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MEDICAL ASSISTANCE IN DYING: A PATIENT-CENTRED APPROACH

Report of the Special Joint Committee on Physician-Assisted Dying

**Hon. Kelvin Kenneth Ogilvie and Robert Oliphant
Joint Chairs**

FEBRUARY 2016

42nd PARLIAMENT, 1st SESSION

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has the honour to present its

FIRST REPORT

Pursuant to its Orders of Reference from the Senate and from the House of Commons dated December 11, 2015, the Committee has studied Medical Assistance in Dying: A Patient-Centred Approach and has agreed to report the following:

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MEDICAL ASSISTANCE IN DYING: A PATIENT-CENTRED APPROACH

INTRODUCTION

On 6 February 2015, in *Carter v. Canada (Attorney General)* (*Carter*, or the *Carter* decision),¹ the Supreme Court of Canada declared section 14 and section 241(b) of the *Criminal Code*² void

insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. “Irremediable”, it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.³

The Court found that the prohibition infringed the claimants’ rights under section 7 of the *Canadian Charter of Rights and Freedoms*.⁴ The Court noted that “[i]t is for Parliament and the provincial legislatures to respond, should they so choose, by enacting legislation consistent with the constitutional parameters set out in these reasons.”⁵ While the issue of medical assistance in dying (MAID)⁶ is complex and many observers are concerned about protecting vulnerable individuals from being induced to seek MAID, the Court also noted that the trial judge “concluded that a permissive regime with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error. While there are risks, to be sure, a carefully designed and managed system is capable of adequately addressing them.”⁷

The Court suspended its declaration of invalidity so that it would not come into effect for 12 months, and then, on 15 January 2016, granted a further four-month extension

1 For more information on *Carter v. Canada (Attorney General)*, please see Martha Butler and Marlisa Tiedemann, [Carter v. Canada: The Supreme Court of Canada’s Decision on Assisted Dying](#), Library of Parliament, Background Paper No. 2015-47-E, October 2015.

2 [Criminal Code](#), R.S.C., 1985, c. C-46.

3 [Carter v. Canada \(Attorney General\)](#), 2015 SCC 5, para. 127.

4 [Constitution Act, 1982](#). Section 7 states that: “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”

5 *Carter*, 2015, para. 126.

6 The Committee is adopting the term “medical assistance in dying” instead of “physician-assisted dying,” as it reflects the reality that health care teams, and not only physicians, will be involved in the process. This report will continue to use the term “physician-assisted dying” in any quotes from witnesses or external material reviewed by the Committee if that is the term that has been used.

For an explanation of other terms relating to medical assistance in dying, please see the section “Terminology” in this report.

7 *Ibid.*, para. 105.

to that suspension. Quebec's *An Act respecting end-of-life care* was exempted from the extension, and the Court also granted an exemption "to those who wish to exercise their rights so that they may apply to the superior court of their jurisdiction for relief in accordance with the criteria set out in para. 127 of our reasons in *Carter*."⁸

On 11 December 2015, motions were passed in the House of Commons and the Senate to establish a special joint committee (Committee) whose purpose is:

to review the report of the External Panel on Options for a Legislative Response to *Carter v. Canada* and other recent relevant consultation activities and studies, to consult with Canadians, experts and stakeholders, and make recommendations on the framework of a federal response on physician-assisted dying that respects the Constitution, the Charter of Rights and Freedoms, and the priorities of Canadians.

The motions also stated that "the Committee be directed to consult broadly, take into consideration consultations that have been undertaken on this issue, examine relevant research studies and literature and review models being used or developed in other jurisdictions."⁹

Guided by *Carter*, the Committee held 16 meetings and heard from 61 witnesses (listed in Appendix A). It also received over 100 written submissions (listed in Appendix B). Witnesses highlighted the need to ensure that everyone who meets the eligibility criteria (which the Committee recommends below) has access to MAID, regardless of where they live as reflected in the *Canada Health Act*¹⁰ criteria of accessibility and universality. To further ensure access to this constitutional right, the Committee has provided recommendations not directly addressed in *Carter*. As the Supreme Court of Canada wrote in the decision: "The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought."¹¹ With respect to accessibility, the Committee also affirms that MAID should be able to be performed in any appropriate location, not only in hospitals, including in a person's home. Our response to the *Carter* ruling must be focused on the needs and wishes of patients. The Committee was unanimous in recognizing the overarching need to have safeguards to protect the vulnerable.

Submissions were both thoughtful and thought-provoking, raising issues that were directly relevant to the Committee's task of proposing a federal framework for MAID. The Committee heard overwhelming support for a collaborative approach among the federal government, the provinces and territories, and the provincial/territorial medical regulatory authorities to develop a framework relating to MAID. Witnesses wanted to avoid what some describe as a "patchwork approach" to the issue, in which the eligibility criteria and process for accessing MAID vary greatly from one province or territory to

8 [Carter v. Canada \(Attorney General\)](#), 2016 SCC 4, para. 7.

9 House of Commons, *Journals*, No. 7, 1st Session, 42nd Parliament, 11 December 2015, p. 50; Senate, *Journals*, No. 6, 1st Session, 42nd Parliament, 11 December 2015, p. 56.

10 [Canada Health Act](#), R.S.C., 1985, c. C-6.

11 *Carter* 2015, para. 127.

another. The recommendations that flow from our hearings relate to who should be eligible for MAID, and what sort of process should be put in place to ensure that only those individuals who are eligible for MAID can avail themselves of it.

The Committee emphasizes the need “to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients” as recommended in the Final Report of the Truth and Reconciliation Commission of Canada.¹² In addition, there was an overwhelming consensus among witnesses that palliative care needs to be improved more generally, and that better supports need to be provided for individuals with disabilities, individuals with mental health issues, and individuals with dementia. We recognize that considerable work needs to be done to ensure that individuals do not seek MAID as a result of a lack of proper community and other supports. The Committee provides recommendations on this issue at the end of this report.

Below, the Committee also puts forward its findings and recommendations for a legislative framework that will include, but not be limited to, amending the *Criminal Code*. The recommendations relate to eligibility for MAID (which are substantive safeguards), procedural safeguards, and oversight. The substantive and procedural safeguards that the Committee recommends are listed below, and are described later in this report.

Substantive Safeguards:

- A grievous and irremediable medical condition (including an illness, disease or disability) is required;
- Enduring suffering that is intolerable to the individual in the circumstances of his or her condition is required;
- Informed consent is required;
- Capacity to make the decision is required at the time of either the advance or contemporaneous request; and
- Eligible individuals must be insured persons eligible for publicly funded health care services in Canada.

Procedural Safeguards:

- Two independent doctors must conclude that a person is eligible;
- A request must be in writing and witnessed by two independent witnesses;

12 Truth and Reconciliation Commission of Canada, [Honouring the Truth, Reconciling for the Future](#), Summary of the Final Report of the Truth and Reconciliation Commission of Canada, 2015.

- A waiting period is required based, in part, on the rapidity of progression and nature of the patient’s medical condition as determined by the patient’s attending physician;
- Annual reports analyzing medical assistance in dying cases are to be tabled in Parliament; and
- Support and services, including culturally and spiritually appropriate end-of-life care services for Indigenous patients, should be improved to ensure that requests are based on free choice, particularly for vulnerable people.

BACKGROUND

A. Division of Powers between Federal and Provincial Governments¹³

1. Criminal Law and Administration of Justice

Sections 91 and 92 of the *Constitution Act, 1867* assign exclusive legislative authority over certain matters to either Parliament or to provincial legislatures. Section 91(27) of the *Constitution Act, 1867*¹⁴ assigns exclusive jurisdiction over criminal law to the federal government, including criminal procedure. To establish that a law is a valid use of Parliament’s criminal law jurisdiction, there must be a prohibition, a penalty and a criminal law purpose (suppression of an evil). Such purposes that have been recognized by the courts include health, morality, public safety and security.

Of note, the administration of justice, including the conduct of most prosecutions, is a provincial power under section 92(14), as is the imposition of punishment for violating provincial laws (section 92(15)).

2. Health

While some health-related subjects are listed in sections 91 and 92 of the *Constitution Act, 1867*, there is no specific reference to “health” as a general matter. Health-related subjects and measures can be characterized as being within the jurisdiction of either Parliament or provincial legislatures depending on the purpose and effect of a particular measure. Parliament can and has exercised its jurisdiction over health matters under its criminal law power (section 91(27)); the federal spending power, which is inferred from its jurisdiction over public debt and property (section 91(1A)); and its general taxing power (section 91(3)).

13 This section is based on Martha Butler and Marlisa Tiedemann, *The Federal Role in Health and Health Care*, Library of Parliament, In Brief No. 2011-91-E, September 2013.

For more detailed information about the division of powers, see Peter W. Hogg *Constitutional Law of Canada*, Fifth Edition Supplemented, Volumes 1 and 2, Thomson Carswell, Toronto, 2007.

14 [Constitution Act, 1867](#), 30 & 31 Victoria, c. 3 (U.K.).

Examples of the use of the federal criminal law power with respect to health matters include the *Food and Drugs Act*,¹⁵ the *Human Pathogens and Toxins Act*¹⁶ and the *Assisted Human Reproduction Act (AHRA)*.¹⁷ The test involved in determining whether legislation related to health based on the federal criminal law power is validly enacted is (1) whether the legislation contains a prohibition and a penalty; and (2) whether it is directed at a “legitimate public health evil” (or other criminal law purpose). In a 4-4-1 decision, parts of the AHRA were struck down by the Supreme Court of Canada in 2010 as being outside the power of Parliament.¹⁸ In that case, the majority stated:

Although a reasoned apprehension of harm necessarily constitutes a criminal law purpose, health, ethics and morality do not automatically arouse such an apprehension in every case. For an activity to fall under the criminal law, it must be found that there is an evil to be suppressed or prevented and that the pith and substance of the provisions in issue is the suppression of that evil or the elimination of that reasoned risk of harm.

When Parliament exercises a power assigned to it, it can establish national standards. However, administrative efficiency alone cannot be relied on to justify legislative action by Parliament (*Margarine Reference*, at p. 52). The action must be taken within the limits of an assigned head. Recourse to the criminal law power cannot therefore be based solely on concerns for efficiency or consistency, as such concerns, viewed in isolation, do not fall under the criminal law. The three criteria of the criminal law must be met.¹⁹

With the exception of matters that fall under the aforementioned sections, health is for the most part an area of provincial jurisdiction. For example, the province has jurisdiction over most hospitals and health care services, the practice of medicine, the training of health professionals and the regulation of the medical profession, hospital and health insurance, and occupational health. Power over these areas is granted by sections 92(7) (hospitals), 92(13) (property and civil rights) and 92(16) (matters of a merely local or private nature) of the *Constitution Act, 1867*.

However, drawing a clear line between federal and provincial jurisdiction can be difficult, as noted in *Canada (Attorney General) v. PHS Community Services Society*:

The provincial health power is broad and extensive. It extends to thousands of activities and to a host of different venues.... To complicate the matter, Parliament has power to legislate with respect to federal matters, notably criminal law, that touch on health. For instance, it has historic jurisdiction to prohibit medical treatments that are dangerous, or that it perceives as “socially undesirable” behaviour: *R. v. Morgentaler*, [1988] 1 S.C.R. 30; *Morgentaler v. The Queen*, [1976] 1 S.C.R. 616; *R. v. Morgentaler*, [1993] 3 S.C.R. 463. The federal role in the domain of health makes it impossible to precisely define what falls in or out of the proposed provincial “core.” Overlapping federal jurisdiction and the sheer size and diversity

15 [Food and Drugs Act](#), R.S.C. 1985, c. F-27.

16 [Human Pathogens and Toxins Act](#), S.C. 2009, c. 24.

17 [Assisted Human Reproduction Act](#), S.C. 2004, c. 2.

18 [Reference re Assisted Human Reproduction Act](#), 2010 SCC 61.

19 *Ibid.*, paras. 243–244.

of provincial health power render daunting the task of drawing a bright line around a protected provincial core of health where federal legislation may not tread.²⁰

In *Carter*, the Supreme Court concluded:

In our view, the appellants have not established that the prohibition on physician-assisted dying impairs the core of the provincial jurisdiction. Health is an area of concurrent jurisdiction; both Parliament and the provinces may validly legislate on the topic: *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199, at para. 32; *Schneider v. The Queen*, [1982] 2 S.C.R. 112, at p. 142. This suggests that aspects of physician-assisted dying may be the subject of valid legislation by both levels of government, depending on the circumstances and focus of the legislation. We are not satisfied on the record before us that the provincial power over health excludes the power of the federal Parliament to legislate on physician-assisted dying.²¹

The federal response to *Carter* and implementation of a framework surrounding MAID will need to take into account this complex division of powers and will require close cooperation with the provinces and territories. A number of witnesses expressed concern about a “patchwork” approach to MAID.²² One option was outlined by constitutional scholar Peter Hogg:

[A]lthough it would be very nice if the provinces all came out with uniform legislation, you have to recognize that it may not happen. One thing you can do is recommend a provision in the federal law that in effect provides what I call an “equivalence provision”, which in effect would say that if the federal Minister of Health or the Governor in Council — you could use any framework — is satisfied that a province or a territory has enacted safeguards that are substantially equivalent to the federal safeguards, then the federal law would not apply in that province.

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

[I]f a province doesn't have a physician-assisted dying regime, then your legislation will be the only game in town. It will have to operate and it will have to include adequate safeguards against error or abuse.²³

20 [Canada \(Attorney General\) v. PHS Community Services Society](#), 2011 SCC 44, para. 68.

21 [Carter v. Canada \(Attorney General\)](#), 2015 SCC 5, para. 53.

22 See, for example, Parliament, 1st Session, 42nd Parliament, Special Joint Committee on Physician-Assisted Dying (PDAM), *Evidence*, 27 January 2016, 1705 (Dr. Jeff Blackmer, Canadian Medical Association); PDAM, *Evidence*, 26 January 2016, 1830 (Jennifer Gibson, Co-Chair, Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying).

23 PDAM, *Evidence*, 25 January 2016, 1150 & 1225 (Peter Hogg, Scholar in Residence, Blake, Cassels & Graydon LLP, As an Individual).

B. Quebec's Legislation²⁴

The Committee wishes to note Quebec's extensive debate on the issue of MAID, which proved helpful in our deliberations.

The Quebec legislature struck the Select Committee on Dying with Dignity (Select Committee) on 4 December 2009. The Select Committee heard from 32 experts and more than 250 individuals and organizations and received 273 briefs during its work in 2010 and 2011. In March 2012, the Select Committee tabled its report, making 24 recommendations on palliative care, palliative sedation, advance medical directives, end-of-life care, and "medical aid in dying."²⁵

In response to the Select Committee's report, the Quebec government appointed an expert panel to explore how to implement the recommended legislative changes. The panel released its report in January 2013. The report recommended that "medical aid in dying," in certain circumstances, be understood as part of the continuum of care. When seen as an element of end-of-life care, "medical aid in dying" could fall under provincial jurisdiction over health care delivery.

On 12 June 2013, Bill 52, An Act respecting end-of-life care, was introduced in the Quebec National Assembly, and received Royal Assent on 5 June 2014. Most of the Act's provisions came into force on 10 December 2015.

The law establishes rights with respect to end-of-life care, rules for those who provide end-of-life care, rules relating to continuous palliative sedation, powers of the Minister of Health and Social Services, rules relating to advance medical directives, and rules relating to "medical aid in dying." The law outlines requirements in order to obtain "medical aid in dying," requirements for physicians prior to administering "medical aid in dying" and various other elements in order to regulate the practice.

C. Federal External Panel on Options for a Legislative Response to *Carter v. Canada*

On 17 July 2015, the federal Minister of Justice and the federal Minister of Health announced the establishment of an external panel to consult Canadians regarding options to respond to the *Carter* decision. The panel was to consult with medical authorities and interveners in the *Carter* case specifically and, through an online public consultation, with Canadians more generally. The panel was to report on its findings and propose options for a legislative response. However, after the election of a new government, a letter to the panel from the new federal Minister of Justice and the new federal Minister of Health released publicly on 14 November 2015 extended the deadline for the panel's report by one month to 15 December 2015 and modified the terms of the mandate, asking the panel

24 This section is based in part on forthcoming revisions to Julia Nicol and Marlisa Tiedemann, *Euthanasia and Assisted Suicide in Canada*, Library of Parliament.

25 "Medical aid in dying" is the term used in the Quebec law.

to focus on summarizing the results and key findings of its consultations. It was no longer to provide legislative options.

As part of its work, in addition to consulting the groups mentioned in the paragraph above, the External Panel travelled to the Netherlands, Belgium, Switzerland and to the state of Oregon in the United States to learn about how assisted dying is regulated in those jurisdictions. The External Panel's report was submitted to the government on 15 December 2015.

In its final report,²⁶ the External Panel summarized the evidence it received with respect to the following topics:

- forms of assisted dying and terminology;
- eligibility criteria;
- the request for MAID;
- assessing the request;
- participation and compliance; and
- system oversight.

D. Provincial–Territorial Expert Advisory Group

In mid-August 2015, a provincial–territorial expert advisory group on MAID was announced.²⁷ The Advisory Group's work was to “complement the work of the federal panel” and “provide advice on the development of policies, practices and safeguards for provinces and territories to consider when physician-assisted dying is legal within their respective jurisdictions.”²⁸

The Advisory Group's final report, dated 30 November 2015 and posted publicly on 14 December 2015, contained 43 recommendations.²⁹ Key recommendations include:

- “Provinces and territories, preferably in collaboration with the federal government, should develop and implement a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying”;

26 External Panel on Options for a Legislative Response to *Carter v. Canada*, [Consultations on Physician-Assisted Dying - Summary of Results and Key Findings](#), 15 December 2015.

27 All provinces and territories participated in the advisory group except for Quebec, which had passed its own legislation, and British Columbia, which was an observer to the process.

28 Government of Ontario, “[Provinces, Territories Establish Expert Advisory Group On Physician-Assisted Dying](#),” News release, 14 August 2015.

29 Provincial–Territorial Expert Advisory Group on Physician-Assisted Dying, [Final Report](#), 30 November 2015 [Provincial-Territorial Report].

- establishing a program within the publicly funded system that will link patients with an appropriate provider;
- amending the *Criminal Code* to allow MAID by regulated health professionals acting under the direction of a physician or a nurse practitioner, and to protect health professionals who participate in MAID;
- amending the *Criminal Code* to ensure that eligibility for MAID is based on competence rather than age;
- having medical regulatory authorities develop guidance/tools for physicians;
- not requiring a mandatory waiting period between a request and provision of assistance in dying;
- requiring “conscientiously objecting” health care providers “to inform patients of all end-of-life options”, including MAID, and requiring providers to give a referral or direct transfer of care or to contact a third party and transfer the patient’s records;
- having provincial and territorial governments establish review committee systems to review compliance in all cases of MAID;
- establishing a pan-Canadian commission on end-of-life care (preferably in collaboration with the federal government); and
- providing public education about MAID and engaging the public so that it can inform future developments of related law, policies and practices.

TERMINOLOGY

Euthanasia is the “intentional termination of the life of a person, by another person, in order to relieve the first person’s suffering.” Voluntary euthanasia is euthanasia performed in accordance with the wishes of a competent person, expressed personally or by advance directive.³⁰

Assisted suicide is the act of intentionally ending one’s life with the assistance of another person who provides the knowledge, means, or both, of doing so.

Generic terms such as “assisted dying” or “assisted death” are also used to describe both assisted suicide and voluntary euthanasia. “Physician-assisted death” and “physician-assisted dying” are generic terms used when a doctor is involved either directly or in supervising another person who is assisting a suicide.³¹

30 [Carter v. Canada \(Attorney General\)](#), 2012 BCSC 886, para. 38.

31 *Ibid.*, para. 39.

In the *Carter* decision, the Supreme Court of Canada used the terms “physician-assisted death” and “physician-assisted dying,” which were the terms used by the plaintiffs. According to the plaintiffs, these terms include “physician-assisted suicide” and “consensual physician-assisted death.” Quebec’s *An Act respecting end-of-life care* uses the term “medical aid in dying,” which is defined as “care consisting in the administration by a physician of medications or substances to an end-of-life-patient, at the patient’s request, in order to relieve their suffering by hastening death.”³² This term includes voluntary euthanasia but not assisted suicide.

Many witnesses who appeared before the Committee discussed the language that should be used in relation to MAID. For example, Joanne Klineberg, Senior Counsel, Criminal Law Policy Section at the Department of Justice, noted:

Some stakeholders take the view that the expressions “physician-assisted suicide” and “euthanasia” are well defined and clear and must be used in order to avoid confusion and misunderstanding that arise from more general terms like “physician-assisted dying”. Others disagree with the use of the terms “physician-assisted suicide” and “euthanasia”, believing that they are loaded and stigmatizing terms and that only something more general, like “physician-assisted dying” should be used.³³

In its report, the External Panel confirmed that some of the experts and organizations they consulted prefer the terms “physician-assisted suicide” and “euthanasia,” while others prefer “physician-assisted dying.”³⁴ The Committee heard that other organizations would rather use the term “physician-hastened death.”³⁵ The Committee prefers the term “medical assistance in dying” to “physician-assisted dying”, as it reflects the reality that health care teams, consisting of nurses, pharmacists, and other health care professionals, are also involved in the process of assisted dying. The Committee recommends that “medical assistance in dying” (MAID) be used in any future legislation on this topic, and it is also the term that the Committee will use throughout this report.

With respect to the terms “grievous and irremediable,” some witnesses suggested to the Committee that they should be defined in legislation,³⁶ while other witnesses felt that this was unnecessary.³⁷ Maureen Taylor, Co-Chair of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying stated that “grievous” should be defined as

32 Civil Code of Quebec, *An Act respecting end-of-life care*, c. S-32.0001, s. 3(6).

33 PDAM, *Evidence*, 18 January 2016, 1405 (Joanne Klineberg, Department of Justice).

34 External Panel Report.

35 PDAM, *Evidence*, 27 January 2016, 1720 (Dr. Monica Branigan, Canadian Society of Palliative Care Physicians); A Network of BC Physicians, *Submission to the Special Joint Committee on Physician-Assisted Dying*.

36 See for example, PDAM, *Evidence*, 4 February 2016, 1925 (Michael Bach, Canadian Association for Community Living); A Network of BC Physicians; Daniel Santoro and Dr. Althea Burrell, *Submission to Special Joint Committee on Physician-Assisted Dying*, received 27 January 2016.

37 See for example PDAM, *Evidence*, 1 February 2016, 1100 (Grace Pastine, Litigation Director, British Columbia Civil Liberties Association); PDAM, *Evidence*, 2 February 2016, 1920 (Dr. Douglas Grant, Nova Scotia College of Physicians and Surgeons); PDAM, *Evidence*, 4 February 2016.

“very severe” or “serious.”³⁸ The Canadian Medical Association had a similar definition (“serious or severe”), and stated that “irremediable” should be defined as “not able to be put right or cured.”³⁹ Jocelyn Downie, a professor at Dalhousie University, and David Baker, a lawyer practising at Bakerlaw, both of whom presented draft legislation on MAID to the Committee, had a number of terms defined in their respective bills, including “grievous and irremediable.”⁴⁰ The Ontario College of Physicians and Surgeons has defined “grievous” as “a legal term that applies to serious, non-trivial conditions that have a significant impact on the patient’s well-being,” and “irremediable” as “a broad term capturing both terminal and non-terminal conditions.”⁴¹ The Alberta and Manitoba colleges of physicians and surgeons have also defined “grievous and irremediable” in their respective policies.⁴²

The Committee agrees with the witnesses who said the terms “grievous and irremediable” do not need to be defined beyond what is set out in *Carter*, and notes that the Court stated that “irremediable ... does not require the patient to undertake treatments that are not acceptable to the individual.”⁴³ We believe that these terms are sufficiently well understood to operate without further statutory definition and recommend:

RECOMMENDATION 1

That the terms relating to medical assistance in dying do not require further statutory definition.

ELIGIBILITY CRITERIA FOR MEDICAL ASSISTANCE IN DYING

A. Condition

The Supreme Court of Canada’s declaration in *Carter* allows MAID where there is “a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.”⁴⁴

38 PDAM, *Evidence*, 26 January 2016, 1835 (Maureen Taylor, Co-Chair of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying).

39 PDAM, *Evidence*, 27 January 2016, 1730 (Dr. Cindy Forbes, President, Canadian Medical Association).

40 PDAM, *Evidence*, 28 January 2016, 1845 (Jocelyn Downie, As an Individual); Submission to the Committee, *Presentation to Special Joint Committee on Physician Assisted Dying* (David Baker, Trudo Lemmens, Gilbert Sharpe), 28 January 2016.

41 College of Physicians and Surgeons of Ontario, *Interim Guidance on Physician-Assisted Death*, January 2016.

42 College of Physicians and Surgeons of Alberta, *Advice to the Profession: Physician-Assisted Death*; College of Physicians and Surgeons of Manitoba, *Standards of Practice for Physician-Assisted Death*.

43 *Carter*, 2015, para. 147.

44 *Ibid.*

There was a strong consensus in the testimony and briefs that there should be no list of included conditions.⁴⁵

1. Terminal Illness as a Requirement

Witnesses diverged in their interpretation of the *Carter* decision and its implications for future legislation. Some witnesses said that only individuals with a terminal diagnosis should be able to access MAID while others said that *Carter* clearly did not include such a requirement. Prof. Hogg argued that, while it was not impossible for Parliament to require that the condition be terminal, such a law would be more susceptible to constitutional challenge.⁴⁶

Imam Sikander Hashmi, representing the Canadian Council of Imams, argued that MAID be limited to individuals “in an advanced state of irreversible decline” and Margaret Somerville, professor at McGill University, expressed the view that only individuals with less than four weeks to live should qualify.⁴⁷ In contrast, the External Panel stated that *Carter* did not require a terminal diagnosis.⁴⁸ Professor Downie stated:

[Terminal illness] was not included by the Supreme Court in *Carter*. It is too vague and indeterminate. It is arbitrary and it has no moral justification as a barrier to access.⁴⁹

A brief from the Centre for Inquiry Canada said that limiting MAID to terminally ill individuals, “would not fully respect the Court’s decision and the value of individual autonomy that underpins it.”⁵⁰

The Committee agrees with the External Panel and does not interpret *Carter* as limiting MAID to terminally ill individuals. Furthermore, limiting MAID in this way would result in Canadians with grievous and irremediable conditions faced with enduring and intolerable suffering having to continue suffering against their will. For these reasons, the Committee recommends:

45 See, for example, PDAM, *Evidence*, 3 February 2016, 1700 (Vyda Ng, Executive Director, Canadian Unitarian Council); Dying with Dignity Canada, *7 Legislative Principles for a Patient-Centred Approach to Physician-Assisted Dying*, submission to the Committee.

46 PDAM, *Evidence*, 25 January 2016, 1255 (Hogg).

47 PDAM, *Evidence*, 3 February 2016, 1825 (Imam Sikander Hashmi, Spokesperson, Canadian Council of Imams); PDAM, *Evidence*, 4 February 2016, 1705 (Margaret Somerville, Professor, McGill University, as an Individual). Also see, for example, PDAM, *Evidence*, 4 February 2016, 1925 (Bach); and Canadian Society of Palliative Care Physicians, *Submission to Special Joint Committee on Physician-Assisted Dying*, submission to the Committee dated 27 January 2016, pp. 3-4.

48 External Panel on Options for a Legislative Response to *Carter v. Canada*, [Consultations on Physician Assisted Dying Summary of Results and Key Findings: Final Report](#), 15 December 2015, p. 57. Also see, for example, PDAM, *Evidence*, 25 January 2016, 1240 (Jean-Pierre Ménard, Lawyer, Barreau du Québec).

49 PDAM, *Evidence*, 28 January 2016, 1845 (Downie).

50 Centre for Inquiry Canada, written submission to the Committee, 1 February 2016, p. 4.

RECOMMENDATION 2

That medical assistance in dying be available to individuals with terminal and non-terminal grievous and irremediable medical conditions that cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

2. Mental Illness

Because the individuals that brought the case in *Carter* did not have mental health issues, the Court made no pronouncement with respect to MAID and psychiatric conditions. Jeanette Ettel, Senior Counsel, Human Rights Law Section at the Department of Justice, told the Committee that it was open to the Committee to consider whether to include psychiatric illnesses in the conditions that could result in a right to MAID.⁵¹

As was the experience of the External Panel, the Committee heard widely diverging views on how to address mental health in the context of MAID. Benoît Pelletier, member of the External Panel and an expert in constitutional law noted that the External Panel identified greater support from Canadians for MAID in the context of a physical illness but that, *prima facie*, the *Carter* criteria would also apply to psychiatric conditions.⁵² Professor Downie and others supported this position:

[M]ental illness should not be an exclusion criterion. It was not excluded by the Supreme Court, and not all individuals with mental illness are incompetent. Physicians already routinely determine whether someone is competent, even when they have a mental illness. Furthermore, the suffering that can accompany mental illness can be as excruciating as any suffering that can accompany physical illness. Finally, I would argue that excluding individuals on the basis of mental illness would violate the charter.⁵³

A number of witnesses and submissions expressed concern about mental illness in the context of MAID.⁵⁴ Dr. K. Sonu Gaind, President of the Canadian Psychiatric Association, outlined some of the challenges that will need to be addressed:

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.⁵⁵

51 PDAM, *Evidence*, 18 January 2016, 1530 (Jeanette Ettel, Senior Counsel, Human Rights Law Section, Department of Justice).

52 PDAM, *Evidence*, 26 January 2016, 1750 (Benoît Pelletier, Member, External Panel on Options for a Legislative Response to *Carter v. Canada*).

53 PDAM, *Evidence*, 28 January 2016, 1850 (Downie). See also, for example, Centre for Inquiry, p. 4 and PDAM, *Evidence*, 26 January 2016, 1900 (Taylor).

54 See, for example, *Living with Dignity, Recommendations for the Special Joint Committee on Physician-Assisted Dying*, p. 3, written submission to the Committee; Derek B.M. Ross & Johnathan R. Sikkema, Christian Legal Fellowship, *Submission of the Christian Legal Fellowship to the Special Joint Committee on Physician-Assisted Dying*, 1 February 2016, p. 4.

55 PDAM, *Evidence*, 27 January 2016, 1935 (Dr. K. Sonu Gaind, President, Canadian Psychiatric Association).

Dr. Tarek Rajji, Chief of Geriatric Psychiatry at the Centre for Addiction and Mental Health, told the Committee that:

[M]ental illness may be grievous to an individual, and symptoms can cause enduring psychological and sometimes physical suffering. However, suffering should not be equated with an irremediable nature, and the lack of inevitable and predictable death by natural history provides us with an opportunity to deliver recovery-based treatment.

[P]eople with mental illness may be vulnerable to the impact of the social determinants of health. They may live in poverty, have poor housing, and lack social support. These circumstances may exacerbate suffering and a person's perception that their illness is irremediable ... within a clinical recovery-based environment, there is always the potential for mental illness to be remediable.⁵⁶

In response, Professor Downie reminded the Committee of the following aspect of the *Carter* judgment:

"Irremediable", it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.⁵⁷

The Committee recognizes that there will be unique challenges in applying the eligibility criteria for MAID where the patient has a mental illness, particularly where such an illness is the condition underlying the request. However, where a person is competent and fits the other criteria set out by law, the Committee does not see how that individual could be denied a recognized Charter right based on his or her mental health condition. Furthermore, we do not understand the *Carter* decision to exclude mental illnesses.

Any individual applying for MAID would need to satisfy all the criteria, including irremediability and capacity. As several witnesses reminded the Committee, health professionals will need to strike an appropriate balance between the rights of all Canadians to access this constitutionally protected right, and the protection of those vulnerable persons who might be coerced into requesting MAID. Cases involving mental illness may prove challenging to address for health care practitioners, but the Committee has faith in the expertise of Canadian health care professionals to develop and apply appropriate guidelines for such cases. The difficulty surrounding these situations is not a justification to discriminate against affected individuals by denying them access to MAID. The Committee expects that cases where the underlying condition is a mental health condition will be rare, as is the case in other jurisdictions that have legalized MAID.⁵⁸ A more detailed discussion of appropriate safeguards can be found below. The Committee therefore recommends:

56 PDAM, *Evidence*, 3 February 2016, 1805 (Dr. Tarek Rajji, Chief, Geriatric Psychiatry, Centre for Addiction and Mental Health).

57 *Carter*, 2015, para. 127.

58 Regarding Belgium, for example: neuropsychiatric disorders were 1.2% of cases in 2004/05, 2.8 % (or 58 cases) in 2010/11 and 3.7 % (or 67 cases) in 2013/14 according to Trudo Lemmens, *Why Canada Should Avoid A Belgian-Style Regulatory Regime for Physician Assisted Dying*, *Memorandum for the Special Joint Committee on Physician-Assisted Dying*, written submission to the Committee, p. 6.

RECOMMENDATION 3

That individuals not be excluded from eligibility for medical assistance in dying based on the fact that they have a psychiatric condition.

B. Suffering

The Supreme Court did not specify in *Carter* whether suffering is limited to physical suffering. Witnesses voiced different opinions, with some advocating for the inclusion of physical suffering only and others recommending that psychological suffering be included as well.⁵⁹ The Committee received at least one submission arguing that mental suffering is as severe as physical suffering and should not be excluded from MAID.⁶⁰ In addition, the Supreme Court referred to suffering “from the knowledge that they lack the ability to bring a peaceful end to their lives at a time and in a manner of their own choosing,” which would be psychological in nature.⁶¹ The requirements that the suffering is enduring and intolerable to the person are safeguards to ensure that someone in temporary or minor pain does not make a rash decision to die. In addition, the suffering must relate to a grievous and irremediable condition. Where mental illness is an issue, Dr. Gaind noted that what is considered enduring and intolerable suffering may be affected by the mental illness itself.⁶² The Committee has confidence that health care professionals will proceed cautiously in such cases, as in all cases, and ensure that all criteria are satisfied before accepting a request for MAID and recommends:

RECOMMENDATION 4

That physical or psychological suffering that is enduring and intolerable to the person in the circumstances of his or her condition should be recognized as a criterion to access medical assistance in dying.

C. Informed Consent

There appeared to be a general consensus in the testimony and briefs that the request for MAID must come from the patient in a voluntary manner and after he or she has received sufficient information to make an informed choice. The concern voiced most often during the hearings was about ensuring genuine consent to MAID. All witnesses and authors of briefs were concerned about the protection of vulnerable individuals, though the proposed solutions varied considerably. Prof. Pelletier explained:

As for vulnerability, it is, of course, a complex and subtle concept. Although the term “vulnerable populations” has been used to describe certain identifiable groups in society, the panel heard from many sources that vulnerability is not simply a characteristic of an

59 See, for example, PDAM, *Evidence*, 4 February 2016, 1705 (Somerville), regarding limiting MAID to physical suffering; and PDAM, *Evidence*, 1 February 2016, 1155 (Wanda Morris, Dying With Dignity), regarding psychological suffering.

60 Marcia Hogan, *Brief to the Joint Committee on Physician Assisted Dying*, submission to the Committee, p. 2.

61 *Carter*, 2015, para. 14.

62 PDAM, *Evidence*, 27 January 2016, 1935 (Gaind).

individual or group, but rather is a state that any one of us could be in under certain circumstances. We heard that sometimes people are made vulnerable in particular contexts and situations when personal autonomy, status, wealth, and well-being are compromised in any significant way.

What this means in the context of physician-assisted dying is that all persons are potentially vulnerable. Being vulnerable does not disqualify a person who is suffering intolerably from seeking an assisted death, but it does put that person at risk of being induced to request a death that he or she does not desire. This is the risk that the Supreme Court called upon Parliament and provincial legislatures to address in a complex regulatory scheme.⁶³

Jennifer Gibson, Co-Chair of the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, suggested that almost all patients considering MAID would be vulnerable, with some facing particular vulnerabilities as a result of issues such as mental illness or social conditions. She suggested that, rather than vulnerability being a barrier to access, the process should take these vulnerabilities into account through safeguards and that training for health care professionals be offered.⁶⁴ Biomedical ethics Professor Carolyn Ells of McGill University and others felt that current standards and processes for establishing consent should be used.⁶⁵ Ms. Klineberg from the Department of Justice said that:

It was because the court had expressed confidence that Canadian physicians can assess both mental competence and the vulnerability of a person at the individual level that it felt the absolute prohibition was unconstitutional and you could provide physician-assisted dying to those who wanted it while protecting the vulnerable.⁶⁶

Nonetheless, many witnesses called for further supports for individuals who may be vulnerable as a result of poverty and mental health issues, and identified the need for adequate palliative care and for patients to be provided information about these options in order to make MAID a genuine choice.⁶⁷ Some witnesses, such as the Coalition for HealthCARE and Conscience, felt that no safeguards would be sufficient to protect the vulnerable.⁶⁸ In contrast, Linda Jarrett, a member of the Disability Advisory Council of Dying with Dignity, told the Committee:

63 PDAM, *Evidence*, 26 January 2016, 1740 (Pelletier).

64 PDAM, *Evidence*, 26 January 2016, 1915 (Gibson).

65 PDAM, *Evidence*, 2 February 2016, 1745 (Carolyn Ells, Associate Professor, Medicine, Biomedical Ethics Unit, McGill University, As an Individual). See also, for example, PDAM, *Evidence*, 1 February 2016, 1105 (Josh Paterson, Executive Director, British Columbia Civil Liberties Association).

66 PDAM, *Evidence*, 18 January 2016, 1530 (Klineberg).

67 See, for example, PDAM, *Evidence*, 28 January 2016, 1940 (David Baker, Bakerlaw, As an Individual); PDAM, *Evidence*, 28 January 2016, 1750 (Dean Richert, Co-Chair, Ending of Life Ethics Committee, Council of Canadians with Disabilities); PDAM, *Evidence*, 2 February 2016, 1815 (Sharon Baxter, Executive Director, Canadian Hospice Palliative Care Association).

68 PDAM, *Evidence*, 3 February 2016, 1705 (Cardinal Thomas Collins, Archbishop, Archdiocese of Toronto, Coalition for HealthCARE and Conscience).

The members of our disability advisory council strongly feel that the law needs to strike a balance to protect vulnerable people from having an assisted death they don't really want and ... to ensure access to assisted death for those who do have an enduring wish for it...

Our diseases and disabilities have robbed us of much, and I ask you, do not add to this burden by compromising our choices and our autonomy.⁶⁹

The Committee understands the concerns with respect to both protecting vulnerable persons and respecting their autonomy, and is recommending a number of safeguards which are both described throughout this report and summarized in the introduction.

As noted by the Supreme Court of Canada in *Carter*:

The evidence supports ... [the trial judge's] finding that a properly administered regulatory regime is capable of protecting the vulnerable from abuse or error.⁷⁰

The Court also noted that “[w]e should not lightly assume that the regulatory regime will function defectively, nor should we assume that other criminal sanctions against the taking of lives will prove impotent against abuse.”⁷¹

As is outlined in further detail below, the Committee endorses recommendations to provide more supports and services to reduce the vulnerabilities of those seeking MAID. At the same time, issues such as poverty and social isolation are general societal and systemic problems that will, unfortunately, not be resolved overnight. Safeguards and oversight are the best way to ensure informed consent and voluntariness while not refusing access to individuals who may be experiencing intolerable and enduring suffering. The process of evaluating a request for MAID must include consideration by the relevant health care provider(s) of any factors affecting consent, such as pressure from others, feelings of being a burden or lack of supports. Training will also be crucial to ensure that such factors are identified appropriately. The Committee fully agrees with the statement of Rhonda Wiebe, Co-Chair of the Ending of Life Ethics Committee of the Council of Canadians with Disabilities who said:

[T]here are many social, economic, and other environmental factors that increase the vulnerability of persons with disabilities, especially the newly disabled. Careful scrutiny must take place to ensure that there aren't other remedies, besides death, that will lessen the suffering and indignity of these people.⁷²

At the same time, though there may be cases where vulnerable persons are affected by external factors to want to die, the criteria should not be overly restrictive, as the Hon. Steven Fletcher, former Member of Parliament reminded the Committee:

69 PDAM, *Evidence*, 28 January 2016, 1740 (Linda Jarrett, Member Disability Advisory Council, Dying with Dignity Canada).

70 *Carter*, 2015, para. 3.

71 *Ibid*, para. 120.

72 PDAM, *Evidence*, 28 January 2016, 1755 (Rhonda Wiebe, Co-Chair of the Ending of Life Ethics Committee of the Council of Canadians with Disabilities).

Having someone suffer, starving themselves to death, or being in pain or in terrible suffering, down the hall or down the street at the seniors residence or in a hospital or at home, having them live in pain and terror — it doesn't make my life better as a Canadian with a disability. It just makes me sad.⁷³

Cases must be assessed on an individual basis to ensure the appropriate balance between protection of the vulnerable and respect for autonomy. The Committee believes that the safeguards and oversight measures outlined below, as well as other measures that the provinces and regulators of health care professionals will develop, will ensure that individuals who do not really want to die are identified, that the vulnerable are protected and that individuals who satisfy the criteria and with a genuine and enduring desire to die are provided with MAID to end their suffering. The Canadian Medical Association's recommendations are reassuring on this point, as one of the foundational principles they include is that:

All the requirements for informed consent must clearly be met, including the requirement that the patient be capable of making that decision, **with particular attention to the context of potential vulnerabilities and sensitivities in end-of-life circumstances**. Consent is seen as an evolving process requiring physicians to communicate with the patient in an ongoing manner. [bold added]⁷⁴

In addition, the Committee notes that section 241(a) of the *Criminal Code*, which addresses counselling to commit suicide, remains in place should a patient be faced with pressure from family or others to request MAID.

The Committee strongly believes that to protect vulnerable individuals, only individuals who are able to provide informed consent to MAID should have access to it. The Committee therefore recommends:

RECOMMENDATION 5

That the capacity of a person requesting medical assistance in dying to provide informed consent should be assessed using existing medical practices, emphasizing the need to pay particular attention to vulnerabilities in end-of-life circumstances.

D. Age

The *Carter* decision dealt with plaintiffs who were adults, so no decision was made with regard to minors' eligibility for MAID. However, as Prof. Pelletier made clear, Parliament can choose to allow minors to access MAID.⁷⁵ In response to a comment stating that it was up to the Committee to determine what the age of consent would be in relation to a specific offence, Prof. Hogg replied:

73 Ibid., 1800 (Hon. Steven Fletcher, as an Individual).

74 Canadian Medical Association, *Principles-based Recommendations for a Canadian Approach to Assisted Dying*, written submission to the Committee, p. 3.

75 PDAM, *Evidence*, 26 January 2016, 1805 (Pelletier).

Yes, I think that's right. The Supreme Court, in its order, spoke of a "competent adult person". I don't think it would be open to you, for example, to have 16 as an age of consent for this purpose, because that would not be a competent adult person. Between 18 and 21, I would think you would have some leeway within the word "adult" to decide that.⁷⁶

Certain witnesses, such as the Nova Scotia College of Physicians and Surgeons, chose not to take a position on this issue, simply asking for greater clarity to be provided.⁷⁷ Some witnesses who appeared before the Committee and the External Panel recommended that legislation define an age below which MAID would not be available (generally 18 but one submission suggested as old as 25).⁷⁸ Other witnesses wanted all individuals who are competent to make the decision to be eligible for MAID.⁷⁹ One witness also flagged the need to consider the suffering of children who are not competent, though did not go so far as to suggest including them in any MAID regime.⁸⁰ To date, Belgium and the Netherlands are the only two jurisdictions that allow minors access to MAID.⁸¹

Stakeholders who prefer competency-based criteria, such as the Provincial/Territorial Expert Advisory Group and the British Columbia Civil Liberties Association, argue that the trend is toward increased recognition of the competence of minors in health care decision making and that age limits are arbitrary.⁸² Prof. Pelletier stated that suffering is suffering, regardless of age and that there is a risk that the provisions may be challenged on the basis of section 15 of the Charter (equality rights) if minors are excluded.⁸³

The Canadian Paediatric Society advocated against including minors, regardless of competence, in any MAID regime. The organization made this argument for a number of reasons, including the lack of evidence before the court in *Carter* regarding minors; the fact that an age limit is not arbitrary; and the lack of social consensus with respect to MAID for minors. The organization also rejected the idea that a constitutional challenge by excluded minors would clearly be successful. It suggested addressing whether to allow minors to access MAID at a later date, after there has been time to gather data, as was the case in Belgium which legalized minors' access to MAID in 2014, 12 years after adults were granted access.⁸⁴

76 PDAM, *Evidence*, 25 January 2016, 1240 (Hogg).

77 PDAM, *Evidence*, 2 February 2016, 1940 (Grant).

78 See, for example, PDAM, *Evidence*, 4 February 2016, 1640 (Carmela Hutchison, President of DisAbled Women's Network of Canada) (DAWN); PDAM, *Evidence*, 4 February 2016, 1920 (Bach). Regarding the suggestion of age 25, see Colette Squires, *Physician Assisted Dying Public Consultation, January 30, 2016 in Langley, B.C.*, submission to the Committee, p. 4.

79 Provincial-Territorial Report, Recommendation 17. Also see, for example, PDAM, *Evidence*, 2 February 2016, 1735 (Dr. Derryck Smith, Chair of Physicians Advisory Council, Dying with Dignity Canada).

80 PDAM, *Evidence*, 2 February 2016, 1735 (Smith).

81 PDAM, *Evidence*, 18 January 2016, 1415 (Klineberg).

82 PDAM, *Evidence*, 26 January 2016, 1835 (Gibson); PDAM, *Evidence*, 1 February 2016, 1100 (Pastine).

83 PDAM, *Evidence*, 26 January 2016, 1810 (Pelletier).

84 PDAM, *Evidence*, 3 February 2016 (Mary Shariff, Associate Professor of Law and Associate Dean Academic, University of Manitoba, Canadian Paediatric Society).

In contrast, Dr. Derryck Smith, Chair of the Physicians Advisory Council of Dying with Dignity Canada who was head of psychiatry at Vancouver's Children's Hospital for 30 years, argued for a competence-based approach, saying:

I have worked with many teenagers over the years and I have worked with a number who have been facing death, and I think they would be competent in the legal sense to consent to physician-assisted dying as they would be legally competent to agree to other kinds of medical care.

...Why would we want teenagers to suffer, but we're prepared to relieve adults of suffering?⁸⁵

Other witnesses such as Margaret Birrell, President of the Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society, and Dr. John Soles, President of the Society of Rural Physicians of Canada, were open to minors possibly having access, but felt that this should not be allowed at the present time.⁸⁶ Dr. Hartley Stern, Executive Director and CEO of the Canadian Medical Protective Association, said that if "mature minors" are to be entitled to MAID, clarification is needed as to how their competency will be assessed.⁸⁷ Quebec's *An Act respecting end-of-life care* restricts "medical aid in dying" to "a person of full age."⁸⁸

The Committee understands the concerns of many witnesses regarding the capacity of minors to understand the implications of such a serious decision. However, it is important to remember, as noted in the External Panel's report, that the Supreme Court has stated that minors have a right "to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding."⁸⁹ Allowing competent minors access to MAID would not be eliminating the requirement for competence. Given existing practices with respect to mature minors in health care⁹⁰ and the obvious fact that minors

85 PDAM, *Evidence*, 2 February 2016, 1815 (Smith).

86 PDAM, *Evidence*, 4 February 2016, 1730 (Margaret Birrell, President, Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society); 4 February 2016, 1900 (Dr. John Soles, President, Society of Rural Physicians of Canada).

87 PDAM, *Evidence*, 4 February 2016, 1915 (Dr. Hartley Stern, Executive Director and CEO, The Canadian Medical Protective Association).

88 *An Act respecting end-of-life care*, section 5.

89 [A.C. v. Manitoba \(Director of Child and Family Services\)](#), 2009 SCC 30, para. 69.

90 In [A.C. v. Manitoba \(Director of Child and Family Services\)](#), 2009 SCC 30, the Supreme Court of Canada discusses the ability of minors to consent to medical treatment in the context of protective legislation that allows a court to authorize treatment for a child when it deems it to be in the child's best interest. At para. 46, Justice Abella (for the majority) states:

The latitude accorded to adults at common law to decide their own medical treatment had historically narrowed dramatically when applied to children. However the common law has more recently abandoned the assumption that all minors lack decisional capacity and replaced it with a general recognition that children are entitled to a degree of decision-making autonomy that is reflective of their evolving intelligence and understanding. This is known as the common law "mature minor" doctrine. As the Manitoba Law Reform Commission noted, this doctrine is "a well-known, well-accepted and workable principle which ... raise[s] few difficulties on a day-to-day basis" (*Minors' Consent to Health Care* (1995), Report #91, at p. 33). The doctrine addresses the concern that young people should not automatically be deprived of the right to make decisions affecting their medical treatment. It provides instead that the right to make those decisions varies in accordance with the young person's level of maturity, with the degree to which maturity is scrutinized intensifying in accordance with the severity of the potential consequences of the treatment or of its refusal.

can suffer as much as any adult, the Committee feels that it is difficult to justify an outright ban on access to MAID for minors. As with issues of mental health, by instituting appropriate safeguards, health care practitioners can be relied upon to identify appropriate cases for MAID and to refuse MAID to minors that do not satisfy the criteria.

The Committee acknowledges that a competent mature minor who has a grievous and irremediable medical condition should not be forced to endure intolerable suffering. Moreover, there are serious questions whether a restriction of the right to MAID only to competent adults would be consistent with the Charter. However, the Committee realizes that witnesses and briefs received were of differing opinions on the subject of extending the right to MAID to mature minors, and that these differences reflect a divergence of opinion among the Canadian public. After reflecting on the issue, the Committee recommends the following:

RECOMMENDATION 6

That the Government of Canada implement a two-stage legislative process, with the first stage applying immediately to competent adult persons 18 years or older, to be followed by a second stage applying to competent mature minors, coming into force at a date no later than three years after the first stage has come into force; and

That the Government of Canada immediately commit to facilitating a study of the moral, medical and legal issues surrounding the concept of “mature minor” and appropriate competence standards that could be properly considered and applied to those under the age of 18, and that this study include broad-based consultations with health specialists, provincial and territorial child and youth advocates, medical practitioners, academics, researchers, mature minors, families, and ethicists before the coming into force of the second stage.

E. Advance Request

The *Carter* decision dealt with plaintiffs who would remain competent while they faced significant physical decline. It did not address whether an individual who is not competent at the time of death could identify the circumstances in which he or she would choose MAID in advance. With respect to advance requests for MAID, witnesses and briefs outlined diverging opinions, from recommending not to allow such requests, to allowing them only after an individual is diagnosed, to allowing advance requests to be written prior to any illness. There was general agreement however that, if requests are to be allowed in advance, the individual must be competent at the time the advance request is drafted.

An advance request could be considered in three different situations:

- where a person’s request has been accepted but the individual loses competence before MAID takes place;

- where a person has been diagnosed with a grievous and irremediable condition but is not yet experiencing enduring and intolerable suffering; and
- prior to diagnosis.

Professor Downie recommended that advance requests be permitted in the first two cases, but not the third. She argued that advance requests prevent the suffering of someone who has been approved for MAID but then loses competence and must continue to suffer. It also prevents individuals from ending their lives earlier than they would otherwise in order to avoid losing competence before the suffering becomes intolerable, something which was a major factor in the *Carter* case.⁹¹ Finally, an advance request allows the process to be undertaken before the suffering is enduring and intolerable. Otherwise, the person would have to continue to endure the suffering during the processing of the request and any waiting period.⁹² Linda Jarrett and the Hon. Steven Fletcher, both living with disabilities, also told the Committee they believed advance requests should be respected.⁹³ Other witnesses also voiced support for advance requests.⁹⁴ Wanda Morris, outgoing CEO of Dying with Dignity Canada, argued in a similar vein to Professor Downie:

In their decision, the Supreme Court justices wrote that to force someone to choose between undergoing a premature, perhaps violent, death and enduring prolonged suffering is a cruel choice. We submit that unless the committee recommends that informed consent be allowed by advance consent, the injustice will continue.

Nowhere does this play out more than around the issue of dementia....

I think that what we do will actually be life-affirming if we are able to provide a clear advance consent mechanism.⁹⁵

Ms. Morris explained that objective, verifiable criteria must be included in any such request to assist a health care team in assessing whether the criteria outlined in the advance request have been satisfied. As examples, she listed being bedridden, being unable to feed, wash or shave oneself or being unable to speak for 30 days or more. The same safeguards for a contemporaneous request must be in place for an advanced request to confirm informed consent and capacity.⁹⁶

91 *Carter*, 2015, para. 57-58.

92 PDAM, *Evidence*, 28 January 2016, 1850 (Downie).

93 PDAM, *Evidence*, 28 January 2016, 1735 (Jarrett); 1805 (Fletcher).

94 See, for example, PDAM, *Evidence*, 1 February 2016, 1105 (Paterson); PDAM, *Evidence*, 4 February 2016, 1655 (Angus Gunn, Counsel, Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society); Centre for Israel and Jewish Affairs, *Brief for the Special Joint Committee on Physician-Assisted Dying*, submission to the Committee, p. 4-5.

95 PDAM, *Evidence*, 1 February 2016, 1120 (Morris).

96 *Ibid.*, 1155.

Jean-Pierre Ménard, representing the Barreau du Québec, noted that the panel of legal experts appointed by Quebec's government, of which he was a member, recommended allowing advance requests but that the legislation adopted in Quebec does not permit them for MAID. He explained that there were a number of questions that were raised about how to assess competence at the time an advance request is made: whether the individual would fully understand the decisions being made; how to know whether the individual had changed his or her mind; and whether a third party could act against the interests of the patient. He concluded that there was much debate, with valid arguments on both sides, and that a decision was made in Quebec to prioritize protection of the vulnerable.⁹⁷

Jay Cameron from the Justice Centre for Constitutional Freedoms expressed concerns that advance requests could result in abuse if a patient becomes incompetent and that it would not be possible to verify if the request was made under duress. He also argued that it is too difficult to know how one will feel once in a changed state, such as when one is experiencing the symptoms of dementia.⁹⁸ Michael Bach, Executive Vice-President of the Canadian Association for Community Living, argued that the requirement for the suffering of the patient to be intolerable "in the circumstances of his or her condition" bars the use of advance requests.⁹⁹ Similarly, Prof. Trudo Lemmens from the Faculty of Law and Dalla Lana School of Public Health at the University of Toronto expressed concern in written submissions after his appearance before the Committee. He felt that someone with dementia who is still enjoying life could end up dying by MAID because he or she met the criteria related to suffering, such as not recognizing family members, that was included in his or her advance request for MAID.¹⁰⁰

Dr. Jeff Blackmer, Vice-President, Medical Professionalism at the Canadian Medical Association noted that the organization had not consulted its membership on the issue of advance requests because the issue was not addressed in *Carter*. However, he did say that implementing advance directives 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."¹⁰¹ Dr. Douglas Grant, Registrar and CEO of the College of Physicians and Surgeons of Nova Scotia, without taking a position on whether advance requests should be permitted, also noted that "a myriad of new issues" would need to be addressed if such requests were permitted.¹⁰²

97 PDAM, *Evidence*, 25 January 2016, 1255 (Ménard).

98 PDAM, *Evidence*, 1 February 2016, 1205 (Jay Cameron, Barrister and Solicitor, Justice Centre for Constitutional Freedoms).

99 PDAM, *Evidence*, 4 February 2016, 1925 (Bach). See also, for example, PDAM, *Evidence*, 4 February 2016, 1930 (Gerald Chipeur, Lawyer, As an Individual).

100 Trudo Lemmens, *Response to Comments Made During the Committee Hearings of January 28, 2016*, 2 February 2016, submission to the Committee.

101 PDAM, *Evidence*, 27 January 2016, 1750 (Blackmer).

102 PDAM, *Evidence*, 2 February 2016, 1925 (Grant). See also, for example, PDAM, *Evidence*, 3 February 2016, 1850 (Rajji).

The Committee understands these challenges but is deeply concerned that by excluding individuals who want access to MAID but have lost competence, such individuals will be left to suffer or end their lives prematurely. This situation was exactly what the *Carter* decision sought to avoid. Allowing advance requests also provides comfort to individuals, reducing their psychological suffering, knowing that their lives will not end in a way that is against their wishes.¹⁰³ Limiting the option of advance directives to individuals who already have a diagnosis makes it easier to ascertain that there was informed consent. At that point, the person knows more about what he or she may expect in the future to provide relevant direction in the request. The same safeguards to ensure competence and consent must be in place for advance requests, and consideration could be given to additional safeguards. Thought should be given to encouraging and possibly requiring health care practitioners to communicate regularly with their patients while they are still competent to ensure that their advance requests continue to reflect their wishes. The concerns of Dr. Blackmer, Dr. Grant and others will need to be examined as the system is put in place to minimize the risk of abuse and error, but the Committee is confident that this can and must be done to ensure the autonomy of Canadians and the protection of the vulnerable. The Committee therefore recommends:

RECOMMENDATION 7

That the permission to use advance requests for medical assistance in dying be allowed any time after one is diagnosed with a condition that is reasonably likely to cause loss of competence or after a diagnosis of a grievous or irremediable condition but before the suffering becomes intolerable. An advance request may not, however, be made, prior to being diagnosed with such a condition. The advance request is subject to the same procedural safeguards as those in place for contemporaneous requests.

F. Residency Requirement

Few witnesses discussed the issue of residency as an eligibility requirement for MAID, either before the External Panel or this committee. Prof. Ells argued for eligibility based on eligibility for publicly funded health care services in the province or territory where the request is made. MAID should occur in the context of a patient-physician relationship and the Committee does not want Canada to become a destination for people seeking MAID. For this reason, the Committee recommends:

RECOMMENDATION 8

That medical assistance in dying be available only to insured persons eligible for publicly funded health care services in Canada.

103 Provincial-Territorial Report, p. 31.

THE PROCESS INVOLVED IN REQUESTING MEDICAL ASSISTANCE IN DYING

The majority of witnesses noted that the process for applying for MAID should have built-in safeguards to identify vulnerable individuals and ensure that an individual meets the eligibility criteria. Witnesses agreed that the request has to come from the person seeking MAID; the request cannot be made by a substitute decision maker. The Committee also agrees and wishes to recognize that witness testimony was invaluable for the Committee's deliberations and consideration of appropriate safeguards.

There was general agreement that there should be a process appropriately documenting a person's request for MAID, that when possible, the request should be made in writing (with alternatives if a person cannot write) and witnessed by someone who has no possible conflict of interest. The person should also be given the opportunity to rescind his or her request. The Committee agrees with these suggestions as well.

The Committee believes that where possible the request should be made in writing, and that it should be witnessed by two people who have no conflict of interest. The Committee therefore recommends:

RECOMMENDATION 9

That the Government of Canada work with the provinces and territories and their medical regulatory bodies to ensure that, where possible, a request for medical assistance in dying is made in writing and is witnessed by two people who have no conflict of interest.

A. Conscientious Objection to Participating in Medical Assistance in Dying

The External Panel's report noted that "the medical profession is divided over the issue of MAID."¹⁰⁴ Many witnesses who appeared before the Committee, and briefs/letters that were submitted to the Committee, discussed the extent to which health care practitioners should be able to refuse to participate in MAID for reasons of conscience.¹⁰⁵ No one was of the opinion that a health care practitioner should be obliged to perform MAID. As the Supreme Court of Canada stated in *Carter*, "[i]n our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying."¹⁰⁶

It was argued by some witnesses that strong protections for health care practitioners who refuse to participate for reasons of conscience need to be put in place, including the possibility that such protection be established in legislation.¹⁰⁷

104 External Panel Report, p. 98.

105 The issue of freedom of conscience of pharmacists was raised by the Canadian Pharmacists Association (CPhA), PDAM, *Evidence*, 27 January 2016 (Phil Emberley, Canadian Pharmacists Association).

106 *Carter*, 2015, para. 132.

107 See for example, PDAM, *Evidence*, 27 January 2016, 1725 (Branigan); PDAM, *Evidence*, 3 February 2016, 1905 (Hashmi); 1705 (Collins); *Letter to Minister Wilson-Raybould and Minister Philpott*, Canadian Conference of Catholic Bishops, 20 January 2016.

Other witnesses were concerned about the effect a practitioner's refusal to participate in MAID would have both on the individual who was seeking an assisted death and on the availability of MAID more broadly. As Vyda Ng from the Canadian Unitarian Council told the Committee, "[i]t's very much in keeping with Canadian values to put the needs and wishes of Canadians ahead of the values of individual doctors and institutions, and to respect each person's dignity at the most traumatic period of their lives."¹⁰⁸ Some witnesses and submissions to the Committee recommended that a practitioner who conscientiously objects to MAID should be required to provide an effective referral or transfer of care for their patient,¹⁰⁹ while some felt that referring the individual to a third-party organization should be sufficient.¹¹⁰ Joanne Klineberg from the Department of Justice noted that provinces and territories "have legislation and policies in relation to the rights of physicians to refuse to partake in certain types of medical practices, so it is definitely something that the provinces and territories already are responsible for."¹¹¹ In Quebec, a physician must notify a designated individual if he or she refuses to participate in MAID so that a willing physician may be identified.¹¹²

The Committee notes that the Supreme Court of Canada in *Carter* stated that the Charter rights of patients and physicians will need to be reconciled.¹¹³ The Committee believes that having health care professionals who conscientiously object to MAID provide an effective referral for a patient who seeks MAID is an appropriate balancing of the rights of patients and the conscience rights of physicians. The Committee therefore recommends:

RECOMMENDATION 10

That the Government of Canada work with the provinces and territories and their medical regulatory bodies to establish a process that respects a health care practitioner's freedom of conscience while at the same time respecting the needs of a patient who seeks medical assistance in dying. At a minimum, the objecting practitioner must provide an effective referral for the patient.

Witnesses and briefs also addressed whether a health care facility should be permitted to refuse to either provide MAID or to allow MAID to be provided on its premises. One witness told the Committee that in Quebec, hospices (which the witness stated are largely privately funded) sought and received an exemption from having to provide

108 PDAM, *Evidence*, 3 February 2016, 1705 (Ng).

109 See for example, PDAM, *Evidence*, 26 January 2016, 1900 (Gibson); PDAM, *Evidence*, 1 February 2016, 1125 (Morris); Rhonda Morison, Submission to the Committee, 30 January 2016.

110 PDAM, *Evidence*, 1 February 2016, 1105 (Paterson); submission to the Committee, *Vivre dans la Dignité*, 2016; Ellen Agger, submission to the Committee, 1 February 2016.

111 PDAM, *Evidence*, 18 January 2016, 1535 (Klineberg).

112 *An Act Respecting End-of-Life Care*, RSQ c S-32.0001, section 31.

113 *Carter*, 2015, para. 132.

MAID.¹¹⁴ A number of witnesses argued, and the Committee also believes, that if a health care facility is publicly funded, it must provide MAID.¹¹⁵ The difficulty in transferring a patient from one facility to another was highlighted.¹¹⁶

The Committee recommends therefore:

RECOMMENDATION 11

That the Government of Canada work with the provinces and territories to ensure that all publicly funded health care institutions provide medical assistance in dying.

B. Assessments

A number of witnesses maintained that a person who seeks MAID should be assessed by at least two physicians to verify that he or she meets the eligibility criteria.¹¹⁷ The External Panel Report explained that “[e]very jurisdiction that has enacted legislation permitting assisted dying requires that a second physician (often called a ‘consulting physician’) confirm the attending physician’s approval of a request.”¹¹⁸ Other witnesses felt that to always require two assessments was unnecessary and could act as a barrier to access; and that in the scope of normal medical practice, a physician or other health care provider would seek out a second opinion as needed.¹¹⁹ In situations where MAID was being sought primarily due to grievous and irremediable suffering caused by a psychiatric disorder, a consultation with a psychiatrist was recommended by some witnesses. Other witnesses argued that a vulnerability assessment should occur.¹²⁰ Carmela Hutchison, President of DisAbleD Women’s Network of Canada, told the Committee that “[w]omen with disabilities need to have had a consultation with peer support groups before being eligible for physician-assisted death.”¹²¹

The Committee strongly believes that having two physicians who are independent of one another carry out two assessments to ensure that the MAID eligibility criteria are met will protect people who may be vulnerable. Considering the need to ensure that the MAID eligibility criteria are met, the Committee recommends therefore:

114 PDAM, *Evidence*, 2 February 2016, 1845 (Baxter).

115 See for example, PDAM, *Evidence*, 3 February 2016, 1700 (Ng); British Columbia Humanist Association, *Allow assisted dying for all who choose it: A brief for the Special Joint Committee on Physician-Assisted Dying*, 25 January 2016; Lori Goodwin, submission to the Committee, 30 January 2016.

116 PDAM, *Evidence*, 2 February 2016, 1850 (Baxter).

117 PDAM, *Evidence*, 27 January 2016, 1745 (Forbes); 1750 (Birrell); 1900 (Soles) 1 February 2016, 1245 (Dr. Francine Lemire, College of Family Physicians of Canada).

118 External Panel Report, p. 79.

119 See for example, PDAM, *Evidence*, 28 January 2016, 1920 (Downie).

120 PDAM, *Evidence*, 4 February 2016, 1950 (Bach); PDAM, *Evidence*, 28 January 2016, 1750 (Richert). David Baker and Gilbert Sharpe also note in their draft bill that a patient deemed to be vulnerable should have counselling.

121 PDAM, *Evidence*, 4 February 2016, 1640 (Hutchison).

RECOMMENDATION 12

That the Government of Canada work with the provinces and territories, and their medical regulatory bodies to establish that a request for medical assistance in dying can be carried out only if two physicians who are independent of one another have determined that the person meets the eligibility criteria for medical assistance in dying.

C. Who Should Provide Medical Assistance in Dying?

Defining which health care professionals can perform MAID is an essential part of the discussion, as those involved will require an exemption from the *Criminal Code* provisions that currently prohibit MAID (sections 14 and 241(b)). Under Quebec's *An Act Respecting End-of-Life Care*, only physicians may provide what is referred to in the law as "medical aid in dying." While for the most part it was agreed that physicians were well-placed to perform MAID, a number of witnesses advocated for nurse practitioners to be able to perform MAID, particularly in regions that have limited access to physicians. It was also recommended that registered nurses and physician assistants, working under the direction of a physician or a nurse practitioner, be able to provide MAID.¹²² In such cases, telemedicine could be used to carry out any physician or specialist consultations. The Committee shares these concerns regarding access.

Some witnesses suggested the need for a defined and regulated medical subspecialty for those physicians who can practice MAID.¹²³ The Committee is concerned that such a system would affect access.

Regardless of who performs MAID, the Committee recognizes the need for training, particularly with respect to identifying vulnerabilities, as was highlighted by a number of witnesses.¹²⁴

Taking into account the limited access that people living in rural and remote regions of Canada may have to a physician, to ensure access to MAID across Canada, the Committee recommends:

122 See for example PDAM, *Evidence*, 1 February 2016, 1100 (Paterson); PDAM, *Evidence*, 2 February 2016, 1745 (Eills); PDAM, *Evidence*, 3 February 2016, 1755 (Ng); Provincial-Territorial Report.

123 PDAM, *Evidence*, 4 February 2016, 1705 (Somerville); Constant H. Leung, submission to the Committee: *Physician Hastened Death: Seeking Substantive Safeguards and Effective Access for All Canadians*, 1 February 2016.

124 See for example PDAM, *Evidence*, 25 January 2016, 1110 (Abby Hoffman, Assistant Deputy Minister, Strategic Policy, Department of Health); PDAM, *Evidence*, 26 January 2016, 1915 (Gibson); PDAM, *Evidence*, 27 January 2016, 1725 (Branigan).

RECOMMENDATION 13

That physicians, nurse practitioners and registered nurses working under the direction of a physician to provide medical assistance in dying be exempted from sections 14 and section 241(b) of the *Criminal Code*.

Pharmacists and other health care practitioners who provide services relating to medical assistance in dying, should also be exempted from sections 14 and section 241(b) of the *Criminal Code*.

The Canadian Nurses Protective Society also recommended amending section 241(a) of the *Criminal Code* to protect nurses and other health care professionals who “engage in discussions with patients about end-of-life options and wishes.”¹²⁵

The majority of testimony focused on physicians. However, it should be understood, as per the recommendation above, that the Committee supports nurse practitioners, as well as registered nurses working under the direction of a physician, providing MAID as well.

D. Waiting or Reflection Period

There was a great deal of variation in submissions with respect to the concept of a mandatory waiting or “reflection period between the time of the request and the provision of MAID.”¹²⁶ Some witnesses felt that a fixed waiting period is required, while others felt that the waiting period should be flexible, based in part on a person’s prognosis.¹²⁷ In particular, it was felt that a waiting period should be required in cases of traumatic injury where a person might still be adjusting to a new condition. Professor Downie claimed that in such situations, a waiting period would not be helpful anyway, as an individual would likely not have the capacity to provide an informed consent, and would therefore not meet the eligibility criteria.¹²⁸ The External Panel Report noted that “most groups were of the view that a certain degree of flexibility in the waiting period is necessary.”¹²⁹ The Committee notes that the waiting periods indicated in various provincial college of physician and surgeon guidelines vary.

The Committee agrees that any waiting period must be flexible, and firmly believes that attending physicians are best placed to determine what an appropriate period of reflection would be, taking into account the patient’s medical condition and any circumstances that may be unique to that patient. For that reason, the Committee recommends:

125 Submission, *Re Canadian Nurses Protective Society Submission on Physician-Assisted Death*.

126 See for example, PDAM, *Evidence*, 28 January 2016, 1835 (Fletcher).

127 See for example, PDAM, *Evidence*, 27 January 2016, 1735 (Blackmer); 1720 (Branigan).

128 PDAM, *Evidence*, 28 January 2016, 1910 (Downie).

129 External Panel Report, p. 90.

RECOMMENDATION 14

That the Government of Canada work with the provinces and territories, and their medical regulatory bodies to ensure that any period of reflection for medical assistance in dying that is contained in legislation or guidelines is flexible, and based, in part, on the rapidity of progression and nature of the patient’s medical condition as determined by the patient’s attending physician.

E. Prior Review of Medical Assistance in Dying Requests

Some witnesses recommended that to ensure that eligibility criteria are met, the MAID request should be reviewed by some type of panel or a judge.¹³⁰ Other witnesses opposed the idea of any prior review of a request for MAID for a number of reasons, including that such prior review “is not a safeguard, it is a barrier.”¹³¹ The Hon. Steven Fletcher stated that if there is a panel to approve requests, “you might as well have kept the law the way it is, because the end result is the same. People would not be able to access physician-assisted death, they’ll take the actions on their own, and they will suffer in the interim.”¹³² The External Panel Report listed three prior review options that were put forward by stakeholders they consulted: prior judicial authorization, prior authorization by administrative tribunal, and a MAID panel.¹³³

The Committee agrees that requiring a review by either a panel or a judge would create an unnecessary barrier to individuals requesting MAID. The Committee recommends therefore:

RECOMMENDATION 15

That the Government of Canada work with the provinces and territories, and their medical regulatory bodies to ensure that the process to regulate medical assistance in dying does not include a prior review and approval process.

F. Ancillary Considerations

The Committee wishes to highlight the need to ensure that health care professionals who are acting in good faith are protected from civil liability, as well as the need to ensure that the estates of individuals whose immediate cause of death was MAID are protected. The Committee feels strongly that MAID should not affect life insurance.

130 PDAM, *Evidence*, 4 February 2016, 1700 (Somerville); PDAM, *Evidence*, 4 February 2016, 1935 (Chipeur); Baker et al (2016).

131 See for example, PDAM, *Evidence*, 1 February 2016, 1120 (Morris); PDAM, *Evidence*, 1 February 2016, 1240 (Lemire).

132 PDAM, *Evidence*, 28 January 2016, 1810 (Fletcher).

133 External Panel Report, pp. 93-95.

These issues need to be considered by the provinces and territories as they move towards establishing MAID frameworks within their jurisdictions.

Some witnesses noted that Indigenous organizations and communities had not been involved in discussions relating to MAID, and that such conversations would need to take place as the legislative process unfolds, taking into account the need to be respectful of cultural differences and sensitivities to MAID that may be present in communities afflicted with high rates of suicide.¹³⁴

The Canadian Pharmacists' Association highlighted the need to ensure that the drugs recommended for use in MAID are available in Canada, and not subject to a manufacturer back order.¹³⁵ The College of Physicians and Surgeons of Nova Scotia also cautioned that "there needs to be a robust system for the return of unused medication, and the college would welcome that this system be mandated through legislation."¹³⁶

OVERSIGHT OF THE MEDICAL ASSISTANCE IN DYING PROCESS: REPORTING REQUIREMENTS AND DATA COLLECTION

Oversight as it was referred to by witnesses can include reviewing specific cases of MAID, as well as reviewing the MAID framework more broadly. Many witnesses stated that oversight of MAID was critical, and many expressed the opinion that this oversight should occur at the federal level. Oversight was seen as desirable for a number of reasons, including that "it would safeguard good processes,"¹³⁷ and that it would provide "a pan-Canadian way of ensuring that everybody has access to this service."¹³⁸ Joanne Klineberg from the Department of Justice explained to the Committee that representations to the External Panel suggested "that monitoring at a national level would be especially important because otherwise you could have 13 different bodies monitoring and it may become especially cumbersome."¹³⁹ Prof. Pelletier from the External Panel stated that:

[t]he idea of oversight is quite reassuring for the population. The population likes to know that there might be a body or different bodies collecting data and analyzing how physician-assisted dying is provided all across Canada, and maybe doing some study on the impact that it has on human rights in general.¹⁴⁰

134 PDAM, *Evidence*, 2 February 2016, 1915 (Dr. Alika Lafontaine, Indigenous Physicians Association of Canada); PDAM, *Evidence*, 1 February 2016, 1635 (Carrie Bourassa, First Nations University of Canada, as an individual).

135 PDAM, *Evidence*, 27 January 2016, 1950 (Carlo Berardi, Canadian Pharmacists Association).

136 PDAM, *Evidence*, 2 February 2016, 1930 (Grant).

137 PDAM, *Evidence*, 3 February 2016, 1705 (Ng).

138 PDAM, *Evidence*, 27 January 2016, 1710 (Branigan).

139 PDAM, *Evidence*, 18 January 2016, 1445 (Klineberg).

140 PDAM, *Evidence*, 26 January 2016, 1810 (Pelletier).

Professor Downie suggested to the Committee that two levels of oversight would be needed: a retrospective case review and oversight of the regulatory framework itself.¹⁴¹ Jay Cameron recommended that “federal legislation should mandate a parliamentary review board every three to five years to review the physician-assisted suicides that have occurred, and make recommendations for legislative amendments.”¹⁴²

The Committee recognizes the importance of having an oversight mechanism that will compile data and analyze medical assistance in dying cases to monitor the operation of the medical assistance in dying framework and to identify any potential areas that require refinement. For that reason, the Committee recommends:

RECOMMENDATION 16

That Health Canada lead a cooperative process with the provinces and territories creating and analyzing national reports on medical assistance in dying cases, and that such reports be compiled on an annual basis and tabled in Parliament. Such reports must ensure respect for the privacy of affected individuals.

RECOMMENDATION 17

That a mandatory statutory review of the applicable federal legislation be conducted by the appropriate committee(s) of the House of Commons and of the Senate every four years after the coming into force of the applicable federal legislation.

IMPROVED SUPPORTS AND SERVICES

The Committee agrees with the witnesses and written submissions that highlighted the need for improved supports and services to accompany implementation of MAID, particularly for individuals with disabilities, mental health conditions and/or socioeconomic challenges.¹⁴³

A. Support for Indigenous Peoples and Communities

Both Professor Carrie Bourassa, Indigenous Health Studies, First Nations University of Canada and Dr. Alika Lafontaine, President of the Indigenous Physicians Association of Canada, emphasized the need to ensure that work in Indigenous communities is culturally appropriate and recognizes the systemic issues and power imbalances between patients and health care workers as well.¹⁴⁴ Keeping these remarks in mind, the Committee recommends:

141 PDAM, *Evidence*, 28 January 2016, 1850 (Downie).

142 PDAM, *Evidence*, 1 February 2016, 1115 (Cameron).

143 See, for example, 28 January 2016, 1830 (Richert); 1855 (Lemmens).

144 PDAM, *Evidence*, 1 February 2016, 1715 (Bourassa); PDAM, *Evidence*, 2 February 2016, 1910 (Lafontaine).

RECOMMENDATION 18

That the Government of Canada work with the provinces and territories, and their medical regulatory bodies to ensure that culturally and spiritually appropriate end-of-life care services, including palliative care, are available to Indigenous patients.

B. Palliative Care

Though statistics on access to palliative care are incomplete and out-of-date according to witnesses, it is fair to say that many Canadians do not have access to high quality palliative care when they need it. All witnesses who addressed the issue agreed that Canada could and needs to do more in this area, as does the Committee. The Committee was pleased to hear from Abby Hoffman, Assistant Deputy Minister, Strategic Policy, Department of Health, that planned investments in home care services will include support for palliative care, but the Committee feels that more can be done.¹⁴⁵ For this reason, the Committee makes the following recommendations:

RECOMMENDATION 19

That Health Canada re-establish a Secretariat on Palliative and End-of-Life Care; and that Health Canada work with the provinces and territories and civil society to develop a flexible, integrated model of palliative care by implementing a pan-Canadian palliative and end-of-life strategy with dedicated funding, and developing a public awareness campaign on the topic.

C. Mental Health

As noted above, teasing out the impact of mental health issues on requests for MAID will be a challenging aspect of implementation for health care practitioners. Additional services and supports may be needed to assess whether individuals with psychiatric conditions satisfy the requirements for MAID. For this reason, the Committee recommends:

RECOMMENDATION 20

That the Government of Canada support the pan-Canadian mental health strategy, *Changing Directions, Changing Lives*, developed by the Mental Health Commission of Canada and work with the provinces, territories and civil society to ensure that appropriate mental health supports and services are in place for individuals requesting medical assistance in dying.

145 PDAM, *Evidence*, 25 January 2016, 1105 (Hoffman).

D. Dementia

Witnesses also outlined the difficulties experienced by individuals with various forms of dementia and their families, the care required and the low quality of life experienced by many in the later stages of such conditions. The Alzheimer Society called for a national dementia strategy to address the needs of our growing population faced with these conditions.¹⁴⁶ The Committee agrees and recommends:

RECOMMENDATION 21

That Health Canada and the Public Health Agency of Canada work with the provinces, territories and civil society organizations to develop a pan-Canadian strategy to improve the quality of care and services received by individuals living with dementia, as well as their families.

146 PDAM, *Evidence*, 1 February 2016, 1230 (Mimi Lowi-Young, CEO, Alzheimer Society of Canada).

LIST OF RECOMMENDATIONS

RECOMMENDATION 1

That the terms relating to medical assistance in dying do not require further statutory definition.....11

RECOMMENDATION 2

That medical assistance in dying be available to individuals with terminal and non-terminal grievous and irremediable medical conditions that cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition. 13

RECOMMENDATION 3

That individuals not be excluded from eligibility for medical assistance in dying based on the fact that they have a psychiatric condition..... 15

RECOMMENDATION 4

That physical or psychological suffering that is enduring and intolerable to the person in the circumstances of his or her condition should be recognized as a criterion to access medical assistance in dying. 15

RECOMMENDATION 5

That the capacity of a person requesting medical assistance in dying to provide informed consent should be assessed using existing medical practices, emphasizing the need to pay particular attention to vulnerabilities in end-of-life circumstances. 18

RECOMMENDATION 6

That the Government of Canada implement a two-stage legislative process, with the first stage applying immediately to competent adult persons 18 years or older, to be followed by a second stage applying to competent mature minors, coming into force at a date no later than three years after the first stage has come into force; and

That the Government of Canada immediately commit to facilitating a study of the moral, medical and legal issues surrounding the concept of “mature minor” and appropriate competence standards that could be properly considered and applied to those under the age of 18, and that this study include broad-based consultations with health specialists, provincial and territorial child and youth advocates, medical practitioners, academics, researchers, mature minors, families, and ethicists before the coming into force of the second stage..... 21

RECOMMENDATION 7

That the permission to use advance requests for medical assistance in dying be allowed any time after one is diagnosed with a condition that is reasonably likely to cause loss of competence or after a diagnosis of a grievous or irremediable condition but before the suffering becomes intolerable. An advance request may not, however, be made, prior to being diagnosed with such a condition. The advance request is subject to the same procedural safeguards as those in place for contemporaneous requests. 24

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That medical assistance in dying be available only to insured persons eligible for publicly funded health care services in Canada. 24

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APPENDIX A LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
<p>Department of Justice</p> <p>Jeanette Ettel, Senior Counsel Human Rights Law Section</p> <p>Joanne Klineberg, Senior Counsel Criminal Law Policy Section</p>	2016/01/18	2
<p>Barreau du Québec</p> <p>Jean-Pierre Ménard, Lawyer</p> <p>Marc Sauvé, Director Research and Legislation Services</p>	2016/01/25	3
<p>Department of Health</p> <p>Sharon Harper, Manager Chronic and Continuing Care Division</p> <p>Abby Hoffman, Assistant Deputy Minister Strategic Policy</p>		
<p>As an individual</p> <p>Peter Hogg, Scholar in Residence Blake, Cassels & Graydon LLP</p>		
<p>External Panel on Options for a Legislative Response to <i>Carter v. Canada</i></p> <p>Stephen Mihorean, Executive Director Secretariat</p> <p>Benoît Pelletier, Member External Panel</p>	2016/01/26	5
<p>Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying</p> <p>Jennifer Gibson, Co-Chair</p> <p>Maureen Taylor, Co-Chair</p>		
<p>Canadian Medical Association</p> <p>Dr. Jeff Blackmer, Vice-President Medical Professionalism</p> <p>Dr. Cindy Forbes, President</p>	2016/01/27	6
<p>Canadian Nurses Association</p> <p>Josette Roussel, Senior Nurse Advisor</p> <p>Anne Sutherland Boal, Chief Executive Officer</p>		

Organizations and Individuals	Date	Meeting
<p>Canadian Pharmacists Association</p> <p>Carlo Berardi, Chair Phil Emberley, Director Professional Affairs</p>	2016/01/27	6
<p>Canadian Psychiatric Association</p> <p>Dr. K. Sonu Gaind, President Katie Hardy, Director Professional and Member Affairs</p>		
<p>Canadian Society of Palliative Care Physicians</p> <p>Dr. Monica Branigan</p>		
<p>Council of Canadians with Disabilities</p> <p>Dean Richert, Co-Chair Ending of Life Ethics Committee Rhonda Wiebe, Co-Chair Ending of Life Ethics Committee</p>	2016/01/28	7
<p>Dying With Dignity Canada</p> <p>Linda Jarrett, Member Disability Advisory Council</p>		
<p>As individuals</p> <p>David Baker, Lawyer Bakerlaw Jocelyn Downie, Professor Faculties of Law and Medicine, Dalhousie University Hon. Steven Fletcher Trudo Lemmens, Professor Faculty of Law & Dalla Lana School of Public Health, University of Toronto</p>		
<p>Alzheimer Society of Canada</p> <p>Debbie Benczkowski, Chief Operating Officer Mimi Lowi-Young, Chief Executive Officer</p>	2016/02/01	8
<p>British Columbia Civil Liberties Association</p> <p>Grace Pastine, Litigation Director Josh Paterson, Executive Director</p>		
<p>College of Family Physicians of Canada</p> <p>Dr. Francine Lemire, Executive Director and Chief Executive Officer</p>		

Organizations and Individuals	Date	Meeting
Dying With Dignity Canada Shanaaz Gokool, Chief Operating Officer and National Campaigns Director Wanda Morris, Chief Executive Officer	2016/02/01	8
Justice Centre for Constitutional Freedoms Jay Cameron, Barrister and Solicitor		
Canadian Cancer Society Kelly Masotti, Assistant Director Public Issues Gabriel Miller, Director Public Issues	2016/02/01	9
As an individual Carrie Bourassa, Professor Indigenous Health Studies, First Nations University of Canada		
Canadian Hospice Palliative Care Association Sharon Baxter, Executive Director	2016/02/02	10
College of Physicians and Surgeons of Nova Scotia Dr. Douglas Grant, Registrar and Chief Executive Officer Marjorie Hickey, Legal Counsel		
Criminal Lawyers' Association Leo Russomanno, Member and Criminal Defence Counsel		
Dying With Dignity Canada Dr. Derryck Smith, Chair of Physicians Advisory Council		
Indigenous Physicians Association of Canada Dr. Alike Lafontaine, President		
As an individual Carolyn Ells, Associate Professor, Medicine Biomedical Ethics Unit, McGill University		
Canadian Council of Imams Imam Sikander Hashmi, Spokesperson	2016/02/03	11
Canadian Paediatric Society Dr. Dawn Davies, Chair Bioethics Committee Mary J Shariff, Associate Professor of Law and Associate Dean Academic, University of Manitoba		
Canadian Unitarian Council Vyda Ng, Executive Director		

Organizations and Individuals	Date	Meeting
<p>Centre for Addiction and Mental Health</p> <p>Dr. Tarek Rajji, Chief Geriatric Psychiatry</p> <p>Kristin Taylor, Vice-President Legal Services</p>	2016/02/03	11
<p>Coalition for HealthCARE and Conscience</p> <p>Cardinal Thomas Collins, Archbishop Archdiocese of Toronto</p> <p>Laurence Worthen, Executive Director Christian Medical and Dental Society of Canada</p>		
<p>Alliance of People with Disabilities Who Are Supportive of Legal Assisted Dying Society</p> <p>Margaret Birrell, President</p> <p>Angus M. Gunn, Counsel</p>	2016/02/04	12
<p>Canadian Association for Community Living</p> <p>Michael Bach, Executive Vice-President</p>		
<p>DisAbled Women's Network of Canada</p> <p>Carmela Hutchison, President</p>		
<p>Society of Rural Physicians of Canada</p> <p>Dr. John Soles, President</p>		
<p>The Canadian Medical Protective Association</p> <p>Dr. Hartley Stern, Executive Director and Chief Executive Officer</p>		
<p>As individuals</p> <p>Gerald Chipeur, Lawyer</p> <p>Margaret Somerville, Professor McGill University</p>		

APPENDIX B LIST OF BRIEFS

Organizations and Individuals

A Network of British Columbia Physicians

Abramson, Jana and Abramson, Kenneth

Adams, Andrew

Advance Practice Nurses of the Palliative Care Consult Service in the Calgary Zone of Alberta Health Services

Advocacy Centre for the Elderly

Agger, Ellen

Alliance for Life Ontario

Altschul, Denise

Anglican Church of Canada

Association of Registered Nurses of Prince Edward Island

Baker, David

Bennett Fox, Sara

Bracken, Susan

Brienen, Arthur-Leonard

British Columbia Civil Liberties Association

British Columbia Humanist Association

Brooks, Jeffery

Brzezicki, Barbara

Canadian Association for Community Living

Canadian Bar Association

Canadian Civil Liberties Association

Canadian Coalition for the Rights of Children

Organizations and Individuals

Canadian Conference of Catholic Bishops
Canadian Council of Imams
Canadian Federation of Nurses Unions
Canadian Medical Association
Canadian Medical Protective Association
Canadian Nurses Association
Canadian Nurses Protective Society
Canadian Paediatric Society
Canadian Pharmacists Association
Canadian Society of Palliative Care Physicians
Canadians Advocating for Ethical Hospice Palliative Care
Catholic Organization for Life and Family
Centre for Addiction and Mental Health
Centre For Inquiry Canada
Centre for Israel and Jewish Affairs
Chipeur, Gerald
Christian Legal Fellowship
Christian Reformed Churches in Canada
Clay, Pat
Clemenger, Lauren
Coalition for HealthCARE and Conscience
College of Physicians and Surgeons of British Columbia
College and Association of Registered Nurses of Alberta
College of Registered Nurses of Nova Scotia

Organizations and Individuals

Congress of Union Retirees of Canada

Congress of Union Retirees of Canada – Hamilton, Burlington and Oakville Chapter

Council of Canadians with Disabilities

DisAbled Women’s Network of Canada

Downie, Jocelyn

Dying With Dignity Canada

Dyment, Alan

Dyrholm, Joan

Eayrs, Jonathan

Euthanasia Prevention Coalition

Evans, David

Evangelical Fellowship of Canada

Farrow, Douglas

Fernihough, William

Fischer, Marilyn

Fleming, Loretta

Frazee, Catherine

Frizzell, Sue

Gobbi, Greg

Goodwin, Lori

Guichon, Juliet; Alakija, Pauline; Doig, Christopher; Mitchell, Ian; and Thibeault, Pascal

Hammond, Katherine

Hartman, James

HealthCareCAN

Organizations and Individuals

Hogan, Marcia

Holmen, Denise

Holub, Robert

Hudgins, Janet

Inch, Carolyn

Johnson, Shirley

Justice Centre for Constitutional Freedoms

Koch, Jule

Kuchta, Gay

L'Arche Canada

Lemmens, Trudo

Leung, Constant

Lindstrom, Lena

Living With Dignity

Lods, Margot

Lovell, Jane

Lydon, Patrick

Mackay, John

MacLellan, Pat

Mandel, Ezra

Maple, Doris

Marchand, Michele

Martin, Mary

Maryon, Betty

Organizations and Individuals

McPhee, Margaret

Meaney Svec, Katherine

Mental Health Commission of Canada

Morison, Rhonda

Mount, Balfour

Munroe, Pamela

Nurses Association of New Brunswick

Perks, Alan

Peterson, Heather

Physicians' Alliance against Euthanasia

Protection of Conscience Project

Rankmore, Carol

REAL Women of Canada

Registered Nurses Association of the Northwest Territories and Nunavut

Saba, Paul

Salvation Army

Santoro, Daniel and Burrell, Althea

Secular Connexion Séculière

Seeley, Patricia

Shapray, Howard

Somerville, Margaret

Spencer, Richard

Squires, Colette

Sullivan, William

Organizations and Individuals

Sumner, Wayne

Surgeon General, Canadian Forces Health Services Group

Toujours Vivant-Not Dead Yet

Underwood, Katherine

UNICEF Canada

United Church of Canada

Vandenberghe, Joris

von Fuchs, Ruth

Walker, Ken

Warren, John

Widas, Mary

Willoughby, Annette

Wilson, John

Wilson, Linda

MINUTES OF PROCEEDINGS

A copy of the relevant Minutes of Proceedings ([Meetings Nos. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16](#)) is tabled.

Respectfully submitted,

Hon. Kelvin Kenneth Ogilvie and Robert Oliphant
Joint Chairs

More Safeguards are needed for the Vulnerable

Special Joint Committee on Physician-Assisted Dying: Dissenting Report

This dissenting report reflects the views of the following Members of Parliament who served on the Special Joint Committee on Physician Assisted Dying (the “Committee”): Michael Cooper (Co-Vice Chair of the Committee, St. Albert-Edmonton), Mark Warawa (Langley-Aldergrove), and Gérard Deltell (Louis-St-Laurent), as well as, Harold Albrecht (Kitchener-Conestoga), who participated in a majority of the Committee meetings as an alternate member.

Background

On February 6, 2015 in its ruling *Carter v. Canada*, 2015 SCC 5, the Supreme Court of Canada (the “SCC”) unanimously struck down Canada’s longstanding criminal prohibition against voluntary euthanasia and assisted suicide (“physician-assisted dying or PAD”), ruling that it was in contravention of the right to life, liberty, and security of the person guaranteed under Section 7 of the *Charter of Rights and Freedoms* (the “*Charter*”). Specifically, the SCC found the *Criminal Code* prohibition against PAD to be void because it deprived:

A competent adult of such assistance where (1) the person affected clearly consents to the termination of life; and (2) the person has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.¹

The SCC has stayed its ruling until June 6, 2016 to allow Parliament to craft a legislative response.²

The Committee has been tasked by Parliament to make recommendations to the Government on how to best respond to the *Carter* decision.

Reasons for a Dissenting Report

In *Carter*, the SCC aptly described the difficult task now before Parliament: “it must weigh and balance the perspective of those who might be at risk in a permissive regime against that of those who seek assistance in dying.”³ The SCC agreed that there would be real risks to the vulnerable without a blanket proscription of PAD but that these risks could be managed “through a carefully designed and monitored system of safeguards.”⁴

Additionally, the Committee heard from many groups representing healthcare professionals, including the Canadian Medical Association, about the need to protect

¹ *Carter v. Canada*, 2015 SCC 5, at para. 4

² We note here our *significant* concern that under these timelines it will be virtually impossible to sufficiently analyze the far reaching consequences of allowing PAD in Canada. Quebec took six years and three different administrations to finally come to a model that they deemed acceptable.

³ *Carter v. Canada*, 2015 SCC 5, at para. 98

⁴ *Ibid.*, para. 117

the *Charter* rights of health professionals and health institutions that may conscientiously object to taking part in PAD.

Unfortunately, the regime recommended in the Committee's main report falls *far* short of what is necessary to protect vulnerable Canadians and the *Charter* protected conscience rights of health professionals.

Moreover, the SCC gave a reasonably straightforward roadmap for Parliament to follow in its legislative response. Regretfully, the Committee failed to adhere to the roadmap contemplated in *Carter*. On the contrary, the Committee recommends a legal framework that does not conform to *Carter*.

Taken together, we as Members of Parliament on the Committee, therefore, feel that it is our duty to our constituents, to Canadians, and to future generations to respectfully present this dissenting report.

The Quebec Experience

Quebec is the only Canadian province to have adopted a law on end of life care. The Committee's main report presents the chronology of events leading to the adoption of Quebec's legislation but omits the most important factors.

In Quebec, only patients aged 18 and older, with severe and incurable physical illnesses and whose medical condition is characterized by an advanced and irreversible decline can request medical help to die. The law does not allow for advanced directives.

The attending physician must ensure that his or her patient has clearly consented to PAD, ensuring among other things that it is not the result of external pressure; provides the patient with a full prognosis on the condition and possible treatment options, along with likely consequences. The physician must also ensure the continuation of consent with interviews with the patient held at different times, spaced by a reasonable time, having regard for the patient's condition.

Quebec physicians are free to act according to their conscience. If they do not want to proceed, they must refer the patient to an independent body which will contact another physician. Two independent physicians must confirm that the patient meets all the criteria prescribed by the subject legislation.

The work leading to the adoption of the law took place over a period of six years under three different legislatures in a non-partisan working process. Ultimately, the legislation was passed in a free vote of members of the National Assembly: 94 members voted in favor of the legislation and 22 against. All votes against were from members of the governing party, including 11 cabinet ministers.

Overall, we acknowledge that the Quebec experience is a result of a careful, thoughtful and serious approach that better respects individual autonomy and better protects vulnerable persons than the proposal set out in the main report of the Committee.

The Committee’s Report Fails to Respect *Carter*

The *Carter* decision is the law of the land. Any legislative response must adhere to the parameters set out in *Carter*. Unfortunately, the Committee has recommended a legal framework that fails to adhere to *Carter*.

Opening the door to minors contrary to *Carter*

The Committee, in Recommendation 6b of the main report, has recommended allowing PAD in cases expressly excluded by *Carter*, including the possibility of mature minors at a future date. The SCC was clear in saying that PAD should be available to “competent adult persons”.⁵ If the SCC wished to extend PAD to mature minors, it would have said so. Instead, the SCC went out of its way to expressly preclude this. This is supported by the evidence of Professor Peter Hogg, Canada’s foremost constitutional scholar who said:

The Supreme Court, in its order, spoke of a “competent adult person”. I don't think it would be open to you, for example, to have 16 as an age of consent for this purpose, because that would not be a competent adult person. Between 18 and 21, I would think you would have some leeway within the word “adult” to decide that.⁶

Likewise, a senior official from the Department of Justice concurred with Professor Hogg, stating “the court clearly limited its ruling to mentally competent adults.”⁷

Further, the Committee heard important evidence about policy reasons for why PAD should be available only to adults. The Canadian Pediatrics Society, whose opinion on this matter carries significant weight, was unequivocal: “I think for the purposes of your legislation, I would say 18 is an adult. I would be as conservative as you can possibly be;”⁸ and again: “today I am here to speak to the matter of children, and with respect to children I would argue that you should not go beyond the Supreme Court’s pronouncement.”⁹

No Safeguards for the Mentally Ill

Additionally, the Committee’s proposed legislative framework fails to sufficiently balance respect for individual autonomy with the need to protect vulnerable persons, as Parliament was called upon to do by the SCC in *Carter*. For example, shockingly, neither in Recommendation 3 of the main report, nor anywhere else in the Committee’s main report is there a requirement for patients diagnosed with an underlying mental health challenge to undergo a psychiatric assessment by a psychiatric professional to determine whether they have the capacity to consent to PAD. This, notwithstanding that the Canadian Psychiatric Association was of the opinion, and we think that the vast

⁵ *Carter v. Canada*, 2015 SCC 5, at paras. 4, 68, 127, and 147

⁶ Peter Hogg, *Special Joint Committee on Physician-Assisted Dying* (January 25, 2016).

⁷ Joanne Klineberg, *Special Joint Committee on Physician-Assisted Dying* (January 18, 2016).

⁸ Dr. Dawn Davies, *Special Joint Committee on Physician-Assisted Dying* (February 3, 2016).

⁹ Dr. Mary Shariff, *Special Joint Committee on Physician-Assisted Dying* (February 3, 2016).

majority of Canadians would strongly agree, that in instances where a person seeking PAD has a mental condition a “psychiatrist needs to be involved to do a proper assessment as soon as the request is made.”¹⁰

The SCC ruled that PAD *could* be practiced in a way that protects the vulnerable *provided* it is accompanied by stringent safeguards. A regime that is not rigorous enough to protect the vulnerable, if challenged, would almost certainly be found to violate the *Charter* as well. There is little sense in replacing a law that was found to violate the *Charter* in one way with a law that violates the *Charter* in another way. Unfortunately, the Committee in its main report fails to strike the right balance between individual autonomy and the need to protect vulnerable persons.

Other Concerns with the Main Report

We are of the view that the Committee’s main report should have placed greater concern in three other areas: (1) palliative care; (2) conscience protections for physicians and health institutions; and (3) advanced directives.

Palliative Care

During Committee hearings witness after witness highlighted the importance of palliative care in the context of PAD. We also heard about the overall lack of proper palliative care services across Canada. The Canadian Cancer Society highlighted the “serious gaps in palliative care across the country.”¹¹ The Canadian Society of Palliative Care Physicians also described the training given to providers of palliative care as “woefully inadequate.”¹²

The importance of palliative care in the context of PAD is effectively stated in the *Final Report of the External Panel on Options for a Legislative Response to Carter v. Canada*: “a request for physician-assisted death cannot be truly voluntary if the option of proper palliative care is not available to alleviate a person’s suffering.”¹³ A genuinely autonomous choice for a person to end their life is not possible if they are not offered palliative care as they will see their choice as only intolerable suffering or PAD. Testimony by the Canadian Cancer Society confirmed this: “any responsible policy on assisted dying must guarantee access to quality palliative care for all Canadians.”¹⁴

We therefore believe that it is essential that the federal government work with the provinces and territories and provincial/territorial medical regulatory authorities to ensure that the option of palliative care is offered and available to any person contemplating PAD.

Conscience Protections

¹⁰ Dr. K. Sonu Gaiand, *Special Joint Committee on Physician-Assisted Dying* (January 27, 2016).

¹¹ Gabriel Miller, *Special Joint Committee on Physician-Assisted Dying* (February 1, 2016).

¹² Dr. Monica Branigan, *Special Joint Committee on Physician-Assisted Dying* (January 27, 2016).

¹³ Dr. Harvey Max Chochinov, Professor Catherine Frazee, Professor Benoît Pelletier, “Final Report on Options for a Legislative Response to *Carter v. Canada*” (December 15, 2015), page vii.

¹⁴ Gabriel Miller, *Special Joint Committee on Physician-Assisted Dying* (February 1, 2016).

Section 2 of the *Charter* guarantees all Canadians “freedom of conscience and religion.”¹⁵ There was near unanimous agreement amongst witnesses that physicians who object to taking part in PAD for reasons of conscience should not be forced to do so. Unfortunately, the Committee in its main report does not sufficiently protect the *Charter* rights of physicians and health institutions.

The Committee recommends that physicians who conscientiously object to PAD be obliged to refer patients through an “effective referral”. We believe that such a regime is unnecessary and would infringe on the *Charter* rights of physicians. We note that Canada would be first jurisdiction in the world to require an effective referral regime. Instead, we believe that there are better models which protect *Charter* rights of physicians and provide access to PAD for patients in other jurisdictions, including Quebec. Physicians who conscientiously object to PAD are required to provide information to patients on how to access PAD, and to advise a government agency of the patient’s request. The government agency then connects the patient to a physician willing to provide PAD.

Likewise, healthcare institutions that object to offering PAD should be exempted in accordance with the Supreme Court’s determination that individual and collective aspects of freedom of religion and conscience guaranteed under the *Charter* are “indissolubly intertwined”.¹⁶

Advanced Directives

We are concerned about the advanced directive regime proposed in the Committee’s main report. The regime proposed falls outside the parameters set by *Carter*. Moreover, several witnesses recognized that from a policy perspective the type of regime proposed is inadvisable, including the Canadian Medical Association.¹⁷

We further note that issues respecting advanced directives are extremely complicated. Significant more time than was given to the Committee is required to explore the legal and policy implications of advanced directives.

Conclusion

We strongly encourage the Government to craft legislation that takes full stock of the abovementioned thoughts, concerns, and recommendations. We recognize the need for law to comply with the *Charter* as interpreted by the SCC in *Carter*. The Committee failed to adhere to the parameters set out in *Carter*, and likewise failed to propose meaningful safeguards, as Parliament was called upon to do in *Carter*. In light of the foregoing, the Committee’s main report is not supportable. We hold out hope, however, that the Government will take note of the glaring flaws contained in the Committee’s main report and do much better when it introduces its legislative response to *Carter*.

¹⁵ *Constitution Act* (1982), s.2a

¹⁶ *Loyola High School v. Quebec (Attorney General)*, 2015 SCC 12, at paras. 92 to 94

¹⁷ Dr. Jeff Blackmer, *Special Joint Committee on Physician-Assisted Dying* (January 27, 2016).

Respectfully submitted,

Michael Cooper, M.P.
St. Albert-Edmonton

Mark Warawa, M.P.
Langley-Aldergrove

Gérard Deltell, M.P.
Louis-St Laurent

Harold Albrecht, M.P.
Kitchener-Conestoga

Supplementary Opinion

Submitted to the Special Joint Committee on Physician-Assisted Dying by New Democrat MPs Brigitte Sansoucy (Saint-Hyacinthe-Bagot) and Murray Rankin (Victoria)

The committee has worked diligently—in spite of its short timeline and deeply sensitive subject—to deliver a report that honours the diversity of evidence it heard and makes important recommendations for the government to consider in its legislative response. It is a report in which we invested much time and care in shaping and are proud to support. We thank each of the 61 witnesses who made themselves available to the committee as well as the staff whose support was essential for the committee to deliver on its mandate in due time.

We offer this supplementary opinion to provide Canadians with additional information, beyond what could be included in the main report, that we believe they will find helpful in understanding the context in which the committee worked and the options now facing the government. As the government moves forward, it must continue to engage with Canadians.

A principles-based approach to legislating on medical aid in dying

In making health policy, New Democrats believe in putting the patient first. In the case of medical aid in dying, that approach is the only way to be respectful of the complex and sensitive issues facing patients and their families, as well as responsive to the urgency of their suffering. And yet for five months following the Supreme Court's unanimous decision in *Carter*, the previous government chose to neither take action in Parliament nor consult with Canadians. Their failure to act was an affront to this patient-centred approach and a derogation of their duty to govern for all Canadians, particularly those whose suffering was the concern of the Court and this committee. Those five wasted months created additional challenges which the committee worked admirably to overcome. Having now received the committee's report, the government must move efficiently to introduce legislation that protects the Charter rights of these patients.

This legislation must consider not only the specific recommendations found in the committee's main report, but the principles that drove our deliberations. It must ensure that every eligible patient's right to access medical aid in dying is upheld, and protect any healthcare professional who objects for reasons of conscience from disciplinary action. It must honour patients' autonomy and self-determination—ensuring that their privacy is not violated or their rights undermined by arbitrary bureaucracy—while still maintaining effective safeguards to protect vulnerable individuals. Recognizing the initiatives by provinces and territories since *Carter*, as well as the exemplary consultation process adopted by Quebec with respect to Bill 52, the federal government

must adopt an approach of collaborative federalism, respecting provincial jurisdiction while providing the leadership necessary to avoid a regional patchwork.

As parliamentarians, New Democrats approach the question of medical aid in dying with the understanding that, however our views may differ, every parliamentarian is guided by deeply held values and the best interests of their constituents, and that the views of each Canadian must be respected as we seek to protect the Charter rights of all. We were pleased that the committee shared this desire to work in a non-partisan and respectful manner. This is the approach Canadians expect of Parliament, and we are hopeful that it can be maintained in the coming months as Parliament considers legislation relating to the committee's report.

Respecting the priorities of Canadians: expanding palliative care, supporting caregivers

In its mandate from Parliament, the committee was tasked with providing recommendations on a federal response that “respects the Constitution, the Charter of Rights and Freedom, and the priorities of Canadians.”

The fact that palliative care can and must be improved was emphasized by every witness who testified on the subject before our committee, was repeatedly affirmed by representatives of all parties and both chambers of Parliament, and was recently the subject of a motion tabled by NDP MP Charlie Angus (Timmins – James Bay) and passed with near-unanimous support in the House of Commons in 2014. We can imagine no more conclusive proof that palliative care is truly a priority for Canadians and inextricably linked to the issue of medical aid in dying.

It is our view that making recommendations on the improvement of palliative care fell squarely within the committee's mandate and remains essential to any balanced response to medical aid in dying. To that end, we introduced a package of concrete measures to improve palliative care.

Several motions introduced by Mr. Rankin on February 4, 2016, were adopted as recommendations in the final report, including:

- ✓ Re-establishing a secretariat on palliative care
- ✓ Creating a properly funded Pan-Canadian Strategy on Palliative and End-of-Life Care
- ✓ Providing culturally and spiritually appropriate services to Indigenous communities

At the same time, New Democrats believe the report could have gone further, to include steps that were within the committee's mandate to recommend and are necessary for the government to take. These omissions are an opportunity missed but not yet lost. Alongside the recommendations in the main report, the government can now:

1. Demonstrate leadership by providing palliative care within federal jurisdiction.

Palliative care can and must be improved, and the government has significant scope to do so. The federal government is the fifth largest healthcare provider in Canada, providing direct health services to specific populations such as First Nations and Inuit peoples, veterans and active members of the Canadian Forces. Providing palliative care for those within direct federal health responsibility would help a significant number of Canadians and demonstrate leadership to provinces and territories.

2. Help every Canadian family by improving Compassionate Care benefits.

Family members can experience chronic financial, physical, and emotional stress when caring for a loved one. Helping caregivers provides significant benefits, both for the individual families and the health care system.

Under pressure, the last government adopted the NDP's proposal to extend EI Compassionate Care benefits from 6 weeks to 6 months. Unfortunately, they failed to address the narrowness of eligibility criteria so too many families caring for loved ones will still be left out.

We believe that families should be able to access these supports not just when a loved one faces a terminal illness, but also when other serious family health events require time away from work.

Recognizing the broader health context

The committee report touched on several issues it described as “ancillary considerations,” including the needs for meaningful consultation with Aboriginal peoples, better support for mental health, improved palliative care, and a national dementia strategy.

We wish to recognize initiatives by several parliamentarians who have worked hard to address these priorities for Canadians, including former MP Libby Davies' Continuing Care Act, former MP Claude Gravelle's bill to create a National Dementia Strategy, and MP Charlie Angus' motion to establish a Pan-Canadian Palliative and End-of-Life Care strategy.

New Democrats see these issues as not only intrinsically linked to the issue of medical aid in dying, but fundamental to a successful model of public healthcare in Canada for the 21st century. Canadians want better access to primary care, as well as a stronger continuum of care, including home care, long term care and palliative care. They want greater equality of access and outcomes, regardless of their postal code. They want a

government that not only strongly supports the *Canada Health Act*, but that is committed to ensuring its full implementation from coast to coast to coast. And they want to see the shameful deficiencies in on-reserve healthcare addressed and Aboriginal peoples respected as full partners in the development and implementation of health programs.

We therefore urge the government not to address medical aid in dying in a vacuum, but to consider its connections to other aspects of health policy, including social determinants of health. New Democrats recognize that social determinants—such as income and social status, education, employment conditions, social environments and support networks, gender, and healthy child development—play a role in health outcomes. These must be considered in relation to medical aid in dying to determine how they may affect health outcomes, access to care, and potential vulnerability. The government must take action to fight poverty, tackle rising food insecurity and address the affordable housing crisis so that Canadians are on more equal footing as they make end-of-life decisions.

In conclusion, we are proud to support the committee's main report and wish to recognize the hard work of all our colleagues who worked alongside us throughout its development. Having taken a broader view of the committee's mandate, we urge the government to take note of the additional issues and recommendations put forward in this supplementary opinion and to seize this opportunity to respond to the priorities of all Canadians.