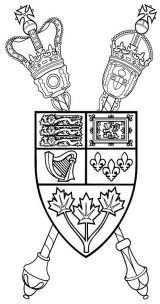

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Special Joint Committee on Physician-Assisted Dying

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Special Joint Committee on Physician-Assisted Dying

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● (1400)

[*English*]

The Joint Chair (Mr. Robert Oliphant (Don Valley West, Lib.)): I will call our second meeting of the Special Joint Committee on Physician-Assisted Dying to order. I believe we have a quorum. Welcome back.

This afternoon we begin with witnesses from the Department of Justice.

Thank you very much for appearing before us today on relatively short notice. We'd like to take about 20 minutes. I'm going to be a little bit liberal with you, because you're going to help us lay the groundwork for where we stand. Given the mandate of this committee to advise the minister on the changes in legislation that will be required, your advice and wisdom will be extremely helpful.

We have a number of new committee members here. We'll hear from witnesses for 20 minutes and they'll be able to divide the time up between themselves.

I hope you will introduce yourselves so we will have an understanding of who you are and why you're here. Then we'll begin the first, second, and, I expect, third rounds of questioning this afternoon.

Thank you.

Ms. Joanne Klineberg (Senior Counsel, Criminal Law Policy Section, Department of Justice): Thank you very much.

Thank you for the opportunity to be here today as the committee begins its study of the very difficult, complex, and profound question of physician-assisted dying.

Before I get going, I would just apologize for not having available my opening remarks in both English and French, which I know the committee likes to see. That is on account of the short notice we had. My apologies for that.

I'm Joanne Klineberg. I am senior counsel with the criminal law policy section of the Department of Justice. My colleague here is Jeanette Ettel. She is senior counsel with the human rights law section of the Department of Justice. Just by way of background, ever so briefly, both Jeanette and I were part of the litigation team that worked on the Carter case, helping our litigators behind the scenes.

Today I will make some brief opening remarks to provide this committee with some background on the criminal law-related aspects of this issue. It may be helpful to begin with a very brief summary of what the court found in Carter.

In its ruling, the Supreme Court found that the blanket prohibitions against physician-assisted dying violated the right to life, liberty, and security of the person in a manner that was not in accordance with the principles of fundamental justice, and that the violation could not be justified as a reasonable limit in a free and democratic society. The court concluded, at paragraph 105, that, “While there are risks, to be sure, a carefully designed and managed system is capable of adequately addressing them”.

As a result, and as noted at paragraph 127 of the ruling, the provisions were found to be unconstitutional to the extent that they prevent competent adults from obtaining assistance to die when they clearly consent to the termination of life and have a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the person.

As a preliminary matter, there sometimes appears to be some uncertainty, at least among some Canadians, about what physician-assisted dying is and what it is not. Physician-assisted dying is not the act of withdrawing medical treatment that a patient does not want, nor does it refer to a patient's right to refuse treatment or medicine in the first place. In these circumstances, if death does result from the withdrawal or the refusal of the medication, this is not a crime because the cause of death is the underlying medical condition. No mentally competent person can be compelled to receive treatment they do not want, as this would amount to an assault in criminal law and also a civil wrong. Physician-assisted dying refers to conduct that involves someone, a physician, actively participating in bringing about the death of another person.

Before Carter, this kind of conduct in any form was criminally prohibited in a variety of ways. The court considered that only two Criminal Code provisions were at the core of the prohibition against physician-assisted dying. The first is section 14 of the Criminal Code, which states:

> No person is entitled to consent to have death inflicted on him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted on the person by whom consent is given.

Section 14, therefore, operates in conjunction with the crime of murder, which is in essence the intentional causing of another person's death. Section 14 means that a person's consent to die has no effect on the criminal responsibility of the one who caused their death. It has always been murder, even if the victim wanted to die.

The second provision is paragraph 241(b) of the Criminal Code, which reads, everyone who “aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence” punishable by up to 14 years in prison.

These two provisions prevented a person from receiving a physician's help to die in all circumstances. It is critical to note that, like most other criminal provisions, they are of a general nature. They also serve to prevent non-physicians from helping others to die in situations that are totally outside the context of physician-assisted dying.

These two provisions were at issue because there are two ways in which a physician can help a person. One is by providing the person with the means to end their own life, such as by providing or prescribing a lethal dose of drugs. The individual who receives the assistance takes the necessary final actions that cause their own death. They are the agent of their own death, with someone else's assistance. This is known as physician-assisted suicide.

The other way is generally referred to as euthanasia. It is where the physician directly causes the person's death, typically by injecting a lethal medication. This does meet the definition of murder, which is the most serious offence in Canadian criminal law. It is punishable by a mandatory sentence of life in prison and at least 10 years of parole ineligibility.

● (1405)

Murder is considered the most serious offence under Canadian criminal law and in most other countries, because one person is actually causing the death of another rather than just helping that person end their own life. The differences between the two practices, including the different types of risk that each could entail, formed no part of the litigation before the Supreme Court. The court did not differentiate between the practices but dealt with both under the general term “physician-assisted dying”, or “physician-assisted death”.

On another general note about terminology, it may not surprise the committee to know that there are differing views on which terminology should be used in this particular context. Some stakeholders take the view that the expressions “physician-assisted suicide” and “euthanasia” are well defined and clear and must be used in order to avoid confusion and misunderstanding that arise from more general terms like “physician-assisted dying”. Others disagree with the use of the terms “physician-assisted suicide“ and “euthanasia”, believing that they are loaded and stigmatizing terms and that only something more general, like “physician-assisted dying“ should be used. This is just one of the many difficult issues that this committee will face.

One overarching consideration the committee will encounter very quickly is the divided jurisdictional nature of physician-assisted dying in Canada. Under our constitution, Parliament has exclusive jurisdiction for criminal law. The Supreme Court confirmed in Carter, at paragraph 51, that Parliament has the power to make laws that touch on health on the grounds of dangerousness or social undesirability. The criminal law is about morality and fundamental values such as those related to the devaluation of human life. It can also reflect public health concerns such as risk of abuse and the safety of individuals, particularly vulnerable individuals. Parliament's concerns, from a criminal law perspective in the context of physician-assisted dying, therefore relate to the minimization of risks and the protection of social values that are considered to be of fundamental importance in Canadian society.

The provinces and territories also have constitutional responsibilities in the context of physician-assisted dying. They are responsible for hospitals, the delivery of health care, and the regulation of the medical professions, among other things. At the policy level, the constitutional jurisdiction of the provinces and territories in this area relates to how to make physician-assisted dying available as a beneficial health practice.

There are aspects of physician-assisted dying regulation that could be seen to fall squarely within Parliament's criminal jurisdiction, such as the essential elements of an exemption from what would otherwise be considered criminal conduct. There are also elements that could be seen to fall squarely into provincial jurisdiction, such as conscience protections for physicians who seek to balance the competing rights of physicians against those of patients. There are also issues that could potentially be regulated by both levels of government but again from different perspectives: by Parliament, from the perspective of minimizing risk and protecting public health and morality, and by the provinces and territories, from the perspective of making available a beneficial health practice.

In this regard, Canada is unique compared to the other jurisdictions that have legislated in relation to physician-assisted dying. In all other places around the world, the same level of government is responsible for both criminal and health laws, so your challenge is especially daunting.

In the United States, four states have legislated access to physician-assisted dying. In the country of Colombia, the supreme court ruled on two occasions that terminally ill individuals had the right to a physician's help to die, and in early 2015 the government published a detailed resolution on the practices that should be followed, though technically this resolution does not have the force of law. In Europe, three countries have legislated access to physician-assisted dying: Belgium, the Netherlands and Luxembourg, which collectively can sometimes be called the Benelux countries.

You may also hear references to Switzerland, where a form of physician-assisted dying is available. Although the practice is not considered criminal, it is also not regulated in any specific way, so there is no law to look to that outlines the situation in Switzerland. Finally, there is also the law in Quebec that came into force recently.

These are the only existing models for physician-assisted dying. These laws have many common features that are important from the criminal law point of view.

● (1410)

One, they permit either one or both practices, that is, either physician-assisted suicide or euthanasia or both. Two, they describe the medical and other circumstances that render a person eligible to receive physician-assisted dying. Three, they contain some form of mandatory procedures to be followed in assessing a request for physician-assisted dying. Four, they contain some form of mechanism to review the patient's request, to determine whether all of the applicable rules have been complied with. Five, they also contain some form of mechanism for the collection of data on all individual cases of physician-assisted dying, which is then analyzed and made public.

Sorry, I've just received a note, and I will confirm that we will be sharing copies of the report, which are on their way to the committee. The report is also now live on the Department of Justice website, I believe. Sorry for that interruption, but I thought you would want to know.

Those are the five critical elements that you see in all these physician-assisted dying laws. I'll talk more about these elements shortly, as these really reflect the major policy issues for this committee to look at in considering a Canadian physician-assisted dying law, in addition to determining the extent to which these elements should be addressed at the federal level or left for the provinces and territories to regulate.

In terms of procedures for assessing requests, compliance review with requests for physician-assisted dying, and the monitoring of physician-assisted dying, most laws contain relatively consistent features. However, the choices made in these other places in respect of which practices would be permitted and who is eligible are quite different.

In terms of whether physician-assisted suicide and/or euthanasia are permitted, about half of the laws permit only physician-assisted suicide, and of the other half, some permit only euthanasia and some permit both.

In terms of medical eligibility, the laws can be characterized as falling into two categories that are quite distinct at the conceptual level and, as a result, in terms of their scope in concrete human terms.

The U.S. laws, Quebec, and the Colombian resolution permit physician-assisted dying only for people who are nearing a natural death that otherwise cannot be avoided—natural in the sense that it is as a result of an illness. In essence, these laws give people who are dying, who are at the end of life, a choice of how to die. They can die from their underlying condition, or if they would find such a death prolonged, painful, frightening, or otherwise undignified, they can choose a peaceful death with a physician's help.

It should be noted that these laws define the end-of-life circumstances somewhat differently. For example, the U.S. states make a person eligible if they are terminally ill and have a prognosis of six months or less, with no requirement that they be unbearably suffering. The Quebec law, on the other hand, contains a more general requirement that the person be at the end of life, without any reference to a particular prognosis, and does include a requirement that they be suffering unbearably, as well as some other requirements.

The Benelux laws are different. While these laws do allow individuals at the end of life to choose how to die, they also provide people who are not dying, but instead who are suffering from serious chronic but otherwise not life-threatening conditions, with a choice to end their lives if they find continued living intolerable. Conceptually, these laws provide physician-assisted dying as a means of relieving intolerable suffering from one's medical circumstances, because people can experience suffering not only as part of the dying process but also from living with difficult medical conditions. As a result, the Benelux approach to eligibility includes a wide range of circumstances, such as people suffering on account of mental illnesses, individuals who are tired of life but not necessarily ill, and individuals who fear future pain or suffering. Data from Belgium and the Netherlands seem to indicate that the circumstances for which physician-assisted dying is sought continue to expand, all within the confines of the law.

Over the past several years there have been a number of high-profile and controversial cases in Belgium and the Netherlands that have received international media attention. It is also interesting to note that the differences in scope of eligibility are also reflected in the Belgian law under which, for example, amendments in 2014 made physician-assisted dying available to children of any age, but within a narrower scope of eligibility than is available to adults. Specifically, physician-assisted dying is permitted for children only when the child would die in the short term, is experiencing unbearable physical pain—but not mental pain—and only where additional safeguards are satisfied.

● (1415)

A review of these laws provides a fairly effective road map for the policy issues before this committee. In terms of policy issues to consider from a criminal law point of view, Parliament would be considering an exemption for conduct that is otherwise criminal, namely, the crimes of aiding suicide and murder, which correspond to the two different types of physician-assisted dying. An exemption is needed to shield physicians and possibly other medical practitioners, such as pharmacists and nurses, who may provide assistance in physician-assisted dying from criminal liability.

First, the committee may consider whether an exemption should be created to only one offence or to both. It may also want to consider whether any specific additional limitations should be made from a safety, risk minimization, public health, or morality point of view, such as whether physician-assisted suicide should be required to be supervised by a physician in order to minimize the risk of a person taking the drugs when they are intoxicated or the risk of medical complications from taking the drugs alone; or instead, whether it would be appropriate for the patient to receive the lethal medication to take home for use at a time and place of their choosing. The committee will likely hear a range of different views on which practice or practices to make available and what the relative merits and risks of each are.

The second question is eligibility, which would define the circumstances necessary for the exemption to apply. The court clearly limited its ruling to mentally competent adults, but some stakeholders may express the view that physician-assisted dying should also be available to children where they are capable of discernment. Only two countries, Belgium and the Netherlands, currently provide this access to children.

In terms of the person's medical situation, the Supreme Court did not highlight any particular medical condition. It defined the scope of the right from a general medical perspective as applying where a person experienced enduring intolerable suffering as a result of a "grievous or irremediable" illness. If one looks at the dictionary, one sees that "grievous" is typically defined as very serious, severe or grave. "Grievous" does not appear to be a medical term. It is employed in the Criminal Code, in the phrase "grievous bodily harm", which courts have held to mean a harm or injury that is very severe or serious, but not limited to a harm or injury that is permanent or life threatening. The court also held that "irremediable" does not require the patient to undertake treatments that are not acceptable to the individual.

On their face, these terms could be interpreted as being quite broad or even narrow.

The court, at paragraph 127, expressly limited its ruling to the factual circumstances of the case. Gloria Taylor suffered from the terminal disease of ALS and actually died of natural causes while the court case was still proceeding. Kay Carter was 88 years old and suffered from severe spinal stenosis, which rendered her largely immobilized. Both women were, arguably, at the end of their lives. The court said that it makes no pronouncements on other circumstances in which physician-assisted dying may be sought. Other aspects of the ruling may arguably appear to equate physician-assisted dying with other forms of end-of-life care. Thus, the scope of the constitutional right pronounced by the court is not entirely clear.

The court was determining whether the absolute prohibition was consistent with charter rights. The court also made clear that it was Parliament's task to undertake the policy work and to make the difficult policy decisions. The court recognized, at paragraphs 97, 98, and 125, that complex regulatory regimes are better created by Parliament than by the courts, that a number of possible solutions may exist, that these issues involve complex issues of social policy and a number of competing social values, that Parliament must weigh and balance the perspectives of those who might be at risk in a permissive regime against those who might seek a physician's assistance to die, and that a complex regulatory regime would be entitled to more deference from the court than the absolute prohibition.

In light of the uncertainty surrounding the meaning of the key terms and the constitutional dialogue that is permissible between the courts and Parliament, it is open to Parliament to provide a greater or narrower scope to the words of the Supreme Court, provided that it respects the constitutional parameters set by the court's judgment and that the evidence presented to and considered by Parliament justifies such legislative measures.

The committee will no doubt hear different views from stakeholders on the question of eligibility and which physician-assisted dying practice should be permitted. Those who are more concerned about individual autonomy will favour more choice and more access. Those who are more concerned about risks to the vulnerable and about social values, such as public messaging about the quality and value of lives of individuals with disabilities, will likely favour more limits and restrictions.

● (1420)

Other policy issues for the committee to consider could include whether to include procedural safeguards that should be applied in assessing requests; whether to include a mechanism for reviewing whether those procedures had been complied with; and whether to include a mechanism for collecting data for the purpose of analysis and publication, and in order to detect trends and potential abuse.

Those are my hopefully brief opening remarks. We would be happy to take your questions.

The Joint Chair (Mr. Robert Oliphant): Very good—and very good timing as well, thank you. That was very thorough and a helpful way to begin our committee.

I'm assuming the committee has questions.

Ms. Dabrusin, would you like to begin?

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

Having looked at the legislation that has been put in place in other jurisdictions, what do you see as this committee's greatest challenges in trying to create a framework of our own?

Ms. Joanne Klineberg: In the Canadian context, the jurisdictional difficulties will be a big challenge. In all the other places, one level of government makes all the decisions and really administers the regime. In Canada, because the regulation of the health practice, the health delivery, is under provincial and territorial jurisdiction but the criminal law is under federal jurisdiction, I think a very big challenge will be deciding which aspects of a physician-assisted dying regime are best dealt with at the federal criminal level and which elements are best dealt with at the provincial level.

I think another major challenge, more from a policy perspective, will be achieving some consensus on the question of under what conditions a person should be eligible to receive physician-assisted dying.

● (1425)

Ms. Julie Dabrusin: If I may follow up, do you know of any other jurisdictions that have studied the possibility of such legislation and that have a constitutional framework that's similar to ours here in Canada?

Ms. Joanne Klineberg: I don't know of any that have a similar constitutional framework. That said, there certainly are many other jurisdictions that have considered legislation in this area. There are other models you might wish to look at, but none where I'm aware of...their constitutional frameworks.

Ms. Julie Dabrusin: You mentioned that we might want to look at some other models, or other studies. Where would you recommend we also look?

Ms. Joanne Klineberg: The Parliament of the United Kingdom has looked at this issue quite a few times over the last 20 years. They had a parliamentary committee study the issue in the mid-2000s, I believe.

They also recently had something akin to a private member's bill that was debated and was defeated I believe in September of last year. One of the interesting features of that legislation is that it would have adopted a model quite close to the U.S. state model, which is physician-assisted suicide only and only where the person is terminally ill and facing death in the short term.

One of the interesting things about the U.K. legislation is that they clearly were just uncomfortable with the idea. In the U.S. models, the patient receives the prescription, which they then take home. About one third of patients don't ever take it. About two-thirds do, but they're able to take it whenever they feel the need.

I think the U.K. Parliament was troubled by the prospect of those drugs being available to the person, perhaps to take at a time when they were not competent. They developed a process whereby the medication would only be delivered to the person at the time when they were going to take it. They would always be in the presence of a medical professional. If they decided not to take it after it had been delivered, then the drugs would be removed by the medical professional. They could always be brought to the patient again on another occasion.

That's an interesting thing to look at if you're interested in this area, because it does provide a model for a supervised physician-assisted suicide regime.

Ms. Julie Dabrusin: Do you know of any other regimes you've looked at? Are there any other models for supervised physician...?

Ms. Joanne Klineberg: That's the only one of that sort that I'm aware of. I believe there also have been some bills studied recently by the legislature of Scotland, and probably also in a number of jurisdictions in Australia. I haven't looked at those very closely. There are also always a handful under debate in legislatures in the various U.S. states.

There's quite a number. If one goes back 10 years or so, one could find quite a number.

Of course, in the Parliament of Canada there have been private members' bills recently. Bill S-225 was introduced in the Senate last session. That's another model you could look at.

Ms. Julie Dabrusin: Thank you.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you, Ms. Klineberg. You spoke briefly with respect to the models in the Benelux countries. I was wondering if you might comment on whether it would be fair to say that the Supreme Court contemplated a legal regime quite distinct from the Benelux countries. In that context, I would draw your attention to paragraph 111 of the Carter decision wherein the court said that cases of assistance in dying in Belgium were inapplicable because they "would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions."

I was wondering what your thoughts are on that.

● (1430)

Ms. Joanne Klineberg: All I can really share with the committee is that there are different ways of reading and interpreting the Supreme Court ruling. Some ways focus on the dictionary definition of the key terms and some ways may focus more on a contextual reading of the case. For instance, there's a variety of places in the court's ruling where they talk about physician-assisted dying in a manner that compares it to other end-of-life decision-making, so that might suggest to some that they were thinking in more of an end-of-life context.

There are the words in paragraph 127 where they talk about the ruling being responsive to the facts of the case and not to any other circumstances, so the facts of Kay Carter's and Gloria Taylor's medical situations may be of interest to you.

I think it's a very good question, one for which I can't really provide a concrete answer except to say that it's subject to being interpreted in a variety of different ways. I guess I would bring you back to what the court said was really Parliament's task, which is to make the tough policy choices. I think the court understood that it wasn't its role to be legislating on behalf of Canadians. It was deciding a very specific constitutional question that was before it, namely, whether the prohibition in an absolute form was constitutional. It may be just as important for you to consider the full range of information that is before you, as it is to try to decipher with precision what it was the court was saying.

Mr. Michael Cooper: Okay. I guess if Parliament decided to adopt, for example, what might be characterized as a permissive legal framework that included one or more of the groups identified at paragraph 111, whether it be minors or people with minor medical disorders, it would be accurate to say that type of framework would run the risk of a section 7 challenge.

Ms. Jeanette Ettel (Senior Counsel, Human Rights Law Section, Department of Justice): I think the starting point is just to note the litigation that's already under way in Quebec in the D'Amico and Saba case, where a constitutional challenge has been brought, mainly on division of powers grounds but also on charter grounds, to the legislation that's recently come into force there. One of the arguments that's been put forward is that the legislation creates insufficient safeguards to protect the vulnerable. It's also been alleged that it is contrary to the section 7 life, liberty and security-of-the-person rights and section 15 equality rights for people who are at risk under what is alleged to be a permissive regime.

I don't think there's any easy answer to your question, though, about what we take from the Carter ruling itself, just because of the way in which cases like this are decided. What was before the court was a very specific constitutional question framed in light of the specific applicants and the specific plaintiffs that were before the court. The court had to decide whether the blanket prohibition was unconstitutional, but then the further constitutional implications of where the lines get drawn, whether Parliament chooses to go narrower or broader than what might appear to be the language in the Carter decision, are going to be a matter for another new piece of litigation. We can't really know, until we have Parliament's objective and the evidence before it, how that assessment is going to be made in the end.

[*Translation*]

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

Mr. Rankin or Ms. Sansoucy, you have the floor.

Mr. Murray Rankin (Victoria, NDP): I am going to share my speaking time with my colleague.

[*English*]

I just wanted to pose a question to Ms. Klineberg that some of us have been asked, particularly with regard to remote communities of Canada, where physicians may not be available to provide the constitutionally mandated service that the court has unanimously said is available. According to her reading of the Carter decision, would it be legitimate for nurses, under some sort of supervision, to perhaps be available for that?

Number one, do you think that would be a legitimate part of our work? Number two, would it be within the federal domain should we choose to do so?

● (1435)

Ms. Joanne Klineberg: I'll start with the second part of your question, which I think was about the jurisdiction responsible for that.

Which types of facilities may engage in which types of health care practices, and so on, is probably predominantly a provincial and territorial matter. The regulation of doctors and physicians, and what each is able to do—I know that some provinces have nurses who are able to do some functions that are otherwise limited to physicians—are parts of provincial and territorial regulation. On the other hand, from a criminal perspective, I would say that there are at least two things you have to keep in mind, though there are surely others as well. First, if you set up a regime such that some requirements in it will bar access to some people in remote locations, that fact may weigh in a court's consideration of the constitutionality of those limits, so any arbitrary barriers to access are something that you should consider.

Second, if it appears as though medical professionals other than physicians must be involved, or will be involved, for reasons of access or otherwise—in this regard, I'm thinking of pharmacists, who are the types of physicians who are dispensing the drugs—any medical practitioners who would be involved may need to be captured under an exemption for otherwise criminal conduct. Failure to include them in an exemption may cause them to be less willing than they otherwise would be, so there's a real, pure criminal law angle to ensure that any exemption would cover all of those who would be involved. There's also a policy question, which relates to the levels of expertise they have and whether they can undertake the functions. For instance, assessing an individual's mental competence is a big part of the delivery of physician-assisted dying. Who's able to do that function?

Third, there's the question of access. The committee will no doubt hear about more types of issues that will also bear on that question, but those are, at least, the three that come to mind right now.

[*Translation*]

The Joint Chair (Mr. Robert Oliphant): Ms. Sansoucy, you have the floor.

Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP): You have outlined the issue of our double jurisdiction in the area of health very well.

Last December 22, the court of appeal sided with the Government of Quebec. I would like to understand what motivated the Minister of Justice to mandate the Attorney General of Canada to challenge the setting aside of the superior court's decision.

Ms. Joanne Klineberg: Unfortunately, I am not in a position to explain the minister's reasoning. I can however say that one of the reasons why the constitutionality of the Quebec law raises questions is the fact that the issue is a matter of shared jurisdiction, and criminal law is of exclusive federal jurisdiction.

The Quebec law says that whoever acts pursuant to section 26 of the law is not guilty of a criminal offence. A court might decide that this is a matter of criminal law and that the provinces and territories do not have the jurisdiction to determine in which circumstances a given act is criminal or not. So there is a constitutional issue. That is all I can say about that.

Ms. Brigitte Sansoucy: Thank you.

[*English*]

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

Senator Seidman.

● (1440)

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

Thank you very much. This is a complicated issue, of course.

In reviewing Quebec's Bill 52, An Act respecting end-of-life care, have you encountered problems specifically with regard to those jurisdictional issues that you have put forward as huge challenges—issues or problems that we might keep in mind specifically when making recommendations for federal legislation?

Ms. Joanne Klineberg: I don't think so, other than to say that, as I mentioned in my opening remarks, the criminal jurisdiction is exclusively federal. As my colleague mentioned, there is litigation that's currently suspended in relation to Quebec's law. That's still ongoing. It will be revived either at the time of the expiry of the Supreme Court suspension, which was just extended for four months, as this committee may know, or upon the coming into force of new federal legislation.

That litigation raises the question about whether certain parts of Quebec's law conflict with federal criminal law. Of course, we can understand why the litigation is delayed, because at present that federal criminal law is not there. But if the federal Parliament were to amend the Criminal Code in order to do something narrower, for instance, than what is available under Quebec's legislation, then that could give rise to these constitutional questions. We will really only know the answers to those questions once Parliament has completed its job, and, if there is subsequent litigation, once that litigation has been completed.

In terms of there being jurisdictional difficulties, I'm not certain that's a helpful way for you to proceed. It may be more helpful for the committee really to stay focused on what it thinks the right solutions are for Canada through the lens of the criminal law. Any inconsistencies will have to be dealt with at that time.

I'm afraid that's the best way I can answer that question.

Hon. Judith G. Seidman: In your best expert opinion, there aren't particular aspects of assisted dying that Parliament itself, at a federal level, should address in legislation and those that must be left to the provinces.

Ms. Joanne Klineberg: Surely, any amendment to the Criminal Code that says these are the conditions under which conduct that otherwise meets the definition of a crime shall be free from criminal liability is exclusively the responsibility of Parliament.

There is a variety of ways that Parliament can go about that. It can put very little in such an exemption. It could say, for instance, that so long as the conduct is in accordance with a very detailed provincial law, then that will result in an exemption for criminal purposes for the same conduct; or Parliament could say that for the criminal exemption to apply, it is going to determine to which offences it applies and it is going to determine under what circumstances it applies. With respect to the fundamental circumstances in which physician-assisted dying would be available, there's a very strong claim that it is Parliament's jurisdiction as a matter of criminal law.

The other aspects of Quebec's legislation are really the protective, safeguarding measures. There are things like the steps that the physicians must take in working with a patient who's made a request or the documents that have to be filled out. Once they have been completed, the documents are sent to the commission for the purposes of a compliance review, data collection, and monitoring so that the public can have confidence that physician-assisted dying is being administered in a safe way and is being administered in accordance with the objectives of the legislation. Those are the kinds of elements where it's more challenging to determine which level of government is the best place to do them. Maybe some of those protective features could be done by both levels of government, at which point you want to balance duplication of effort with ensuring that whatever Parliament thinks is necessary from a federal perspective is present.

In that regard, one of the things that I would bring to your attention is in relation to the compliance assessment function, which most physician-assisted dying statutes have. The body that would be referred a case, when non-compliance has been found, could be either the medical colleges responsible for governing the behaviour of physicians or it could be the police or the prosecution service. You will see in a variety of statutes that sometimes they say exactly who the reference should be made to when non-compliance has been found.

In terms of Canadian jurisdiction, the regulation of physicians is a provincial and territorial responsibility. Policing and prosecutions are also primarily a provincial responsibility, though in the territories they are more of a federal responsibility. There's an added complication there. That's something you might want to keep in mind when the committee is considering which level of government is best placed to do certain functions.

● (1445)

The Joint Chair (Mr. Robert Oliphant): Thank you. That's our time.

Thank you, Senator Seidman.

Senator Cowan.

Hon. James S. Cowan (Senator, Nova Scotia, Lib.): Thank you. I'm just following up on my colleague's comments about jurisdiction.

It seems to me that it's inevitable that the federal Parliament will legislate in its wisdom and that provincial legislatures may or may not legislate in areas that they think appropriate. There will be some inconsistencies and some gaps, and then there will be a second round where people will get together to try to reconcile those differences.

Is that the way you would see the legislative and regulatory framework evolving over a period of time? It's unlikely, is it not, that it would all come together exactly the way the puzzle should?

Ms. Joanne Klineberg: I know that this committee will be hearing from our colleagues at Health Canada in the coming days. Many of these questions might be better put to them, because through their federal, provincial, and territorial contacts, they will be most closely working with the provincial and territorial health ministries. But I can tell you that the provinces and territories are working diligently on this issue. They are all seized of the issue. The overwhelming majority of them worked together to appoint a panel of independent advisers to make recommendations to them, so they are in discussions with each other. Internally, they are all following up as diligently as they can and I think there will be a real concerted effort to have everything in place in the appropriate time frames.

Hon. James S. Cowan: Do you see a particular area in which we should be particularly conscious of the federal and provincial jurisdictions rubbing together? Some are clearly provincial. Some are clearly federal. Some are within the purview of the regulatory authorities of the professions, but there are some areas where things are not so clear. Can you point us in those directions?

Ms. Joanne Klineberg: I think the areas in which there is the most scope for overlap relate to the procedural safeguards, things like the physician needing to assess the patient's mental competency, the physician needing to have discussions with the patient on several occasions, the patient needing to fill in a form that is signed and dated and witnessed by at least three independent witnesses. I think these are measures that Parliament could consider as part of a regulatory regime from a criminal perspective if it felt that those sorts of details were necessary to protect vulnerable individuals, but that said, those are the sorts of medical practices that are not terribly dissimilar from what physicians already do under applicable provincial regulations, laws, and medical policies. The provinces and territories may well also feel that those are matters they are quite comfortable dealing with.

The issue of compliance review is one that I've already talked about. Bodies to which a referral would be made if a case of non-compliance were found would largely be provincial.

When you get to the question of data collection and monitoring and oversight for public accountability and public confidence, representations have been made to the various advisory bodies, which have been consulting over the last few months, suggesting that the monitoring at a national level would be especially important, because otherwise you could have 13 different bodies monitoring and that situation might become especially cumbersome.

I know there are concerns about differences and concerns that Canadians might find one regime more friendly to them than another. On the other hand, there are existing mechanisms already in place provincially to deal with discipline of physicians, policing and law enforcement and that sort of thing. With regard to the safety features, there are some complications, but perhaps monitoring stands out the most as the one that would benefit from a national review.

On questions of medical eligibility, from a purely criminal law perspective, when we would create a defence or an exemption to a crime, Parliament would normally say it would be a defence under certain circumstances. From a purely criminal perspective, that would be part of criminal law, but there would be scope if the committee wanted to allow provinces and territories to make those decisions to proceed that way as well.

● (1450)

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

Mr. Arseneault.

[*Translation*]

Mr. René Arseneault (Madawaska—Restigouche, Lib.): Ms. Klineberg, I looked at approximately 20 definitions of the word "euthanasia", in both French and English dictionaries. Earlier, you said that several terms could be used, but that the strict definition of the word "euthanasia" does not necessarily imply that someone is asking for help in dying. I wanted to specify that for the record.

However, medical aid in dying, contrary to euthanasia, always means that a person wants assistance in dying and says so; and that has to be an informed request.

Which brings me around to the question I was asking you. In everything you have read about what is done in other jurisdictions, in what context can we say that a person has, in a free, informed and lucid way, in possession of all the facts, really asked for assistance in dying?

Ms. Joanne Klineberg: Please forgive me, I understood everything you said, except for the question you asked at the end of your comment.

Mr. René Arseneault: Based on everything you read regarding other jurisdictions and other countries, what is the definition of what constitutes informed, free, lucid consent to assisted dying?

Ms. Joanne Klineberg: With your permission, I am going to reply in English.

Mr. René Arseneault: Yes, of course.

Ms. Joanne Klineberg: Because the answer is very technical.

[*English*]

You are very correct. I may have misspoken. I generalized slightly when I indicated that euthanasia was a term that's well defined. It is well defined, but there are subcategories of euthanasia.

In the context of the Carter case, the court was only ever speaking of what could be called "voluntary euthanasia", which involves the person who asks being competent to make the decision. They are aware of their circumstances; they have received the necessary medical information; and they are capable of understanding the consequences of the different decisions that they might make. In such a case, where a person requested assistance to die and they received that assistance from a physician, that would be called voluntary euthanasia.

It could be involuntary if, for instance, a physician terminated the life of a patient contrary to their wishes. That could be called "involuntary euthanasia".

There is another subcategory that could be called "non-voluntary euthanasia", which would happen when the wishes of the patient were unknown.

I thought it might be best to try to avoid some of these complications, but it turns out that it's impossible.

In the Benelux countries, they define euthanasia just as the voluntary termination of human life. In the European countries, where you see the term euthanasia used in some of the legislation, it means voluntary euthanasia. In pretty much all of the jurisdictions, physician-assisted dying is really limited to patients who have requested the assistance, who are mentally competent to make that decision, and who have been fully informed regarding their medical situation and the options available to them.

In the Benelux countries, it is possible for an advance directive for assistance in dying to be made, such that the assistance would be provided when the person was unconscious. However, the request would have been made when they were mentally competent and conscious.

The Supreme Court didn't deal with those sorts of circumstances. They really limited themselves to the situation where the person is competent when they make the request, and competent when the assistance would be provided. There are a few notable exceptions in the European countries, where physician-assisted dying can be provided under a slightly broader set of circumstances, but always with the request having been made by a mentally competent person.

● (1455)

[*Translation*]

Mr. René Arseneault: This leads me to a sub-question. Perhaps you found an answer to it when you were elsewhere, like Benelux.

Do you think that an individual, even when he or she is in the best of health, before becoming ill, could make a request which could then be considered an informed request, stating that he would like assistance in dying when the time comes? Did you see anything like that in other countries?

I have not expressed that well, but I will give you an example: people consent to donating their organs on their driver's licence. People do that when they are young and in good health.

Does something like that exist?

[*English*]

Ms. Joanne Klineberg: No, I think that in the Benelux countries —if I were permitted the time, I could look it up, since I have it with me—there must be a fairly close temporal connection between the advance directive and the wishes being carried out. It may be up to five years. I would have to confirm that for you.

No, I do not recall seeing any situation in which it could be made 20 years in advance and be carried out.

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

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

Thank you to the witnesses from the Department of Justice.

I'm sure that almost all of us around this table have been discussing this in a number of different formats, including meetings with constituents, and have heard diverse opinions on this issue.

I wanted to confirm with you, because I believe I heard you say that under the Carter decision, you do not have to be terminally ill to qualify. There could be emotional, irremediable, grievous suffering. It does not have to be a terminal illness. Is that correct?

Ms. Joanne Klineberg: That is what is not entirely clear. Certainly many commentators have said there's nothing in the Supreme Court's decision that says this is limited to people who are terminally ill. On the other hand, there's nothing in the Supreme Court decision that clearly says this is not limited to people who are terminally ill. Both of those expressions would have taken a very small number of words. Neither one of those statements is there, so we cannot say with certainty what the court had in mind.

Mr. Mark Warawa: The mandate of this special committee is to prepare a report to the government and make recommendations of what should be included in legislation.

The government introduces legislation. If they get this at the end of February, they have about three months to introduce it, get the bill through all levels of the House, committee, the Senate, and then royal assent. They have about three months to meet that deadline.

No matter what is introduced in the form of legislation, it likely will be challenged. What I think I'm hearing you say is that because of its not being clear, this committee could recommend that we require it to be a terminal illness, and then it might meet the Carter decision. Is that what you're saying?

Ms. Jeanette Ettel: There are maybe three things to keep in mind.

The first is, as my colleague pointed out, the indeterminacy within the judgment itself. It's subject to competing interpretations, including the statement where they say this is about the facts of this case. It's hard to know exactly what the court had in mind.

There are two other things that I think are relevant in answering your question.

The first is that you have to have regard for the type of evidence that was before the court in Carter in relation to the type of question the court was being asked, which was whether you can have a blanket prohibition. That was round one.

Round two, as I think you rightly predict, will be a different question. That's going to be the question based on not having a blanket prohibition anymore. What we have is Parliament's best efforts, based on its objectives and the evidence before it, to strike a reasonable balance between the life, liberty, and security-of-the-person rights of people seeking assistance in dying against the objectives in relation to the protection of the vulnerable. The kind of evidence that will be before Parliament and before the court in an eventual challenge will be different, because it will be evidence comparing the relative merits and risks of the different regimes, which really wasn't what the court was looking at in Carter. We can't know now how the court will respond to that particular question.

The last piece that is also important to bear in mind is the notion of the constitutional dialogue between the courts and the legislative branch, which has been recognized by the Supreme Court of Canada in a number of cases. The best example, if you're interested in some light reading, is what transpired between the Supreme Court decisions in O'Connor and Mills. Basically what happened there was that the court articulated a very specific regime as its way of balancing the competing rights that were at issue in that case. It was in a sexual assault context. It had to do with the rules around the production of third-party therapeutic records that complainants in sexual assault cases might have.

The court created a regime, as a matter of common law, that was designed to address the constitutional issues that had been raised in that case. Not long after that decision, Parliament came back with a legislative scheme that differed in some significant respects from what the court had come up with. What the court said was that it could not be presumed, just because Parliament's scheme looked different from what the court had envisaged, that it was unconstitutional, because there's this notion of a dialogue between the legislative branch and courts. Although courts are mandated to uphold the Constitution and although they provide the general parameters within which legislators must act, they don't necessarily have the last word on how you craft a regime that meets those constitutional parameters.

In Mills, the legislative regime was upheld. The bottom line there is that there is some scope within which to manoeuvre. Obviously the committee and Parliament will have to have regard to the principles and the broad parameters that the court articulated in Carter. At the end of the day, whatever regime Parliament comes up with is going to be assessed against the objective that Parliament was striving to achieve and how rational and proportionate Parliament's solution is as a means of achieving that objective.

That's as much of an answer as I think I can give. I hope that's helpful.

● (1500)

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

I will just mention to the committee members that I am being generous with the time, mainly because of the high quality of the answers we are getting. If we don't always get high-quality answers, I won't be quite so generous, but the answers are really helpful for our committee. For that reason, we've been going over the time limit because your answers are laying a very important foundation for our work. Thank you.

Are you okay to keep going? Do you need a break?

You're good. Okay.

Senator Nancy Ruth.

Hon. Nancy Ruth (Senator, Ontario (Cluny), C): Thanks for raising the issue of equitable and affordable access to justice.

Are there any real alternatives to relying on existing consent and capacity laws and processes, as recommended by the provincial-territorial expert advisory group on physician-assisted dying in recommendations 17, 20, and 24? If so, what are the alternatives and how would they work? Do you have any specific concerns about these consent and capacity laws and processes in the context of physician-assisted death?

Ms. Joanne Klineberg: I'm not able to share any concerns necessarily with the adequacy of those laws. All I can do for the benefit of this committee is to relay that the jurisdictions that have legalized physician-assisted dying have found that it was necessary to have fairly specific procedures tailored to this context in light of the seriousness of the decision being undertaken and in light of the fact that in all of those other jurisdictions it is conduct that would otherwise be criminal.

In some cases there are very specific measures. For instance, the requirement that there be a written request that is signed by the patient and witnessed by two or three independent witnesses could potentially serve as evidence that a physician complied with the law. It might be a more direct and concrete piece of documentary information that can give everyone greater confidence that the individual was acting in a voluntary way and was not being coerced by family members and that the time was taken by all the parties to treat this issue with the seriousness that it implicates, given the fact that when the procedure is provided, a physician is contributing to causing the death of a person.

Unfortunately, I wouldn't really feel comfortable commenting on the adequacy or inadequacy of existing provincial regulations. I would only bring to the committee's attention that it might want to consider whether more is needed in the circumstances of physician-assisted dying.

● (1505)

Hon. Nancy Ruth: Okay. I'm going to move now to the issue of who's going to follow up on this.

I know some groups in Canada are very keen to set up special panels or a panel of one that will deal with whether this should be justified and allowed, so my question is this. What legal processes do we currently have in place to monitor physician-assisted death cases without adding new entities, as compared to the review committee and other new processes recommended by the provincial-territorial panel? For example, we have medical examiners and we have coroners in every province, and I note your comment about having a federal monitoring agency. I throw that into the mix.

Do we have enough with the coroner system?

Ms. Joanne Klineberg: That is yet another very good question. Unfortunately, I'm not very familiar with provincial and territorial legislation on coroners.

It is my understanding that unnatural deaths are brought to the attention of coroners, and then an investigation is undertaken. In terms of whether that process alone would be sufficient to determine whether physician-assisted dying had been provided in a manner that gave Canadians confidence that the person was mentally competent and had been informed of all health care options and was not under coercion or duress, I'm not in a position to say, unfortunately.

It is a very good question, though.

Hon. Nancy Ruth: I have one last question and it's a charter question.

I spoke with a well-known constitutional lawyer who often appears before the Supreme Court and who mentally has issues. She said to me, “How dare you design a law that would exclude us who have mental illness? If you do so, I'm in court.” What's your response to that?

Ms. Jeanette Ettel: I think the response really falls along the lines of what I've said already. As I think one of the members has already noted, it would not be unreasonable to conclude that whatever Parliament comes up with will be subject to challenge, whether for being too broad or too narrow, and that there will be inevitably an exercise of line-drawing that has to take place. That will be on grounds of age and on grounds of what kinds of illnesses, whether mental or physical, get you in the door.

What I can tell you is that I'm not in a position to tell you what would be the outcome of that litigation right now, because it would depend entirely on that equilibrium between the objective and the evidence before Parliament in establishing that this was a reasonable way to strike a balance. Absolutely, drawing the line to exclude types of illnesses could be challenged on section 15, equality grounds. Similarly, it could be challenged on the same basis whereby the court found the prohibition violated the charter under section 7. But what the court would conclude would really depend on what would be in the record to show why the line was drawn in that way.

● (1510)

Hon. Nancy Ruth: If my job is to represent—

The Joint Chair (Mr. Robert Oliphant): I think we have to move on.

Did you have one comment you needed to make?

Ms. Joanne Klineberg: I only wanted to add, if it's at all helpful to the committee, that in the Benelux laws, which have the broader scope of eligibility for individuals who are chronically but not terminally ill, there is not one of them that distinguishes between mental illness and other types of illnesses. There's no existing law out there that would allow physician-assisted dying for chronic conditions that are not life-threatening, but would exclude individuals with mental illness. It's always an individual assessment of the person's mental competence.

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

Senator Cowan.

Hon. James S. Cowan: Thank you, Chair.

To go back to the point I was pursuing earlier about the patchwork of legislation and regulation, our objective obviously would be to design a system that would be equally applicable and available to all Canadians wherever they live. Access to that, to any system, is difficult in a country as diverse as Canada, with its large urban centres and small rural populations. If you add to that the federal-provincial and perhaps even professional regulatory players in this thing, do you see a legitimate concern there that whatever we decide as the Parliament of Canada will afford unequal access and therefore unequal availability across the country?

Is there anything we can do to minimize that, other than to continue to talk to provincial counterparts, territorial counterparts, and the regulatory agencies? Is that the answer?

Ms. Joanne Klineberg: Yes, I think that is the answer.

It's very much going to be in the details of what are the kinds of communities where only certain types of medical professionals are available. I've been told that there are some communities in the north where no physicians are available. There are video links for people to be seen by physicians. In fact, they may only have access to nurse practitioners. The committee won't really be able to proceed without getting that kind of detailed information.

Again, the concern will be to not be placing barriers in the way of individuals having access unless there's a very good reason for that. I think the dialogue and hearing from provincial and territorial governments—and likely also our colleagues from Health Canada—will be able to give you more detailed information on these sorts of issues.

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

Mr. Aldag.

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

This is my first committee, so I'm not entirely sure what to expect for a flow of information, but we've just been handed what looks like a very thorough report. Does this come from your department? Where is this coming from?

Ms. Joanne Klineberg: What you have before you now is the report of the federal external panel that was created by the last government, by the ministers of justice and health, to consult with Canadians, experts, and stakeholders. Originally they were tasked with providing legislative options to the government.

On account of the federal election, there was insufficient time for them to produce a report like that by their original deadline, which was November 15, so the current ministers of health and justice extended their deadline to December 15. They also modified their mandate by asking them to report not on legislative options, but only on the findings of their consultation activities.

The report before you has some preliminary chapters that discuss some of the things we've been talking about today—the division of power situation, the Carter ruling—followed by a number of chapters that recount the consultations and meetings they had, both with experts from the jurisdictions we've been talking about that have existing physician-assisted dying regimes, and with some Canadian experts and some stakeholders, such as some of the parties that were active in the Carter litigation, and others.

They are documenting for Canadians—but this will be especially important for this committee—the things they heard from all of those stakeholders and experts. They also posted online a questionnaire for Canadians to answer. One of the annexes at the back of the report will have a summary of the findings from the online questionnaire, which quite a number of Canadians filled out.

This was commissioned by the previous ministers of health and justice, but it's a report by an independent expert panel. The three members of the panel were Dr. Harvey Chochinov, who is a renowned expert in palliative care from Canada; Dr. Catherine Frazee, who is an expert in disability rights issues; and Benoît Pelletier, who is a law professor and an expert in division of powers and federal-provincial issues.

● (1515)

Mr. John Aldag: Thank you.

So we have this piece, which I'll be taking home to read, as I'm sure everybody will. I wanted to make sure that we were gathering all of the work that had been done previously, just to build on the work that has happened. Is this the sole piece that came from the work or is this a companion piece to other things? I just hope that the committee will actually get the full resources on this file. I don't know if this is it or if there's more to come.

Ms. Joanne Klineberg: In addition to that report, at the same time that this panel was consulting with Canadians and experts on behalf of the federal government, the provinces and territories appointed an advisory group to undertake largely the same activity but in aid of the provincial and territorial objectives. They produced their final report in I think mid-December. That is available online. We can absolutely provide it to the committee if it's not otherwise available to you.

Many other exercises have been undertaken in Canada across the jurisdictions over the last year. Quite a number of medical colleges within each of the individual provinces have been examining the issue, and a number of them will have reports available online that you can look to. As well, just last week I became aware of a report by the University of Toronto Joint Centre for Bioethics. They created a task force to look at this issue. This report also has a lot of information and viewpoints.

If these are not already available to you through your clerks, please let us know, and we can ensure.... They are all publicly available documents.

Mr. John Aldag: I think it would be helpful to have the committee somehow gather a bibliography of works and get it to us.

Another question I have is simply around the process of drafting legislation. What kind of time frame will the Department of Justice require once we get our work in to you? What does that timeline look like? Could you just give us a sense of what that process will involve?

Ms. Joanne Klineberg: I think what will happen is that this committee will make its report to the two chambers of Parliament. Then the ministers will consider the report. In the normal course, they would be discussing with their cabinet colleagues what the federal government's policy ought to be. From that process, we would receive instructions to draft legislation. How long that would take really depends on the detailed nature of it and the number and complexity of the issues.

Mr. John Aldag: What's the best-case scenario?

Ms. Joanne Klineberg: All I really feel comfortable saying is that we at the Department of Justice are very well aware of the timelines, and we know the committee is as well.

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

[*Translation*]

Mr. Arseneault now has the floor.

Mr. René Arseneault: Before asking my question, I want to put it in context.

I read in the new Quebec law that for people who are severely disabled or incapable of asking for physician-assisted death, a third party could do so for them. There is no more explicit definition, but even though I am not yet an expert in this area, I imagine that that is included in the law. I believe something similar exists in Oregon, or in another state.

Do you have any specific examples of situations, from other states or other countries, where established criteria or parameters would allow a physician to receive a request from a third party, asking for physician-assisted dying on behalf of a severely disabled individual or a person unable to make that request?

● (1520)

Ms. Joanne Klineberg: No, I do not think that exists. The request must always come from the person who wants to die. Physician-assisted dying may not be requested by a third party.

There are, however, advance directives, that is to say situations where the request was made by the person before they lost their mental capacity. A third party can never make a request in that person's name.

I might mention a single exception, from The Netherlands. There is an agreement between physicians and attorneys that is known as the Groningen Protocol. It is mentioned in one of the documents prepared by the Library of Parliament. It discusses the euthanasia of severely disabled babies. This has not yet been included in legislation.

Mr. René Arseneault: So it is a protocol, but it has not yet been included in legislation.

Ms. Joanne Klineberg: Yes, that is correct.

Mr. René Arseneault: Nevertheless, it is accepted. It is being done.

Ms. Joanne Klineberg: Rarely, but, yes, it is done. In such cases, it is done at the request of the parents, and with their consent.

Mr. René Arseneault: In fact, the purpose of my question may be to avoid our going around in circles regarding what the Supreme Court of Canada is telling us in Carter. We are in a position to protect vulnerable persons, however section 14 and paragraph 241(*b*) of the Criminal Code are not convergent. We must always continue to protect vulnerable persons, but if someone can ask for assisted dying for another person, this could mean, in some respects, that we may fail to protect a vulnerable person.

That was the purpose of my comments regarding the Groningen Protocol.

Ms. Joanne Klineberg: The court was very well aware that in a context where there is an absolute rule, but exceptions are being created, one exception could lead to another. In this matter, as my colleague said, no matter where we draw the line, there will always be people on either side of the line. Those who are excluded may always ask to be included.

We cannot foresee everything that may happen. However, if Parliament describes its objective clearly, the reasons that underlie it as well as the limits and the grounds that justify those limits, this will at least provide a context in which to study the cases that will come up. All that said, we cannot predict the future.

Mr. René Arseneault: So, your interpretation of the Carter ruling is that it is absolutely impossible for a severely disabled person who cannot speak, to make his consent known through a third party. I am thinking of cases where people are incapable of speaking or moving.

Ms. Joanne Klineberg: If a person is unable to speak but has another means of communicating, it is always possible for that person to make his or her wishes known. However, if the person has no means of communicating, we cannot know if the person understands. There is nothing in the Supreme Court ruling indicating that someone may give that consent on behalf of another person.

Mr. René Arseneault: Thank you.

[*English*]

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

Monsieur Deltell.

[*Translation*]

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

Ladies, welcome to your Parliament.

I don't want to tell you my life story, but I will say that I was a provincial member of the Quebec National Assembly for the past seven years, and as such I witnessed the work of the commission, and the work that led up to the adoption of that law. I was there right from the beginning and I am one of the 120 members who voted for it.

You mentioned, quite rightly, that this was often a battle of definitions. That is quite true, because in certain cases we talk about “physician-assisted dying”, whereas in Quebec the act that was passed refers to “end-of-life care”. We are talking about exactly the same thing, but with totally different words. Since we are legislators and the Supreme Court has ordered us to adopt a law, we have to bear in mind that words are very important.

In Quebec, they talk about “grievous and irremediable health problems” causing “persistent and intolerable suffering”. In your opinion, should the law the federal government will be putting forward for us to adopt include a definition of those words, that expression, so that we know what we are talking about?

● (1525)

Ms. Joanne Klineberg: If I understood the question correctly, my answer is that Parliament may legislate as it sees fit, if justified.

Mr. Gérard Deltell: I know. I don't want to quote Churchill, according to whom Parliament can do what it likes. However, at the time there were no transgendered people, but now, there are.

But seriously, in your opinion, and in order to avoid all ambiguity, should the law contain a definition of the terms?

Ms. Joanne Klineberg: All the words that need a definition should be defined, yes, absolutely.

Mr. Gérard Deltell: In that context, does that apply, in your opinion?

Ms. Joanne Klineberg: There are a lot of words. And so the most pertinent ones have to be chosen, those that may be interpreted in various ways, that is to say narrowly or broadly. If the legislator has an opinion on the meaning he wishes to give those words, it is always better to be clear.

Mr. Gérard Deltell: Thank you very much.

Mr. Joint Chairs, if you read between the lines in all of this, you will of course understand that we want to protect the most vulnerable.

[*English*]

The most sensitive people of our community, we are there for them.

[*Translation*]

We have to protect them, and we must constantly have them in mind in the course of the coming days and months, during the legislative process we are undertaking today.

Ladies, in that same context, what should the law the government is going to propose contain in order to describe things, and especially to avoid potential blunders?

I'm doing this to help the government, you know.

Ms. Joanne Klineberg: I don't know how to answer you, other than by repeating things I have already said. Even the Supreme Court observed that vulnerable persons were at risk in several ways. For instance, people could ask for physician-assisted dying because someone in their family pressured them to do so. Or, a vulnerable person may not have access to other care, or was poorly informed on the state of her health. It could also happen that her understanding has been compromised by her mental state. There are several circumstances where there could be doubt as to the real wishes of a person who asks for physician-assisted dying.

In order to avoid blunders, abuse and errors, you have to put careful thought into what the risks are and try to find answers to minimize those risks. Generally speaking, that will be the objective.

[*English*]

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

We're really blessed to have with us today two very fine public servants, and they are answering very forthrightly. I just want to remind the committee members that it isn't really appropriate to ask them what something should be. It's more important, more appropriate, to ask them what is, or what has happened, or something like that.

I just want to caution you. It has happened a couple of times now that we are putting them in a little bit of a difficult position by asking them what they think they should do. They can answer that somewhere else, but in this committee they're public servants responsible for making sure they help us with that.

You've been doing a fine job of that. Thank you.

Madame Sansoucy.

● (1530)

[*Translation*]

Ms. Brigitte Sansoucy: I am going to try to avoid doing what you just described. That said, I do like your analysis.

The provisions of the Act Respecting End-of-Life Care came into effect in December in Quebec. If I understood correctly, you told us earlier that our decisions must take into account the fact that laws in various provinces may be different.

I don't want you to tell us what we should decide, but according to your analysis and your knowledge of the Quebec legislation on end-of-life care, could it be a model that other provinces could follow? We heard that six years of work went into the making of that law. Do you feel that that law contains what a provincial law should contain?

Ms. Joanne Klineberg: I think it is a good model, one that could give some indication to the other provinces and territories of all of the consequences and all the other legislation that will be affected by decisions on a law regarding physician-assisted dying. Moreover, certain aspects clearly fall under provincial or territorial jurisdiction. In the Canadian context, since that is the only model that exists for the other provinces and territories, yes, absolutely, it is a good model. However, I would say to everyone that it is worth examining all of the other legislation that exists on this matter, as there are other decisions that were taken, and other reasons underlying those decisions. In order to do work that takes everything that exists into consideration, you have to look at the whole picture.

Ms. Brigitte Sansoucy: Thank you.

I am going to give my remaining time to my colleague Murray Rankin.

[*English*]

Mr. Murray Rankin: I wonder if you could you tell us a little more about the Supreme Court and the components of the decision that deals with psychiatric or mental health issues. That came up earlier, and I think it's distinct from the Quebec bill. I wonder if you could give us some guidance as to what they said, so that we can consider how far we might go in that regard.

Ms. Jeanette Ettel: I think the first thing to note is that because that wasn't what they were dealing with, we don't really have a clear answer that was part of the ratio of the decision or part of what they had to decide. There are some comments—and my colleague might have more at top of mind than I do—that they made from a policy perspective and that give us some clues. But again, like many other aspects of the judgment, the clues point in tension with one another in certain circumstances, so I don't think it's entirely clear. It certainly was not before the court.

I think it's fair to say that it would be open to the committee to consider psychiatric illness in the gamut of medical conditions that it has to consider. Whether it makes sense in light of your mandate to come up with some kind of permissive regime, that is a fair issue for the committee to consider, sort of *de novo* in a way, as to whether or not that should be included. I don't think you have a clear answer there.

Ms. Joanne Klineberg: I may be able to add just a few more references to certain aspects of the Supreme Court's ruling that you might find interesting on this point.

The only place in the Supreme Court's judgment where it talks about mental illness is in paragraph 111, where it says:

> Professor Montero's affidavit reviews a number of recent, controversial, and high-profile cases of assistance in dying in Belgium which would not fall within the parameters suggested in these reasons, such as euthanasia for minors or persons with psychiatric disorders or minor medical conditions.

That's really the only place where it talks about it.

There are two other aspects of the court's ruling that I would bring to your attention, as you may find them relevant on this point. One is that there is a variety of places, mostly in the first half of the judgment, where it talks about Ms. Taylor and people like her and the kinds of conditions it had in mind. It mentions things like individuals with Huntington's disease or ALS, and individuals with terminal cancer. These are the kinds of medical conditions it actually talks about.

The final point that I would make that may be relevant is that a large part of the basis for the court's ruling that the absolute prohibition was unconstitutional was that it found that competence and vulnerability can be assessed on an individual basis. It said doctors already, when they're treating patients, individually assess that patient's mental competence, whether they're being coerced or making decisions that somebody else is pressuring them to make, whether they're thinking clearly. It was because the court had expressed confidence that Canadian physicians can assess both mental competence and the vulnerability of a person at the individual level that it felt the absolute prohibition was unconstitutional and you could provide physician-assisted dying to those who wanted it while protecting the vulnerable.

● (1535)

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

Senator Seidman.

Hon. Judith G. Seidman: The Supreme Court decision speaks to charter rights not only of patients but also of physicians. Therefore, patients have the right to access but physicians have the right to conscientious objection. I'm wondering if you have any advice to offer us on how to reconcile what are potentially competing charter rights.

Ms. Jeanette Ettel: As my colleague was mentioning, the issues around that and the approach that's taken as to how and when physicians may object is going to be a part of the provincial-territorial response, most likely. That, to my mind, would be one of the lower-order issues that arises for this committee in terms of what the federal response is going to be but at a very general level.

As with other cases where the court has had to deal with the issue of competing rights of different parties, it always comes down, at a very general level, to a kind of balancing and whether whatever balance has been struck is reasonable and proportionate in the circumstances. I would think overarching that would be the decision and the holding in Carter that there has to be access. That's sort of the baseline. Whatever approach would be taken to give appropriate respect and protection to the freedom of conscience rights of physicians would have to be reasonably balanced by access for the rights holders that were described in Carter.

Hon. Judith G. Seidman: Okay. You're suggesting that it's the provinces that would deal with this particular aspect of the Canadian charter rights.

Ms. Joanne Klineberg: Yes. Currently, the provinces and territories have legislation and policies in relation to the rights of physicians to refuse to partake in certain types of medical practices, so it is definitely something that the provinces and territories already are responsible for. There is a fairly limited scope of action on this particular issue from Parliament's criminal law jurisdiction.

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

I'd like to change the subject to something you mentioned right at the very beginning of your presentation on terminology. You said that there are differences in terminology used in discussions by different groups and there are subtleties implied in their usage. We know that, in Quebec, the term "medical aid in dying" is used. I have heard that palliative care prefers the term "physician-hastened death". We ourselves see in the Carter decision "physician-assisted death" and "physician-assisted dying". We hear "euthanasia", "suicide". There are a lot of terms used.

From a legal point of view, what is important when we think about the terminology that will be used in the legislation?

● (1540)

Ms. Joanne Klineberg: From a criminal law point of view, it would be important to be clear on which are the criminal offences for which we will create an exemption. There is an offence; it's called aiding suicide. That doesn't necessarily mean that it wouldn't be possible or appropriate to coin a different term for what I'm calling physician-assisted dying today. But the legal elements, from a true criminal law perspective, should be clear so that physicians and other medical practitioners can know what they're able to do and what they're not able to do. That's what they will want to give them the confidence, if they're otherwise willing, to provide this service. The legal clarity, from a proper criminal liability point of view, is very important.

At a more social policy level, what do we want to call this practice? That is a very challenging question. There are even finer distinctions to be made. For instance, I could bring it to the committee's attention that some of the stakeholders who spoke to the federal panel—you will all see this when you peruse the report—were also drawing a distinction between dying and death. Dying is a process, whereas death is an event. Some have even made the recommendation that we should never be calling this physician-assisted dying. Many palliative care physicians feel that this is what they already do; they assist patients who are dying by making them as comfortable as possible throughout the dying process.

There's also a danger with these kinds of terms in that people don't necessarily understand what they mean. There was some polling done at the time when Quebec's legislation was before the National Assembly. Quebeckers were asked what they thought *aide médicale à mourir*, or physician-assisted dying, meant. I think something close to 50% said they thought it referred to withdrawal or refusal of treatment, which has been legal in Canada for 20 years. If people are mistaking what a general phrase means, that's not going to facilitate discussions between doctors and patients, and it could confuse things.

I fully recognize the difficult nature of choosing the right terminology on this.

[*Translation*]

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

Mrs. Shanahan, you have the floor.

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

The Criminal Code is of particular interest to me. In its ruling, the Supreme Court mentions two provisions in particular: paragraph 241 (*b*), and section 14.

[*English*]

I did some reading as a layperson. I am not a lawyer, nor do I play one on TV.

[*Translation*]

I noted that section 226 refers to hastening someone's death.

[*English*]

Further down, in section 228, it talks about “influence on the mind”. It's about influencing a person. I don't know if that means counselling. It says that the exemption “does not apply where a person causes the death of a child or sick person by wilfully frightening him.” This was all a revelation to me.

In subsection 231(3), it's like a contract:

> Without limiting the generality of subsection (2), murder is planned and deliberate when it is committed pursuant to an arrangement under which money or anything of value passes or is intended to pass from one person to another,

Are there other clauses that we should be concerned about and looking at that could be called into question and in fact challenged in subsequent court challenges?

Ms. Joanne Klineberg: There are definitely a number of other Criminal Code provisions that, on the periphery, may be implicated. There's another offence for administering a noxious substance. There are offences in relation to failing to meet one's duties to protect human life. However, I think the Supreme Court was correct that the core provisions are section 14 and paragraph 241(b).

I should also add for the committee to note that paragraph 241(a) was raised by the plaintiffs in the Carter case as being relevant, but the court found that it was not core to the prohibition. That is a prohibition on counselling someone to commit suicide. A number of stakeholders may tell you they're concerned that this offence might inhibit discussions between doctors and patients.

I think we can help the committee if more information is wanted about what these provisions are, but I think the issues before the committee are at a somewhat higher level. When the Department of Justice works on legislation, we go through the entirety of the statute to see if there are other sections that may be affected. Often there are small consequential amendments that just make sure that something said in one section gets tracked to other relevant sections.

I think it's probably less of a priority for the committee to be worrying about those, and more of a priority to be thinking about what the conditions should be and what medical eligibility should look like. There will always be some little details to work out, but I think those two provisions the court identified are really the crucial ones. Any consideration you want to give to other sections will, of course, be welcome.

● (1545)

Mrs. Brenda Shanahan: Very good. I do have another question on the laws surrounding this area already.

We have the Civil Code of Québec.

[*Translation*]

A warrant may be issued in cases of incapacity. In another context, I would like to ask for more information on how that concept was reconciled with the current Quebec law.

However, I'd like to get back to our committee's objective. I would like to know whether we are planning another exercise for a study of living wills and that sort of thing.

[*English*]

Ms. Joanne Klineberg: I would answer by saying there's nothing in the Supreme Court's ruling that addresses, from a constitutional perspective, whether Canadians have the right to make an advance directive for medical aid in dying that would be provided to them after they had lost their ability to say that it's what they want or don't want. There's nothing in the Carter ruling that tells Parliament that is something it has to consider.

I can say that the National Assembly of Quebec did not take that step in Bill 52. Certainly there are some who might have sought that, and they did have a special piece of analysis done, because it raises very different issues.

For instance, the person who makes an advance directive before the time that a family member, for instance, brings it to the physician's attention, is no longer able to say whether or not they want physician-assisted dying. They're not able to articulate the nature of their suffering. These are elements that would need to be present under the law right now in order for a person to access it at a later time. At the time when it would be provided, the person would not be able to say whether they were suffering.

It presents unique challenges for physicians, and it's an issue that is dealt with separately. Is it something Parliament and this committee might wish to consider? It may be, but I don't think there's anything in the Carter ruling that instructs Parliament to go there.

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

Mr. Cooper.

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

Ms. Klineberg, in your presentation, you identified a number of common features in jurisdictions that have euthanasia or assisted suicide or both. One of the common features you cited was oversight or review mechanisms. It's my understanding that when you look at the European examples, as well as jurisdictions such as Washington state and Oregon, those review mechanisms occur after the fact, when the individual is already dead.

I was wondering if you were aware of any jurisdictions that have oversight in the way of judicial authorization or otherwise at the front end as opposed to the back end.

● (1550)

Ms. Joanne Klineberg: There's only one, and that is the country of Colombia, which I mentioned in my opening remarks. In early 2015, the government promulgated a resolution to guide the practice of physician-assisted dying. What they foresee in that regulation is that there would be an interdisciplinary committee that would review the patient's request, and it would not just review the request but would almost have carriage of the patient's request and their file through the rest of the process.

The patient would make the request to their physician, and the physician would then notify an interdisciplinary committee, which has on it a lawyer, a physician, and also, I believe, a mental health expert. The committee would be part of the hospital administration. That committee would take over the patient's case and would work with the patient and the patient's family to give them the support they need to ensure that palliative care is offered. They would accompany the patient, basically, right through to the end of the process. It is the independent body—not the physician administering it—that would be ensuring that all of the conditions had been satisfied beforehand.

Mr. Michael Cooper: In terms of the example from Colombia, it's my understanding that Colombia has had euthanasia, at least on some level, for the last 16 or 17 years. It's my further understanding that this framework that has recently been unveiled is a consequence of a Colombian court decision that said there were simply not enough checks and balances at the front end to protect vulnerable persons. I wonder if you might be able to elaborate on the history in Colombia.

Ms. Joanne Klineberg: I will do my best, but before I do, if I may note this, I forgot to mention in response to the previous question that the U.K. private member's bill I mentioned earlier had been amended by the U.K. Parliament when it was being studied by Parliament as a committee of the whole. What was added to it was a mechanism that would require the person's request to be approved by the family court before physician-assisted dying could be provided. As I mentioned, this bill was defeated, so it's not in law, but there's another model that this committee could look to.

Returning to Colombia, we have spotty information. It's a little difficult to get the information, but what seems to have happened in the 1990s is that a decision of the Constitutional Court, which is the high court of Colombia, found that a terminally ill person who was going to die in the very short term had the right to have a physician provide a lethal injection, so euthanasia is what they had considered. What seems to have happened is that physicians were unwilling to do that on the basis of the court's ruling alone. The government never did introduce legislation or decide on what the protocol should be.

About 20 years later, another individual who wanted to have access and couldn't find a willing physician brought another case before the courts. The Constitutional Court again said that this was a right, and if the government didn't put rules in place so that everyone could feel safe carrying out this practice, it would do it for the government. It was shortly after the second constitutional ruling in 2014 that the government did in fact bring forward the resolution.

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

We have time for a short question from Senator Nancy Ruth.

Hon. Nancy Ruth: You used the expression “advance consent”. Sometimes it's known as prior consent. There are other phrases for it. Is there any difference in law between these?

Ms. Joanne Klineberg: This is one of those questions where I have to say that it is a matter of provincial-territorial law, so I can't claim any expertise. I am sure there are some differences in the modalities, in the technical details about what the form must look like, if there is a specific form that an advance directive needs to be in, and how many years in advance a person can make one. There might be some differences.

But on the whole, the idea is the same everywhere, which is that people can state, “If something happens to me and I become unable to express my wishes, these are my wishes that I want carried out when I'm no longer able to convey them.” The general principle would be the same everywhere, I would think, but there may be some small differences.

We think this might be something my colleagues from Health Canada would be better able to answer.

● (1555)

Hon. Nancy Ruth: And this would simply be in the form of a letter of wishes given to your health power of attorney.

Ms. Joanne Klineberg: I'm sorry, I really wouldn't want to speculate.

Hon. Nancy Ruth: Okay.

For my last question—to create some work for you—is it possible to have some kind of spreadsheet with this new report from the external review committee, from the provincial–territorial committee, and from other committees that have reported on what they say with regard to issues like consent, eligibility, and so on? I mean, it would be a huge amount of work.

Ms. Joanne Klineberg: Well—

The Joint Chair (Mr. Robert Oliphant): It would be a huge amount of work, and I'm sure our analysts will help us with that.

Hon. Nancy Ruth: Thank you.

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

Thank you very much. We have a large mandate and a short period of time to get it done, and you responded quickly. I hope you're not going on holidays anywhere quickly, because on behalf of the committee, I would like to both thank you and reserve the right to call you back. You've laid a foundation for us, and have given us both answers and more questions. Thank you very much for your time.

I want to hold the committee for one more minute, as our joint chair has something as well.

The Joint Chair (Hon. Kelvin Kenneth Ogilvie (Senator, Nova Scotia (Annapolis Valley—Hants), C)): As a quick piece of information for all members of the committee, the Library of Parliament has a number of documents: a summary of previous studies on legal framework, a plain language summary of the Carter report, euthanasia and assisted suicide in Canada, law in selected countries, and federal health power. These are available to all members and staff. They are currently available on the Senate portal as well as on the House of Commons SharePlus system.

Those documents are all available to you for immediate access.

The Joint Chair (Mr. Robert Oliphant): I think that is our day. Thank you to the committee, and thank you to the witnesses for fine work today.

We will adjourn until Monday morning at 11 o'clock.

I would remind you to have your witness list and issue list in by Wednesday at 5 p.m.