID-19 Economic Response Plan		Hon. Donald Neil Plett		
Hon. Yonah Martin	889	Motion in Amendment Negatived		
Hon. Marc Gold	890	Hon. Donald Neil Plett		
Foreign Affairs		Hon. Frances Lankin		
Islamic Revolutionary Guard Corps		Hon. Marc Gold		
Hon. Linda Frum	890	Hon. Mohamed-Iqbal Ravalia		
Hon. Marc Gold	890	Hon. Pierre J. Dalphond		
Justice		Hon. Salma Ataullahjan		
Medical Assistance in Dying		Hon. Marie-Françoise Mégie		
Hon. Éric Forest	891	Hon. Mary Jane McCallum		
Hon. Marc Gold	891	Hon. Stan Kutcher		
Health		Hon. Renée Dupuis		
COVID-19 Pandemic—Rapid Testing		Hon. Julie Miville-Dechêne		
Hon. Bev Busson	891	Hon. Fabian Manning		
Hon. Marc Gold	891	Hon. Pamela Wallin		
Internal Economy, Budgets and Administration		Motion in Amendment Adopted		
Business of the Committee		Hon. Pamela Wallin		
Hon. Diane F. Griffin	892	Hon. Paula Simons		
Hon. Sabi Marwah	892	Hon. Jane Cordy		
Canadian Heritage		Hon. Kim Pate		
Official Languages—Appointment of Governor General		Hon. Chantal Petitclerc		
Hon. Jean-Guy Dagenais	892	Hon. Diane Bellemare		
Hon. Marc Gold	892	Hon. Lucie Moncion		
		Hon. Marc Gold		
		Hon. Frances Lankin		
		Hon. Pierre J. Dalphond		
		Hon. Pierre-Hugues Boisvenu		
		Hon. Claude Carignan		
		Hon. Jim Munson		
		Hon. Renée Dupuis		
		Hon. Colin Deacon		
		Hon. Patricia Bovey		
		Criminal Code (Bill C-7)		
		Bill to Amend—Third Reading—Debate		
		Hon. Denise Batters		

CONTENTS

Wednesday, February 10, 2021

	PAGE		PAGE
Motion in Amendment Negatived		Hon. Marie-Françoise Mégie	925
Hon. Denise Batters	915	Hon. Fabian Manning	926
Hon. Marty Deacon	916		
Hon. Chantal Petitclerc	916		
Hon. Pierre J. Dalphond	917		
Hon. Donald Neil Plett	918	APPENDIX	
Hon. Yonah Martin	920		
Motion in Amendment Negatived			
Hon. Yonah Martin	922		
Hon. Chantal Petitclerc	922	DELAYED ANSWER TO ORAL QUESTION	
Hon. Pierre J. Dalphond	922		
Hon. Michael L. MacDonald	922	Agriculture and Agri-Food	
Hon. Stan Kutcher	923	AgriStability	926
Hon. Mary Jane McCallum	924		
Hon. Rosemary Moodie	924		