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Official Report of Debates (Hansard)

Thursday 30 March 2017

Journal des débats (Hansard)

Jeudi 30 mars 2017

**Standing Committee on
Finance and Economic Affairs**

Medical Assistance in Dying
Statute Law Amendment Act,
2017

**Comité permanent des finances
et des affaires économiques**

Loi de 2017 modifiant des lois
en ce qui concerne l'aide
médicale à mourir

Chair: Peter Z. Milczyn
Clerk: Eric Rennie

Président : Peter Z. Milczyn
Greffier : Eric Rennie

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LEGISLATIVE ASSEMBLY OF ONTARIO

**STANDING COMMITTEE ON
FINANCE AND ECONOMIC AFFAIRS**

Thursday 30 March 2017

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

**COMITÉ PERMANENT DES FINANCES
ET DES AFFAIRES ÉCONOMIQUES**

Jeudi 30 mars 2017

The committee met at 0900 in room 151.

MEDICAL ASSISTANCE IN DYING
STATUTE LAW AMENDMENT ACT, 2017
LOI DE 2017 MODIFIANT DES LOIS
EN CE QUI CONCERNE L'AIDE
MÉDICALE À MOURIR

Consideration of the following bill:

Bill 84, An Act to amend various Acts with respect to medical assistance in dying / Projet de loi 84, Loi modifiant diverses lois en ce qui concerne l'aide médicale à mourir.

The Chair (Mr. Peter Z. Milczyn): Good morning. The Standing Committee on Finance and Economic Affairs is meeting this morning to have public hearings on Bill 84, An Act to amend various Acts with respect to medical assistance in dying.

Each witness will have up to six minutes for their presentation, followed by nine minutes of questioning from the committee, or three minutes from each caucus. The first round of questioning will begin with the government caucus this morning.

COLLEGE OF PHYSICIANS
AND SURGEONS OF ONTARIO

The Chair (Mr. Peter Z. Milczyn): Our first witness of the morning: The College of Physicians and Surgeons of Ontario. Good morning. You've heard that you have up to six minutes. If you could all state your names for the official record as you begin your presentation.

Mr. David Rouselle: I'm David Rouselle. I'll introduce the group, if that's okay.

Thank you for the opportunity to speak today. I'm David Rouselle. I'm the president of the College of Physicians and Surgeons. I'm an obstetrician at Southlake Regional Health Centre in Newmarket. Joining me is Dr. Rocco Gerace, college registrar, and Ms. Vicki White, co-director of the college's legal department.

Should I start, then?

The Chair (Mr. Peter Z. Milczyn): Absolutely.

Mr. David Rouselle: The College of Physicians and Surgeons of Ontario regulates the province's medical profession, as you know. The college has a legal mandate to serve and protect the public interest, a role we take very seriously. All of our work, including that on medical

assistance in dying, or MAID, is undertaken with a view towards fulfilling our public interest mandate. In keeping with our mandate, the college supports respect for patient autonomy and patient access to care.

The college has been actively engaged in the issue of medical assistance in dying since the Supreme Court of Canada's Carter decision several years ago. The college has provided guidance to physicians and support to patients through the development of a medical assistance in dying policy and other reference documents, including a frequently asked questions document, a fact sheet on effective referral, and a second frequently asked questions document developed specifically for the public. Copies of these documents have been left for the committee's information.

I'll just start by saying that the college strongly supports Bill 84. We feel the bill aligns with federal legislation on MAID and also provides important clarity and protections on a range of issues that fall under provincial legislation. It demonstrates respect for patient autonomy and access to care, as noted, two goals which have underpinned our work on MAID.

We note, in particular, and with support, that the bill ensures that patients' benefits and claims are not withheld should they proceed with MAID. This prevents patients from being placed in the position of having to choose between a legally available care option, such as medical assistance in dying, and obtaining the benefits and claims that they and their families are entitled to.

We further note, with support, the fact that the bill clarifies the coroner's role and involvement in relation to MAID. This is an important aspect of Bill 84. It provides reassurance for patients who may consider exploring MAID and for clinicians in terms of the role and involvement of the coroner.

The college's medical assistance in dying policy sets out the legal and professional obligations that physicians have with respect to MAID. The policy includes a process map that sets out the nine steps involved in managing a request and is consistent with the federal law, specifically the safeguards set out in federal law. It also includes direction on record-keeping, informed consent and conscientious objection.

In terms of conscientious objection, where a physician declines to provide MAID for reasons of conscience or religion, the policy requires that an effective referral must be provided to the patient in a timely manner. An

effective referral means a referral made in good faith to a non-objecting, available and accessible physician, nurse practitioner or agency.

An effective referral does not guarantee that a patient will receive a treatment or signal that the objecting physician endorses or supports the treatment. It ensures access to care, and it demonstrates respect for the patient's autonomy. Physicians can make the referral themselves or they can assign the task to a designate.

This committee heard testimony on March 23 from Dr. Chantal Perrot, who has been working with MAID patients. She spoke to the vulnerability of people seeking MAID and the impact on these patients if the college's effective referral policy is not followed. Dr. Perrot commented, "These are very ill, fragile, frail and vulnerable people, many of whom do not have the wherewithal to do these searches, some of whom are physically incapable of using a telephone, let alone a computer. To ask them to do this themselves is tantamount to patient abandonment.... Not all patients will have family members or friends who can help them navigate the system or advocate for them."

The college's expectations are designed to address the needs of vulnerable patients such as those identified by Dr. Perrot. The college's fact sheet on effective referral contains more information and provides a number of examples of scenarios that would satisfy the requirement for an effective referral.

This committee has heard testimony that in requiring an effective referral, the College of Physicians and Surgeons of Ontario stands alone, and that its expectations of physicians are out of line with those of other jurisdictions. With great respect, this is inaccurate. Many health regulators in Ontario and in other provinces, such as Nova Scotia, Quebec and Saskatchewan, have the same or similar requirements. This is detailed in our written submission for your information.

In summary, the college strongly supports the passage of Bill 84. We appreciate the opportunity to share with the committee our views on Bill 84 and to provide further information about the college's expectations with regard to medical assistance in dying. We'd be pleased to answer any questions the committee may have. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Rouselle. We'll start this round with the government side. Mr. Fraser.

Mr. John Fraser: Thank you very much for being here today. What is the college's mandate, just in general?

Dr. David Rouselle: As I said, we feel our mandate is to serve and protect the public interest in the provision of medical care.

Mr. John Fraser: Thank you. You mentioned Dr. Chantal Perrot, who we heard from last week. She did recount to us a number of situations where she felt that not only was there a failure to make a connection to a service that people needed, but even when that connection was made, the documentation, the records—the

things that had to come forward—were slow or not coming.

Can you explain to me how your policy of effective referral protects those vulnerable people who are looking for this service and are unable to access it in a timely way?

Dr. David Rouselle: The requirements are set out clearly in the policy, which we expect our members to follow: that they should not allow an untimely delay in access to service and that if they are unable to participate in MAID, they need to make an effective referral to a non-objecting doctor, nurse practitioner or agency. We feel that's quite clear.

The issue of transfer of records is not covered specifically, but there are lots of other policies that the college has—that records have to be provided when requested by an authorized health care provider. So that kind of delay wouldn't be supported either.

Mr. John Fraser: I thank you for your comments supporting the specific measures that are already set out in the bill, but of course, we have now had discussions about conscience rights and effective referral. I know that there are pathways there where objecting physicians have found ways to work—and many of them who I hear want to continue to work with their patients. I know at the Ottawa Hospital, for instance, they've found a way on the team—there are people who object, but they're there. Can you make any comment on that? Is there anything that's—

Dr. David Rouselle: For us, it's all about access. If a patient has access to the service, then we're satisfied; that's our goal. It's not about taking away people's conscience rights or anything like that. It's really about respecting patients' autonomy and providing them access to a legal service in a timely manner. As you can appreciate, in the circumstances that patients are often under, they don't have a lot of time and we really can't allow a lot of delay.

0910

Mr. John Fraser: So it's—

The Chair (Mr. Peter Z. Milczyn): Thank you, Mr. Fraser. That's all your time.

Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in. We've had a few discussions on this and other issues, and I appreciate the time you offer myself and my colleagues when you give your time.

Just taking Mr. Fraser's question further: You mentioned that your concern is access, that a patient is not left behind. Is there any room or flexibility in the effective referral if the government comes out with a self-referral system, much like other jurisdictions have come forward with to ensure that patients actually have a wider range of access to medical assistance in dying? Is there any flexibility in this effective referral? Or is it that this is your position going forward?

Dr. David Rouselle: I think the problem we have right now is, we're not sure what the referral service would look like and we would need to see some details to know how that fits into the effective referral requirement.

Mr. Jeff Yurek: But if the government includes the CPSO in the design of this service, if the CPSO is included in the design of the effective referral and it meets the needs that you believe—I'm being hypothetical here, and I know you may not want to answer hypothetical questions. But if it meets the needs—is there flexibility in this effective referral for the doctors, the relief of knowing that their licence isn't in jeopardy or any discipline action will be taken on them if they consciously want to not be part of the process?

Dr. David Rouselle: We're not opposed to increasing access or even making available patient-centred access, let alone direct access, but we don't think it would take away from a doctor's duty to provide an effective referral if a patient requests a service. It just doesn't apply to MAID; it applies to other things in health care that people may object to for one reason or another. Specifically regarding a care coordination service, again, it would just depend on the details of that, and yes, the college would welcome involvement in the design of such a thing.

Mr. Jeff Yurek: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Madame Gélinas.

Mme France Gélinas: Thank you so much for coming here. I'm sure you are aware of the people who presented last Thursday. There is tremendous pressure on us to put an amendment to the bill that would say that mandatory referral would be something that would not be allowed. Like, we would put an amendment into the bill that would tell the college that your policy on effective referral has to change.

I've never had an archbishop come to Queen's Park before. I've been here for 10 years, and I've never had the association of bishops. I should be more respectful to the name of the association, but you know who I'm talking about. They are really, really pushing hard to say that this has to change.

What would happen if we change that, and what do you answer to those people?

Ms. Vicki White: The one thing the committee should know is that the college's effective referral requirement contained in its medical assistance in dying policy is currently the subject of litigation. There is a challenge in the courts respecting that obligation, so I am here to caution my colleagues, as the lawyer in the room, because we have ongoing litigation. I think the college's position has been stated fairly by Dr. Rouselle, which is that the purpose of that effective referral requirement is to ensure access to care for vulnerable patients—patients the type of whom you've heard from Dr. Perrot, those who need help from their trusted caregiver to seek a legally accessible service in Ontario, and that is part of the college's mandate to protect the public interest. That is the purpose and goal of the provision. Of course, without such an expectation, the concern is that vulnerable patients would be left on their own, without the assistance they need to access a service that is available and has been found by the Supreme Court of Canada to be a constitutionally protected right.

Mme France Gélinas: So even if the government does put in place a very robust system of MAID that is available throughout and that you, your neighbours, your family, your physician or any part of your team can access, you feel that you would still need to keep the effective referral from physicians?

Ms. Vicki White: I think you need to look at the effective referral fact sheet that has been provided to the committee members, which describes a range—it's not an exhaustive list, but it describes examples of the ways in which this effective referral requirement can be met. There are any number of ways to meet that, and, as Dr. Rouselle mentioned, a care coordination service may be one of the ways in which that duty is met, depending on how it all unfolds.

Mme France Gélinas: What would be the—

The Chair (Mr. Peter Z. Milczyn): Thank you. That's all of our time, unfortunately. We do have your written submission, but if there's something additional you'd like to submit in writing, you have until 6 p.m. this evening to do that through the Clerk.

ONTARIO MEDICAL ASSOCIATION

The Chair (Mr. Peter Z. Milczyn): Our next witness this morning is the Ontario Medical Association. Good morning. You have up to six minutes for your presentation. Please state your names for the official record as you begin.

Dr. Rachel Forman: Rachel Forman.

Ms. Barb LeBlanc: Barb LeBlanc.

Dr. Rachel Forman: Thank you, Mr. Chair. I am Rachel Forman, and I'm here today in my capacity as spokesperson for the Ontario Medical Association. I am trained as an obstetrician/gynecologist, with subspecialty training in reproductive endocrinology and infertility, and I practise here in Toronto. With me today is Barb LeBlanc, executive director, health policy and promotion, at the Ontario Medical Association.

I would like to start by acknowledging that medical assistance in dying is a challenging issue for the medical community, as it is for society. The Supreme Court of Canada recognized this when they said in their ruling that the rights of physicians to exercise conscientious objection will have to be reconciled with citizens' rights to receive aid in dying. To date, this challenge has gone unanswered. I'll return to this issue in a moment.

I would like to commend the Ministry of Health and Long-Term Care for Bill 84, and for the process leading up to it. Ministry staff sought input from the Ontario Medical Association early in their policy formation process and took our input into account. They had regular update calls with stakeholders to keep us apprised of progress. Good consultation processes inevitably result in a better legislative product, and today the OMA speaks in support of Bill 84.

Before I get to the OMA's one suggested amendment to the bill, I would like to spend a moment speaking in support of the privacy provisions in Bill 84. Specifically,

I want to support the sections that will exempt information about MAID from freedom-of-information requests. Medical assistance in dying, like abortion services, attracts disagreement based upon very fundamental beliefs. Unfortunately, we have learned with abortion services that sometimes those deeply held personal beliefs spill over into beliefs and action about what is acceptable for others.

Protecting the identity of physicians who provide these controversial services is vital. This is not an abstract issue. As an obstetrician/gynecologist, I can tell you that the bombing of the Morgentaler Clinic, the stabbing of a Vancouver doctor, the shooting of an Ancaster doctor, threats to a Vancouver doctor conducting a trial of RU-486 and the shooting of a Winnipeg doctor create real fear among physicians. It is vital that you, as legislators, play your part to protect the professionals who provide these services so that access is not compromised.

I'd now like to return to the Supreme Court and its statement that we need to address the issue of conscientious objection. The OMA believes that it is possible to reconcile patient access with physician rights, and we urge you to fill this regulatory gap by introducing an amendment in support of conscientious objection. There are means to ensure access, such as patient self-referral, which have been discussed. There are also services in place, most notably public health units, which have a long track record through their work in reproductive care in helping citizens to access the services they need. There are solutions, if we are willing to look for them.

0920

I would like to end by saying a few words about end-of-life care more generally. The OMA believes that we can and should do better for Ontario patients at the end of life. MAID is a solution for a very small number of individuals. Good palliative care, on the other hand, is something that improves the lives and the deaths of many Ontarians. We must educate our citizens and our health care providers about what palliative care can offer and ensure that palliative care is available across the province. To do otherwise is unethical.

Thank you for the opportunity to speak with you. I look forward to your questions and discussion.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Forman.

Mr. Yurek, you have three minutes.

Mr. Jeff Yurek: Thank you for coming today and giving us a quick discussion on Bill 84. In your comments, I noted protecting access to freedom of information. What are your thoughts on publishing where medical assistance in dying is being done in our hospital facilities in the province? There's a discussion that has come up in other deputations about releasing the names, and then there's the other half saying not to release. What are your thoughts on giving locations of those procedures?

Ms. Barb LeBlanc: While I think there's some utility in having statistical information available, there are real

questions around having the names of individual facilities, simply because that information is then used for targeted lobbying or, in some sad cases, targeted violence. That's the risk.

I think the other thing about MAID is that we don't yet know whether or not most of it will occur in hospitals or in other facilities or in the community. It's not completely clear how that would work, if you would end up releasing information about individual offices, for example.

Mr. Jeff Yurek: We've heard, as well, at committee that the death certificate is currently signed off as suicide as the root cause of death. Should that be the cause of the death, or should there be something else?

Ms. Barb LeBlanc: I actually had the opportunity to speak with the coroner's office last week about this issue. As I understand it, in a corollary to the legislative work, they're going to do some policy work that will change that. In fact, the cause of death will be noted as whatever the underlying condition is, with MAID as a secondary contributor. We think that's great and is consistent with the framework that you've laid out in Bill 84.

Mr. Jeff Yurek: Finally, back to conscience rights: What are you hearing from your members? Is it a stressful time for them in this time period? Just fill us in.

Ms. Barb LeBlanc: As Ms. Gélinas said, this is just one of those issues that has created a tremendous amount of interest. For our members who have religious beliefs contrary to MAID, this has created tremendous personal angst for them. We recognize that.

Now, what we do have to recognize is that this issue, as Dr. Forman said, is very divisive within the medical community. About half of members support MAID and believe that it's a useful medical service, and about half don't. That puts us in a very challenging position, in order to try and recognize the legitimate patient need out there while protecting the conscience rights of objectors.

The Chair (Mr. Peter Z. Milczyn): Thank you, Madame Gélinas.

Mme France Gélinas: Welcome to Queen's Park. I'm delighted to hear that OMA was consulted and had a chance to work with the government on this particular bill and that your input was taken into account. I think good things come of that.

The position of the CPSO was known way before we tabled the bill. When you talked to the ministry about conscientious objections—why is it that it's not in the bill? What kind of arguments did they give you?

Ms. Barb LeBlanc: I think the discussions about conscientious objection have really been at that higher level. To some extent, the ministry has relied on the fact that CPSO has existing policy and has told us that they want to be consistent with that policy to the extent possible. There hasn't been a lot of detailed discussion on that point. It's really been left for this committee to thrash through.

Mme France Gélinas: Really? Okay, this is where my happy feelings go out the window because, as you said, half your membership supports, half your membership

opposes. You are the ones who know your membership best. You are the ones who are the closest to them and most likely to come up with something that will be respectful of them as well as respectful of the law. None of us are physicians. None of us will ever be in the position of having to make the decision, "Do I make an effective referral or not?"

You say that you will be coming with an amendment. What's your amendment?

Ms. Barb LeBlanc: We do not have a specific amendment crafted. What we have said is that we would encourage an amendment, on point, and we would be pleased to work with the committee if you were to craft such an amendment.

M^{me} France Gélinas: To what goal? An amendment to what goal?

Ms. Barb LeBlanc: To acknowledge that conscientious objection should be recognized and respected, and that it should supersede any regulatory college requirement.

M^{me} France Gélinas: So the end goal is so that the conscientious objector doesn't have to refer?

Ms. Barb LeBlanc: That there are other options, yes.

M^{me} France Gélinas: And those other options are?

Ms. Barb LeBlanc: Well, among them is access through other agencies; for example, public health.

M^{me} France Gélinas: How would that work?

Ms. Barb LeBlanc: Historically, abortion services in smaller areas where, perhaps, there isn't availability—public health units have taken on that role for many years. So I think as a model—

M^{me} France Gélinas: Public health units—

The Chair (Mr. Peter Z. Milczyn): Thank you. That's all your time.

Mr. Fraser.

Mr. John Fraser: Thank you very much for being here today and for your comments on the privacy of information. I think it's critical. I've said this before in committee: We don't have proximity to this issue. Many of us have not been faced with it, and not every physician, and we're trying to sort our way through this. As we do that, I think an environment that helps us work together is a good thing.

I just want to confirm, and thank you again for raising, the definition—how it will be assigned on the death certificate. That policy change is going to be made. I just want to confirm that. That's actually one of the big purposes in this bill. It's really patient-focused. If you take a look at the bill, most of it is looking at what are the things that are going to put people at a disadvantage. I want to thank you for raising that.

I want to thank you, too, for raising that you were consulted on Bill 84, because we have done a lot of consultations all the way through this process, trying to get this piece of legislation right. We just heard today that we've got the rights of access to patients and the rights of conscience, and that conscience goes both ways because people come here on both sides, with a conscience and love and compassion, and saying, "This is

what we need to be able to do," so I appreciate how difficult it is to square that as an association.

I've said this a couple of times in committee, so I'll just get your comment. We need to have pathways, pathways where people can have access to service, and for how their physician can follow them. I just talked about the Ottawa Hospital. Other places have found ways for people of different views and conscience to work together. Do you have any thoughts on that?

Ms. Barb LeBlanc: I think those are the kinds of solutions that are very creative and that will help us to find answers that will absolutely allow access, but will not offend people's deeply held personal beliefs.

0930

Mr. John Fraser: Thank you very much.

The Chair (Mr. Peter Z. Milczyn): Thank you very much for coming today. We do have your remarks in writing, but if there's something additional that you'd like to submit, you have until 6 p.m. today.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Peter Z. Milczyn): Our next witness this morning is the Ontario Hospital Association. Good morning. You have up to six minutes for your presentation. Please state your names for the official record as you begin.

Ms. Jeanette Despatie: Good morning. My name is Jeanette Despatie. I'm the president and chief executive officer at Cornwall Community Hospital, as well as a member of the Ontario Hospital Association's board of directors. Today I am joined by Andrea Frolic, who is the director of clinical and organizational ethics at Hamilton Health Sciences Corp. We are both members of the Ontario Hospital Association's working group on assisted dying.

I would like to thank you for this opportunity to present on Bill 84 on behalf of the OHA and its 145 member hospitals.

As you know, medical assistance in dying, or MAID, represents one of the most significant social policy changes in Canadian health care. Ever since the 2015 release of the Supreme Court of Canada's decision in Carter v. Canada, the OHA has made every effort to support Ontario hospitals in navigating this complex issue from legal, clinical and operational standpoints. This has included both ongoing education and the development of substantive member resources, as well as collaboration with our health partners across the system.

The hospital sector is committed to providing high-quality end-of-life care and supporting patient autonomy with respect to their health care choices. However, Ontario hospitals continue to operate within an environment of considerable legal uncertainty with respect to MAID.

As Ontarians, we share the common goal of ensuring that clinicians and institutions providing MAID feel safe. We want to ensure that those providing MAID in good faith are protected where their conduct is reasonable and in accordance with the law.

We are concerned that Bill 84, as currently drafted, does not offer appropriate protections. It leaves clinicians and institutions vulnerable to civil liability. The language in Bill 84 is not only inconsistent with how other jurisdictions have protected those involved with MAID, but also with other health-related statutes in Ontario. Other Ontario statutes have struck an appropriate balance to shield clinicians and institutions for good-faith conduct in carrying out their functions. In contrast, Bill 84 leaves providers open to civil sanctions even where they have acted in good faith. This may serve as a disincentive to their participation in MAID, ultimately creating barriers to patient access.

Now I would like to turn things over to Andrea Frolic, who will speak to other important considerations around Bill 84.

Dr. Andrea Frolic: Thank you, Jeanette. I'm Andrea Frolic, director of the office of clinical and organizational ethics at Hamilton Health Sciences. I am also the coordinator of the MAID program that facilitates access to and provision of assisted dying in my hospital.

The OHA welcomes amendments to the Freedom of Information and Protection of Privacy Act, or FIPPA, which would protect confidential and sensitive information about MAID. These amendments are necessary to safeguard the privacy of health care providers, patients, their families and others involved in the provision of MAID.

However, the OHA recommends that any amendments to FIPPA relating to freedom of information facilitate the disclosure of institutional policies and statistical-level information about MAID. This is crucial information to be available for patients and the public so they can understand what services are available and offered in any particular institution. This information sharing with the public is essential to patients' informed decision-making and advancing their access to assisted dying.

The OHA also believes that in order to facilitate appropriate and consistent public access to MAID-related information, it's important to ensure internal legislative coherence within FIPPA, particularly around MAID. As such, we are proposing amendments to ensure that access to information is consistent across the sector.

In addition to these legal issues, I feel it's important to conclude with some remarks about patient access. At present, there is too little capacity in the community setting for MAID services and, in some circumstances, this makes it extremely challenging to meet patients' needs.

Currently, the majority of assisted deaths in Ontario are provided in hospital. This is a globally unprecedented situation. Around the world, assisted dying, over 90% of the time, is provided in the patient's home by the patients' general practitioner. We do not have capacity in the community to enable this. This significantly impacts on patients' choice related to the location of the death that they choose. This overreliance on hospital-based MAID is not sustainable, it's not efficient, and it's not effective or patient-centred.

Hospitals and clinicians need clearer guidance and supports on implementing MAID at a local, regional and provincial level. All of this will require centralized efforts because MAID is an interprofessional practice. It requires a team to wrap its arms around this patient, around their family and around the providers who are often undertaking this without any structures of support, standards of practice, education or peer support in their community.

The OHA sees Bill 84 as an important step forward in providing Ontarians access to MAID and we look forward to continuing to work with our system partners on this issue.

We thank you for your time and we are happy to take your questions.

The Chair (Mr. Peter Z. Milczyn): Thank you, Madame Gélinas.

M^{me} France Gélinas: Thank you so much. I'll focus on two parts of what you've asked. The first one has to do with FIPPA. I understand that you would like us to amend the bill so that which hospital, which health care institution offers MAID—that this information is clear, it is accessible, it is available. Did I hear you well?

Dr. Andrea Frolic: Yes.

M^{me} France Gélinas: Okay. Some people who have come here say that this comes at a cost, a cost that will increase the level of anxiety or danger for those who do. You don't share this position?

Dr. Andrea Frolic: I do not, and nor does the OHA. The truth is that since the beginning of the relationship between health care providers and patients, patients have been asking for assistance in death. We know this. Some 3,000 years ago, Hippocrates and others were writing about how you respond to a patient who asks you for help in dying. The great thing about Bill C-14 is it brought this practice out of the closet, and the more we continue to treat it as a clandestine practice, as something taboo or unfavourable or distasteful, the more that people will continue to feel fearful about it and the more clinicians will feel at risk. So the more transparency we have, the more we normalize this practice, the more that we celebrate the fact that this is now an option, a legal option and a safe option for our patients, I think the better everyone will feel, and patients will have better access and information to make their own choices.

M^{me} France Gélinas: What changes would you like to see in the bill to better protect providers and institutions? You said that you feel vulnerable right now. What would you like to see?

Dr. Andrea Frolic: I think that the provisions around FIPPA, in terms of protecting the individual identities of health care providers and patients and families, are sufficient and perfect. I think what we could do to make clinicians, patients and families feel less vulnerable is actually develop comprehensive infrastructure to facilitate meaningful access.

M^{me} France Gélinas: Do you see this as a requirement of the LHINs, that they must have a range of MAID available, focusing on the community?

Dr. Andrea Frolic: I think community-based care coordination is a great model. It allows the development of therapeutic relationships within the circle of care. It allows clinicians who are providing the service to get to know each other, to provide peer support, and it allows for much more timely access in the patient's community instead of having to transfer the patient out.

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M^{me} France Gélinas: Would it be the ministry that has this responsibility, or the LHINs, or the hospital? Who do you see being the champion of putting forward those pathways, putting forward that care coordination?

Dr. Andrea Frolic: My sense is that the government could create a mandate for LHINs to create regional care coordination, in addition to supporting local care coordination at the hospital level, institutional level, in addition to providing information at the provincial level. To me, it seems like a multi-level responsibility.

M^{me} France Gélinas: And nothing has been done so far, unless you had a willing provider that did all the work by themselves and reinvented the wheel 152 times?

Dr. Andrea Frolic: There's local infrastructure that has been created, like within hospitals, for example, and much less within community. That infrastructure isn't sustainable, necessarily, over the long term, nor does it help to really address the fact that these patients move from hospital to community and back to hospital.

Having a regional model would allow us to really follow the patient—to not just localize capacity in a hospital environment but to really develop that capacity in community to support that patient's choice to die where they choose.

The Chair (Mr. Peter Z. Milczyn): Madame Des Rosiers.

M^{me} Nathalie Des Rosiers: Thank you very much for coming. That's very helpful. I just want to understand well. You would prefer, on the FIPPA, that we could protect the identity of the practitioner but not of the facility?

Dr. Andrea Frolic: That's right.

M^{me} Nathalie Des Rosiers: It is the word "facility" that you would like—

Dr. Andrea Frolic: It's the word "facility," yes.

M^{me} Nathalie Des Rosiers: The other part that I think I understand your position on—I think your position, as I understand it, is that the more normalization that we do around this, while recognizing the moral choices that it poses, is probably something that will take place over the next five, 10 years. In this context, why would we have specific provisions to immunize against negligence? Because already it does provide for the fact that no action or other proceeding for damages can be instituted against physicians for anything that is done in good faith in the performance of MAID. It just says that you cannot be negligent in this, which is kind of the law of Ontario in general. So I don't understand why we should create a specific protection in the context of normalizing—

Ms. Jeanette Despatie: Sure. This really refers to the civil liabilities that are not protected in the statute as it is currently prepared.

M^{me} Nathalie Des Rosiers: Yes, it does. The civil liability is in the statute, I think. I'm talking about section 13.8. Is that your understanding? Oh, you don't have it.

Ms. Jeanette Despatie: I don't have it in front of me, but the issue—

M^{me} Nathalie Des Rosiers: Tell me your concern, and I'll try to see whether—

Ms. Jeanette Despatie: My understanding is really around the preparation of the statute and it not being consistent with that provided for in other jurisdictions that are performing assisted dying.

M^{me} Nathalie Des Rosiers: So to the extent that it's similar to other jurisdictions, then you wouldn't have a problem with it?

Ms. Jeanette Despatie: That's right.

M^{me} Nathalie Des Rosiers: Okay. I have one more question. I just wanted to say I think you've referred to the fact that, currently, there are some examples of organizational work that is going on at the local level among hospitals. Could you give us some examples of how it is happening on the ground, according to what you know?

Dr. Andrea Frolic: For example, at our hospital and other hospitals, we've developed an interprofessional team model of willing providers, to be able to receive requests and to be able to receive referrals from those clinicians within our organization who are conscientious objectors. That interprofessional team model allows us to recognize that assisted dying is always a team. It always involves a physician. It always involves a nurse to put in an IV. It always involves a pharmacist, and consultants, usually, with palliative care, as well as psycho-emotional supports to wrap around that patient and the family at this crucial moment, as well as psycho-emotional supports to wrap around the clinician team.

Dying an assisted death is a death unlike any that we've seen before. It is a profound moment. I have sat at the bedside of patients with their mother, their spouse and their children. The moment of assisted death is a moment of legacy, and it can reverberate down multiple generations. It is essential that we have structures of support—mandatory education, standards of care, quality standards—in order to make this a positive generative experience for our patients as well as for our providers. It asks something of you, as a provider, to facilitate the death of a patient you've developed a relationship with. How are we supporting those clinicians?

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek.

Mr. Jeff Yurek: Welcome this morning. Just two things that I wanted to touch on—one was just a comment. Your one paragraph discussed what little capacity there is in the community setting for MAID services. I would probably agree that that's true. But I would also think, in certain sections of this province, there is little capacity for palliative care in the community setting. There is little capacity for keeping people in their homes longer than we want to; that's why we have the bed blockage in our hospital system.

Could we tie that all together? Perhaps, when we're trying to fix a solution for capacity with medical assist-

ance in dying, we could maybe take a look at the other problems that are in a community setting, and maybe that would be a win for everyone. Thoughts, perhaps?

Ms. Jeanette Despatie: I would just echo your comments. Our position at OHA and the hospitals is really around the total end-of-life care provision. Today we're speaking specifically to MAID, but our arguments would be the same on palliative care. Being able to provide those services where the patient chooses is important. It really is about patient access to the right location and preferences.

Mr. Jeff Yurek: I would think capacity would have to be expanded in equal terms for palliative care as well as medical assistance in dying. We want people to have options.

Ms. Jeanette Despatie: Absolutely.

Mr. Jeff Yurek: My second point was what you were mentioning earlier about civil liability. I do note that under 13.8—which was noted—stitutions aren't listed. That's what you'd like added—

Ms. Jeanette Despatie: I'm glad you brought that up, actually. I wanted to provide that clarity as well, that we refer to the individual and the institution, and that may not have been highlighted.

Mr. Jeff Yurek: In comparison to other statutes that you referenced, institutions have that protection where health care professions do as well. Is that basically what you're referencing?

Ms. Jeanette Despatie: Correct.

Mr. Jeff Yurek: Okay, so it's just making things equal to what is out there.

Ms. Jeanette Despatie: Exactly. And I think that that gets to the access, again, from a patient perspective—that people, obviously, and institutions are more willing to engage if they're assured of that protection.

Mr. Jeff Yurek: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you very much for coming in this morning. If there's something additional you'd like to provide to us in writing, you have until 6 p.m. today.

DR. JODIE CALVERT WANG

The Chair (Mr. Peter Z. Milczyn): Our next witness: Jodie Wang. Good morning. You have up to six minutes. Please state your name for the official record as you begin.

Dr. Jodie Calvert Wang: Good morning. My name is Dr. Jodie Calvert Wang. I'm a family doctor from Kitchener. I've recently been elected to the council of the Ontario Medical Association. I'm also a member of the grassroots groups Concerned Ontario Doctors and Doctors for Justice. These groups, along with the OMA and the CMA, have all issued statements in support of conscience rights for doctors.

I thank you for the opportunity to address the standing committee today about Bill 84, and implore that an amendment be added to this bill to protect conscience

rights for physicians and not enforce that doctors must provide mandatory effective referrals for MAID services.

I have been a doctor in Ontario since 1991. I have a large and varied practice, and I care for patients from newborn to close to 100 years of age. I have patients who are transgender, refugees, mentally ill, unemployed and from many other disadvantaged groups. I take on all new patients who come to me for care, regardless of their gender, sexuality, religion, race or income.

While I do not screen patients for their beliefs, I find it a regular occurrence to find myself screened by patients before they decide whether to accept me as their doctor. Patients ask me very frank questions about my beliefs. I have been asked: "If my children were in charge of my care and they wanted to end my life, what would you do?" And, more poignantly, "If, one day, there are no Catholic doctors, who will take care of me?"

Health care professionals and legislators alike will agree that medical assistance in death is an issue that elicits passionate opinions that range from enthusiastic support to adamant refusal to participate, and emotions on this topic are as passionate as they are because this issue forces us to face some of the most fundamental questions of life: How do we meet the end of life? How do we respect the wishes of the one we are caring for? Is it ever right to end a life?

This is neither the time nor place to examine these questions, but we must recognize that the yardstick by which we each determine our answers to these questions is different for each one of us, given our broad, multi-cultural fabric. For many of us in medicine, it is the Hippocratic oath we took on our graduation day—because it is not just a tradition to follow, but it is also a guiding map upon which we could build careers of honour, integrity and service to others. These words echo to us still: "Most especially must I tread with care in matters of life and death.... Above all, I must not play at God."

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The Geneva declaration of the World Medical Association was written in the aftermath of World War II and the shocking Nuremberg trials, which showed the disastrous consequences of medicine practised without a moral compass. The declaration states:

"I will practise my profession with conscience and dignity;

"The health of my patient will be my first consideration...;

"I will maintain the utmost respect for human life...."

"But what is the big deal?" many say, "The law is not forcing any objecting physician to perform an active MAID procedure. The CPSO is simply saying you must do an effective referral for it, as for anything else." The reason that we cannot brush this off as inconsequential is because effective referral is collaborating. It is assisting and allowing an action to occur.

In the eyes of the law, assisting or permitting a crime to happen itself is a crime. Likewise, forcing me to participate in arranging for a MAID consultation opposes

every fundamental belief I hold about my sacred duty to always act in the best interest of my patient. It forces me to choose between breaking my Hippocratic oath or breaking the law. It forces me to choose between facing the disciplinary committee of the CPSO or facing the judgment of God. It forces me to choose between my career or my conscience.

Freedom of conscience—and, by that, I mean not just the freedom to hold a certain belief but, most importantly, the freedom to avoid punishment for holding a certain belief—is a fundamental human right. It is the hallmark of what makes a society just and good. It is enshrined in the Canadian Charter of Rights and Freedoms and, in fact, is granted the privilege of being the first right that is mentioned:

“Everyone has the following fundamental freedoms:

“(a) freedom of conscience and religion;

“(b) freedom of thought, belief, opinion and expression....”

Canada has always been a land of tolerance, so it is difficult for me to even believe that today, in 2017, a group of citizens must come forward and plead to the Parliament of Ontario for protection of our most fundamental right as Canadians. It does not have to be this way.

When abortion became legalized in Canada, clinics were set up to allow patients direct access to it, precisely for the reason that conscientious objectors would impede patients from requesting abortions. Now, as we see MAID legislation take effect in many countries of Europe and in Canada, we see the same framework being constructed. Access is more consistent if physician referral is removed from the equation.

A direct telehealth initiative will remove barriers to patient access and protect the conscience rights of physicians. It will strike the perfect balance of rights and freedoms, as envisioned by Justin Trudeau when he said, “My idea of freedom is that we should protect the rights of people to believe what their conscience dictates, but fight equally hard to protect people from having the beliefs of others imposed upon them.”

All of the doctors who have appeared before you share one thing in common, and that is that we went into medicine to serve people. I have given 27 years of my life to the service of others. It is hard for me to convey the discouragement I feel, knowing I may soon have to make a heartbreakin choice between my conscience or my patients.

I, therefore, beg that this issue demands urgent attention. Protecting the conscience rights of physicians is not a Catholic, Christian or even a pro-life issue. It is, rather, a fundamental human rights issue. We stand on the brink of becoming the first jurisdiction in the democratic world to see a group of individuals without conscience protection. The Charter of Rights and Freedoms must not apply to most Canadians, but must apply to all Canadians.

I, therefore, ask today, on behalf of all of the doctors of Ontario, that our charter rights be respected and reinforced by an amendment to Bill 84.

Thank you very much for your time today.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Wang.

We'll start this round with Mr. Fraser.

Mr. John Fraser: Thank you very much, Dr. Wang, for being here today and for presenting to us. You're a family physician?

Dr. Jodie Calvert Wang: Yes, I am.

Mr. John Fraser: In your practice, do you practise palliative care, or what's your pathway for your patients in palliative care?

Dr. Jodie Calvert Wang: We have a palliative care team in Kitchener. When patients are needing palliative care, to initiate, I will either refer someone on to there or, quite often, it's through the cancer centre or through the cardiac centre. Often, it's done by specialists. But there is a palliative care team in Kitchener.

Mr. John Fraser: That's great. You're supported by that team, from the perspective of being able to refer?

Dr. Jodie Calvert Wang: Yes.

Mr. John Fraser: And do you have support from the perspective of any questions if you're helping a patient along with palliative care? Do you provide palliative care?

Dr. Jodie Calvert Wang: I don't do palliative care myself, but we do have a number of physicians who just do that in Kitchener.

Mr. John Fraser: Thank you. You were probably in the room a bit earlier. Patients are at the centre of this, as they are, I know, in your practice. I'm going to ask you a question I've asked a number of other people, about pathways. In my experience, it's critical. I know that physicians want to follow their patients and care for them. We've seen examples of people wanting to follow people on the journey, even when that journey may include assisted dying.

You mentioned the care coordination service, which we're committed to, which the government—the minister—has said very clearly that we're going to establish. Did I understand you right, that you see that as a pathway to ensure care for your patients?

Dr. Jodie Calvert Wang: What the doctors of Ontario want is not to impose our beliefs upon anybody or restrict access to anybody for anything that's legal. But what we are asking for with this amendment is that it not be a requirement upon us that we have to make that referral.

For example, for abortion services in our community, patients simply self-refer. Patients access that directly. Of course, in other provinces across Canada that are now getting their MAID programs in, they have similar systems, as do the countries in Europe where this has been enacted, in that patients have either a number they phone, a service that they access, or a website they can go to or family members can go to. They can access this directly.

Mr. John Fraser: Thank you very much.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek.

Mr. Jeff Yurek: Thank you for coming in today from Kitchener. I hope the traffic wasn't too bad, or you used the GO train, if that's up and running.

I just wanted to clarify: Palliative care has nothing to do with any conscience belief.

Dr. Jodie Calvert Wang: That's right. Of course, that's right. It's very different.

Mr. Jeff Yurek: It's something that we should be expanding in this province and having more access to. I don't know what it's like in Kitchener, but I know in my area of the province—southwestern Ontario, especially Elgin county—it's really in its infancy still, palliative care, in this day and age. It's far behind, and I wish there would be more resources sent to grow that service. I'm assuming Kitchener, being an urban centre, has more access to palliative care.

Dr. Jodie Calvert Wang: Right. Absolutely.

Mr. Jeff Yurek: My one question, just to also clear up: If the government comes forward with a self-referral system, which we're supportive of as well, and conscience rights protection is instituted in the effective referral stance, does that clear up your situation? Does that clear up your concerns? Would self-referral itself clear up things?

Dr. Jodie Calvert Wang: Yes. If patients can access a service themselves, then it is not requiring us to participate if we feel morally obliged to not participate.

Mr. Jeff Yurek: But if the effective referral was still in place, where you still have to refer if a patient asks you—

Dr. Jodie Calvert Wang: That's right. If there's no amendment to this bill, then we'll be required to refer the patient to access this. Similarly, we have to refer to the CCAC. If I have a diabetic patient with a leg wound, or if I have a patient needing palliative care, I need to do that referral, so I'm co-operating in that action and I'm assisting that to happen. What the doctors of Ontario are asking for is that there be an amendment in place to protect our conscience rights, so that we don't have to do that referral.

Of course, if a system is in place where patients self-refer, which is similar to abortion services, then we're not going to be punished or disciplined by the CPSO for not doing that referral. Currently, it is my understanding that Ontario is the only province that doesn't have this system in place and where doctors are facing this situation of possibly being disciplined for not doing these referrals, and a referral is going to be a mandatory step for patients to access this.

Mr. Jeff Yurek: Conscience protection and patient self-referral go hand in hand in fixing the situation.

Dr. Jodie Calvert Wang: Correct, yes. I greatly appreciate what you said about palliative care, because for many doctors in Ontario, regardless of where we practise, we see that there is a huge discrepancy in the palliative care that's available in various communities. A very valid concern is that some of these patients, perhaps because they don't have access to palliative care, they don't have access to pain control or to other services that are going to make them comfortable in their home or provide what they need toward the end of life, may choose MAID instead because of their fear of not being able to access palliative care and pain control.

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The Chair (Mr. Peter Z. Milczyn): Madame Gélinas.

Mme France Gélinas: Thank you for coming. I fully understand what you want us to do. I'm going to drill down a bit. If you don't feel comfortable, you don't have to answer, okay? So don't feel that you have to.

I'm reading the CPSO physician test for effective referral: "The physician takes positive action to connect a patient with another physician, health care provider or agency." Let's say this agency was now the CCAC, that we would have put in a network of MAID teams that are connected to the CCAC. Would that be acceptable to you?

Dr. Jodie Calvert Wang: If we have to do that referral or the patient is barricaded from accessing it, then yes, we would have a problem with it because we don't want to be in a position where we have to pick: "Am I going to follow my conscience, or am I going to allow my patient to access what they want to access?" There isn't any need for there to be that command that referral be in place for patients to access it. There isn't a reason why there can't be a telehealth number or a website or an agency that patients or families can contact directly. It doesn't need to be with a physician referral as the only door to get into this service.

Mme France Gélinas: Okay, because right now, anybody can refer to the CCAC. Your neighbour can call upon it; your family can call upon it. But this still wouldn't meet—you're really saying that a referral is collaborating or participating, and this is why you want your conscience rights to be respected.

I'm going to bring you down a little bit further. You don't have to refer the family. The patient has a way to access MAID. Now two MAID assessors call you because you are their family physician and they need access to the chart or they need access to their medication list. How would you respond to that?

Dr. Jodie Calvert Wang: Well, of course I'd be very happy to share anything that a patient wants to have provided, as long as I have the consent to share anything with any other provider. We have no problem with transferring a patient's charts or transferring their records or sharing medication lists, anything like that. That is not our issue. What is our issue is being forced to make a referral; in other words, family doctors being the only door for patients to access this.

The Chair (Mr. Peter Z. Milczyn): Thank you. That's all the time for today.

Dr. Jodie Calvert Wang: Okay.

The Chair (Mr. Peter Z. Milczyn): We have your submission, but if there's something further, you have until 6 p.m. today to submit it to us.

Dr. Jodie Calvert Wang: Good. Thank you very much.

GTA MAID

The Chair (Mr. Peter Z. Milczyn): Our next witness: GTA MAID.

Good morning. You have up to six minutes for your presentation. Please state your name for the official record.

Dr. Edward Weiss: My name is Edward Weiss. Ladies and gentlemen, honoured committee members, thank you for taking the time to hear my comments today. I'm a family doctor who practises here in Toronto, actually not too far from Mr. Milczyn's constituency office. I'm also an assessor and provider of medical assistance in dying, and I'm a co-founder of GTA MAID, which is a peer group of local MAID providers, as well as a website for patient self-referral.

I love the work I do in medicine every day, and I wouldn't trade it for anything else. Family medicine really lets you make a difference in people's lives from womb to tomb, and it's about the latter that I'd like to talk today. Suffering at the end of life is unfortunately all too common, and it makes an impression on you that's not easily forgotten. It used to be that when patients were facing the prospect of a long, debilitating and existentially upsetting journey towards death, we had no good answer when we were asked to help them end their suffering on their own terms, in a humane and dignified manner. Now we do. I strongly believe that MAID is a vital part of the options that we can offer our patients, and I'm appreciative of your efforts to help clarify some of the issues surrounding MAID with the proposed legislation in Bill 84.

I'd like to focus my comments on the rather contentious debate about conscience rights that has been taking place since the bill went into second reading. I'd like to dispel some of the erroneous and misleading arguments that have been put forward so far.

First, I'd like to point out that my colleagues and I who provide MAID pride ourselves on having in-depth, heartfelt conversations about the nature of a patient's suffering and why they wish to end their lives. We ask them about their personal histories with their families and their loved ones, their hopes and dreams, and why death has become the only desired option for them. We take the time that is necessary to understand the person as a whole and what drives their request.

We are explicitly mandated by federal law to ensure that patients are aware of the alternatives to MAID which are available to them, and, indeed, most of the patients who I've seen are already extremely well-informed about these.

No one in our field is eager to perform MAID. We recognize that it's a decision that's often difficult and fraught with mixed emotions, and we aim to guide our patients through this time in a non-judgmental and non-directive manner. Not everyone who requests a MAID assessment will receive an assisted death. Many patients that we see do not meet the legal criteria. Conversely, we regularly encounter people who are eligible but believe, in the end, that MAID is not for them after having had an honest discussion.

I would also ask you to consider that although we can hear stories of those whose consciences are pained by the

thought of having anything to do with a patient's death, we cannot hear from the hundreds of people who have utilized their right, now enshrined in Canada's laws, to put an end to their suffering in a way that they thought to be the most dignified, painless and even life-affirming way possible. We cannot hear their relief and their comfort in making that most final of decisions, but we can listen to those who they've left behind, like the patient's wife who told me, after an initial assessment for MAID, that we were the first to actually listen to her husband and understand his suffering without judgment.

We can also listen to those whose voices are the hardest of all to hear: those who depend on their health care professionals to advocate for them. I was recently asked by another physician to see a gentleman for a MAID assessment. He is a frail man with advanced HIV-related complications who is virtually housebound and whose telephone broke recently. He can't afford another one and he has no friends or family to ask for help with his request. I ask you to ponder how someone like him can access MAID if not through the referral of his trusted doctor.

Or what about the proud, independent 86-year-old woman with rapidly advancing cancer whom I saw a few months ago? She was driving on her own in October of last year and, by December, was bed-bound in a hospice due to the painful spread of cancer to her bones. She didn't want to live like that, a shell of her former self, completely dependent on others for every bodily function.

Despite multiple requests, none of her doctors or nurses even told her that MAID was legal, let alone referred her for an assessment. By the time she came to my attention, she was suffering intolerably despite the very best symptom management that the palliative care staff at the hospice was able to provide. This was an unnecessary delay that denied her the peaceful and dignified end that was rightfully hers.

It's for the sake of patients like these that we need to ensure that people requesting MAID face fewer barriers and not more. I would absolutely welcome a centralized referral or coordination system such as other provinces have in place, but we simply don't have this here in Ontario yet, and even if we did, it would not absolve physicians of their responsibility to advocate for those who don't have the ability to access such a service on their own. We, as physicians, have a fiduciary duty to stand by our most vulnerable and neglected patients in their time of need.

To my colleagues who claim conscience rights, I say that you went into medicine to be a force for good and to be an advocate for your patients, which means that sometimes you have to make decisions you're not comfortable with, not rest on your laurels and leave the helpless to fend for themselves in a system that can be difficult to navigate even at the best of times. By referring a patient for a MAID assessment, whether to another physician or to an agency willing to coordinate requests, we are respecting the patient's autonomy and allowing them to make this decision for themselves.

I've actually had the privilege of dealing with religious physicians who personally object to MAID but who have gone out of their way to ensure that their patients can still access it without them being personally involved. This kind of behaviour which respects our patients is what should be applauded and required.

To conclude, I thank you for your work in further improving the delivery of MAID here in Ontario through the provisions of Bill 84. I hope that you will continue to support this important part of our health care landscape.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Weiss. Mr. Yurek.

Mr. Jeff Yurek: Thanks for coming in, Doctor, and for the information coming forward on your side of the argument. We're trying to hear a balance at committee.

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The stories you told are terrible, and I think this speaks volumes to the government's need to create a system to support a medically assisted dying self-referral system. But here, I'm seeing two stories. Where was the CCAC involved with the care of these patients, either for the gentleman who was at home with the broken telephone and/or the patient in the hospice? Obviously, the system broke down somewhere where they didn't get a referral even to the CCAC to get help in maintaining their health at home. Did you hear about any of that going on? Did you know what happened with regard to the CCAC being involved in the services?

Dr. Edward Weiss: As far as I recall with these two patients in particular, they were already receiving CCAC services. The first patient that I mentioned, with HIV, has an extensive support network. But there's no way for a non-physician at this point to connect someone with MAID services.

To be honest, I've been a MAID provider since the Supreme Court decision came into effect, and I've been frankly disappointed at the level of administrative and bureaucratic hurdles in dealing with some of the provincial agencies like CCACs. Last year, we had to scramble to learn how to insert IVs on our own, because the CCAC wouldn't provide nursing care, because their policies were not composed yet.

I don't think that trying to pin it on the CCAC is really the answer here.

Mr. Jeff Yurek: If the system is set up, then that would open up the opportunity for the CCAC to provide the necessary connections that would open up more avenues to access to services—

Dr. Edward Weiss: It would certainly open up more avenues, but again, I believe that it would not be universally applicable to everyone.

Mr. Jeff Yurek: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): Madame Gélinas.

Mme France Gélinas: Thank you for coming to Queen's Park, and thank you for your deputation. You were here in the room when you heard, like we did, many other physicians saying that an effective referral, they feel, is actually collaborating and participating in something that they do not want to do. Do you see it that way?

Dr. Edward Weiss: I heartily disagree. To be honest, I think the words "effective referral" reflect a phrasing that people find unacceptable. But in other provinces that have different policies—for example, in Nova Scotia, the words used are that they require an "effective transfer," not an "effective referral." And yet, the substantive content of their requirement for physicians is basically the same.

I actually have the Nova Scotia college of physicians' policy here, which says that a physician unwilling or unable to provide medical assistance in dying must advise the patient of this; must provide the patient with a copy of the college of physicians' standard; must provide all relevant patient medical records to the physician providing MAID services; and must continue to provide medical services unrelated to MAID.

Really, all we're asking is that physicians who are unwilling to participate in MAID ensure that their patients can access it through whatever means possible, and be willing to work with us as providers, to share their records and share their opinions of their patients.

Mme France Gélinas: That's my next question. How much collaborative work will happen? A patient has been referred to you. Do you still need the help of the family physician in order to complete your assessment and do your work?

Dr. Edward Weiss: Absolutely. In many cases, if not all, we do. As I believe Mr. Yurek pointed out last week, we do hope to have an electronic medical records system that's universally available. But even that would not cover the very long history that a family doctor might have with their patient. They know their patients best and could tell us more about what's driving this person's request and what their health issues are.

Mme France Gélinas: Have any of them refused to give you that information?

Dr. Edward Weiss: I've had one family doctor who basically used the Ministry of Health referral line to connect a patient with me, gave me the patient's information and said, "I don't want to hear anything more about this." I guess—if that counts.

I haven't had anyone refuse outright to have a discussion at all, but certainly there have been referrals sent to me without the necessary information that I need, and that has created unnecessary delays and roadblocks for patients.

Mme France Gélinas: So you are telling me that it's not—

The Chair (Mr. Peter Z. Milczyn): Thank you. That's all your time.

Madame Des Rosiers.

Mme Nathalie Des Rosiers: Could you just pursue your answer here? I'd just like to know: What are the things that you need? I understand from your testimony that, basically, you are in support of the position of effective referral as currently drafted by the CPSO. Just tell us a little bit more, if you want to complete your answer to Madame Gélinas. You need the patient's records—what else do you need?

Dr. Edward Weiss: Absolutely. Most recently, as you may know, the coroner's office in Ontario has set up a system of nurse investigators to handle all MAID reporting. I have been told that these investigators require extensive information regarding a patient's health history. As MAID providers, we're not always presented with all this information, and oftentimes we do need to go to a family doctor and say, "I need copies of the consultation with the oncologist or copies of a CT scan." Without this information, it's hard to really form a professional opinion about whether a person is eligible and to properly document their case for eligibility and make that proper reporting to the coroner's office.

M^{me} Nathalie Des Rosiers: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you very much, Dr. Weiss. We have your submission, but if there's something additional, you have until 6 p.m. today to provide that.

Dr. Edward Weiss: Thank you very much.

The Chair (Mr. Peter Z. Milczyn): The committee stands recessed until 1 p.m. this afternoon.

The committee recessed from 1015 to 1300.

The Vice-Chair (Ms. Ann Hoggarth): Good afternoon. We're meeting here this afternoon for public hearings on Bill 84, An Act to amend various Acts with respect to medical assistance in dying.

Each witness will receive up to six minutes for their presentation, followed by nine minutes of questioning from the committee, or three minutes from each caucus. The first round of questioning this afternoon will begin with the NDP caucus. Are there any questions before we begin?

NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO

The Vice-Chair (Ms. Ann Hoggarth): Then I will call the first witness, which is the Nurse Practitioners' Association of Ontario. Welcome, and would you please state your name for the official Hansard record.

Ms. Theresa Agnew: Thank you so much. I'm Theresa Agnew and I'm the chief executive officer of the Nurse Practitioners' Association of Ontario.

NPAO is the professional association representing more than 3,100 nurse practitioners in Ontario. We've been actively involved in supporting our members related to the appropriate and lawful implementation of medical assistance in dying in Ontario. We are pleased to have the opportunity to speak to members of the standing committee about Bill 84.

In 2016, nurse practitioners were included in the federal legislation, Bill C-14. The Criminal Code was amended to exempt physicians, nurse practitioners and others from prosecution for those involved in lawfully participating in MAID for eligible patients. Ontario's Bill 84 provides additional protections and clarifications.

NPAO supports the Wynne government's Bill 84. In particular, we strongly support the amendments to the Freedom of Information and Protection of Privacy Act

and the Municipal Freedom of Information and Protection of Privacy Act that enhance privacy for health care providers participating in MAID.

In addition, we have added four recommendations that we believe will promote patient access to MAID and will enhance safe, effective and holistic palliative and end-of-life care.

Recommendation number one: NPAO recommends that the government expeditiously pass the regulations authorizing NPs to prescribe controlled drugs and substances. The regulations were approved by the College of Nurses of Ontario at its March 8 council meeting. We're now waiting for those regulations to pass through government.

To help ensure that patients who request and qualify for MAID have access to it across Ontario, especially those patients who wish to die at home, and to promote and deliver effective and efficient palliative and end-of-life care to patients, the government should approve the regulations without delay that give independent authority to nurse practitioners to prescribe controlled drugs and substances, as Ontario is the last jurisdiction in North America to authorize NPs to prescribe controlled drugs and substances. This is a matter that NPAO has long advocated for. We strongly recommend approval without delay.

Recommendation number two: NPAO recommends that nurse practitioner professional liability protection requirements be strengthened for those NPs participating in MAID. NPAO appreciates that Bill 84, if passed, will indemnify NPs and physicians from civil liability if there is no negligence. In order to ensure that practitioners are protected from liability arising from the lawful provision of MAID, the government should also ensure that all NPs have the appropriate type and level of professional liability protection.

All NPs who are members of NPAO currently have access to \$10 million in occurrence-based PLP provided by the Canadian Nurses Protective Society, which is similar to the PLP provided to physicians by the Canadian Medical Protective Association.

NPs who are not members of NPAO may not have the type of PLP that covers them for participation in MAID after hours and outside of their work environment. This may put practitioners, teams, patients and families at risk. Thus, NPAO recommends that the government require all NPs participating in MAID to have occurrence-based PLP.

Recommendation number 3: NPAO recommends that NPs be appropriately compensated for their participation in MAID.

NPs work across the province in all settings, but many provide primary care and work in the community. To help promote access and the safe delivery of MAID to patients who desire it, it is important that NPs who are providing this service be compensated. NPs are compassionate and caring practitioners who want to meet the needs of those who request assistance in dying. We have heard stories from NPs who have participated in MAID,

either outside of usual business hours to their patients, or to patients referred to them through the ministry's clinician referral services. These NPs have told us that they are not being compensated for consultation services, for travel, or for providing services associated with MAID.

Unlike physicians, NPs cannot use their OHIP billing number to bill for the provision of clinical services. Appropriate compensation will help to ensure access, particularly once demand for NP services increases with the additional controlled-drugs-and-substances prescribing authority.

Then, in terms of non-legislative measures, in addition to the care coordination service announced by the government, NPAO strongly recommends that the government fund programs and supports for practitioners providing MAID. Given that this is such a new area of practice in Ontario, we have learned from other jurisdictions around the world that practitioners participating in MAID require specific education, supports and mentorship. Supporting practitioners will enhance access and ensure that the patient always comes first. Thank you.

The Vice-Chair (Ms. Ann Hoggarth): Thank you, Ms. Agnew. Ms. Gélinas?

M^{me} France Gélinas: It's always a pleasure to see you. Thank you for coming to Queen's Park today.

My first question is something you didn't touch on. I'm just curious to know if there have been many nurse practitioners who have asked for a conscientious exemption, as in they do not want to make a referral, because I understand your college mandates a referral if they don't. Has there been any discussion at NPAO about this?

Ms. Theresa Agnew: We undertook a survey of our members prior, actually, to the federal bill being approved. From our members, there is a small percentage of nurse practitioners who would not participate in MAID individually. They would not provide the service because of matters from a moral, religious or cultural perspective. In addition, there may be nurse practitioners who would decline to provide MAID services because they feel they don't have the knowledge, skill or judgment.

However, according to the College of Nurses of Ontario, nurse practitioners are required to make an effective referral so that the client is not abandoned and the practitioner does not stand in the way of the client receiving appropriate care and services.

M^{me} France Gélinas: Have any of your members come to you and said that they oppose the effective referral?

Ms. Theresa Agnew: No, we have not had members come forward saying that.

M^{me} France Gélinas: Okay. You gave an example. Some of your members have started to take part. From what you're telling us, you're asking us to do a lot of work that is not there yet. The coordination services that you talked about—is this something that works in some part of the province for some of you?

Ms. Theresa Agnew: We understand from the press release that came with the announcement of Bill 84 that the government is planning to introduce care coordina-

tion services. This would be a service in addition to the ministry's current clinician referral services. We don't know much about that particular service. But, in addition to that, we do feel that our practitioners require more educational supports and mentorship with respect to this new area of practice.

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M^{me} France Gélinas: I would agree to all of the above. I can tell you that in my riding, somebody reached out to me because they could not gain access. Their physician was trying really hard to help them, but we discovered that in all of the northeastern Ontario LHIN, there is nobody who is registered with the 1-800 number, which means that care was not available.

The Vice-Chair (Ms. Ann Hoggarth): Thank you, Ms. Gélinas.

Government: MPP Fraser.

Mr. John Fraser: It's nice to see you again, Ms. Agnew. Thank you for presenting today.

Ms. Theresa Agnew: Thank you.

Mr. John Fraser: I first want to assure you that your first recommendation is being worked on very hard, and I think we're close to getting to a resolution of that, which will help you provide not just these services but a whole host of really important services. I want to thank you for advocating for that.

As well, I see that you're supportive of the protection of the freedom-of-information provisions that are in that bill that basically exempt practitioners and institutions like hospices, hospitals and community health centres from that. I think that from our end—from my end, anyway—that's a critical part of the bill.

Ms. Theresa Agnew: We think it's a critical part as well. We're fully in support of that piece.

Mr. John Fraser: As you can imagine, we've heard from both sides. This bill is largely technical in nature. We've heard from both sides essentially around access, and access is a critical thing.

I want to get into the care coordination service. You said that you were supportive of that. I guess the best question is, from a nurse practitioner's point of view, how do you see the care coordination service working for your members?

Ms. Theresa Agnew: First of all, the provision of MAID is really the extension also of palliative care services and end-of-life services, which nurse practitioners are already involved in across the province. None of this is done alone. It's always done as part of a team, and it always includes a large number of health care providers and other services as well—community supports, transportation services etc.

My colleague and I actually just came from a meeting with the Ontario Pharmacists Association, talking to them about how we can enhance the connection of nurse practitioners to pharmacy services, specifically in this area as well.

But again, I think that what is important here is to ensure that we do have fair and equitable access to services across the province and that we not see the type

of situation that France Gélinas explained to us, and that we also provide care coordination services not just for the client at this one point in time but, prior to that, also to the family, and as well, bereavement services, and support for practitioners as well.

Mr. John Fraser: Thank you very much.

The Vice-Chair (Ms. Ann Hoggarth): MPP Yurek.

Mr. Jeff Yurek: How are you?

Ms. Theresa Agnew: Good.

Mr. Jeff Yurek: Good. Thanks for your deputation and submission.

It's interesting that you met with the Ontario Pharmacists Association. I've mentioned this before, that perhaps there's some form of partnership where nurse practitioners could actually be operating some form of clinic or something inside pharmacies, which already have the infrastructure across the province. It wouldn't cost the government much of anything, other than to ensure that nurse practitioners have their full scope of practice that they've been waiting for, for quite a long time.

It must be tough for current nurse practitioners to be involved with medical assistance in dying right now, if there's inhibiting of their availability of scope.

Ms. Theresa Agnew: At this point in time, the nurse practitioner can participate, but only to a certain extent. The nurse practitioner cannot be the primary provider of medical assistance in dying. Once the changes come through with controlled drugs and substances, that will change.

But we have heard from our members. For example, our president had a patient who is terminally ill and wanted to die at home, surrounded by the love of her friends and family, with medical assistance. This patient has been seen by the nurse practitioner for 15 years and has developed a really deep and close relationship with that NP, but unfortunately, the NP had to make a referral to another practitioner who doesn't know this patient. We're really talking also about continuity of care here. That will be enhanced as well.

Mr. Jeff Yurek: How long have you been waiting for the authorization to prescribe the controlled medications?

Ms. Theresa Agnew: Controlled drugs and substances: The changes came through enabling nurse practitioners—changes to federal legislation came through in November 2012. Ontario is now the last jurisdiction in Canada—actually, it's the last jurisdiction in North America to enable nurse practitioners to be able to prescribe controlled drugs and substances.

As MPP Fraser said, this isn't just about MAID; it's about providing services to people with psychiatric or mental health conditions, learning disorders and relieving pain, whether it be acute or chronic pain, in a number of settings.

Mr. Jeff Yurek: I would imagine the expanded scope for nurse practitioners might deal with the situation in the northeastern part of Ontario that—

Ms. Theresa Agnew: Well, one would certainly hope that that would increase access to appropriate services across the board.

Mr. Jeff Yurek: Thanks.

The Vice-Chair (Ms. Ann Hoggarth): Thank you very much for your presentation. The deadline: You already gave us a submission, but if you have anything further that you wish to send to us, a written submission can be sent to the Clerk of the Committee by 6 o'clock this evening. Thank you, Ms. Agnew.

Ms. Theresa Agnew: Thank you very much.

CATHOLIC CIVIL RIGHTS LEAGUE FAITH AND FREEDOM ALLIANCE

The Vice-Chair (Ms. Ann Hoggarth): I now call on the Catholic Civil Rights League and the Faith and Freedom Alliance. You will receive six minutes for your presentation followed by nine minutes of questioning, three from each caucus. The round of questioning this time will start with the government. Would you please state your names for the official record?

Mr. Philip Horgan: Absolutely. My name is Philip Horgan. I'm the president of the Catholic Civil Rights League and serve as chair of the Faith and Freedom Alliance. To my left is Catherine Pawluch, a lawyer in Toronto who has been active in our organizations, and to my right is the executive director of the Catholic Civil Rights League, Dr. Christian Elia.

If I may proceed, Madam Chair: First of all, thank you very much for the invitation to allow us to appear today. Our organizations have been active on this issue for quite some time. I've given a brief; it's being passed around. You'll find on page 2 the history of our organizations as well as some information on the fact that we are an intervenor in the current applications before the court to be heard in June with respect to the CPSO policies, specifically on effective referral.

It was my intention to let my written submission be my guide, and hopefully address some of the issues on my review of last week's March 23 presentations, since that seems to be an indication of where your inquiries may arise.

At the bottom of page 2, I've indicated that there are several concerns with the bill. In particular, we share the concerns of privacy commissioner Brian Beamish from his presentation last week on the need for transparency in reporting and access to information on assisted suicides and the data provided by that publicly funded process.

I am aware of the previous applications that were brought to seek that effort to suppress abortion statistics a few years ago, which led to litigation, which led to the release of the data. In effect, by trying to prevent that data going forward, you're just inviting litigation and incurring costs for the taxpayers of Ontario.

The real focus of our submission, though, follows on page 3. I will not review the various policies, but based on the exchanges from last week, I put forward some information to help you unpack the history of the deliberations at the CPSO which gave rise to the concerns being addressed by many of the conscience advocates that you've already heard and will continue to hear.

I've highlighted there at the top of page 4 a poll that was taken back in 2014 in that process, where 77% of those 32,912 respondents had indicated the need for better conscience protection. I've highlighted again the various other consultations undertaken by the CPSO, and at every stage the majority of participants sought religious and conscientious protections, and those discussions were largely accepted but not implemented in the two final versions of the policy.

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I've also added, midway down on page 4, the recent information disclosed by an access-to-information request of the position of the registrar of the CPSO in his deliberations with the federal advisory panel in November 2015 prior to the MAID policy—even the draft policy which was only released in December of that year, in which he effectively said, "This is going to be our policy." I urge you to have a quick look at that. It's also part of the court case which is going to be heard in June. The overall proposition is to reiterate what you've already heard from others, which is, you have a delegated authority in the CPSO which is exercising its judgment without engaging in a true balancing of those competing rights. In that context, it's our submission that the Legislature has an opportunity, an obligation, in my view, to intervene to correct that imbalance.

On page 5, I put forward some of our submissions, which is a repeat of some of the arguments we're raising in the Divisional Court. In that context, at the bottom of page 5, I've itemized a concept which I urge you to read because it's nuanced, which is a framework of an analysis of what we mean by conscience—of the notion of a preservative exercise of conscience versus perfective. The easy example in the perfective would be the doctor or the patient seeking assisted suicide. They're pursuing what they choose to be the right thing to do; whereas the doctors or health care workers who are seeking to avoid being implicated in that process are engaging in a preservative exercise of freedom of conscience. In law, we talk about the difference between a sword and a shield. Any imposition or infringement of those preservative notions of freedom of conscience, we submit, should be extremely limited and rarely afforded. In fact, I can't think of an example where it should be allowed.

If I could turn, then, to the other main submission which is found on page 7 and following, it's the concern about a self-reporting regime. We've already seen circumstances in other jurisdictions—most notably Quebec, recently, where the first six months of the exercise of assisted suicide in that province led to, I believe, 21 different instances of non-compliance by doctors. In particular, the relationship between the proposed changes to the Coroners Act and the Vital Statistics Act creates a bit of an anomaly, in that the current proposal is, "Send in a letter after the deed is done," but then under the Vital Statistics Act you are relieved from having to provide further information under the current 21(5) and (6) if the coroner doesn't have a concern.

The Vice-Chair (Ms. Ann Hoggarth): Thank you, Government?

M^{me} Nathalie Des Rosiers: I understand that you're suggesting some wording in terms of framing the exemptions at the end, and you're suggesting that the exemptions should be linked to not having to perform—for sure, I think everybody agrees with this—assist or make a referral. This morning, we heard from some people who say it's actually necessary to make the assessment because not everybody who will seek information for MAID will be eligible for it. To make the assessment, you have to know the patient's medical history. It's impossible to determine whether that person is eligible or not without having access to the medical history. Is it your position that, even in that case, someone could say, "I'm not even going to provide the information"?

Mr. Philip Horgan: The medical chart goes with the patient. That's their choice. It's their chart. Having said that, I think you're speaking to something more important, which is the sum notion that an objecting physician will intend to abandon their patient. That's not the proposition at all.

M^{me} Nathalie Des Rosiers: Can you just enlighten me as to what you would be comfortable with?

Mr. Philip Horgan: I refer you to the submissions made last week by Dr. Wolfs, Dr. McQueen and various others. They're in that field and they know what goes on there. My sense is that the proposition that seems to have met with some approval from committee so far is this notion of a 1-800 number or some other self-referral regime.

That doesn't take away the opportunity for the attending objecting physician to nevertheless engage in a counselling exercise, understand if the root cause of the request may be depression, may be an episode of some temporary nature or, if it's even a pain management issue, can't be addressed in that fashion.

M^{me} Nathalie Des Rosiers: But once, for example, the patient would have decided to take the number and call and be appropriately treated by someone else, then the—I'm just worrying about the word that you're using. You're saying to prevent assistance. I think the word "assistance" could be interpreted as negating any obligation to forward information or to support this. But for you, it means something different.

Mr. Philip Horgan: I think in that context, if a patient goes that route and takes up that opportunity, the new physician would be requesting the chart on behalf of that patient. I don't think there's going to be an objection to the release of that information. It doesn't belong to the doctor.

The Vice-Chair (Ms. Ann Hoggarth): Thank you, MPP Yurek.

Mr. Jeff Yurek: Thank you for coming in. Did you want to touch on the Coroners Act? You didn't get to finish that.

Mr. Philip Horgan: Yes. If you look at page 8, for example—I'm trying to connect the dots between the Coroners Act provision under section 10.1 and then how it relates to section 21 of the Vital Statistics Act. As I

understand the process now—and I could prepare to be educated, since it's new—the expectation is that the person who performs the act will provide a report and provide circumstances in some form, which I presume may be addressed in regulations; I don't know.

The concern is, that's it. Thereafter, if you look at subsections 21(5) and 21(6) of the Vital Statistics Act—which I haven't appended, but it's certainly available to you—that process provides for other information that is normally provided by a doctor. But it's only relieved from that process if the coroner accepts, I presume, the submission made on the assisted suicide. So at what point is a doctor not in compliance with the act, if he or she sends in that one-page report but then doesn't comply with subsections 21(5) and (6) of the Vital Statistics Act until he or she gets word back from the coroner?

My solution, my suggestion, is that if in fact there is a reporting requirement—which I think invites trouble. It invites a proposition where doctors who are not compliant will not report themselves. Or they won't report it as an assisted suicide; they may just treat the cause of death as the underlying illness, symptom or whatever the case may be.

My suggestion is that if there's going to be a reporting requirement—and the Criminal Code provides for a 10-day window—after that original proposition or demand is put forward, properly witnessed, and is properly the subject of a second opinion, send in that report at that point so that at least there's an opportunity. If you send it by email, you get a 10-day window. So if the coroner has an issue, a question could be raised.

At that point, if in fact it proceeds, it seems to me a better effort at compliance as opposed to trying to do something after the fact when the patient is dead.

The Vice-Chair (Ms. Ann Hoggarth): Madame Gélinas?

M^{me} France Gélinas: Sorry; I had to go introduce a bill and I could not be here.

I'm looking quickly through your submission. I'm curious about this part about the coroners and your recommendations. What specifically would be your recommendation? You're asking for an amendment to the bill regarding—

Mr. Philip Horgan: Yes, I think I put it there at the mid-part of page 8. Section 10.1 talks about submitting a report to the coroner after the death. I'm suggesting that the Criminal Code provides this safeguard of a 10-day period for reflection, which itself could be abbreviated, as you know, if there's a concern that death may be imminent in any event. If we have that 10-day window, that should be the point when the submission is made to the coroner saying, "This request has been received and, in fact, it appears to either comply or I have concerns." At that point, a coroner charged with that review could have a look at it.

Let's look at the numbers. If it's going to be upwards of, we predict, 1,000 or more of such situations a year, is it too demanding to ask the coroner to look at two, three or four of these in a day, and on a rush day there may be

10? That's why that 10-day window gives that opportunity for someone in the coroner's office to at least make sure we're on board. If we're really talking about safeguards, I don't think the proposal that's in the act currently provides that level of security.

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M^{me} France Gélinas: Go ahead.

Dr. Christian Elia: From a data management and record-keeping statistical standpoint, there's a better opportunity for easier tracking across the board which would be of assistance as well to long-term-care facilities and nursing homes, where these demands for assisted suicide, these propositions, would be given—so whether the 10-day period or if a provision for a reduction in that, because of imminent death, at the time of the first proposition.

M^{me} France Gélinas: But you're not opposed to also reporting to the coroner once a death has taken place; you're just putting in an extra opportunity for action by the coroner.

Mr. Philip Horgan: Correct. We're dealing with an unusual circumstance. My suggestion is that it doesn't relieve the doctor from reporting a death and filling out a death certificate; that remains. We're talking about safeguards, are we not?

M^{me} France Gélinas: Yes.

Mr. Philip Horgan: In that context, there's an opportunity here that if there's going to be a reporting requirement—which we find weak to begin with, based on the experience of other jurisdictions—let's do it right. Let's at least get the base information upon which a patient has made these decisions, in advance of a matter which is irredeemable.

M^{me} France Gélinas: The care coordination: I have no idea if you touched on that, and I apologize profusely. Was this something that you supported, that you've been involved with, that you see—

The Vice-Chair (Ms. Ann Hoggarth): Thank you for your presentation. If you have a further written submission, you can hand it to the Clerk by 6 o'clock this evening.

Mr. Philip Horgan: Thank you, Madam Chair.

Dr. Christian Elia: Thank you.

DR. RAMONA COELHO

DR. PHILIPPE VIOLETTE

The Vice-Chair (Ms. Ann Hoggarth): At this time I'd like to call on Ramona Coelho and Philippe Violette. Each witness will receive up to six minutes for your presentation, followed by nine minutes of questioning from the committee, or three minutes from each caucus. This round will begin with the PC Party. Please identify yourself for Hansard.

Dr. Ramona Coelho: My name is Dr. Ramona Coelho. For five years I practised in Montreal as a home care doctor for dying and disabled persons. Now I'm in London, Ontario for five years, where I have a regular

family practice with mostly refugees, immigrants, and people with mental illness and chronic pain.

Dr. Philippe Violette: My name is Philippe Violette. I grew up in Val Caron, near Sudbury, Ontario. I then attended McGill University, Western and McMaster. I now practise as a urologist and clinical epidemiologist, with affiliations to both Western and McMaster.

Dr. Ramona Coelho: We're going to save you guys time because we thought we had three minutes each.

I will start by saying that part of my passion is mentoring medical students in residence. I did that when I worked at McGill in Montreal, and I continue to do so in London, Ontario.

The Vice-Chair (Ms. Ann Hoggarth): Just before you go on, there's a total of six minutes for you.

Dr. Ramona Coelho: Okay, perfect.

The Vice-Chair (Ms. Ann Hoggarth): For both of you it would be three minutes each.

Dr. Ramona Coelho: Perfect. We'll be three minutes each.

The Vice-Chair (Ms. Ann Hoggarth): Then there are three minutes of questioning from each caucus.

Dr. Ramona Coelho: Very good. My first story is of a woman who's in her last year of a neurology residency. She is brilliant, she is capable and she is very likable, yet she wonders whether she will be hired on by a hospital and whether she will be discriminated against since she cannot participate in MAID.

Another young family doctor I know, whose family was persecuted in Iraq for religious reasons—they fled here some years ago. Her friends absolutely applauded this brilliant stroke of luck that her family could finally practise their religion in freedom. Now she understands that she will be disciplined by our college, or even be forced to leave her family medicine practice, because our provincial government is not willing to guarantee the religious freedoms that her family had understood they would have when they came here.

This problem of discrimination and intolerance is real. It was created by our CPSO and now is being furthered by MPPs. Instead of asking us, your conscientious objectors, for creative ways to work together and to build the system, the CPSO came up with a policy that tries to coerce us to do something against our will.

In fact, the CPSO public consultations were ignored. The working group came out with their publication before 80% of the submissions were received. The OMA, which you heard today, the CMA and AMA were all very clear, as well as the public, in their overwhelming response that conscience protection is important.

Here is a part of the CMA's submission, paraphrased, that makes my point: Pitting conscience rights and patient rights against each other, as is done by the CPSO, is not respecting conscience rights in their full integrity and creates a false dichotomy and an unnecessary trade-off. No jurisdiction has a requirement for a mandatory effective referral, and yet patient access does not seem to be a concern.

We are willing to give information. We are not trying to obstruct. I think this has been a mark of our goodwill

and shows that we are trying to find a compromise. The CPSO trying to violate our conscience and coerce us cannot be seen in the same light.

We might disagree with one another, but in a pluralistic, beautiful society such as Canada, we should try to respect each other's opinions and beliefs. Coercion to act against one's deeply held beliefs is an erosion of our liberties, which we have prized together as a society and which, until now, were greatly admired by the whole world.

Dr. Philippe Violette: I am very concerned about the rhetoric developing around the issue of conscientious objection to MAID. The CPSO, Dying with Dignity and others claim that effective referral is actually a solution that respects the conscience rights of the objector. I would like to propose that this is deliberate misinformation. One would think that only the conscientious objector can decide what is and what is not in keeping with their values—to claim otherwise is a campaign of confusion.

Numerous physicians that I know have lobbied for many months to explain to the Ministry of Health, MPPs and the CPSO that effective referral is not a solution we can work with. My lovely wife has met with the Deputy Minister of Health and quite a few MPPs as well to explain just that.

Today, I attach a letter of solidarity from Jewish, Muslim and Christian leaders that states that effective referral is not possible while adhering to our faiths. Many of my family and friends writing into Liberal ridings have received the following response: "We care about conscience protection and therefore objectors can simply refer to the care coordination service." No one involved in this process can pretend that they didn't know that this kind of effective referral is not a workable solution.

Dying with Dignity and the CPSO could be looking to increasing access through licit avenues of influence, not through the disrespectful way of using physicians against their will. This coercion can only result in a monoculture of doctors with the same ideologies and many physicians discriminated against and forced to leave the practice of medicine.

It seems to me that there is a deliberate attempt not to hear or to understand the simple position of the conscientious objector. If I were to participate deliberately in ending one of my patient's lives, they would die, but I would still be alive, and I couldn't live with that.

Effective referral places undue duress on physicians who do not want to participate in MAID, especially when there is an easy solution: Provide patients with direct access and strongly protect physicians who don't want to participate—

The Vice-Chair (Ms. Ann Hoggarth): Thank you. We begin the questioning in this round with MPP Yurek.

Mr. Jeff Yurek: Do you have a few more sentences that you want to—

Dr. Philippe Violette: Well, I feel that if MAID is a ministry priority, then providing the infrastructure for direct access should not be a difficult task. It's definitely

worth the challenge of exploring solutions that can maintain access and respect conscience.

Mr. Jeff Yurek: Thanks for coming down. I, too, have heard that doctors can basically just effectively refer, call that number, and they're not part of the process. Is that a way of basically telling you what your beliefs are by saying that, when in fact you are in total belief that you're part of the process, even by calling that 1-800 number for the patient?

Dr. Philippe Violette: Yes, absolutely. It's certainly participating in the end result. That wouldn't be something that the majority of conscientious objectors would be comfortable with.

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Mr. Jeff Yurek: Further to that, in general, any type of referral you do make—and if it's done in error or for other reasons, you're held liable for that referral, so it seems like the college is picking and choosing what they deem as—

Dr. Ramona Coelho: This is a sign of ethical supremacy, right? For everything else, if they agree with us and our referral is bad, we can be punished, but here they're telling us it shouldn't bother us because they're right.

Mr. Jeff Yurek: If you can confirm: Last week we had a députant mention that their billing number or doctor number follows the patient even if you make that 1-800 call and transfer the patient. Do they still utilize your OHIP number?

Dr. Ramona Coelho: I don't know.

Dr. Philippe Violette: When I make a referral to another physician, the other physician uses my billing number to be paid for the service.

Mr. Jeff Yurek: So technically, looking at how the system operates, you're linked even though the CPSO says you're not and others are saying you're not. Following the paper trail, you are linked to that referral.

Dr. Ramona Coelho: Yes.

Mr. Jeff Yurek: Earlier today, the CPSO said that there are other jurisdictions which have effective referral, but I'm quickly doing some research and it doesn't seem we're comparing apples to apples. Do you have any comment?

Dr. Ramona Coelho: We are perfectly comfortable—I notice that you brought up that question about transfer of care. If a patient or another doctor asks for a transfer of care, of course we will transfer care; of course we'll provide our medical chart. But to be the one to initiate that for the purpose of MAID is not permitted for us.

Mr. Jeff Yurek: Thank you very much.

The Vice-Chair (Ms. Ann Hoggarth): MPP Gélinas.

Mme France Gélinas: Merci beaucoup d'être venus.

Je connais beaucoup de familles Violette toujours à Nickel Belt, et tu ressembles à quelqu'un que je connais bien, également. Est-ce que tu as encore de la famille à Nickel Belt?

D^r Philippe Violette: Oui. Bien, la majorité de ma famille est à Sudbury, quand même.

Mme France Gélinas: Il y a plusieurs personnes qui sont venues nous dire exactement la même affaire que

vous nous dites en ce moment. Ils veulent que leur droit de ne pas faire de renvois en service soit respecté.

Les lettres que vous avez reçues parlent de « care coordination ». Est-ce que vous connaissez ça? Est-ce que ça existe là où vous pratiquez?

Dr. Ramona Coelho: The care coordination service, as I understand it, is not set up yet. I'm asking Mr. Fraser—

Mr. Jeff Yurek: You can't really ask questions here.

Dr. Ramona Coelho: Oh, sorry. I don't know. I'd be lying to you. I don't know if it's set up. But, hypothetically, the service would offer many services, including MAID. I know about it, but I don't know if it exists in my area yet.

Mme France Gélinas: I can tell you that it does not exist, but let's pretend we're in the future and this thing exists. Would you feel comfortable making a referral to a care coordination service if it includes end of life, palliative care, home care and other services?

Dr. Ramona Coelho: The problem with that concept for us is that all of those other services can be accessed elsewhere, so the only real reason we'd be consulting the care coordination service would be for the MAID consult.

Mme France Gélinas: Okay, so that doesn't change—

Dr. Ramona Coelho: It's problematic the way it's structured, yes.

Dr. Philippe Violette: Perhaps a better way of framing it would be, if there is a source, like an access point into the health care system, period, and within that health care system there is whatever is covered within the health care system, that's a reasonable point, because that's access to everything and not only accessing a service that is essentially a funnel into MAID, whereas we can access these other services separately. I don't know if that was clear, so I apologize.

Mme France Gélinas: No, not that clear.

Dr. Ramona Coelho: We can get palliative care, home care, oncology—all of those things—through the way that we've been referring already to the hospital. The only reason we'd be changing our referral pattern would be to accommodate a MAID assessment.

Mme France Gélinas: Okay. But you do go on to say that you would not have any problem providing a chart?

Dr. Ramona Coelho: No, or information. We're not trying to obstruct people. We're willing to tell them it's legal and that they could call the hospital and contact—we're not trying to hide or obstruct. We just don't want to participate.

Mme France Gélinas: So you haven't made a referral, but there's a system in place, the patient got access, got assessed, and then one of the assessors calls back and says things like, "Okay, we can see that he's on an anti-depressant. He says that it's to help him sleep, but"—

The Vice-Chair (Ms. Ann Hoggarth): Thank you. The government: Madame Des Rosiers.

Mme Nathalie Des Rosiers: Oui. Encore une fois, merci beaucoup d'être à Queen's Park et de nous faire part de votre point de vue. Je voudrais un peu poursuivre

la même question. On essaie de trouver une façon de réconcilier plusieurs points de vue et de s'assurer qu'il y a un accès aux services pour tous les patients qui y ont droit et dont c'est le choix. On veut s'assurer qu'ils sont bien évalués, que l'information est appropriée pour savoir s'ils sont vraiment éligibles et qu'ils aient tous l'environnement pour prendre la bonne décision.

Obviously there are lots of palliative care investments that have been done in Ontario, and that continues to be core to the policy. You were struggling with what exactly the thing is that would be appropriate for you. For a long time, we have been talking about the Alberta model as being one, but the Alberta model requires the physician to give the phone number. I hear you saying that you wouldn't be prepared to do that. We're struggling to say that if the care centre could be there, you would not be prepared to talk about it; is that it?

Dr. Philippe Violette: No. If it exists, certainly we can talk about it, say that it exists. Especially in the context where the patient has direct access, they can access this directly. That's not a problem, and where it's the Ministry of Health's prerogative to provide funding for whatever resources or whatever things that are appropriate within the health care system, then provide the funding and the infrastructure to make sure that it's easily accessible and easy for patients. That's not a problem.

As far as perhaps following up with Ms. Gélinas' question, if parts of the chart are required, of course that's our obligation—we don't own the chart, as was said by the previous speaker—to provide this information.

Dr. Ramona Coelho: We would be willing to clarify for safety issues, of course. Of course, for safety issues, if someone called us and was like, "Are you sure—the depression?", whatever, of course we'd be willing to clarify.

M^{me} Nathalie Des Rosiers: Okay.

The Vice-Chair (Ms. Ann Hoggarth): Thank you. Thank you for your presentation.

M^{me} France Gélinas: Point of order, Speaker.

The Vice-Chair (Ms. Ann Hoggarth): Yes.

M^{me} France Gélinas: You made a reference to a letter that you have received that talks about care coordination. If you could share this letter with the Clerk so that it can be shared with the committee.

Dr. Ramona Coelho: Yes, absolutely.

M^{me} France Gélinas: Thank you,

The Vice-Chair (Ms. Ann Hoggarth): If you have a further written submission, it needs to be to the Clerk by 6 o'clock tonight. Thank you.

MS. MARGARET RUSSELL

The Vice-Chair (Ms. Ann Hoggarth): We call the next presenter, please: Margaret Russell. This round of questioning will start with the NDP. Please identify yourself. You have six minutes to present.

Ms. Margaret Russell: Hello. I'm Margaret Russell, and I'm simply an individual who's concerned with the issue at hand.

Good afternoon. Thank you for allowing me to appear before this committee. I'll speak for about three minutes and then make just a few points.

I'm here today to ask that the term "medical assistance in dying," as referred to in Bill 84, incorporate a right to an advance directive for medical assistance in dying. I see this as protecting the principle of equal access for all, which should explicitly include those who choose to set out their preferences while they are capable of doing so. I did not see this in the bill as it stands, so I'm here today.

I'm 67 years old. My perspective is informed by the following:

(1) As a caregiver, I watched helplessly for two years as my Alzheimer's father begged in anguish to die. He was unable to take his own life, and the law prevented us from relieving him of his mental and physical agony. He deserved better.

(2) I have post-traumatic stress disorder and will likely develop Alzheimer's disease. As I age, I expect to suffer terribly, reliving the traumatic memories of an assault victim. I will also be retraumatized when eventually institutionalized—for strangers/attendants, including males, will be allowed to bathe me, despite my protests. I don't want this future.

(3) As a woman who views the right to determine what happens to my own body to be an inalienable human right, which I can express in the form of an advance directive for medical assistance in dying.

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My general view is that persons anticipating serious decline of cognitive or physical abilities should be able to make decisions in advance, well before they have reached a stage where their intellectual, emotional or physical capacity to make such a decision no longer exists or could be challenged legally.

In closing, let me offer two ideal scenarios for me in my situation, dependent upon the parameters set out in my advance directive:

(1) Having decided my time had come for my prescribed milkshake, I would simply take it home or to another comfortable place of my choosing and sip it in the company of my husband or loved ones; or

(2) Having arrived at the predetermined state of decline I'd previously identified in my advance directive, and being unable to indicate or perhaps even notice that I've reached that state of decline, the person vested with my power of attorney for health would then procure the prescribed milkshake and administer it according to my wishes as set out in my advance directive.

Thank you for hearing my voice.

The Vice-Chair (Ms. Ann Hoggarth): Thank you. Madame Gélinas?

M^{me} France Gélinas: Thank you. If you follow this issue, you will know that—

Ms. Margaret Russell: I'm sorry, I have a hearing problem.

M^{me} France Gélinas: If you follow this issue, you will know that the province to the east, Quebec, had in-depth consultation with their residents, put out a paper,

went out to consultation again and came forward with a bill that their population was behind and that they were ready to move on with. They are just going out for a second round of consultations to deal with the exact issue that you bring forward.

Right now, under the law, it is illegal to consider an advance directive. You have to meet a set of nine criteria; one of them is that you need to give consent, have your 10 day cooling-off period, consent again, and consent again just before the act takes place.

You should not have to come here to have this discussion. We should have a safe place for Ontarians to discuss those things, come to an agreement and move forward as a society. Ontario did not do their homework. We did not consult with people like you. We never gave people like you an opportunity to be heard, to be listened to.

I thank you for coming today, but I won't give you false hope. The chance of this making it into this bill is very, very slim. But you are planting a seed. Hopefully, we will listen to you and create this safe place for people to be heard, so that we can have this discussion that would include an advance directive, how we frame it, how we make sure that it is 100% sure and accurate—the will of the people. I think we could do this, if the political will to listen would be there.

Ms. Margaret Russell: Yes. Thank you very much for saying that.

M^{me} France Gélinas: Thank you.

Ms. Margaret Russell: Can I add something to that?

M^{me} France Gélinas: You can, sure.

Ms. Margaret Russell: Unless there's somebody with another question—

The Chair (Mr. Peter Z. Milczyn): You can respond to Madame Gélinas. You have about 30 seconds.

Ms. Margaret Russell: Just in the case that this committee can't do it now, then I would hope that the committee will use this report to flag this matter in the Legislature as something that has merit and should be addressed by this or another committee.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser?

Mr. John Fraser: Thank you very much for being here today and for your deposition. We've heard a lot of different things from a lot of different people, but not a lot directly from people who are talking in such a personal way about themselves and that decision. I think it's critical for the committee to hear that.

I do have to address, from a consultation perspective, that we broadly consulted, both online and in person, in communities across Ontario. I think we had 11 town halls, and even two in Sudbury: one in French and one in English. But it is an issue that there is a lot of sensitivity around.

As my colleague said, this is an issue that's now—actually, before the court referred it. The court, in their decision and in the federal legislation, made a commitment to take a look at the issue that you were talking about. Right now, in Ontario, informed consent is the law for not just this but any treatment.

That will be an interesting conversation, because there are both sides to that argument as well, because there are great risks in that. I look forward to that conversation. I think we'll have that nationally.

The question I want to ask you is—because we've had a lot of questions about access. You may have heard some of this—I don't know if you've been watching or following it—just in terms of the patient's right to access and issues of conscience. Part of this committee's job is to help to find a pathway through to find some balance, to strike a balance in there.

Do you have any comment on that, in terms of how you feel as somebody who would—if you went and approached a professional, whether it be a nurse, nurse practitioner or doctor, what would your expectation be?

Ms. Margaret Russell: Well—

Mr. John Fraser: You don't have to answer it if you don't want to.

Ms. Margaret Russell: No, that's fine. Having had this conversation with my doctor and knowing what the result is, and realizing that she's going to be retiring soon, I'm going to have to re-address this with another doctor. That's going to be an issue for me. In other words, there's trouble already.

I'm sorry, I haven't paid a lot of attention to all of the intricacies around what you've been deciding—but at the fastest, safest, quickest opportunity, that you provide people information.

I can only relate to an experience I've had. When I was a young woman, I decided that I would never want to have children. But could I convince a doctor that I had control of my own body? Not until I was 26 did I find a doctor who would agree to the procedure. I met with him, and he said, "Fine." He listened to my story. But I had been trying since I was 18. He listened to my story, and he said, "My nurse will call you in a month." And his nurse called me in a month. Then his nurse set up the operation date 11 months later.

He took the time he needed for his conscience and to be safe. I'm not saying that you should do that with what we're talking about today, because I don't need a year. I think that there are all of these safeguards that people are starting to discuss, that you're working through right now. But certainly, having a 911 number, doing things anonymously, getting the information easily and up front—because I couldn't get the information that I needed when I was young. I'm only here by accident, because if I hadn't seen the Star with an ad in it—and I certainly didn't know about your meetings that you were talking about going through Ontario, and I'm certain that a number of people I know who are all in their eighties and nineties also didn't know.

So with due respect, I appreciate your question, but I am not able to answer it properly, I'm sure.

Mr. John Fraser: No, you answered it well. Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek.

Mr. Jeff Yurek: Thank you very much for your deposition. You do bring new elements for the next set of

the debates. I echo the member from Nickel Belt that the government needs to take this further in consultation with Ontarians, if they so want to deal with other issues that are arising from medical assistance in dying. So thank you again for being here.

Ms. Margaret Russell: Thank you very much.

The Chair (Mr. Peter Z. Milczyn): Thank you, Ms. Russell.

CANADIAN ASSOCIATION OF MAiD ASSESSORS AND PROVIDERS

The Chair (Mr. Peter Z. Milczyn): Our next witness is the Canadian Association of MAiD Assessors and Providers. They will be joining us by teleconference. Can you hear me?

Dr. Stefanie Green: Yes, I can. Can you hear me?

The Chair (Mr. Peter Z. Milczyn): Yes, we can. You have six minutes for your presentation, following which we will go to questions. There are members from each of the recognized parties at committee. Your round of questions will begin with the government caucus. As you begin speaking, please state your name for the official record.

Dr. Stefanie Green: It's Stefanie Green.

Thank you for allowing me the opportunity to present today. My name is Stefanie Green, and I am here today in two different capacities. Firstly, I'm here as the president of the Canadian Association of MAiD Assessors and Providers, CAMAP, a national organization that represents and supports the people who do the work of medical assistance in dying. We currently have membership in nine different provinces, and I'm in daily contact with providers from across the country.

Perhaps even more pertinent to today's testimony, I am here as a medical practitioner. I have been practising medicine for 22 years. I have practised as a family physician, an expert in maternity and newborn care, and most relevantly and more recently as a leader in medical assistance in dying. I have personally conducted almost 100 consultations for MAID and provided assistance to 36 individuals. I work both in the community and in hospital facilities. I work in a small city and travel when needed to more remote locations.

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I state all of this to establish that I am here today not in the theoretical, not in the academic and not in any political role. I am here today as a provider of this care.

I live in British Columbia and I will not claim to be familiar with all aspects of Bill 84. While I may have opinions on certain aspects of the draft bill, I will focus my talk today on an issue that has recently been discussed in the Ontario Legislature and recurrently here at these hearings. That is conscience rights and effective referral.

My understanding is that the current draft of Bill 84 does not address conscience rights. I think this is logical, because the issue of conscientious objection to me is most appropriately addressed by professional licensing

bodies, such as the College of Physicians and Surgeons of Ontario. Currently, the CPSO has a policy regarding MAID that strives to balance the rights of a conscientious objector with the rights of patients to access this care. This policy includes the requirement of an effective referral by clinicians who conscientiously object to providing care for patients who request MAID.

I recommend that the committee endorse this CPSO policy. I understand there has been discussion about the possibility of adding wording to Bill 84 regarding conscience rights that might reduce or even eliminate the requirement of effective referral. It is my opinion that if there were a reduction of the requirement for effective referral, the result would be reduced access to care.

The federal legislation regulating MAID, Bill C-14, has the specific inclusion of a variety of safeguards to help protect what are deemed the most vulnerable members of our society. Eliminating effective referral for conscientious objectors to MAID would have the exact opposite effect: Our most vulnerable would have reduced access to care. Even in the current climate of a requirement for effective referral or similar but varying language across the country, there are examples of patients having difficulty in finding access to clinicians who provide MAID, and examples of patients having difficulty accessing MAID care in a timely manner, with a resulting loss in capacity and therefore loss of ability to receive MAID.

I'd like to tell you about Mr. X, who, despite being only 66, lives in a long-term-care facility and requires 24-hour care. He has little family and few friends left and is, as he describes himself, "paralyzed from the armpits down" due to end-stage multiple sclerosis. He lives in Baptist Housing and describes his care as very good. He has no access to a computer and cannot use the telephone that sits in his room.

With no one to advocate for him and no ability to self-refer, what happens to his request for information about MAID? If his family physician conscientiously objects and there is no policy of effective referral, this man would be living in an urban centre of Canada, fully aware of the existence of MAID and having no access to information or possible care for himself.

What about Mrs. Y, whose progressive neurologic condition robbed her of her vivacious self and has left her cruelly frail, virtually non-verbal—a shell of who she once was? Her wishes are private. She does not wish to share them with her family, who are quite religious. She feels certain they would not support her wish to access MAID. Like Mr. X and despite having family and friends, she is also wholly dependent on her family physician or a clinician at the hospital where she's currently being treated. Without effective referral, she too would not be able to access care.

Then there's Mr. Z, the gentle giant who always spoke of his support of the idea of dying with dignity. He finds both his life and his independence have been stripped away by a gruelling terminal cancer. He is weak and at his most vulnerable, but is surrounded by family who are

aware and supportive of his wishes. He requested MAID, was assessed and qualified; but his family doctor was not originally aware of whom to refer him to and was not eager to find out.

It took Mr. Z a bit longer to get his answers. He was reasonably informed and had family to support him. But having to self-refer, he was too late in getting access to care. Can you imagine what it felt like to stand in his living room, next to his hospital bed, trying to explain to his family that yes, I knew what his wishes were and he had followed all the correct procedures, MAID was finally legal, but I could no longer help him because his disease had progressed to the point that he had lost capacity? We were literally one day too late.

These are stories of people I have personally met. My colleagues from across the country have stories of their own. The policy of effective referral mandated by the CPSO helps to ensure timely access to care for patients who have a lack of knowledge of how to navigate our complex health system, for those with no ability to do so on their own, for those who wish to be private in their wish to access this care, and for patients who have no one to advocate on their behalf.

I firmly respect the right of every clinician to conscientiously object to providing any care they feel uncomfortable providing. I simply ask that we balance that right with the rights of our most vulnerable patients.

I encourage this committee to endorse the CPSO policy on effective referral for physicians who conscientiously object to providing MAID. If there is interest in adding a clause to Bill 84 about conscience rights, I would encourage such a clause to reflect a fair balance between a physician's right to conscientious objection and a patient's right to access compassionate care.

Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Ms. Green. The first round of questions will start with the government side. Mr. Fraser.

Mr. John Fraser: Thank you very much for joining us today, for your deputation and for those real-life examples of what access to care, and quick access to care without barriers, means to people.

Some of the things that we've been discussing here at committee are just how we create those pathways that allow faster access to care, that can provide for patients if they wish anonymity, and remove barriers to getting information as well as care.

In Ontario, we're going to be going forward with a care coordination service. Do you have any thoughts on that?

Dr. Stefanie Green: I think, overall, the idea of a centralized care coordination service is probably an excellent one, from a provincial point of view. It certainly makes things easy for the physicians. They can refer in; there's one number. Obviously, it needs to be very well-publicized. I've heard of experiences across the country and other places where there are centralized systems. There are many, many good things about it.

There are still issues with people referring to that line. There are certainly examples of physicians conscient-

iously objecting to MAID who are uncomfortable referring to a line that is specifically set up for this care. There is certainly an issue, as I've highlighted in my talk, for patients who need to self-refer to that line. Bluntly, it's just inadequate.

I think that a coordinated central system that can be well publicized to the medical community and to the public, that demands that physicians, professionally speaking, have to make that call for the patient if they've been approached, could be a very good idea.

Mr. John Fraser: Thank you very much. Actually, just as a quick follow-up, medical assistance in dying is also part of a continuum. It's different from but part of a continuum that includes end-of-life services and palliative care. In terms of your experience, can you talk about how you've seen that integration across the country?

Dr. Stefanie Green: I can tell you anecdotally what I'm hearing from my colleagues, and I can tell you what I experienced personally in British Columbia.

I actually have to tell you that I'm very lucky in British Columbia, where I have an excellent working relationship with local palliative care doctors and hospice teams. It is my impression from my colleagues in many provinces that that is an exception to the rule across the country—that there are hospices and palliative care teams that are simply not willing to accept these patients or to provide that care.

I think that's a blanket statement, and I don't mean it to be derogatory. I think there are exceptions, but I don't think this care has been broadly embraced by that community yet. I am optimistic that that will change, and I would encourage that to be the case.

I know that in other global jurisdictions—in Belgium, it's actually mandatory for all people who are applying for and receiving euthanasia to receive outstanding palliative care prior to. It's actually an integrated system. I think that's what we should be working towards. I think we have the opportunity to do things properly in Canada, to set up an excellent model, to learn from other jurisdictions and to really model how this can be done well. We're at the very early stages, but I'm still optimistic.

The Chair (Mr. Peter Z. Milczyn): This round of questions is with the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Thank you very much for calling in and adding your voice. Can you touch on access to medical assistance in dying in comparison to other provinces and what you've heard?

Dr. Stefanie Green: Access in British Columbia, you're asking me, or access in general?

Mr. Jeff Yurek: In each province that you have members in that you said you've been in conversation with—what their response would be or what you've heard back as feedback.

Dr. Stefanie Green: Sure. It does vary very widely across the country. I happen to live in a province where we had health authorities and infrastructure working proactively in advance of the law changing. Everything was set up and ready to go as of June 16. The demand for this care, the amount of providers here and the number of

people receiving MAID is probably higher here per capita than anywhere else in the country. I think that's a combination of all of those factors for why that is.

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That's contrasted by my colleagues out at the other end, in the east, where there has not been a lot of infrastructure support. It is coming online in some provinces now, slowly. Through our organization, we've been able to model some of the programs that we've developed out here. We lent that care and those models to colleagues out east, and they are now developing rural programs as well as urban programs. But the support in the Atlantic provinces has certainly not been anywhere near what we had hoped. As far as I know, PEI doesn't actually have any MAID, and New Brunswick has very little. Nova Scotia has a core group of providers but the infrastructure is missing; they're working very hard on that right now. Quebec is distinct. I'm not going to talk about them.

Ontario seems to be not as smooth as expected. It's a very large area, and my understanding of Ontario is that they don't have the health authorities structure and maybe that has something to do with how it is rolled out. Manitoba has a very unique system, as I'm sure you're aware. They have a MAID team and a centralized coordinator. That has gone very smoothly for them. They have also been fairly advanced in how that has gone forward, but it's a very unique model I've not seen anywhere else in the country. Alberta, of course, has the centralized coordination centre. That's gone very smoothly with good infrastructure behind it, but their numbers are so small. They have a very large presence of Catholic-based health authorities that is not accepting MAID to happen on the premises.

So there are a number of issues there that are still going on. There is a wide variety.

Mr. Jeff Yurek: And just a quick question: In BC, are doctors penalized for not participating in medical assistance in dying?

Dr. Stefanie Green: Absolutely not.

Mr. Jeff Yurek: No?

Dr. Stefanie Green: I've never heard of that.

Mr. Jeff Yurek: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): The next round of questions is with the New Democratic Party. Madame Gélinas.

M^{me} France Gélinas: Good afternoon, Dr. Green. I represent a riding in northeastern Ontario, mainly rural. I had one family reach out to me. The way it works in Ontario is that you phone a 1-800 number. The physician was willing to make the referral, was very supportive of the family. They phoned the 1-800 number, and we discovered that in all of the northeast, no physician had put their name forward to be on the list of physicians providing MAID. Therefore, nobody was available for about 1,000 kilometres around.

Dr. Stefanie Green: Wow.

M^{me} France Gélinas: We ended up having a conference call, telemedicine, with somebody from down south who assessed the man and did the first assessment. We

tried to find another person to do the second assessment. It was extremely difficult, and nobody was found before he lost the capacity to consent. He ended up dying at home with his wife and kids: a horrible scene.

Are we the only one having such a tough time?

Dr. Stefanie Green: No. I wish you were. I wish that wasn't your case. Look, I could couch this in different ways. These are relatively early days, so certainly the penetration of providers being available in all corners of the country is not optimal. I don't think anyone expected it to be perfect in the first couple of months.

But physicians are reluctant to come forward, certainly reluctant to do so publicly. I'm one of the few. There is still a lot of misinformation about what MAID is and what MAID isn't. There is a reluctance to do anything with such weighty legal ramifications if it's not done exactly right. There is an issue with compensation for physicians and their time. There are a number of issues why physicians aren't running forward to do this work.

I'd like to think that our organization will help change that. I think, with the support of colleagues, preceptorships, mentoring, collegial networking across the country, we can help each other, support each other, grow, answer some tough questions, help people in smaller centres learn from other places. I'd like to think we'll make a very big difference in that.

But it's not unique.

M^{me} France Gélinas: Thank you. Do you have mandatory referral in British Columbia?

Dr. Stefanie Green: In British Columbia we have what's called, I think, effective referral. It does not mandate the actual consult. Let me just get the actual wording for you; I've got it somewhere here.

It's actually suggested by our college that you have to advise the patient that you object—it's called providing effective transfer of care. It's just defined as advising the patient that other physicians may be available and suggesting that they see another physician, and that you have to transfer the medical records, but it is not required to make a formal referral. Interestingly, we have probably one of the weakest recommendations from our college regarding this.

The Chair (Mr. Peter Z. Milczyn): Thank you, Ms. Green. That's all the time we have for this afternoon. If there's something further you'd like to provide to the committee in writing, you can do so until 6 p.m. eastern time today. Thank you for calling in.

Dr. Stefanie Green: Thank you.

DR. PHILIP DRIJBER

The Chair (Mr. Peter Z. Milczyn): Our next witness is Dr. Drijber. Good afternoon, Doctor. You have up to six minutes for your presentation. Your round of questions will begin with the official opposition. Please state your name for the official record as you begin.

Dr. Philip Drijber: My name is Philip Drijber. I'm a family physician in rural Ontario, and have been so for 20 years.

First, I'd like to thank the members of the committee for allowing me the privilege to address my concerns about Bill 84. You've all received a copy of my written submission; it will form a rough framework for my discussion. Much of what I will say, however, is not in the submission. It needed to be delivered in person. You, as the committee, need to have a face attached to that message, and that is why I am here. This message is important for me, but is far more important for my patients, who cannot be here. The present policies affect my ability to practise, and therefore their ability to have access, and if there aren't amendments, that will be a big problem.

Much of the debate centres on rights. Whose rights should be paramount? Is it patients? Is it physicians? Is section 2 of the charter more important than section 7? The real question is, why does there have to be a conflict? Can't the situation be rectified in a way that the rights of all are met and honoured? The answer is absolutely yes. It can be done through an amendment.

The next concern is that of access. Will offering conscience rights deny access? Will the marginalized and vulnerable be denied access? The truth is that the present policies do more to deny access than granting conscience rights will ever do.

Another salient point is the difference between MAID and palliative care. Although the Ministry of Health's and the Legislature's discussion tried to equate the two, they are very different. As a palliative care physician for over 20 years, I understand the difference. Palliative care is patient- and family-centred and focused on allowing a natural death. MAID is an active decision that hastens death and often excludes family, as even outlined in Bill 84. They represent two distinctive models of care, and all Ontarians have the right to choose their end-of-life plan.

I now move to the body of my discussion and why amendments need to be made.

The first is the college policy of an effective referral, which is supported by the ministry through its physician-only access line. The first problem is access to MAID. The problem with the current policy is that an effective referral limits it to those who have a health care professional. Currently, 8% of people in Ontario do not have a physician. That goes up to 15% in rural areas, where I live, and up to 40% among those who do not have English or French as their first language. This is a far greater inequity than accessing conscience rights, and can be addressed in the proposed amendment.

The second problem is the conflict it creates between health care providers and patients' rights. This policy states that patients' rights usurp health care providers' rights. I doubt this would be defensible if a charter challenge was made. Regardless, no one wins when the rights of one party are gained at the rights of another.

The third problem is the college's stance that an effective referral is not assisting in MAID, which is not even defensible by its own standards. Other college policies indicate that physicians are responsible for their referrals, and have penalties up to and including

punishment for professional misconduct for inappropriate referral. The college cannot have it both ways. Either a referral is participation or it is not.

Further, the college's stance is not supported by the standards of Canadian law. Whether one is the hit man or calls the hit man—the effective referral—both are equally responsible. Intent and assisting are equal in the common law, and the courts have always held so. An effective referral is participation, and that's what makes it morally repugnant to health care providers of conscience.

The fourth problem: The college has stated that those not wishing to participate ought to withdraw from primary-care practice and engage only in those areas of medicine where encountering a request for MAID would never happen. The alternative would be disciplinary action and loss of licensure.

That brings me back to my point. Why am I here? I'm here to present the case of a health care practitioner, but more importantly I'm here to represent the faces of my some 1,500 patients who cannot be here. If this law and policy go through unchanged, what will it mean? To me personally, it means I will have to stop doing family practice. Will that affect me? Certainly. My passion and life's work has been family medicine. I have a special interest in the care of geriatrics. I am greatly saddened to lose the opportunity to serve the people of my practice.

I am lucky, though: I can retire, although it would be a forced retirement. For my patients, my employees and my community, however, that's a different story. My patients will be without a family doctor. They will not only not have access to MAID, but to any care. My employees will lose their jobs. My local hospital will lose 20% of their active staff. The local nursing home and retirement home where I work will lose their medical director. The 20 or so palliative care patients that I see will have no physician. The vulnerable and infirm, for whom I do house calls, will be denied not only in-house care but all care.

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Now, I ask the committee, what does it want its legacy to be? Do you want to create a situation where those accessing MAID need only have the skills to make a doctor's appointment and access is universal? Do they want to create a system that is inclusive for all health care professionals? Does it want to create a system like every other province in Canada where health care professionals, both practising and those entering practice, do not have to choose between practice location and province or conscience? Or do they want to stay with the status quo and see untold Ontarians lose access to health care practitioners? Do they want to explain they did nothing when they had it within their power to change that? Does this committee wish to explain to my patients, who are among the most weak and vulnerable, why they chose not to listen to my plea to create an amendment that would help me and many others continue to provide care?

What am I asking for? I'm asking for three amendments.

First, an amendment that would be modelled after Alberta's care coordination service for MAID: This is a self-referral system. The multiple good points of this approach are outlined on pages 8 and 9 in my submission, which you have.

Second, an amendment on palliative care services: Palliative care services are woefully inadequate and not universally accessible. It is inconsistent to pass a law that strives to ensure universal access to medical assistance in dying but does not address the universal need for palliative care. A clause in the bill should be made to the effect that we recognize the need for equal access to palliative care. Ontarians need a choice for their end-of-life decisions. Although this bill does not specifically address palliative care services, it is the goal of this bill to promote equal access to all end-of-life services for all Ontarians.

Third, an amendment to ensure non-discriminatory practices; an amendment that states and enshrines a policy of non-discrimination with words to the effect that if the goal of this bill is to promote aid, this bill does so in the context of recognizing the rights of people of faith and conscience to refuse to participate in the process, directly or indirectly, without fear of reprisal or discrimination. This bill promotes the rights of all Ontarians, both those wishing to participate and those who do not.

In closing, I thank you—

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Drijber. I gave you a little bit of extra time.

Mr. Yurek, for three minutes.

Mr. Jeff Yurek: Thank you for coming in, Doctor, and making the distinction between palliative care and MAID. When I bring up palliative care, I'm trying to highlight the fact that we need more investment and growth—and I'm sure I'm about to say something that will have the government respond, but I'm hearing that they want to incorporate the two into one by the sound of their questions they've been asking. Hopefully, they can clarify.

My point that I'd maybe bring up from the last deposition that we had: British Columbia seems to have the best access to medical assistance in dying but, at the same time, doesn't have an effective referral in place. I think that speaks volumes. Did you want to comment on that?

Dr. Philip Drijber: Certainly. The Alberta system, the BC system and the New Brunswick system all have a self-referral line. Like I said, you only need to pick up the phone, which is as hard as making a doctor's appointment. If you can pick up a phone, you can access MAID. The feeling that it has to be done through a physician's office or by a physician is ludicrous.

To take another example, abortion care services, I've never referred anyone for an abortion in my 20-odd year career, but if a young lady comes to me and says, "Dear Doc, I'm pregnant. I don't want to be pregnant," I sit down with them and I say, "Okay, let's look at your options. You could have this baby, you could adopt this

baby or you could terminate this baby. That is your choice. If you want me to follow you through your pregnancy, if that's what you really want to do, I'm here for you. If you want me to help you get an adoption, I'll follow through and help with that process. And if you want to terminate this baby, there is a website. There's a number of 800 numbers. You can find them and you can call them." That's informed consent, but I'm not participating. Since they're capable of coming into my office, they're capable of looking it up on the Internet for the number they want.

Mr. Jeff Yurek: And your other point here in the model is even utilizing the CCACs, through their case-worker, to help people navigate the system.

Dr. Philip Drijber: Yes, absolutely.

Mr. Jeff Yurek: I think they can be used for other services in the health care system—

Dr. Philip Drijber: Yes. The problem with the present system is that it's physician-only. So again, if you don't have a physician, you're not accessing MAID anyway. The weak and the vulnerable are why the college put out this policy of effective referral. They wanted to make sure that the weak and vulnerable were not denied access on the basis of their physician's conscience. Unfortunately, there's a lot of weak and vulnerable who don't have physicians.

Mr. Jeff Yurek: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you. Madame Gélinas for three minutes.

M^{me} France Gélinas: Thank you so much for coming and sharing. I come from northeastern Ontario; 30% of the people I represent do not have access to primary care. You're preaching to the choir when you say that a lot of people don't have access, as in zero access. They go to the emerg or they go to walk-ins.

First of all, you don't have to answer my question, but have you had anybody talk to you about MAID?

Dr. Philip Drijber: Yes.

M^{me} France Gélinas: And would you mind sharing with us—

Dr. Philip Drijber: I've had two people approach me. Again, I really oppose this more on the basis of medicine than I do with my conscientious objection. I'm a family physician and a fellow of the College of Family Physicians. I'm a palliative care physician.

When people come to me and say they want to die, I go, "So what is it that you're really trying to tell me? What is it that you really want?" In both cases, they said they wanted it. I said, "So what is it that you really want?"

In one case, one person wanted the right to stop treatment and just be let go, which I did quite happily. That's palliative care.

For the other person, I can't recall the exact situation, but I think it was more that he was suffering and he just felt his pain was intractable. Control his pain? Happy. He doesn't want to die now; his pain is good.

M^{me} France Gélinas: Okay. So when you opened up the conversation and showed them the options, they opted not to follow through?

Dr. Philip Drijber: Again, I do not wish, as a family doctor, to lose the opportunity to interact with those people who are in my practice and give them good, informed consent and present all of the options. All I'm asking for is, if they choose the option that I don't personally support, that there's a way they can easily access that, and I can inform them of it, but I don't actually have to do it for them.

M^{me} France Gélinas: Okay. Let's say we're at some time in the future where this thing exists. Do you have any apprehension as to a MAID physician calling back to your office to clarify that he's on anti-depressant medication. "He tells us that it's for sleeping, but we think there may be a mental illness." Would you discuss it?

Dr. Philip Drijber: Absolutely. That's good patient care.

M^{me} France Gélinas: So you don't have any problem—

Dr. Philip Drijber: No problem whatsoever.

M^{me} France Gélinas: Okay. You don't feel that you would be taking part?

Dr. Philip Drijber: No, no. They're asking me, as his former primary care provider, for information to help them make a good assessment. That's my job, and I'm glad to do it. I care about my patients.

M^{me} France Gélinas: Okay, although if—

Dr. Philip Drijber: I believe in the autonomy of people to make their choices, even if I don't agree with them. I just don't agree that they have the right to tell me that I have to participate in those bad choices.

M^{me} France Gélinas: Okay. You're making that clear—

The Chair (Mr. Peter Z. Milczyn): Thank you. Ms. Hoggarth for three minutes.

Ms. Ann Hoggarth: Thank you, Doctor, for your presentation. Our government's goal is to support quality end-of-life care for all patients in Ontario in all health care settings, including home, hospital and community health care settings. This includes promoting greater choice in palliative care and end-of-life care.

As part of the 2016 budget, we are investing an additional \$75 million over three years to provide patients with more options and access to palliative and end-of-life care. This investment aims to support community-based hospice and palliative care services, including the expansion of up to 20 new hospices.

Can you please elaborate, in your experience with palliative care, on what further action our government can take in other areas of end-of-life care to improve options for Ontarians?

Dr. Philip Drijber: Well, you could rescind one law that you just made. I find it very difficult that—I get the fentanyl crisis; I get the opioid crisis. But delisting the strongest medications, which I used to be able to use to treat my palliative care patients, was not a good idea.

Now, I have managed, because I am a palliative care physician, to get an exceptional access licence, but if I wasn't the nursing home director, I never would have

known about it. That was poorly rolled out; it was poorly thought out.

Most family doctors who do palliative care don't have the level of training I do, but we all do it, and we all love to do it because we care for our patients. But we need access to the right medications. We don't need them limited. We don't need to have to get a special hoop to jump through, just to prescribe the medications that we need. We need to give them a choice.

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Again, at this point, the only choice that they have for a painless death is MAID, and I don't think that's a great option.

Ms. Ann Hoggarth: So you are okay with the—that we are going to be setting up a patient care coordination service?

Dr. Philip Drijber: I applaud it, if it's available to someone other than physicians, who are currently, on your website, the only people who can call in. It denies access to those who have no family doctors.

Ms. Ann Hoggarth: You have been in the room while we've been talking, and you heard the teleconference. There are people who cannot make those phone calls themselves. What would you do?

Dr. Philip Drijber: Then they couldn't make an appointment to see their family doctor either, so they would probably have someone. As I pointed out on page 7 of my submission, in the Alberta system, your family member can call in to that line, or your friend or your significant other, which would be that you would access MAID the same way as your family physician. If someone is of that capacity where they cannot do it themselves, they can have someone do it for them, just as they do when they want to see me.

Ms. Ann Hoggarth: If they have someone.

Dr. Philip Drijber: If they have someone—and if they don't have a family doctor, then I'm sorry but I don't know what to do. That is a problem that's far greater than this committee can examine.

Ms. Ann Hoggarth: There are also—I'm sorry.

The Chair (Mr. Peter Z. Milczyn): Thank you. That's all of our time for today. Thank you for coming in and for your submission, Doctor.

DR. NATALIA NOVOSEDLIK

The Chair (Mr. Peter Z. Milczyn): Our next witness is Dr. Novosedlik. Good afternoon. You have up to six minutes for your presentation, which will be followed by questions. Your round of questions will begin with the New Democratic Party. Please state your name for the official record as you begin.

Dr. Natalia Novosedlik: Hi, my name is Natalia Novosedlik. Thank you for allowing me the opportunity to speak today. I'm a palliative care physician, and I practise mainly home-based palliative care in Scarborough, Ontario, a community that has historically had limited palliative care resources, despite great need.

I have the great honour of accompanying patients lovingly and diligently into the final days of their lives,

aiming to make this challenging passage as comfortable as possible. It is never my intention to hasten another person's death.

I am here to speak to you about the need for conscience protection for health care providers, and for a way to access medical assistance in dying that does not rely on effective referral. I understand this is a message that you have heard from a number of parties, but I hope that my story will add to the picture of why this is necessary.

Arguments for the legalization of physician-assisted suicide and euthanasia are largely centred around patient autonomy. However, in practising palliative care, I am reminded every day that autonomy is a narrow lens through which to view the human experience.

To me, the dying process is a beautiful illustration of our interdependence. Studies from Oregon and Washington demonstrate that the most common reasons patients choose assisted suicide are not, in fact, pain or other symptoms, but fears associated with the loss of autonomy and function. While these fears are understandable, I believe they stem from a society in which life is, sadly, valued according to function and independence. Those parts of being human that expose our vulnerability, that require the giving and receiving of care on a profound and intimate level, are things that we wish to avoid rather than accept as integral threads in the shared tapestry of life.

To do away with a life that no longer functions as it did before is, to me, an affirmation of worthlessness, both for the individual patient and at a societal level. I do not believe that this is in anybody's best interests and, therefore, I cannot align it with appropriate medical practice.

I also cannot align MAID with the goals of palliative care, which, according to the WHO definition, "intends neither to hasten nor postpone death." Moreover, I believe that the timing of death is something that humans simply are not equipped or intended to control. An attempt to do this crosses into a realm of moral decision-making that is truly beyond our capacity and involves a process—death—which none of us can claim to really understand.

For these reasons, my conscience commands me not to participate in MAID.

This brings me to the issue of effective referral. Effective referral is not an acceptable reconciliation of patient and physician charter rights. The idea that arranging for an act to be done equals complicity in the act is not new.

Prior to the Carter decision, I was present at an educational session that discussed how to handle requests for referrals to the Dignitas program in Switzerland. We were advised by the lawyer giving the presentation that this could be considered abetting a suicide, and we were advised not to do this.

Those of us who feel effective referral for MAID makes us complicit in it are upholding the already existing idea that facilitating a bad thing is a bad thing.

The options that effective referral gives to a conscientious objector are to ignore your conscience or change

your conscience. I don't know how consciences are changed, but as I understand, I have a right to keep mine the way it is.

As for ignoring one's conscience, I can offer some insight into that, because I did it. Just after Bill C-14 was passed, a patient of mine persistently requested MAID. My attempts to address the underlying reasons for the request were not accepted by the patient. Working in a community with few physicians who do home-based palliative care, none of whom were in favour of MAID, I did not have the option to transfer care.

I caved. I ignored my conscience, opting instead to follow the college policy and convincing myself that I had no choice. In the end, the patient died comfortably and naturally. However, this was destructive to my very core. I felt like a shell of myself. Months later, I often still do.

I came very close to leaving palliative care at the time, and every day I continue to question my ability to stay in this field. I care deeply for my patients, and I feel great satisfaction in my work, but I practise in fear. I drive from home to home, afraid that at any time this situation will arise again. So far it has not, but it will.

I do not want to abandon the people in my community who need care. I can't imagine how I would begin to disentangle myself from the service of dying patients. Moreover, good palliative care is crucial in preventing patients from feeling that hastening death is their only option.

I hope that I will continue to move forward, caring for patients and somehow avoiding further breaches of my moral integrity, but in the current environment, it is hard to imagine how I will sustain that without burning out or finding myself in a situation that results in disciplinary action.

In palliative care, we talk about treating the whole person. You have to be a whole person to treat a whole person. A policy that attempts to divorce physicians from their conscience, which I believe should be at the very core of why we practise medicine, will ultimately only serve to drive objecting physicians out of practice, one way or another.

I would suggest, as others have, that a system which patients or anyone in their care circle can access directly would solve the problem that conscientious objectors currently face. I am familiar with the argument that this would be too difficult for very ill patients to access and that effective referral is the necessary solution to this potential issue.

I do not know if there is any evidence that a system of self-referral results in less access than a system of mandated effective referral, but I don't think that patient access can be the only measure by which we assess the acceptability of this policy.

Although patient access may be the genuine goal of the effective referral model, it is being achieved through an attempt to align the medical establishment in Ontario with a specific ideological perspective; namely, that MAID is a morally acceptable act and a legitimate med-

ical practice like any other, and to limit the right to object to that perspective to a minimalist interpretation of that part of the Carter ruling that stipulates physicians not be compelled to participate in the ending of life.

This is a subtle, or perhaps not so subtle, way of telling people what to think about an extremely contentious moral issue. Surely this is incompatible with a free and democratic society. Surely we can find a better way to approach patient access, as many other jurisdictions have.

Before closing, I would just like to reiterate that physicians who conscientiously object to MAID have no desire to abandon their patients. I am devoted to the people for whom I am privileged to care, and I believe that those who are having thoughts of hastening death in particular need more care and not less.

I wish to be able to provide that care without being thrust into the role of gatekeeper to a service that I cannot reconcile with the principles that guide me in my practice. I took on that role once, and I will spend the rest of my life coming to terms with that. I cannot do it again, but the same part of me that tells me that compels me to continue on in palliative care.

There is absolutely no easy way out of this, so I implore you, committee members: Please add an amendment to Bill 84 that will protect conscience rights, including the right to refuse to refer, and please consider a direct access model.

Thank you very much for listening to my presentation today.

The Chair (Mr. Peter Z. Milczyn): Thank you, Doctor. Madame Gélinas.

M^{me} France Gélinas: Thank you so much for coming, and thank you for sharing this very, very personal story with us. It does bring a perspective that we had not heard before, and I realize it hasn't been easy on you.

Dr. Natalia Novosedlik: Thank you.

M^{me} France Gélinas: Thank you for choosing to practise in palliative care. We need more of you. This brings me to my question: How would you like to see this self-referral work? You work with people who are at the end of life. You see what their life conditions look like. How would it work? Walk me through it.

Dr. Natalia Novosedlik: I think the idea that making a phone call is as easy as seeing your family doctor is true for most patients. There are lots of ways that the number or the way to access that system could be made known to patients.

When you're at home getting home care, you have a lot of people coming into your home from various health care disciplines. You have a lot of information coming into your home—a lot of just pamphlets and brochures and things like that, with lots of information about all of the different programs, all of the different things that you can access. I don't see how it couldn't be somehow worked into the system that exists.

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I think the idea of making a phone call where you are connected to somebody who has a compassionate ear and

can listen to your request and, if you so choose, put you on the path toward getting an initial assessment for MAID makes a lot of sense. It's my understanding that that's what's done in provinces where this exists. At the same time, I don't want my patients to feel that they can't discuss thoughts about hastening death. That's very common in the vast majority of cases. It's not actually a request for having their life ended. I'm comfortable having those discussions, and I want to continue having those discussions, but it becomes very difficult when the discussion is focused on that patient getting to the assessment as opposed to really being able to address all of the issues—and then not having that adversarial chunk, that fear within them and me, too, about how we're going to approach that issue.

M^{me} France Gélinas: So when you first get accepted for home care, the CCAC sends you those pamphlets. If you want Meals on Wheels, you phone that number. There would be information in there that would say, "Here's what MAID is, here's who qualifies and here's a 1-800 number"?

Dr. Natalia Novosedlik: I don't know if that would be the most appropriate time to introduce that. I certainly don't want it to be something where it's like we're advertising this as an option. And I realize that's very difficult; this is a very, very difficult problem. I do not have a perfect model of how it should be, but I do think that direct access can happen—at least a system whereby anybody in the care team can access it and anybody in the care team knows the number, and it's readily available if you look online and things like that. It means that for most people, there would be a pretty easy way for them of asking anybody who they interact with in their care and being able to get information about how to access.

The Chair (Mr. Peter Z. Milczyn): Thank you. Madame Des Rosiers for three minutes.

M^{me} Nathalie Des Rosiers: Nathalie Des Rosiers. Thank you very much for coming and thank you very much for enlightening us about a dilemma that we know is very complicated.

One of my questions is—I think we've heard a lot and we're struggling—

Dr. Natalia Novosedlik: Of course. We all are.

M^{me} Nathalie Des Rosiers: We all are—trying to find what's the right model. I think we're committed to having a care office that will be proactive.

When I'm reading the document from CPSO, they talk about the fact that it's appropriate for a physician to have an alternate provide the information. I was thinking about how it's normal that a patient would want to discuss all options with her doctor. In that context, would you be comfortable saying, "These are all the options. I will not go this way myself; I want to help you. I'm a palliative care doctor and I think we can go through this, but you have the right if you decide to go this way"? Would you be comfortable with having to say, "My assistant outside will provide you with where you can get the information about that"?

Dr. Natalia Novosedlik: I think I would. I would have to really think about that and be clear in my head, but I think I would be okay with saying, "This is a place where you can get more information."

M^{me} Nathalie Des Rosiers: I think we're trying to design a little bit this model of how close and what's—

Dr. Natalia Novosedlik: Yes, it's really hard.

M^{me} Nathalie Des Rosiers: —because the way I read the document from the CPSO, they do say an alternate can be providing the referral. I'm just struggling with how detailed do we have to be to create this comfort zone for you to continue to practise the way you want to.

Dr. Natalia Novosedlik: Thank you. I appreciate it.

M^{me} Nathalie Des Rosiers: Anything else on palliative care that you think we should know about? Certainly it's a big part of this policy. My background is in law, so I know all about the struggles to make sure that people are not pushed into decisions that they would not want to do. Anything you can help us with on palliative care?

Dr. Natalia Novosedlik: In palliative care? Just that we need more of it, particularly home care. If I can use this as a plug for home care, in the community where I work, you can get—this is just an example—21 hours a week of PSW support, maximum. So if you're bed-bound and you need two people to move you, it's not a lot. And it's not uniform across the board. Palliative care is very geographically based both in terms of physician access but also access to services, and how much of that service you can get. That's something that I feel should be addressed.

I think just people talking more about palliative care, about death and dying, and becoming more comfortable with it as a society—that's probably not something this committee is going to accomplish, but I think that's important.

M^{me} Nathalie Des Rosiers: Thank you.

The Chair (Mr. Peter Z. Milczyn): Mr. Yurek.

Mr. Jeff Yurek: Thank you very much for coming and sharing your personal story. I made a few notes which I'll just discuss a little bit and then have your comment.

I think we've built doctors up on such a high pedestal that people don't actually consider them to have the same feelings as average people. I think we expect our doctors to be superhuman, in a sense. That's just the way the profession has always been, and it's the respect that people have for doctors.

But you're raising the point that doctors are human and they do experience emotions, and the fact that what you had to experience obviously affected you greatly; and you're not the only doctor who feels this way—which you mentioned leading to burnout.

And you have fear, and, in fact, this piece of legislation could be utilized to not only protect people's rights but also remove that fear from your life. We hold greatly in our hearts—we live in Canada, the best country in the world. People move here to run away from fear and intimidation; however, we're kind of creating a culture of that fear. I think this piece of legislation has an opportu-

nity to be fixed so that we return that type of lifestyle back to this province.

I don't know if you want to touch upon it and maybe talk about what your colleagues are thinking as well.

Dr. Natalia Novosedlik: Yes. Most of the palliative care doctors who I know are not okay with MAID. There is probably some degree of variability in their feelings around referral; I don't know about everybody, but I certainly know many who have difficulty with the idea of referral and who don't feel that it's—well, if you look at the survey that was done by the Canadian Society of Palliative Care Physicians right before the Carter decision, regarding attitudes about euthanasia and assisted suicide, most palliative care physicians were not in favour of legalization, actually. I think 74% said they didn't feel it should be a part of palliative care. It's not something we're terribly comfortable with as a group of physicians.

I don't know what more to say except that it's scary just thinking that I'm going to be put in that situation again. It will just be a moral dilemma. There's no way out of that moral dilemma that will be easy—not that it should be easy; it's a difficult decision. I've chosen a difficult field; I realize that. I wouldn't be doing this job if I wasn't prepared for that, but it would be nice to not have that fear.

Mr. Jeff Yurek: You raised a good point, that 74% don't believe it should be part of palliative care. We're hearing a lot of intermixing of the two terms, and I just want to set the record straight: I don't think they should be intermixed. It's a service that you could access, but palliative care should be funded, treated and accessed in a different and total manner than medically assisted dying, just like dialysis should be and other treatments, cancer treatments and such. When you access palliative care, that's your end-of-life journey, hopefully in less pain than you currently are, and you die with dignity.

Medically assisted dying shortcuts the palliative care, but that's the patient's decision.

Dr. Natalia Novosedlik: It's the patient's decision.

Mr. Jeff Yurek: I just don't like mixing the two terms, one as another.

Dr. Natalia Novosedlik: Yes, and I hope that people in the general public realize the difference. Certainly, that was one of the major points that the CSPCP made when Bill C-14 was being developed, I guess throughout that year between 2015 and 2016: that palliative care needs to be distinctly recognized as separate from MAID, and I think that's something that most people in our community would agree on.

Is it allowed to just go back to the question that—

The Chair (Mr. Peter Z. Milczyn): No, I was just about to say that that's all the time we have for this afternoon.

Dr. Natalia Novosedlik: Okay.

The Chair (Mr. Peter Z. Milczyn): If there's something further you'd like to submit in writing to the committee, you can do so until 6 p.m. today.

Dr. Natalia Novosedlik: Okay. Yes, I just wanted to clarify something about that, so I will do that. Thank you very much.

The Chair (Mr. Peter Z. Milczyn): Thank you.

1450

DR. SEPHORA TANG

The Chair (Mr. Peter Z. Milczyn): Our next witness is Dr. Sephora Tang, who is calling in. Dr. Tang, can you hear me?

Dr. Sephora Tang: I can hear you.

The Chair (Mr. Peter Z. Milczyn): You will have up to six minutes for your presentation, which will be followed by rounds of questions from each of the recognized parties. Your questions will begin with the government caucus. As you begin, if you could please, for the official record, state your name and where you are calling from.

Dr. Sephora Tang: Okay. My name is Dr. Sephora Tang. I am calling from Ottawa. Thank you for the opportunity to speak today on Bill 84 from my perspective as a psychiatrist.

The key issue I wish to focus on today is my sincere belief that this legislation, as currently structured, will have a significant negative impact on the quality of patient care in Ontario. I personally know family and palliative care physicians who, due to conscientious objections to euthanasia and assisted suicide, otherwise known as MAID, have either left Ontario, changed specialties or are considering early retirement because of the threat to freedom of conscience in Ontario.

Further loss of physicians in Ontario will inevitably result in a significant reduction in the level of patient care, not only for the issue of MAID but across the whole spectrum of services provided by physicians. To sustain a good level of patient care in all areas, we need to ensure that as many physicians as possible agree with whatever system is in place.

Unfortunately, the current system in Ontario does not achieve this, with the College of Physicians and Surgeons of Ontario, CPSO, mandating that physicians provide an effective referral for MAID even if it goes against their conscience.

Despite the right to freedom of conscience enshrined in the Canadian Charter of Rights and Freedoms; the Supreme Court ruling that no physician would be compelled to provide MAID; and the preamble of Bill C-14 reiterating section 2(a) of the charter, the lack of explicit provincial legislation upholding conscience rights has led college policies to encroach upon freedom of conscience, despite public outcry.

Whereas just laws add stability to a free society by upholding common societal values, of which freedom of conscience is fundamental, college policies change every few years with no accountability to public consensus that is at the core of a democracy.

It is the government's responsibility to create laws and systems that allow for the flourishing of a free and civil

society, not regulating bodies. The CPSO has itself acknowledged that it will realign all its policies in accordance with provincial legislation.

It makes little sense for a government to ignore the concerns of health professionals, who wish to provide care for patients but who simply wish to refrain from engaging in one controversial procedure. For some physicians, providing an effective referral for euthanasia and assisted suicide renders them complicit in killing and is a violation of their freedom of conscience to abstain.

My reasons for not participating in MAID also stem from the nature of my work as a psychiatrist. I listen daily to patients, many of whom suffer from chronic thoughts of suicide, who share with me both their physical and emotional pain—in short, all the human experiences of suffering that can drive someone to suicidal despair.

In order for me to do my work effectively, there must be a clear separation between what the patient sees that I am there to do for them, and the tacit agreement of facilitating their suicide by referring them for it.

My role is to provide support in living and in finding hope. For the safety and well-being of my patients, I must not be confused with life-ending processes, especially when my patients come to me for help at the weakest, most vulnerable time of their lives.

The provision of an effective referral for MAID is a betrayal of my patients and the ethos to first do no harm, at a time when my patients are most in need of support and a safe space, and undermines psychiatry's work in suicide prevention by cutting short the time I have to work with them. I anticipate with sadness the day when assisted suicide will be expanded to include solely psychological illness.

My inspiration to practise medicine came from my mentor, who fell ill with ALS, a debilitating neurodegenerative disorder. By showing me how to live life with courage and dignity until the end, and the meaning behind caring for the sick, he taught me the value of life despite debilitating disease, that sparked my interest in palliative medicine.

Following the completion of my residency training, I had hoped to combine my psychiatric skills with palliative care. As a psychiatrist, I knew I could give real hope and closure to dying patients and their families by treating a depression or existential distress that robbed them of precious time with their families. I was offered a position to work in a cancer clinic where I could pursue this work. However, I declined. Why? Because I had anticipated even then the CPSO's forthcoming policy and the outcome of the Carter case that would legalize euthanasia. I opted to work in general psychiatry until expectations of physicians became clear in the milieu of legalized euthanasia. The current socio-political climate does not grant me the reassurance I need to re-enter the palliative arena with my skill set, and patients are suffering for lack of care I otherwise could provide.

I am committed to the well-being of my patients, and, as such, I cannot compromise my conscience and integ-

rity by engaging in procedures that are diametrically opposed to why I originally pursued medicine as a vocation. To facilitate the death of my patients through a mandatory referral is to destroy the very heart of my work. To maintain the integrity of medicine, physicians must not be forced to make a referral for MAID. Patients should be given reasonable access to MAID by implementing a system such as the one used in Alberta, which allows for patient access without referral.

By including legislation to protect the freedom of conscience of physicians and simultaneously implementing this direct system of access, we can achieve a solution acceptable to both patients and physicians.

Thank you for your time.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Tang. We'll begin this round of questions with Mr. Fraser.

Mr. John Fraser: Thank you very much, Dr. Tang, for your presentation, for your deputation today and for your work. I want to start by asking you some questions around your suggestions for a coordinating service. You've heard that the government is working on a co-ordinating service. How do you see that working?

Dr. Sephora Tang: I think the model that the Alberta system has in place is very good. It allows for access from several points of contact, whether it's at the doctor's office, in the home, in a facility or even in a facility that doesn't permit MAID. They have a telehealth number that patients can access directly without requiring referral.

If it's for a patient in the community—I understand that there's a lot of concern about patients who may not be able to make a phone call or are isolated. In that case, those patients are likely too ill to be living in the community on their own and they need to have supports in place to be able to support them—for example, the CCAC, the community care access centre. Other people coming into the home would be able to provide some of that assistance. Or if they are so frail and sick, they really should be admitted to hospital, in which case there would be a team of health care professionals who would be able to support the patient. There are even patient advocacy centres that can advocate for the patient if this is something that they wish to pursue.

Mr. John Fraser: We have a deputation from Dr. John Scott with regard to this issue. He spoke about how, inside the Ottawa Hospital, they have found a way—he's a physician of conscience—to work so that he could follow his patient along through a process. Do you have any comments on that? We're looking at different models—we're in the community; we're in hospitals; we're in hospices. Do you have any comments on that?

Dr. Sephora Tang: I think that model is good. It does allow for physicians who have conscientious objections to not participate directly in the process, and patients are able to have access to the service.

Right now, my main concern is that despite these local systems that are working, the policy that the College of Physicians and Surgeons of Ontario has in place still

mandates an effective referral from a physician, which would implicate that physician who has a conscientious objection. That's the reason why we are asking for protection within legislation: so that this wouldn't be imposed upon us and so that we can continue to care for our patients.

Mr. John Fraser: Do I have any time left?

The Chair (Mr. Peter Z. Milczyn): That's all of your time.

Mr. John Fraser: Thank you very much, Dr. Tang.

The Chair (Mr. Peter Z. Milczyn): The next round of questions is with the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Good afternoon, and thanks for calling in.

The government has come out and said that they're going to have something in place by late spring, so I'm hoping that they're further along than they are about asking about different programs. I'm hoping that they can release their program to all of the concerned groups to have some form of conversation before they introduce it. Hopefully, they have your name now and will send you an outline or a frame of how they intend to create the self-referral program.

1500

No matter what type of self-referral system is created by the government, unless they protect conscience rights, we'll still have the same problem we have today. Would you agree to that?

Dr. Sephora Tang: I agree, yes.

Mr. Jeff Yurek: We had a doctor from BC who was not in favour of conscience rights; however, she is in BC. Currently, due to her feedback, BC provides the best access to medical assistance in dying, and they don't have effective referral in place for their doctors. Your thoughts on that—and perhaps discuss that the two aren't one and the same.

Dr. Sephora Tang: I agree with that. There are several policies across Canada that explicitly do not require effective referral, including BC, as you mentioned, Manitoba and New Brunswick, and other policies across Canada requesting that physicians provide reasonable access, for example. If a care coordination system was available that would allow for patient direct access, this issue of going against the conscience of physicians would not really be an issue. I think the fact that other provinces have been able to come together and develop a system that allows for patient access while, at the same time, being respectful of the conscience objections of physicians goes to show that there is a solution that's possible where we can make this work for everybody.

At the end of the day we're all here because we care about our patients; we want to work together. I think if we're able to implement a system that allows us to provide care for our patients and allow patients who wish to have access to MAID to have access to it, this would be the best solution possible.

I think the reason why we need to have legislation within provincial law to protect and uphold conscience rights is because, as I said in my presentation, college

policies change every few years. Five or 10 years from now, I don't know what the landscape is going to be like in medicine. At that point in time, will policies change to say that we need to be performing medical assistance in dying?

I know that the Supreme Court ruling and Bill C-14 said that no physician should be compelled to do this, but it's almost like a sliding slope right now where, very slowly, policies are starting to encroach upon freedom of conscience. That's why I think it is a responsibility of government to enact legislation to uphold freedom of conscience and to protect it.

The Chair (Mr. Peter Z. Milczyn): The next round of questions is with the New Democratic caucus. Madame Gélinas.

M^{me} France Gélinas: Thank you so much for connecting with us today. I very much appreciated listening to the suggestions and solutions that you're putting forward. Were you ever consulted before the bill came forward? Did you have an opportunity to state those issues before today?

Dr. Sephora Tang: I did not know about the existence of the bill until after it had passed first reading, and then I started to receive some emails about it. But honestly, I wouldn't have expected to be consulted on it because I'm only one individual physician. I'm not representing a large organization. However, if it had been advertised that the government was trying to put together such a bill on medical assistance in dying, I would have been interested to know about it at that time and I definitely would have tried to submit something at that time to allow the government to know my thoughts on the issue.

M^{me} France Gélinas: I would say that right now the clock is ticking and has been ticking for the last couple of years. In July, it became legal. We have this policy vacuum, as in, we still don't have a bill in Ontario and it has been over nine months. How was it for you to go through this period of time?

Dr. Sephora Tang: Because I knew what the CPSO policy was, and I had anticipated that moving forward, this was one of the reasons why I decided not to take up the position at the cancer clinic because I'm still very early in my profession. I'm hoping to work for at least another 30-plus years, if I can, but I was not willing to place myself in such a situation where I would be more likely to have a request from a dying patient for medical assistance in dying without protection from the CPSO policy requiring a mandatory effective referral.

In the past, when I was training as a resident, I was working with a palliative care team and we had requests from patients to help them die or end their life. At that point in time, I could say, "Well, the law doesn't allow for this," and that gave me enough to continue working with my patients and to provide them with the best palliative care and psychiatric care possible while they continued to live.

Honestly, as a psychiatrist, the reason why we get consulted is because patients are expressing a wish to die.

For example, at that time, there was a patient who was in a lot of pain from aggressive cancer. She was alone, isolated, had no family, and I was called to work with her. The palliative care team did an excellent job controlling her pain. A few days later, we had a very good session and she told me, "I would never forget this moment," and she passed away about two weeks later.

That's just a personal anecdote about the reason why I believe it's so important to allow physicians to continue working with their patients—and especially for physicians who have a conscientious objection to medical assistance in dying. It's because we see this other side that we want to continue offering patients care and hope at even the last stage of life. This is the reason why I do my work.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Tang. That's all our time for today. If there's something further you'd like to submit in writing to the committee, you can do so by 6 p.m. today.

Dr. Sephora Tang: Okay. Thank you very much.

CHRISTIAN LEGAL FELLOWSHIP

The Chair (Mr. Peter Z. Milczyn): Our next witness is the Christian Legal Fellowship. Good afternoon.

Mr. Derek Ross: Good afternoon.

The Chair (Mr. Peter Z. Milczyn): You have up to six minutes for your presentation. Please start by stating your names for the official record.

Mr. Derek Ross: Certainly. I'm Derek Ross, CLF executive director and general counsel.

Ms. Deina Warren: My name is Deina Warren and I'm legal counsel with CLF.

Mr. Derek Ross: Thank you very much for the opportunity to be with you this afternoon. CLF, by way of background, is an association of some 700 legal professionals across Canada. As an organization, we've been very much involved in this issue. We are one of the few organizations to intervene at all three levels of court in Carter and we're also currently intervening in the constitutional challenge surrounding the CPSO policy.

We appear today to express our concerns and comments in three main areas: First, we are concerned about the lack of human rights protections that currently exist surrounding the provision of medical assistance in dying and wish to provide some comments on why we believe that protection is so essential; second, that conscience protection must apply not only to individuals but also to institutions; and finally, that protecting conscience is in fact not antithetical to but in keeping with a patient's best interests.

We, like many others who have appeared before you, are troubled by the fact that in Ontario physicians currently face this requirement to participate in MAID contrary to their constitutionally protected freedom of religion and freedom of expression. This committee, of course, has heard directly from many physicians on the impact that this type of compulsion has on their conscience, on their personal integrity, their sense of auton-

omy, their sense of human dignity. And it is clear from their testimonies that forcing them to participate through effective referrals is, to them, tantamount to committing murder, and whether everyone in the room agrees with that assessment or not, that is their constitutionally protected conscientious conviction. They don't have the luxury of simply switching them on and off after the Supreme Court strikes down provisions of the Criminal Code. They continue to exist and survive that.

Nor does the Supreme Court's decision in Carter—and I think it's very important that we clarify what exactly the court decided in Carter. The decision does not necessarily require the purging of conscientious objectors from the practice of medicine—quite the opposite. As you know, the decision's very clear in saying that nothing in the decisions requires physicians to participate in medical assistance in dying. Simply put, Carter does not require effective referrals. The charter does not require effective referrals. So why are we insisting on it?

Of course, integral to this discussion is not just physicians' rights but the best interests of patients, and perhaps therein lies the rub. I appreciate that many members of this committee are rightly concerned about patients' access and patients' best interests, as are we. The government does have a responsibility to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified health professionals. That is clearly a legislative objective within the Regulated Health Professions Act. It's not a charter right, mind you, but it is a legislative objective.

1510

There's no clear evidence, and I haven't heard anything in the committee hearings today, to substantiate the idea that effective referrals are necessary to achieve that objective.

The Canadian Medical Association has recognized that this argument is not supported internationally, where no other jurisdiction in the world requires effective referrals and patient access does not seem to be a concern in those jurisdictions. The CMA has also recognized that it is in a patient's interest and in the public interest for physicians to act as moral agents and not as mere service providers devoid of moral judgment. After all, how could it possibly be in a patient's best interest to expect them to receive care from physicians who have been forced to check their conscience at the door, to abandon their moral convictions?

That is what we're concerned we are at risk of doing here: that we're forcing a profession to segregate their conscience, their convictions, their ethically informed judgment, from the practice of medicine. That sends us down a very dangerous path. We know that individuals who consistently act against their conscience also become desensitized to it. Surely that is not what we want or expect of our health care professionals.

On the other hand, it's very much in the public interest to allow a broad range of perspectives and beliefs for professionals and health care institutions. That's what state neutrality requires: a diversity of beliefs and perspectives.

And patients, too, are diverse. We must be careful here not to be characterizing them as a monolithic block. Yes, some will seek medical assistance in dying. Others will seek to receive care from physicians and institutions that do not provide MAID and do not refer for MAID. If we're seriously committed to protecting patient choice, should we not be enhancing the freedom for both of those options?

Again, it's important to also recognize that Carter did not create a positive, free-standing constitutional right to demand assisted suicide. In order to give effect to such a right, the state would be forced to have someone, some third-party agent, provide that service for them, violating their rights. I think what's lost in the discussions sometimes is that Carter was predicated on a premise, and that premise was that the plaintiffs there had a willing physician. That physician was one of the parties to the litigation. There was no question about forcing a physician to participate.

Patients do not have charter rights against physicians. As we heard earlier today, physicians are people too, and that means they also have charter rights. It is the government that is obligated to accommodate both.

Wherever one stands on the euthanasia debate—and I appreciate that we have a spectrum of views on that issue—I think we can all agree that there is a significant moral component to these complex end-of-life decisions. The resolution of those components often rightly lies within one's conscience. The law requires that health care professionals be afforded the right to practise medicine in accordance with their conscience, and that right must be robustly protected.

Ontario prides itself, and rightly so, as a province committed to inclusivity, diversity and human rights. We should not stand as the only jurisdiction in the world—a global anomaly—that fails to protect those rights.

The Chair (Mr. Peter Z. Milczyn): Thank you. I'll stop you there.

The first round of questions goes to the official opposition. Mr. Pettapiece.

Mr. Randy Pettapiece: I thank you for your presentation and for coming in here today.

If you were the one to make up the legislation as to this matter, I was just wondering if I could ask you how you would put it down on paper or how you would see this legislation being written to help satisfy your concerns.

Mr. Derek Ross: Thank you very much for that question. We have, in fact, circulated our draft amendments. I appreciate the committee probably hasn't had a chance to review them yet, but they are in front of you, I believe—that's right—with the very specific legislative amendments that we would propose. They are certainly there for your consideration, but you'll see it does provide protection both for individuals and for institutions. We draw from other jurisdictions in crafting the language in creating this precedent.

Did you want to add anything to that?

Ms. Deina Warren: Yes, just that we did a survey and some research on the other jurisdictions and the type

of protections that they provide. There is positive protection affirming conscience rights for physicians and there's also protection from any negative consequences. Those are laid out in the document.

Mr. Randy Pettapiece: Okay. What feedback have you been getting personally, doctors calling you up? Is there quite a high number of doctors calling you up about this issue and expressing their opinions?

Mr. Derek Ross: Yes, I think it's certainly fair to say that a large number of physicians are deeply concerned about this. I think what is maybe lost in all of this is the practical outcome of failure to act here. If the government were not to provide a legislative amendment to protect in legislation, we will be left with a policy that requires doctors to either consistently and continuously act in violation of their conscience, or leave the practice of medicine. Those are the two options that we're presenting a large number of physicians with.

Neither option is good. We've got very capable, qualified, caring physicians that we need in the profession. We don't want them to leave. On the other hand, we don't want them to act against their conscience either. So strictly from a policy perspective, we think that it would be very problematic for this legislation to pass without adequate and specific protection.

Mr. Randy Pettapiece: Thank you.

The Chair (Mr. Peter Z. Milczyn): Madame Gélinas.

Mme France Gélinas: Thank you for clarifying. I was trying to quickly read the amendments that you are—I was not able to go through them and listen at the same time, although I'm usually pretty good at doing that. You've made it clear, when it comes to effective referral, where you stand. I read through your papers that if the physician or nurse practitioner doing the assessment for MAID requests a chart, you wouldn't have any problem with the conscientiously opposing physicians sending the chart over.

What about consultation—as in the opposing physician has prescribed an anti-depressant medication, and then the physician who is doing the MAID assessment reviews this and says, “Well, if there's a case of mental illness or depression, he doesn't get MAID until his mental illness and his depression is treated,” but then the patient says, “Oh, no. He prescribed me that medication to help me sleep, not because I have depression.” How do we handle those follow-up questions and that follow-up of the patient once the referral has been dealt with? They didn't have to do a referral, but this is where we ended up. We still need the physician's collaboration.

Mr. Derek Ross: To that point, we're not here as a body representing physicians, so I don't want to speak for them other than to say that I think we heard in testimony today from a number of physicians that their first and foremost commitment is to assisting their patients and providing care, providing information and not withholding information that is necessary for the care of that patient. My understanding is—and I would defer to the testimony of the actual physicians and the Coalition for HealthCARE—that that would not create an issue for

many of them, subject to any comments from my colleague.

Ms. Deina Warren: I would agree. I would also defer to the physicians' groups on this. However, my understanding is that any communication in that regard would be similar to a transfer of the patient's record. As long as it's patient-initiated, my understanding is that physicians are willing to respond in terms of providing information.

Mme France Gélinas: Okay. Are you surprised that Ontario has done so little? When we look at the success of BC or Alberta, they did all of the work to make the service available before they brought in a law. Are you surprised by the way Ontario is going at it?

Mr. Derek Ross: I think we're certainly surprised at how adamant a number of people are about the effective referral requirement, simply because no other jurisdiction requires anything close to it and it doesn't seem to be necessary. I think what that raises some serious questions about is, is the effective referral requirement really necessary to ensure access, or is it about something else? Is it about, dare I say, moral conformity, in requiring that all physicians basically abandon any ethical opposition they might have to medical assistance in dying, or leave the profession? If that's the case, then we have concerns about state neutrality.

The Chair (Mr. Peter Z. Milczyn): This round of questions: Madame Des Rosiers.

Mme Nathalie Des Rosiers: Thank you very much for your presentation. It was very interesting. I've gone through your paper. I have a couple of questions. The first one is a little bit about interpretation generally about the case. In Bill 84, effective referral is not mentioned at all.

Mr. Derek Ross: That's correct, yes.

1520

Mme Nathalie Des Rosiers: And presumably, as you know, we would interpret all legislation in light of charter protections, and effective referral is not in there. It's something that does not belong to us. It's a document that is drafted by a different body.

We could start from the proposition that indeed all legislation is to be read in compliance with the charter and, therefore, implicitly—and I think it was always the intention never to oblige any physician to do something against his or her conscience.

You use the word “participate” in your proposed amendment, and it doesn't seem to me that much clearer in light of Ms. Gélinas's question, if you're being asked to comment, and the question: Is that participation in the assessment? Yes, it is. A necessary aspect of the assessment would be to convey the information.

We're struggling with wording, so I'm just wondering whether “participate” is too wide or whether you had some questions about this.

And I just have a question about institutional protection.

Mr. Derek Ross: Sure. I think the first part of your question seems to be gearing towards: Is it really necessary for us to have explicit reference to conscience in Bill

84? Certainly we do have the charter, and we could leave it to the courts to determine whether the CPSO policy violates the charter, and that of course is before the courts, and CLF is intervening in that litigation. I also don't think that that necessarily means that the Ontario government needs to vacate the issue. You are legislators. Even in the Supreme Court decision in Carter, they said that what follows lies in the hands of the provinces, among other groups.

The judiciary does not have the monopoly on human rights protection. This government has a responsibility to protect human rights. In the absence of your taking action, we will have a period of continued uncertainty at least, and physicians living in fear, as the evidence we heard earlier today suggests. Why not take a stand and provide clarity that is so deeply needed in this legislation, and set an example for the rest of the country, quite frankly.

In terms of your second question on participating, where do we draw the line? Again, this is part of the problem—I shouldn't say “problem.” This is something that's inherent in conscience. We each have individual consciences; right? We each will say, “This is where the line is drawn and this is as far as I can go”—

The Chair (Mr. Peter Z. Milczyn): Thank you. I have to cut you off.

We have your submission. If there's something additional you'd like to provide to the committee, you have until 6 p.m. today to do so.

Mr. Derek Ross: Thank you very much for the opportunity.

COUNCIL OF CANADIANS WITH DISABILITIES

The Chair (Mr. Peter Z. Milczyn): Our next witness is Barry McMahon. Can you hear me over the phone?

Mr. Barry McMahon: Yes.

The Chair (Mr. Peter Z. Milczyn): You have six minutes for your presentation, which will be followed by questions beginning with the New Democratic caucus. As you begin, please state your name for the official record and where you are calling from.

Mr. Barry McMahon: Okay. Thank you very much. It's a real pleasure. My name is Barry McMahon, and I am calling from Ottawa South. I'm going to take a patient's perspective on the question.

I'm also going to speak on behalf of the Council of Canadians with Disabilities. CCD is a national human rights organization of people with disabilities, working for an accessible and inclusive Canada.

We represent people who have physical, sensory, intellectual, developmental and psychiatric disabilities, either permanent, temporary or episodic. Many are considered extremely vulnerable. Imagine that you are poor, marginalized and in poor health, with minimum education, and unemployed. For the most part, that defines the major portion of the population with disabilities. Their immediate surroundings are often very precarious. Their

supports are often few and far between, and they feel isolated and marginalized.

The CCD has lobbied hard at the federal level to make sure that Bill C-14 had robust safeguards and didn't create an enormous threat. We knew there had to be legislation, but we wanted to minimize the impact on people living with disabilities.

Many of these people can't speak on their own accord. They need to have absolute trust that the health care professional and the facilities in which they are treated are all to be trusted to be doing all they can to improve their quality of life. Being aware of moral convictions and ethics of our doctors and the immediate team is reassuring.

People with disabilities often empathize with their caregivers, family members, and experience frustrations and social pressures and don't want to be a burden. They want to trust that their doctors are not going to be coerced or pressured by their governing bodies to kill them. The government must not make suicide a tempting option for the vulnerable; nor should the family members of a person with severe disabling conditions ever feel they would be doing the honourable thing by euthanizing the individual, as with the Tracy Latimer case. Our lives, as they are, in all their humanness, frailty, beauty and needs, are worth living and must be valued as any other life.

There are doctors who share this perception of dignity and respect for life from the very beginnings to the last breath. These are the doctors most people want. The health care professionals whose ethical values are out in the open and who are unencumbered by government and professional bodies should be made available.

It's vitally important that health care facilities are free to resist being coerced into killing their patients. The Ontario health care system could create safe havens so that people with disabilities can be protected from MAID as it morphs into common practice for even the slightest reasons.

We, as patients, should be able to consult a roster of doctors who would be willing to participate in killing patients so that they can be avoided. The default group, we assume, are all the others who swore the Hippocratic oath as young doctors and who do not want to be involved even by giving an effective referral.

My wife and I, being Catholics, sought out our family physician because of his reputed moral, ethical and religious convictions. We were grateful that this very busy doctor accepted our case files. He is a general practitioner, as well as a palliative care specialist.

My wife contracted a severe type of breast cancer in 2008. She had a mastectomy and then chemotherapy and, afterwards, radiation and then more chemotherapy and, finally, ran out of effective treatments. In 2013, she entered an excellent palliative care program run by Élizabeth Bruyère Hospital in Ottawa, and during her last days had hospice at home. She brought us much love and received much love from her family, friends and religious community. Her ethics, morals and, above all, her willingness to accept her illness coincided with her entire

palliative care team's approach. I can't imagine a scenario where MAID would have been on the minds of all of us of the family. It would have denigrated a very beautiful death experience for everyone.

I will conclude with the scariest notion I've ever heard regarding this whole MAID paradigm. I actually heard the suggestion that medical schools in Ontario should start screening out candidates who are unwilling to participate in killing their patients. I can understand how this sort of totalitarian thinking has emerged from the College of Physicians and Surgeons of Ontario's edict that all its members must comply or risk sanctions and other significant threats.

1530

Is this the brave new world Ontario aspires to become? If not, I ask you to sort out this mess quickly. Give doctors back their freedom of choice—

The Chair (Mr. Peter Z. Milczyn): Mr. McMahon, we'll go on to questions now, starting with the New Democratic caucus. Madame Gélinas.

M^{me} France Gélinas: Thank you so much for reaching out to us and sharing your views on this important topic. From the top, it becomes obvious that because the government failed to provide this safe place for people to get accurate information in this information vacuum, all sorts of news was spread around on an issue that is very polarized. There are people at one end who want access and there are people at the other end who do not want anything to do with it. Our government never provided this safe place for us to come together.

I can assure you that the news you heard that an Ontario university would screen their medical students' applications for willingness to participate in MAID is false news. It has never happened, and hopefully it will never happen.

But I don't blame you. I thank you, actually, for bringing this forward, because it really illustrates the failing of our government to engage with the population, to find that safe ground, to have those conversations so that everybody can be respected. There is a lot of opportunity to make sure that the frail, vulnerable people you represent through the Council of Canadians with Disabilities have the protection needed, but none of that had an opportunity to be aired. None of that had an opportunity to be worked on collaboratively to come out to something that would have informed the bill. So good people like you are left with the worries, the stress of that information being circulated around, and this is pretty terrible.

I agree with you. I worked for 25 years in health care before becoming a politician, and I worked with a lot of people with severe disabilities. I was telling stories—I worked with spinal cord injury for quite a few years. Every new quadriplegic patient asked to end their life, the ones I worked with—I shouldn't say "every," but nine out of 10 in the beginning of their new disability would ask to end their life. They just could not see how they could overcome this. But fast-forward a few years later, and those people are happy, functioning, married; they have kids. They have a full life, and they certainly

want to live. It would have been awful if their wishes, at that point, had been acted upon.

I do realize that some people are in need of protection—

The Chair (Mr. Peter Z. Milczyn): Okay. Thank you, Madame Gélinas. That's been three minutes.

M^{me} France Gélinas: Thank you for communicating with us.

The Chair (Mr. Peter Z. Milczyn): For the government caucus, Mr. Fraser.

Mr. John Fraser: Thank you very much, Mr. McMahon. I very much appreciate you making the delegation all the way from Ottawa South.

I do have to address something my colleague on the other side said. The government did broadly consult on this, both online and in person. We had 11 town hall meetings, and actually two in Sudbury, a community that is very close to her constituency.

I want to thank you for bringing up the concerns of people with disabilities. My work in government is around palliative care and improving access to that. In the hearings, we heard consistently the concerns of those with disabilities in Ontario. I want to reassure you, and I'm sure you are aware, that we don't have presumed consent. We have to have informed consent. There are no advance directives. That is a law that's currently in Ontario right now.

As my colleague across the way said, I have not heard of anybody screening anybody out of medical schools, and I don't believe that's going to happen.

I want to thank you for sharing your wife's story and your family's journey. We had a similar journey in our family with my father, who had inoperable oral cancer. We went through the bumps that are there. We got some great care. We had some real challenges.

It's incumbent upon all of us to improve access to palliative care—not just the government, but associations of health care professionals, communities. There is a lot of work to be done.

I was really happy, as you were, with the care for my dad's journey. But I realize too that there are changes in the law and that there are issues of access. We heard very passionately from some people today about their inability to access quickly information and access to this care.

I would just like to get your take on that. How do we square those two things?

Mr. Barry McMahon: I think access to early palliative care makes a world of difference. It has got all kinds of benefits for everyone involved—not only the patient, but the families associated with the current level of palliative care.

The one thing that I really think is very important from the patient's point of view, especially the patient with a disability, is this ability to trust the people who are immediately serving that particular patient, to know where they stand, to know that their values coincide with the values of the doctor and the other health care professionals whom they come in contact with. I think that's the biggest concern that we have at this point.

The Chair (Mr. Peter Z. Milczyn): Thank you. And now Mr. Pettapiece from the Progressive Conservative caucus.

Mr. Randy Pettapiece: Hello. Thanks for your presentation so far. It has been quite interesting. I guess I didn't know about the trust factor that some people with disabilities have in the health care system, especially when it concerns this topic.

What I would like you to do is expand a little bit on the hospice business. I know that my friend from Ottawa has worked on this hard, and I'm certainly working in my riding on getting more hospice care in the riding. You certainly have first-hand experience. If you had some wishes or could wave a magic wand on the hospice business, what would you like to see? More spaces or better spaces? What would you like to see?

Mr. Barry McMahon: I would like to see a combination of hospice at home and hospice in properly equipped facilities. I think that, in my mind, I separate palliative care from hospice. I think that palliative care is an essential part of living with a disability, when the disability is difficult to manage, and hospice comes in near the very, very end. But if the two are merged—not merged, but complementary, and you enter into palliative care knowing that you will be well taken care of during your last days—I think that that's a very, very good way of approaching it.

I realize that palliative care is a luxury and not everybody has access to it. I was very, very lucky to have all of the bits and pieces line up properly for us. I think that, with more emphasis on palliative care, with more medical specialists focusing on palliative care, the impact of medical assistance in dying is going to be minimized.

Right now, it's a very scary thing. A lot of people just give up hope very early and they just want to commit suicide or get their doctors to end their life as quickly as possible. I think that's got to be the focus of attention, not giving doctors the onus of trying to just cater to the wishes of the patient or the family of the patient as they're nearing the end of their days.

1540

The Chair (Mr. Peter Z. Milczyn): Okay. Thank you, Mr. McMahon, for calling in this afternoon. If there is anything further you would like to submit to the committee, you can do so in writing until 6 p.m. today.

Mr. Barry McMahon: Thank you very much for this opportunity.

CONCERNED ONTARIO DOCTORS

The Chair (Mr. Peter Z. Milczyn): Our next witness is Concerned Ontario Doctors. It's two days in a row that we're seeing each other.

Dr. Mark D'Souza: It's nice to see you again.

The Chair (Mr. Peter Z. Milczyn): You have up to six minutes for your presentation. As you begin, please state your name for the official record.

Dr. Mark D'Souza: Sure. Good afternoon. It's great to be here. My name is Dr. Mark D'Souza, and I am a

family physician, an emergency room physician and a palliative care physician. I'm also a constituent in the riding of King-Spadina. I am also the newly elected chair of district 11 for the Ontario Medical Association and, in that capacity, represent the 13,000 physicians of Toronto. I thank you for this opportunity to address the Standing Committee on Finance and Economic Affairs about Bill 84 today as a board director for Concerned Ontario Doctors.

Concerned Ontario Doctors is a grassroots, not-for-profit organization representing thousands of community and academic family physicians and specialists in every corner of this province. We advocate for a patient-centred, sustainable, accessible and quality health care system.

Ontario's doctors have grave concerns over Bill 84. It is unfathomable that the government has introduced this legislation without any consultation with Ontario's physicians, the very physicians who provide essential medical care for 155,000 patients every single day.

In these last three years without a contract, the government has subjected us to senseless, unilateral cuts that have directly impacted our ability to deliver timely and quality patient care. Instead of collaboration, this government has chosen to vilify and shame Ontario's doctors. Ontario physicians have now seen three key pieces of health care legislation introduced with absolutely no consultation from front-line physicians. Effective health care reform requires meaningful and respectful engagement of all stakeholders, including physicians. It requires genuine collaboration. None of this has occurred with Bill 84.

Concerned Ontario Doctors affirms that protection for conscientious objection will safeguard the medical profession's freedom to act in the best interests of patients. We call on the Ontario government to amend Bill 84 to protect physicians from being forced to refer for, perform or assist in the performance of medical assistance in dying against their conscience or professional judgment. In addition, discrimination against physicians who hold these views should be illegal.

Medical aid in dying can be provided through direct patient access through a care coordination service, or through other mechanisms within community-based programs or institutions. All other jurisdictions in the world have protected physicians' conscience rights through such means, while preserving patients' rights to access care. There is no need to sacrifice professional independence to provide access.

Bill 84 deeply troubles me and countless other palliative care physicians in Ontario. Let me continue by starting on common ground: access to a legal service. The act, as it stands, will actually decrease access to assisted aid in dying. The proposed amendment that doctors seek will prevent this paradoxical effect at no cost. Other jurisdictions in the world and in Canada have been able to protect physicians' conscience rights while preserving patients' access to medical aid in dying through a self-referral process. It could be as simple as a

toll-free number, a website or, heck, even just an app, or it could take the form of a care coordination service that many other provinces have adopted.

In section 2a of Bill C-14, the federal government encourages provincial legislation to uphold the conscience rights of doctors. Every other jurisdiction in the world offering euthanasia has self-referral. Ontario stands alone in lacking such an amendment. Abortion in Ontario has the option of self-referral, so why can't euthanasia?

Speaking of infringements on beliefs, the dean of Queen's University's faculty of health sciences' strong views against conscientious objectors has caused widespread fear, hinting that beliefs on euthanasia would be a part of their screening process. This year, Queen's medical school included in their interview process a scenario in which the candidate was asked by a patient to provide euthanasia. This was followed by a series of questions from the interviewers aiming to reveal the candidate's beliefs on the subject matter. I am deeply saddened to learn of such a discriminatory filtering process existing in a country that claims to have tolerance in its bedrock.

Let me elaborate on why Bill 84, unamended, will actually create less access to essential medical care, particularly palliative care. Several Canadian studies, including Health Quality Ontario assessments, show that most people would prefer to die in their homes. However, about 60% of deaths in Ontario actually occur in the hospital. Moreover, Ministry of Health data reveals that 10% of alternate-level-of-care beds were filled with palliative patients who otherwise could have been in their homes. Most limiting, it's estimated there are only 500 palliative care physicians in the province.

I'm actually part of a group of six physicians who visit palliative care patients in their homes in Scarborough. We are the only group that specifically does this there, and we are all conscientious objectors. I believe you met my colleague earlier today, Dr. Novosedlik.

As it is, Scarborough palliative care is grossly underserviced. We reached a wait-list high of 32 patients waiting for a palliative care doctor in their home this month. Imagine being told your days are numbered. You're nauseated, you're constipated, and you are in absolute agony with cancer all over your body, and yet you call and find out, "Okay, don't worry; you've got 30 patients left before you get seen." Great, right?

I do my job dreading being asked to kill someone. Euthanasia is the shadow that hangs over me, even on sunny days. Two days ago, I accepted my final palliative care patient. While I will not abandon my current patients, I will not be accepting any more new patients until I know conscience protection is guaranteed.

Half of our group of six is considering leaving the field. One is even considering leaving the profession entirely. It breaks my heart that this is happening. And do you know what? What happens in Scarborough is a microcosm of the way palliative care will go for the rest of the province.

Bill 84 creates access to a new legal service on the surface, but when you peel back just one layer of this

onion, it paradoxically reduces access to multiple medical services. All of this can be fixed with just one simple amendment.

Please remember that health care is delivered at the bedside, not on paper, and that patients will never come first when doctors are put last. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. D'Souza. This round of questions begins with the government side. Mr. Fraser.

Mr. John Fraser: Thank you very much, Dr. D'Souza, for being here today, and for your presentation.

Just for the record, we had the OMA here this morning. They said they were happy with the consultations that we did—very pleased. As this legislation was coming forward, as I said earlier, we had a number of town halls and lots of opportunity for people to apply. But it is an ongoing conversation, and it's important for all of us to have.

I appreciate the work that you're doing in the community. I'm glad you brought up your wait-list. I think one of the challenges we have is having enough trained professionals and having a safety net for family physicians so that they'll take that on. That's some of the work that I'm doing inside government—the Ontario Palliative Care Network, which we established. I want to let you know that that work is being done in earnest. And we had the nurse practitioners here today, which I think will be able to help you in your work.

I know you care about your patients, and I know you want to follow your patients. You've asked us to protect your rights of conscience. How do we ensure that there is a way for you to follow your patients who make that request, but you still want to provide the care for them? That's the question. How do we do that? How do we create that pathway? Because I don't think that you want to say to a patient, "You've just asked me for this, so go over there."

Dr. Mark D'Souza: No.

Mr. John Fraser: That's not what you want to do, right?

Dr. Mark D'Souza: No. Not at all.

Mr. John Fraser: You don't want to do that. So you want to find a way of, "Okay, you've asked for this. I can't connect with you on this, but I still want you as my patient." How do we do that?

Dr. Mark D'Souza: Very briefly, first of all, I do explore the "why" too, because a lot of it is because symptoms are inadequately controlled. This question is usually brought up at the beginning, and if I can get it under control, that question of "I want to commit suicide" usually disappears. But you're saying—

Mr. John Fraser: How do we achieve it? Because that's what is in front of us.

Dr. Mark D'Souza: I think other groups have talked about a care coordination service. For me—I've talked about it in my presentation—it could be a number, like Telehealth. "Here's a number; call it. Here's a website. Here's an app." It's 2017; we can get creative on this. And I could still be that doctor for them until they're connected. Does that make sense?

Mr. John Fraser: Yes, it does. We heard from a deposition yesterday—

Dr. Mark D'Souza: Can I answer one other thing that you mentioned? You said the OMA earlier today was very—

Mr. John Fraser: Very positive.

Dr. Mark D'Souza: I think you're all aware of the struggle that the OMA has gone through. I'm part of the new OMA; I was elected three weeks ago. There are going to be a lot more people—you've got a chance to meet some of the new OMA faces. Things will be very different going forward.

Mr. John Fraser: There are 30,000. I do want to say one thing very quickly just in terms of, we had this discussion about palliative care and assisted dying. Assisted dying needs to include palliative care. That's part of the pathway through there, and you just described that very clearly. You can't have assisted dying without palliative care somewhere in that equation.

The Chair (Mr. Peter Z. Milczyn): I'll stop you there, Mr. Fraser.

Next round: Mr. Pettapiece.

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Mr. Randy Pettapiece: I don't know if you were here when the last witness testified over the telephone. I don't know whether you heard what he was saying.

Dr. Mark D'Souza: Parts of it. No, not really.

Mr. Randy Pettapiece: One of the things he brought up too was information. He said that they didn't have the information, or some information. They were afraid some people with disabilities were going to—he was talking about physical disability. He used the word "killing" just too many times. That's the word he used in some of his oratory. I think it gets back to a lack of information that the government has provided to different groups.

You're saying the same thing: "It is unfathomable that the government has introduced this legislation without any consultation with Ontario's physicians"

I don't know why that is, but to me, there seems to be a disconnect with what the government has been supplying your profession and other groups as to where they're going with this thing. You have a man here who is very concerned about the people he represents, because of a lack of information. Maybe that is what has caused some of the wrong statements to get out, the wrong information to get out, because people maybe start dreaming a little bit about what has happened or what's going to happen, I guess. That's what I'm seeing.

I want to ask you a question on the hospice business too, something that is very important to me. How can that be worked into the system more effectively, I suppose, than what it is now in some communities? Do you have enough hospices, or do you have any hospices in your area?

Dr. Mark D'Souza: We have several in the Scarborough region that we access. First of all, my practice is restricted to visiting patients in their homes. Really, it's patient-driven, so a patient says, "I want to be in the hospital," "I want to be in the home," "I want to be in the

hospice." That doctor availability is granted. But sometimes for patients that I see in their home, they or their families say, "You know what? I'd rather be in the hospice," and we would help facilitate that. I do transfer care over that way.

Mr. Randy Pettapiece: The availability of hospices?

Dr. Mark D'Souza: I can't give you hard numbers. I do know that there usually is a bit of a delay, and we try to minimize that.

Mr. Randy Pettapiece: I see. Well, you must be doing a good job, because sometimes people want it done right like this, but obviously they want to stay with you, so they're staying in their homes, which is good. I mean, that's great.

Dr. Mark D'Souza: Thank you. I appreciate that.

Mr. Randy Pettapiece: My parents were the same way. They were able to stay at home until their last days, so it was a blessing.

Dr. Mark D'Souza: It's very meaningful work for me.

Mr. Randy Pettapiece: Right, yes.

The Chair (Mr. Peter Z. Milczyn): Thank you. I'll just remind everybody to stick to Bill 84, which is medical assistance in dying. Palliative care is important but not exactly what the bill is on.

Madame Gélinas, for three minutes.

M^{me} France Gélinas: Thank you so much, Dr. D'Souza, for coming here today. It's the first I've heard of an app—quite creative.

You practise in the field, you see the patient at the end of their lives, and you fear somebody asking you for an effective referral. Do you feel, with the refugees, the people from different cultures, different languages, different views of the world that make up who we are as Ontarians, that a toll-free number, a website or an app would be enough to ensure equitable access and that everybody would be able to gain access through that?

Dr. Mark D'Souza: Are you hinting that if people don't have Web accessibility or have language barriers, that wouldn't be enough?

M^{me} France Gélinas: Correct.

Dr. Mark D'Souza: I haven't encountered such a situation where, just in theory, any of my patients I've ever seen has not been able to do something like that: Make a phone call or go to the Internet. Everyone that I've had has had some sort of family or friend involved.

M^{me} France Gélinas: Okay, because if you've ever called a government number, we all know that you will have to listen for half an hour, to know that if you press 1, 2, 3 or 4, then somebody will—

Dr. Mark D'Souza: That's a very hypothetical situation. It's hard to answer that, because I've never really come into such a scenario.

M^{me} France Gélinas: Okay, but—

Dr. Mark D'Souza: Yes, I do feel that with all these technologies that we have, why does it have to be just in English? Aren't we a multicultural country? It would be so easy to do, if you've got your app, to change it to

Mandarin or change it to Hindi. It doesn't have to be limited that way.

M^{me} France Gélinas: I agree that it is doable. Are you surprised that nothing has been done, that this procedure has been legal now for the last eight, nine months and nothing has been done in Ontario?

Dr. Mark D'Souza: To facilitate this? Yes, absolutely. I've been waiting for that to happen, for something to help us out, to facilitate the process. We're not here to obstruct. We're not here to judge patients' views or their values. That's part of being Canadian. Just don't judge us.

M^{me} France Gélinas: And give you the opportunity?

I would be curious to see where—I know that the interviews for the school of medicine just happened. Some of them just happened last weekend. Where did you hear about follow-up questions? How did you find that out?

Dr. Mark D'Souza: It's my colleague's son who went for an interview there. My brother has actually been helping him prepare for the interviews. The first person he called, apparently, after his parents, was my brother and told him these questions.

M^{me} France Gélinas: Oh, wow. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. D'Souza, for your comments today. If there is anything further you'd like to submit in writing, you can do so until 6 p.m. today.

Dr. Mark D'Souza: Thank you all.

ONTARIO COLLEGE OF PHARMACISTS

The Chair (Mr. Peter Z. Milczyn): Our next witness will be over the phone: the Ontario College of Pharmacists. Can you hear me?

Ms. Nancy Lum-Wilson: Yes, I can.

The Chair (Mr. Peter Z. Milczyn): All right, thank you. You have up to six minutes for your presentation, which will be followed by questions. Your round of questions will begin with the Progressive Conservative caucus. When you begin, could you please state your name for the official record?

Ms. Nancy Lum-Wilson: Thank you, Mr. Chair, for inviting me today to provide comments on Bill 84. My name is Nancy Lum-Wilson. I am the CEO and registrar of the Ontario College of Pharmacists. I am also a trained pharmacist who, prior to my career in the public service, spent several years serving patients in both community and hospital practice settings.

As you know, the Ontario College of Pharmacists is a registering and regulating body for professional pharmacy in Ontario. The college's mandate is to serve and protect the public and to hold Ontario's pharmacists and pharmacy technicians accountable to the established legislation, standards of practice, code of ethics, and policy and guidelines relevant to pharmacy practice. The college also requires community- and hospital-based pharmacies across the province to meet a certain standard of operation for accreditation.

Our mission is to regulate pharmacies to optimize the public's access to quality services and care. We are also committed to the advancement of pharmacy practice to strengthen Ontarians' health and wellness through patient-centred care. This includes supporting patient access to the quality care, treatment and therapies they need and want, and respecting patients' desire for and right to choice.

There are over 15,000 pharmacists and 4,000 pharmacy technicians registered to practise in Ontario. Pharmacists and pharmacy technicians understand the important relationship they play in a patient's life and quality of life. They know that patients trust them as health care professionals that will respect and protect their right to choose and access the treatments they want or need.

Health professionals are expected to use their knowledge, skills and abilities to do their best to meet their patients' needs and wishes within established standards of practice, policies and regulations.

All registered pharmacists and pharmacy technicians in Ontario must understand and follow the college's code of ethics. There are four principles within our code of ethics, which are as follows:

The first foundational principle is beneficence, which establishes the fact that the primary role and function of pharmacists and pharmacy technicians as health care professionals is to benefit the patients whom they serve. Pharmacy professionals must remember that patients seek their care and services because they believe and trust that they will apply their knowledge, skills and abilities to help improve the patient's life or quality of life.

The second foundational principle is non-maleficence. This addresses the reality that as pharmacy professionals strive to benefit their patients, they must be diligent in their efforts to do no harm and, whenever possible, prevent harm from occurring.

The third foundational principle merges the principles of respect for persons and justice. Respect for persons acknowledges that all persons are worthy of respect, compassion and consideration. Pharmacy professionals demonstrate this when they respect patients' vulnerability, autonomy and right to be self-governing decision-makers in their own health care. The principle of justice requires that pharmacy professionals fulfill their ethical obligation to treat all patients fairly and equitably.

Accountability is the fourth foundational principle that rounds out the code of ethics. It directly ties pharmacists and pharmacy technicians to their professional promise to be responsible fiduciaries of the public trust: Keeping their promise to their patients and society to always and invariably act in their best interests and not their own.

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Nine months ago, with Bill C-14, the federal government enacted amendments to the Criminal Code of Canada to include circumstances under which medical assistance in dying is permitted. When this became law, the federal government did not provide further guidance to health care professionals. We were put into a situation

where there was pent-up demand for the service without a clear process to access it. In an effort to assist patients in accessing the service, and in keeping with our professional code of ethics that I have just described, the college developed a MAID guidance document to assist pharmacy professionals in navigating the interpretation of the legislation in order to comply with our legal obligations and professional expectations with respect to MAID. This guidance has been widely communicated to registered pharmacy professionals.

In the Carter decision, the Supreme Court of Canada ruled that while the Canadian Charter of Rights and Freedoms entitles a health care professional to limit the health services he or she provides for reasons of conscience or religion, this choice cannot impede, either directly or indirectly, access to these services for existing patients or for those seeking to become patients. The guidance document developed for pharmacy professionals is consistent with the Supreme Court ruling, and this thinking is already embedded within our code of ethics.

Bill 84 supports the implementation of the federal Bill C-14 by addressing issues such as privacy and liability. In the absence of Bill 84, health care professionals are not protected from civil liability, and this is a considerable barrier to a patient's access to health care professionals who are willing to support and facilitate a patient's decision to access MAID services.

Bill 84's inclusion of liability protection for health care workers is a critical piece of this legislation, and we applaud its inclusion.

Finally, the college is fully supportive of Bill 84 as we believe that its intent is, first and foremost, to protect patients and their right to choice and access. On March 28, the college received the ministry's invitation to participate in the development of the care coordination service, and we look forward to participating and continuing to work with the government as this area of health care evolves.

Thank you for your time.

The Chair (Mr. Peter Z. Milczyn): Thank you very much. This round of questions will begin with the Progressive Conservative caucus. Mr. Pettapiece.

Mr. Randy Pettapiece: Thank you very much for your presentation and for joining us today. I was having a little trouble hearing this clearly, and it's not your fault. I just wonder if you could restate your thoughts on the assisted dying part of it and the compulsory business.

Ms. Nancy Lum-Wilson: We understand right now that there are some health care professionals who object to providing these services, but of course we know that Bill C-14 became law nine months ago, and so, as a result, we have to support the Supreme Court of Canada's ruling that patients have the right to access medical services and the right to choice.

While we understand that we need to balance the rights of conscientious objection of our health care providers, we also need to remember that we cannot unduly delay access for a patient to the services to which they are entitled which are available and that they have

indicated that they would like to make use of. So, when we look at this, we think that the balance has to be there in terms of the guidance document that has been provided and the ability to access these services for these patients.

Mr. Randy Pettapiece: What are your thoughts as to how that could be better balanced, then?

Ms. Nancy Lum-Wilson: Given that we didn't have any hard policies, when it comes down to what we developed for the guidance document, it was what was best at the time to be able to help health care professionals navigate the interpretation of the legislation and their obligations as health care providers. I recognize that there's an opportunity now to begin some more discussions around a care coordination service, and I think it remains to be seen what that could possibly look like. I think that as the government continues to have these consultations, it will enlighten how we can move forward.

Mr. Randy Pettapiece: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): The next round is with the New Democratic Party. Madame Gélinas.

M^{me} France Gélinas: Thank you very much for calling in.

Did I hear you right, that you received an invitation from the Ministry of Health to talk about care coordination on March 28?

Ms. Nancy Lum-Wilson: That is correct.

M^{me} France Gélinas: That's this week.

Ms. Nancy Lum-Wilson: Yes, it is.

M^{me} France Gélinas: All right. Have you had your first meeting?

Ms. Nancy Lum-Wilson: No, we just received it. We've indicated that we would be happy to participate, but we just received it.

M^{me} France Gélinas: Do you know when your first meeting will be?

Ms. Nancy Lum-Wilson: No, we don't have that information yet.

M^{me} France Gélinas: Do you know what the terms of reference are going to be?

Ms. Nancy Lum-Wilson: We don't have that information yet.

M^{me} France Gélinas: Is it just me, or nothing has been done so far, except for an invitation for you to think about participating?

Ms. Nancy Lum-Wilson: I think that, a while ago, back in December, there was a commitment made to move forward with the care coordination service, so the first step, of course, would be that invitation to individuals—I would say organizations—to participate in that. Given that it was only two days ago, I think that there was an intent to move forward by the government, and we would be very happy to participate as they move forward with this.

M^{me} France Gélinas: Me too.

Do you have any of your members who have said that they would not carry the medication in their pharmacy or would not dispense the medication if they received a prescription for it?

Ms. Nancy Lum-Wilson: We have not heard anything at this point in time.

M^{me} France Gélinas: Do you expect that some of them will do that?

Ms. Nancy Lum-Wilson: I think it would be difficult to say at this point, but if and when it does come, we would be prepared to work with them.

M^{me} France Gélinas: And what would that work look like?

Ms. Nancy Lum-Wilson: At this point, we haven't received any comments around not being able to provide services and not having these medications in their dispensary. But as the college has always indicated, there is a need for health care providers to collaborate as we're going forward, and if that collaboration means that there is going to be an early conversation with pharmacists, then that allows them to bring in the medications that are necessary when they're necessary.

We also understand that there are local networks that are set up in the various areas, where folks have been working together for some time, and they've been working through any challenges that could possibly come up.

M^{me} France Gélinas: Thank you. Right now, I understand that most hospitals have those drugs available. Is it your understanding that most community pharmacies would have access to those drugs if a prescription were to come their way?

Ms. Nancy Lum-Wilson: I can't speak to that right now, but certainly that's why we are recommending strongly that there is collaboration with and involvement of the pharmacists very early on when patients are considering this.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you. This round of questions is with the government side. Mr. Fraser.

Mr. John Fraser: Thank you very much for your presentation.

I have one specific question, just so I can understand your policy. And I want to thank you, as we broaden the consultations, for wanting to be part of that. I think it's critical that that happen. I know that the ministry's been in conversations with a number of organizations outside asking what they're looking for in this care coordination service, and I look forward to that work.

Specifically, the question is: I'm a pharmacist; I conscientiously object. What's my pathway?

Ms. Nancy Lum-Wilson: Right now, the guidance document is set out that if you are conscientiously objecting, then you are making an effective referral to someone else who can provide that service.

I think it comes down, really, to patient access and choice without undue delay. It's important that we are letting patients know that they can access the services.

Also, as pharmacists working in the pharmacy, it's critical that our managers are aware that we conscientiously object and that there may be others in the pharmacy who can provide this service, or there are other

pharmacies within the local network that could provide the service.

1610

Mr. John Fraser: I guess I'm trying to ask you to be a little bit more specific around that pathway. What I heard, partly—

Interjection.

Mr. John Fraser: Just more specifically around—I guess if it's in a hospital, you may have another person who does not conscientiously object. What if you're in a small town?

Ms. Nancy Lum-Wilson: So there are local networks. We actually haven't heard of any issues within small towns at this point. We know that there are the local networks out there, that folks have been working together for a while, so they know who it is that they need to talk to.

Again, when you have a patient who would like to access this service, if there is an early discussion—which is why we keep on stressing the need for collaboration and early involvement of the pharmacist. If there is a discussion early on, then it allows all of these issues and challenges to come forward, and it allows folks within that local network to work together to make sure that the patient can actually access the services that they want.

Really, in terms of specifics, it comes down to accessing the local network and accessing other pharmacists who may not conscientiously object, so the folks in those local areas know who they are.

The Chair (Mr. Peter Z. Milczyn): Thank you, Ms. Lum-Wilson, for your presentation this afternoon. If there is something further you'd like to provide to us in writing, you can do so until 6 p.m. today.

Ms. Nancy Lum-Wilson: Thank you very much for having me.

DR. EWAN GOLIGHER

The Chair (Mr. Peter Z. Milczyn): Our next witness is Dr. Ewan Goligher. Good afternoon, Doctor. You have up to six minutes for your presentation, and your round of questions will begin with the New Democratic caucus. Please state your name for the official record as you begin.

Dr. Ewan Goligher: Sure. My name is Dr. Ewan Goligher. I am an intensivist and an attending physician in the ICUs at Toronto General Hospital and Mount Sinai Hospital, and I'm a member of the interdepartmental division of critical care medicine at the University of Toronto. I'm a physician-scientist; my MD is from UBC and my PhD is from the University of Toronto.

I'm a conscientious objector to physician-assisted death, and I am grateful for the opportunity to briefly outline my position.

To understand the position of conscientiously objecting doctors, please consider the following five questions.

First, should doctors provide physician-assisted death merely because it is legal?

Doctors should provide physician-assisted death only if it is both ethical and legal. The Canadian Supreme

Court has ruled that physician-assisted death ought not to be legally prohibited, but it cannot define whether it is ethical for doctors to intentionally cause death. In their decision on the legality of assisted death, the Supreme Court justices explicitly stated that nothing in this decision would compel physicians to provide assistance in dying. The justices recognized that we need not automatically accept that assisted death is ethical in the wake of this sweeping change in law.

Secondly, must all doctors accept the assumptions underpinning the claim that physician-assisted death is good medical care? Advocates for assisted death contend that death should be used to treat suffering because, for some patients, death is better than life. This assumes some notion of what it is like to be dead, yet the medical profession has no idea what it's like to be dead. All beliefs about the afterlife—including the belief that there is no afterlife—are metaphysical, quasi-religious beliefs which cannot be confirmed or refuted by scientific medical evidence. Thus, assisted death is innately experimental, and its outcomes are hidden from us. Medical care must be based on evidence, observation and sound reasoning. Doctors should not be forced to base patient care on quasi-religious assumptions.

Furthermore, the case for assisted death assumes that respect for the patient's desires, rather than respect for the patient herself, is the foundational value of medical ethics. Respect for the patient's wishes is unquestionably part of respecting the patient, but valuing these wishes above the patient herself would prevent doctors from ever refusing any patient request, even if it would clearly harm her.

The long-accepted, firm foundation of medical ethics, including the duty to respect the patient's wishes, is the incalculable, intrinsic, objective worth of the patient. Intentionally causing death requires us to render valueless that which is of essential value: the patient. The key point here is that the case for assisted death is based on quasi-religious assumptions. Proponents of assisted death bring their personal philosophical foundations to bear on medicine at least as much as those of us who oppose assisted death. Given these tenuous assumptions, doctors need not accept that assisted death is good medical care.

Thirdly, if assisted death remained illegal, would doctors be legally liable for making an effective referral? Suppose a patient comes to me and requests a prescription for oxycodone, purely for its euphoric effects, apart from any medical indication. If I decline to provide this prescription, but provide an effective referral to a willing physician, I would be complicit in a grievous breach of medical ethics.

This moral responsibility is recognized in law. Doctors are legally liable for referring a patient for a procedure that is forbidden in law. Knowingly referring a patient to the physician willing to cause the death of the patient makes us complicit in the death of that patient. Therefore, if upon considered moral reflection we find that assisted death is unethical, we ought not to provide referrals for such.

Fourthly, how does respect for conscientious objection affect medical care and patient care? Robust respect for conscientious objection is ultimately good for patients. Patients entrust themselves to their doctors, and doctors must be worthy of this trust. The doctor's moral integrity, a commitment to acting in accordance with moral norms, is foundational to his or her trustworthiness.

Suppressing conscientious objection prizes conformity over moral integrity and systematically teaches physicians to suppress their basic moral intuitions in favour of constantly evolving social conventions. It also teaches the profession to be less sympathetic of and tolerant toward patients' diverse beliefs. Thus, robust respect for conscientious objection should be viewed as an important public good that upholds the quality of medical care.

Fifthly and finally, will respect for conscientious objection seriously obstruct access to physician-assisted death? Upholding respect for objection need not present a serious obstacle to obtaining assisted death. Conscientious objectors have proposed simple solutions allowing patients to refer themselves for assisted death. This is, in fact, probably the most reliable means of facilitating access. Carefully considered policy frameworks, such as that that you reviewed last week, for providing assisted death can show robust respect for conscientious objection while enabling universal access.

Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Goligher. Madame Gélinas for three minutes.

M^{me} France Gélinas: I don't want to make any assumptions. You made reference to a solution that was presented last week. We were presented with many different scenarios. Could you point us to the one that would respect your belief?

Dr. Ewan Goligher: Sure. I'm intimately familiar with the case outlined by the Coalition for HealthCARE and Conscience. You should have hopefully received a chart that looks much like this. This essentially provides contingencies for access, regardless of where the patient is located.

As a hospital-based physician working in the ICU, I have arrangements to make complete transfer of care of a patient who requests access. I am not there to obstruct the patient's access. I cannot directly facilitate it myself, but I do think that they should have the choice of who their MRP should be, most responsible physician.

In the outpatient setting, those of us who object are willing to discuss their options with the patient. We're not trying to hide the availability of this option. We're certainly happy to tell them that the service is available through the Telehealth link number that's available. I think that we outlined a comprehensive system for providing access that does not require us to violate our moral integrity or make decisions as a consequence of that.

M^{me} France Gélinas: In a hospital setting, you talk about an effective transfer, so you transfer the care to a non-objector physician. Do you see the same thing happening in the community where it would be a transfer of care, where you would not receive the rest of your care

from your primary care physician, and all of your care would then be assumed by the medical aid in dying team or whoever that is?

Dr. Ewan Goligher: That's a really important point and I think it's very important to make a very critical distinction between in-patient care and outpatient care. Objectors have no objection to continuing to provide full medical care for patients who wish to pursue that option. They simply object to providing this particular aspect of so-called medical care. If the patient wishes to access that option, they can do so through the care coordination service that they can access themselves. There's no need in that situation for a full transfer of care.

In the hospital, because of the way the system works, if I am the most responsible physician, I have to make a referral for a patient to access. There's no other way for the patient to get access, other than for me to transfer the patient to a different MRP. In fact, in hospital, such transfers of care happen on a weekly basis, for example, in the ICU, so it's certainly not out of the ordinary.

1620

M^{me} France Gélinas: Thank you.

The Chair (Mr. Peter Z. Milczyn): This round: Mr. Dong.

Mr. Han Dong: Dr. Goligher, thank you very much for coming in to give the presentation. I was listening carefully.

I just want to ask a question around the care coordination service. As you know, the government will be establishing the service to be accessed by both clinicians and patients. This service could be a single phone number where any patient or caregiver or family member can make the call.

I just want your view. Do you think that this program is important? Do you think it's going to provide some help to you and your colleagues?

Dr. Ewan Goligher: I think it's important for those who believe that assisted death is a good thing, to make it as widely available as they can. It's an interesting point that nobody seems to discuss, that the issue of access is predicated on the notion that this is a good thing to be doing. I think the discussion should begin with the ethical discussion, not the access point.

Nevertheless, for those of us who are unwilling to do it, I'm thankful that others are prepared to create a system that allows us to continue to practise in Ontario, being faithful to our foundational beliefs of how medicine ought to be practised. But, ultimately, that responsibility lies with those who believe that this is a good thing to provide.

Mr. Han Dong: Okay. I'm good. Thank you, Chair.

The Chair (Mr. Peter Z. Milczyn): Thank you, Mr. Dong.

Mr. Oosterhoff, for up to three minutes.

Mr. Sam Oosterhoff: Excellent. Thank you very much for your presentation and your well-thought-out approach to this issue. Obviously, this is an issue that is one that matters to a lot of people, patients and physicians included.

There are a couple of steps to this. First you have the Carter decision and then you have Bill C-14 and now we have the cleanup after Bill C-14. So there are a few steps.

I'm just wondering if we could go back to the Carter decision where the court made it very clear that it was important to have scrupulously monitored and enforced regulations surrounding this. Would you say that a combination of Bill C-14 and Bill 84 are scrupulously monitored and enforced regulations? Do you think there are adequate regulations scrupulously monitoring this here in Bill 84?

Dr. Ewan Goligher: To be honest with you, sir, it's difficult for me to comment on that. That's not an issue that I've studied, personally, in detail.

I certainly do think that there seem to be some efforts to make the process needlessly opaque. For example, writing on death certificates causes of death other than the fact that the patient had their life deliberately ended by a medical act, I think, is not telling the truth, to be honest with you. That's an issue with respect to the overall monitoring.

I haven't studied that issue sufficiently to be able to speak with confidence.

Mr. Sam Oosterhoff: So you don't think that's a good idea, then, to have the underlying conditions that led to the request for medical assistance in dying? You think we should have just straight medical assistance in dying?

Dr. Ewan Goligher: Any time you fill out a death certificate, you're always reporting a causal chain of events: the final cause of death and any antecedent conditions that contributed to that final cause of death. But, in my view, if there's nothing wrong with causing the death of the patient, why we're not simply putting that as the actual cause of death on the death certificate, to me, is very strange.

Mr. Sam Oosterhoff: You mentioned you work in the ICU in the hospital. Thank you very much for the work you do. What sort of approach have your colleagues had towards this? I'm sure you've had conversations. What seems to be the consensus around this issue?

Dr. Ewan Goligher: Most of my colleagues seem to support the legalization and provision of assisted death, but I'm grateful that I have a very collegial group that I work in, and I was very open and transparent. Those of us who object have been open and transparent, and people have clearly indicated their willingness to work with the system that we proposed. In fact, one of the leading national advocates of assisted death, James Downar, is in my physician group, and we co-wrote a paper on this, recently published in an academic journal, outlining the pros and cons, but describing a unified approach to handling the issue of conscientious objection—

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Goligher. That's all the time we have this afternoon. If there's something further you'd like to provide to the committee in writing, you can do so until 6 p.m. today.

Dr. Ewan Goligher: Thank you.

Interjection: Could you give us the name of that paper?

Dr. Ewan Goligher: Sure. How can I provide the paper to you?

The Chair (Mr. Peter Z. Milczyn): You could send an email to the Clerk, and it will be forwarded.

DR. SANDRA BRICKELL

The Chair (Mr. Peter Z. Milczyn): Our next witness this afternoon is Dr. Sandra Brickell by teleconference.

Dr. Sandra Brickell: Hello.

The Chair (Mr. Peter Z. Milczyn): Can you hear me?

Dr. Sandra Brickell: I can indeed. Thank you.

The Chair (Mr. Peter Z. Milczyn): All right. You have up to six minutes for your presentation. Following will be questions, starting with the government caucus. Please state your name and the location that you're calling from for the official record as you begin.

Dr. Sandra Brickell: Certainly. My name is Dr. Sandra Brickell, and I'm in the village of West Montrose, Ontario. Good afternoon.

I'm a physician from Waterloo region, as I mentioned. I trained as a general internist and I work as a hospitalist, so I take care of hospital in-patients.

Thank you very much for the chance to present.

I have conscientious objections to medical aid in dying, or MAID. While I am grateful for the efforts stakeholders have made to attempt to balance between patient access and doctors who object to MAID, requiring a referral is still prohibitively problematic.

I believe I can convince you of three things: (1) referral for MAID is a meaningful form of participation; (2) an amendment to Bill 84 that provides for conscience protection for those unwilling to refer will actually also protect patients, including possibly someday somebody you care about; and (3) requiring a referral is unnecessary to ensure access to MAID for those who wish it.

About my first point, that referral is a meaningful form of participation in MAID: Bill C-14 reassures us that individuals are not compelled to assist in providing MAID. Referral is, however, a form of assistance, as can be demonstrated by both a fictional scenario and the policy of the College of Physicians and Surgeons of Ontario, or CPSO. Consider this scenario: Somebody asks me to break into your house and steal your valuables. I refuse, citing moral objections, but then I refer this person to a thief who is willing to do the deed. In addition, circumstances are such that if I do not make that referral, the burglary cannot happen. If I do make that referral and your valuables are stolen, would you not consider me to have provided assistance in the theft?

Even more compelling is the CPSO policy on female genital cutting and mutilation surgery, or FGM, which is available on the CPSO website, a PDF of which is attached to my written brief. FGM is considered aggravated assault—

Interruption.

The Chair (Mr. Peter Z. Milczyn): Dr. Brickell?

Dr. Sandra Brickell: Pardon me?

The Chair (Mr. Peter Z. Milczyn): Dr. Brickell, I apologize. We're being called to vote up in the legislative chamber, so we have to recess the committee for about 10 minutes, and then we will recommence. I apologize for that.

Dr. Sandra Brickell: That's no problem. Are you going to phone me back, then?

The Chair (Mr. Peter Z. Milczyn): We will make that arrangement with you.

Dr. Sandra Brickell: So I should hang up now.

The Chair (Mr. Peter Z. Milczyn): Yes.

Dr. Sandra Brickell: Okay, great. Thanks very much.

The Chair (Mr. Peter Z. Milczyn): Oh, no. Don't hang up.

Dr. Sandra Brickell: Don't hang up. Okay.

The Chair (Mr. Peter Z. Milczyn): If you could stay on the line.

Dr. Sandra Brickell: Yes, I will. May I ask one more question? When we do resume, should I start at the beginning or just where I left off?

The Chair (Mr. Peter Z. Milczyn): You did about a minute and a half of a six-minute presentation, so—

Dr. Sandra Brickell: Yes. So I should pick up where I left off.

The Chair (Mr. Peter Z. Milczyn): Pick up where you left off.

Dr. Sandra Brickell: Yes, okay. I'll do that.

The Chair (Mr. Peter Z. Milczyn): The committee is recessed for 10 minutes.

The committee recessed from 1628 to 1641.

The Chair (Mr. Peter Z. Milczyn): The committee is back in session. Dr. Brickell?

Dr. Sandra Brickell: Yes.

The Chair (Mr. Peter Z. Milczyn): All right. I apologize for that. We've voted, and everybody is back in their seats.

Dr. Sandra Brickell: All righty.

The Chair (Mr. Peter Z. Milczyn): You have about four and a half minutes left, if you need it.

Dr. Sandra Brickell: Okay, great. I was saying that female genital mutilation surgery is considered aggravated assault, and the CPSO forbids its members from performing it. In addition, CPSO policy states that "physicians must not refer patients to any person for the performance of FGC/M procedures." It also states that referral for FGM "will be regarded by the college as professional misconduct."

If referral is not a form of assistance, why is this prohibition against referral in the CPSO policy, and why is there a penalty for violating it?

About my second point, that conscience protection will protect patients: Something often overlooked is the potential for involuntary MAID. C-14 does state that a request for MAID must be without external pressure, but I submit that people who have not freely chosen it will have their lives ended by MAID. This is one of my primary objections to MAID.

How might this happen? Well, three factors will lead to this. First, there's the stress of a swamped health care

system. Consider our often-packed emergency rooms, long wait times and the acute-care hospital beds occupied by those waiting for long-term care. It is naive to think that the availability of MAID won't influence decision-making within the hospital, even if we try to put safeguards in place.

Can you confidently tell me that no Ontario patient has ever been prematurely discharged in an effort to free up hospital beds? Are you convinced that no patient in Ontario has ever given in to subtle pressure to accept a course of treatment with which they did not feel comfortable? Anyone with any front-line experience with health care knows that, unfortunately, the answer to both questions is no. People will die of MAID because of systemic pressure to choose it.

Next there is the pressure for patients of feeling that they're burdens. The fact is that being a patient, especially with chronic conditions, does tend to strain our loved ones. Many families shoulder this emotional and sometimes financial burden willingly, but it's a fair assumption that every doctor has encountered situations where family members did not have the patient's best interests at heart, and this put the patient at risk. The stakes are too high to overlook this possibility with MAID.

Also consider financial constraints. Any system that pays for both conventional treatment and MAID has an inherent conflict of interest. Imagine you have terminal cancer, and you could have an operation and chemo to extend your life for six months. The cost might be in the tens of thousands of dollars. Or, if you choose MAID, it would cost the system a mere fraction of that. Which do you think the system would prefer? Who among us has such confidence in the system that we can be certain this will never be a problem? My written brief cites a case in the US where this did take place.

It is true that most health care professionals are diligent, dedicated and genuinely care about their patients. But taking care of patients can be very complicated. If the right decisions were always straightforward, we would not need medical ethicists, but we do. And if health care professionals never made errors in judgment or ever put their own interests ahead of patients, we would not need malpractice lawyers or provincial regulatory colleges, but we do.

Explicitly supporting conscience protection in Bill 84 would send a message to patients that declining MAID is a perfectly valid choice. This would influence institutional culture and thereby empower patients to resist any subtle pressures.

Finally, my third point: Mandatory referral is unnecessary for effective access to MAID for those who wish it. The CMA has expressed support for a self-referral service that patients could access for MAID in the same way Ontarians use Telehealth Ontario. Both GTA MAID and Canadian Association of MAiD Assessors and Providers have information on their websites to assist patients.

A centralized provincial self-referral agency, well publicized, would ensure effective access for anyone in

the province, including marginalized populations, who desired MAID. It is baffling to me that other provinces, most notably Alberta, are willing to consider or actually provide this kind of service while Ontario is not.

To summarize, I hope I have persuaded you of three things:

- (1) Referral for MAID is a form of assistance, and conscientious objection to referral is therefore legally protected in Canada and should be provided in Bill 84;

- (2) Conscience protection will also protect patients, not just physicians; and

- (3) Requiring a referral is unnecessary to provide effective access for MAID. This is recognized in other provinces; why not Ontario?

The Chair (Mr. Peter Z. Milczyn): Thank you, Doctor. This round of questions is with the government caucus. Madame Des Rosiers.

M^{me} Nathalie Des Rosiers: Thank you very much, Dr. Brickell, for joining us by phone, and thank you for sharing your viewpoint. It's quite interesting and very enlightening. And I want to thank you for all the services that you give to your community.

I want to reassure you that indeed, I think in the Supreme Court of Canada decision in Carter it's quite clear that the court was trying to balance and insist on making sure that we are not exerting pressure on people to end their life prematurely. I understand and I agree with you that certainly it's our responsibility to ensure that that does not take place. You will see in the bill that there are provisions for the coroner to examine the way in which it has been done. It also provides—which I was quite pleased with—a possibility for this legislation to be evaluated in a certain period of time so that we can evaluate how indeed it will unfold in practice.

On conscientious objection, did I hear you that—we've heard lots of different scenarios, and I just want to make sure that I understand what you would be prepared to live with. The Alberta model requires the physician in a way to give a phone number.

Dr. Sandra Brickell: That's right.

M^{me} Nathalie Des Rosiers: The care coordination model that we have in mind would be something similar, where there would be a phone number. You're satisfied with that?

Dr. Sandra Brickell: If you mean that I don't have to make the phone call myself, then yes, I am. I'd be content to pass the phone number along to the patient. I'm not interested in trying to get in the way of any patient's access to MAID. If a patient requested MAID, I would want to discuss the background behind that request, their emotional state, their various medical conditions, make sure it's not a cry for help, all that sort of thing. Then, in the spirit of truly informed consent, you would explain all the available options and the pros and cons of each option and then allow the patient to make the decision. Part of providing information about each option would include information on how to access those things.

M^{me} Nathalie Des Rosiers: That's where I'm a bit confused, because I understand the guidelines of the

college to say that you can ask an alternate to give the information. For example, you could say, "We've discussed the pros and cons and I'm not comfortable recommending this course of action; it goes against my beliefs. But my assistant will provide you with the appropriate information." Would that satisfy you as well?

Dr. Sandra Brickell: Yes, it would.

M^{me} Nathalie Des Rosiers: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you. This round of questions is with the official opposition. Mr. Oosterhoff.

Mr. Sam Oosterhoff: Thank you very much for your presentation and for your heartfelt approach to this sensitive topic. It was definitely thought-provoking, some of the examples you used and gave.

I just had a quick question. I always go back to C-14, which was the federal euthanasia legislation—or the medical assistance in dying legislation. In the preamble it says, "Whereas the Government of Canada recognizes that in the living conditions of Canadians, there are diverse circumstances and that different groups have unique needs, and it commits to working with provinces, territories and civil society to facilitate access to palliative and end-of-life care....", and then it goes on to describe some culturally and spiritually appropriate end-of-life care as well.

1650

I'm just curious if you've seen, from the federal government, a reaching out to the provinces, to the territories and civil society, as the preamble suggests, to develop this palliative and end-of-life care, and what would you suggest would be beneficial in that regard?

Dr. Sandra Brickell: I don't know that I'm qualified to fully respond to your question, but my understanding is that the federal government's approach to this matter was that because health care provision is a provincial matter, they have been inclined to leave the decision-making around end-of-life care, including MAID, up to the individual provinces.

Mr. Sam Oosterhoff: Okay, fair enough, because it just says "it commits to working with the provinces," so I'm curious what that working would look like, and it says also "civil society." As a physician, I was wondering if you have noticed any reaching out from the feds?

Dr. Sandra Brickell: That's an excellent question and, to answer it, I have not been aware of any example of federal involvement. My understanding, like I said, is that it is considered a provincial thing, and the federal government had a disinclination to be involved. I've certainly not seen, personally, at least, any involvement at the federal level.

Mr. Sam Oosterhoff: Excellent. I appreciate that.

If you had one suggestion to make this piece of legislation a better piece of legislation—we've heard from a lot of people about the need for conscientious objectors to have that capability; you mentioned the Alberta model—what would your one suggestion be?

Dr. Sandra Brickell: My one suggestion would be that there would be an explicit statement that physicians,

and other health care workers for that matter, would not be required to participate in the provision of MAID and that the definition of participation would include referral or any other form of assistance, as well as the actual provision of MAID itself.

Mr. Sam Oosterhoff: Perfect. Thank you very much.

Dr. Sandra Brickell: Thank you.

The Chair (Mr. Peter Z. Milczyn): Thirty seconds. Mr. Walker.

Mr. Bill Walker: I'll just say thank you very much for your input, because I'm not going to get the question out and you won't get the answer in. Thank you so much.

The Chair (Mr. Peter Z. Milczyn): The New Democratic caucus: Madame Gélinas.

M^{me} France Gélinas: Thank you very much for reaching out to us today and sharing your view. You've made it clear that if you had to make one change to the bill, it would be to protect conscientious objection. Can you see other changes we could make to the bill to avoid this systemic pressure that you fear could develop in our overcapacity, overworked health care system? Can you think of other protections that we could provide?

Dr. Sandra Brickell: I think having a universal information package made available in multiple languages and in different levels of vocabulary, and make it easily available within every health care facility and through family physicians' offices and so on, so that all the different issues attached to this one question are made available to your average patient and that they can get what would be truly informed consent to make a decision.

M^{me} France Gélinas: You're not afraid that if we make such a brochure available to all—I mean, this is a very, very small fraction of Ontarians who will ever think of using MAID, and an even smaller proportion of Ontarians who will ever use the service—that we would be working in reverse, that we would be—

Dr. Sandra Brickell: Encouraging it.

M^{me} France Gélinas: Yes.

Dr. Sandra Brickell: Yes, that's a very good point. I suppose one way to do this is to make sure that everybody knows, when they encounter the health care system and whatever professionals they're working with, that there is reinforcement of the opportunity to make a fully informed decision on their own, and in regard to assisted death, emphasizing the opportunity for palliative care and explicit alternatives to all the different options out there in every situation would be helpful. That would be a lot to cover, obviously.

M^{me} France Gélinas: We've heard other physicians say that they are comfortable with doing a care transfer—so if you worked in a hospital, you transfer the care to somebody else. In the community, there seems to be the same openness. It is more awkward, where you keep providing primary care, but you transfer the care for MAID to another physician. You don't make a referral; you just transfer.

Dr. Sandra Brickell: That's right.

M^{me} France Gélinas: You would be comfortable with that too?

Dr. Sandra Brickell: Absolutely, yes, because if the patient requests something that I'm unwilling to give, it is certainly within their right, their prerogative to request transfer of care for all or part of that care to another physician.

M^{me} France Gélinas: Okay, very good. That's it for me. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you very much, Doctor, for being a witness this afternoon. If there is anything further you'd like to provide us, you have until 6 p.m. this evening to do so, in writing.

Dr. Sandra Brickell: Yes. Thank you very much to you all.

The Chair (Mr. Peter Z. Milczyn): Thank you.

PATIENTS CANADA

The Chair (Mr. Peter Z. Milczyn): Our next witness: Patients Canada. Good afternoon.

Mr. Andrew Ignatieff: Good afternoon.

The Chair (Mr. Peter Z. Milczyn): You have up to six minutes for your presentation, following which the round of questions will begin with the official opposition. Please state your name for the official record as you begin.

Mr. Andrew Ignatieff: Okay. My name is Andrew Ignatieff and I'm a board member at Patients Canada. We're a charitable organization dedicated to bringing the patient voice to bear on health care delivery and policy-making. I should also say that I am a lifetime family caregiver and am presently working as an in-home hospice care worker providing palliative care to people in their homes.

In passing legislation enabling patients to seek doctor-assisted death, the federal and provincial governments must do everything in their power to protect the rights of the individual and to facilitate and protect a required process for providing this assistance.

The decision to end one's life by anyone with severe affliction is among the most difficult and painful that he or she will ever face. It is not a decision that is taken on a whim or on the spur of the moment. It considers the consequences on loved ones as well as thoughtful reflection on the possibilities of a miraculous outcome, including the reversal of a life-threatening illness.

It cannot be emphasized enough that the decision to seek a doctor's assistance in dying is the patient's decision to make—not the doctor's, not the family members, not the religious counsellors' or the community, though they may be asked to provide advice beforehand.

In addition, this decision should only be made as a result of the patient's own free will and not subject to undue pressure from others, including family. In seeking a doctor's assistance, the patient is assuming full responsibility for ending his or her own life.

People living with life-threatening illness often retain optimism and hope in the face of drastically limited prognoses, excruciating levels of life-limiting pain, and harsh and unexplainable side effects of the disease or

treatment. However, people who seek a doctor-assisted death have given up all hope. They see no further purpose for living. They feel themselves beyond the comfort of religion, philosophy of life or further medical treatment to extend their lives any longer.

Since June 2016, the federal Bill C-14 has provided a necessary legal framework enabling patients to seek a doctor's assistance in dying. We applaud this bill but believe that C-14 is still too restrictive in facilitating access to this essential service; too attentive to the moral, social and professional qualms of different interest groups rather than to the patients themselves.

With regard to Bill 84, Patients Canada maintains that the patient experience and voice will be better reflected through the following five recommendations:

(1) That the vague term "foreseeable death" be replaced by a more patient-focused term such as "all hope for recovery is lost" or "there is no further purpose in living." Who can foresee when death will come? It is precisely the right to take responsibility to determine the time of death that the patient is seeking.

(2) That the right for patients to request doctor-assisted death is extended to people suffering from many conditions such as those that are catastrophic, protracted, degenerative or lifelong and for which there is no possibility of amelioration, recovery or which places unacceptable limits on the patient's ability to live with dignity and enjoyment.

(3) That a free-standing verification process is put in place throughout Ontario to ensure that in every case it is the patient's will to end their life. These processes, including a reflection period, must be professionally and ethically sound but not so onerous as to slow down a very difficult decision, thus putting the patient through more unnecessary pain and anguish. The processes must be easily accessible to patients in their time of greatest need.

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(4) Access must not depend on a physician who is unwilling to have a role in physician-assisted death for whatever reason. Forcing a doctor to do what goes against their belief system, including referring, will not work for the patient. Therefore, in this case we ask for a process that is independent, whereby patients can be immediately directed to a practitioner within easy reach and willing to help ensure a dignified end to life at an opportunity of the patient's choosing.

(5) That special consideration be given for procedures for obtaining advance consent from people suffering catastrophic mental and degenerative disease to guarantee that the request for doctor-assisted death comes from the patient's own free will, rather than imposed by any surrounding interested party.

The Chair (Mr. Peter Z. Milczyn): Thank you, Mr. Ignatieff. This round of questions is with the official opposition. Mr. Walker for three minutes.

Mr. Bill Walker: Thank you, Mr. Ignatieff. Thanks for your time and effort to put this together and for your presentation. I don't want to put words in your mouth, but I want to ask a point of clarification. I think I'm read-

ing this correctly that, I think, your premise is that the absolute decision, the priority decision here, has to be the patient's at any time.

Mr. Andrew Ignatieff: That's right.

Mr. Bill Walker: It's not up to the doctor; it's not about their rights. It is up to, truly, the patients' rights.

Mr. Andrew Ignatieff: They need all the support they can in terms of advice and direction, but the ultimate decision has to be in the hands of the patient.

Mr. Bill Walker: Can you just give me a bit of an example in number four? Can you just share with me in a more anecdotal perspective—when you say, “whereby patients can be immediately directed to a practitioner within easy reach and willing to help ensure,” can you just walk me through what you see that would actually be?

Mr. Andrew Ignatieff: I think what would happen is that if the person indicates that they would like to make a request for doctor-assisted death, whoever is around—family members—could refer them, take them, and put them in contact with a free-standing system that would be in place in communities across Ontario. That process would be staffed with people who were predisposed to this process. I think that it would be good to have an interview with a physician so that they're familiar with the actual state of the disease, and with a psychologist to be sure that they were psychologically prepared and were not subject to external pressures. Then, the interviews. Then, there would be a short period for reflection so that everybody could prepare. Then, a physician who was prepared to do it could go to the person's home or to the hospital room and administer the medication.

Mr. Bill Walker: I believe you shared in your introduction that you work currently in a hospice palliative care setting, so you're very familiar. You're right there. In the case where a doctor would say, “No, I'm not prepared or I'm not willing to do that,” again, just share with me how that would exactly work in your mind if you were with that patient.

Mr. Andrew Ignatieff: It's a very critical moment—the last days and weeks of a person's life. The emotions are very much at the surface. So you need to be assured that there is a person available so that, if the person says that they want to have this, that they have access immediately to this process—not to death, but so that it can be set in motion—and that the person is protected by law from all the external pressures. They're human beings, and they're very subject to pressures.

The Chair (Mr. Peter Z. Milczyn): Thank you. We have to move on to the next round. Madame Gélinas?

M^{me} France Gélinas: Thank you so much for coming here. I thank you for sharing your thoughts with us. You are part of a very well-known, very well-respected not-for-profit advocacy and policy influencer. Were you contacted? Did you have an opportunity to share the thoughts that you've shared with us today ahead of the bill being introduced in Ontario?

Mr. Andrew Ignatieff: I've been an advocate for this position within Patients Canada since the beginning

because we speak on behalf of the voice of patients and the experience of patients—

M^{me} France Gélinas: And you've done a good job of it.

Mr. Andrew Ignatieff: —and I think there's no situation more relevant than this.

I also have a life outside where I'm a palliative care volunteer. I have been instructed and told not to raise this subject in my dealings with the people I'm caring for. If they ask me, then I am to refer them to someone. But palliative care is something quite different than what is being asked for here.

M^{me} France Gélinas: Agreed.

Mr. Andrew Ignatieff: Also, I'm part of a faith community, and this subject is a very hot subject in debate in my faith community as well. So I'm very familiar with all the reasons why not.

M^{me} France Gélinas: When you answered the questions from the PCs, you saw it in your mind—you saw an independent agency that was easy to access, that provided you—do you see any of that in Ontario right now? Does that agency exist?

Mr. Andrew Ignatieff: I find it a bit difficult to say this, but one of the people I've cared for in hospice care I think took an option for doctor-assisted death. It has never been referred to, but I know that it was available.

What I would say about that is that it's very difficult to ensure the freedom of action of such a free-standing thing because this is such an animated debate at the individual level, at the family level and at the community level. I think the state has to guarantee the protection of the individual as they go through this process.

The Chair (Mr. Peter Z. Milczyn): Okay. Thank you.

Next round: Madame Des Rosiers.

M^{me} Nathalie Des Rosiers: I want to thank you for being here, and thank you very much for the work that Patients Canada does. It's very helpful, and I think we want to hear from you.

In your presentation, I understand your advocacy, I think very thoughtfully, for a place for true access for all Ontarians to have the possibility to decide for themselves whether it's an option that they want to consider, and if they do, to have access to the full range of services that are necessary.

Mr. Andrew Ignatieff: This issue of access is fundamental. It's my belief, and our belief, that so much of the debate around this is about doctors' concerns, religious leaders, moral leaders and politicians' concerns and qualms about this and not about what the patient actually wants and needs.

M^{me} Nathalie Des Rosiers: That's why it's very important to have you here, so thank you very much. You know that this is, a little bit, the beginning of a change in Canada. Many of your suggestions, I think, are not within the Criminal Code definitions yet, but we think that this will continue to be a large conversation in Canada, particularly on advance directives, which is the next step,

really. Are you satisfied that the protections here in the bill are sufficient for patients?

Mr. Andrew Ignatieff: I think it will entirely depend on the implementation of the bill. But I think that the politicians and the health care professions must undertake this with real seriousness. If there are moral qualms, they should set themselves aside.

M^{me} Nathalie Des Rosiers: Yes. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you very much, Mr. Ignatieff, for your presentation this afternoon.

Mr. Andrew Ignatieff: Thank you very much.

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DR. STEPHANIE KAFIE

The Chair (Mr. Peter Z. Milczyn): Our next witness is Dr. Stephanie Kafie. Are you on the line, Doctor?

Dr. Stephanie Kafie: I am. Can you hear me?

The Chair (Mr. Peter Z. Milczyn): Yes, not very clearly.

Dr. Stephanie Kafie: Is this any better?

The Chair (Mr. Peter Z. Milczyn): Just a little bit.

Dr. Stephanie Kafie: And how about now?

The Chair (Mr. Peter Z. Milczyn): That is much better. Thank you.

Dr. Stephanie Kafie: Wonderful.

The Chair (Mr. Peter Z. Milczyn): That's perfect now.

You have up to six minutes for your presentation, following which will be a round of questions, beginning with the New Democratic caucus. As you begin the presentation, could you please state your name and where you are calling from for the official record?

Dr. Stephanie Kafie: Sure. Stephanie Kafie, Hamilton, Ontario.

Good afternoon, and thank you for the opportunity to speak to you today. I'm a family medicine resident in Hamilton. Thank you for accommodating my schedule. I'm sure my patients are grateful that I could speak to you via teleconference instead of having to reschedule all of their appointments today.

I'm a young doctor, a resident doctor, only three months away from independent practice as a family physician. I have focused much of my family medicine training on both geriatric and palliative care.

As I prepare to work and serve the people of Ontario as a family physician, I am deeply concerned with an omission in Bill 84. Ontario is the only jurisdiction in Canada where medical assistance in dying has been legalized and doctors cannot opt out of directly referring for the procedure.

The current policy of the College of Physicians and Surgeons of Ontario requires physicians to provide an effective referral for medical assistance in dying, or MAID, but for myself and countless other colleagues this is akin to participating in the procedure itself. I make referrals to various specialists each day and by referring a patient for a procedure or consultation, I'm an active

participant in obtaining that procedure as part of the patient's extended care, providing continuity of care.

Bill 84 has the opportunity to provide strong conscience protection for health care workers so that they are not forced to refer for, perform or assist in MAID against their will. Other alternatives have been explored and successfully implemented in different areas of Canada. Making a referral should not be needed for MAID access in Ontario.

As you have already heard through the public hearings, I am not advocating for abandoning patients who are faced with many challenges near the end of life. Instead, I am advocating for an approach that facilitates the protection of conscience rights for health care workers while their patients may seek out these services. Family physicians, in particular, who are conscientiously opposed to MAID can continue to provide health care to their patients.

Now, it's easy for me to speak from a theoretical framework, but allow me to tell you a real-world story with identifying details altered to protect confidentiality.

This past summer, I worked in a hospital setting, providing palliative care. One of my patients was a man who was admitted to hospital with a great deal of pain due to a tumour the size of a football protruding through his abdomen. With tears in his eyes, he said he had peace, did not see purpose in his life and wanted to die. We discussed his family, his faith and his sense of purpose. Distress about his family was causing him a great deal of emotional pain in addition to his tremendous physical pain.

I was not trying to dissuade him from physician-assisted death. Instead, we agreed upon a plan to give our palliative care medicine team a chance to assist him before pursuing assisted death further. I returned to speak to him daily and prescribed pain control medication for him. Within the week, he was mending relationships with his family members, thrilled to have his pain at manageable levels and even enjoying ice cream three times a day with every meal. He appeared happy and smiling every morning when I went to see him, despite his grim prognosis.

Now, if I had simply offered him a referral for assisted death when he told me he wanted to die, I would have felt that I did not provide appropriate care to this patient. In fact, those actions would have fallen below the standard of care by not treating his emotional and physical pain, nor providing an opportunity for him to complete very important aspects of his life and relationships. What if I had simply referred him for assisted death in compliance with the current provisions of Bill 84 and our college's regulations?

Physicians have an important role in discussing available options with their patients. In fact, these discussions can certainly offer patients new perspectives. The Supreme Court and our federal legislation have paved the way for provinces to assure appropriate access to assisted death while harmonizing conscience rights of providers. To be effective practitioners, we must be able to be proper moral agents and not mere technicians. We do this

each day as we utilize our skills and knowledge to serve our patients who are trying to navigate complex care and treatment decisions. Other Canadian jurisdictions have developed workable mechanisms that do not delay access or create barriers for patients while not forcing physicians to be participants in an action that contravenes their moral foundations.

To conclude, entering independent practice as a family physician is an exciting time. Entering family practice in Ontario without protection of conscience rights makes Ontario a frightening place for me to practise and might deter young graduates from practising here. Many young graduates I have spoken with are looking at practising elsewhere in Canada or in other countries, due to the lack of protection of conscience rights in our province. Many young graduates do not want to risk disciplinary action or suspension of their new licences by adhering to their moral commitments. They would rather just practise elsewhere. It would be a great loss to the people of Ontario to lose young doctors who cannot, for reasons of moral conscience, practise in the province where they were trained.

I thank you for the work that you do, and I hope that you will revise Bill 84 to respect conscience rights. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Doctor. This round of questions begins with the New Democratic Party. Madame Gélinas.

M^{me} France Gélinas: Thank you so much for phoning in today and taking the time to share your views with us.

I would like you to describe to us what would be an adequate access for patients whose physicians have conscience objections.

Dr. Stephanie Kafie: Adequate access could include a phone number that the patient could call themselves to self-refer for the procedure or to self-refer to discuss further options.

M^{me} France Gélinas: Would you be willing to give your patients—after you've had a conversation about options for pain control and options for palliative care or whatever else needs to be done, as a primary care physician, would you be willing to share that phone number?

Dr. Stephanie Kafie: I would be willing to share the phone number, as long as it didn't require an effective referral or referral directly to a provider who provides the service.

M^{me} France Gélinas: Okay. Let me explore with you another opportunity, another possibility. Would you be willing to do a transfer of care?

Dr. Stephanie Kafie: As stated by previous members, a transfer of care can be requested by any patient at any time, if they find that the care they've been receiving has not been adequate or has not been meeting their needs. If they require a transfer of care, it's certainly within our ability as physicians to transfer to a different physician who may be able to provide an alternate perspective.

M^{me} France Gélinas: Would you be willing to initiate the transfer of care, not at the request of your patient?

Dr. Stephanie Kafie: Yes, I would be willing to transfer care if I could not adequately provide what my patient was requesting.

M^{me} France Gélinas: Okay. I'm going to take you down—so we'll pretend that, here in Ontario, we have a way for patients to gain access to MAID assessors, and we are there. Now, the MAID assessor needs to get back in touch with you to clarify some medications that they're on, to clarify some of the test results that could, basically, disqualify this person from MAID. How would you handle that?

Dr. Stephanie Kafie: I think providing more information is part of our role as family physicians. As family physicians, there's a huge difference from providing a referral for a procedure and providing more information. More information, I think, is vital in making a decision, and if another physician was making that decision with the patient then they would need access to their medications, their medical history, and, as their family physician, I do have access to that and can provide that with a unique perspective. That is different, completely, from providing a referral. There wouldn't be any medications that I know of that would disqualify them, unless you're referring to psychiatric medications and a psychiatric history, which wouldn't be included at this time. But there would certainly be a sharing of information, something that is frequently done within the health care system. It would be nice if we had an electronic medical record where all practitioners could access different patient records in Ontario, but we're not there yet. At that point, the family physician can give information to an alternate physician.

The Chair (Mr. Peter Z. Milczyn): Thank you. This round of questions is to the government caucus. Mr. Fraser.

Mr. John Fraser: Thank you very much, Dr. Kafie, for taking time to make a deputation to us. I want to highlight something that you said and that I think I very inarticulately tried to express earlier, which is that palliative care, by definition, does not include medical assistance in dying, but medical assistance in dying must include access to palliative care. When we talk about that care coordination service, that's a service that I and all my colleagues here believe has to include access to palliative care, as well as other options.

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I want to ask a question, though, with regard to your hospital experience. We heard in testimony from Dr. Scott at the Ottawa hospital about how that team is working there. We heard from another physician this afternoon how they had worked out a way for objecting physicians and non-objecting physicians to work together. Does that occur in the hospital that you are working in?

Dr. Stephanie Kafie: It certainly does. There's usually a procedure that's led by an ethicist in various hospitals. I actually work in various hospitals in the region, where physicians who object can transfer care to another physician in order to facilitate access to services

that the patient may be requesting. But of course, there has to be a detailed evaluation of the patient. Is this truly informed consent? Is this patient making this request for different reasons that don't qualify under the current legislation? What's behind the request? Is it a depression? Is it pain? Is it something else? That has to be treated and adequately addressed as well.

Mr. John Fraser: Okay. Just another point of clarification: We heard this afternoon about systems where you would change the physician or the practitioner most responsible for that patient. It sounded to me like that is something that's initiated by the physician. Am I incorrect in that regard, that transfer of care?

Dr. Stephanie Kafie: There could be a number of ways that that's done. I'm not sure how that's done exactly in various hospitals in Ontario, but usually it would have to be initiated by the physician.

Mr. John Fraser: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): This round of questions goes to the Progressive Conservatives. Mr. Walker.

Mr. Bill Walker: Thank you, Dr. Kafie. It's Bill Walker. If you could give me a little bit more clarification in regard to the transfer of care versus effective referral. I think what I heard you say was that you were okay, comfortable, in agreement with—you would be quite happy to pass a name along, being the transfer of care. Can someone ask you to have a number, for example, and that group goes through the proper process, a proper assessment, and they call back to you with a form for transfer of care?

Dr. Stephanie Kafie: I'm not clear on what you're asking, but let me clarify my remarks. Effective referral would indicate that I am sending a patient to a practitioner or someone else who will provide the service to them. That's what I'm not comfortable with and that's what many of my colleagues are not comfortable with. Transfer of care simply means that I'm transferring to another family physician or to another main responsible physician who is not necessarily providing the patient with that service. I think there's an important differentiation between those two.

Mr. Bill Walker: So just let me ask that back, because I think we're on the same track. If I come to you and I want to have assisted dying, and you're not comfortable with that, but you're willing to hand me a number to an agency or an organization that's well-structured and goes through the proper assessment process, and they were to come back to you and ask to transfer care, does that still meet your comfort level? You haven't referred to a specific person in this case, but they have actually gone through a consultation. You haven't abandoned them. They come back to you and they can say, "I want to change from you to another doctor."

Dr. Stephanie Kafie: The patient can initiate that change themselves and they don't need a referral from me. To get a new family doctor in Ontario, you actually don't need me to refer to do that for you at all. You can just end the relationship with your family doctor and you

can seek out that new family doctor on your own. Certainly, this agency would be able to help the patient to do that.

Mr. Bill Walker: In essence, then, it really doesn't offend the doctor who may have a moral or religious concern—

Dr. Stephanie Kafie: Absolutely not, no.

Mr. Bill Walker: —because you haven't really done anything, in your mind, to help or assist.

Dr. Stephanie Kafie: That's correct.

Mr. Bill Walker: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Kafie, for calling in this afternoon. If there's anything further that you'd like to submit to us, you have until 6 p.m. today to do it in writing—so not much time, but we'd welcome it nonetheless.

Dr. Stephanie Kafie: Wonderful. Thank you for the opportunity to speak to you.

The Chair (Mr. Peter Z. Milczyn): Thank you.

CANADIAN PHYSICIANS FOR LIFE

The Chair (Mr. Peter Z. Milczyn): So our next witnesses will also be calling in. I don't know if they're on the line yet: Canadian Physicians for Life. Dr. Bouchard?

Mr. Bill Walker: Will we make any effort to call to make sure—because there is a drastic time change?

The Chair (Mr. Peter Z. Milczyn): That's what we're asking right now.

Dr. Thomas Bouchard: Hello?

The Chair (Mr. Peter Z. Milczyn): Good afternoon, Dr. Bouchard?

Dr. Thomas Bouchard: Yes.

The Chair (Mr. Peter Z. Milczyn): Thank you for being patient with us this afternoon. We're a little bit behind schedule.

Dr. Thomas Bouchard: No problem.

The Chair (Mr. Peter Z. Milczyn): You have up to six minutes for your presentation, which will be followed by questioning from the various caucuses. Your questions will begin with the Liberal caucus. As you begin your presentation, please state your name and where you are calling from for the official record.

Dr. Thomas Bouchard: Sure. My name is Thomas Bouchard. I'm a family physician in Calgary, Alberta. I am a member of the Canadian Physicians for Life, and I have been for about the past nine years. I've been on the board of directors in the past as well. As an organization, we're very grateful for you guys to hear us out and to listen to us. We have made a written submission as well as this oral submission.

Canadian Physicians for Life was founded in 1975 by a Christian, a Jewish and an atheist physician. That is the truth; it's not a bar joke. They did really get together and wanted to bring people together based on the principles of the traditional Hippocratic oath, which has guided the medical profession for 2,000 years and more and, really, to affirm basically the inviolability of every human life, regardless of age or infirmity.

Here we are about 40 years later with about 3,500 physicians, both retired and actively practising, residents and medical students. One of the things that we do is an annual educational conference especially focused on students who are given scholarships to attend and learn more about the Hippocratic tradition in the modern context.

One of the things that we're quite concerned about is the hostile attitude the College of Physicians and Surgeons of Ontario has taken towards physicians like us. We're hoping that the government of Ontario will show a respect for the diversity of different physicians in Ontario, and tolerating physicians of all different walks of life—I would say physicians who reflect the diversity of the population of Ontario.

Really, none of us have a desire to abandon patients or even impose our beliefs on them. What we're simply requesting is the opportunity to step back from participating in a procedure which we don't think is beneficial for our patients. Nevertheless, we would respect patients who disagree with us and who might want to access MAID.

What we would like to see is a system, for example, like Alberta is running and practising, where patients can make a request directly without needing a referral. In Alberta, for example, patients can call our general Health Link line, which I understand is similar to Telehealth Ontario.

Really, other jurisdictions don't require a referral for MAID. It seems heavy-handed that Ontario would be pursuing this. I would say that, if the government of Ontario takes a hard line on effective referral, it's very likely that many physicians with our views will retire early or leave the province because our convictions are so serious that we'd rather leave medicine, for example, than be forced to do something that we believe is harmful for patients.

I can tell you already that one of our members has left Ontario for Alberta in this past year for this very reason, and another has requested an Alberta licence, again, for the same reason. That doesn't bode well for the population of doctors in Ontario. Our organization receives regular requests from patients who are looking for physicians who share their perspectives and world view. So to exclude physicians who have taken the traditional Hippocratic oath would also rob Ontario patients of choice in health care.

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Our recommendations, as we've stated in our written submission, are twofold: amending Bill 84 to include provisions to protect conscience rights of physicians and other health care practitioners who cannot participate in the provision of MAID either by providing it, assisting in the provision or making arrangements for it or referring for it; and creating, for example, a care coordination service, like we have in Alberta, which allows patients to access it directly without having to need a referral from a physician.

We're grateful that you're receiving our submission, and we hope to work alongside the province to ensure a

health care system that reflects the diversity and plurality of Ontario.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Bouchard. This round of questions is with the government caucus. Mr. Fraser.

Mr. John Fraser: Thank you very much, Dr. Bouchard, for being on the phone, for your presentation and for your work.

As we've been hearing in this committee, we've heard different sides with regard to conscience rights and access, and we've been talking a lot about a care coordination model. Can you describe for the committee exactly what that means, functionally, for you in Alberta?

Dr. Thomas Bouchard: The way this works is this service is what allows a patient to access it through various routes, no matter where they are in the care pathway. There is what's called the care placemat that Alberta Health Services has set up. If you haven't seen this placemat, it's worth looking at, because it shows very clearly at the top of this placemat that patients have an ability to access this directly, either through Health Link, which is the general phone number, or they can contact the care coordination service, or they can talk about it with their physicians. So there are multiple routes into this care coordination service, and that is key when it comes to allowing patients to make their own decisions while still allowing physicians to maintain their integrity.

Mr. John Fraser: So, as a practitioner, how do you interface with it? There's a patient in front of you. They've made a request. What happens?

Dr. Thomas Bouchard: The first thing, of course, is an assessment to see whether their care needs are being met. Usually, asking for MAID is a cry for help. So the most important thing, no matter who is assessing them—in favour of MAID or opposed to MAID—the first question is whether their care needs are being met. The next thing is, say somebody is persistent in their request, which I assume is what you're asking, I would say that physicians who share our views would be willing to talk about everything: all the different options and how it looks, the pluses and minuses, even the downsides and side effects of everything. After a thorough discussion about those things, if a patient says, "You know, I appreciate what you're saying, but I still would like to pursue this," very practically speaking, it would just be a matter of saying, "Although I don't think this is good for your health, you are certainly entitled to pursue this, and if you would like more information on how to access or pursue this, you can call Health Link, if you would like."

Mr. John Fraser: And one other question is Health Link—do I have time, Chair?

The Chair (Mr. Peter Z. Milczyn): No.

Mr. John Fraser: No? Okay. Thank you very much.

The Chair (Mr. Peter Z. Milczyn): Our next round of questions is with the official opposition. Mr. Walker.

Mr. Bill Walker: Thank you very much, Dr. Bouchard. Maybe we'll see how much Mr. Fraser and I think alike because I think we were kind of going down the same path here.

My question is going to go backwards a little bit. Does a patient have to even acknowledge the doctor? Because the way I thought I heard you say it first was that they can access it from anywhere. They can pick up the phone and say, "I want to do this," and go right to Health Link and go through your care coordination service. Is that accurate?

Dr. Thomas Bouchard: That is correct.

Mr. Bill Walker: And then, if they pursue that—so I'm in northern Alberta, I make this phone call and I go through the process. Are you, as the physician, even if you're that person's general practitioner, even involved in the process?

Dr. Thomas Bouchard: No.

Mr. Bill Walker: And do you have any concern with that?

Dr. Thomas Bouchard: The important thing here is that there have to be checks and balances in the system. There might be requests for information on the patient. If this care coordination service needed more information, I could provide the patient's chart to them so that they could pass that information along to whoever needs it.

Mr. Bill Walker: Okay. Then that kind of answers it. In this way, you're not really complicit and you're not making any kind of an effective referral. The patient truly is making a decision based on their own interest.

How long has your Health Link been in actual practice?

Dr. Thomas Bouchard: For many, many years. It's for coughs and colds, or pregnancy issues, and now, if they have questions about MAID, they can get that there too.

Mr. Bill Walker: Any anecdotal examples of an abuse of this system or where it's not working?

Dr. Thomas Bouchard: No. Prior to this phone call, I did speak to the people who organized the system. They have reported absolutely no concerns or obstacles with the use of this system.

Mr. Bill Walker: Do you have any recollection of the people who would be concerned, in regard to allowing this to move forward, that it offends their religious or moral beliefs?

Dr. Thomas Bouchard: No. In fact—

Mr. Bill Walker: I'm not hearing that they have to be complicit in anything here.

Dr. Thomas Bouchard: Sorry. Can you ask the question again?

Mr. Bill Walker: What I'm trying to clarify is that, from what I've heard you say so far, I don't see that this would offend anyone who is concerned about it being mandated and having to have an effective referral, because you really don't even have to be a part of the process.

Dr. Thomas Bouchard: That's right.

Mr. Bill Walker: Okay. Thank you.

The Chair (Mr. Peter Z. Milczyn): Our next round is with the New Democratic caucus. Madame Gélinas.

M^{me} France Gélinas: The Alberta model has been talked about here very heavily, so I will continue to quiz you to get as much information about the Alberta model from a person who lives in Alberta, rather than reading it on your website.

You talked to the people who organized this system. Who are they? How long ago did they do that? And what exactly does "organizing the system" mean?

Dr. Thomas Bouchard: The person who is in charge of this system, through Alberta Health Services, is Dr. Jim Silvius. We had meetings with him prior to the implementation of the system to talk about the importance of respecting people with different conscientious objection views. He was very respectful in the initiation of this system, that all parties should be respected.

When it comes to how things have been implemented, it has been very smooth. It's a credit to Dr. Silvius and the other people who were his consultants in this whole process that they have continued to respect all parties while making things available to patients who are requesting it.

M^{me} France Gélinas: The Alberta Health Services—the equivalent of our Ministry of Health, once removed—did all of this work before the law came into place. Is this what I'm reading?

Dr. Thomas Bouchard: No. It came into place after the federal law.

M^{me} France Gélinas: After the federal law? Okay. Do you have a provincial law also that further defines it?

Dr. Thomas Bouchard: No.

M^{me} France Gélinas: Okay.

Since July of last year, the Alberta health system has had this Health Link, it has been used, and physicians with conscientious objections are comfortable with what you have?

Dr. Thomas Bouchard: That's right.

M^{me} France Gélinas: Okay. When you say they need to get back in touch with you to get information, do you simply put a chart in the mail, or do they actually talk to you about the patient?

Dr. Thomas Bouchard: You could put a chart in the mail. You could provide a chart to the patient. I haven't heard of any situation where somebody needed to be talked to over the phone.

M^{me} France Gélinas: What would happen if that situation arose?

Dr. Thomas Bouchard: I think it would depend on what kind of information they were asking me about, but an important principle here is that people who are opposed to either providing the procedure or referring for the procedure are not opposed to information—either giving information to a patient or giving information about a patient. The sharing of information is not the problem. It's the participation in the procedure, as well as the referral.

The Chair (Mr. Peter Z. Milczyn): Thank you. That's all the time we have for this afternoon. Thank you for your patience today, Dr. Bouchard.

1740

DR. JARO KOTALIK

The Chair (Mr. Peter Z. Milczyn): Our next witness is Dr. Jaro Kotalik. Hello?

Dr. Jaro Kotalik: Dr. Kotalik. I'm online. Can you hear me?

Mme France Gélinas: I can barely hear you.

The Chair (Mr. Peter Z. Milczyn): Not very well.

Interjections.

Dr. Jaro Kotalik: I'm sorry to hear that. That's a land line they told me to use, and I'm doing my best.

The Chair (Mr. Peter Z. Milczyn): No, you're fine now.

Dr. Jaro Kotalik: So I will be a bit more loud. My name is Jaro Kotalik, and I am a physician and a bioethicist, a professor at the Northern Ontario School of Medicine, and a founder and director of the Centre for Health Care Ethics at Lakehead University.

Do you hear me?

The Chair (Mr. Peter Z. Milczyn): Yes. You have six minutes for your presentation.

Dr. Jaro Kotalik: Thank you very much. I wish I could be there in person, but anyway, I'll do my best.

Concerning Bill 84, I am going to advocate for insertion of a clause that will assure that physicians and other health care professionals cannot be forced by anyone to refer for, assist in or perform medically assisted dying against their will.

Now, others have likely made a similar point today or in their submissions, and they may have told you that it's because it is necessary because of personal or religious freedom or respect for personal or professional autonomy and so on. I will suggest that there is another good reason to insert a conscience protection clause into the bill, and my argument is not political or legal or religious. It is based on human psychology and on the nature of services that physicians and other health professionals provide.

My main occupation for the past 18 years has been providing ethical advice and teaching biomedical ethics and promoting professionalism in the medical school, in the regional health sciences centre and outside. During these years, I have learned that a well-functioning conscience of a professional is the best protection that patients can have. It is the conscience of a professional that tells him which of the many medical interventions that science and technology can offer are best suited for a particular patient at a particular time.

The health care environment is now just too complex and too rapidly changing, so it is not possible to regulate and police every decision and every act. This is why medical schools and health institutions try to impart a strong commitment to professionalism; that is, a set of attitudes, behaviour and characteristics that are desirable in medical professions and that are guided by conscience.

Now, here's my main point. If a physician would be forced to act against his or her conscience because of some legal instrument, it would weaken the physician's

commitment to conscientious behaviour in other instances of their clinical practice. One day, he can refer a patient to MAID even if his conscience is telling him that it is wrong. The next day, he or she may act against one's conscience because it would bring about prestige or power or money, or simply because to be true to one's conscience would be just inconvenient.

Let me use some glaring examples of what I mean. A physician could, without anybody actually detecting what's happening, postpone an urgent assessment or an operation for a time slot in which he or she could charge higher fees; or not tell the patient about an error that was made in their care; or he or she—the physician—may start the patient on a new medication, not because it is the best one for the patient, but because such a prescription would improve the prestige of a physician as a consultant with that particular pharmaceutical company.

I'm saying that the price of not protecting physician conscience would be just too high, both for individual patients and society. A well-functioning conscience is the best protection—the best guarantee—that society can have that the patients' and society's interests are well served in health care.

This is my statement. I will be glad to answer any questions you may have.

The Chair (Mr. Peter Z. Milczyn): Thank you very much. This round of questions is with the official opposition: Mr. Walker.

Mr. Bill Walker: I guess what I've mostly been hearing—and I've only been here for half the afternoon—is really the ability to try to respect both the right of the patient and the doctor. You've gone in a little bit of a different way from most of the other presenters. Are you aware of any of the other processes across the country that you think are the best processes?

Dr. Jaro Kotalik: I'm sorry; what process?

Mr. Bill Walker: The process for MAID: Do you believe one of the provinces or a number of the provinces are better than the other?

Dr. Jaro Kotalik: I hear that there's a variety of arrangements, and certainly I'm clear that there are arrangements—like in Alberta, I hear—which can ensure access without compromising any physician's conscience. I wanted to focus on just that one point: why I think it would be wrong to try to compromise a physician's conscience, even if it is on such special occasions and even if that would happen fairly infrequently. I think it's a dangerous way of proceeding in our health care.

Mr. Bill Walker: I may have just missed the very first part of your answer. Did you give a specific province or area that you believe is the leading example?

Dr. Jaro Kotalik: Again, I have not studied that issue, but I hear that Alberta's system is operational to some people's satisfaction. I understand that British Columbia is also developing, or is about to deliver, a system which will provide access.

We know from other countries where assisted death of some sort or another has been legal that actually it's a small percentage of physicians who need to be engaged

to provide this particular service, like 3% or 5%, even in places like Holland or Belgium.

So the attempt to force every physician in some way to participate, even by referral, I think is totally unnecessary because of the risk that it would cause by affecting a physician's conscience overall and creating in their mind a disrespect for the work they do. I think we need to find another instrument for how we can provide access. And this instrument, as you mentioned—the province is now showing us the way it can be provided.

Mr. Bill Walker: Thank you. Just a final clarification: I believe what you're saying is you're not a supporter of mandatory effective referral.

Dr. Jaro Kotalik: Yes. I'm against effective referral. Conscience is an individual matter. For some physicians, a referral will not be a matter of conscience. They would not want to carry out the act, but they may be prepared in good conscience to refer patients of a certain kind. For other physicians, even the referral would be a major attack on their conscience and they would not want to do that. Those few physicians I would imagine would be—we have to really respect that.

1750

The Chair (Mr. Peter Z. Milczyn): Okay. The next round of questions is from the New Democratic caucus. Madame Gélinas.

Mme France Gélinas: Thank you so much for participating in this debate, and thank you for that work that you do at NOSOM. It's much appreciated.

I come from northeastern Ontario, so within the North East LHIN. In the North East LHIN we have zero physicians who have identified themselves as willing to provide MAID. Do you know if the North West LHIN is faring any different than the North East?

Dr. Jaro Kotalik: Well, I believe that there are a number of physicians in the northwest who did identify and did provide the service already.

Mme France Gélinas: Okay.

Dr. Jaro Kotalik: I guess, obviously, there is a lack of intraprovincial collaboration and information. From a number of presentations I have done on that topic, people and participants tell me that this has been implemented and practised. We just have to find out how to do it best.

Mme France Gélinas: Very good. Let's say somebody in Kenora or somebody in Rainy River—how would they access the service?

Dr. Jaro Kotalik: I would not really be able to tell you how to access, except I would say, probably, talking to some of the chiefs of services like the chief of family medicine—or maybe the chief of staff at the Thunder Bay Regional Health Sciences Centre would be the person who would know how many physicians would be available. Maybe he can give you some advice in that regard. So chiefs of staff or chiefs of some of the departments like family practice and so on would be familiar with the situation.

There is a great deal of sensitivity that this data are kept private. Physicians do not want to be advertised as providing this service openly, I think, for obvious

reasons, so the hospitals have to respect that. But I believe in our region there is access to the service functioning at this time.

Mme France Gélinas: And outside of the hospital, or just—

Dr. Jaro Kotalik: I believe both inside and outside.

Mme France Gélinas: Okay; thank you.

The Chair (Mr. Peter Z. Milczyn): The next question is from the government caucus. Madame Des Rosiers.

Mme Nathalie Des Rosiers: Yes. Thank you very much for your presentation. You make a pretty good case about the need for a system to support what I would describe as the ethical compass of any physician on any grounds, and I understand that.

One of my concerns is whether there is any point at which the college can demand of the members to do something that is not in compliance with their ethical conscience. Let me give an example. Even in Alberta, a physician who has an ethical objection must still provide "reasonable access" to the patient. There's an obligation to provide reasonable access. What if a doctor objects to even providing reasonable access? How would you resolve that tension?

Dr. Jaro Kotalik: Yes. I would not know, as a practitioner. I've not been in practice; I've been a bioethicist for the past decade and a half so I'm not practising on a clinical level, but I would say "reasonable access" would say nothing to me. That may mean to have a number on the wall and pointing to the number to call, or it can mean, "My secretary will dial the number for you," or anything in between. That does not really provide very much.

So I would say that the concern is that the physicians—the one point maybe to be made is that here we have an act which until 2015 was a criminal act and everybody would have been prosecuted for carrying it out. Now the criminality is removed and the act is now legal but, at the same time, the physicians are instantly, on demand, to move from a position of understanding the act as criminal to, in effect, as something which is absolutely essential to provide by everyone to everyone who is legally eligible.

We're talking about asking for huge adjustments of attitudes and values in the medical profession. I think it will take time to settle these things and for the professions to find some way to cope with it, as other professions coped with it in other countries. But I would think that forced participation would not be helping that matter.

The Chair (Mr. Peter Z. Milczyn): Thank you, Dr. Kotalik, for presenting today. It has been very helpful.

Dr. Jaro Kotalik: You're very welcome. I wish you success in your undertaking.

The Chair (Mr. Peter Z. Milczyn): Thank you

Dr. Jaro Kotalik: It's a difficult one to have.

The Chair (Mr. Peter Z. Milczyn): Yes.

Dr. Jaro Kotalik: If I could be of any help, I would be glad to be called.

The Chair (Mr. Peter Z. Milczyn): Thank you.

That was our final witness. Madame Gélinas, you have something?

M^{me} France Gélinas: I would like to put a suggestion out to the committee that next Thursday morning is the normal meeting time for the committee, and we're not going to meet on that Thursday. I was thinking that we would use Thursday morning at 9 o'clock to ask the Ministry of Health to come and brief us as to anything they can share with us about the care coordination for MAID, or anything else that could be of—but this is the main thing I would like, and, if it's possible, to have this as a consensus where the Chair would write a letter and request that the Ministry of Health come and talk to us next Thursday morning at 9 o'clock.

The Chair (Mr. Peter Z. Milczyn): Mr. Fraser.

Mr. John Fraser: Chair, we just had the conversation earlier. I know there are people here from the minister's office, in terms of making that request to go forward.

As to the timing of it, I'm not sure whether that's part of that request. When can we do it? Is there an appropriate time? Are people available?

I don't see anything—I think to go ahead with the request is—

M^{me} France Gélinas: The problem is that if we don't meet at our regular time, we need to go back to House leaders and be allowed to—it becomes a big ordeal. The committee can meet at its regular time without going out of this room. We can decide together that next Thursday at 9 o'clock, we invite the Ministry of Health. It's an invitation. If they don't come, they don't come, but we would put out the invitation.

The Chair (Mr. Peter Z. Milczyn): Do you want a moment to confer?

Interjections.

The Chair (Mr. Peter Z. Milczyn): Just from the committee perspective, we can meet at 9. We can also meet at 1 o'clock in the afternoon. That is also—

Interjection.

The Chair (Mr. Peter Z. Milczyn): 2 o'clock. Sorry. That's the regular meeting time. We just need to know who we are inviting, what we are inviting them for, and for how long of a presentation, whether we want time for questions, and then how much time for questions in a rotation.

M^{me} France Gélinas: Let me answer all of those. We'll invite the Minister of Health, and he can decide who he wants to send. He does a 15-minute presentation. We each get five minutes to ask questions. We do that—whatever fits them—at 9 o'clock or at 2 o'clock next Thursday, whatever fits.

You don't have to answer right now. You just have to say, "Yes, we'll send the request."

The Chair (Mr. Peter Z. Milczyn): Ms. Martins.

Mrs. Cristina Martins: Can I just ask something? Are we all expected to be here? We've had briefings on this, so is it necessary for all of us to be here for that?

The Chair (Mr. Peter Z. Milczyn): If it's a regular meeting of the committee, then it's a regular meeting of the committee.

Mrs. Cristina Martins: So briefings can be executed at any time outside of the meeting; right? Am I understanding?

The Chair (Mr. Peter Z. Milczyn): This would be a regularly scheduled committee meeting time, so it is a meeting of the committee for a specific purpose.

Mr. John Fraser: I would like to take this to subcommittee, to take a look at what our options are for that briefing. I think that's the best way to do it, so we can sort that out. I think it would be good for the committee for that to happen. Just how and when and where it happens—I think we need more than a two-minute conversation about it, to be fair.

The Chair (Mr. Peter Z. Milczyn): Subcommittee could meet by telephone tomorrow or Monday, or we could meet in person on Monday morning. I'll wait to hear from all of you.

M^{me} France Gélinas: Are you the representative for the PCs on the subcommittee? No?

Mr. Bill Walker: No, Jeff is.

The Chair (Mr. Peter Z. Milczyn): Is there any other business?

M^{me} France Gélinas: The Clerk will send out the possibility of a meeting of subcommittee—okay. Good luck.

The Chair (Mr. Peter Z. Milczyn): At this point, committee is adjourned until Tuesday, April 11, at 9 a.m.

The committee adjourned at 1800.

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