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Co-Chairs

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

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• (1705)

[English]

The Joint Chair (Mr. Robert Oliphant (Don Valley West, Lib.)): I call to order this meeting of the Special Joint Committee on Physician-Assisted Dying.

Thank you, especially right now to our witnesses, and my apologies on behalf of all of us in the House of Commons for twice changing the time of this meeting. Times often change once and rarely twice, but when votes and ministerial statements happen, we seem, at least on the House side, to demand a lot of flexibility. Thank you, both for being so willing to come in any case and for coming despite our change in meeting time.

I will just note that our co-chair, Senator Ogilvie, is at another meeting and will get here as soon as he can.

I'll remind the committee that we will be meeting for an hour in this first session. We may ask for a few minutes of flexibility because we have three panels tonight, so I may ask for another five minutes at the end if we want to keep questioning for a bit. I'll check with you about that. We have some time before the vote in the House, so that should be okay.

Go ahead, Mr. Warawa.

Mr. Mark Warawa (Langley—Aldergrove, CPC): On that issue, Chair, if we do have now an extension of time because of the vote, I have something I'd like to share in camera with the committee. If you could allow five or ten minutes for that at the end of meeting, I'd appreciate it.

The Joint Chair (Mr. Robert Oliphant): Sure. The bells aren't until 6:45, I believe, so we have a little time there. We'll go in camera after we have a good discussion.

Our first witnesses today are from the Canadian Medical Association, Canada's physicians.

We thank you very much for coming. We have 10 minutes for your presentation. The time is yours. You may introduce yourselves and your titles as you go.

Dr. Cindy Forbes (President, Canadian Medical Association): Thank you, Mr. Chair.

I'm Dr. Cindy Forbes, president of the Canadian Medical Association. I'm also a family physician from Nova Scotia. I'm joined today by Dr. Jeff Blackmer, vice-president of medical professionalism at the CMA. Dr. Blackmer has led the CMA's work on assisted dying.

Today I'd like to begin by first reviewing a brief history of CMA's public and physician consultations on end-of-life care, followed by an overview of our report, "Principles-based Recommendations for a Canadian Approach to Assisted Dying".

Before doing so, I would like to flag two critical issues for the committee's consideration. Both issues will be central to ensuring effective patient access.

First, how can we ensure that the legislative and regulatory framework achieves an appropriate balance between physicians' ability to follow their conscience and patients' ability to access physician-assisted dying? Second, how can we ensure that we emerge with a consistent, pan-Canadian framework?

We will speak to these issues as part of our remarks and will welcome your questions during this appearance. We want to highlight the potential role of federal legislation as an efficient and effective means of addressing these issues.

I'll start with a bit of history. As the national professional association representing Canada's physicians, the CMA has long recognized the importance of end-of-life care. We've played an important role over the past couple of years, in particular by leading the national discussion on end-of-life care, including assisted dying. Over the course of 2014, the CMA initiated the broadest consultation in Canada in recent years. We hosted town hall meetings across the country, as well as an online dialogue, to consult with the public as well as physicians on issues related to end-of-life care. This consultation has been instrumental in informing both our position and our focus on this issue.

During the Carter case, the CMA appeared before the Supreme Court as an intervenor, as a friend of the court, with the purpose of representing the physician perspective. In its ruling, the court made reference to the CMA's position. Following the Supreme Court's landmark decision last February, the CMA initiated the development of recommendations to guide the implementation of assisted dying. The development of these recommendations included extensive consultation and deliberation with CMA's committee on ethics, with Canadian physicians, and with key medical and health stakeholders.

In addition, over the course of the fall the CMA met with numerous provincial and territorial health ministers to discuss these recommendations. Our recommendations have now been finalized and were publicly released last week. The committee has been provided with our “Principles-based Recommendations for a Canadian Approach to Assisted Dying”. Guided by a set of ten foundational principles, the recommendations address the following four areas: patient eligibility for access to an assessment for assisted dying; procedural safeguards to ensure eligibility criteria are met; the roles and responsibilities of the attending and consulting physicians; and how to appropriately balance conscientious objection with a patient's request to access assisted dying.

This last issue, that of conscientious objection, is one we would like to discuss in more detail, as it is of particular concern.

I will now turn the microphone over to my colleague, Dr. Jeff Blackmer, to discuss this issue.

Dr. Jeff Blackmer (Vice-President, Medical Professionalism, Canadian Medical Association): Thank you, Dr. Forbes, and thank you, committee members.

Ensuring effective patient access across Canada will depend in part on how this issue is addressed. I would like to point out that a key focus of the CMA's work has been to ensure that both physicians and the patients for whom we care are represented in the overarching regulatory and legislative response to the Carter decision. As it remains in society, assisted dying is a difficult and controversial issue for the medical profession. It must be recognized that this represents no less than a sea change for physicians in Canada. As the national organization representing physicians, I cannot underscore enough the significance and the importance of this change.

As we have mentioned, the CMA has extensively consulted physicians before and since the Carter decision. Our surveys and consultations indicate that approximately 30% of physicians indicate that they would provide assistance in dying. It's important to note that for the majority of physicians who will choose not to provide assistance in dying directly, providing a patient with a referral will not be an issue for them. They will not consider it to be a violation of their conscience or of their moral code.

For other physicians, however, making a referral for assisted dying would be categorically, morally unacceptable. For these physicians, it implies forced participation procedurally that may be connected to, or make them complicit in, what they deem to be a morally abhorrent act. In other words, being asked to make a referral for assisted dying respects the conscience of some physicians, but not of others.

Part of the obligation of government and stakeholders is to ensure effective patient access by putting in place sufficient resources and systems. The CMA's framework accounts for differences of conscience by recommending the creation of resources in order to facilitate that access. It is critical that we provide clarity for physicians and their patients and that we develop a consistent approach across all jurisdictions.

The CMA is keenly aware of the risk if we don't—that a patchwork of differing and potentially conflicting approaches may easily emerge. That would not serve anyone well, doctors or patients.

Today I can inform you confidently, and with gravity, that we are facing this risk. A number of provincial regulatory bodies have recently released draft or final guidelines on this issue. They differ either slightly or substantively on a number of important points. This is no longer a theoretical issue. We are indeed faced with a patchwork of approaches.

We look to Parliament for leadership to support the development of a pan-Canadian, national approach. The CMA's framework provides critical guidance for decision-makers in this respect. I must reiterate that in developing these recommendations, the CMA has given the issue our most careful and thoughtful deliberations, perhaps in the history of our organization, through the past two years. We've consulted at every step along the way with our membership, with the public, and with other health care stakeholders. Our recommendations are the result of this significant consultation in addition to our expert review of existing international frameworks.

I'm pleased to tell you that Canada's doctors stand ready to work with you to make sure that we are ready to respond in four months from now. As a country, we do not currently have a system in place to support us, but I'm pleased to tell you that the CMA's framework stands ready for your adoption.

Dr. Forbes and I would welcome any questions or comments you might have.

Thank you.

• (1710)

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

We'll now turn to the Canadian Nurses Association and hear from Ms. Sutherland Boal.

Ms. Anne Sutherland Boal (Chief Executive Officer, Canadian Nurses Association): Good afternoon. My name is Anne Sutherland Boal, and I'm chief executive officer of the Canadian Nurses Association.

The CMA is a national professional association representing 135,000 registered nurses and nurse practitioners across the country in every province and territory. Today I'm joined by Josette Roussel, a senior nursing adviser in our organization.

At our core, our national association is an advocate for nurses, for Canadians, and for better health for all. Thank you for including CNA in the sixth meeting of the Special Joint Committee on Physician-Assisted Dying. It is our hope that the joint committee will consider the insight and specialized knowledge and expertise that nurses have to offer on the topic of physician-assisted death. We will also make remarks on the more general topic of end-of-life care.

Registered nurses and nurse practitioners are Canada's largest group of health providers. By the sheer size of the profession, which includes over 350,000 nurses, and the countless settings in which we work, we have the most consistent and direct interaction with Canadian patients and families seeking health care. Nurses are caring for people 24 hours a day, seven days a week, building trustworthy relationships with their patients, families, and caregivers. RNs and NPs are where Canadians are: at home, in the community, and in the hospital. In my following comments, when I use the term "nurses", I am referring to RNs and nurse practitioners.

Canadian nurses have been closely monitoring the issue of physician-assisted death. In October 2015 we provided our views before the External Panel on Options for a Legislative Response to *Carter v. Canada*. We were also discussing and exploring implications for nursing practice long before the February 2015 Supreme Court of Canada decision and the Quebec Court of Appeal decision in December 2015. It is a topic of everyday discussion for Canadian nurses. Just yesterday, during a CNA webinar on end-of-life care, over 350 nurses focused on the ethical issues and nursing care related to physician-assisted death.

Canadians know that there is nothing easy, and Canadian nurses know that there is nothing easy, about watching someone you love experience pain and distress. We face these situations by advocating for patients and supporting one another as health care providers in honouring their wishes. Nurses have long supported patients and families during end-of-life care and planning and discussions. We are vocal advocates for improved access in palliative care across Canada. We believe that in addition to the work of your committee, efforts by policy-makers and providers must also continue the area of palliative care services and resources for all Canadians.

Nurses' practice in Canada is grounded in our code of ethics for registered nurses. My colleague Josette Roussel will now speak on the code and how relevant this issue is for nurses in Canada.

With that, I would like to introduce Josette.

• (1715)

Ms. Josette Roussel (Senior Nurse Advisor, Canadian Nurses Association): Thank you, Anne.

[*Translation*]

I am a nurse, and I spent many years of my career taking care of end-of-life patients.

I will continue my presentation in English.

[*English*]

The Code of Ethics for Registered Nurses is a foundational document for nurses in Canada. To help me explain why it's important and how it helps nurses, I ask you to consider a scenario. An 85-year-old man is in the hospital after suffering a massive brain hemorrhage. He tells his daughter he's scared. He lies awake in his hospital bed throughout the night contemplating what will happen next. Is he going to die? When will he die? Will there be a lot of pain? These are big questions for anyone to face. As he lies there at 3 a.m. in the hospital bed, surrounded by strangers, one of the only people to turn to may well be the nurse.

Our code of ethics for registered nurses and the resources that CNA provides are to prepare nurses for those 3 a.m. discussions. The code is there to help nurses practise in a competent, compassionate, responsible, and ethical manner. It provides guidance on the person's right to refuse or withdraw consent. It also emphasizes the importance of recognizing power differentials between the care providers and the person in care, and what to do when care conflicts with conscience. The code provides practical steps on how a conscientious objection comes about: before employment, anticipating and planning for a conflict, and when one is involved in nursing care that is creating a conflict.

While nurses have their code to guide their nursing practice, they also need legislation, regulation, policies, and procedures. These structures will in turn help us as providers to ensure that Canadians have access to the care they deserve.

Ms. Anne Sutherland Boal: Thank you, Josette.

As nurses, we know that physician-assisted death is intricate and complex and we acknowledge the potential conflict between professional values, personal values, and health practice. However, with the Supreme Court's decision made, the CNA's priority is to help nurses deliver the best ethical and competent care to all patients.

I wish to speak to the requirements that are the most important to the Canadian Nurses Association.

First are safeguards to support individual decision-making by patients. Safeguards are needed to ensure that physician-assisted death is dealt with carefully, competently, and ethically. We recommend mechanisms for an individual patient to have conversations with families, caregivers, and the interprofessional team; policies and procedures to ensure competency assessment throughout the journey; processes for patients to reconsider their decision; processes to ensure that vulnerable patients are protected; mechanisms for nurses to contribute to the decision-making and assessment of the supports required by patients; and guidelines for the documentation by the interprofessional team of the discussions held and the plans made.

Second is equitable and timely access to information about end-of-life options, including palliative care and physician-assisted death. Canadians need to have equal access to physician-assisted death regardless of their postal code and their physical setting, whether home or hospital. Culture and gender as well as the acknowledgement of inequalities and disparities are also considerations.

Canadians and health care providers need to have access to resources and information to inform them on all end-of-life options. As plans for processes for physician-assisted death are being developed, we support a parallel pan-Canadian approach to palliative care. We recommend information, resources, and navigation for nurses to use in every setting to respond to questions posed by individuals, families, and caregivers, as well as education for health care professionals to support individual patient palliative and end-of-life care options.

Third, we request support for patient choice through a person-centred approach. The desire for a dignified death with relief from suffering should be considered at the core of a patient's request. Dignity is a key element of any plan. Patient-centred care honours people's values and health care wishes by promoting autonomy, choice, and control as well as shared decision-making. We recommend policies and procedures that outline how the team will communicate with individuals, families, and caregivers. We also recommend that there be guidance to ensure open discussion and sensitive listening that recognize cultural sensitivity and appreciate personal autonomy and spirituality.

Fourth are quality and safety mechanisms. It is essential to establish a rigorous process for assessing patients and forming a decision. The process must be well defined, documented, and understood in a consistent manner across Canada. We recommend systematic mechanisms, including standardized data collection systems and standardized policies and procedures to ensure accurate national data collection. We also recommend public reporting and a harmonized framework led by regulatory bodies that standardizes education and evaluation related to the competencies required of health care professionals.

• (1720)

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

Ms. Anne Sutherland Boal: Fifth is equitable access to psychological supports for health care providers. The current health care context brings pressures and stresses for health care providers. We recommend educational support on physician-assisted death as part of provider curricula. We also recommend competency development within continuing professional education, as well as access to psychological support.

Finally, there's the protection of nurses and other health care providers under the Criminal Code. Nurses are intimately involved in end-of-life processes. The nurse may well be the first person with whom a patient chooses to discuss end-of-life care and options. We recommend amendments to the Criminal Code. This position has been well described by the Canadian Nurses Protective Society in the brief they submitted to the external panel. We also recommend guidance on conscientious objection.

Thank you very much for the opportunity to present to you today.

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

Our third presentation is from Dr. Monica Branigan.

Dr. Monica Branigan (Canadian Society of Palliative Care Physicians): Good evening, everybody. It gives me great pleasure

to come here. My intention is to be helpful and to really let you know the experience of a palliative care physician.

I am a palliative care physician. I see patients in their homes in Toronto, and I am here trying to represent the views of the Canadian Society of Palliative Care Physicians. I'm going to respect the fact that you've had a lot of information thrown at you and just focus on four priorities.

The number one priority is that, at the same time as we legislate hastened death, we need to increase palliative care. There are three reasons for that. Number one is that less than 3% of Canadians are likely to avail themselves of services to hasten their death, yet 100% of Canadians can benefit from palliative care. Number two is that we know that palliative care is underserved, and we know that 65% of patients currently die in hospital, which is not what Canadians want. Number three is that this is more than a political issue; it's a personal issue. All of us sitting around this table have had loved ones die. Some of them have died not so badly, and some of them have died badly. If we really want to respect choice, there has to be an option and there has to be good palliative care.

One of the ways in which we think this need for palliative care could be met is through a national secretariat for palliative care. There are lots of organizations that have laid the groundwork for a national strategy in palliative care, such as the Canadian Cancer Society and the Canadian Medical Association. People have thought of lots of ways to navigate this area.

The whole reason for having this done nationally is that Canadians support fairness, and right now, there's a patchwork. What you get really depends on where you live.

This initiative needs to be carried out at a national or federal level in order to set standards, monitor standards, and collect data—which we don't have—and to advise on such things as how to shift care from acute-care hospitals, which currently have 95% of the budget, to the community, which currently has 5%. We need some guidance, and we need to think about it nationally. How do we provide public education to try to dispel some of the fear around death and dying?

The second priority is reducing the risk of premature death. As palliative care physicians, we've all seen patients ask for assistance in hastening death, and then change their mind and say something like, "I'm so glad I couldn't do this." This is not to imply that everybody will do that, but we need to have safeguards in place, and one of them is a waiting time that is proportionate to the amount of time that this person may lose in their living.

For example, when a woman who's dying of breast cancer, with potentially four weeks of life left, makes this request, we should be able to respond much more quickly than in the case of a 21-year-old gentleman who's just had a spinal cord injury and cannot imagine his life in a wheelchair. We know that people can accommodate a new normal, and a rigid waiting time will not do that.

We also need to make sure that the people who are exploring this request are skilled. If this young man spoke to a physician who didn't know about options, this physician might conclude that the situation was hopeless and that of course he would need hastened death. We know, as palliative care physicians, that most requests are expressions of despair, some of which we can help with. With great humility, I know that we cannot help everybody.

We also need to make sure we have access to addiction counsellors, psychiatrists, and spiritual care professionals to make sure that this patient has truly been supported. In the brief, I have made some comments on graduated implementation, and I'd be happy to answer questions about that.

The third priority is having a national oversight organization so that we have a pan-Canadian way of ensuring that everybody has access to this service. This could be bigger than that, because right now we do not have a problem, as Dr. Blackmer pointed out, with finding willing providers, but we have a big problem with connecting patients to these providers, and it should not be on the shoulders of Canadian doctors to self-organize.

• (1725)

This national oversight could not only be collecting data, looking at trends, and setting Canadian standards; it could also be a repository of willing providers, information, and referral services. Not every health care provider who is asked for assistance is going to have the resources to give this good information.

In addition to supporting institutions and regions that don't have a lot of resources, this separate oversight would really make the distinction that physician-hastened death is not synonymous with palliative care. We're concerned about this point because we've had to work very hard to make palliative care a safe option for people. If, in their minds, assisting in dying—which is what I do every day as a palliative care physician—is the same as hastened death, then we are going to prevent access to palliative care for some patients.

Finally, as a priority, we need to create a sustainable system. We need to offer protections in the Criminal Code for all of our health care practitioners—everybody, not just physicians. We also need to consider legislating for protection of conscience, because you cannot build a sustainable system on moral distress. I think Dr. Blackmer talked to you about this point. We need to make sure that institutions that opt out do so in a way that doesn't overly burden other institutions. As Anne pointed out, those providers who actually provide this service need to be supported with psychological support and spiritual support to make sure they're not overburdened.

Part of the sustainable system, I would put to you again, is making sure that this is seen as distinct from palliative care. I hope I've offered some ways that might happen.

Thank you.

• (1730)

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

We will begin our questioning with Mr. Aldag.

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

To start, Dr. Forbes and Dr. Blackmer, I'm interested in a figure that I saw with regard to the willingness of the physicians you surveyed to participate in assisted dying. I was trying to find it in the reports and I didn't.

One of the documents I read indicates that the Carter case provides the floor, not the ceiling, for physician-assisted dying. In terms of the doctors you surveyed, I'm curious to know where you're starting from. Was it taking the Carter case and looking at it as a grievous and...?

A voice: Irremediable.

Mr. John Aldag: Yes. It was a grievous and irremediable condition. I couldn't read my writing there.

If we start looking into extending the ceiling on things—if we start exploring age, incompetency, and other factors—at what point does the support from the body represented by the CMA start to shift? There really is that continuum from restrictive to permissive, and I am trying to get a sense of where your members are at and where policy may be able to go while still maintaining support.

Do you have any comments on that?

Dr. Jeff Blackmer: You know, they say if you can't read your own writing, you may actually be a physician.

Voices: Oh, oh!

Dr. Jeff Blackmer: Thank you very much for that question. We did actually explore that a little bit with our membership. We did not do it in a very granular way, but when we asked them what their level of support would be overall, we came up with a number of around 30%.

Once we start to add in some additional factors—for example, if the pain and suffering is purely psychological versus physical as well—the support drops. Once we add in a non-terminal versus a terminal illness, the support drops again. You can see that physicians' level of discomfort will increase as we add in more of these variables. We didn't use things like age or the possibility of using advance directives as variables specifically, but in the conversations we've had with our colleagues, there's a lot of discomfort around those areas as well.

Our starting point for a lot of the discussions was the Carter decision as we interpreted it, which is not what some people are calling “Carter plus” but more the floor than the ceiling, I think. The more variables you add in, the more difficult health care providers find those scenarios, the lower the support becomes, and the lower the percentage of providers willing to step forward and provide assisted dying becomes.

Mr. John Aldag: Thank you.

I'll talk a little bit about safeguards, if we have time, but I'd like to get into the “grievous and irremediable” piece and look at the defining of these terms.

Were there discussions about it? You talked in your statement about having a pan-Canadian approach. I'm struggling with who is best to define that. Is it done by legislators in legislation? Is it done by practitioners? How do we go about dealing with the terminology, which will be very important?

Dr. Cindy Forbes: Thank you for that question. It's certainly a question that we've had lots of debate about as well.

In our document, we have actually come up with a definition. I could read it to you, but the essence of it is that “grievous” is serious or severe, and “irremediable” is not able to be put right or cured. We recognize that these are not medical terms. There is not a medical definition of these terms, and there's definitely a subjective component associated with them.

As we worked through this question, we realized that it is clearly a dialogue between the patient and the physician. There's also the issue of suffering. Patients are really the only ones who can account for how much suffering they have.

We recognize that this is a discussion between the physician and the patient, and hopefully, as in most cases in medicine, we'll come to a decision together through a dialogue and through understanding where the patient is coming from, with the physician giving his or her advice as well. A decision will be made jointly in that respect.

Mr. John Aldag: Similarly, would you see safeguards being dealt with through legislation?

We heard from one of the others—I think it was Dr. Branigan—about wait times and how they might need to vary, depending on outcomes such as life expectancy. How do we deal with those? Are they hard legislated pieces? How do we deal with safeguards?

• (1735)

Dr. Jeff Blackmer: Thank you. It's a very important question, and we do see that as a legislative response, for sure.

Very similar to what Dr. Branigan was saying, we've been advocating for safeguards and waiting periods based on the facts of an individual case. There will clearly be differences between someone who's at the end of their natural life and is suffering terribly, without hope of alleviating that suffering, and someone with a newly diagnosed injury or with a depression that may or may not resolve itself.

We didn't feel comfortable putting in a strict definition; rather, there needs to be a recognition that it may change depending on the

circumstances. However, the concept itself and having that consistent federal level were very important.

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

I need to go to Mr. Cooper.

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

My question is to Dr. Branigan.

There is evidence from other jurisdictions that persons can be motivated to request euthanasia or assisted suicide by factors other than a medical condition—for example, victimization, social isolation, economic disadvantage, and so on.

You alluded briefly to the need for training, but I wondered if you might be able to comment on what kind of training physicians currently have to identify this wide range of factors.

Dr. Monica Branigan: Our palliative care training is woefully inadequate. At the University of Toronto, medical students get less than 16 hours in their whole curriculum. What kind of training have they had for exploring these kinds of requests? As a palliative care physician, I talk to patients about this at least once a week.

Absolutely, you're talking about the question of burden. If you look at burden, that is one of the more common reasons that requests for hastened death are granted, and burden is sometimes a perception of burden.

Other reasons that come up are not being able to live one's life in the way that one wants to, meaning loss of autonomy. A big reason is being unable to accept help in toileting. For many people, that is grievous and intolerable.

Regarding the other question, what I think you're getting at is whether somebody would potentially be granted the ability to hasten the end of their life because of poverty, for example. That, I think, would be part of the equation. We always look at how much support is available in the home, and that's a big part of the assessment.

Mr. Michael Cooper: To follow up on the issue of training, I think that there have been some who have come before this committee and, I would suggest, have framed this whole procedure of euthanasia or assisted suicide as a simple one, but there are many instances of people literally waking up in the middle of being euthanized, so in a lot of respects, it's a complex procedure.

I was wondering if you might be able to comment on that in the context of the need for training.

Dr. Monica Branigan: I don't think the actual procedure itself is that complex; I think the ability to respond compassionately to a request to hasten death is complex.

If you look at why people request euthanasia, it breaks down into four areas. It's often an expression of despair. As well, for some people it's a hypothetical exit plan, and that means in Oregon about 40% of people who get a prescription never use it, and they derive benefit from it. These kinds of requests also come along when someone is imminently dying. Then there is that group of people who persistently request and follow through, and in that group such things as burden and autonomy and dignity tend to be reasons much more common than pain or uncontrolled symptoms.

The Joint Chair (Mr. Robert Oliphant): I'll give you a little extra time because Dr. Forbes wanted to get in.

● (1740)

Dr. Cindy Forbes: Just for the information of the panel, I wanted to let you know that the Canadian Medical Association recognizes the need for physician education around physician-assisted dying, and we are currently developing educational programs for physicians. Dr. Branigan is actually an adviser.

We see two main aspects to these programs. One would be education for all physicians, so as a family physician, if I had a patient requesting physician-assisted dying, I would be able to have the early conversations and be able to access information and resources for the patient. The second part would be a more intensive training program for physicians who are willing to assist patients, and that would definitely go into some of the more complex issues, including the means and medication procedures involved as well.

The Joint Chair (Mr. Robert Oliphant): Take another minute.

Mr. Michael Cooper: Dr. Branigan, when Maureen Taylor came before this committee yesterday, she disputed some statistics. She is from the provincial-territorial panel and she suggested that the statistics of somewhere in the neighbourhood of 15% to 30% of Canadians having access to palliative care were outdated, and, second, she also said that Canada is so vast geographically that palliative care really need not be part of the discussion surrounding assisted dying.

I wonder if you might be able to comment on those points.

Dr. Monica Branigan: The truth is we don't have adequate data to know what access to palliative care is. That's the truth. We do know from the latest report from the Canadian Cancer Society that 45% of cancer patients are not seen by palliative care practitioners in their last year of life, so I don't think there is too much doubt that access is a problem.

I'm sorry, but I've forgotten the rest of your—

The Joint Chair (Mr. Robert Oliphant): Thank you, but I do need to go on. We've had an extra minute and a half.

Mr. Rankin is next.

Mr. Murray Rankin (Victoria, NDP): Thank you very much.

I'd like to first ask the Canadian Medical Association this question.

In your materials, you talk about the need for Parliament to develop a pan-Canadian national approach, and you point out that seven provincial regulatory bodies have released draft or final guidelines, presumably from the colleges in the provinces.

It's a two-part question. First, are you content to leave it to the colleges to do this work, or do you think there is a role for Parliament in addressing these questions? In other words, can the doctors, as a self-governing profession, do the job, and if so, what about the uniformity we are hoping to achieve here if we do leave it to the regulatory bodies in each of the provinces?

Dr. Jeff Blackmer: Thank you very much. That's an extremely important question for the profession at the moment.

What we had hoped to see as the provinces developed these guidelines was a much higher degree of consistency among the various approaches. There is a national body that represents them, but we've certainly seen a diversity of views and a diversity of policies being developed. As I said, some are slightly different, while some are very substantively different.

We're very clear on the fact that if this is left at the provincial level, we will have a patchwork. We already have a patchwork, as I said. It's no longer a theoretical concern. It exists in reality now, and our members are telling us about their concerns. I have phone calls every day from people saying, "I live in this province. I think I am going to move to that province because I like their rules better and they coincide better with my own moral views." It is not a theoretical issue anymore.

Because of that, we certainly would look for a very rigorous federal approach to try to make sure that we do have consistency from province to province on some of these very difficult issues to resolve some of these uncertainties.

Mr. Murray Rankin: Second, I very much appreciate your principles-based recommendations for a Canadian approach. In "Stage 2: Before undertaking assisted dying", you call for a "second, independent consulting physician".

I've heard from others that this second physician ought to be a specialist in the field—an oncologist in one case, or someone familiar with ALS, or perhaps a psychiatrist in another case. Would you subscribe to that idea? Would you agree that it ought to be...?

Is there a fear that two doctors in the same small town might see the world very differently, and one needs an outsider, perhaps a specialist, to intervene?

● (1745)

Dr. Cindy Forbes: I think the issue varies. If the first physician feels that it is complex, we've certainly suggested that they may wish to get a specialist referral, especially with the assessment of capacity when they aren't sure whether this patient is capable of consenting, so in some instances, having a regulation that it be a specialist would actually restrict access.

We feel that in the framework we put in place, we were very clear about what's expected of the two physicians. We feel that if those guidelines are followed, the second physician shouldn't necessarily have to be a specialist.

Mr. Murray Rankin: I'd like to ask a general question, perhaps for Dr. Branigan, perhaps for the CMA.

How would you feel about this service being provided at home for a patient who's gone through all of the steps you require, or that we will require, who wants to exercise this right at home? Do you see it only being done in a hospital setting?

Dr. Monica Branigan: I'm sure that many more patients will want this at home, surrounded by their family, rather than in an institution.

Mr. Murray Rankin: So you would have no medical difficulty with either route to that end?

Dr. Monica Branigan: As long as there was a willing provider in the home, absolutely. I think that's where people want to die.

Mr. Murray Rankin: Okay.

You both spoke about the proportionate waiting time issue. I'd like to ask you a little bit more about that.

Dr. Blackmer, I think you talked about legislative guidelines for the waiting time issue, yet I can see there's a vast difference, depending on the disease and the circumstance. You talked about a breast cancer patient with four weeks to live versus a 21-year-old.

How could one legislatively provide these guidelines? Isn't this something that ought to be left to the discretion of the physicians—subject, of course, to discipline by their self-governing profession?

Dr. Jeff Blackmer: Perhaps I'll try to address that first. It's an excellent point.

I think we'd like to see clarification on the need for some sort of a reflective waiting period. I have heard people in discussions say that it really should just be one doctor, and that five minutes after the request is made, the intervention should be available. There should be no opportunities for that sober second reflection or for further discussion with family and loved ones.

I think we'd like to see the principle become clear, but recognize that absolutely there will need to be room for decision-making between health care providers and patients, depending on the situation.

Dr. Monica Branigan: I agree with what Dr. Blackmer is saying. It's hard to just have a rigid waiting period that will be appropriate. I would support that.

Mr. Murray Rankin: Not specific rules—

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

I'll move now to Senator Seidman.

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

I'd like to pursue Mr. Rankin's issue about uniform access.

You yourselves talked about a pan-Canadian approach. I'd like to know how all of you might respond to a recommendation that we heard yesterday from the provincial-territorial expert advisory group. Their recommendation to us was that regulated health care professionals, including registered nurses or physician assistants, should be able to provide physician-assisted dying under the direction of a physician or a nurse practitioner.

Might I have your impressions, from all three of your associations, about this proposal?

Dr. Cindy Forbes: To date, we've always assumed that there would be a team involved in the care of the patient, but our understanding of the Carter decision is that it's physician-assisted dying. That was our interpretation, so we've looked at it in that light. It is certainly within the realm of possibility that it could be expanded. We have not put that forward, or either supported or opposed it, but we could see that, for access purposes, there may be instances in isolated areas when it could occur.

• (1750)

Dr. Monica Branigan: This isn't something that our association has discussed. Certainly, our association supports access, so I can see that it might be a viable solution in some places.

Ms. Josette Roussel: We all know that nurse practitioners are autonomous professionals and currently are prescribing medication. They have an expanded scope and are working in areas where they are sometimes the lead providers. In terms of access, we believe that this proposed model will enhance access and will enable teams to provide this service together.

That's our comment.

Hon. Judith G. Seidman: Particularly in this enormous country that we live in, with a lot of rural areas and no physician access at all... However, you're quite right that the Supreme Court ruling refers to “physician-assisted dying”, although the Quebec ruling through Bill 52 talks about “medical aid in dying”, which is a different term. It is, indeed, much broader. If you think about it, “medical aid in dying” is broader than physician-assisted dying, I suppose, if you want to dissect the language.

Dr. Jeff Blackmer: However, in Quebec it is limited to physicians only.

Ms. Josette Roussel: I just want to clarify that there's a role for nurses for Quebec in the assessment component. They're also part of the team that provides support, because they have the structure in place.

However, I agree that the administration of it is physician-led.

Hon. Judith G. Seidman: Another issue that has come up in our discussions with previous witnesses has to do with advance directives. The Supreme Court didn't contemplate advance directives, and the debate in Quebec on Bill 52 was very conflicted on advance directives, which were actually dropped from the final draft of the bill.

However, again, the provincial-territorial expert advisory group recognized the roles of advance directives and that they vary across the country. They did recommend, though, that a patient's wishes to consent to physician-assisted dying in advance should be permitted through what they called a standardized patient declaration form, or a living will.

What is your impression of that recommendation?

Dr. Jeff Blackmer: That's a very important issue. This is another one where our interpretation of the Carter decision did not include the ability to provide advance directives. We read it, and our constitutional lawyers read it, to indicate that it applied to someone who was capable at the time of request and at the time of the activity of assisted dying. It's not something that we consulted the membership on.

What I can tell you is that in real-life practice, putting advance directives into action is incredibly complex and difficult, because it's very hard to capture all of the nuances and the specifics of a very complicated medical condition and intervention. Even in the best of situations, physicians have a lot of difficulty actualizing an advance directive.

What our members have told us is that they see a lot of potential difficulties if we were to layer on the concept of providing advance directives with a very complex set of circumstances in this type of novel intervention, especially right out of the gate. It would, again, be one further level of complexity that would make it more difficult for a lot of physicians to participate and to actualize the assisted dying process.

Certainly it's not our official policy, but I would caution that it opens up another whole set of circumstances.

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

Before Senator Joyal asks his questions, I'm going to take the chair's prerogative and ask a question.

In the nurses' presentation, you were recommending that we have policies and procedures to ensure competency assessment throughout the journey. Dr. Branigan was talking about a worry that we could be prematurely hastening death as a result of some of the processes around physician-assisted dying.

Is there a concern that ensuring competency until the moment that assistance is given could hasten death because someone might want to make sure that they make that decision while they are deemed competent, yet could still be competent and could enjoy a quality of life for a number of months afterward? Might they be so afraid that they will not have their advance directive honoured that we would actually be encouraging them to die earlier?

I'm concerned about a difference that I'm hearing in the panel. Do you have thoughts on that?

• (1755)

Ms. Anne Sutherland Boal: What we were referring to was that during this journey, which we believe is complex, there needs to be robust assessment and input from the team to ensure that when patients are seeking assisted dying, they have all the information to make a decision that is in their best interests and that they will periodically have the opportunity to reflect on that decision, because sometimes circumstances change. We wanted to ensure that there were mechanisms to ensure that patients would have the opportunity to revisit the decision they had made.

The Joint Chair (Mr. Robert Oliphant): You do say that—to reconsider the decision—but that point is separate from competency

assessment throughout the journey. Does that truly mean competent at the moment of death when assistance is given? Is that what you...?

Ms. Anne Sutherland Boal: No.

The Joint Chair (Mr. Robert Oliphant): Okay. That was unclear. I think I was hearing elsewhere that you didn't want to hasten death unnecessarily. I just want to be clear on that.

Okay. Very good.

Senator Joyal.

Hon. Serge Joyal (Senator, Quebec (Kennebec), Lib.): : Dr. Forbes, I would like to come back to a statement you made in your opening remarks that is troubling to me.

You said that 30% of the physicians you have canvassed have answered that they would provide physician-assisted dying, which means that 70% won't. While the Supreme Court has stated very clearly that, according to section 7 of the charter, a person has a right to request assistance from a physician, you have to reconcile that with the freedom of thought, or the freedom of conscience, of a doctor or a physician under paragraph 2(b) of the charter. Which one prevails in such a case? Could you be very clear on what your position is in relation to a physician who would feel hurt in his or her conscience if he or she would be compelled to provide assistance in dying, and what the responsibility of that physician is in relation to advising the patient or referring the patient to a proper service or proper information so that the person could seek the support they need in these circumstances?

Dr. Cindy Forbes: That is essentially one of the main issues we've been dealing with. I think it would be important to actually focus on what we feel are the responsibilities of the physicians. We feel that those physicians who are not willing to provide the service and who may feel that a referral is also against their moral beliefs do have responsibilities to advise the patient on all of their options—to have the conversation we talked about on all end-of-life options, including physician-assisted dying, and to make sure the patient has the information they need to access that service.

When you mentioned that only 30% of physicians are willing to provide the service, I think you have to look at the fact that we're expecting that less than 3% may actually choose this option. We have about 82,000 member physicians in the Canadian Medical Association, so you're actually talking about a large number of physicians. After that you're really talking about distribution and access to care in different regions. I think it helps to put it into perspective.

I know Dr. Blackmer wants to comment as well.

Dr. Jeff Blackmer: I think it's absolutely critical to recognize that 30% represents 24,000 Canadian physicians. I can sit here today in front of this committee and guarantee that simply from a numbers perspective, access will not be an issue.

As Dr. Branigan has already indicated, it's about connecting the people who qualify for assisted dying with the providers who are willing to undertake assisted dying with a patient. The whole issue of connecting access with the right to conscientious objection is a false dichotomy. The two are not interrelated. In fact, we have a very small percentage of members who said they feel very conflicted about the obligation to refer; however, the entire rest of the profession says that even though they may not share that view, they will fight for the right of the others to not have mandatory referral.

In summary, if you have a very small percentage of the profession and a very small percentage of patients actually requesting assisted dying, that is not going to impact access in any way.

The final point I would make on that, which I think is critically important, is that no other jurisdiction in the world has mandatory effective referral. None of the jurisdictions that currently allow either assisted dying or euthanasia have mandatory effective referral, yet access is not a problem anywhere. I can guarantee, on behalf of the medical profession, that access will not be a problem in relation to respecting conscience rights. We still have work to do in rural and remote areas, but that's another issue.

● (1800)

Hon. Serge Joyal: Will that be part of the instructions or interpretation that you will provide to the medical profession in terms of the provincial colleges of doctors, which have the responsibility for *déontologie* and ethics, in relation to what the role is in relation to physician-assisted dying?

Dr. Jeff Blackmer: They're very clear on our views on this issue, yes.

Hon. Serge Joyal: Thank you.

If I may, Mr. Chair, I have one very small question.

The Joint Chair (Mr. Robert Oliphant): Be very quick.

Hon. Serge Joyal: Dr. Blackmer, you made the statement that there is already a patchwork of directives among provinces. We had a witness earlier this week, Professor Hogg, who advised us that one way to alleviate that would be for the authority of the federal government—or a federal agency of some sort, yet to be defined—to establish equivalence of norms across Canada. In other words, elements of the service of course fall under provincial jurisdiction, but since it seems there is already a patchwork, we already have the problem and we already have to find a solution. This is not a theoretical situation. It is, according to your own statement today, a practical situation we face to maintain equality and universality of services across Canada.

Would you advise us that this is a way for us to go—to establish a national framework, and when there is a capacity for a province to intervene, that there be a measure of equivalence to make sure that Canadians are served equally all through the country?

Dr. Jeff Blackmer: I think that's an approach we would support, yes.

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

Ms. Dabrusin.

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

We've been talking a lot today about the issue of access, and particularly access in remote communities. Can you tell me a bit about the role of nurses and nurse practitioners in terms of the scope of the care they currently provide in remote areas?

Ms. Josette Roussel: Currently we have over 4,000 nurse practitioners in Canada and we have 250,000 nurses. I don't have the numbers in remote and rural communities, but those two categories are present throughout the remote and rural areas.

They have access to teams. Sometimes they are virtual teams. Sometimes they serve in areas where they are the sole providers. Nurse practitioners have an expanded scope. They are able to provide diagnostics and management of conditions and have prescribing authority. Nurses in those communities do work under some medical directives, so their scope is expanded as well.

I hope I've answered your question around the rural and remote situation.

Ms. Julie Dabrusin: Thank you.

We've heard a little bit of discussion about the use of telemedicine for nurses. I think it was referred to in the provincial and territorial report. Can you describe for us how that works?

Ms. Josette Roussel: We know of a few examples and models. I'm thinking about a Newfoundland model that uses telemedicine sometimes to access specialized services. It's been very successful at reaching out to specialists who are not able to physically go into those communities. A lot of consultations are done through that service.

There are a few models and innovations across Canada that have been successful.

Ms. Julie Dabrusin: For those of us who aren't actually working in this sphere, can you perhaps describe to me how telemedicine works? Let's say you have a nurse who has a patient in a remote area and they do not have a doctor present there.

Ms. Josette Roussel: They will have access to a visual aid, such as a TV, and a communication tool. The patient would be there, and they would be able to communicate with the specialist. Sometimes it's very sophisticated, so that through the technology you're able to do a fairly comprehensive....

I'm looking at my physician colleagues here. My experience as a nurse has been around advanced specialized wound care. I've used telehealth, and it was very successful in terms of getting a fairly good quality of image and communication and getting access to a specialist.

I hope I've answered your question.

● (1805)

Ms. Julie Dabrusin: You have, but perhaps I can continue on with that. Once the nurse gets that information, they proceed to actually administer the care under the doctor's direction?

Ms. Josette Roussel: Yes.

Ms. Julie Dabrusin: Thank you.

What role do nurses play in examining capacity? When nurse practitioners, for example, do training, do they do any training on how to assess capacity?

Ms. Josette Roussel: We have RNs and nurse practitioners who are able to do the initial assessment. Capacity assessment requires special training, and we need specialized individuals to help us. The nurses are able to do some initial evaluation, but those next steps around capacity are usually done by specialized trained professionals. The laws and legislation are different in all jurisdictions.

Ms. Julie Dabrusin: I just wanted you to define the term “professionals” for our purposes. When you're referring to specialized trained professionals, are you referring to doctors?

Ms. Josette Roussel: Usually it's a legal professional. Nurses do not usually sign for those capacity tools and assessments. We can contribute to that assessment throughout our initial interactions with the patients, but the legal and formal part is not done by the nurses.

Ms. Julie Dabrusin: For the CMA witnesses, are there any medical interventions that are currently excluded from advance directives?

Dr. Cindy Forbes: I'm not sure of the answer to your question. I know there is quite a process for a procedure to be considered as an advance directive. It has to be approved through the regulatory bodies of physicians working in conjunction with the nurse regulatory body. There have to be guidelines around it, and there are very specific ones. Not all procedures are advance directives. Certainly something like physician-assisted dying would have to go through a regulatory process.

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

We may ask you for help with that question later in a written question.

Mr. Warawa.

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

Thank you to the witnesses.

Doctors Blackmer and Forbes, what you've shared with us today at the committee is a compilation of consultation, and you're representing the CMA and not your personal views. Is that correct?

Dr. Cindy Forbes: Yes.

Mr. Mark Warawa: Thank you for the work, the paperwork, and the reports you've provided.

Under your recommendation 5.2, regarding conscientious objection by a physician, it says:

Physicians are not obligated to fulfill requests for assisted dying. This means that physicians who choose not to provide or participate in assisted dying are not required to provide it or to participate in it or to refer the patient to a physician or a medical administrator who will provide assisted dying to the patient. There should be no discrimination against the physician who chooses not to provide or participate in assisted dying.

Would this apply to physicians and facilities and organizations, or just to physicians?

Dr. Jeff Blackmer: It applies only to physicians.

Mr. Mark Warawa: So your recommendation is based on consultation with physicians? Thank you.

Dr. Branigan, you touched on wait times, and I think you said that most people would like to die at home. I think you're quite right. Almost everyone around this table has enough years under their belt to have experienced the death of a loved one. I've watched both parents, my stepmom, and my in-laws die. It was not easy, but I was blessed in being able to say goodbye to each of them.

Regarding palliative care and its involvement, as a physician dealing with people who would like to consider premature death, as I think you called it, or physician-assisted suicide, euthanasia, or assisted dying, have you ever been with a patient who, after receiving palliative care, has changed their mind?

• (1810)

Dr. Monica Branigan: Yes.

Mr. Mark Warawa: Could you elaborate on some examples of that and of how palliative care has changed somebody who might have chosen death but now wants to live?

Dr. Monica Branigan: I'm not sure I want palliative care to take all the credit. There's also personal growth and a chance of accommodation.

There are two that come to mind. One gentleman showed up in emergency, saying he wanted his life shortened because he was too sick to get on the plane to Switzerland, where he'd already been accepted by Dignitas. He had prostate cancer. He had uncontrolled pain. He came into the hospital, and we got his pain under control. He ended up marrying his girlfriend and dying in a palliative care unit, and he was very happy. I remember walking into his room, and he said, “I don't have to do anything. I can just enjoy this time of my life.”

I also worked with a woman with ALS who, the first time I walked in to see her, gave me the papers for Dignitas. In the end, she changed her mind. She ended up getting a feeding tube, which prolonged her life. She could have chosen not to do that and could have ended her life earlier.

Just this week I met a woman who wanted assistance in shortening her life because she simply could not tolerate being helped to go to the toilet. We have not been able to relieve that kind of suffering. I'm not sure we would ever be able to do that.

Mr. Mark Warawa: Thank you. I have many more questions.

You shared that most physicians have not been trained in palliative care. Am I right in assuming that they do not have proper training and knowledge in what assistance palliative care could provide to somebody considering assisted death?

Dr. Monica Branigan: I think that might be generational. Medical students in residence now are getting more of it. There's a bigger cadre of people who do have palliative care skills, but I think a lot of people do not understand what palliative care is and are not referring appropriately because there's this thinking that it's going to upset the patient. That still happens.

Mr. Mark Warawa: Thank you.

The Joint Chair (Mr. Robert Oliphant): Thank you very much to our witnesses. We're going to stop there for today.

I suspect individuals may still be in touch with you for your further opinions as we continue over our very short course.

Committee, we are going to now clear the room and have an in camera meeting for a very short period of time, because there will be a vote in the House shortly.

I thank our guests. I'd ask that we turn it around in three minutes so that we can have a short in camera meeting. Thank you.

[Proceedings continue in camera]

- _____ (Pause) _____
-

[Public proceedings resume]

- (1925)

The Joint Chair (Mr. Robert Oliphant): Thank you, especially to the senators, for allowing us to go and do this part of our civic duty.

Welcome to some substitute members, Mr. Wrzesnewskyj and Mr. Maloney. Mr. Albrecht is still here.

Thank you also to our witnesses tonight. I would apologize if it was really our fault. Votes happen. We apologize that we've kind of danced around with you for the last two days on the time that you were going to come. Thank you for your patience with us, and we look forward to your testimony.

We have two presentations in this section. They are from the Canadian Pharmacists Association and from the Canadian Psychiatric Association. We ask for about 10 minutes from each of those groups and then we'll turn it over to members for questioning. Thank you.

We'll start with the pharmacists.

Mr. Carlo Berardi (Chair, Canadian Pharmacists Association): Thank you, co-chairs, honourable members of Parliament, and senators, for the opportunity to present before this committee.

My name is Carlo Berardi. I'm a practising pharmacist in Sudbury, but I'm here today in my capacity as chair of the board of directors for the Canadian Pharmacists Association.

CPhA is the national voice for pharmacy in Canada, focused on advancing the health and well-being of Canadians through excellence in pharmacist care. Through our 10 provincial associations, we represent more than 20,000 pharmacists and pharmacy students across Canada.

I'm joined today by my colleague, Phil Emberley, who is also a practising pharmacist and the director of professional affairs with CPhA. We recognize that you all have an incredibly difficult task at hand, one that must balance the views and perspectives of various stakeholders, the public, and, most importantly, the patients. We are here today to speak to you about the role of pharmacists in physician-assisted dying and, conversely, the impact that physician-assisted dying could have on pharmacists.

Since the Supreme Court ruling almost a year ago, much of the public debate has focused on the role of physicians in assisted dying, and understandably so. However, physicians don't work alone. Rather, they are part of a larger system that relies on nurses, pharmacists, social workers, and other health care providers, each with their own scope of expertise and responsibility. While the Carter decision focused primarily on the role of doctors in providing end-of-life care, we have had the opportunity to reflect on the important role of pharmacists in both end-of-life care and assisted dying.

You have heard from various witnesses on the scope of the Carter decision and the extent to which other health care professionals should be involved in assisted dying. It is our opinion that regardless of how assisted dying is regulated in Canada, pharmacists will have a role to play.

Pharmacists are consistently rated as being among the most trusted professionals in Canada. Their accessibility and visibility within their communities also mean that pharmacists are often the first point of contact for patients who are looking for timely, evidence-based, and informed health information.

As a practising pharmacist, I know first-hand how the public relies on pharmacists for information on a wide variety of health issues, so it's quite likely that pharmacists will be asked to provide information on assisted dying to help in making an informed choice.

Over the past several months, CPhA has been consulting extensively with our members and with experts in the field in order to develop a policy position and framework to help inform governments as they themselves grapple with the issue. This consultation has included a national survey of pharmacists and pharmacy stakeholders, to which we received nearly 1,000 responses. The number of responses we received speaks to the high degree of interest within our profession.

We have also reviewed existing literature and looked at experiences in other jurisdictions that have legalized assisted dying to help inform our policy, and we will provide this information to the committee.

While we have not yet finalized our policy recommendation or a proposed framework for the role of pharmacists in assisted dying, we would like to highlight some of the areas that have consistently been raised.

As primary health providers, we are not surprised that assisted dying elicits various perspectives from within the profession, similar to what you have heard from our physician and nurse colleagues. We consistently heard that pharmacists care first and foremost about the health and well-being of their patients and about ensuring that their patients have access to the best possible care through their end-of-life journey. This means having access to high-quality palliative care, effective pain management, and assisted dying.

However, our consultations have also revealed some more practical considerations for pharmacists that we would like to bring forward today. While many of the concerns mirrored those of other health providers, including what you heard a short while ago from our colleagues at CMA and CNA, there are also issues that are unique and of particular relevance to pharmacists.

Regardless of the legislative framework that is put in place or of how the practice is regulated either federally or provincially, one of our primary concerns is ensuring the appropriateness and accessibility of drug therapies. There is no single drug that exists for the purpose of ending someone's life, so, as in the case of any other medication, we believe that the federal government must ensure that the prescribers and the pharmacists have access to the necessary drugs in order to provide the best possible care, including drugs for assisted dying.

• (1930)

In addition, we also recognize that existing jurisdictions that have legalized assisted dying have taken different approaches, each with different implications for how the actual practice is administered. While we have not finalized our policy and proposed framework on the role of pharmacists in assisted dying, we want to provide some context as to how some of the models could have an impact both on patient care and on the role and the responsibilities of pharmacists.

If we take Quebec as an example, assisted dying there is limited to medical aid in dying, which requires the physician to directly administer the lethal injection. The exact dosage and mix of drugs is set within the provincial framework, and while it's prepared by a hospital pharmacy, it is then administered by the physician in a hospital setting.

However, in parts of Europe and in the state of Oregon we've seen a broader approach that also allows for the oral ingestion of drugs in various settings, including in a home or community setting. In such cases, while physicians continue to play an important role as the prescribers, the role of pharmacists would expand significantly.

Beyond these issues that we feel are particularly relevant to pharmacists, we have also heard feedback from the profession that is consistent with that of other health providers. Pharmacists overwhelmingly support the inclusion of a protection-of-conscience provision in legislation. Like other professions, pharmacists feel strongly that they should not be obligated to participate in assisted dying if it is against their moral or religious convictions. In its ruling, the Supreme Court clearly stated that nothing in the declaration would compel physicians to provide or participate in assisted dying, and we believe that such protection must be extended to pharmacists as well.

While we also believe that patients have the right to receive unbiased information about assisted dying and how to access end-of-life care, like other health care professionals, pharmacists are divided on the obligation to refer someone to another pharmacist who is willing to fill a prescription for the purpose of assisted dying. Our priority remains ensuring patient access, so we encourage the government to examine options that could help facilitate referral while also protecting pharmacists' right to conscientious objection. Further to this, for those pharmacists who wish to participate, we strongly urge legislative frameworks that would limit the liability of health care professionals.

Regardless of the legislative framework, we want to ensure that pharmacists who are members of the interdisciplinary patient care team and also dispensers of lethal doses of medications are fully equipped to provide the necessary care to their patients. This means ensuring that there is effective collaboration between prescribing physicians and pharmacists and ensuring that pharmacists have access to appropriate information, support, and resources should they choose to participate in assisted dying.

Information about a patient's diagnosis and the purpose of the prescription, as well as confirmation of the patient's consent and confirmation that the patient has met all of the eligibility criteria, are key to ensuring appropriate dispensing and will enhance patient care at all points of contact in the system. We believe that this could help mitigate liability for all health providers involved.

We recognize that there is very little precedent to guide the government in addressing this important issue. This is a new area for pharmacists. Nevertheless, the pharmacist profession has the expertise in drug therapy, counselling patients on medications, and drug distribution to play an integral role in ensuring quality end-of-life care.

In conclusion, as this is a new and evolving practice, we believe that it will be critical to monitor and review the implementation of both federal and provincial legislation for years to come. We suggest that this be done through a national advisory panel of interdisciplinary health professionals that would include pharmacists.

In the coming weeks, we will be finalizing our policy and our proposed framework and we would be happy to share these with the committee.

We thank you for your time and we welcome any questions you might have.

• (1935)

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

We'll now have Dr. Gaind or Ms. Hardy, please.

Dr. K. Sonu Gaind (President, Canadian Psychiatric Association): Thank you, Mr. Chair. I'll start for us.

On behalf of the Canadian Psychiatric Association, we'd like to thank the co-chairs and committee members for this opportunity to present to you on this important issue.

My name is Karandeep Sonu Gaiind, and I'm president of the CPA. The CPA is the national voice for Canada's 4,700 psychiatrists and more than 900 psychiatric residents. Founded in 1951, the association is dedicated to promoting an environment that fosters excellence in clinical care, education, and research.

My remarks today will focus on specific issues related to mental illness that must be considered in any physician-assisted death framework. The CPA is actively engaged in developing a full position with a range of specific recommendations. My comments today are meant to raise key points for the committee to consider in its deliberations, but should not be construed as CPA's final position on this issue. That definitive position is still being developed.

I'll start with key issues that need to be taken into consideration when discussing terms like "irremediable", "intolerable and enduring suffering", and "capacity" in the context of mental illness.

The evaluation of what is intolerable and enduring suffering due to illness symptoms is affected by the severity of those symptoms and impairment and by the individual's perception of their experience. The subjective assessment of "intolerable" and the predictive assessment of "enduring" can both be affected by mental illness in particular ways.

Mental illnesses can affect cognition and impair insight and judgment. Symptoms of cognitive distortions common with clinical depression include negative expectations of the future; loss of hope; loss of expectation for improvement, even when there may be realistic hope for positive improvement; loss of cognitive flexibility; loss of future-oriented thought; and selective ruminations focused on the negative and minimizing or ignoring the positive. There are commonly distortions of a person's own sense of identity and role in the world, including feelings of excessive guilt and worthlessness or feeling like a burden to others.

When clinically depressed, people also have lower emotional resilience and are less capable of dealing with normal life stressors. They can experience even moderate levels of stress as being intolerable or overwhelming. While we are not at the point of being able to apply this clinically, increasingly research findings are suggesting that there are areas of the brain with altered functioning during times of severe depression that correlate with some of these cognitive changes.

In terms of what is "irremediable", careful consideration needs to be given about what this means in the context of mental illness. Irremediable, of course, cannot simply mean incurable. Many conditions in psychiatry and medicine are considered chronic and not curable, but things may be done to remediate or improve the situation. Multiple treatment options exist typically for even the most severe instances of mental illness, whereby symptoms and suffering may be treated and reduced, even if not cured.

It is equally important and essential to remember that the person is more than the illness. Psychosocial factors play an enormous role in a person's illness experience, particularly so in many mental illnesses. For example, if you take an overly narrow view of assessing "irremediable" only in the context of potential symptom improvement through biomedical treatments in severe depression, you potentially ignore remediating or improving the person's

experience by addressing such key factors as social isolation or poverty.

I'll make some comments on "capacity" now.

In medicine we consider four broad components when assessing capacity: the ability to make a choice, the ability to understand relevant information, the ability to appreciate the situation and the consequences of decisions, and the ability to manipulate information rationally. Even when persons with mental illness can express a choice and understand and recall information, their appreciation of the situation and of present and future expectations, as well as their ability to manipulate information rationally, can be affected by the cognitive distortions previously discussed.

• (1940)

I want to emphasize that none of this is to suggest that simply the presence of any mental illness alone impairs people's judgment and cognition, but in the PAD discussion, by definition, we are talking about the most severe situations, and in severe cases of mental illness, the risk of such cognitive distortion is, of course, higher. We think with our brains, not with our hearts or limbs.

All these issues speak directly to the court's concern about ensuring the person is not induced to take his or her life at a time of weakness. Apart from the actual suffering caused by symptoms, if cognitive distortions are present, these distortions risk undermining the person's decision-making process. In the court's consideration of factors of coercion or duress, it would be as if the mental illness is undermining the person's autonomy to make a decision free from the influence of cognitive distortions. It's this recursive effect of symptoms on the evaluative process, where the very symptoms of mental illness may interfere with people's evaluation of their mental illness and its present and future impact, that poses the challenge.

Finally, one other point bears consideration. In the context of the court's finding of loss of liberty if a person chooses to end his or her life prematurely because the person fears eventually becoming unable to take their life in the face of progressive physical incapacity and suffering, mental illnesses on their own very rarely, if ever, lead to such progressive and severe physical incapacity.

With that as a general background, and again emphasizing that the full CPA position is still being developed, there are a few guiding principles we can offer at this time.

First, when a psychiatric illness is present, in order to ensure that nuanced issues that could affect decision-making are properly assessed and to allow for time for potential remediation of symptoms and/or psychosocial factors, multiple assessors with suitable skill sets should do sequential assessments over a period of time. Our final position will reflect more specifics, and there may be varied mechanisms depending on jurisdictional needs and resources, but spreading the assessment over multiple suitable assessors who are aware of the potential impact of mental illnesses on cognition, capacity, etc., and also having sequential assessments are necessary safeguards.

Second, the concept of irremediable and intolerable and enduring suffering should not be exclusively focused on the biomedical condition but must be considered in the full context of the person's condition, including the potential impact of possible psychosocial interventions on suffering and symptoms.

Next, psychiatrists may choose not to be involved in the PAD process, consistent with what you have heard from other professional organizations. In such situations, patients requesting PAD should have access to information regarding available PAD resources and the referral processes, including psychiatric resources as required.

Finally, it is important to recognize that the term "treatment-resistant depression" or "treatment-resistant mental illness" in general does not define an illness that is irremediable. "Treatment-resistant" in this context is typically used to help guide the course of further treatment options using an evidence-based approach. This should be explicitly articulated in any PAD framework to avoid risking conflation of the terms "treatment-resistant" and "irremediable".

I'd like to end by thanking the committee once again for your thoughtful consideration of these issues, and I'm happy to answer any questions that you may have.

● (1945)

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

Go ahead, Madam Shanahan.

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

This question is for the Canadian Pharmacists Association. Either one of you can answer.

I'd like to explore with you the relationship between the pharmacist's role and the doctor's role. Specifically, we're looking at how the process could take place. Then I'd like to talk about the canvassing you did of your members when you were assessing their position on this matter.

Mr. Carlo Berardi: To answer that question, it would be best to focus on the different types of models that could potentially be out there. If we're talking about a hospital-only setting, then the physician-pharmacist relationship would be much different from what it would be in an at-home setting for patients. It would be a much different type of relationship.

Pharmacists don't want to be involved in that determination of eligibility or competency, but certainly if a directive was given that involved the pharmacist's procurement of the medication, the directive would have to be clear in satisfying the eligibility and competency of the patient. That directive could not be misunderstood or misinterpreted, so that the pharmacist would be fully aware that the criteria or guidelines had been fully satisfied before an actual procurement or dispensing of medications could take place.

That would involve a lot of collaboration between the pharmacist and the physician, or maybe more than one physician, or maybe the medical team that would give the directive. In today's environment, pharmacists and physicians are collaborating on a whole range of therapeutics and options and treatment modalities for patients.

Physician-pharmacist collaboration is not a new experience for our profession.

Mrs. Brenda Shanahan: Excellent.

You mentioned canvassing your members. What is the degree? We heard from the CMA that it was 30% of doctors. What's the number for pharmacists at this point?

Mr. Phil Emberley (Director, Professional Affairs, Canadian Pharmacists Association): Thank you for the question.

We did not specifically ask the question that the CMA mentioned earlier. We did ask the following questions, which I think are relevant to this discussion.

When we asked respondents to express their level of agreement with the statement "Pharmacists should be obligated to participate in assisted dying", 70% of pharmacists either disagreed or strongly disagreed that pharmacists should be obligated, so there's fairly strong disagreement with that statement.

The other pertinent statement was "If a pharmacist does not wish to participate in any aspect of assisted dying, they must refer the patient and/or physician to another pharmacist who will fulfill the request." We actually had 65% agree with the statement that they must refer.

● (1950)

Mrs. Brenda Shanahan: Thank you.

Can you talk to us a little bit without getting overly technical? We have heard, of course, there's an administration of a drug, and it can differ from person to person. How well equipped do you feel pharmacists are to make the professional judgment as to what is appropriate, given that they have not been doing this up until now?

Mr. Carlo Berardi: To answer your question, there are a couple of things.

First of all, there is no one single medication or one single prescription that will fit all. While I can't tell you exactly the types of medications that are used or the combinations, they certainly would be related to a lot of things. Weight, height, and body surface area would all be really relevant. Pharmacists today make those clinical or therapeutic decisions using those parameters every day. It's not that the type of practice would be new. There would be different training required for this aspect, of course, but that type of practice is not alien or foreign to pharmacists.

I would caution the committee that whatever protocol or treatment is decided on, it should ensure that those drugs are not subject to what is called "manufacturer backorder" or "manufacturer cannot supply". That would be devastating.

We've heard about certain medications not being available in Canada, so I would caution the committee to ensure that, whatever protocols are designed, our drug system has the safety, the integrity, and the ability to supply those medications.

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

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Thank you, Mr. Chair.

Thank you to our witnesses for being here tonight.

I was particularly encouraged to hear you, as professionals, openly declare your concerns about some of the subjective nature of the language that is being used—“irremediable”, “intolerable”, “enduring”. I think this underscores for us as committee members the severe nature of this topic that we're dealing with and how important it is for us to deal with it seriously and to move with extreme caution.

Over the last number of years, I've devoted a fair bit of my time to dealing with mental health issues and suicide prevention. I know that since 1991, there have been no fewer than 15 initiatives in Parliament to authorize physician-assisted suicide. All of these have been defeated. Parliament, in fact, in the last couple of years, has strongly supported some suicide prevention initiatives. Currently the Public Health Agency of Canada is undertaking the job of creating a federal framework for suicide prevention, which is a result of the passage of Bill C-300. In fact, today the Bell Let's Talk initiative is all over Twitter. I don't know how many thousands or millions of tweets have gone out.

Society is concerned about continuing their concerted efforts on suicide prevention. For me, then, it's something of a paradox that we have these initiatives to prevent suicide going on in our country and our health agency, yet here we are, looking at ways to give greater access to suicide.

It's quite clear that physician-assisted suicide is an irreversible act. We know from some of the mental health studies that have been done that people go up and down and that people's minds change over time. We also know that depression is by and large a treatable condition, and you pointed out in your testimony, Dr. Gaiind, that there are varying degrees of success.

One of my concerns is that in terms of giving access to people who may be suffering with mental health issues or depression, what additional safeguards should this committee be looking at to make sure we are protecting some of our most vulnerable at the most vulnerable times in their lives?

Dr. K. Sonu Gaiind: Thank you for your very considered question.

You know, it is a challenging issue to differentiate, when we're talking about the death of a person, what leads to that death. When we're talking about physician-assisted death or suicide prevention initiatives, it can seem that they're at odds with each other. However, there are some differences that I think are helpful to elucidate.

I'll get to the question you asked about some of the particular safeguards we need, because that actually comes back to what I was discussing in the comments—

• (1955)

Mr. Harold Albrecht: We have a small amount of time, so I'd appreciate it if you answered that last part first.

Dr. K. Sonu Gaiind: Okay.

Both lead to the patient's death. That's true. However, one way of looking at it would be that suicide, in our suicide prevention initiatives, occurs when somebody has a desire to die. In physician-assisted death, the patient is suffering with some sort of illness, and they have a wish to stop living with suffering. It's the suffering component that is one differentiation.

When people have wishes for suicide or even have just clinical depression, they very often are unable to even articulate what might be leading to the feelings of depression. You have people who will say, “I shouldn't be feeling depressed, but I can't stop feeling this way.”

In terms of the evaluative process, this is why we are suggesting that you need people who are properly trained in trying to understand what is leading to the person making the decision. It is the decisional process that is key, not the outcome of it.

Mr. Harold Albrecht: Just to follow up on the point of conscience rights, you point out that the Canadian Psychiatric Association affirms the right of physicians not to participate if they choose not to. In fact, the Supreme Court has confirmed that physicians cannot be forced to provide assistance to an individual who is seeking assistance to die. You agree, and the CMA agrees. I would also point out, as Dr. Blackmer pointed out today, that currently no other jurisdiction that allows euthanasia or assisted suicide imposes a legal duty on physicians who conscientiously object to make referrals for physician-assisted suicide.

How important is that measure of conscience rights protection? How important is it that we include that?

The Joint Chair (Mr. Robert Oliphant): I'm sorry, you've run out the five minutes. If you want to provide a written answer, that would be okay.

Madame Sansoucy is next.

[Translation]

Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP): Thank you, Mr. Chair. I will share my time with my colleague Murray Rankin.

I want to thank the witnesses for their presentations.

The experts we have heard from so far agree that oversight mechanisms are essential to ensure the protection of vulnerable individuals. At what point in the physician-assisted dying process do you think that oversight should be provided? Would it be before the person receives assistance to die, or would the experience be analyzed only after the fact?

[English]

Dr. K. Sonu Gaiind: I want to make sure I understand the question properly. Are you asking at what point in the evaluative process should a psychiatrist start getting involved?

[Translation]

Ms. Brigitte Sansoucy: Yes, exactly.

[English]

Dr. K. Sonu Gaiind: If there is a mental illness present, then this would apply whether the person is applying for PAD on the grounds of mental illness or whether they're applying on the grounds of a physical illness when they also have a mental illness. We feel that the psychiatrist needs to be involved to do a proper assessment as soon as the request is made.

[*Translation*]

Ms. Brigitte Sansoucy: When it comes to the decisions we will have to make over the next few months, we are being asked to establish pan-Canadian oversight mechanisms. The goal is to ensure that everything is taking place according to the rules, so that vulnerable individuals can give their consent in a truly informed way.

Should those oversight mechanisms be established before the individual even receives assistance to die? Do you instead believe that the process does not make that possible and that only the analysis of various situations will enable us to do an evaluation?

[*English*]

Dr. K. Sonu Gaiind: I think your question actually speaks as well to the idea of patients having access to necessary treatment options even prior to making or requesting this decision. We know that is a huge problem with mental illness. The Canadian Mental Health Commission tells us that only about one in three Canadians who have mental illness or mental health-related problems get help for them, and for children and adolescents it's closer to one in four. I know that patients committing suicide is a different discussion, but even there we know that a only significant minority of them have seen a mental health professional in the past month. It's only about one in five.

In terms of what you're asking, this involvement should not be seen as the end point. We actually need to get involved much earlier to help people with these mental illness-related issues, and that may remediate suffering far before they get to the point of a request.

● (2000)

Mr. Murray Rankin: Dr. Gaiind, if I may, you said that we should not conflate two important terms, the “irremediable”, which is the test in Carter, and “treatment-resistant depression”. I'm trying to understand. I can't think of a scenario in which a purely mental condition could meet the criteria in Carter. You say we shouldn't conflate those two terms. Are there irremediable psychiatric conditions that you can suggest that would meet the test? Are there stand-alone psychiatric illnesses, not biophysical ones, that would meet the test of being irremediable?

Dr. K. Sonu Gaiind: As I mentioned, in the vast majority of cases and even in the most severe situations, something can be done to attempt to ameliorate. Failing all of that, it is conceivable that there could be an illness that's irremediable. Honestly, that would have to be assessed on a case-by-case basis. We're suggesting that the thinking process behind the patient making this request needs to be teased apart very carefully, because while they have a perception of something being irremediable, it may not actually be irremediable.

Mr. Murray Rankin: That's the problem. I'm having trouble thinking of a situation, based on your testimony, that would meet that very stringent requirement of being irremediable.

Dr. K. Sonu Gaiind: I can't make a definitive statement that nothing ever could. I don't believe that anyone could say that, but I share your difficulty in thinking of many, if any, that would.

Mr. Murray Rankin: I'd like to speak to the Canadian Pharmacists Association.

In your material, you talk about pharmacists and the point of access, and you say that the federal government should ensure that prescribers and pharmacists have access to the most appropriate drugs. What specifically are you suggesting the federal government would do? I can't see that being a federal matter. I don't understand what you're suggesting we would be able to achieve as a concrete recommendation.

Mr. Carlo Berardi: As I mentioned before, whatever protocols, treatment modalities, or therapeutic regimens are chosen, I caution the committee again to make sure that those drugs are available and accessible to Canadians and that the drugs are not subject to what we call “manufacturer backorder” or “manufacturer cannot supply”. In terms of the drug distribution channel for manufacturers, whatever we decide, thought and consideration have to be given that the availability of those regimens or drugs is not at the whim of a manufacturer or subject to other influences that could make them unavailable.

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

Senator Nancy Ruth is next.

Hon. Nancy Ruth (Senator, Ontario (Cluny), C): To the psychiatric association, you just said—and you testified to this in front of the external panel—that when a patient who has a mental illness requests physician-assisted death but it's for another condition, let's say cancer, the mental health people should be brought in to do an assessment.

I live in Toronto. Some of the folks I know with mental illness don't go to psychiatrists. They have their normal doctor, their family physician, treat them. Is this not so in other parts of Canada too?

Dr. K. Sonu Gaiind: With regard to the latter part of the statement, about whether it is common practice, yes, I would say it's common practice in many areas. The primary care physician, the family physician, does play a key role in mental health provision.

However, in evaluating the thought processes that are going into a request like PAD, if there's a mental illness present, it's essential that people who have the required training be the ones who make that assessment.

I'll give you an example. I mentioned to your colleague that in the month prior to completed suicides, about one in five people have seen a mental health provider. In the same month, nearly half—about 45%, typically—have seen their primary care physician.

That's not to suggest that the primary care physician is not able to look at mental health needs. They can, but when we're doing complex risk assessments and complex assessments of what's behind someone's wish to die, we do need to bring in psychiatrists at that point.

● (2005)

Hon. Nancy Ruth: Would that be done by Telehealth or a similar means in rural parts of Canada or in the north?

Dr. K. Sonu Gaiind: Again, this is part of why we haven't come with a concrete recommendation on the best way for it to be done. It's because there may be jurisdictional logistics that determine that. In some areas, you may have psychiatrists available who could physically go to the patient, or you may have psychiatrists in some areas who aren't able to physically go.

In Ontario, for example, we have review board panels for capacity assessments that have been challenged. Those panels will be under provincial jurisdiction, rather than a local responsibility.

To answer your question, it might be a different mechanism in different places, depending on resources and needs.

Hon. Nancy Ruth: But you're very clear that there needs to be a psychiatric assessment, for the pharmacists.

Dr. K. Sonu Gaiind: Yes, or you'll miss things, potentially.

Hon. Nancy Ruth: You mentioned in your presentation that there are some jurisdictions—the Netherlands, for example—where standard packages of drugs are available, as well as detailed technical guidelines. Given that you need to have the drugs approved and that they need to be readily available in all parts of Canada so that we don't run out of them like isotopes or something like that, are there any barriers to this being done in Canada? Is there any reason that these packages couldn't also be used here, as they are in other jurisdictions?

Mr. Phil Emberley: It's quite likely that some of the precedents that have been set in other jurisdictions, such as Oregon and the Netherlands, would be used here in Canada as well.

Typically, patients who consume these drugs in the home setting use long-acting barbiturate drugs, which is a class of drugs that hasn't been used very much in Canada in the last 20 years. Barbiturate drugs are used primarily for sleep.

There are some availability challenges with these drugs. For example, one of the drugs that's used is no longer marketed in Canada. Therefore, part of the process of considering which drugs would be used would be to look at what is currently available in Canada, and if certain drugs were not available, to look at how to make them available if they've been used successfully in other jurisdictions.

Hon. Nancy Ruth: Would that be the responsibility of Health Canada?

Mr. Phil Emberley: There is a process within Health Canada to provide increased access to drugs that are available internationally and to make them available in Canada through, for example, the special access program. However, if those drugs are deemed to be the most appropriate ones in this setting, there is a role for the federal government to make those drugs available.

Hon. Nancy Ruth: Thank you.

The Joint Chair (Mr. Robert Oliphant): I'd like to just ask one question to Dr. Gaiind.

I am a minister in a church. I have done many funerals of people who have died with and from mental illness. If their deaths were all preventable, if nothing is irremediable or refractory, where is the gap? This is a genuine question. If you are saying virtually nothing is

irremediable, yet I know of dozens and dozens of people who have died with and from mental illness, where is the gap?

Why have they died if it was possible to...? Where have you failed, or where have we failed?

Dr. K. Sonu Gaiind: There are many facets to that question. In some cases, if the person has committed suicide, as I was mentioning, it often reflects that they haven't actually had access to psychiatric care. It's not to say all suicide is preventable—

The Joint Chair (Mr. Robert Oliphant): Many of them that I know have actually... Three of them have been in hospital, in care, and have committed suicide under the watch of a physician who was a psychiatrist.

Dr. K. Sonu Gaiind: As I said, I'm not suggesting that we're saying all suicide is preventable if someone is seeing a psychiatrist. That's not what I was saying.

You're asking a bit about what the threshold is for defining something as irremediable. I don't know if that's a question for the profession to answer or for society to answer.

In some ways, there are concepts in law that talk about probability. My clinical background was as a psycho-oncologist at Princess Margaret Cancer Centre, and when patients have cancer, you can anticipate what the outcome may be, but you don't know 100% for sure in many cases. At what threshold do we say something is completely irremediable or not?

• (2010)

The Joint Chair (Mr. Robert Oliphant): That's exactly what we're asking you.

I think I'm not going to get an answer, so that's okay.

Dr. K. Sonu Gaiind: I don't have an answer for you on that right now.

The Joint Chair (Mr. Robert Oliphant): Okay, we have a statement but not an answer. We have a statement from you that says nothing is irremediable, but not an answer on what the threshold could be.

Dr. K. Sonu Gaiind: Actually, we were not saying that nothing is irremediable. That's not what we said.

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

Senator Cowan.

Hon. James S. Cowan (Senator, Nova Scotia, Lib.): Thank you for your presence tonight and the information you provided to us.

My question has to do with advance directives. If we were, as a committee, to recommend that advance directives should play a part in this legislative regulatory regime that Parliament will bring into effect, what additional precautions or protections should we build in when we're dealing with mental illness as opposed to physical illness?

Dr. K. Sonu Gaiind: Again, I'll go back to the principles that we're talking about when mental illness is present, and that is the need for a very careful assessment to understand what is influencing the patient's decision-making process. It's not a question of making a value judgment on their decision but a question of evaluating the rationality of all of the pieces that are in the process going toward making the decision. That would need to be brought in at any point where someone is providing a directive. Again, if mental illness is present, then we think any decision needs to be properly evaluated.

I just want to clarify one point. I don't want my prior comments to be misconstrued as a suggestion that a psychiatrist needs to be involved in every decision. We were saying that when mental illness is present, a psychiatrist needs to be involved.

Hon. James S. Cowan: It would be the same as if it were a physical illness, I suppose. You would call in the specialist in the physical illness that was causing the distress.

Dr. K. Sonu Gaiind: Yes, although in the case of mental illness being present, it is about how it affects the thought process. In some other illnesses it might be not as much of an issue and would be more about assessing the suffering and irremediable nature of it.

Hon. James S. Cowan: Do you consider that to be more difficult from the point of view of a trained professional with respect to mental illness than it is with respect to physical illness, or does it just require a different skill set, different experience?

Dr. K. Sonu Gaiind: It requires a different skill set with awareness of how the mental illness itself could affect the person's thought processes. That's the difference. If I have an illness in my heart or if I have diabetes, I may well have symptoms from it and I may suffer from it and it can be problematic, but it doesn't necessarily affect how I think about what I have.

Hon. James S. Cowan: You mean your cognitive process.

Dr. K. Sonu Gaiind: Exactly. With mental illness, you have the presence of both suffering and symptoms, and you also have influence on the person's thought processes. Teasing that apart is challenging, but we do capacity assessments like that already—not for this purpose, but we do capacity assessments.

Hon. James S. Cowan: Of course. You do it for all kinds of other reasons apart from that. This would simply be another action, perhaps more finite or final, but you're called upon to make capacity assessments every day for other legal action to be taken by your patients.

Dr. K. Sonu Gaiind: Yes, absolutely.

Hon. James S. Cowan: You may have answered this earlier, and if I missed it I apologize. I'm wondering whether there is a need, in your view, to define those terms that are used in Carter, or whether those are terms that physicians—in your case, particularly psychiatrists—are trained in and are familiar with. Do professionals know when those conditions, those thresholds, are met from a professional point of view? Can you comment on that?

Dr. K. Sonu Gaiind: That's an excellent question, because that gets to the heart of actually some of the other questions about this.

In some areas, when we're looking at the impact of suffering and how a person is perceiving and experiencing it, yes, clinically we are often able to do a thorough assessment and tease apart the impact on

them. Terms like “irremediable”, again, are more in the legal framework you're looking at. I actually think that people will need some guidance on what level of irremediableness the framework is asking for.

• (2015)

Hon. James S. Cowan: Is it a medical assessment, a professional medical assessment, or is it only a legal definition issue? I can appreciate the need for clarity, but are you looking to Parliament for that clarity, or would you be looking to the college of physicians and surgeons in your province?

Dr. K. Sonu Gaiind: I don't have the best answer for you on that right now. It's the most challenging question right now: what threshold should be required for defining something as “irremediable”?

Hon. James S. Cowan: The term “grievous” is easier to comprehend, is it?

Dr. K. Sonu Gaiind: “Grievous” suggests a degree of severity. “Irremediable” is on or off. It either is or is not. It's a dichotomous definition, whereas most of the things we do in medicine, and certainly these assessments—

The Joint Chair (Mr. Robert Oliphant): Okay. Thank you, Dr. Gaiind.

[*Translation*]

Mr. Arseneault, go ahead.

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

Dr. Gaiind, as your testimony is really important, I will ask my questions quickly.

I would first like to know whether we could have access to your introductory document.

[*English*]

Dr. K. Sonu Gaiind: By introductory document, do you mean the speaking notes?

Mr. René Arseneault: Yes.

[*Translation*]

Exactly.

[*English*]

Dr. K. Sonu Gaiind: We can provide it afterwards, but we didn't prepare it in advance for circulation.

Mr. René Arseneault: Okay. Thank you.

[*Translation*]

I wanted to talk about the Carter decision, which led to the establishment of this committee and to these meetings.

One of the things established in the decision is that, according to the spirit of section 7 of the Canadian Charter of Rights and Freedoms, we must be able to provide assistance to die. The decision states that, “a competent adult person who clearly consents to the termination of life...”

Could you tell me whether you think that, when we talk about the same individual, the concepts of a competent adult and clear consent boil down to the same thing?

Can we take that view?

[*English*]

Dr. K. Sonu Gaiind: No, those are different. You can clearly have a wish for something, but that doesn't necessarily imply that you have capacity or competence for it.

The other issue I'll point out is that capacity assessments—in medicine, we often call them that—are specific to what is being assessed. They're specific to the decision. Therefore, it's conceivable that someone can have capacity to make one decision and lack capacity to make a different decision. The capacity assessments for PAD requests need to be very focused on the nuances of what could be behind the process of making that specific decision.

[*Translation*]

Mr. René Arseneault: Let's take for example a typical case, that of an adult with no pre-existing mental illness who has learned that they have an incurable disease. The disease does its damage, and time passes. At some point in their disease and their suffering—you get the picture—they ask to be provided with assistance to die by referring to the Carter decision.

Do you think that Canadian medical professionals can do that analysis? In other words, can they determine whether the adult is capable of deciding and whether they are clearly making such a request?

[*English*]

Dr. K. Sonu Gaiind: I believe physicians are able to determine if patients are competent and have capacity. In the example you're giving, if the person doesn't have a mental illness, a psychiatrist may not need to be involved.

[*Translation*]

Mr. René Arseneault: Thank you.

Let's go a bit further. We are still talking about a typical case of someone who has no pre-existing mental illness. In that context, does learning that they are suffering from a disease that will inevitably lead to death affect their ability to clearly request physician-assisted dying?

• (2020)

[*English*]

Dr. K. Sonu Gaiind: I can't make a blanket statement answering that, because it would need to be assessed on a case-by-case basis to understand how that news has affected the patient. I've seen people react with all sorts of ranges of reaction when they learn that they have a terminal illness. It needs to be assessed on an individual level. To some extent, life is a terminal illness. When people learn something, the reaction to it is very individual and needs to be teased apart. It can't be answered by a general statement.

[*Translation*]

Mr. René Arseneault: Thank you.

Using the same example, would you also say that Canada's health care professionals can always determine an adult's capacity to clearly express their will to receive assistance to die?

[*English*]

Dr. K. Sonu Gaiind: I think that on some of these questions, I would probably defer to my colleagues at the CMA, because they're the ones who would be providing more guidance on the issues when mental illness is not present.

[*Translation*]

The Joint Chair (Mr. Robert Oliphant): Mr. Deltell, go ahead.

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

Ladies and gentlemen, welcome to your Canadian Parliament.

We appreciate the richness and depth of your statements. The debate is at a very high level and all of us are benefiting from that. This shows how delicate today's topic of discussion and the reason for our meeting is. We must always keep in mind that our duty as legislators is first and foremost to protect the most vulnerable individuals. We are not here to protect those who can protect themselves. We must remember that we have to protect the most vulnerable people.

Why are we here? It's not to determine whether physician-assisted dying is good or not. That is not the debate. The debate is to figure out how to adapt that reality to the Criminal Code of Canada, since the Supreme Court has ordered us to do so. We will obey the order of the very honourable judges of the Supreme Court.

In this spirit, it's important to know that health care in Canada is a provincial responsibility, while the Criminal Code is a federal piece of legislation. By voting for or against the legislation that will be introduced, the government and the House will have to reconcile provincial power and the Criminal Code.

My question is for both groups. Do you think the government's proposal should contain very prescriptive elements for the provinces, or should the government instead focus solely on the Criminal Code?

[*English*]

Mr. Carlo Berardi: Thank you.

Certainly, I can appreciate that each province or jurisdiction in health care is under their directive. Regarding the guidelines that emanate from the law, I can't speak on the Criminal Code, as I don't have the knowledge base there, but certainly the guidelines that come out from the federal government should be clear such that each provincial regulator can adapt it to their province for their own profession.

[*Translation*]

Mr. Gérard Deltell: If I have understood correctly, medical care is still a provincial responsibility, but the legislation the government will propose will have to establish guidelines for the provinces and tell them what the extent of their authority is.

Is that what you said, Mr. Berardi?

[English]

Mr. Carlo Berardi: Yes. We're saying the guidelines may have to be adapted by the regulators for uniqueness in their own province. I think the guidelines are the foundation to build upon to assist the regulators in that province to provide the guidance and the regulations in their particular jurisdiction.

Mr. Gérard Deltell: As we can see, it's not an easy task, especially for you who have the experience with those who have suffered from mental illness. What is a guideline that we can propose to the provincial legislator for that specific issue? We're not talking about harm from a scratch. We're talking about illness, which is quite difficult. You're the one who said it's impossible to define 100% that it's the end or that it's inevitable, because nothing is irreversible. That's what you said. What are the guidelines the government should propose in the law?

• (2025)

Dr. K. Sonu Gaid: You asked a question about the federal versus provincial roles. Certainly, as far as the Criminal Code goes, that would seem to be a federal role, but the operationalization of how these things actually play out may be jurisdictional, depending on the resources available. The guidelines or recommendations that we will be forwarding will address some of that. We have not finalized all of those right now. We're trying to articulate some of the principles that would need to be there, along the lines of multiple assessors and assessments over time. The time is also crucial, because with mental illness, it can take time for a response to various treatment options or interventions.

Mr. Gérard Deltell: Thank you.

Hon. Judith G. Seidman: The Canadian Nurses Association stressed the importance of an interprofessional team to undertake a comprehensive assessment in making the evaluation for physician-assisted dying. I'd like to know, if I may, from either of the two witnesses from the pharmacists, what specific role they could recommend for pharmacists to play in this interprofessional team.

Mr. Carlo Berardi: As we mentioned tonight, we're not saying that pharmacists should have a role in the determination of either eligibility or competency or compliance with regard to the determination for assisted dying. The role of pharmacists would be to ensure the right drug for the right patient under the right circumstances and at the right time.

Hon. Judith G. Seidman: Would the pharmacist have anything to say about what would happen to this drug if it wasn't used, for example?

Mr. Carlo Berardi: Yes. Pharmacists already have expertise in the handling, storage, and distribution of toxic and dangerous drugs. The patient-education component, what to do if someone refuses the medication or the patient dies before the medication is given, and what to do when dangerous and toxic drugs are returned are things that pharmacists already deal with on a daily basis.

Hon. Judith G. Seidman: Exactly.

For example, in the U.K. there was in fact a bill that had a specific instruction on how to deal with the return of a drug to the pharmacy from which it was dispensed. In your opinion, should a similar kind of provision be included in the legislation?

Mr. Carlo Berardi: Absolutely. Of course.

Pharmacists have the infrastructure, the capacity, and the supply chain management experience to deal with product returns like that.

Hon. Judith G. Seidman: Thank you.

Dr. Gaid, you spoke very clearly about the issue of mental health. I was trying to understand the role that you thought psychiatrists should play for patients with a terminal illness or physical health issues who might request physician-assisted dying. Do you see a role for psychiatrists in determining competency, for example, which is a very big issue?

Dr. K. Sonu Gaid: To some extent that question is already answered in practice on the ground because psychiatrists are not involved in all competency assessments, and that includes ones that have life-and-death consequences.

For example, in oncology, if a patient wishes to decline chemotherapy or their treatments, it does not require a psychiatrist to always be involved. If the oncologist feels that it goes beyond their ability—and when I say this, it is not in a pejorative way—or if the oncologist is uncertain whether they're getting the whole picture and whether, perhaps, there are other influences or mental illnesses present, then they can pull in the psychiatrist. It's not something that is routinely done by default.

• (2030)

Hon. Judith G. Seidman: Thank you.

The Joint Chair (Mr. Robert Oliphant): Senator Joyal is next.

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

I would like to come back to one of the criteria that the Supreme Court has stated in Carter. I'll read it to you. You certainly know it. It says a person has to have “a grievous and irremediable medical condition”—and this is my point—“that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.”

In other words, there is an element of subjectivity on the part of the person who endures the suffering. When you endure the suffering, you can endure physically and you can endure mentally. It's you who endures. A doctor might come to the conclusion that what you endure may be curable. However, if the person has the specific conviction that it is intolerable to that person, where do you intervene, or should you intervene, to prevent that person from exercising his or her right to physician-assisted dying?

Dr. K. Sonu Gaid: You're actually hitting on issues we struggle with in medicine and psychiatry all the time between the principles of autonomy and beneficence. As physicians, we want to take care of patients. The patient also has his or her own autonomy to make decisions.

The tricky part with mental illness is that sometimes the illness can actually undermine the patient's autonomy. That applies to decisional points and processes that I've alluded to before, that idea of having a sense of a foreshortened future, perhaps literally not being able to see that there is a future. If a patient makes a decision because they're unable to see something because of the illness, then how do we reconcile that with full capacity?

I'll give you another example from my own practice. It was just a few weeks ago, actually. I have a patient I've been following for many years. He's chronically suicidal, on and off, and in between actually has good quality of life at times. The latest thing that brought him close to the suicidal state was ameliorated by getting some public transport for him so that he could be a bit more independent and go around the city and actually interact with people. Sometimes when things seem irremediable to a patient in the state of depression, it's because cognitively they cannot see a future. They cannot anticipate that something positive could change. That's part of our role, then, to make that assessment if the cognitive distortions are impairing their decision.

Hon. Serge Joyal: Then you would impose a treatment.

Dr. K. Sonu Gaiind: Again, not necessarily. The issue of capacity is specific to each question.

Hon. Serge Joyal: In that very specific context of the person deciding they want to be assisted by a physician in order to die, you would prevent that person from exercising that decision.

Dr. K. Sonu Gaiind: There's a difference between imposing a treatment and saying that a person lacks capacity to get a treatment.

Hon. Serge Joyal: But in that context, you would prevent that person. In his or her opinion, the suffering is intolerable for that person in that specific condition, in relation to what that person feels himself or herself, so in fact you would substitute your capacity or your decision for the decision of the person.

Dr. K. Sonu Gaiind: At that point in time, if the person lacked capacity, that is true. If the person were deemed to lack capacity, that is true.

There is a model called the recovery model. In that model, patients want to be able to make their own decisions, even if they're mistakes. The idea is that they want to learn from their mistakes. In the case of this particular decision, you can't learn from it if it's a mistake.

Hon. Serge Joyal: Yes, but which distinction do you make between a person who is in a mental condition and another person who suddenly discovers that he or she is suffering from, for instance, terminal cancer and has two or three months to live, and that person's mental capacity totally changes? Of course we cannot prevent, or we don't know, as you said yourself, how a person will react to his prospective death in front of him.

Dr. K. Sonu Gaiind: Those decisions we are already making. We already make those kinds of capacity decisions.

Hon. Serge Joyal: In that case, you will not intervene to prevent that person from making that decision, because that person doesn't suffer from a permanent mental illness condition. Even though you say it doesn't happen to be remediable, in the context of somebody who is in the course of being terminally ill, that person's mental capacities totally change as much as the person who suffers from a mental condition.

● (2035)

Dr. K. Sonu Gaiind: You can have two people with the exact same symptomatology and experience, and one may have capacity to make a decision and the other one might not. This is why I'm saying it comes back to the principles of capacity assessment.

The Joint Chair (Mr. Robert Oliphant): Thank you, Doctor Gaiind, and thank you, Senator.

That is the end of our time for witness help this evening. We've had such a very good time that I'm going to suggest we come back tomorrow.

Voices: Oh, oh!

The Joint Chair (Mr. Robert Oliphant): Just as a reminder, we'll be meeting in this room. We'll have a three-hour meeting. From 5:30 until 7:30 we'll have a series of witnesses: the Hon. Steven Fletcher, the Council of Canadians with Disabilities, the disability advisory council from Dying With Dignity, and three individuals—Jocelyn Downie, David Baker, and Trudo Lemmens.

That will be our agenda. Then we'll be in camera reviewing our progress and the witness list for the following week, as much as we have available.

I want to thank the witnesses. We do know that it's part of your job, but we also know that we are greatly enriched by your taking the time to be with us. Your associations are well served by your presentations tonight. Thank you very much for being with us.

The meeting is adjourned.

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