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Speaker: The Honourable Geoff Regan

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HOUSE OF COMMONS

Monday, May 2, 2016

The House met at 11 a.m.

Prayer

PRIVATE MEMBERS' BUSINESS

● (1105)

[*English*]

PROTECTION OF PREGNANT WOMEN AND THEIR PREBORN CHILDREN ACT (CASSIE AND MOLLY'S LAW)

Mrs. Cathay Wagantall (Yorkton—Melville, CPC) moved that Bill C-225, An Act to amend the Criminal Code (injuring or causing the death of a preborn child while committing an offence), be read the second time and referred to a committee.

She said: Mr. Speaker, I am honoured to stand today in support of my private member's bill, Bill C-225, the protection of pregnant women and their preborn children act, which I will refer to as Cassie and Molly's law.

I was motivated to bring forward this bill after learning about the very tragic story of Cassie and Molly Kaake from Windsor, Ontario. Cassie was seven months pregnant with Molly when she was brutally attacked and killed in her home in December 2014. Molly's father, Jeff Durham, has been working tirelessly to bring some good out of this horrific tragedy.

I would like to quote a statement that Jeff Durham made on the day I introduced this bill in the House. He said:

> Without a shadow of a doubt in my mind, neither Cassie nor any pregnant victim of homicide or violence would want their choice, their babies, to go ignored. Just because they're not here to say this law is needed, for anyone with a conscience and the power to do something about it, I say for them that this bill is needed.

I would like to explain now exactly what Bill C-225 would do and, just as importantly, what it would not.

This bill would create new offences for injuring or causing the death of a pregnant woman's preborn child while committing or attempting to commit a criminal offence against the woman—for example, while assaulting or killing a pregnant woman—with the knowledge that she is pregnant. These offences are not stand-alone offences. They would only apply when a person is, which I stress, committing or attempting to commit a criminal offence against a pregnant woman. In addition, it would only be when the offender has the knowledge that she is pregnant. The new offences are called "causing the death of a preborn child while committing an offence" and "injuring a preborn child while committing an offence".

With this law in effect, two charges can be laid in crimes involving attacks on pregnant women that result in harm or death to their preborn children. One charge would be in relation to the criminal offence against the woman, and the second charge would be in relation to one of the new offences created by the bill, which would be either causing the death of the preborn child or causing injury to her preborn child.

This bill would also add pregnancy to the list of aggravating factors for sentencing purposes. Although judges can already treat pregnancy as an aggravating factor, codifying it in the criminal law is a way to more clearly and strongly denounce violence against pregnant women. We know from researching the case law that it is often unclear to what extent a woman's pregnancy is considered in sentencing. This bill would send a strong message to the courts that pregnancy must now be considered in the sentencing hearing.

Pregnancy should be a joyful and exciting time, the building of a family and a new generation. Unfortunately, the tragedy of Cassie and Molly, along with too many other Canadian women who were targeted and harmed because of their choice to carry their children to term, reminds us that the safety of women remains threatened.

According to the Canadian perinatal surveillance system, women abused during pregnancy were four times as likely as other abused women to report having experienced very serious violence, including being beaten, choked, threatened with a gun or knife, or sexually assaulted. Cassie and Molly's law would be a strong deterrent to committing violence against pregnant women because of the severe penalties it would carry for intentionally causing the death of a preborn child.

In existing criminal law, if a pregnant woman is assaulted, not killed, and her child dies, the offender is charged only with assault on the woman, which carries a maximum penalty of 14 years for aggravated assault. Under Cassie and Molly's law, the offender would be charged not only with the assault on the woman but also with the new offence for causing the death of her fetus. If her attacker's intention was to kill her preborn child, then that person would be liable to imprisonment for life, with a minimum punishment of 10 years. This is a far stiffer penalty than the offender would get under the simple charge of assaulting the woman.

Not only that, a judge has discretion on whether to impose consecutive or concurrent sentences. Therefore, in cases where this new law is applied, judges may very well require the offender to serve the sentence for each offence consecutively. In the most tragic case, both the woman and her preborn child die, as was the case with Cassie and Molly. It was also the case with Olivia and Lane Jr., the assailant confessing that his intention was to kill the child, shooting Olivia three times in the abdomen before shooting her twice in the head. In these cases, the judge may impose two life sentences and, at the judge's discretion, these could be served consecutively.

I want to be very clear about the intent of this bill so that there is no misunderstanding of what it is attempting to do. Cassie and Molly's law is about protecting pregnant women and their preborn children from the actions of third parties who want to do them harm. It would protect a pregnant woman's choice to bring her child safely to term.

● (1110)

I have been assured by legal experts that this bill cannot in any way be used to impact a woman's choice to terminate her pregnancy. Abortion is by definition excluded from the bill, because of the clear wording that makes causing injury or death to the preborn child an offence only if the person does so, and I am quoting from the bill, “while committing or attempting to commit an offence under this Act against a female person that the person knows is pregnant”.

I want to reinforce that these new offences are not stand-alone offences. The new offences in Cassie and Molly's law address only the situations where a third party harms or kills a woman's preborn child while committing or attempting to commit a criminal offence against the woman, action which she is clearly not consenting to.

This legislation honours and protects a woman's right to choose to give birth to her baby free from harm committed by others against her will.

Cassie had chosen to have Molly, and was so looking forward to mothering her. As Molly's father, Jeff, stated:

> Before they were killed, Cassie was the happiest anyone had ever seen her. She was happy to have chosen to be having our baby girl. She beamed with excitement and anticipation that was impossible for anyone who knew her not to see.

As the title of Bill C-225 makes clear, this law would protect pregnant women and their preborn children. With respect to preborn children, our health care system already offers them substantial protection, so why not our criminal justice system? In the area of fetal medicine, surgeons are able to perform delicate surgeries while babies are still in the womb, such as treatments for fetuses with spina bifida and life-saving heart interventions.

In the case of a pregnant woman who is rushed to the hospital after sustaining serious injuries in a car accident, physicians will do everything in their power to save the lives of both the woman and her unborn child. Even if the mother tragically dies, the doctors will not give up hope on saving her baby's life. No one questions these policy decisions because they are common sense. It makes perfect sense to save the baby in utero who is struggling to survive after its mother was harmed or killed in a car accident.

However, in the house across the street, there is another pregnant woman, and she is being beaten and kicked in the abdomen and loses her baby as a result. What does not make sense is that this woman's child does not matter in the eyes of our justice system, just like Molly, just like Lane Jr. Our justice system says it does not matter that their lives were brutally taken when their mothers were brutally attacked.

Why should women at their most vulnerable not have the backing of our criminal law to help them to protect what is most precious to them? It is simply wrong, and completely incoherent, when compared to the efforts and resources that our health care system puts into improving and saving prenatal life.

No one makes the argument that in order to protect abortion, we should not be performing life-saving surgeries on babies in utero. We allow both types of surgeries to take place in our hospitals, based on a woman's choice.

Our criminal justice system should do the same. If we can allow abortion to coexist with life-saving fetal surgeries in our health care system, then we can allow legal abortions to coexist with the law in our justice system that makes it a crime for a third party to harm or kill a woman's preborn child against her will. To do otherwise not only lacks coherence, it lacks compassion.

I turn now to concerns that have been expressed in the past by the medical profession. I understand that several physicians groups feared that a similar bill, Bill C-484, which was debated in Parliament in 2008, could criminalize doctors for performing abortions. I want to assure Canada's physicians that I have paid close attention to those concerns in the drafting of Cassie and Molly's law. Provisions in the earlier Bill C-484 explicitly excluded consensual abortion under a “for greater certainty” clause. However, that provision was causing concern amongst some physicians, who thought it would criminalize them for performing abortions. It was not a necessary provision and was only included for greater certainty.

Given that it did not have its intended effect, what was to make it clear that abortion would not be criminalized, and on the advice of my legal drafter, I decided not to include that provision in my bill. I have been assured by legal experts that this law cannot be used to criminalize doctors for performing abortions. I am confident this new approach will assuage any concerns that Canadian physicians had with the earlier bill.

● (1115)

The reason the bill does not interfere with the duties of physicians is that a person could only be charged with one of the new offences created in the bill if that person commits or attempts to commit a criminal offence against the pregnant woman. A doctor performing an abortion on a consenting woman is not committing any criminal offence against the woman, since abortion is not regulated by criminal law in Canada, and has not been since 1988.

Therefore, these new offences would not apply. They are not stand-alone offences, meaning that they can only apply while committing or attempting to commit a criminal offence against the woman.

I have also been assured by legal experts that Cassie and Molly's law cannot be used to prosecute a pregnant woman in Canada for any harm she may cause to her own preborn child. This is because, by definition, the new offences only apply when a person knowingly commits a criminal act against a pregnant woman and thereby harms or kills her preborn child. Simply put, the bill is strictly aimed at third parties who knowingly commit a crime against a pregnant woman and in the process harm or kill her preborn child.

Importantly, Bill C-225 could never act as a precedent for the courts to criminalize the behaviour of pregnant women, because Canada's criminal justice system does not allow courts to create criminal offences. That is the exclusive jurisdiction of Parliament. There is absolutely no way that Cassie and Molly's law could now or ever be used to criminalize any act or omission by a pregnant woman with respect to her own pregnancy.

Another point that must be stated clearly to negate any confusion about the bill relates to the definition of “human being” in the Criminal Code. The bill does not change the legal definition of human being or create fetal personhood, as some critics have tried to claim. Because the Criminal Code definition of human being precludes preborn children, the existing criminal offences against human beings, for example, murder, manslaughter, and assault, do not apply when the preborn child is harmed or killed during attacks against the pregnant woman. Instead, the bill creates brand new offences to cover the very narrow circumstances whereby a preborn child is harmed or killed during the commission of an offence against the mother, in spite of the fact that these children are not considered human beings in our criminal law.

The criminal law can be used to protect entities other than what is covered under the Criminal Code's definition of a human being. For example, the Criminal Code, in section 238, already protects a child during “the act of birth". It makes it an offence to cause that child's death in such as way that if the child were a human being it would be murder, even though that child during the act of birth is not a human being under the Criminal Code's definition.

We have criminal laws to protect animals from cruelty, and against the unlawful killing or injury of animals. There are also criminal law protections against the destruction of private property.

Families are the foundation of our country. The Criminal Code is missing a crucial component to protect Canadian women and their families. The increased penalties under Cassie and Molly's law create a legal mechanism that will enhance the safety of Canadian women and recognize the safety of their families. This approach is specific and robust. It is a common-sense approach designed to fill a gap in the Criminal Code that renders women and their preborn children vulnerable.

I truly believe that all of my colleagues want to do what they believe is compassionate and just. We should not turn a blind eye to the brutal violation of Cassie's choice to continue her pregnancy. We should not turn a blind eye to Molly's death.

We as parliamentarians have the long overdue opportunity to bring something good out of a horrific tragedy that is actually only one of many.

It is my sincere hope that we can put partisanship aside. I am asking all my colleagues to listen to their conscience. I am asking them to listen to everyday Canadians who instinctively know that it is wrong to violate a woman's pregnancy and cause the death of her yet to be born child against her will.

As legislators, we must hold to our responsibility to protect the innocent, with sound reasoning combined with compassionate and caring instincts.

Let us protect pregnant women. Let us work together to increase the chances that a pregnant woman will be able to continue her pregnancy free from violence. Let us protect the child she longs to bring into her family.

One of the tools we as federal parliamentarians have at our disposal to offer this much-needed protection is the criminal law. It is the 21st century, and the time is right.

Protect pregnant women and their preborn children. Vote for the passage of Cassie and Molly's law.

● (1120)

[*Translation*]

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.): Mr. Speaker, I congratulate the member on her work on this file, which is clearly deeply important to her. Nobody here believes that life is unimportant. However, this bill is clearly designed to reopen the abortion debate. The law already protects mothers. Pregnancy is already a factor that our justice system takes into account in sentencing.

This bill could end up reducing the total time served because sentences would be served concurrently instead of consecutively.

In my colleague's opinion, how would this bill really change the behaviour of those who commit violent acts against women?

[*English*]

Mrs. Cathay Wagantall: Mr. Speaker, it is pretty clear to me that the member's question was formulated before my speech or, possibly, the member did not listen to my speech.

The law is very clear. It would not in any way change the definition of a human being. We are not dealing with a circumstance where a woman would be in any kind of danger or positioned in any kind of danger of being charged. This deals with a third party committing a criminal offence against a woman who he or she knows is pregnant and causing harm or the death of the pre-born child.

There are women all over our country to whom this law would apply. Women are women are women. We want to carry our children to term. We want the right to choose to have our children and to have this law in place.

One individual wrote to me and said that she was a young woman. She had a miscarriage, which was devastating. She got pregnant again and was not ready to have my family, so she chose to have an abortion. Now that she was having children, she wanted this law in place.

Today I am not just speaking on my own behalf, but I am speaking on behalf of women across the country. Having this bill in place to protect them and their pre-born children is long overdue.

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Mr. Speaker, we are cognizant in Canada that the vast majority of women who are victims of murder are killed by someone they know. Almost nine in ten women are killed by an acquaintance or, even worse, by a spouse or intimate partner.

I am interested to hear the member's view on the great need for Canada to adopt a national domestic violence strategy to combat violence against women. I hope this will have an increased priority, which will affect most women and will have the greatest impact on women and their families.

Mrs. Cathay Wagantall: Mr. Speaker, we are concerned about any kind of any violence, in any circumstance, against women, men, and children.

The truth is that this is a specific law that needs to be put in place because of the extra vulnerability women face when they want to carry their children to term and end up in a situation such as Cassie's. An intruder came into her home when she was seven months' pregnant and ready to deliver to this child. She was attacked in ways that I do not even want to talk about, but clearly it was an attack as well on her child who was fully expected.

There are situations everywhere in which we, as Canadians, need to stand up and intervene on behalf of the vulnerable. In this circumstance, vulnerable women who want to carry their children to term are being attacked. We need to put this law into place.

● (1125)

Mr. Bill Blair (Parliamentary Secretary to the Minister of Justice and Attorney General of Canada, Lib.): Mr. Speaker, I rise today to join in the second reading debate of the private member's bill, Bill C-225, an act to amend the Criminal Code, injuring or causing the death of a pre-born child while committing an offence.

I would like to begin by acknowledging the member for Yorkton—Melville for her compassion and sincerity in bringing the bill forward. I also want to assure her that I have listened very carefully to her speech. In addition, I have read her bill very carefully and I have also examined some of the case law and some of the preceding matters brought before the House.

Bill C-225 would make it a separate offence to cause injury or death to a fetus during the commission of an offence against the fetus' mother. Similar reforms, but not identical, have been proposed by two former private members' bills before the House: Bill C-484, An Act to amend the Criminal Code (injuring or causing the death of an unborn child while committing an offence); and Bill C-291, An Act to amend the Criminal Code (injuring or causing the death of a child before or during its birth while committing an offence). Bill C-484 died on the Order Paper in 2008, and Bill C-291 was designated a non-votable item in 2006 because it was deemed not charter-compliant.

Unlike these previous private members' bills, Bill C-225 seeks to codify abuse of a pregnant woman as an aggravating factor for sentencing purposes. We can all agree that protecting women from violence, including pregnant women, is a pressing objective. I, quite frankly, have spent much of my adult life in attempting to deal with issues of domestic violence and the protection of the most vulnerable citizens in our society, in particular women and pregnant women.

However, I am concerned that most of the proposals in Bill C-225 will not ultimately meet this objective. In order to reach this objective, the focus must be placed upon violence against women and not on the fetus. In fact, by focusing on the fetus, we may have the unintended effect of negatively impacting women, in particular women's right to choose. Please allow me to explain.

First, providing protection from violence to pregnant women would likely involve ensuring longer sentences in these types of cases. However, sentencing an offender for two separate offences in cases involving abuse of a pregnant woman, one for the harm caused to the fetus and the other for harm caused to its mother, will very likely result in not a longer sentence since sentences are generally served concurrently in cases involving two convictions arising out of the same set of facts or series of events. In other words, it is unlikely the convictions for two offences would result in a lengthier sentence than a conviction for one offence under these aggravating circumstances.

Second, the law already protects pregnant women from violence. First and foremost, case law shows that abusing pregnant women in committing an offence is already considered an aggravating factor for sentencing purposes and is punished severely. As an example, in 2015, the Ontario Superior Court of Justice in R. v. Grandine, a 15-year sentence was imposed and the offender convicted of manslaughter in the killing of his 20-week pregnant wife. In that case, the judge very specifically stated, “...I consider the fact that the deceased was pregnant to be an aggravating factor”.

Acts of violence against pregnant women are already addressed by existing criminal law in several ways.

Subsection 223(2) and section 238 of the Criminal Code, which carry a maximum penalty of life in prison, prohibit causing the death of a child, who has not become a human being, in the act of birth under certain circumstances. Subsection 223(1) of that section provides that a child becomes a human being when it has completely proceeded, in a living state, from the body of its mother...”.

The Criminal Code contains comprehensive assault and homicide offences which apply to violent acts against pregnant women, and case law shows that abusing a pregnant woman in committing an offence is considered an aggravating factor for sentencing purposes and is punished severely.

I realize that Bill C-225 would not directly impact a woman's right to choose. However, because its proposed offences apply to a fetus at any stage of its development before birth, which means they could apply from the moment of conception, they give the fetus a status that is not currently recognized in law.

● (1130)

Moreover, unlike Bill C-484, Bill C-225, as the member for Yorkton—Melville has mentioned, does not specify that its proposed offences do not apply to cases involving lawful termination of pregnancy, persons acting in good faith to take steps to preserve the life of the mother or the fetus, or any act of omission by the mother.

The fact that the bill's proposed reforms indirectly implicate women's rights issues is deeply problematic in my view. The possibility of restricting a woman's right to choose was decided by the Supreme Court of Canada in 1988 in the Morgentaler decision, and we have known for quite some time now that any kind of limit on access to abortion implicates women's section 7 charter rights.

A woman is indivisible from her fetus. Protecting her necessarily means protecting her fetus. We must therefore focus on protecting pregnant women from the violence that they experience, and supporting legislative changes that may lead to a loss of a woman's section 7 charter rights is not the answer to the serious problem of violence against pregnant women. Simply put, gender-based violence has no placed in our society.

Our government has committed to addressing violence against women in all of its forms. A federal gender violence strategy and action plan is being developed which will include measures to better protect victims of domestic violence. This approach will include prevention, support for victims and appropriate criminal justice responses. Examining this issue through the violence against women lens is the best way to ensure the protection of pregnant women.

The criminal law already treats abuse of pregnant women very seriously. Judges routinely consider abuse of pregnant women as an aggravating factor for sentencing purposes. While there may be some merit in ensuring that this is clearly stated in the Criminal Code, I am not convinced that Bill C-225 is the right legislative vehicle to effect that, since the bill's main purpose is to protect the fetus by creating separate offences for those who would cause it harm, not to protect pregnant women by codifying a principle already routinely applied by sentencing judges.

I acknowledge the very good intentions of Bill C-225. I acknowledge the compassion and sincerity that the member has demonstrated in bringing this matter forward. However, with great respect, I do not think it would achieve the important objective of protecting pregnant women. Therefore, I will be opposing it for the following reasons.

The criminal law already takes violence against women, including pregnant women, very seriously. The bill fails to address the broader issues of violence against women. In addition, it is very likely in my opinion that the bill would be challenged under the charter.

I would like to thank the sponsor for bringing this important issue forward for debate. Violence against women is a terrible crime and impacts us all. It has no place in our society and I join with the member in condemning it.

Mr. Murray Rankin (Victoria, NDP): Mr. Speaker, let me first say a few words to the people who I am sure are following this debate closely.

To Jeff Durham, his friends, family, and the people of Windsor, Ontario, who have stood with him since December 2014, and all of those who have lost loved ones to violence, I would say that every member of this House stands with them. I cannot fathom the depth of grief that they must feel. However, we can all see their strength and determination to fight to save other Canadians from experiencing a similar grief.

I want to begin by acknowledging the passionate speech by my colleague, the member for Yorkton—Melville. I hope that all members, wherever they stand on this particular measure before us, will take this opportunity to rededicate themselves to the task of not just reducing but ending violence against women.

Let me say at the outset that although I understand and sympathize with the important objective of the bill, I have serious concerns about the legal implications of some of the provisions within it. Whether intentional or incidental, some of the provisions in the bill would have effects far beyond the principle and scope of this bill. After careful review, we have decided that these flaws are so fundamental and potentially harmful that they would undermine the very objective of the bill. For those reasons, we will not be supporting the bill at second reading.

The bill would, for the first time and in defiance of multiple rulings by the Supreme Court of Canada, legally separate a fetus from its mother. The inescapable effect of that separation would be to reopen the debate on the reproductive rights of women, which has rightly and definitively been resolved by Canadians. It has been the object of more than 40 bills or motions in this House since 1987.

The member for Yorkton—Melville has said that it will not reopen the debate on the reproductive rights of women. She has said that abortion is explicitly excluded from the ambit of this bill. However, even if that is not the intention of the bill, its effect would be to lay the groundwork for the reopening of this contentious debate on the reproductive rights of women.

If these particular provisions seem familiar to members, it is because they are nearly a carbon copy of a measure previously proposed in the House in Bill C-484, the so-called unborn victims of crime act. The member does not seem to grasp that by enshrining the term “preborn child” it will have a significant ripple effect on the law in this context. It is defined as “a child at any stage of development that has not yet become a human being”.

First, I would note that under existing laws the victim's pregnancy is already used by judges as an aggravating factor in sentencing, despite the absence of any specific statutory requirement to do so in the Criminal Code. Second, I would note that Cassandra's killer already faces the most severe punishment available since the abolition of the death penalty, namely, a life sentence without parole for at least 25 years. Third, the victim's family members will have the opportunity to express their views in court by means of a victim impact statement. Fourth, even if separate charges were laid in the death of the fetus, they would most likely be served concurrently, that is, subsumed within the life sentence for first degree murder of the mother, leaving the number of years to be served unchanged.

The bill I mentioned earlier was debated in 2007. It did not proceed at that time in part because of the opposition of more than 100 organizations across Canada, many of which are dedicated full time to ending violence against women and upholding the rights of all. We cannot proceed with a flawed bill that fails to provide effective relief to those it seeks to protect and that may well jeopardize the constitutional rights of Canadian women.

● (1135)

Indeed, the experience of jurisdictions that have adopted such laws, including many in the United States, failed to reduce violence against women, and despite the best intentions of their sponsors, have been used to launch legal actions against mothers.

What is to be done?

The best way to protect fetuses is, of course, to protect mothers, which means directly protecting pregnant women by providing all the necessary resources to ensure good pregnancy outcomes, and by upholding women's constitutional rights. What is required then is a holistic approach to ending violence against women through both the protection of the constitutional rights of women and the prevention of violence, including intimate-partner violence.

The present government made a number of platform promises in the most recent election with relevance to this debate. They include the following: Criminal Code amendments to tackle intimate-partner violence, including listing it as an aggravating factor in sentencing; increased investment in shelters and transition houses; and a comprehensive federal gender-violence strategy and action plan.

The NDP supports these goals and other measures, such as restarting the police officer recruitment fund to ensure that communities have the officers they need to keep every family safe, yet no action has been taken to update the Criminal Code. Resources for shelters and transition houses remain woefully inadequate. Also, there has been no discernible progress on the development and implementation of a comprehensive federal gender-violence strategy and action plan.

Just last week, *The Globe and Mail* reported that the majority of women and children seeking shelter from violence, 73%, are turned away because of a lack of resources, and nearly half of the shelters that were studied had received clients from other provinces. This is truly a national problem. It is a crisis, from my home on the west coast in Victoria, to small towns, big cities, and remote communities all across Canada. The government must do more to ensure that no woman in Canada is denied the help she needs to escape violence and abuse.

In a previous session, the NDP member for Churchill—Keewatinook Aski tabled a motion to develop a national action plan to end violence against women. I salute the ongoing work to that end by the member for Nanaimo—Ladysmith who has taken up this initiative. This is the kind of holistic approach that will be required to eradicate violence, including intimate-partner violence, but also to take positive steps to achieve equality in our society and our economy.

This is not the time for tinkering. This is the time for bold national action. Sadly, the bill before us is neither the solution we need nor is it free of further problems. For those reasons, we cannot support proceeding with further consideration of the bill.

I hope all members will join us in not only ensuring the government delivers on its platform promises to address intimate-partner violence, funding for shelters, and public safety, but also in bringing forward proposals of its own to ensure we are doing everything in our power to end violence against women in Canada.

● (1140)

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Mr. Speaker, it is a privilege to rise today to speak in support of Bill C-225. At the outset, I want to congratulate my colleague, the hon. member for Yorkton—Melville for bringing forward this important and much-needed legislation to protect women and close a glaring void in justice under the Criminal Code.

The legislation is appropriately named after Cassie Durham and her preborn daughter, Molly. Just 10 weeks away from giving birth to Molly, Cassie was brutally murdered. Cassie's killer was appropriately charged with first degree murder. However, what charges did Cassie's killer face for targeting Cassie as a pregnant woman and terminating a perfectly viable pregnancy against the wishes of Cassie? The answer is that no charges were laid, because there were no charges to be laid under the Criminal Code.

In 2005, Olivia Talbot was pregnant with her preborn son, Lane Jr. Like Cassie Durham, Olivia Talbot was brutally murdered. Her killer shot at Olivia three times and by his own admission he specifically targeted Lane Jr., yet no charges could be laid for those crimes.

The victims' families, Olivia Talbot's, Cassie Durham's, and other families, ask where the justice is. Where is the justice when there is no provision in the Criminal Code that would hold criminals who target pregnant women accountable? Where is the justice when there is no provision in the Criminal Code to hold accountable those persons who violently terminate a woman's pregnancy against that woman's choice? The answer to those families who ask, "Where is the justice?" is that there is no justice.

The stories of Cassie Durham and Olivia Talbot are not isolated stories. Indeed, over the last 15 years some 24 reported cases have involved women being attacked or murdered while pregnant.

There are some who say this legislation is not necessary. They say, simply provide that, for those who target pregnant women, that can be an aggravating factor in sentencing. It already is an aggravating factor in sentencing in common law. Bill C-225 would codify the common law and that is a step in the right direction. However, simply providing that targeting a pregnant woman is an aggravating factor at sentencing is not sufficient for justice to be truly done.

An important component of our criminal justice system is that criminals are held accountable for all of the crimes they commit against their victims and not just some of the crimes. However, clearly in the cases of Cassie Durham and Olivia Talbot their killers were only charged and held accountable for some of the crimes, not all of the crimes. That is unjust.

● (1145)

With respect to sentencing, we can take for example someone who knowingly targets a pregnant woman, assaults her, and in the process of the assault terminates her viable pregnancy. What would happen to that individual if targeting a pregnant woman were merely an aggravating factor? It is likely that the individual would be charged with aggravated assault. The maximum penalty for aggravated assault is 14 years, and because it is an aggravating factor, it is more likely that the perpetrator would be sentenced closer to 14 years than less, which is a positive thing.

Let us face the reality that what would have occurred in that situation is something more than aggravated assault. A woman's viable pregnancy would have been terminated against her will, her bodily integrity infringed upon, and her choice as a woman violated.

Bill C-225 recognizes that reality and would give judges the tools they need to hold criminals who commit those kinds of crimes truly accountable by potentially putting those types of criminals away a lot longer than 14 years.

There are some who say, and we have heard it today from several hon. members who spoke, that this is really about reopening the abortion debate. The fact is that, in Canada, abortion is available and lawful for the full nine months of a woman's pregnancy, and Bill C-225 does absolutely nothing to change that fact.

Not only does Bill C-225 do nothing to change that fact, but Bill C-225 expressly provides that a preborn child is not a human being in law, to leave no ambiguity and no confusion: Bill C-225 has absolutely nothing to do with abortion.

What Bill C-225 has a lot to do with, however, is justice. It is justice for women who are targeted because they are pregnant; justice for women who are injured because they are pregnant; justice for women whose rights are violated; and justice for women by ensuring that those who violate the rights of women are held accountable to the fullest extent of the law.

Let us, as a House of Commons, do what is right, what is fair, and what is just. Let us close this glaring loophole in justice under the Criminal Code, and pass Bill C-225.

● (1150)

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.): Mr. Speaker, I very much want to address the private member's bill, Bill C-225, an act to amend the Criminal Code, injuring or causing the death of a preborn child while committing an offence, at second reading.

The sponsor introduced the bill in response to the murder of Cassandra Kaake, who was seven months pregnant with a girl she intended to name Molly.

First, I would like to offer my deepest sympathies to Ms. Kaake's family. Such an incredible loss must cause the deepest of suffering.

Sadly, statistics show that pregnant women often experience violence. According to the Statistics Canada 2009 general social survey, 11% of female spousal violence victims were pregnant during the violent incident, which amounts to about 63,300 pregnant women who were violently victimized by their spouses in the five years preceding 2009.

Police-reported data from the homicide survey also show that pregnancy is not a protective factor in intimate partner homicide. From 2005, the year data first became available on whether a homicide victim was pregnant, to 2010, 12 intimate partner victims were pregnant at the time of their death.

However, as the case of Ms. Kaake shows us, homicide during pregnancy is not limited to intimate partners, as eight pregnant women were killed by someone other than their intimate partner—the source being “Family violence in Canada: A statistical profile, 2010”, a Statistics Canada *Juristat* article. These numbers are a serious cause for concern.

Bill C-225's objective is to protect pregnant women and their fetuses by making it a separate offence to cause injury or death to the pregnant woman's fetus. The penalties vary, depending upon the mental state of the accused, but range from 18 months' imprisonment to life imprisonment; and where the accused intends to cause injury or a death, a mandatory minimum penalty of 10 years would be imposed.

Other elements of the bill would include non-application of the mandatory minimum if the accused were provoked in committing the offence, within the meaning of the defence of provocation under section 232 of the Criminal Code, and codifying abuse of a pregnant woman as an aggravating factor for sentencing purposes.

Although I appreciate the bill's objectives, I have a number of concerns with its proposed reforms.

First, it does not make sense to make the same conduct both an aggravating factor for sentencing purposes and the subject matter of a separate offence. It should be one or the other. Sentencing judges already consider abuse of a pregnant woman as an aggravating factor, resulting in lengthier sentences for offenders.

In particular, I am concerned that making harm to a fetus the subject matter of a separate offence could actually result in shorter jail time, since a sentence for harm done to the mother and a sentence for harm done to the fetus are likely to be served concurrently, given that they necessarily arise from the same event.

In contrast, if an offender is charged with one offence against the mother and her pregnancy is considered as an aggravating factor, the sentence is likely to be longer than a sentence served concurrently for two separate offences. Serving shorter sentences than are currently imposed under existing law could not be the bill's intended effect, as this would mean less protection for pregnant women.

I am also concerned about the bill's mandatory minimums. Except for the mandatory minimum for murder, 10 years would be the longest mandatory minimum in the Criminal Code.

We are all well aware of the Supreme Court of Canada's 2015 Nur decision, which struck down a three-year mandatory minimum for gun crimes. More recently, the Supreme Court of Canada's decision in the Lloyd case struck down a one-year mandatory minimum for drug trafficking involving repeat offenders.

Indeed, there has been a proliferation of litigation challenging mandatory minimums, with lengthier mandatory minimums and mandatory minimums that apply to a broad range of conduct attracting a higher level of scrutiny.

I wonder whether imposing a mandatory minimum is the most effective way to address the severity of harming pregnant women, especially when judges are already factoring in the severity of that conduct when imposing sentences on offenders.

Another concern is the bill's reference to the provocation defence. Normally, this defence reduces murder to manslaughter where the victim provoked the accused into killing, to allow greater discretion in sentencing. However, the bill proposes to make the defence applicable to an offence that is not murder.

Obviously, a fetus—the proposed victim of the offence—cannot provoke a person; so the intent of the proposed reform must be to remove the application of the 10-year mandatory minimum where the accused's conduct is provoked by the fetus' mother.

In creating a new offence for harm done to the fetus, the bill would treat the fetus as a victim separate from its mother but then, through its provocation defence proposal, the bill would provide less protection to the fetus due to the conduct of its mother. Such an approach seems internally inconsistent.

Moreover, the provocation defence has only ever applied to murder. Expanding the application of the defence to other offences could set an unfortunate precedent, especially since the defence has been invoked by men who killed their current or former female partners after alleging that they were provoked by conduct they perceived as insulting or offensive. Although the defence was recently narrowed, it may still raise some of these same issues.

● (1155)

However, my overarching concern is that the bill treats the fetus as a separate entity from its mother, when in fact the two are indivisible. This creates multiple legal problems, such as the one I described earlier regarding the provocation defence. Also, creating a separate offence for harm done to the fetus gives the fetus a status not currently recognized in law and detracts from the real issue: violence against pregnant women.

The long-standing legal principle that fetuses do not possess rights independent from their mothers until born alive requires the law to focus on this very real and pressing issue. Significantly, this principle is also at the root of a woman's right to choose.

Ever since the Supreme Court of Canada struck down the Criminal Code's abortion provision in 1988, abortion services have been a health care matter because the Supreme Court of Canada found that restricting access to a woman's right to choose implicates women's section 7 charter rights. I would not want us to develop laws or policies that could in any way erode these rights.

Although Bill C-225 does not directly address a woman's right to choose, its provisions would give fetuses a status in law that is separate from their mothers, despite the fact that, in reality, the two cannot be separated. In my opinion, the best way to protect fetuses is to protect their mothers, and that is what existing law already does.

I am pleased that the government has committed to strengthening Canada's approach to the main issue here, violence against women, including pregnant women. I look forward to the results of the government's criminal justice system review and its implementation of the federal gender violence strategy and action plan, which should provide greater support and protection to women subjected to violence.

Although Bill C-225 raises many concerns, I cannot support this bill given its real-world effects beyond the bill's intended scope. I want to thank the sponsor for giving me the opportunity to speak today and discuss the critical issue of women's safety and well-being. These are pressing issues that require ongoing examination and analysis.

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Mr. Speaker, I first want to acknowledge the terrible tragedy that gave rise to this bill. Our hearts go out to Jeff Durham, his family, and his community for such a terrible loss.

Despite the good intentions of the bill's sponsor, this bill has the unintended consequence of reopening Canada's debate on abortion, and New Democrats will not risk jeopardizing a woman's right to choose. There are 36 pro-choice groups across Canada—and if I had time, I would read the really long list—all opposing the passage of this bill, describing it as an interference with a woman's constitutional right to choose.

To make the most women and children safe, my proposal is that the kind of legislation Canada needs is much more broad. The best way to protect the most women and children is to take action on gender-based domestic violence against women. Cassie was killed by a stranger, and she is an exception. Nine in 10 women victims are murdered by someone they knew. Therefore, to have the most impact, let us take action to prevent women from being killed by their partners and acquaintances.

First, Canada needs a national plan to end violence against women. Most other western countries have this. Canada is falling behind. New Democrats have led on this issue over the past sessions of Parliament. NGOs and labour organizations have developed a very strong blueprint that charts the way forward. We urge the government across the aisle to take action early on this, and we will stand together on that.

Second, Canada needs more investment in domestic violence shelters. Imagine a woman making a decision to take her children and leave a violent marriage or relationship and then, when arriving at a domestic violence shelter, being told there is no room for her. This is what last week's release of the “Shelter Voices” survey said. Almost three out of four women are turned away due to lack of capacity. With stable, predictable, multi-year funding, both for building and operating, we could prevent women from having to stay in a violent situation.

Because of the strong actions that Parliament can take to truly make women and their children safer without inadvertently jeopardizing a woman's constitutional right to choose, I will not support this bill, and I urge parliamentarians to work together on what will truly make a difference on the ground in women's safety every day.

● (1200)

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, I appreciate the opportunity to address this very important issue and to distill out what is some confusion on the other side of the House. We hear constant efforts by the other side to conflate this very important issue of criminal justice, as the member for St. Albert—Edmonton and the sponsoring member said very ably, with something else, which is the issue of abortion which we know is very contentious and very difficult in this country.

We should be able to have a rational conversation about issues that are different, that are unrelated to abortion, that still touch on justice and still touch on preventing violence against women. It is important that we be able to make these distinctions because when it comes down to these issues, there are two separate questions we can talk about. There is the question about the basic rights of individuals, in this case of preborn children, and then there is the separate question of whether or not the rights of the mother exceed or supersede the rights of that preborn child. What is maybe missed by other hon. members is that these are very clearly two separate questions.

One could come to the conclusion that preborn children should have no rights, should have no acknowledged status as persons, but one could also come to the conclusion that there is clearly some genuine humanity to that preborn child, even if one further concluded that the rights of the mother ought to supersede the rights of the unborn child in that case.

The importance of understanding that these are two separate questions really has been missed by the other side. Members instead infer from the fact that one philosophical conclusion might be drawn in the case of preborn children, that therefore we cannot take this action because it might be inferred to mean something else later on down the road.

The members on our side who have spoken to this issue have already been very clear on that point. They have underlined that we are talking about a particular issue which is addressing violence against women and also recognizing that there is a loss of life involved and that there is a loss of women's choice involved as well.

It is a little disappointing to see members of other parties wanting to stir up these hot button debates when this really should be something on which there is a consensus. I do not think that any member would disagree with the basic philosophical proposition that an unborn human child is in some sense human and can be recognized to be as such without opening up a separate and distinct philosophical question around the rights of women.

The lack of acknowledgement of these separate questions is a problem, and let us be clear that it is a problem with some real practical consequences, with some real implications. Those implications have been laid out well, not only by my colleagues, but by members from other parties who understand the problem of violence against women, who understand the pressing need to address it, to overcome long-standing perhaps cultural ideas that have not addressed this properly in the past. There should be consensus. I look forward to working with members from all sides on this issue.

Before getting elected, I served on the board of an organization called Saffron in my riding which is working to address bullying and violence against women and sexual violence. It is great to see in my community and other communities that this obviously is an issue where there is a consensus across parties and across different political philosophies and perspectives.

From what some other members are saying, it is disappointing because if we do not pass the bill, then we will have missed a very good opportunity. We will have missed an opportunity to do something good. We will have missed an opportunity to make a difference for families who are victims and a difference for potential victims as well. We will have missed this opportunity because instead of confronting an important issue in a concrete, effective way, and members are welcome to propose amendments on some of the specific details that have been mentioned at the committee stage, but by simply rejecting it out of hand, an opportunity will have been missed to make a real positive difference when it comes to something that we should all agree is very important.

● (1205)

The Assistant Deputy Speaker (Mr. Anthony Rota): The time provided for the consideration of private members' business has now expired and the order is dropped to the bottom of the order of precedence on the Order Paper.

GOVERNMENT ORDERS

[*English*]

CRIMINAL CODE

The House resumed from April 22, consideration of the motion that Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), be read the second time and referred to a committee.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, this legislation contains no meaningful safeguards. Even its exceptions are full of holes: the written consent provision excludes those who cannot sign; the waiting period can be routinely waived; mental illness is not excluded; the requirement that death be reasonably foreseeable would exclude no one; and the requirement that two doctors sign off merely encourages doctor shopping. Even if the already ambiguous criteria are not followed, someone who kills an unwilling patient can be let off the hook if he or she claims a reasonable but mistaken belief that the criteria applied.

Clearly, we have a perfect storm of ambiguous criteria and a reasonable but mistaken belief clause which means that it would be nearly impossible to prosecute anyone who kills a patient, even without consent.

Today I want to make three additional points: the decline of moral language, the need for advance review, and the way in which an absence of conscience protection is further undermining an already inadequate system of palliative care.

This debate has been characterized by a decline of language. Terms like “suicide”, “euthanasia”, and “killing” are rejected and replaced by fundamentally inaccurate phrases like “medical assistance in dying”. Every day physicians assist their patients in the context of dying without killing them.

The decline of language is also evident in the euphemistic use of terms like “dignity” and “compassion”. The phrase “dying with dignity” implies that suffering or disabled people do not have dignity, and this reflects a very dangerous world view. For a long time we have understood that dignity is immutable; it is an intrinsic characteristic of all human beings. Our immutable dignity is the reason we put down suffering dogs, but we do not put down suffering humans.

This human exceptionalism, this idea of universal and immutable human dignity is the basis of our conception of human rights. Human rights, the ostensible basis on which this legislation is advanced, stand on a moral foundation of universal immutable human dignity, and those who wish to redefine dignity so dramatically should at least provide us with their alternative definition.

I have encouraged the government to amend this legislation to include a system of advance review by competent legal authority. This could take many forms. It could involve review by a provincial consent and capacity board. It could involve a requirement for review by a judge. It could involve the simple requirement in this legislation that each province set up its own system of advance legal review or that an independent lawyer certified and retained for this purpose replace the role of one of the witnesses.

There are multiple options here, some better than others. The criteria are not worth the paper they are written on if someone with competent legal authority is not making a determination in advance to ensure the legal criteria are met.

The government, though, wants to force doctors into this role. However, doctors do not constitute competent legal authority. Doctors do not make these types of decisions in other parts of their work, given how aberrant the taking of life is from the normal medical process of protecting life, and the proposed legislation's allowance for doctor shopping does not actually mean that the doctor providing the prior care would provide advance review, since the patient, or worse, someone else, could simply go on the Internet to find a doctor with a more liberal interpretation of the criteria.

A simple system of advance legal review by competent authority would eliminate doctor shopping and achieve the central objective: it would ensure that people who have not consented or do not meet the criteria are not killed, without any effective means to investigate that after the fact. Data from Benelux countries show alarmingly high rates of euthanasia for patients who have not consented; however, prosecution of those who take life without consent in a medical environment is almost non-existent.

Finally, a lack of conscience protection pushes people out of the provision of palliative care when already far too few Canadians have access to it. Dr. Nancy Naylor, a family and palliative care physician with 40 years of experience, is now leaving the profession. She said, "I have no wish to stop, but I will not be told that I must go against my moral conscience." She is speaking out because her patients who will be left without access to palliative care cannot. What good does it do anyone to leave conscience protection out of this legislation, and chase good principled palliative care physicians out of the profession at a time when we need them most?

Many doctors say that this is not medical care at all, and we should let them focus on what they do best.

The Supreme Court decision punched a hole in the previous law, and this legislature cannot change that, but the government appears to be taking advantage of these events to widen the hole still further. No law would be a bad situation, but this law could make a bad situation worse. It would leave vulnerable seniors and sick and disabled persons at risk with no meaningful restrictions.

Stop the madness. Fix the bill.

● (1210)

Mr. Robert Oliphant (Don Valley West, Lib.): Mr. Speaker, I have a very simple and direct question for the member for Sherwood Park—Fort Saskatchewan.

Does the member support the unanimous decision of the Supreme Court judges in honouring the request of Ms. Taylor and Ms. Carter to have assistance in dying?

Mr. Garnett Genuis: Mr. Speaker, I was actually very clear about that point in my speech.

Regardless of the private opinions of members with respect to this issue more generally, we know that the government is not addressing at all the task that the court put in front of it. The task that the court gave the government was to develop a system that would make this happen while also protecting the vulnerable. The government replaced some criteria in the court decision with equally, if not more, ambiguous criteria in its response. We are not seeing any development in this regard from the government at all.

I do have to underline, and again we see it in the question that the member asked, the euphemistic language here. Doctors provide medical assistance in dying every day that does not involve killing their patients. If members defend it, good for them, but they should have the honesty to describe the issue properly, because calling something "medical assistance in dying" is clearly misleading. It distracts from the central question we are supposed to be debating.

Mr. Charlie Angus (Timmins—James Bay, NDP): Mr. Speaker, I listened with great interest to my hon. colleague.

The reason Parliament has been put in this position by the Supreme Court is the complete lack of action by the Conservatives in dealing with this issue over a period of 10 years. The Conservatives cut the palliative care initiatives that were in place, took no movement on the issue of palliative care, and refused to deal with the fact that they knew the Supreme Court decision was coming.

The Supreme Court has now stepped into that vacuum and has put this Parliament and, I feel, all Canadians in a very difficult position, because if we do not have a law by June, we will have another legal vacuum in which this door could actually be blown open much wider.

The question is, is the role of this Parliament to do something positive, where we can assure that those who are sick and dying are able to access quality palliative care? We had pushed a motion through the House of Commons last session, and there was no money. The Conservatives and the former prime minister took no steps to put that into action.

We now have Motion No. 46 which talks about the need to establish palliative norms, working with the provinces, working to change the EI provisions so that families can get the support they need to take the pressure off them.

Is my colleague willing to accept a legal vacuum in June if this House does not move? Is he willing to work in a proactive manner with our party in establishing palliative care access so that we can actually present Canadians with more of a balance than simply the law on euthanasia?

Mr. Garnett Genuis: Mr. Speaker, I thank the member for his work on this. I want to address a few of the points the member made.

It is a strange definition of lack of action to say that the repeated express will of the House on the issue of euthanasia somehow constitutes a lack of action. Of course we had proposals that came forward before the court decision, and those were rejected by an overwhelming majority of this House, which included the majority of Liberal and, I believe, New Democrat members at the time, as well.

With respect to the issue of a legal vacuum, I would like to see better legislation come forward which clarifies the situation. I would support this bill if it were amended in a number of key ways. However, the existing legislation does not in any way address the task that the court asked us to do, which is to actually describe and define what the situation would look like in terms of euthanasia and assisted suicide in Canada.

The government has replaced some ambiguity in the court decision with greater ambiguity in the legislation. Legislation is only worth proposing if it improves on the absence of legislation.

In terms of investment in palliative care, I agree with the hon. member that there is more work to do. I would not accept his characterization of the previous government as doing nothing on that issue, but I would certainly agree that more investment is needed.

The problem with this legislation is it moves in the opposite direction. Allowing euthanasia and assisted suicide without conscience protection has the effect of pulling doctors who would otherwise want to be involved in palliative care out of palliative care if they do not want to participate in euthanasia. At the very least, conscience protection should be added. That would preserve the existing system of palliative care that we have, and then we could build on that by working to do more.

● (1215)

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Speaker, I have had the honour of serving the people of Kitchener—Conestoga and being part of many important discussions and debates here in this chamber over the past 10 years. As members of Parliament, we are given the solemn obligation to chart the way forward for our great nation of Canada. The motions we table, the amendments we consider, the legislation we adopt will always impact, positively or negatively, the very people who elected us to represent them in the capital city of our nation, and they will also impact generations of Canadians to follow.

The impact of our deliberations and decisions we make on this critical life and death issue will impact the very fabric of our country. If I may say, it will leave a lasting legacy for good or for ill of our understanding of what it means to part of the human family.

Because of the very serious nature of the topic in front of us today, we, and by that I mean every member of this chamber, must take a step back and consider some very foundational questions. Each of us needs to ask ourselves these difficult questions. How we as members perceive these foundational issues is absolutely key to addressing this sobering topic before us today.

Consider with me for the next few moments these questions. What does it mean to be human? What gives human life meaning and value? Does every human life possess intrinsic value and dignity, regardless of perceived deformity, regardless of perceived disability, regardless of the perception of being a burden, regardless of whether or not a person may have achieved their best before date?

For me, the answer to all these questions is a resounding yes. Every human life is worthy of our utmost respect and protection. Every human life matters. Therefore, needless to say, I do not support physician-assisted suicide, or voluntary euthanasia or any legislation that would further devalue human life.

My world view is influenced by my life experiences, and most profoundly it has been shaped by my faith. I believe every human life has intrinsic value and dignity that needs to be held in high honour and esteemed, in other words, to be considered worthy.

There is a saying in the Talmud, “Whoever destroys a soul, it is considered as if he destroyed an entire world. And whoever saves a life, it is considered as if he saved an entire world.”

On the Peace Tower of our Parliament Buildings carved in stone above the west window, members will find these words taken from ancient Hebrew writings in the book of Proverbs, “Where there is no vision, the people perish.”

What is our vision for Canada? I ask each of my colleagues today what their vision is for Canada.

My vision for Canada is one where every human life is valued and cherished from the moment of conception to the moment of natural death. It is my firm belief that life is a gift from God and that this gift is far too precious to be discarded or destroyed. Every human life is filled with infinite value and, yes, every person, regardless of disability, deformity, depression, or devaluation based on criteria of so-called “usefulness” has something to teach us about what it means to be human.

For those who are suffering, we have the privilege to come alongside and care deeply. We provide proper pain relief, palliative care, human touch and love, in other words, we provide compassion.

The very meaning of the word compassion is “to suffer with”. It is to come alongside and enter into the suffering, to come alongside with feeling and care. Compassion is supporting them. It is to ignore the fact that compassion has everything to do with relationships if we are to allow physician-assisted suicide. We simply cannot have compassion if the relationship has been intentionally terminated.

That being said, the Supreme Court of Canada has established grounds for an exemption from prosecution for physicians who would assist in administering the suicide dose or carry out the act of euthanasia. The Supreme Court of Canada has done this, completely rejecting the fact that the elected members of the House of Commons have rejected initiatives to legalize physician-assisted suicide on at least 15 occasions since 1991. Most recently, a bill to allow physician-assisted suicide was rejected in 2010 by a vote of 59 to 226. My contention is that it is not the job of the Supreme Court to create laws but rather to interpret them.

I was one of the members of Parliament who served on the joint committee appointed to study physician-assisted dying. Our committee heard from many witnesses representing many different viewpoints. We heard from medical professionals, palliative care experts, mental health professionals, the disability community, the aboriginal community, various faith communities, legal and constitutional experts, and ethicists. As members might expect, from such a large variety of people, there was a very diverse response.

● (1220)

The unfortunate reality is that the timeline given to our committee for the completion of our report and recommendations did not allow for the large number of groups who wanted to appear before this committee. Groups like the Euthanasia Prevention Coalition, L'Arche Canada, Living with Dignity, as well as Dr. Balfour Mount, who is considered to be the father of palliative care in Canada and in fact in North America, were not allowed to appear at all.

The joint committee report had no teeth when it came to insisting that before physician-assisted suicide could be offered or even considered in Canada, there should at the very least be a credible offer of accessible and affordable palliative care to those who faced such a final solution of hastened death. Like the committee report, Bill C-14 fails miserably in stepping up with real change on this crucial issue.

Dr. Harvey Chochinov, chair of the external panel, professor of psychiatry at the University of Manitoba, and Canada research chair for palliative care, suggests that all patients requesting medical aid in dying would need to have a palliative care consultation to ensure that patients would be fully informed of all palliative care options that could be initiated in order to mitigate the suffering of patients. To ignore the very real lack of choice without a concurrent real offer of palliative care is to offer no choice, only hastened death.

I am thankful that Bill C-14 has incorporated many of the viewpoints of the dissenting report. However, it still includes very vague and subjective language and does not address many key issues raised by witnesses who appeared before the joint committee.

A major concern in this entire discussion has been the overt attempts to soften the language. Rather than call it physician-assisted suicide or voluntary euthanasia, it was then referred to as physician-assisted dying. Even physicians objected vigorously to the term “physician-assisted dying”, especially palliative care physicians. For many decades these doctors have been assisting patients through the natural dying process.

It has been said that all social engineering is preceded by verbal engineering. We will find no better example of that verbal engineering than in the matter before us today. This topic is far too important to allow this vague and euphemistic language to go unchallenged. As Dr. Chochinov notes, Bill C-14 makes no distinction between physician-assisted suicide and euthanasia, yet both are included in what the bill calls “medical assistance in dying”. It is extremely important to outline the difference, because international experience reveals that they are vastly different in terms of their uptake and lethality. In jurisdictions that offer only physician-assisted suicide, such as Oregon, these deaths account for about 0.3% of all deaths. In jurisdictions that offer euthanasia, hastened death accounts for approximately 3.0%, a tenfold increase.

If we were to extrapolate these figures to Canada where there are approximately 260,000 deaths per year, under a physician-assisted suicide regime, there would be approximately 780 deaths per year. However, if we were to extrapolate that to allow for euthanasia, the number of deaths would increase to 7,800 per year, which as I pointed out is a tenfold increase. The reason for the lower numbers under a physician-assisted suicide regime is ambivalence. It is crucial that at the very least the government needs to point out that if we are to proceed with this, we have to ask that those who request physician-assisted death must follow through on physician-assisted death rather than voluntary euthanasia because the numbers are so different.

Another key missing component is the matter of conscience protection for doctors and health care workers. If it is possible to ensure a “consistent approach to medical assistance in dying”, as the preamble asserts, there is no reason why at the same time a consistent approach to guarantee conscience rights cannot be included in Bill C-14.

Finally, Bill C-14 should include a system of judicial oversight in order to protect vulnerable persons. While two independent witnesses and two independent doctors sounds good on paper, the risks of overt or subtle coercion are too great and the possibility of abuse too real. These assertions need to be verified under a framework of legal oversight.

In summary, we should be offering hope to all Canadians. As legislators, we should be doing everything in our power to ensure that not one single person dies needlessly. It is with this in mind that I repeat the need for at least three major amendments to Bill C-14: first, vulnerable Canadians need better protection with a system of judicial oversight; second, doctors, health care personnel and institutions need clear conscience protection; and, finally, Canadians who are suffering need a real option of palliative care not hastened death.

● (1225)

Mr. Anthony Housefather (Mount Royal, Lib.): Mr. Speaker, it is clear that the hon. member is very passionate about life, and that certainly comes through in what he has said.

I want to ask the member about his comments with respect to the Supreme Court. He seems to believe that the Supreme Court needs to defer to the will of Parliament. However, that is not the Charter of Rights oriented system we now have in Canada. We adopted the Charter of Rights because we believed it would guarantee the protection of individual liberties, regardless of what the majority necessarily believed. In this case, whether the member, other members or I like it or not, the Supreme Court came to a decision in Carter that said medically assisted dying was open to a certain segment of the Canadian population.

Based on what the hon. member has said, it sounds as if he is suggesting the only real path is using the notwithstanding clause to override the court's decision. Is the hon. member asking us to do that?

Mr. Harold Albrecht: Mr. Speaker, I know my colleague is also passionate about life.

It is clear that there was a very short timeline for the committee to hear witnesses, take all of that input and come up with a report to give to the government, and then the government to craft legislation. Now we are under a very strict timeline, even in terms of debate in the House. The justice committee itself will be under an extremely short timeline. It is clear to me that we do not have adequate time to give this serious topic the serious consideration it really needs.

Whether the government wants to invoke the notwithstanding clause or not, I will not suggest that. It certainly would be one option. What I do know is that by rushing ahead the way we are at this point, we will not have the kind of law Canadians deserve.

Mr. Charlie Angus (Timmins—James Bay, NDP): Mr. Speaker, I have great respect for the work my colleague has done on issues of palliative care over the years with the parliamentary committee.

We agree on many things and disagree on some things, as wont in the House. I share his frustration with the Supreme Court's decision on the timelines. I respect the Supreme Court's right and power to establish rules and laws where it believes Parliament has left a vacuum. However, the new government should have been given the opportunity, as a form of goodwill, to engage the population of our country in this very important discussion as it affects every person and cuts across party lines. It would have been fair to give the new government the ability to hear from Canadians. I agree with the member. We are now under a very strict timeline of which Canadians are watching but are not a part.

Given these are the limits that have been placed on us by the Supreme Court, my concern is the legal vacuum that happens if we as the House do not respond to this, and the dangers that legal vacuum will create with other individuals and organizations stepping forward knowing they can go to the Supreme Court if Parliament has not acted.

Therefore, has my colleague considered the danger of that legal vacuum if we do not have a law in place by the end of June?

Mr. Harold Albrecht: Mr. Speaker, I want to thank my colleague for the work he has done on palliative care. I was honoured to support the motion he presented to the House last year. It was an honour to work across Parliament, across partisan lines, to facilitate the report “Not to be Forgotten”, which includes many recommendations. I am proud to say that a number of those recommendations have been completely or partially implemented, but we have a long way to go.

I am concerned as well about the potential legal vacuum that could exist if we do nothing. However, I have pointed out in my comments that there are at least three key amendments that the legislation needs if it is in any way going to resemble what I think are adequate safeguards for vulnerable people. Those include that vulnerable Canadians need better protection with a system of judicial oversight. It is fine to say that there are two medical doctors, two independent witnesses, and yet no way of actually asserting that those are in fact independent.

Another one is health care protection for conscience of health care workers. It would be totally inappropriate for an institution that was set up to improve end-of-life care and to walk with patients through that end-of-life natural process to demand that they go diametrically opposite to the principles under which they were founded and now have to participate in physician hastened death.

● (1230)

Mr. Robert Oliphant (Don Valley West, Lib.): Mr. Speaker, I will be sharing my time with the member for Oakville North—Burlington.

I want to begin by taking a moment to pay tribute to two Canadian women whom I did not know but have come to know in their deaths, and who I think are two of the most courageous women. They are Gloria Taylor and Kay Carter. These two women were on a journey of life that was not of their choosing, and they came to the point in their lives where they wanted some assistance in the final days of their lives in the final part of their journey.

As a United Church minister, I walked that journey with many people, hundreds of people in fact, and have done even more funerals where I did not know the people and only came to know them through the stories of their families and the legacy they left behind. Kay Carter and Gloria Taylor are two such women whose courage, tenacity, hopefulness, and love of life have instructed us to this very day, where we are now considering a bill on medical assistance in dying.

In paying tribute to them, I also want to give them thanks for engaging us in what is one of the best civics lessons that we could ever have as a chamber. Each of the branches of our government has a chance to speak to this. There is a legislative branch and a judicial branch, as well as the executive branch.

We actually began this conversation in 1982 where we invoked the charter that is now so much part of our Canadian culture of rights and freedoms. That charter has instructed all Canadians, Canada's courts, and Canada's legislators since the day it was passed. The reality is that when Kay Carter and Gloria Taylor made their appeal to the Supreme Court of British Columbia, and it went to the Court of Appeal in B.C. and then to the Supreme Court of Canada, we had the opportunity to have our judicial branch take a look at their rights and the possibility of their having assistance in their deaths. The courts ruled on that and gave one year for the parliamentary branch and the executive branch to come up with a law.

The parliamentary branch then spoke by having a joint committee with the House and the Senate. I need to say to this chamber that it was probably the richest experience I have had as a member of Parliament. Men and women—senators and members of this House—engaging in a discussion, listening to the stories of life and of death and of healing and of hope, changed me profoundly. It gave me the opportunity to recognize that the parliamentary system that we have gives Canadians a great opportunity to hear their voices being heard at committee and now in this House.

The executive branch then picked up from the report and has presented Bill C-14. I want to thank the minister for her work on this, and the work of her office and of justice, for taking the report that we did seriously, engaging in it further, and coming up with a piece of legislation that at this time I am very clear I will be supporting at second reading.

That does not mean that I think we are finished with this piece of legislation, because it is now back to the parliamentary system where we are to engage in the dialogue with the executive branch about making a law that could be good enough better. When we are dealing with issues of life and death, I do not think "good enough" is good enough. We can honour the quest that Gloria Taylor and Kay Carter engaged in and that the Supreme Court of Canada ruled on and that the executive branch has presented a law on, and as parliamentarians take seriously the Charter of Rights and Freedoms, take it to our hearts and look at what it is that we as members of Parliament are sworn to. It is more than allegiance to Her Majesty. It is about upholding the Constitution of this country and engaging in it with love, with commitment, with passion, and with hope, and looking at how the decision that the Supreme Court made can actually live out in the life of Canada.

We have a piece of legislation that is before us today, and it was decided that section 7 of the charter could not be used to deny the rights of two women looking for assistance in their deaths. The government of the day tried to fight that section 7 declaration of rights by invoking section 1 of the charter, saying that there were reasonable grounds to withhold those rights. However, the Supreme Court of Canada did not allow that. It said it would be unreasonable to deny those rights to be given to those women. The court made a very specific decision on a very specific case at a specific time.

● (1235)

The Supreme Court also said in paragraph 127 of the decision that it did not pronounce on things that were not before it in that case. That was a requirement for Parliament and also the bill, which, yes, does engage all Canadians in a discussion about what it is that we can have as a continuum of care that continues to the place where we help people on that final journey.

We come at it differently. I have full respect for the hon. member for Kitchener—Conestoga. He has engaged this subject well and I have taken into account the fact that he has passion. We have come at it differently, but I have no doubt that everyone on both sides of the House is concerned about the well-being of Canadians. However, I think the bill needs to go even further to be faithful to our Constitution.

I have concerns in that I think there could be further challenges to the bill in the courts, which I do not think Canadians should have to endure. I have a couple of very specific concerns that I would like to raise in the House and one is the use of the word "incurable".

The court was very clear that it did not want to use the word "incurable". Instead, it used the word "irremediable". By invoking the word "incurable", one begins to look at the disease instead of the person. What I mean by that is that sometimes a disease may be incurable or curable, but the person has the right, the Supreme Court said, not to undertake treatments that are not acceptable to that person. The treatments may be cruel or punishing and the reality is that the court said they do not need to undertake them. The disease may be curable, but that person has chosen a different path and that, under section 7, is their right. I have that concern about invoking that word.

The other concern I have is the introduction of the concept of foreseeable death or death in the foreseeable future. All of us live a precarious life. Life is fragile, life is precious, and life is dear, but for some life has become intolerable. Some diseases are not necessarily mortal in the sense that people are automatically going to their final days with that disease, but people still have pain that is intolerable. The Supreme Court decision in Carter says they have the right to medical assistance in dying.

The introduction of that concept of death in the foreseeable future has muddied the waters. Physicians are asking what it means. Does it mean "terminal"? Some hospitals have a different definition of "terminal" than other hospitals and other physicians have. We have to be very careful on that.

The third point I would make is about one of the safeguards. This is robust legislation. There are safeguards in place that I do not believe are of great concern. One safeguard worries me, and that is the final one in the third section on safeguards, proposed paragraph 241.2(3)(h), which says that immediately before the administration of those substances that will cause death, the person needs to, once again, declare competently that they want death to happen.

I have been in too many hospital rooms. I have sat with too many dying people. Most of the people who will access this kind of continuum of care are dying and will probably be receiving morphine. To take them off the morphine to ensure they have the capacity to give consent is cruel. The reality is that in a 15-day period, that person should be allowed to make a gracious exit and be given the compassion not to be once again required to become competent, because the morphine is helping them with their intolerable suffering. That they are suffering intolerably has already been declared.

With those exceptions, I am supportive of the bill. The justice committee has its work to do. I am looking forward to thorough deliberations. I have utter confidence in every member of that committee. I am looking forward to the bill returning to the House and going to the other place. I know that Canadians will have a law that helps them and makes Canada a richer and stronger country.

● (1240)

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Speaker, I want to thank my colleague for his work as co-chair of the committee and for the good working relationship that our committee had.

There is one concern I have, and this happened frequently during our committee hearings as well, I believe unintentionally, or perhaps intentionally. There is a conflation of two issues. One is physician-assisted dying or physician-assisted suicide, and the other is simply discontinuing medical treatment.

Patients have always had the right to refuse what my colleague refers to as punishing medical treatment that may prolong their lives. I wonder if my colleague would clarify that this was not his intent, and that, in fact, patients have always had the right to refuse medical treatment that would extend their lives unnecessarily or, as people say, "It's okay to pull the plug".

These are issues that we have dealt with for many years. That is not the issue that we are talking about today. I am concerned that this kind of language is creating some confusion on the part of people who may think we simply want to extend life at all costs with whatever medications are necessary, or with medical procedures that may go beyond what the patient requests.

Mr. Robert Oliphant: Mr. Speaker, indeed, I think the member for Kitchener—Conestoga has it right. There are a variety of ways that people die and there are people who have been very clear about having a "do not resuscitate" order or that no heroic measures be taken.

However, there also comes a time when certain people have reached the end and physicians are working with them. There is a covenant. There is a sacred covenant, I believe, between our physicians and patients that allow them to understand that the role of the physician is to end suffering. It is not necessarily to prolong life. There are certain times when the natural course of life is taking too long for people who are suffering.

There was a case in Quebec recently where someone did not meet the bar because their death was not in the foreseeable future. They had to actually starve themselves, stop taking food, stop taking water, for 53 days, until they were finally allowed to pass away, as people say these days. I think that is unfair, and the Supreme Court has ruled that unfair.

The reality is that the Supreme Court has said it both allows for physicians to assist people in dying and for people to take that upon themselves with physicians helping them. I am proud to live in a country that is that compassionate.

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Mr. Speaker, I want to thank my friend the member for Don Valley West and also my friend the member for Kitchener—Conestoga. I do not recall, in the five years that I have been in this place, a conversation or a debate that has taken place over an issue that is this difficult where there has been as much respect given one side to the other, one member to the other. We all recognize this is a deeply difficult issue. It is an ethical issue, it is an issue of rights, and it is also an issue of individual morality. It is a tough one, to put it mildly.

However, I am concerned about one part of this legislation that the hon. member for Don Valley West touched upon; that is, the notion of insisting that the person be capable of, once again, reasserting their decision to ask for physician-assisted death even after they have lost the capacity to have mental competence.

Again, on this question of an advance directive, this section of the legislation goes against the very essence of what the Supreme Court of Canada said we must do, which is to not put people in a position where they feel they must take their own life prematurely. They want to be able to trust the fact that they have made determinations for their end-of-life care.

I put that to my friend, the member for Don Valley West. Is that not, in a sense, asking the impossible, to ask someone who lacks mental competence to reaffirm a very clear decision that was made when they had mental competence?

Mr. Robert Oliphant: Mr. Speaker, I want to thank the hon. member for her passion and compassion, as well.

This is the largest issue that has been raised in my riding in the last several weeks. Along with the member for Don Valley East, we held a town hall with about 200 people; 90% of whom asked for some capacity for an advance directive. They are very afraid that they are going to have to have a premature death because they are so worried that if dementia, Alzheimer's, or other diseases take place that would rob them of capacity, they are going to have to do that early. They are very concerned about that.

I had another meeting this week, in Leaside, and again, that issue came up.

I think the reality is that this will be unfolding over time. I think it is very important to review this legislation. We are going to take time as a society. I believe it has to happen.

One member I need to acknowledge is the late Francine Lalonde from the Bloc Québécois who brought this up and I also forgot to—

● (1245)

The Assistant Deputy Speaker (Mr. Anthony Rota): Resuming debate. The hon. member for Oakville North—Burlington.

Ms. Pam Damoff (Oakville North—Burlington, Lib.): Mr. Speaker, I am grateful for the opportunity to rise today to speak about Bill C-14, medical assistance in dying.

Death is a word that elicits strong emotions. We celebrate life. We embrace life. We talk about living. However, we avoid talking about death. We shy away from those conversations because they make us uncomfortable.

It is my sincere hope that this legislation will open the door to conversations about end of life and palliative care, about dying with dignity, and death.

I first want to thank all Canadians who participated in consultations with their provinces and the federal government on this issue. I want to acknowledge the work of all members of the Special Joint Committee on Physician-Assisted Death, who reported to Parliament at the end of February, and in particular my colleague, the member for Don Valley West, as well as the Minister of Justice and the Minister of Health. I personally appreciate their sensitivity and thoughtful dialogue.

I listened to the Minister of Justice and the Minister of Health when they spoke in the House on this bill. I have complete confidence in them to steward us as we begin the legislative process on Bill C-14, as well as in conversations about death and dying.

This is an issue that we have struggled with for many years. I recall in the early 1990s when former MP Svend Robinson compassionately took Sue Rodriguez's hand as she unsuccessfully sought permission from the Supreme Court to end her life as her ALS progressed.

The reasons for the need for this legislation are clear. The Supreme Court, in the Carter decision, unanimously decided that Canadians suffering intolerably have the right to request assistance to end their suffering.

With this legislation, the government has attempted to reach a balance, but, of course, in doing so will not please all people. Are there areas where the legislation does not go far enough? In my opinion, the answer is yes. Those with dementia will remain without an important option for end of life.

When on a journey with a terminal illness, there remains many questions pertaining to this legislation. I have no doubt that there will be fulsome discussion at committee on the legislation. I have received correspondence from residents concerned about implementation of this legislation by the territories and provinces. I am pleased that there will be additional study. This is just the beginning of the conversation, as it should be.

I know there are those who feel that this legislation goes too far. For the most part, I believe these people are fundamentally opposed to the Carter decision. However, regardless of where people fall on this legislation, I think we can all agree that the way we deal with death needs improvement.

Whether a grievously ill patient chooses to die at home, in a palliative care facility, or chooses medical assistance in dying, we should be having these conversations sooner, and lovingly assisting them in their end of life. These are not decisions that should be made during a health crisis, which is often the case. Rather, each of us should be engaged in advance care planning.

I recall, shortly before my father passed away a few years ago, sitting in his hospital room as he battled pneumonia. My sister and I had to talk to him about his wishes should his heart stop. As members can tell, it was one of the most difficult conversations that we ever had. While it was painful and heartbreaking, it was also necessary.

While I recognize that this legislation is not the same as deciding on a do-not-resuscitate order, talking about death is difficult. Talking about the death of a loved one is incredibly difficult. However, because it is difficult does not mean we should not talk about it. In fact, I would say that because it is difficult is the very reason we should talk about it.

We do such a poor job of educating people about their choices for end of life. There are choices. We also do a really poor job of making available those choices for end of life. For those who wish to die at home, there are a lack of resources available to them. For those wishing palliative care, those options too are limited.

● (1250)

I believe the federal government needs to work with the provinces and territories to develop a better framework for end-of-life care. Our platform has included a much-needed $3 billion over four years for home care and palliative care.

Today marks the beginning of National Hospice Palliative Care Week. Shortly after I was elected, I had the opportunity to visit Carpenter Hospice in Burlington, one of the only palliative care options available in Oakville and Burlington for those in the last days and months of their lives. While I was there, we not only talked about the wonderful facility, but we talked about how we as a society need to have more open conversations about death.

I was deeply touched by Bonnie Tompkin's story. She is a community health coordinator at Carpenter Hospice, but her story is a very personal one. When her fiancé Ian was diagnosed with terminal cancer, he was adamant that he wanted medical assistance in dying. As is common, his biggest concern was the burden he would place on loved ones as his illness progressed. After he saw Carpenter Hospice and was educated on the options available to him, he made the choice to spend his last days at the hospice.

Carpenter Hospice is actively working with the City of Burlington on adopting a compassionate city charter. Widely implemented in the United Kingdom, citizens in compassionate communities are engaged, knowledgeable, and informed about death, dying, loss, and bereavement.

As our health and well-being extends beyond our health care system to our friends and loved ones, our connections to public spaces, and those in community, the thinking behind the compassionate city charter is that the community plays a similar role at the end of life. To quote from the compassionate city charter:

> Compassionate Cities are communities that recognize that all natural cycles of sickness and health, birth and death, and love and loss occur everyday within the orbits of its institutions and regular activities. A compassionate city is a community that recognizes that care for one another at times of crisis and loss is not simply a task solely for health and social services, but is everyone's responsibility.

Compassionate cities are supportive of diverse religious and cultural beliefs. I met with a couple in my riding who were concerned that this legislation would normalize suicide, but if we are building compassionate communities and talking about both life and death, then we can give people the tools they need, and options for life.

There was a time when we did not talk about cancer. That changed when a one-legged young man embarked on the cross-country Marathon of Hope on April 12, 1980, forcing us to acknowledge not only his cancer, but the fact that people with disabilities need not be hidden from view.

We are only now starting to have a conversation about mental health, another subject that until recently was only spoken about in hushed tones. In fact, today on Parliament Hill, there was a walk for mental health awareness.

Death is another taboo subject, and one we do not want to talk about. However, because we do not talk about it, we do a disservice to our friends and loved ones when the time comes to face their own mortality.

I recently had a conversation with one of my best friends about death and dying, about this legislation, what end-of-life care should be, and what is lacking. Her husband, my good friend, is living with a terminal illness, ALS. Another of my good friends is currently navigating his father's end-of-life journey. These conversations are very hard, but perhaps in having these conversations we will make it easier for all of us to have choices, dignified choices about how our lives will end.

Death will never be easy to talk about, nor should it be, but death needs to be as much a part of our conversation as is life. We need to talk about life options and death with dignity. The time is long overdue.

We should perhaps take a page from the compassionate city charter and acknowledge that how we deal with death, dying, loss, and bereavement should be shared with the entire community, in every city from coast to coast to coast.

● (1255)

Mr. Todd Doherty (Cariboo—Prince George, CPC): Mr. Speaker, I would like to thank the member for sharing her heartfelt feelings on this matter.

I am a new member of Parliament, and this is obviously a topic that is important to Canadians from coast to coast to coast. I wish we had more time to debate and discuss the topic.

The hon. member for Don Valley West referenced Quebec in his presentation. However, Quebec took six years to make its recommendations. Quebec took the time to meet with groups from all over, including families and those who were for and against. Again, I wish we had more time on this, but clearly we do not.

I met with a group of nursing students the other week. My son is going through sciences and wants to be a doctor. They all had the same question. This is something that through their chosen field they will ultimately be faced with, and it is a difficult decision. They go into this industry to help, protect, and make people better, yet at one point they are going to have to make the choice to administer this. The nursing students were flabbergasted that this responsibility could come down to them. The comments they had were, “I don't know if I can do that. I don't know if this is the right profession for me.”

What are we supposed to say to them? There should be more discussion about conscience protection in this. I understand all sides of the issue, and I have witnessed family members at end of life go through terrible areas. I have a special needs adult child, and I have concerns.

What are we supposed to say to the next generation of doctors and nurses, that we have not put safeguards in place through the bill before us?

Ms. Pam Damoff: Mr. Speaker, to be honest, I know that people struggle with how to do many things when going into the medical profession. Doctors and nurses have to struggle with care throughout their careers. There are options for referrals if people feel strongly about this, but I think it is something that will be part of the discussions with the provinces and associations that govern nurses and doctors. It is a very important conversation to have, but certainly those professions already deal with very difficult decisions every day.

We trust them. I believe it was the member for Don Valley West who said that we trust the medical profession with our lives, and we need to trust them with our deaths.

As I said, it is the start of the conversation, not the end of the conversation. I think that is also the conversation we would have with new people going into nursing or medicine.

Mr. Charlie Angus (Timmins—James Bay, NDP): Mr. Speaker, I listened with great interest to my hon. colleague, and I am hearing the word "compassion" a great deal, and "options". The problem is that most Canadians do not have those options because they do not have access to quality palliative care.

My colleague mentioned an election promise, but an election promise does not create it. This is done in the budget, and there were zero dollars for palliative care. This has to be spoken about in the House. Otherwise, everything else we are talking about is a fiction.

In areas of competence under federal jurisdiction, the word "compassion" strikes me because of section 12.1 of the non-insured health benefits for indigenous people. When they are being flown out to die, it says that under absolutely no circumstances will a loved one be allowed to travel with them. The federal government's rule for denying those from being with their loved ones who are dying is the word "compassion". It is written into the federal guidelines that for these families, for compassionate reasons, their loved one has to die alone.

However, we can change this in the House. This is an area under federal jurisdiction. Will the Liberals look at dealing with this now so that we can be credible on this larger topic of compassionate choice at end of life?

● (1300)

Ms. Pam Damoff: Mr. Speaker, I would like to thank the member for his passion on this issue. It is an important one. I know that he has done a lot of work with our Minister of Indigenous and Northern Affairs on this.

We do have to be more compassionate. Whether it is for our indigenous people or any people across the country, we need better options for palliative care.

To answer your question, that is why we need to start talking about it and to start investing and looking at how we can deliver.

The Assistant Deputy Speaker (Mr. Anthony Rota): I want to remind the hon. members that they do speak through the Speaker.

This a very difficult topic, and I just want to comment on the level of respect that is taking place in the House this morning. That is a tribute to all of the members who are here today.

Resuming debate, the hon. member for Louis-Saint-Laurent.

[*Translation*]

Mr. Gérard Deltell (Louis-Saint-Laurent, CPC): Mr. Speaker, as I rise today, I feel a sense of gravity and strong emotion. This is not the first time. Two years ago, when I was a member of the National Assembly of Quebec, I rose to debate the extremely sensitive subject of medical assistance in dying. At the provincial level, the debate was about end-of-life care.

This is therefore the second time that I have participated in the debate and the vote on this extremely delicate subject, and I intend to do so with diligence, careful consideration, and a great deal of compassion.

[*English*]

Usually when I rise I want to convince. That is the job of all politicians, to convince people. In this case, I do not want to convince; I just want to talk and to explain where I stand. Also, in political debate there is good and there is bad. In this case, no one is good and no one is bad; they are only honest Canadian citizens who want the best for the future of this country and the best for the future of our people, even if this debate is quite difficult and fragile.

Why are we here today?

[*Translation*]

We are here because a year ago, in February 2015, the Supreme Court made a ruling that had very serious and important consequences. It was the Carter decision that centred on medically assisted death.

The Supreme Court did not ask the House of Commons and Canada's Parliament to take a position for or against medically assisted death, but to develop a legal framework for it. That is the principle underlying this whole debate. We are not here to debate whether medically assisted death is good or bad. We are here to figure out how to give people access to it.

However, I have often said, and I want to repeat now from my seat in the House, that I find it very unfortunate that the Supreme Court gave the Parliament of Canada just under a year to take action. That is completely irresponsible. I know what I am talking about. I was a member of the Quebec National Assembly for almost seven years. I was there for the six years of detailed, painstaking work that led up to the passage of Bill 52. It took six years and three different governments with three different premiers: the Hon. Jean Charest, the Hon. Pauline Maurois, and the Hon. Philippe Couillard. We worked on it for six years. There were two full years of direct consultation, and over 275 Quebeckers shared their opinions on the subject. However, the Supreme Court ordered the Parliament of Canada to take action within one year.

Why do I find that irresponsible? Because the Supreme Court knew that it was an election year and that this is not a subject for partisan political discussion. Despite all that, the Supreme Court ordered us to come up with legislation in under a year. The court knew that, as of February, the countdown was on to the month of June and that everything would then come to a grinding halt because the election was called for the fall and a new government would be taking office. In theory, parliamentarians could do nothing until December or January, and that proved to be true. In short, we lost six months in which we could have been debating this extremely important issue.

However, all was not lost. The previous government, led by the right hon. member for Calgary Heritage, set up a committee of three experts, including a former Quebec minister, whom I salute. This committee assessed all of the legal and parliamentary options regarding this sensitive issue and produced a document over 400 pages long. I am very proud to know that this work was done, despite the fact that it was an election year. I will come back to that a little later in my speech.

The report was written, but there was an election, and the new government created a parliamentary committee that could be described as bilateral, since it was made up of MPs and senators. The committee was co-chaired by a Liberal MP and a Conservative senator. Basically, the foundation for non-partisanship was laid, so that was good.

Despite the fact that we had very little time to do our work, in fact barely five or six weeks, we had 13 meetings, we heard from 61 witnesses, and 132 briefs were submitted. That is great, considering the time we had. I want to commend all of my colleagues who are here. I see the House co-chair, as well as my colleague from Toronto. I apologize, but I do not know all the riding names by heart. The names are very long, and perhaps we should change that one day, but that is another matter altogether.

I want to commend all of my colleagues for working in such a positive, constructive, and non-partisan manner. It was an extremely delicate and difficult subject, but we took a serious and thorough look at it.

● (1305)

After all our work, two reports were produced: a main report and a dissenting report signed by the member for Langley—Aldergrove, the member for Kitchener—Conestoga, the member for St. Albert—Edmonton, and me.

Before I get into the substance of the dissenting report, which I signed, I want to point out that the Conservative MPs on the committee were the ones who signed it. However, it was not a Conservative dissenting report, since the Conservative senators did in fact sign the main report.

[*English*]

Let there be no mistake: in this case the dissenting report was not a Conservative dissenting report. It was a dissenting report from members of Parliament, because the Conservative senators signed the majority report.

It is very clear, and we have to be very careful with that. There was not a political agenda behind our dissenting report.

[*Translation*]

In the dissenting report, my three colleagues and I were driven by the need to protect the most vulnerable, but also by Carter and especially by what we referred to in our report as “the Quebec experience”.

I am proud to say that I witnessed the Quebec experience. Together, we applied that experience in the dissenting report and used it as a model in determining what should be done. We did that because in Quebec, we took our time to address this issue properly.

In Quebec, after six years of debate, work, intellectual rigour, and careful consideration, we came to certain conclusions. Bill 52 became law to ensure that everything is done properly with a certain social consensus.

[*English*]

It is very tough to have consensus on this difficult issue.

[*Translation*]

Our dissenting report outlined five concerns. I will read them, then go over them one by one.

First, we felt that end-of-life care should not be provided to minors. Second, we established that people suffering from mental illness should not have access to medical assistance in dying. Third, we raised the need to protect the conscience of doctors and health care professionals. Fourth, medical assistance in dying should be provided only to people at the end of their life. Lastly, we had some serious concern over palliative care. Those are the five concerns outlined in our dissenting report. Let us look at them one by one.

First, this should not apply to minors. This is a very sensitive topic. The Supreme Court was talking about adults, not minors. What is more, the Quebec experience applied only to adults. This otherwise creates almost insurmountable problems.

Imagine if the parents of a 16-year-old son or daughter refuse to allow their child to receive end-of-life care. What then? Who is right, the child or the parents?

[*English*]

In the worst case scenario, if a 17-year-old child asks for end of life care, which his father wants but not his mother, who is right? Do we try to convince the mother? That is so difficult, so touchy, so fragile.

That is why our dissenting report put aside minors, aided by the Quebec experience.

● (1310)

[*Translation*]

We do not want this bill on medical assistance in dying to apply to people with mental illness because it is almost impossible to determine at what point they are capable of giving informed consent. People with mental illness are unaware of what is happening. I know that it is terrible to say such things, but it is the truth.

[*English*]

This is the truth. For those who suffer from mental illness, it is very tough and difficult for them to be very clear on what they want to do. If we were to put them in that kind of situation, we would see the worst. Again, based on the Quebec experience, we put it aside.

[*Translation*]

Let us now discuss conscience protections for physicians and health care practitioners. This is a delicate but very important subject. Quebec came up with a rather unique solution, and one that the government should use as a model.

We must respect the patient who, in his heart and soul, wants to receive end-of-life care. However, we must also respect the physician who must provide this care. If the physician does not want to proceed, we must respect that. This is Quebec's solution: the physician who does not want to provide this care must refer his patient to a third party, namely, the administrator of the hospital or CLSC, and this third party will refer the patient to another physician. Thus, a physician does not refer his patient to another physician because a third party is involved. Consequently, a physician who is uncomfortable dealing with this situation does not find himself referring his patient to another physician. This decision must be respected. This is a detail, but it is all about the details in this bill and the entire medical assistance in dying situation. We must have conscience protections.

Once again, based on the Quebec experience, we believe that the same is true with respect to the end of life. At what point can patients give their consent to medical assistance in dying?

Quebec, after examining this issue for six years, concluded that patients were able to give consent at the end of their life and not before. It is quite easy for a guy like me, who is 51 years old, in good shape, and feeling well, to say that if I ever get sick, no problem, the doctors will come and that will be it. It is easy for me to say that at the age of 51, when I am in good health. However, will I feel the same way when I am at the very end of my life? Not necessarily, which is why we need protections in this area. Once again, there are five concerns based on the Quebec experience. The fourth one has to do with the fact that Quebec makes it clear that only patients who are receiving end-of-life care may receive this type of medical assistance.

The last concern is palliative care. My colleague from the second opposition party spoke about this earlier. We believe it is extremely important to have full, comprehensive palliative care for all Canadians, and not just for one-third of Canadians, as is the case now. We really need to focus on this.

There was the main report, the dissenting report, and the five concerns I mentioned, which were based on safeguards for the most vulnerable, the Carter decision, and the Quebec experience. After we presented our report, it was up to the government to proceed and introduce its bill.

[*English*]

Therefore, what we have now is Bill C-14. What we like in the bill is what it does not have. That is funny to say, but it is true, because the bill put aside some of the most touchy subjects that we put in our dissenting report.

[*Translation*]

In our dissenting report, we did not want medical assistance in dying to be available to minors or people suffering from mental illness. The government embraced our position, which is good. We thank it for that. Congratulations.

However, we still have some other concerns regarding this bill, particularly when it comes to conscience protection. This bill contains no provisions regarding the protection of conscience for doctors and other medical practitioners, including nurses and pharmacists, in the context of medical assistance in dying.

I asked the Minister of Health about this during the debate two weeks ago. She said that it was not mentioned because it falls within provincial jurisdiction. Technically, that is true, but we are in a federal Parliament. The bill's own preamble clearly states that the law must adapt and apply consistently all across Canada. We need to have a national policy in order to avoid fluctuations from province to province. Once again, I urge the government to learn from the Quebec experience, which allows for the protection of conscience for doctors.

What will happen if that protection is not ensured? It will be left up to the provinces to decide whether they want to provide, or not, a framework for this in a particular way. I understand the goodwill of the Minister of Health, but there is such a thing as too much vagueness. In this situation, we are not talking about deciding between an apple and an orange; we are talking about deciding whether to live or die. Vagueness is unacceptable in this situation. We need to provide clear guidelines, particularly regarding conscience protection, because there is nothing that is more fragile and more precious than the conscience of someone who is there to save lives or end lives, depending on the patient's wishes.

I invite the government to take a closer look at the Quebec experience and really take note of that experience, as well as what we have said.

● (1315)

As I mentioned earlier, in Quebec it is clear that this type of care is provided at the end of life. In the legislation we find the concept of “reasonably foreseeable”. I have to read that because I have been asked about this a number of times and I always have a hard time because it is a bit vague.

I can assure the House of one thing: I am going to die. That is foreseeable. There is no doubt. I am 51 and I think I have done more than I have left to do. Reasonably, I could die in a few decades. I am in no hurry, by the way.

What I am trying to say is that “reasonably foreseeable” is not clear. The first question I was asked in an interview on RDI by Julie Drolet, a former colleague whom I salute, was whether I really understand this “reasonably foreseeable”. Well, the answer is no, not really. That being said, I am not the one who drafted the legislation. Perhaps we need to ask the minister that question.

All that to say that this needs to be clear, as does “conscience protection”. The same goes for end-of-life and what is reasonably foreseeable. It is much too vague.

During an interview last weekend on Radio-Canada's political television show, *Les coulisses du pouvoir*, Quebec's health minister, Dr. Gaétan Barrette, said there could certainly be a debate about the legality of this bill with respect to the notion of reasonably foreseeable death. He added that it should be reasonably foreseeable regardless of the prognosis on the progression of the disease. After all, if death is reasonably foreseeable, that means a prognosis has been reasonably established.

In situations like that, there is no clear answer. I would ask the government reasonably, no pun intended, to clarify its thinking on this.

There is a similar issue with regard to nurses and doctors. They say that nurses can provide the care. I want to be very clear. I have tremendous respect for nurses. Based on my experience in Quebec, they are the ones who keep the health system going, and I thank them for that. However, we think that a diagnosis of this importance needs to come from a doctor. People might think I am saying the same thing over and over again, but that is the conclusion drawn from the Quebec experience after six years of thorough, serious work.

With respect to palliative care, we all agree that more money should go to that. I would like to point out that the latest budget allocated no money to palliative care, even though that is an extremely important and sensitive subject. In a press conference, the Leader of the Government in the House of Commons talked about allocating $3 billion. That is very nice, but we would like to see that in the budget. The government can be sure we would support that enthusiastically.

[*English*]

Nothing is perfect, especially this bill, but we should be very concerned about that. We should be very concerned, because if we do not adopt a law, good or bad, we will have to deal with the Carter decision. For some people, it will be the worst-case scenario, because in that case, the medical professional associations in some provinces will say one thing and the associations in other provinces will say another thing; some provincial legislatures will adopt certain bills and other legislatures will adopt other bills. There will be a lot of movement in Canada in that case and the last thing we want is movement. We need a clear bill on those issues.

[*Translation*]

I want to say that this is obviously a very emotional debate. Everyone who speaks to this issue will be right. They have the right to do so and we hope they will. No one here is wrong, no one here is right. We are all honest Canadians and we want to do what is best for the future of this country and for the future of Canadians.

● (1320)

Mr. Anthony Housefather (Mount Royal, Lib.): Mr. Speaker, I would like to thank my hon. colleague for his very wise words.

I imagine that as one of the MPs who wrote the dissenting report, he must be generally pleased. In drafting the bill, the government really took a look at the dissenting report.

I would like to ask a question about conscience. We all agree that we must protect the freedom of conscience of medical practitioners and nurse practitioners, but this has to do with criminal law. There is a criminal prohibition, and now there is an exemption from the criminal prohibition.

Where in the bill will we include protection for a nurse's or medical practitioner's freedom of conscience? I understand that it is a good thing to have a bill that will cover all Canadians and that there will be consistency across Canada. However, as you know and as you said in your speech, this comes under provincial jurisdiction.

Do you have other examples? As committee chair, I am interested in this because I want to determine whether we can accept an amendment on this issue or whether such protections already exist in the Criminal Code.

The Assistant Deputy Speaker (Mr. Anthony Rota): Before the member answers the question, I would like to remind members that it is important that they address their comments to the Chair and not directly to other members.

Mr. Gérard Deltell: I will answer my distinguished colleague's question through you, Mr. Speaker. He is a lawyer so he knows what he is talking about when he says that this is a legal issue.

This issue falls under provincial jurisdiction. However, it is such an important one that we need to ensure that we have a consistent approach across the provinces.

If doctors' conscience is not protected in the legislation, some medical associations might challenge it, which will lead to variations from province to province. That will result in delays and the rise of health tourism, a term that horrifies me. For example, dissatisfied people in Alberta may go to Quebec, and dissatisfied people in Quebec may go to Newfoundland.

That could very well happen in this case. As the member so clearly stated, we are all gathered here because this issue relates to the Criminal Code. This issue sits at the very precarious junction where the Criminal Code meets health care delivery, an area of provincial jurisdiction.

I find it hard to imagine that one of the provinces would challenge this sort of law because this issue falls under its own jurisdiction. In the unlikely event that one of the provincial health ministers dared to do so, he would have to face the wrath of the people he represents.

Mr. Robert Aubin (Trois-Rivières, NDP): Mr. Speaker, I thank my colleague from Louis-Saint-Laurent for his wonderful speech. I was listening carefully. He rightly brought up his own experience with the debate held in Quebec, and I think this experience is very important.

In Quebec, legislators realized that this law had to respect Quebec's own areas of jurisdiction, so they quickly started talking about end-of-life care, to ensure that the debate remained focused on health care.

Will the decision that we are making in Ottawa prevent unintended consequences that may not even have been considered in Quebec? For example, people are starving themselves to get access to end-of-life care.

By getting the legislation right in Ottawa, we can ensure that this legislation enables people who have serious medical concerns to make this decision. It always comes back to the issue of a reasonably foreseeable natural death. I agree with my colleague that this concept is rather vague. However, we do not want to have people starve themselves to access a service to which they are entitled.

Mr. Gérard Deltell: Mr. Speaker, unfortunately, no legislation could have prevented that type of situation. We have to realize that.

There is not much we can do about people who are in utter despair. It would be nice to pass legislation asking them not to starve themselves in order to access this care. That goes without saying, but it will not stop those who are in the darkest days of their lives and feeling so vulnerable that they would go to such lengths. Should we pass such legislation? It is too hard.

It is on all of us as parliamentarians. We have certain responsibilities, but we must also work within certain boundaries, including our conscience, which is part of being human. That is why we must protect the most vulnerable among us. That is why this will not apply to minors and especially not to those suffering from mental illness. Those people are far too fragile.

If I said that this could prevent unintended consequences, I would be lying, unfortunately, because we cannot control human nature. We can try to limit them, but preventing them completely is wishful thinking.

● (1325)

[*English*]

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, I want to follow up on the question from the member for Mount Royal about jurisdiction and conscience, because it is a very important question. In fact, the Carter decision recognizes health care as a joint area of jurisdiction, so it is very clear that there is involvement of the federal jurisdiction. Also, it is important to acknowledge the parallels to the same-sex marriage debate and what the then Liberal government did in the Civil Marriage Act with respect to protecting the conscience of religious officials who did not want to perform same-sex marriages. It was important at the time, as part of that debate, to ensure that nobody would be forced to perform that union, a religious official who did not want to. It was put in that legislation, even though the solemnization of marriage is done at the provincial level.

We see a clear parallel, and if it was doable then by a Liberal government, there is no reason not to include conscience protection in this legislation as well. Very similar language could in fact be used in the development of the amendment. That is important. It is something worth considering when we have a major social change like this. Some people will want to be part of that change, but others will not want to be part of that change, and we should respect those who do not want to be part of that change.

I wonder if the member sees a parallel between these two debates and would support including a similar provision in this law, as the previous Liberal government did in the Civil Marriage Act.

[*Translation*]

Mr. Gérard Deltell: Mr. Speaker, I will speak to what I know. I am very familiar with the issue of medial assistance in dying and end-of-life care, as I took part in drafting the two applicable statutes. I can say that in extremely sensitive and fragile cases, we have to respect the doctor. I personally received calls from Quebec doctors about this. They told me that they were there to save lives and what they were being asked to do goes against their long-held beliefs. They agreed to do it, but we have to realize that doctors are ultimately there to save lives.

[*English*]

Mr. Lloyd Longfield (Guelph, Lib.): Mr. Speaker, the hon. member has an excellent approach to the subject. It is definitely something very personal for each of us. I know myself, with my mother's passing, we had some very difficult conversations at that time.

This goes beyond what we do in the House here. However, one of our responsibilities is to provide guidelines for the conversations.

Let us look at the role the provinces play in this conversation. I was personally struggling with recommendation 11 from the committee, as a member of a Catholic community within my riding and having a lot of Catholics reporting to me that they were very concerned about Catholic institutions being mandated to perform services against their conscience.

The current legislation is leaving some very important details up to regulations with the provinces and those who are reporting to the provinces. We have a tight timeline. We have to provide some guidelines that may be seen by some as not restrictive enough and by others as too restrictive.

Could the hon. member comment on the need to have some flexibility in terms of getting this to the provinces for further discussion?

Mr. Gérard Deltell: Mr. Speaker, based on the Quebec experience, we have to have conversations with each other. We need to have good conversations with the provinces. We had that in Quebec.

The member talked about his personal experience, as did his colleague a few minutes ago. I want to say that everyone has the right to act on behalf of their own conscience.

In Quebec, I voted for the law. I voted for the bill. However, 22 members of the National Assembly voted against it, all members of the Liberal Party, the governing party. Among them, 11 cabinet ministers, nearly half of the cabinet ministers, voted against that bill.

I do not want to interfere with everyone.

● (1330)

[*Translation*]

However, every member has to know that he or she is entitled to vote their conscience and that every vote is important, every vote is good because it is the vote of each individual member.

Ms. Julie Dabrusin (Toronto—Danforth, Lib.): Mr. Speaker, I rise today to speak to Bill C-14 regarding medical assistance in dying. This is not the first time I have had the honour to participate in the discussion of this matter as a member of Parliament. I also was a member of the Special Joint Committee on Physician Assisted Dying. As a member of that committee, I was able to hear the thoughts of many people, both in my riding of Toronto-Danforth and across the country, on this very important issue that affects us all, and that is our end-of-life care.

[*English*]

My preference would have been for a bill that would have allowed for a broader scope of application. However, I support this legislation because it is a first step in the right direction, and it was a commitment to study the important issues of age, mental health, and advance directives, as will become apparent as I speak further. We need to take this first step, because this file has been left to languish for too long. My step would have been a bit bigger, but I am ready to start here on this path of incremental change.

Mr. Speaker, I intend to share my time with the member for Hamilton West—Ancaster—Dundas.

[*Translation*]

To date, we have struggled with the question of whether to allow, or not, medical assistance in dying. However, now we are faced with a different question, specifically, how we are going to legislate that assistance. This is an important change for us to consider, because following the Supreme Court of Canada decision in Carter, medical assistance in dying will be legal as of June 6. This bill is important because it gives us the opportunity to create a federal framework to govern medical assistance in dying.

[*English*]

In 1983, the Law Reform Commission of Canada reported on “Euthanasia, Aiding Suicide and Cessation of Treatment”. It found three basic principles reflected in our law, and I find that these principles set a good basis for our debate. The first is that the protection of human life is a fundamental value. The second is that patients have the right to autonomy and self-determination in making decisions about their medical care. The third is that human life needs to be considered from a quantitative and qualitative perspective.

I find it particularly instructive that the second principle creates a basis for a patient-centred approach to medical assistance in dying. This was the approach adopted by the Special Joint Committee on Physician-Assisted Dying on which I served.

Looking at the history of this issue, I have traced a long path of private members' bills, Senate bills, and private motions in the House. The issue has been before us approximately 11 times since 1991. The list of past attempts on this issue is incredible and demonstrates that efforts that have been made to grapple, unsuccessfully, with this issue have continued for too long. It is why I find it so important for the House to cross over this impasse and to take the first step toward legislating a framework.

The issue has not only been before us here. The other place has also considered the matter in committees, subcommittees, and bills. Just over 20 years ago, the Special Senate Committee on Euthanasia and Assisted Suicide released its report “Of Life and Death”.

[*Translation*]

The goal of that committee was to set the stage for the national debate that would take place in the years to come. The majority of senators on the committee were not ready to support medical assistance in dying. The minority on that committee made some recommendations to support medical assistance in dying for an individual who was competent and suffering from an irreversible illness that had reached an intolerable stage, as certified by medical practitioners.

[*English*]

Over the weekend, I finished reading the Hon. Steven Fletcher's book, *Master of My Fate*, which outlines his experience as a parliamentarian, generally, but focuses upon private members' bills that he brought on the issue of medical assistance in dying. The book brought special insight into his journey on this question. He shared his story of the massive accident that rendered him quadriplegic and his election to the House, including the time he served as a cabinet minister.

Our most recent initiative in the House on the issue of medical assistance in dying was two connected private members' bills put forth by the Hon. Mr. Fletcher. The first, Bill C-581, proposed to amend the Criminal Code to permit a doctor to assist a person in taking his or her own life. The eligibility criteria proposed in the bill would track the language in Carter very closely. I will read the most salient eligibility criterion for the sake of the House:

> ...a person must...have been diagnosed by a physician as having an illness, a disease or a disability (including disability arising from traumatic injury) that causes physical or psychological suffering that is intolerable to that person and that cannot be alleviated by any medical treatment acceptable to that person, or the person must be in a state of weakening capacities with no chance of improvement...

His other initiative, Bill C-582, proposed to establish a Canadian commission on physician-assisted death, which would have collected data from physicians who performed physician-assisted death. It recognized the possibility for incremental steps.

The bills were read a first time and left to languish on the Order Paper. However, on December 2, 2014, similar legislation was introduced in the other place and was debated on seven occasions, as late as June 2, 2015.

As we all know, during that time frame of December 2, 2014, to June 2, 2015, the Carter decision was released.

● (1335)

[*Translation*]

It is also worth noting that there have been active discussions in our provinces and territories about a framework for medical assistance in dying. The most notable example is Quebec, which struck a committee in 2009 to develop legislation on medical assistance in dying. The legislation came into effect in December of 2015. Much has been said regarding that law, and I will not repeat it, but it is notable that they too have a terminality provision.

I found it interesting that in testimony before our committee, Jean-Pierre Ménard of the Barreau du Québec stated that he believed the terminality clause of the Quebec legislation would have to be removed in light of the Carter decision. It underscores the point that such legislation will develop through incremental changes.

Working on the joint committee was an amazing experience. It was the first special joint committee in 20 years, and I see a strong value to this form of collaboration on major issues. The witness testimony and the thoughtful written submissions gave us a strong base upon which to form our recommendations. I stand behind the recommendations that we made. We did not come to our decisions easily. We lost sleep, debated a lot, and worked together to formulate our recommendations.

[*English*]

How then does my background on this file inform my views of the legislation we are debating today? I would have preferred that it be broader. Most of what I have heard from my own constituents favours a broader approach. However, the bill is the first step into a complicated matter.

We need to empower individuals to choose how to manage the end of their lives and give value to the law reform commission's idea of a patient-centred approach. Also, we need to consider not only the quantity of life but the quality. We need to respect people's autonomy and their right to be free from suffering, without putting vulnerable Canadians at risk. Bill C-14 gets us much closer to that goal than we currently find ourselves.

I would have preferred that we remove the clause of a reasonable and natural death, which refers to the foreseeability of a natural death. It is a terminality clause of sorts. The clause is vague and could place an overly broad restriction on a sick person's right to be free from pain and suffering. The concern about this terminology is that it tends to devalue the lives of the oldest among us. They are the most likely to be given permission to seek medical assistance in death with the legislation.

The young and sick suffer as much as the elderly. To quote Steven Fletcher “If the person is a cognitive adult, why on earth would we impose our views on what their quality of life is on them?”

The lack of advance directives in the legislation is also too restrictive. A fundamental point of the Carter decision was that the Supreme Court of Canada had found a violation of “Life, Liberty, and Security of the Person” if individuals would feel they would have to cut their lives short because they did not have an expectation that they could end it later when the time would come. It is a tricky issue, but I am happy to see a commitment to study the issue further.

In my opinion, the positives of the bill outnumber the negatives, so I will be supporting the bill. However, I do see it as a first step on the journey.

● (1340)

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Speaker, I want to thank my colleague for her service on the joint parliamentary committee that studied physician-assisted dying.

My colleague referred many times to my former colleague, Steven Fletcher, who appeared before the committee. I have had many conversations with him, and I understand his position. However, my concern is that, had Mr. Fletcher had access to physician-assisted suicide years ago, when his accident first occurred, he very well may have followed through. That would have been a huge loss for Canada and for his family.

My concern is that when we implement these kinds of decisions, there is always the risk of one person inadvertently terminating his or her life, which would be a huge loss. We no longer practise capital punishment in Canada. One of the reasons is that it is too great a risk that one innocent person might die.

How would my colleague ensure that someone like Mr. Fletcher, who in a time of deep depression and deep physical suffering, may have taken the choice that would have hurt him and all of Canada because of the loss of his life and his contribution to our country?

Ms. Julie Dabrusin: Mr. Speaker, I would rather not speak about an individual specifically when I respond to my friend, because I cannot predict what his decisions may or may not have been if this legislation had been in place.

To speak more generally, I understand the point the member is raising. It was a question that was a concern to me and the committee as well when we examined the issue of a person who suffered a traumatic injury and was faced with a change of circumstances. How would that person handle these types of decisions? We did hear evidence before the committee on this issue, especially from Professor Jocelyn Downie, which stands out in my mind.

When we talk about irremediable as part of the determination and the assessment of competence, a person right after a traumatic injury may not, in a medical opinion, be found to be in an irremediable state and able to make the competence test because he or she would be in a state of flux at that moment.

We need to look at that further. That is just something we heard in our evidence. It was one position. That is why I am so happy we are committed to looking at the issues and discussing them further, because it is an important question.

Mr. Charlie Angus (Timmins—James Bay, NDP): Mr. Speaker, this issue affects all of us and we respect the very personal views that are brought forward.

What concerns me in the legislation that has been put before us is that we are not talking about an overall balance in end-of-life choices. We are talking about the very specific responses to the Carter decision. Eighty per cent of Canadians do not have access to quality palliative care. Therefore, 80% of Canadians facing end of life and their families do not have choices about good quality end-of-life care. In this vacuum, there must be a commitment by the federal government, but we have not seen that. We saw zero dollars in the budget for palliative care.

The New Democrats have Motion No. 46 before the House about moving forward not only on a palliative care strategy, but also taking responsibility for areas under federal jurisdiction. The federal government plays a huge role in the delivery of health services and it denies palliative care services often. There are also issues of changing EI provisions to help families.

Where is the government's commitment to the larger discussion on end of life in which Canadians need to be engaged?

Ms. Julie Dabrusin: Mr. Speaker, palliative care is an important part of the discussion about end-of-life care. There is no question that it has come up several times in this place and it is important.

I am a little wary of throwing around percentages and numbers. At committee, we heard a lot of different percentages. Perhaps it is that we do not have a fulsome understanding at this moment about what access to palliative care truly is. This needs further examination as well. On the numbers, I am a little concerned about percentages.

From what we heard and read at committee, the jurisdictions that have introduced medical assistance in dying have increased their access to palliative care at the same time as quality of that care.

● (1345)

Ms. Filomena Tassi (Hamilton West—Ancaster—Dundas, Lib.): Mr. Speaker, I am honoured to rise in the House today to address Bill C-14. This bill is a response to the Supreme Court of Canada's unanimous ruling in the case of Carter v. Canada. The Supreme Court mandated that the Government of Canada create a framework for the provision of medical assistance in dying within a year of the ruling. That time lapsed on February 6, 2016, and an extension was granted until June 6, 2016.

The Supreme Court gave our government a short time in which to study this challenging and historic issue. I have listened to constituents who have argued passionately on both sides of this debate. I have struggled with the moral and ethical implications of this legislation. I understand that this is an emotionally charged and challenging topic.

Civilized societies have always recognized the sanctity of life. Countries around the world have legislated against the taking of another person's life. Historically, the taking of life has been considered to be the worst of crimes. The issue of medical assistance in dying poses a complex challenge to all Canadians because it brings together several different and difficult issues. There are questions of charter rights and personal freedoms. There are questions of protecting the vulnerable and responding to those who are enduring intolerable pain. There are theological, moral, and ethical considerations.

As well, this issue is an emotional one, fraught with the feelings of those who take strong positions on either side of the debate, and leavened by the feelings of those people who are experiencing such grievous suffering that they no longer wish to continue living.

Another element is purely economic, whether it is the pressures of inheritance or financial instability or the overwhelming cost of health care during the end of life. While we do not like to cite these utilitarian perspectives, their existence cannot be denied.

As well, this debate touches upon one's vision of a just society, whether one feels that ultimate justice involves complete choice or whether one feels that justice is best served by sometimes limiting the avenues available to a person so as to keep open the possibility of a happier tomorrow, a more desirable future, one that can be looked forward to rather than dreaded. I feel that this legislation finds a balance between these two perspectives, allowing choice to those who wish to end their grievous suffering and are already far along the path to dying and protecting those who may be vulnerable.

The ruling in Carter v. Canada was expressly limited to a competent adult person who clearly consents to the termination of his or her life. Furthermore, the Supreme Court of Canada did not find that there was a right to medical assistance in dying for minors or persons with psychiatric disorders. I was greatly relieved that these provisions were not included in this legislation.

To ensure that the path to the end is as fair and secure as possible, it is imperative that we accompany any legislation for medical assistance with enhanced support for palliative care. All parliamentarians have stories to share with respect to their engagement with people. We have interactions that have a profound impact upon us and never leave us.

On the campaign trail, I had the opportunity to visit a number of long-term care facilities. On one of these occasions, after the candidates gave speeches, there was an opportunity to mingle. I approached a man, who handed me a piece of paper. It was a petition for more personal support workers. He had tears in his eyes as he asked me to sign the petition. I sat with him and he explained his situation. He was there caring for his wife, who was beside him in a wheelchair. She had endured a serious stroke. This man was not advocating for his wife, as he was there every waking hour to take care of her, but he was advocating for others whom he witnessed daily not getting the care they needed. This was just not fair, not right, and clearly not just.

We have serious work to do in palliative care, which is connected to home care. Our government has pledged $3 billion to home care, and I am strongly encouraged by the health minister's commitment to see that high-quality home care is accessible to all Canadians. I look forward to engaging my colleagues in these debates and fighting for greatly enhanced palliative care for Canadians.

I have spent the last 20 years working with youth as a chaplain in high schools in Hamilton and Ancaster, Ontario. During this time, I have walked with thousands of students as they have negotiated the difficult terrain of adolescence and early adulthood. Their struggles are real, and the burdens they carry through family difficulty, personal struggles with identity, emotional pain, loneliness, rejection, or alienation are all real.

● (1350)

Young people face a complex and often overwhelming world in their physical neighbourhoods, in the relationships they inhabit, and in the virtual worlds in which they are thrown head first, often not ready. One only has to look at the terrible cases of online bullying that have removed the joy from the lives of young people and replaced it with sadness, depression, and in some cases suicide. I believe in our youth. I have spent my life believing for them and in them when they have sometimes stopped believing in themselves. I have made it my life's work. Amazingly, although their worlds sometimes sombred into darkest night and they feared that any light might have been extinguished forever, together we found a glimmer, a flicker that with love, inclusion, acceptance, and safety grew into a flame and then a roaring fire, not only of hope but of a desire to change the world, to bring healing to others who suffer and are rejected. These same teenagers have now stepped up and become leaders with a conviction to change the world. If assisted dying had been available to them when they were in the depths of their depression, they might not be with us today.

I am pleased that this legislation does not include mature minors, and I call for a renewed focus on creating a better, happier, more secure, and stabler world for our young people, online and in the physical world.

I have debated the morality of the question of medical assistance in dying. There are many who believe that in good conscience they cannot support assisted dying. For those who feel this way, I wish to address the issue of conscience.

People often equate conscience with values and beliefs. While conscience most certainly includes these, it also is much more complex. Conscience is at the very core of who we are as people. Conscience deals with reality. It appreciates the facts that are before us. The facts here are that the Supreme Court of Canada has ruled that medical assistance in dying is a charter right. We are not faced with the question of whether we allow medical assistance in dying; rather, we are faced with the question of in what conditions we will allow medical assistance in dying.

In my view, the bill before us is narrow in scope and respects the charter as interpreted in Carter v. Canada. Bill C-14 fulfills the legislative mandate delivered by the Supreme Court in a way that meets the charter but attempts to protect the vulnerable and the powerless. Although we can never fully protect the vulnerable, we can do our best. This is what Bill C-14 does.

Finally, I wish to affirm my support for respecting the personal values and beliefs of doctors and nurses and the mission statements upon which some institutions were created.

As the Minister of Justice has said, and I quote:

> To this end, as I have already mentioned, my colleague, the Minister of Health, will be working with her counterparts to bring forward a coordinated system for linking patients to willing providers.

As is outlined in the government preamble to this bill, the Government of Canada has committed to developing non-legislative measures that will “respect the personal convictions of health care providers”. As the Minister of Health has indicated, “Practitioners will have the right to choose as their conscience dictates”.

I will continue to fight for the protection of the rights of morally objecting physicians and institutions while ensuring access for patients to their charter rights.

In light of all of these arguments, I stand in this House today in support of this fair and thoughtful legislation.

[*Translation*]

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, this bill makes it possible for a person to ask a doctor for help committing suicide. If the doctor refuses because the person does not meet the criteria, that person can go to plenty of other doctors to get help.

Does the member agree that we need some rules around that practice of going from doctor to doctor?

● (1355)

[*English*]

Ms. Filomena Tassi: Mr. Speaker, as I have indicated, I will always respect the conscience rights of doctors. As the Minister of Health and the Minister of Justice have both confirmed, what we are speaking about here is the issue of accessibility. It has been made clear in this legislation and in the comments of both ministers that accessibility is an important issue. We will ensure that our consultations with provincial and territorial partners will provide accessibility that will be open to all Canadians who wish to pursue medical assistance in dying.

In Canada, we have approximately 77,000 physicians and more than 360,000 registered nurses. For me, it is not going to be a matter of having to go from physician to physician. I think that, with the brilliant work of our Minister of Health, accessibility will be available to people, and there is no question of conscience rights becoming an issue because of the accessibility point.

[*Translation*]

Mr. Pierre-Luc Dusseault (Sherbrooke, NDP): Mr. Speaker, I would like to thank my colleague for her speech.

I was wondering whether, like her colleague, she thinks that the bill does not go far enough. Does she have concerns about compliance with the Supreme Court decision that this bill responds to? Does she think that the bill goes far enough? Does she share the same concerns as her colleague who spoke earlier? Perhaps the bill is not enough. Perhaps it is too limited in scope. Perhaps it does not fully comply with the Supreme Court's decision.

[*English*]

Ms. Filomena Tassi: Mr. Speaker, as I made clear in my speech, I think that this bill does go far enough with respect to the Carter v. Canada decision.

I expressed concern with respect to one area, which is minors and psychiatric care, and I am glad to see that the legislation does not include minors and psychiatric disorders. This stems from my work with youth.

I have worked with youth over the past 20 years, and I have seen them struggle through very difficult times. I have been with them in their darkest days. I have taken those same youth to the Dominican Republic on mission trips, and I have seen how the experience of working with the poor has turned their lives around.

My focus would be on ensuring that youth receive the support they want and that those who are at the end of their life, through palliative care, also receive the support they need and deserve.

Mr. Anthony Housefather (Mount Royal, Lib.): Mr. Speaker, I want to congratulate my colleague from Hamilton West—Ancaster—Dundas on her excellent speech. I very much appreciate the conversations I have had with her on this subject, and I appreciate what I have learned from her in her experience with working with teenagers.

With respect to conscience rights, there have been a lot of comments already from the other side that conscience rights should be included in this bill and that we should find a way to include them in the Criminal Code. What is the member's position on that?

Ms. Filomena Tassi: Mr. Speaker, as I have indicated, I believe that the conscience rights of physicians and practitioners will be protected, and that is based on the assurances we have been given by both the Minister of Justice and the Minister of Health.

The other issue I would like to raise with respect to that is that I am cautious of introducing into legislation any restrictions or precedence with respect to conscience rights, because I think that would set a very dangerous precedent.

STATEMENTS BY MEMBERS

[*English*]

GAETANO GAGLIANO

Mr. Francesco Sorbara (Vaughan—Woodbridge, Lib.): Mr. Speaker, I rise today to recognize the life and legacy of a great Canadian, Mr. Gaetano Gagliano.

Mr. Gagliano was an entrepreneur, a visionary, and a person of deep faith. His story is one of 70 years of marriage to Giuseppina, resulting in 10 children and 51 grandchildren and great-grandchildren. He uniquely was a member of the Order of Canada in his adopted country and received the highest honour as a citizen of his birth country of Italy.

After World War II, a young Gaetano emigrated from Italy. He set up shop in the basement of his rented home in 1956 where he founded a printing shop named after Canada's patron saint. Today, St. Joseph Communications is Canada's largest private communications company.

Gaetano, at the remarkable age of 86, founded Salt and Light media and TV, Canada's first Catholic television network, now supported by Pope Francis.

Gaetano lived his entire life with God squarely in the centre of it and was an example to many.

* * *

● (1400)

MULTIPLE SCLEROSIS

Mr. Jamie Schmale (Haliburton—Kawartha Lakes—Brock, CPC): Mr. Speaker, as many of us know, walks were held in communities across Canada yesterday to bring awareness to and raise funds for the fight against multiple sclerosis.

I had an opportunity to attend the MS walk in my home of Lindsay, where over $10,000 was raised.

I would like to congratulate the volunteers and participants not just in my riding but across this great country, including Rheanon Antoniak from Fenelon Falls. This brave woman not only suffers from MS, but she also has been the honorary chair and top fundraiser for three years in a row at the Lindsay walk.

According to the MS Society, approximately 100,000 Canadians, mostly ages 15 to 40, suffer from MS. MS unfortunately is known as Canada's disease. We have the highest rate of people suffering in the world.

I can personally attest to the effect this disease can have on families. My mother passed away in 2013 after a decade of battling a progressive form of MS.

Sadly, there is currently no cure for MS, but each day, researchers are learning more about what causes this terrible disease and—

The Assistant Deputy Speaker (Mr. Anthony Rota): The hon. member for Mission—Matsqui—Fraser Canyon.

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ABBOTSFORD SPORTS HALL OF FAME

Mr. Jati Sidhu (Mission—Matsqui—Fraser Canyon, Lib.): Mr. Speaker, I rise in the House today to congratulate Dean Arsene and Courtney Inman for their induction into the Abbotsford Sports Hall of Fame, and the five teams and 13 individuals who were recognized by the Wall of Fame.

The Wall of Fame honours up-and-coming athletes from the ages of 14 to 25 who had outstanding years in their sport. They are recognized with a plaque in the Legacy Sports Centre for one year.

These athletes have displayed perseverance and dedication in sport which helped them accomplish amazing feats.

Congratulations to the athletes who were recognized last Saturday. It is a wonderful example to young people to stay active in their daily lives, and that practice and commitment in what we love to do can help us accomplish our goals.

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ASIAN HERITAGE MONTH

Ms. Jenny Kwan (Vancouver East, NDP): Mr. Speaker, for over a century, Asian people have been coming to Canada and contribute to the rich multicultural tapestry of Canada.

This month, Canadians will have the opportunity to learn about the diverse Asian cultures in celebration of Asian Heritage Month.

ExplorAsian has brought together different organizations and has created a month-long program filled with great events from music and art shows to thought-provoking documentaries and film festivals to highlight the historic struggles Asian Canadians faced and their many achievements.

To kick things off, this past weekend I attended the opening of Van East's very own award winning Chinese calligrapher Master Wai Yin Lau's art exhibition which showcased six distinct Chinese calligraphy art forms at the Chinese Cultural Centre.

The Chinese Cultural Centre will also host the Together Art Festival, featuring performances from Korea, Japan, China, and Polynesia on May 28.

I encourage all Canadians to take part in the many activities in their own community to learn about and celebrate Asian Canadian culture and history.

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BATTLE OF THE ATLANTIC

Mr. Ken Hardie (Fleetwood—Port Kells, Lib.): Mr. Speaker, yesterday I had the honour of laying a wreath at the Centennial Flame on behalf of Surrey's veterans to commemorate the Battle of the Atlantic.

Throughout World War II, convoys battled storms, submarines, and air strikes, keeping Britain's lifeline open. Brave Canadians in our navy, merchant marine, and air force helped Britain endure and set the stage for the liberation of Europe.

This was my dad's war. As an ASDIC operator, he would go “ping happy” listening for U-boats on the HMCS *Kincardine* and HMCS *Galt*, two tough little corvettes that could, in his words, “roll on wet grass” as they shepherded the runs from Halifax and Sidney.

It was uncomfortable and dangerous. One in seven of our merchant mariners, over 1,600, were killed or wounded, as were over 2,000 in our navy and air force. As we know, many of them were just kids.

I hope the House will join me in honouring these Canadians who fought the longest battle of the war; they fought it well and they won.

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100 MILE HOUSE WRANGLERS

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Mr. Speaker, it gives me great pleasure to congratulate the 100 Mile House Wranglers on an outstanding season. The Wranglers are not only champions of the Kootenay International Junior Hockey League and the British Columbia Junior B division, but the boys from 100 Mile House also lassoed the western Canada championship, the Keystone Cup.

The road to victory was hard fought, but not without a lot of support from back home. When they travelled to Esquimalt, Wranglers fans actually bought 40% of the tickets. The Wranglers then went on to defeat the Kimberley Dynamiters in five games to secure the crown in Regina.

In the words of one local reporter, “People as far away as Thunder Bay, Ont. and all through the West know these 22 lads, who have represented 100 Mile House so well with their respect and their community-mindedness, never gave up and they will work hard every minute of every game”.

Last week's parade and tailgate party was a fitting tribute to the Wranglers players and the organization. Well done, Wranglers. They are the champions of the west.

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● (1405)

VOLUNTEERISM

Mr. John Aldag (Cloverdale—Langley City, Lib.): Mr. Speaker, I recently met two amazing volunteers in Langley City.

The first is Pauline Knight, who turned 100 in February. Pauline still volunteers for the Langley Senior Resources Society in Langley City, as she has done for 24 years.

The second volunteer is Rob Ross. Children have always been important to Mr. Ross. As a retired teacher and principal, along with being a father to his own children, Mr. Ross became a volunteer with Big Brothers Big Sisters of Langley 40 years ago. Since that time he has made the difference in the lives of an astounding 14 “littles”, many of whom still play an important part in Rob's life.

Speaking of volunteers, Mr. Speaker, I invite you, my colleagues, and all Canadians to enjoy our community Cloverdale style. The 70th annual Cloverdale Rodeo, the second-largest community rodeo in Canada, and 128th Country Fair, run from May 20 to 23. With all the components of a great community celebration supported by countless volunteers, there will be activities for all ages and interests.

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MIDGET HOCKEY CHAMPIONSHIP

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Mr. Speaker, Quispamsis, New Brunswick, played host to the TELUS Cup last week, and what a week it was. The cup was the end of the season's journey that began last fall with 152 teams seeking to be crowned Canada's national midget hockey champions.

True to epic storytelling, Canada came together to watch the hometown heroes, the Saint John Vito's, battle against the pride of Ontario, the North York Rangers, in the finals. This was the first time that a New Brunswick team had reached that level. As one of the thousands of fans at the qplex last Sunday, I was moved as the crowd rose to its feet to applaud the Vito's for the last full minute of the game as the team achieved a silver medal standing.

I would like to congratulate all the players, the organizers, and the sponsors, with a special mention to the event chair, Aaron Kennedy, for the spectacular success of the tournament.

I thank the Saint John Vito's for reminding us that hockey truly is our national sport, building character, promoting teamwork, creating lifelong friendships, and bringing communities together.

PARLIAMENTARY FORUM ON RELIGIOUS FREEDOM

Mr. David Anderson (Cypress Hills—Grasslands, CPC): Mr. Speaker, today leading scholars, faith leaders, diplomats, and members of the public will come to Parliament Hill for the fifth annual Parliamentary Forum on Religious Freedom.

The four previous forums touched on specific issues regarding the right to freedom of thought and belief. Each was thought provoking and challenged participants to recommit to new and different ways to this fundamental human right.

This year promises to be no different. This year's forum is entitled, “Religious Freedom or Secularism? A World Safe for Diversity: Living with our Deepest Differences”. We will explore whether an increasingly secular world can, or will, continue to support the notion that all people should be free to decide what they believe, should be able to daily practise their belief, and should be able to change their belief if they choose. This year, leading apologist, author, and social critic, Dr. Os Guinness, will deliver the keynote address. He brings decades of expertise and wisdom to this ongoing debate.

Canada sees these freedoms as essential. However, the way forward is not always clear. That makes tonight's discussion all the more important.

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[*Translation*]

BUDDHIST NEW YEAR

Ms. Linda Lapointe (Rivière-des-Mille-Îles, Lib.): Mr. Speaker, last Saturday evening, I participated in an event organized by the Laotian community in my riding of Rivière-des-Mille-Îles. Over 400 people were in attendance. I had the opportunity to celebrate the Buddhist new year, which involved smiles, good food, and cultural dancing. Did you know that this is the year 2559? The Laotian community in Boisbriand embraces the Canadian values of inclusion, openness, and hospitality that are so dear to all of us.

I would like to tip my hat to the president of that community, Manivanh Dougmala, and commend her for her great leadership. For over 35 years, she has been helping Laotian immigrants integrate into the Montreal area. It is leaders such as Ms. Dougmala who help us create a welcoming and hospitable environment and country for newcomers to Canada.

Keep up the good work, Ms. Dougmala, and happy Laotian new year. Happy 2559.

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● (1410)

STATUS OF WOMEN

Ms. Anju Dhillon (Dorval—Lachine—LaSalle, Lib.): Mr. Speaker, as a proud member of the Barreau du Québec, I am pleased to point out that 75 years ago, in 1941, women won the right to practise law in Quebec.

This did not happen overnight. In 1915, Annie Langstaff was the first Quebec woman to obtain a law degree from McGill University. Despite all her efforts, she was never able to practise law. On April 29, 1941, Quebec's Loi sur le Barreau was finally amended, and the first four women were called to the Quebec bar association in January 1942.

[*English*]

Since that time, women have advanced to become approximately half the lawyers in the province. In doing so, they pay tribute to the groundbreaking women who successfully fought for change 75 years ago.

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WILLIAM H. JARVIS

Mr. John Nater (Perth—Wellington, CPC): Mr. Speaker, I rise today to pay tribute to the life of the Hon. William H. Jarvis, who passed away last week at the age of 85.

Bill was first elected to the House of Commons in 1972 for the riding of Perth—Wilmot. He would go on to serve in this House for the next 12 years, always tending to the needs of his riding and to his constituents. In 1979, he was appointed to cabinet as the minister of state for federal-provincial relations.

After leaving elected politics in 1984, he continued to serve his country, and his party as president of the Progressive Conservative Party of Canada from 1986 to 1989.

I am sure all hon. members will join me in paying tribute and in expressing our condolences to Bill's family, including his wife Louisette, his children Richard and Elizabeth, and their mother Vivian.

While we may mourn the loss of Bill, we can certainly pay tribute and honour his legacy and his dedication to this House, his country, and his constituents.

* * *

VISION HEALTH MONTH

Mr. Robert Oliphant (Don Valley West, Lib.): Mr. Speaker, May is Vision Health Month, a month to celebrate the contributions of blind and partially sighted Canadians, and thank those who are reducing barriers, improving accessibility, providing eye health care, and doing or supporting innovative research in the area of vision loss.

Close to half a million Canadians live with significant vision loss. Over the next decade as our population ages, vision loss among Canadians is expected to rise by nearly 30%. Over five and a half million Canadians have one of four major eye diseases: age-related macular degeneration, diabetic retinopathy, glaucoma, or cataracts.

However, being blind or suffering vision loss should not limit anyone in Canada. This month, CNIB, with its head office in Don Valley West, is asking Canadians to open their eyes to blindness. They will be sharing truly visionary stories of Canadians who are living with vision loss, demystifying what it means to be blind.

Please join me in commemorating Vision Health Month.

SASKATCHEWAN BOOK AWARDS

Mr. Erin Weir (Regina—Lewvan, NDP): Mr. Speaker, the night before last, I attended the 23rd annual Saskatchewan Book Awards, which recognize authors and publishers in our province.

My former professor, Raymond Blake, was nominated for his book, *Lions or Jellyfish: Newfoundland-Ottawa Relations since 1957*. I believe that he would have won an award had there been a category for best title.

I was very proud that my colleague from Timmins—James Bay won two awards for his book, *Children of the Broken Treaty*, published by University of Regina Press. This book provides chilling insight into how Canada, through breaches of treaties, broken promises, and callous neglect, denied first nations children their basic human rights.

Tragedies at Attawapiskat in his riding and at La Loche in my province underscore that we must do better.

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IRAN

Hon. Tony Clement (Parry Sound—Muskoka, CPC): Mr. Speaker, today is the beginning of Iran Accountability Week here on Parliament Hill, which I am proud to co-host alongside Senator Linda Frum.

The objectives of this week are to bring more awareness to the Iranian regime's transgressions, including being the world's foremost state sponsor of terrorism, its nuclear ambitions, aggressively jailing political opponents, and an egregious track record on human rights.

[*Translation*]

We will be giving a voice to the victims of the Iranian regime while informing parliamentarians, the media, and Canadians of the atrocities committed in Iran. Hamas and Hezbollah are listed terrorist entities in Canada and have both received critical support from Iran.

● (1415)

[*English*]

Iran's constant threat to the peace and security of the state of Israel is something that should be concerning to all members of the House, and to all Canadians, as Ayatollah Khamenei has constantly called for the destruction of Israel.

We will be hosting numerous events this week, such as a speakers evening with experts about Iran discussing the regime's transgressions. All are welcome.

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[*Translation*]

YVON CHARBONNEAU

Mr. Pablo Rodriguez (Honoré-Mercier, Lib.): Mr. Speaker, I want to pay tribute to a great man who just passed away, Yvon Charbonneau. He was my friend and was a friend to many members in this House.

Yvon was truly a great man. He was generous and principled, and he was guided by noble values. Most importantly, he had the courage to defend those values. Yvon advanced some very important causes throughout his career as a trade unionist, a member of the Quebec National Assembly, a member of Parliament, and an ambassador. Yvon always managed to bring about change.

When I succeeded Yvon as the member of Parliament for Honoré-Mercier, I knew that I had big shoes to fill. I used the word “succeeded”, because it is possible to succeed Yvon, but no one can ever replace him. He was irreplaceable.

I thank him for his friendship and his invaluable advice. There will always be a little piece of him in everything I do here.

Goodbye, Yvon. Rest in peace.

ORAL QUESTIONS

[*English*]

FINANCE

Hon. Rona Ambrose (Leader of the Opposition, CPC): Mr. Speaker, once again, the Prime Minister's own Department of Finance has confirmed that—drum roll, please—Conservatives left a healthy surplus for Canadians. It is undeniable fact, but, sadly, instead of following our lead of low taxes, balanced budgets, and job creation, the Prime Minister is raising taxes, spending recklessly, and has no plan to create jobs.

If the Prime Minister will not admit basic facts, how can we trust him to run our economy?

Hon. Bill Morneau (Minister of Finance, Lib.): Mr. Speaker, the Department of Finance informed me that we will be in a deficit position for the year 2015-16. The annual financial report will be out in the month of September.

We are focusing on things that really matter for Canadians. Rather than focusing on balancing the budget at all cost, we are investing in Canada; we are investing in Canadians. We started with a tax break, and we will move forward with a budget that is going to help Canadians to live better lives, what they asked us to do on October 19.

Hon. Rona Ambrose (Leader of the Opposition, CPC): Mr. Speaker, on Friday, when the finance minister was asked about the surplus that he clearly inherited from Conservatives, he said, “We don’t want to focus on this issue.” Of course he does not want to, when his own department, the independent parliamentary budget officer, and economists are telling him that now he is solely responsible for any deficit that Canadians will have to pay back.

How can Canadians trust the government to run the economy when its own finance minister will not admit basic facts?

Hon. Bill Morneau (Minister of Finance, Lib.): Mr. Speaker, we are moving forward with a plan that is going to make a real difference for Canadians. It starts by helping middle-class Canadians to have better lives. It started with tax cuts and a move forward with the Canada child benefit that will really improve Canadians' lives. Cheques will be starting this July. Then we are going to move forward with investments that will make a real, long-term difference in the productivity and the strength of our economy so that in the future we will be much better off than we were in the last decade under the last government.

[*Translation*]

Hon. Rona Ambrose (Leader of the Opposition, CPC): Mr. Speaker, the Liberals are ignoring the facts and the truth. We now have confirmation that the Conservatives left a significant surplus.

Will the Prime Minister now admit that we left a surplus and that he is the only one responsible for our current financial mess?

Hon. Bill Morneau (Minister of Finance, Lib.): Mr. Speaker, officials at the Department of Finance told me that we would be in a deficit position for 2015-16. The annual financial report will be ready in September.

This means that we will now take action to grow the economy. That is how we plan to help improve the lives of middle-class Canadians.

● (1420)

Hon. Denis Lebel (Lac-Saint-Jean, CPC): Mr. Speaker, I rarely agree with the Minister of Finance, but this time, he is right. They will be in a deficit position. We had a surplus. I agree with him.

The Department of Finance's “Fiscal Monitor” reported a surplus of $7.5 billion at the end of February, but the government is still announcing a huge deficit.

Will the government be posting a $13-billion deficit just for March? I would like the Minister of Finance to respond.

Hon. Bill Morneau (Minister of Finance, Lib.): Mr. Speaker, what I mean is that we now know we will be in a deficit position for 2015-16. The report will be ready in September. Now we have a plan to grow the economy. That is what we need to do because growth was very slow over the past decade.

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FORESTRY INDUSTRY

Hon. Denis Lebel (Lac-Saint-Jean, CPC): Mr. Speaker, I would like to raise another very important subject. Yesterday, I joined 4,000 people at a rally in Saint-Félicien in support of the forestry industry.

The industry is active across Canada, but for years, it has been subjected to vicious attacks by a number of environmental groups that are spreading misinformation about forestry practices in Canada.

Can the government confirm that it will support Canada's forestry industry, which employs people from coast to coast?

[*English*]

Ms. Kim Rudd (Parliamentary Secretary to the Minister of Natural Resources, Lib.): Mr. Speaker, Canada's forest industry is important to our economy and to communities across the country. Budget 2016 provides $1 billion over four years, starting in 2017-18, to support clean technology in the forestry, fisheries, mining, energy, and agriculture sectors, as part of the Government of Canada's commitment to innovation.

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[*Translation*]

AIR CANADA

Ms. Marjolaine Boutin-Sweet (Hochelaga, NDP): Mr. Speaker, this weekend, the Prime Minister was proud to say that Quebec's voice is being heard in Ottawa. However, when it comes to assistance for Bombardier, the government has been feeding us the same old lines for months.

The Liberals did not present any kind of plan to support the aerospace industry during the election campaign, nor have they done so since taking office. We are talking about an industry that provides direct employment for 76,000 Canadians, and over half of those jobs are in Quebec.

Will the Prime Minister finally recognize how important this sector is to our economy and present a clear plan for the aerospace industry?

[*English*]

Hon. Navdeep Bains (Minister of Innovation, Science and Economic Development, Lib.): Mr. Speaker, our government understands the importance of the aerospace sector. We understand that it creates 180,000 jobs from coast to coast to coast. We understand that it contributes $29 billion to our economy as well.

It is also about supporting the supplier base. That is why we are engaged with the company. We are engaged in a meaningful dialogue with the company to ensure we set it up for success in the long term, because we want to have a thriving and growing aerospace sector in this country.

[*Translation*]

Ms. Marjolaine Boutin-Sweet (Hochelaga, NDP): Mr. Speaker, that was not a clear or specific answer.

This government shows no interest in supporting aerospace workers and their families. It would rather give Air Canada carte blanche with Bill C-10, which sacrifices the jobs and quality of life of 2,600 families. The government does not even have the courage to let us have an in-depth debate on this issue in Parliament.

Is the Prime Minister not ashamed of abandoning the workers like this, especially after he joined them in their protest?

Hon. Marc Garneau (Minister of Transport, Lib.): Mr. Speaker, as members know, the governments of Quebec and Manitoba have indicated that they intend to drop their lawsuit against Air Canada, which allows us to clarify the Air Canada Public Participation Act. That is what we are doing in order to avoid more litigation in the future.

However, I would like to remind my colleague that jobs will be created in Quebec, Ontario, and Manitoba.

[*English*]

THE ENVIRONMENT

Mr. Nathan Cullen (Skeena—Bulkley Valley, NDP): Mr. Speaker, British Columbia's north coast is an incredibly beautiful place, famous for the power of its people.

The Prime Minister and his transport minister, twice, joined with us and the people of British Columbia to ban all oil supertankers off that coast. Asked about the threat posed by Enbridge northern gateway, he said, “I will not be approving this pipeline”.

Will he now stand in his place and finally tell British Columbians when he will finally introduce a legislated tanker ban off our beautiful coast?

Hon. Marc Garneau (Minister of Transport, Lib.): Mr. Speaker, as everyone knows, I was mandated to establish a formal moratorium on crude oil tanker traffic on the north coast of British Columbia. I am doing this in concert with my colleagues, the Minister of Fisheries, Oceans and the Canadian Coast Guard; the Minister of Environment; and the Minister of Natural Resources. We are proceeding with consultations with first nations, with environmental groups, and with the shipping industry. We are doing our homework.

When we have something to say, we will say it.

● (1425)

Mr. Nathan Cullen (Skeena—Bulkley Valley, NDP): Mr. Speaker, how long does it exactly take to just say no?

The government has refused, again, to give us any timeline whatsoever, and offered only more confusion.

Just a few days ago, I visited the central coast and Haida Gwaii. The people there, the first nations there, are particularly shocked and saddened by the government's unwillingness to be clear, and perhaps willingness to betray that sacred promise.

The Prime Minister also stood on Haida Gwaii and promised to the people, promised to the Haida, promised to British Columbians, that he would be an ally and he would bring this tanker ban forward.

When exactly are we going to see it?

[*Translation*]

Hon. Marc Garneau (Minister of Transport, Lib.): Mr. Speaker, as I mentioned, my mandate letter requires me to establish a formal moratorium on crude oil tanker traffic on the north coast of British Columbia. I am doing this in concert with my colleagues, the Minister of Fisheries, Oceans and the Canadian Coast Guard, the Minister of Environment and Climate Change, and the Minister of Natural Resources. We are working on that right now.

We are also consulting with first nations, environmental groups, and the shipping industry. When we have something to say, we will say it.

[*English*]

FINANCE

Hon. Lisa Raitt (Milton, CPC): Mr. Speaker, this is just a little recap from our constituency week.

Last week, Finance Canada announced that the federal government had a $7.5 billion surplus. It is the fourth time that officials at Finance Canada have actually confirmed that we left them with a surplus, and that is because of our strong fiscal management and the fact that we are prudent on balanced budgets.

When the finance minister was asked about this, he waved away the report and said, quite frankly, he is not focusing on that.

I think Canadians want him to focus on the numbers. My question for the finance minister is, when will you stop misleading Canadians on what the actual fiscal situation is?

The Speaker: I believe the member means “he” and not “you”. I hope she is not talking to me.

The hon. Minister of Finance.

Hon. Bill Morneau (Minister of Finance, Lib.): Mr. Speaker, I just want to say, thank goodness for Canadians that they made the right choice on October 19.

Clearly, the members from the other side are still stuck in this whole balanced budget thing. They really—

Some hon. members: Oh, oh!

The Speaker: Order. I know that members are eager to applaud the answer, but they need to wait until we hear the end of the answer.

The hon. Minister of Finance.

Hon. Bill Morneau: Mr. Speaker, there are two things.

One, a fiscal year has 12 months. Two, Canadians hired us to invest in the economy. They hired us to invest in the future growth of this country, and that is exactly what we intend on doing.

Hon. Lisa Raitt (Milton, CPC): Mr. Speaker, the Liberals were indeed left $7.5 billion in surplus. That being said, their plan is to plunge us into billions and billions of dollars of debt. Interestingly enough, the Minister of Finance wrote a book. In his book he said that debt prevents you from doing things, such as sleeping well at night.

My question for the Minister of Finance is this. How is he sleeping at night?

Hon. Bill Morneau (Minister of Finance, Lib.): Mr. Speaker, I am absolutely pleased to tell the hon. member that I am sleeping well at night, knowing that what we are doing is making my children and grandchildren better off. We are making them better off by making investments in the economy. We are investing in infrastructure that will make their lives better, that will allow them to have better lives in the future. We are investing in an innovative economy that can actually increase the productive capacity of our country.

Canadians made the right choice on October 19. They made the choice to invest.

Mr. Phil McColeman (Brantford—Brant, CPC): Mr. Speaker, it must be frustrating for the Minister of Finance that the facts keep getting in the way of his rhetoric. Once again, he has been completely contradicted by his own department, which reported that he inherited a $7.5 billion Conservative surplus.

Will the Minister of Finance at least try to salvage some credibility and finally admit that the Conservatives left him a surplus, and his own reckless spending squandered it?

● (1430)

Hon. Bill Morneau (Minister of Finance, Lib.): Mr. Speaker, I can only say it again.

The professionals in the Department of Finance tell us that we will be in a deficit in fiscal year 2015-16, which has not yet been concluded. When the reports come in September, we will see the results. In the interim, we are focusing on what Canadians really care about, and that is to make investments so that we can make their lives better, which is exactly what we are doing.

Mr. Phil McColeman (Brantford—Brant, CPC): Mr. Speaker, it is bad enough that he squandered the surplus, but the Minister of Finance does not have to keep squandering his credibility while he does it.

For months, the Minister of Finance has ignored the independent analysis of the PBO, private sector economists, and his own Department of Finance. Instead, he has decided to rely on his own magic to build a reckless budget.

Why does the Minister of Finance think that his mismanaging of the public purse is a gain?

Hon. Bill Morneau (Minister of Finance, Lib.): Mr. Speaker, I would like to be clear about what the parliamentary budget officer did say most recently. He said that budget 2016 would in fact help to grow the economy, which is exactly what we put forward to Canadians.

We expect that the measures we put in budget 2016 will actually grow the economy by about half a per cent this year and about a whole per cent next year, with 43,000 jobs this year and 100,000 next year. We are pleased with what we put forward and we know that it will be much better for Canadians for the future.

[*Translation*]

Mr. Gérard Deltell (Louis-Saint-Laurent, CPC): Mr. Speaker, this morning *La Presse* is reporting that, once again, the Liberal government is hiding important information from Canadians, and once again, it has to do with the Department of Finance.

The Department of Finance analyzed the cost of the Liberal promises. The document that was released to the public was heavily censored by the minister, obviously because he knows very well that his promises are going to cost Canadians a fortune.

Why is the minister hiding information that is so important to Canadians' pocketbooks?

Hon. Bill Morneau (Minister of Finance, Lib.): Mr. Speaker, openness and transparency within the Department of Finance are extremely important to me and to our department.

In this case, the department responded to a question in accordance with all the applicable rules. It was independent of me, and that is good.

What I want to point out now is that the figures are in budget 2016, and Canadians can see exactly what we did.

Mr. Gérard Deltell (Louis-Saint-Laurent, CPC): Mr. Speaker, with all due respect to the Minister of Finance, and to put it mildly, we are becoming accustomed to his lack of transparency, which has been an issue from the beginning.

The tax changes were supposed to be revenue neutral, and yet there is a deficit of $1.4 billion. The changes to the Canada child tax benefit were supposed to be revenue neutral, and yet there is a deficit of $1.4 billion.

My question for the minister is clear. Will he commit to releasing the study done by his department on the cost of the Liberal promises?

Hon. Bill Morneau (Minister of Finance, Lib.): Mr. Speaker, as I have already said, the numbers are in the budget. It outlines the exact measures and what they will cost. It is open and transparent for all Canadians.

* * *

INDIGENOUS AFFAIRS

Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP): Mr. Speaker, when the minister found out that the Church did not fulfill its obligation to contribute $25 million to fund programs for victims of residential schools, she said she was powerless and there was nothing she could do. However, that sum is in the court-approved settlement. What is more, it was her department that authorized the agreement that let the Church off the hook.

When will the Minister of Indigenous and Northern Affairs compel the Church to fulfill its obligations to the victims of residential schools?

Hon. Carolyn Bennett (Minister of Indigenous and Northern Affairs, Lib.): Mr. Speaker, while the previous government left no room for legal recourse, this government continues to work with the Catholic entities. It is very important that they play their part in the reconciliation process and that they fulfill their commitments, regardless of their obligations under the legislation.

[*English*]

Mr. Charlie Angus (Timmins—James Bay, NDP): Mr. Speaker, the Human Rights Tribunal has made it clear that it is fed up with the government's inaction on dealing with the issue of racial discrimination against indigenous children. It points out that the Liberal budget failed children in the area of child welfare. The government continues to deny medical services to children and fights their families in court.

The tribunal has effectively put indigenous affairs under third party management because it simply does not trust the government. To the Prime Minister, as the minister of youth, will he respect this ruling and if so, what are the immediate steps the government will take to end the systemic discrimination against indigenous children in this country?

Hon. Carolyn Bennett (Minister of Indigenous and Northern Affairs, Lib.): Mr. Speaker, we are absolutely going to fulfill our obligations under the tribunal ruling, including the new definition and broader definition of Jordan's principle. It is extraordinary. I had a very good meeting this morning with Dr. Blackstock and the AFN. We are going to work with the provinces and territories to get this done.

* * *

● (1435)

INTERNATIONAL TRADE

Hon. Gerry Ritz (Battlefords—Lloydminster, CPC): Mr. Speaker, the greatest opportunity to get the TPP ratified is before the next U.S. president takes office. Former Obama defense secretary Leon Panetta says there is a low probability of its passing Congress if it is not passed before the end of this presidential term. Yet the Liberals are engaging in endless consultations here and the minister says it is not her job to promote the TPP.

When will the minister spend more time on trade promotion and less time on vanity trips to L.A.?

Mr. Omar Alghabra (Parliamentary Secretary to the Minister of Foreign Affairs (Consular Affairs), Lib.): Mr. Speaker, the Canadian government made a commitment to consult Canadians before taking a decision on ratification. That is exactly what we have been doing since taking office. The government has consulted on this agreement on over 250 separate occasions and will continue to do so. I am also very glad that the House of Commons trade committee has invited Canadians to share their opinions with it in public hearings. Perhaps this is something the previous government is not accustomed to, but this is something we have promised Canadians and we are fulfilling this promise.

Hon. Gerry Ritz (Battlefords—Lloydminster, CPC): Mr. Speaker, there was a full round of consultations last spring when we were still in government as it led up to the TPP. On April 20, Canada's lead negotiator for the TPP is quoted in *The Hill Times*, so it must be accurate, saying that this coming year is looking exciting. She will be assisting the international trade minister in ratifying the TPP deal that she worked so hard on, and we agree with that.

Now that we have confirmed the Liberals have already made up their mind, will the minister bring the TPP to the House for ratification and start spending more time on trade promotion instead of costly self-promotion?

Mr. Omar Alghabra (Parliamentary Secretary to the Minister of Foreign Affairs (Consular Affairs), Lib.): Mr. Speaker, I do not know what the hon. member has against consultation. I do not know what the hon. member has against the hard work by the members of the Standing Committee on International Trade. Our minister, our parliamentary secretary, and our government are committed to fulfilling our promise to consult Canadians. We are working very hard on these consultations and I invite the hon. member and his colleagues to participate in these consultations.

* * *

MINISTERIAL EXPENSES

Mr. Blaine Calkins (Red Deer—Lacombe, CPC): Mr. Speaker, documents released through access to information indicate the Minister of International Trade left her officials in the dark about her vanity trip to California and there are significant factual inconsistencies with the answers the minister has provided about her California dream trip. She billed the taxpayer-funded junket to L.A. around her late night TV appearance.

Does the minister believe that her ministry is just an extension of her so-called celebrity journalism career?

Hon. Dominic LeBlanc (Leader of the Government in the House of Commons, Lib.): Mr. Speaker, the minister visited Los Angeles to reinforce the important economic relationship between California and Canada. California and Canada conduct over $40 billion in annual bilateral trade.

The minister has made it clear that all the rules appropriate were followed with this trip. In addition to round tables with the business community and creative industries during the Los Angeles trade mission, the minister was proud to promote Canada to an American audience, including Canada's leadership on the Syrian refugee file.

Mr. Blaine Calkins (Red Deer—Lacombe, CPC): Mr. Speaker, we know the minister rescheduled her personal vanity trip to California from October to November, after she was appointed to cabinet. Emails released through access to information indicate her staff was left in the dark until the final days of her L.A. departure. Apparently, no one but the minister knew she was going to L.A. to spend some time with Bill Maher.

When is the minister going to be honest with Canadians and admit the trip was about her and not about her job as the trade minister?

Hon. Dominic LeBlanc (Leader of the Government in the House of Commons, Lib.): Mr. Speaker, one group of people who were not in the dark about the minister's trip to California was the business leaders, the academic leaders, and the government leaders that she met with when she was in California to promote Canadian trade.

Forty billion dollars a year in bilateral trade is something we think is important. If the member does not think so, then he has a different view from this side of the House.

* * *

PRIVACY

Ms. Hélène Laverdière (Laurier—Sainte-Marie, NDP): Mr. Speaker, Communications Security Establishment Canada, which by the way oversees CSIS, is responsible for reporting serious privacy breaches to the commissioner. However, instead, it is hiding them.

The Privacy Commissioner stated that CSE “does not give the Office of the Privacy Commissioner enough information”. Does the government agree with the NDP that withholding information about serious privacy breaches is simply wrong?

Hon. Harjit S. Sajjan (Minister of National Defence, Lib.): Mr. Speaker, I just want to make it clear for the hon. member that the Communications Security Establishment has no oversight over CSIS.

To answer her question, CSE has proactively worked with the commissioner on all aspects. They do have a good working relationship, because CSE abides by Canadian law, including the Privacy Act.

● (1440)

[*Translation*]

Ms. Hélène Laverdière (Laurier—Sainte-Marie, NDP): That is odd, Mr. Speaker, because that is not what the commissioner said. Clearly the government is not taking privacy protection seriously. Today we learn that the Communications Security Establishment is refusing to report privacy breaches to the Privacy Commissioner. However, it shares data on Canadians with its foreign partners.

Will the government keep its promises of transparency and force the CSE to co-operate?

[*English*]

Hon. Harjit S. Sajjan (Minister of National Defence, Lib.): Mr. Speaker, in the previous report that the commissioner released, he said that a CSE official proactively provided the information to them, which allowed them to conduct a thorough investigation.

I also want to remind the hon. member that CSE plays a critical role in protecting against cyber-threats, foreign espionage, and foreign-based terrorist threats as well.

* * *

CENSUS

Mr. Majid Jowhari (Richmond Hill, Lib.): Mr. Speaker, science and data are the cornerstone of good public policy. Canadians expect us to make informed decisions based on reliable data. This is the role Statistics Canada has been fulfilling for many years with its census program. The data collected through the census survey helps policy-makers and planners make decisions on everything from public health to transit to housing.

Could the government tell the House what we can expect with the return of the mandatory census program this year?

Hon. Navdeep Bains (Minister of Innovation, Science and Economic Development, Lib.): Mr. Speaker, I would like to thank the hon. member for Richmond Hill for his efforts in supporting good data collection.

I am proud to say that my first official act was to reinstate the mandatory long-form census. Today, census letters and packages are being sent to all Canadians from coast to coast to coast. Canadians will have access to high-quality data that truly reflects the needs of our communities and businesses. After 10 years, evidence-based decision-making is back.

[*Translation*]

MINISTERIAL EXPENSES

Mr. Jacques Gourde (Lévis—Lotbinière, CPC): Mr. Speaker, we know that the Minister of International Trade spent public money to appear on a Hollywood talk show and neglected her ministerial duties.

Can the minister explain how she was defending Canada's trade interests by rushing to Los Angeles to be interviewed by Bill Maher, with taxpayers footing the $20,000 bill?

Hon. Dominic LeBlanc (Leader of the Government in the House of Commons, Lib.): Mr. Speaker, as I said earlier, the minister was defending Canada's economic interests when she met with California's business leaders and with elected and public officials.

We believe that a $40-billion-a-year trade relationship is important. The minister signed important agreements during her visit to California.

Mr. Jacques Gourde (Lévis—Lotbinière, CPC): Mr. Speaker, it is clear from the Minister of International Trade's actions that she was not in Los Angeles to negotiate trade agreements in the interest of Canadians.

That said, can her government confirm that it will support the trans-Pacific partnership which, let us recall, is good for beef, pork, maple syrup and blueberry producers?

[*English*]

Mr. Omar Alghabra (Parliamentary Secretary to the Minister of Foreign Affairs (Consular Affairs), Lib.): Mr. Speaker, I would like to repeat that our government is committed to consulting Canadians on the TPP. The House of Commons Standing Committee on International Trade is conducting a study on the TPP. Therefore, I invite all members of the House to participate in this consultation. We are looking forward to a meaningful discussion.

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Mr. Speaker, the trade minister's own officials were not told of the L.A. junket until November 17, two days before she arrived. The department's director of communications did not even know what the minister was doing in L.A. besides the Bill Maher show. Her department scrambled to find events so she could bill the vanity trip to the taxpayers of Canada.

When will the trade minister pay for this personal trip so Canadian taxpayers do not have to?

● (1445)

Hon. Dominic LeBlanc (Leader of the Government in the House of Commons, Lib.): Mr. Speaker, our government does not apologize for promoting Canadian business interests abroad. When the Minister of International Trade was in California, as I and she have mentioned before, she had a series of meetings with business leaders and with officials in the government of California.

We think promoting Canada on critical issues like our support, for example, for Syrian refugees is an important part of every member of Parliament's work. We are proud of our Minister of International Trade.

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Mr. Speaker, the Treasury Board's guidelines require ministers to disclose their travel and hospitality costs quarterly.

For the past eight months the Minister of Finance has been travelling all over Europe, Asia and Canada, but has only disclosed the costs of one trip. The minister is in charge of Canada's finances, but will not even obey the law when it comes to his own travel.

Why is the Minister of Finance hiding his own spending from Canadians?

Hon. Scott Brison (President of the Treasury Board, Lib.): Mr. Speaker, we as a government are committed to the proactive disclosure of ministers' expenses. In fact, it was a previous Liberal government, under the leadership of Prime Minister Martin, that first introduced proactive disclosure of ministers' expenses. It was our prime minister in opposition that for the first time ever members of Parliament proactively disclosed their expenses. We are committed to proactive disclosure, and we will continue to be as a government.

* * *

SEARCH AND RESCUE

Ms. Rachel Blaney (North Island—Powell River, NDP): Mr. Speaker, in a few days the Liberal government will be shutting down the Comox MCTS station. The minister keeps claiming there is no risk.

However, just last weekend a massive communications failure in Prince Rupert meant that the entire west coast of Vancouver Island was left with no marine safety communications. This put the lives of mariners in danger.

Will the minister now reverse the Conservative decision to close the Comox station?

Hon. Hunter Tootoo (Minister of Fisheries, Oceans and the Canadian Coast Guard, Lib.): Mr. Speaker, I am aware of the temporary outage that happened in Prince Rupert. I want to assure all members, including the member herself, that the outage had nothing to do with the modernization of our MCTS systems. The outage was caused by a third-party landline. By the way, Comox has virtually no overlapping coverage in this sector, and it was not a factor in the situation at all.

Mr. Fin Donnelly (Port Moody—Coquitlam, NDP): Mr. Speaker, the Liberals are clearly choosing to ignore the evidence here. During the campaign, the Prime Minister promised Canadians they would reopen the Kitsilano Coast Guard station. Once in power, the minister assured Canadians it would be operational 24/7, 365. Now it appears that is not the case. The base will only reopen on a part-time basis. Why did the minister mislead Canadians about this commitment?

Hon. Hunter Tootoo (Minister of Fisheries, Oceans and the Canadian Coast Guard, Lib.): Mr. Speaker, last December, I announced that we would be reopening Kitsilano. I am proud to say that yesterday we kept that commitment and the base became operational.

We are continuing our phase-in capacity at the base. By the May long weekend, the same number of search and rescue crew will be on site at the facility as was previously.

* * *

FOREIGN AFFAIRS

Hon. Tony Clement (Parry Sound—Muskoka, CPC): Mr. Speaker, as Conservatives host Iran Accountability Week on the Hill, we recognize that Iran is widely considered the world's pre-eminent sponsor of state terrorism through its support of groups, including Hezbollah and Hamas. The Iranian regime has been correctly listed by Canada as a state sponsor of terrorism. This listing has enabled terror victims to sue Iran in Canadian courts and hold the regime accountable.

Will the Liberals do the right thing and commit to keeping Iran designated as a state sponsor of terror?

Hon. Stéphane Dion (Minister of Foreign Affairs, Lib.): Mr. Speaker, we have no current plans to remove Iran from the list of state supporters of terrorism under the State Immunity Act. The inclusion or exclusion in the future will be based on the actions of the Iranian government. I am sure it was the purpose to improve human rights to protect the people of Iran, and it is very clear that it needs to make a lot of progress. Its record regarding human rights and the relationship with our allies, including Israel, is a problem.

[*Translation*]

Hon. Tony Clement (Parry Sound—Muskoka, CPC): Mr. Speaker, the Minister of Foreign Affairs told the Standing Committee on Foreign Affairs and International Development that Canada was taking the necessary steps to engage with Iran and to eventually open an embassy in Tehran.

Will the Minister commit today to consult with Iranian Canadians before a final decision is made and to be transparent and provide the opposition critics the risk assessment for a Canadian delegation in Tehran?

● (1450)

Hon. Stéphane Dion (Minister of Foreign Affairs, Lib.): Mr. Speaker, my colleague knows very well that I always give him my full co-operation.

However, it is common knowledge that we prefer to engage rather than to withdraw or retreat. It was a mistake for Canada to sever ties with Iran. The human rights situation in Iran is no better for it. Israel's situation has also not improved. We are not in a position to help our allies or to help Canadian interests, Canadian families and Iranian Canadians because of the previous government's empty-chair and withdrawal policy.

[*English*]

Hon. Peter Kent (Thornhill, CPC): Mr. Speaker, we need look no farther than Iran's supreme leader and official state media to get a clear and obvious handle on Iran's terrorist agenda. The regime boasts about its financial support of its terrorist proxies, its rogue missile program, and regularly proclaims the destruction of Israel a regime priority. Iran's state television this month is calling for young men to volunteer to fight in Syria, to position to invade Israel.

How can the Liberals, even for an instant, consider delisting Iran as a state sponsor of terror?

Hon. Stéphane Dion (Minister of Foreign Affairs, Lib.): Mr. Speaker, I am obliged to repeat, which I am pleased to do. We have no current plans to remove Iran from the list of state supporters of terrorism under the state Immunity act. The inclusion or exclusion in the future will be based on the actions of the Iranian government. I think it was the purpose of this motion and it is why we will respect it. We want to see improvement in Iran. It is why we are engaging this country: to help all of the people of Iran who want more human rights.

* * *

[*Translation*]

DAIRY INDUSTRY

Mr. Jean Rioux (Saint-Jean, Lib.): Mr. Speaker, the Canada-European Union comprehensive economic and trade agreement is a major priority for our government, since Canadian companies and business owners will be able to take advantage of the many benefits this agreement offers.

We want all sectors of our economy to be able to move forward once this agreement is ratified.

Can the Minister of Agriculture and Agri-Food talk to us about what he is doing to ensure that Canada's dairy industry can continue to grow within a constantly evolving global marketplace?

[*English*]

Hon. Lawrence MacAulay (Minister of Agriculture and Agri-Food, Lib.): Mr. Speaker, I can assure my hon. colleague and the House that our government is fully committed to the Canadian dairy industry and the supply management sector. That is why we have announced today that the government will be sitting down with the dairy industry in the coming weeks to get its views on the mitigation package as part of the CETA trade deal.

Together, our government will help the industry adjust. We will reach the best possible outcome for our dairy industry, and ensure Canadian agriculture is safer, stronger, and more innovative.

HEALTH

Mr. Colin Carrie (Oshawa, CPC): Mr. Speaker, the Liberals have abandoned regulations that would require generic drugs to have tamper-resistant properties. This decision has put the health and safety of Canadians at risk.

Not only does the decision allow for drug tampering and misuse to continue, but doctors themselves are now hesitating to prescribe these drugs to those who need them, fearing the drugs will end up on the illicit market.

Will the Minister of Health listen to physicians on the ground and reintroduce tamper-resistant regulations?

Hon. Jane Philpott (Minister of Health, Lib.): Mr. Speaker, an appropriate response to the problem of problematic drug use and prescription drug abuse needs to be comprehensive. There is no single strategy that will solve the problem, and there is no single drug that needs to be addressed.

The problem of tamper-resistant opioids, if it is applied only to a single drug, will not solve the problem. People will only go to another drug. We will continue with our comprehensive approach that will include increasing education and minimizing harm.

* * *

SMALL BUSINESS

Mr. Gord Johns (Courtenay—Alberni, NDP): Mr. Speaker, small businesses are the job creators of our country. We thought the Liberals understood this when they campaigned to lower small business taxes, but Liberals have clearly broken that promise.

New documents obtained by the parliamentary budget office show the Liberal plan will take $2.1 billion out of the pockets of small business. Why are the Liberals taking billions from small business, and why are they hiding this cash grab in an omnibus budget bill?

● (1455)

Ms. Gudie Hutchings (Parliamentary Secretary for Small Business and Tourism, Lib.): Mr. Speaker, on this side of the House we do understand small business.

One of the things I would like all my colleagues to realize is our bizpal program. Entrepreneurs have made it clear to us that navigating through permits and licences, through all levels of government, is confusing, frustrating, and, most important, time consuming.

We are proud of our bizpal program. It is one of the many ways we align our efforts with provincial, territorial, and municipal governments to support and respond to what all entrepreneurs and small businesses are asking of us.

They want to succeed. They want to create jobs and drive—

The Speaker: The hon. member for Brampton South.

HEALTH

Ms. Sonia Sidhu (Brampton South, Lib.): Mr. Speaker, a number of seniors in Brampton South have asked me about access to better palliative care and home care options.

Our government was elected with a mandate to provide more and better home care services, including palliative care.

On this National Hospice Palliative Care Week, could the Minister of Health update the House about her work to improve home and palliative care for all Canadians?

Hon. Jane Philpott (Minister of Health, Lib.): Mr. Speaker, previously in the House, I have quoted Dr. Atul Gawande, who talks about the fact that people want not only a good death, but they want a good life to the very end. For that reason, I am so committed to palliative care, and so much more work needs to be done.

When Canadians face the end of their lives and when they face suffering, they want dignity, independence, and they prefer, if possible, to die at home. For that reason our government will be investing $3 billion to increase access to home care.

I will work with the provinces and territories to ensure we increase access to high-quality palliative care for all Canadians.

* * *

[*Translation*]

CANADA BORDER SERVICES AGENCY

Mr. Alain Rayes (Richmond—Arthabaska, CPC): Mr. Speaker, in the coming days, controversial French comic Dieudonné is supposed to start a tour in Quebec. A number of politicians, including the mayor of Montreal, do not want him to come, and on the weekend, the Minister of Canadian Heritage implied that the border services officer on duty would be the one to determine Dieudonné's fate.

Can the Minister of Public Safety and Emergency Preparedness tell us what criteria the border services officers will use to decide whether or not to allow this comic into the country?

[*English*]

Hon. Ralph Goodale (Minister of Public Safety and Emergency Preparedness, Lib.): Mr. Speaker, our government celebrates Canadian diversity as a tremendous source of strength, and the Jewish community in Canada is an integral part of that. We will always stand firm against intolerance and hate, as we continue to build an open, inclusive society.

With respect to the admissibility of a particular individual, border security officers make those determinations on the basis of the facts at ports of entry in accordance to Canadian law.

I would point out that past criminality is a factor that is certainly taken into account.

* * *

[*Translation*]

TAXATION

Mr. Xavier Barsalou-Duval (Pierre-Boucher—Les Patriotes—Verchères, BQ): Mr. Speaker, more than 26,000 Quebeckers, including Christian Tremblay, in my riding, will be penalized for selling their businesses to family, because Ottawa does not allow them a deduction for capital gains. Quebec does allow this deduction.

Instead of using Quebec as a model, the government claims that the system is working and that the situation is fair. That is what we hear from the member for Saint-Maurice—Champlain.

When will a Liberal from Quebec stand up for Quebec businesses?

Hon. Bill Morneau (Minister of Finance, Lib.): Mr. Speaker, we understand that this is an important issue for some families.

We believe that the existing system works and that it is fair to all taxpayers. We are listening. We continue to focus on economic growth, and we will listen to Canadians to make sure that things are working.

* * *

FOREIGN AFFAIRS

Mr. Luc Thériault (Montcalm, BQ): Mr. Speaker, selling armoured vehicles to Saudi Arabia is immoral and contrary to the ethics of responsibility. The Minister of Foreign Affairs knows that.

The United Nations confirmed that the Saudi army is targeting schools and civilians in Yemen. PBS showed that Saudi Arabia was using its armoured vehicles against political dissidents. Even so, the minister insists on honouring contracts, and he is using every intellectual trick in the book to justify his decision even though the armoured vehicles are being used for ill. He calls it “responsible conviction”.

When will the minister stop being an accomplice and stop the sale of arms to Saudi Arabia?

● (1500)

Hon. Stéphane Dion (Minister of Foreign Affairs, Lib.): Mr. Speaker, I thank my colleague for giving me an opportunity to repeat my answer once again.

The contract was signed by the previous government, and it was signed in full. During the election campaign, both the Liberal Party and the NDP pledged to honour the contract. That meant the export permits would land on the Minister of Foreign Affairs' desk.

I will block those permits if the military equipment is ever used to violate human rights or against the interests of Canada and its allies.

* * *

[*English*]

COMMITTEES OF THE HOUSE

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Mr. Speaker, my question is for the hon. government House leader.

We all know that in this place, in theory, all members of Parliament are equal, but sometimes large majority parties will use their power, and I think it is an abuse of power, to reduce the rights of smaller party MPs, such as in the fall 2013, where every single committee was told to pass a motion to take away the rights of smaller party MPs at report stage.

I am very distressed to find that the same motion is now being asked to be passed in every committee by the Liberal majority.

Will the hon. government House leader please reflect on his letter of mandate and reconsider?

Hon. Dominic LeBlanc (Leader of the Government in the House of Commons, Lib.): Mr. Speaker, we are following the ruling of your predecessor. As you will know, prior to that ruling, independent MPs could not propose amendments at committees.

We are trying to ensure that members of Parliament from non-recognized parties in this House have an opportunity to play a constructive role in the legislative process at the committee stage, and we are giving MPs from non-recognized parties a bigger role in those committees.

* * *

PRESENCE IN GALLERY

The Speaker: I would like to draw the attention of hon. members to the presence in the gallery of His Excellency Tadamori Oshima, Speaker of the House of Representatives of Japan.

Hon. Lisa Raitt: Mr. Speaker, I apologize that I seem to be stuck on this balanced budget thing, but I do have before me the *"Fiscal Monitor"*, published by the Department of Finance, which gives us to the end of the year up to March.

I wonder if we could table this in the House.

The Speaker: Is there unanimous consent to table this document?

Some hon. members: No.

ROUTINE PROCEEDINGS

● (1505)

[*English*]

COMMITTEES OF THE HOUSE

FINANCE

Hon. Wayne Easter (Malpeque, Lib.): Mr. Speaker, I have the honour to present, in both official languages, the third report of the Standing Committee on Finance, in relation to Bill C-2, an act to amend the Income Tax Act.

The committee has studied the bill and has decided to report the bill back to the House without amendment.

* * *

BUSINESS OF THE HOUSE

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Mr. Speaker, I believe if you canvass the House you will find there have been discussions among the parties, and if you seek it, I think you will find unanimous consent to adopt the following motion:

> That, notwithstanding any Standing Order or usual practice of the House, on Monday, May 2, 2016, the House shall continue to sit beyond the ordinary hour of daily adjournment for the purpose of considering Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), at second reading and when no Member rises to speak, or at midnight on that sitting day, whichever is earlier, the debate be deemed adjourned, and the House deemed adjourned until the next sitting day.

The Speaker: Does the hon. parliamentary secretary have the unanimous consent of the House to propose the motion?

Some hon. members: Agreed.

The Speaker: The House has heard the terms of the motion. Is it the pleasure of the House to adopt the motion?

Some hon. members: Agreed.

(Motion agreed to)

* * *

PETITIONS

SEX SELECTION

Mr. Earl Dreeshen (Red Deer—Mountain View, CPC): Mr. Speaker, it is my pleasure to rise today to present petitions on three separate issues on behalf of my constituents of Red Deer—Mountain View.

The first petition calls upon Parliament to condemn discrimination against sex-selective abortions.

ABORTION

Mr. Earl Dreeshen (Red Deer—Mountain View, CPC): Mr. Speaker, the second petition asks Parliament to enact legislation restricting abortions.

JUSTICE

Mr. Earl Dreeshen (Red Deer—Mountain View, CPC): Mr. Speaker, the third and final petition calls upon the House of Commons to pass legislation that would recognize preborn children as separate victims.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Speaker, I have the honour to present two petitions today.

The first petition calls upon the House of Commons to pass legislation which would recognize preborn children as separate victims when they are injured or killed during the commission of an offence against their mothers, allowing two charges to be laid against the offender instead of just one.

PHYSICIAN-ASSISTED DYING

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Speaker, the second petition is from over 200 petitioners who are calling upon the Government of Canada to enact clear conscience protection for health care workers and institutions with respect to the physician-assisted dying bill that is before the House.

JUSTICE

Mr. Dave Van Kesteren (Chatham-Kent—Leamington, CPC): Mr. Speaker, Canadians want Parliament to know about the tragic story of Cassandra Kaake, who was 31 weeks pregnant when she was murdered in Windsor, Ontario. Tragically, there will be no justice for Cassandra's unborn baby girl, Molly, who was killed in that violent attack. That is because in Canadian criminal law, a preborn child is not recognized as a separate victim in attacks against their mother.

This petition calls upon Parliament to pass legislation to allow a separate charge to be laid in the death or injury of a preborn child when that child's mother is a victim of a crime.

Canadians want justice for victims like Molly.

INSECTICIDES

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Mr. Speaker, I rise today to present two petitions.

The first is from residents of Saanich—Gulf Islands, from Pender, Salt Spring, Saturna, Victoria, and Saanich. They are all calling for the current government to act to protect pollinators and health by following Europe's lead and banning neonicotinoid pesticides in Canada.

● (1510)

GENETICALLY MODIFIED FOODS

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Mr. Speaker, the second petition is from residents throughout Ontario, but particularly from the Thunder Bay area, who are calling for the government to act to label all products containing genetically modified organisms.

PALLIATIVE CARE

Mr. Mark Warawa (Langley—Aldergrove, CPC): Mr. Speaker, I am honoured to present a petition on palliative care. The petition highlights that in the Carter v. Canada decision of the Supreme Court, competent and consenting adults can request assisted suicide or euthanasia. The petition then states that it is impossible for persons to give informed consent who do not have access to adequate palliative care to deal with their suffering. The petitioners are therefore calling on Parliament to establish a national strategy on palliative care.

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QUESTIONS ON THE ORDER PAPER

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Mr. Speaker, the following question will be answered today: No. 72.

[*Text*]

Question No. 72—**Mr. Dan Albas**:

> With respect to the sharing of entry and exit information at land based border crossings with the United States: (*a*) has the government made the United States government aware that some Canadians who cross in to the United States at a land crossing subsequently leave the United States, usually within a few days, to cross by land in to Mexico, or by air for some other destination; (*b*) has the United States government indicated how it plans to avoid incorrectly identifying such Canadians as overstaying their visas; (*c*) what paperwork and information should be kept by Canadians who spend the winter in Mexico after crossing in to that country by land, in order to satisfy United States representatives that they have not spent the winter months in the United States; and (*d*) is there any plan by the United States or Canada to introduce border crossing entry and exit information sharing with Mexico that could make the United States aware when a Canadian leaves the United States to enter Mexico?

Hon. Ralph Goodale (Minister of Public Safety and Emergency Preparedness, Lib.): Mr. Speaker, in response to (a) and (b), the government has not specifically raised this scenario with, nor requested this information from, the Government of the United States. In the “Entry/Exit Overstay Report Fiscal Year 2015”, the U.S. Department of Homeland Security notes that it collects exit data for travellers departing the U.S. through air and sea ports.

Exit information will be used by both Canada and the U.S. to support the identification of potential overstays. Additional measures will be taken to further validate the accuracy of the information and prevent the wrongful identification of travellers. In this regard, Canada and the U.S. will work together to identify and assess potential scenarios which may result from the sharing of information, including implications for Canadians temporarily visiting the U.S. who may depart the U.S. via the southern land border into Mexico.

In response to (c), all questions regarding the paperwork required by the U.S. should be directed to U.S. Customs and Border Protection.

In response to (d), Canada has no plans for such an initiative at this time. The CBSA cannot address current or potential arrangements between the U.S. and Mexico.

* * *

[*English*]

QUESTIONS PASSED AS ORDERS FOR RETURNS

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Furthermore, Mr. Speaker, if a supplementary response to Question No. 53, originally tabled on April 11, 2016, as well as Questions Nos. 71 and 73 could be made orders for returns, these returns would be tabled immediately.

The Speaker: Is that agreed?

Some hon. members: Agreed.

[*Text*]

Question No. 53—**Mr. François Choquette**:

With regard to the Translation Bureau (TB), which falls under the responsibility of Public Works and Government Services Canada: (*a*) since 2013-2014, broken down by year, (i) how many translator, interpreter, terminologist and reviser positions has the TB had, (ii) how many client institutions has the TB had; (*b*) what is the total amount billed to the TB's client institutions for (i) translation or revision services, (ii) interpretation services; (*c*) what are the estimated costs of implementing a machine translation tool as of April 1, 2016; (*d*) what studies were undertaken on (i) the justification for implementing a machine translation tool, (ii) the impact of a machine translation tool on bilingualism in the public service, (iii) the quality of the texts translated by a machine translation tool, (iv) the costs associated with implementing a machine translation tool; (*e*) since 2005-2006, broken down by year and by department, what has been the total value of the contracts sent to external suppliers rather than the TB, broken down by contracts for (i) translation, (ii) interpretation, (iii) revision; (*f*) what financial and human resources, in terms of staff working in full-time equivalent (FTE) positions, has the TB devoted to developing its machine translation tool; (*g*) since 2011-2012, broken down by year and by department, what financial and human resources, in terms of FTEs, have been devoted to external suppliers and allocated to (i) contracting with suppliers for translation and revision, (ii) management of the contracts referred to in (i), (iii) quality assurance for these contracts; (*h*) since 2005-2006, broken down by year and by department, how many words have been translated by external suppliers rather than the TB; (*i*) since 2005-2006, broken down by year, how much has the TB paid suppliers of translation services with which it has contracted; (*j*) since 2005-2006, broken down by year, what financial and human resources, in terms of FTEs, has the TB devoted to (i) contracting with suppliers for translation, (ii) management of these contracts, (iii) quality assurance for these contracts; (*k*) since 2013-2014, broken down by month, how many words have been sent to the TB by client institutions and (i) translated by translators who are indeterminate employees of the TB, (ii) translated by TB suppliers; (*l*) has the government taken steps to hire new employees between now and 2019-2020, and if so, how many translators will be hired internally, broken down by year, (i) in indeterminate positions, (ii) in temporary positions; and (*m*) what is the TB's current pricing structure?

(Return tabled)

Question No. 71—**Ms. Christine Moore**:

With regard to the government's budgets, whether or not all the departments committed to them, as relates to the Economic Development Agency of Canada for the Regions of Quebec: (*a*) what was the amount spent, and what amount remained unspent, for these activities, broken down by (i) fiscal year, (ii) program, (iii) region, from 2002-2003 to 2014-2015; (*b*) what amount has been spent, and what amount remains unspent, for these activities during the current fiscal year; (*c*) what was the amount budgeted to be spent on these activities, broken down by fiscal year from 2002-2003 to 2014-2015; and (*d*) what was the amount budgeted to be spent on these activities during the current fiscal year?

(Return tabled)

Question No. 73—**Mr. Peter Julian** :

With regard to the government's support for the Canadian International Resources and Development Institute (CIRDI): (*a*) what is the breakdown of spending to date by (i) project, (ii) country of focus, (iii) individuals who travelled for each event, (iv) individuals from host countries who participated in each event; (*b*) what are the detailed sources of both committed and received funding by (i) the government, (ii) foreign governments, (iii) extractive sector companies, industry associations or other private sector organisations, (iv) academic institutions, (v) civil society organizations; (*c*) what are the details of all documents that CIRDI has submitted to the government, including project implementation plans, performance measurement framework, baseline study reports, annual work plans, audited financial statements, initial budgetary forecast, secondary budgetary forecast, quarterly or semi-annual financial reports, quarterly and semi-annual and annual narrative reports, and risk reports, as required under the government's contribution agreement with CIRDI, as well as the details of any other related documents; (*d*) does CIRDI meet or fail to meet the three conditions of Section 4(1) of the Official Development Assistance Accountability Act and how has the current government determined so; (*e*) what is the due diligence policy to ensure that a request received from a foreign country official for assistance is a legitimate request, based on principles of democracy, the public interest, and other principles; (*f*) what is CIRDI's role in Canada's "economic diplomacy" concept, announced as part of the 2013 "Global Markets Action Plan"; (*g*) what due diligence has the current government performed prior to giving and renewing its support for CIRDI's mandate and continued funding, to ensure that its mandate and justification for funding (i) are evidence-based provided by reputable, non-partisan sources, (ii) align with the recommendations of the National Roundtables and ensure that Canada is living up to its international obligations to promote universal respect for human rights as signatory to seven human rights treaties, (iii) make due consideration of the solicited responses to the Canadian International Development Agency's 2012 Consultation Note for Request for Proposals development of the Canadian International Institute for Extractives Industries and Development, and (iv) align with what indigenous peoples, citizen groups, and grass-roots civil society organizations in host-countries have requested; (*h*) who from the government participates, and has participated in the past, in the advisory committee to CIRDI and what is the full composition of CIRDI's advisory committee; (*i*) what are CIRDI's activities, projects, and initiatives in (i) Peru, (ii) Ecuador, (iii) Colombia, (iv) Mongolia, (v) Ethiopia, (vi) Western Africa; (*j*) of the activities, projects, and initiatives acknowledged in (i), what are the details of all documentation describing (i) the rationale for each project, (ii) the inception and design of project goals, methodologies, and participant profiles, (iii) a list of project participants, their affiliations, and justification for their participation, (iv) all project proponents and any conflicts of interest, (v) project summary reporting including feedback, criticism, complaints; (*k*) how do the activities, projects, initiatives of CIRDI listed in (i) support mining company interests or other Canadian economic interests; (*l*) for each of CIRDI's proposed, current, or completed projects, how has the long-term effect on poverty reduction and sovereignty been or is being (i) evaluated, (ii) verified; (*m*) what is the update on the $15.3 million project with Ethiopia's Ministry of Mines, and what is (i) the full, official project description, (ii) the complete project scope, (iii) the original request from Ethiopia, and details thereof, (iv) due diligence analysis and reporting to demonstrate that this project aligns both with the Official development assistance Accountability Act and what the Ethiopian people, especially mining-affected communities and the organizations that work with them, are requesting; (*n*) as of May 2016, what is the current directive and mandate of the government for CIRDI; and (*o*) what are the government's plans to either renew or terminate CIRDI after its five-year mandate and funding expires in 2018?

(Return tabled)

[*English*]

Mr. Kevin Lamoureux: Finally, Mr. Speaker, I ask that all remaining questions be allowed to stand.

The Speaker: Is that agreed?

Some hon. members: Agreed.

GOVERNMENT ORDERS

[*English*]

CRIMINAL CODE

The House resumed consideration of the motion that Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying), be read the second time and referred to a committee.

Mr. Mark Warawa (Langley—Aldergrove, CPC): Mr. Speaker, it is an honour to be in the House representing my community of Langley—Aldergrove. This is a very important debate we are having today.

I just want to do a quick review of how we are involved with this debate today. It was approximately a year ago, February 2015, that the Supreme Court made its ruling that Canadians who are suffering should have access to assisted suicide or euthanasia. I will use those terms because they are the terms used in the Criminal Code of Canada.

Terms like “death with dignity” and “medical aid in dying” are used when a physician is helping people in the last days of their life. They are not hastening their death. Palliative care is one of those forms of assistance, in which people are being assisted in the last days of their life. Therefore, to call it medical aid in dying really does not truly capture what we are talking about.

When we had town hall meetings, one of the terms I heard was “medically hastened death”. That more accurately describes what we are talking about. However, I will use the language of the Criminal Code, which the Supreme Court says we have to amend. Those terms are “assisted suicide” and “voluntary euthanasia”.

Mr. Speaker, I will be sharing my time with the incredible member for Abbotsford, the community just to the east of Langley. He is incredible because he was probably Canada's greatest foreign trade minister and did so much for our country. I want to thank him for all his work.

When the Supreme Court made its decision in February last year, what did the previous Parliament do? It knew there was an election coming in October of last year, so it appointed an external panel. The panel was given a clear mandate to consult with Canadians and then create a suggested legislative response.

After the election, the new government contacted the external panel, which had just completed its work of consultation and was in the process of creating the legislative response. The new Parliament could have started right away, because we had until February 6 to deal with the issue.

What did the new government do? It contacted the external panel and said it had changed its mandate. It no longer wanted legislation from the panel. It would create its own legislation. Instead of Parliament being called back and creating a special committee to deal with that legislation—we had until February 6 of this year, which would have given us a few months to debate and work on it—the government changed the mandate, said it was going to create its own legislation, then dithered. For a number of months it dithered, and then it created the special committee. The special committee came up with recommendations. Then what did the government do? It dithered and delayed, to the point now that we have four sitting weeks to basically do what normally takes two years to do.

Quebec took six years and three premiers in a non-partisan environment to create Bill 52 in Quebec, dealing with assisted suicide and euthanasia. It dealt with it in a much more responsible way.

Some would say they wish we did not have this debate. I heard that when we had town hall meetings. However, the Supreme Court in the Carter ruling made that decision for Canada. It said this must be permitted, and it is counting on Parliament to come up with appropriate safeguards to ensure we protect vulnerable Canadians.

What did the new government do? It changed the mandate of the external panel, then dithered. It had a special panel, which was partisan in nature. Then it dithered after the report from that panel. Now we have four sitting weeks.

It is really disappointing the way the new government has handled this. It is too important to be rushed through, but this is what the government is doing.

● (1515)

There are four sitting weeks, and the Liberals are not consulting properly. They are not giving Parliament adequate time to do this properly, and they are ramming it through. It is basically legislation passed by exhaustion.

In the special joint committee, we heard from two witnesses representing aboriginal communities, and they were not consulted. However, another requirement of the Supreme Court of Canada is that we consult properly, but that is not happening with the current government, which is not transparent, not accountable.

I would suggest that the Liberals seriously consider what happens on June 6 if the bill does not pass. What happens in Canada if their mismanagement of this results in no legislation in Canada and we have this legal void, and then the Carter decision takes over? Then we are advocating turning over the responsibility of protecting the vulnerable to each college of physicians and surgeons, and we would have different policies being applied across Canada. It would be a very serious situation.

I am hoping we will work together. I would suggest that the government seriously consider asking for more time from the Supreme Court, because the Liberals have not managed this well, and we have ended up with only four sitting weeks left to do two years' worth of work.

I want to speak to a couple of changes that I believe need to be made in Bill C-14.

The number one thing that I have heard at town hall meetings wherever I was, whether in British Columbia, Saskatchewan, or at home, is the importance of conscience protection.

I had a young nursing student come up to me and say she did not want to be part of this and ask if she would have to be part of this. I said that, at present, the special committee that was formed is recommending that, yes, one would have to be. Also, physicians would have to provide an effective referral. However, Bill C-14 is very silent on this, and it would leave it up to provinces to come up with their own policy on how this would be dealt with.

The Canadian Medical Association said that 70% of physicians in Canada do not want to be part of this, but 30% of physicians in Canada will participate in assisted suicide. Therefore, it is not an access problem, but what do we do about conscience protection?

Bill C-14 clearly needs to be amended to make it a criminal offence to force through intimidation or coercion in any way or threaten a physician that he or she would not be able to practise medicine—or a nurse, pharmacist, or any health care professional—to force them to participate in this against their will. This is the number one thing we heard time and time again: protect conscience rights.

The Criminal Code is being amended, and Bill C-14 needs to be amended to include that type of conscience protection. Without it, we do not have a pan-Canadian approach. We would have different policies in each province and territory, potentially. Some provinces have indicated that some physicians must participate.

On the Charter of Rights protection, the Supreme Court said physicians' charter rights should be protected. However, if we go on and do not provide the legislative protection, if we do not provide proper conscience protection, I am concerned that we will see in Canada physicians leaving the practice, maybe retiring.

I met a physician recently who is 71 years old and he is still practising medicine because he loves to help people. That young student nurse I talked about wants to leave nursing school. I told her not to leave yet. Let us see if we can fix this to make sure her conscience is being protected.

However, if we do not protect the conscience rights of Canadians, of physicians, nurses, and pharmacists, we are going to have people leaving the practice. They will either retire or relocate to another jurisdiction where their conscience will be protected.

We already have a shortage of physicians, nurses, and doctors in Canada. This would create a medical crisis in Canada if we do not protect the conscience rights of Canadians. It is a charter right. It is our responsibility to protect the vulnerable and the conscience rights.

● (1520)

There is a gaping hole in the legislation, Bill C-14. We need to fix that. I see a number of members here who are going to be on the justice committee, and we will be voting as Parliament. I hope we can deal with that.

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Mr. Speaker, I found it interesting that the member allocated quite a bit of debate time to how this legislation came about. It is important to recognize it is because of a Supreme Court of Canada ruling in February. I disagree with virtually almost everything else the member said, in terms of his implication. The void in leadership occurred from the moment of the release of the Supreme Court decision until October 19, when we finally had a Prime Minister who recognized the importance of the issue and that the Canadian government has a lead role to play. This is something the member at the very least should acknowledge.

After listening to many speakers and in particular the ministers responsible for this legislation, I assure the member that the issue surrounding conscientious objections of health care professionals is being taken care of. I wonder if the member might want to provide some comment in terms of why it is so important that we see this legislation passed in a timely fashion so that we do not continue to have a void and we can have some common ground from coast to coast to coast.

Mr. Mark Warawa: Mr. Speaker, I wish the member had answered some of the questions that I put forward, one of which is what happens on June 6, in four sitting weeks, if the Liberals are not able to pass this. After October 19, one of the first things the Liberals did was to change the mandate of the external panel. They should not have done that, but they did. Then they dithered and did not do anything. They created the problem. There was an external panel of eminent people in Canada who had consulted during the election, so we would end up with non-partisan legislation.

What have the Liberals done? They changed the mandate, created a partisan committee with the report's recommendations, many of them not good, and that is why we had dissenting reports. We had bad recommendations from that committee. We need to fix the legislation, and I look forward to working constructively.

● (1525)

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Speaker, I want to thank my colleague for his work on the committee and also his continuing work on seniors care.

Just to follow up with my colleague across the way, in terms of the expert panel, there was a point where I had the report of the expert panel. The unfortunate part is that the Liberals refused any recommendations from the panel. They said it could give them the report but they did not want any recommendations. That was really a sad day, seeing the expert work that was done.

My question goes to the point of definition. Currently, Bill C-14 is called medical assistance in dying. I pointed out on a number of occasions that, many times when we see social engineering projects, they are preceded by verbal engineering, and I think this is another way that this is happening.

I would like my colleague to comment on the difference between physician-assisted suicide and voluntary euthanasia, because we know that the outcomes of those two different methods are vastly different. In fact there is a tenfold increase in people dying by voluntary euthanasia over physician-assisted suicide because of some of the ambivalence that occurs.

Mr. Mark Warawa: Mr. Speaker, there is a vast difference between the two definitions. In physician-assisted suicide, the physician would provide the lethal dose but the person must self-administer. With voluntary euthanasia, the physician or health care professional would administer it. The big question then is, when people use euthanasia, whether the person has been properly consulted. Do they really want this to happen, or are they closing their eyes? Are they able to self-administer, and should they? Therefore, they are two very different definitions.

It was the decision of the Supreme Court in the Carter ruling that it is a competent adult providing consent, proper competence being deemed by, if it is a psychiatric issue, a prior assessment to make sure the person is competent. Bill C-14, to give it credit, requires asking at the last minute to be sure people want to have their life ended. That is very important. The special joint committee did not want this prior asking of “are you sure you want this”. Death is permanent. Bill C-14 has that right, but we need to make sure that the person is competent and is giving consent right to the last moment.

Hon. Ed Fast (Abbotsford, CPC): Mr. Speaker, I appreciate the opportunity to add my voice to those who have expressed serious concerns about this legislation. Bill C-14 would, for the first time ever in Canada, establish a national right to die and the right to seek assistance in the act of committing suicide.

I acknowledge that the issue of assisted suicide is highly complex and of course deeply sensitive. Like it or not, the issue has been dropped in our laps by the Supreme Court of Canada and each one of us has been elected to wrestle with this very tough issue. I hope that, at the very least, we will have the courage to reject solutions that, on their face, may, by some, be characterized as progress, but in reality degrade rather than elevate the intrinsic value of each and every human life.

I believe that every human life is God given and is deserving of dignity, value, and protection. Indeed, from my earliest years as a public official in the community of Abbotsford, I have made it clear that my constituents can and should always expect me to defend human life against all threats. Today is no different. The legislation we are debating today represents a watershed moment in the life of this country, one in which our fundamental values are being re-examined and tested.

I believe Bruce Clemenger said it best when he stated:

> With the introduction of Bill C-14, Canada has crossed a significant threshold.... The decriminalization of euthanasia and assisted suicide constitutes a fundamental shift in how we as a society value and understand life and the duty of care we owe one another. Never before have we as a nation said that intentional killing is an appropriate response to suffering, or that we should take the life of the one who suffers rather than finding ways to alleviate their suffering.

Let me begin by commenting on the role that the Supreme Court should or should not play in articulating a right to die. As a lawyer and lawmaker, I have the greatest of respect for the rule of law, for the courts which sustain it, and for the individuals who occupy the bench. It is the rule of law and our court system that are intended to act as a bulwark against oppression and discrimination and defend our prevailing national values, including our personal freedom and our democratic institutions.

That said, it is eminently within our prerogative as MPs to also respectfully question and challenge the very decisions that our courts make and to suggest what particular issues should more appropriately be left for Parliament to decide. It is my view that matters of protecting life and the taking of life should remain the sole domain and prerogative of the duly elected representatives of the people of Canada, namely, the members of the House.

More to the point, many Canadians are having great difficulty grasping how the court would presume to specifically direct Parliament to implement legislation that effectively creates a right to die and a state-sanctioned role in the taking of a life, all under the threat of the court doing so on its own. Therefore, let me be very clear. I am deeply sympathetic to the suffering of so many whose conditions are terminal, who have concluded that there is no medical hope for healing, who suffer from unbearable pain, whose quality of life has been eroded beyond measure, or who consider themselves an undue burden upon family, friends, and their caregivers. That is exactly why our first and primary focus should be to improve and extend 21st-century palliative care to all Canadians whose lives could be measurably improved by it.

Is it not ironic that at the same time that we are debating the state-sanctioned taking of a human life for compassionate reasons, the Liberal government has failed to follow through on its solemn promise to expand the availability of palliative care. The promised $3 billion would have gone a long way to ensuring that palliative care becomes an essential part of the end-of-life decision-making process.

Instead of barrelling ahead with active euthanasia legislation, is it not incumbent upon us as lawmakers to first explore every opportunity to provide compassionate and effective palliative care to those who are in the terminal stages of disease and health? We owe Canadians so much more than simply an ill-considered rush to implement a directive from Canada's Supreme Court.

● (1530)

A cursory study of assisted suicide regimes around the world quickly reveals that even the most stringent and well-meaning safeguards are never completely effective in ensuring that no wrongful deaths occur. Jurisdictions like Belgium have acknowledged that of the thousands of assisted suicides that have taken place, some have taken the lives of those who could not or did not provide an informed consent, or who otherwise should not have died.

In this country, here in Canada, we abolished capital punishment exactly because we could not guarantee that an innocent life would not be taken. Yet, today, we are being asked to take the morbidly contradictory position of saying that notwithstanding that some vulnerable or unwilling individuals would lose their lives, we are prepared to take that very risk. The hypocrisy is astounding.

I also note that Bill C-14 fails to properly address the right of physicians, nursing professionals, and health care institutions to refuse to participate in the taking of a human life. Leaving it to the provinces, territories, and professional associations to regulate is not the answer, and will simply result in a patchwork of directives that ultimately compromise the ability of doctors and nurses to refuse any direct or indirect participation in assisted suicide.

It is highly likely that a health care professional in one jurisdiction will find his or her right to conscientious objection protected, while a colleague in another province is left without such a fundamental right. That is unconscionable and a clear abdication of the government's obligation to protect the rights of all Canadians, irrespective of where they practice medicine.

The right of medical professionals to refuse direct or indirect participation in assisted suicide should never, ever, be subject to negotiation or compromise. On that measure alone, Bill C-14 fails the test.

Many Canadians have expressed a legitimate fear that Bill C-14 will become the precursor to much more radical right-to-die policies. They are right. I have no doubt that the legislation before us, if passed, will very quickly become the thin edge of the wedge to secure future liberalization of assisted suicide to include children, the mentally and physically disabled, the chronically ill, the elderly, and those no longer considered to be productive contributors to Canada. Is that really the Canada we were elected to build?

This debate exposes an astonishing irony. Today we are experiencing, to our national shame, an unprecedented epidemic of suicides of our youth on first nations reserves. In response, the federal government is undertaking extraordinary efforts to prevent such suicides from happening in the future.

Yet, at the same time, here we are, in this House, debating an assisted suicide bill that the special parliamentary committee recommended should in the future extend the right to die to vulnerable children, the very group we are working so hard to save in first nations communities. Colleagues, what are we thinking?

Over the years, I have gotten to know many doctors and nurses, and have on numerous occasions dialogued with them on the issue of euthanasia. Our health care professionals are deeply compassionate, caring people who go to great lengths to ensure that patients who are terminal and suffering from great pain are made comfortable. They exercise a high level of discretion when they administer medications that alleviate pain, even where such medications may, on occasion, hasten the patient's death. The government's introduction of Bill C-14 failed to take that into account.

Let me close. More than a dozen times in the past this Parliament has considered and consistently rejected assisted suicide legislation. For whatever reason, our Supreme Court has now seen fit to insert itself into this debate by reversing itself on the Rodriguez decision. Its directive to the House to implement assisted suicide legislation calls upon us to act courageously and reject that directive.

Let us resist the urge to tread upon the steep and slippery slope of a policy whose implications are unclear, and whose trajectory represents a fundamental undermining of our foundational values.

● (1535)

We are faced with a monumental decision, one that challenges us to reaffirm the pre-eminence and inviolability of a human life. May we choose wisely and reject this deeply flawed bill.

Mrs. Celina Caesar-Chavannes (Parliamentary Secretary to the Prime Minister, Lib.): Mr. Speaker, the Minister of Justice and the Minister of Health have really gone to lengths to ensure that this legislation strikes a balance between the complexities of medical assistance in dying. The Minister of Health has often stood in the House and talked about the fact that we need to improve our palliative care system as well as our home care system to ensure that people are having the best quality of life up until their time of death.

We now have a situation where we need to have this legislation go through, and I am wondering if my colleague could tell me why the previous government did not act and take charge on this particular issue when they were in power and are questioning our motives now.

Hon. Ed Fast: Mr. Speaker, I can assure the member that we actually did take an active role in addressing the Carter decision. However, our government at the time was taking its time to get this right. Broad consultations across the country is the least that we could do with something this important, this critical to our foundational values.

Since when is the taking of a life defined as health care? That is my struggle. This country was founded upon values that respected the value of human life and protecting human lives. This is a huge step in the wrong direction, one that I am committed to resisting, as a parliamentarian and someone who deeply loves this country.

This legislation is a very dangerous step on a slippery slope of which we do not know where it will lead, but it is very clear it will lead to much greater liberalization and cast a much greater net in the future.

● (1540)

Mr. Charlie Angus (Timmins—James Bay, NDP): Mr. Speaker, I listened with great interest to my hon. colleague. I find it very unfortunate, though, to use the suffering of the children in Attawapiskat in this debate.

I have heard it used by some people in the faith community. I find that it is a real debasement of the issue because of what the children are suffering there, with the lack of basic mental health services from the federal government, the intergenerational trauma of the residential schools, and the churches just walking away from their legal obligations.

Edmund Metatawabin, a survivor of St. Anne's Residential School, who knows these families well says that there is a direct highway between the injustice committed by the federal government and the effect it is having on these children. I can tell my colleague, being in the community, I hear that. I respect his judgment on many things and I am just asking that we be careful when we bring in something tied to this.

My concern in listening to my hon. colleague is that I do believe it is the role of Parliament to offer legislation on what is the right of life and death in this country, but the Supreme Court decision is acted.

I think it is incumbent upon us to be truthful with the Canadian people that if Parliament does not respond to this legislation, it will create a legal vacuum, and in that legal vacuum, all manner of agents may step forward, may be heard, and may be recognized by the Supreme Court. It is not enough to say that we can push back against the Supreme Court. If we do not meet this deadline, then a legal vacuum will ensue and much broader interpretations may result.

Hon. Ed Fast: Mr. Speaker, I want to be very sensitive to the hon. member's comments about not using the children of Attawapiskat as an unnecessary element in this debate, but I think it bears noting that this is a critical issue across Canada when our first nations are struggling with an epidemic of suicide. I look at this legislation in all earnestness and I see how it flies in the face of what we are trying to do, which is not only to protect and defend human life but to create an environment within Canada where life can be lived in a way that is not only happy but productive and contributes to building a better society.

With respect to his specific question, how do we approach this ruling from the Supreme Court of Canada? The government well knows it does have remedies available to address the ruling of the court. It has tools within the charter itself to respond to this decision.

When legislation is so fundamentally flawed, as is Bill C-14, as a person of conscience, as a person of faith, as a person who loves this country dearly, it is my duty to speak up against this kind of legislation and to say, no, there are better ways of addressing this.

I am so pleased with my colleague who has raised the issue of palliative care consistently in this House. That should be the first focus of the work we are doing to help people who find themselves in these circumstances.

Ms. Joyce Murray (Parliamentary Secretary to the President of the Treasury Board, Lib.): Mr. Speaker, I will be sharing my time with the member for Parkdale—High Park.

I am proud to stand in this House today in support of Bill C-14, introduced by the hon. Minister of Justice.

With this bill, our government recognizes the autonomy that Canadians hold over their own lives, the expertise of our medical professionals, and the decision of the Supreme Court of Canada. Through extensive consultation, we have introduced a balanced solution that will restore dignity, protect the vulnerable, and allow our nation's medical professionals to respect the wishes of their patients.

Until now, Canadians faced horribly debilitating end-of-life suffering and had no legal control over their own lives. In desperation, some have gone to court to regain this control. However, it is a difficult process, which has compounded the physical and emotional strain felt by the patients and their families.

Doctors, nurses, and family members alike have felt powerless to assist those they care for, with no legal means to honour the wishes of those who suffer. They face emotional strain and difficult moral dilemmas, as the law prohibits them from respecting the dignity of their patients and doing what they often know is compassionate medical assistance for a good death.

Many of us in this chamber and across the country have personal stories of the kind of suffering I have mentioned. I do as well. I have an indelible memory of visiting a dear friend of many decades in the hospitals, whose body was breaking down from a terminal illness. He was in excruciating pain for weeks. He eventually declared that he would not eat or take any water or liquids. He finally passed away after six days of even more miserable suffering.

We are here to talk about a bill that is setting out a new form of medical service in Canada, which is medical assistance in dying. With this bill, we recognize that the decisions over one's person, including the decision to end one's life with dignity, should ultimately rest with the individual and not with the government.

Through consultation and careful consideration, Bill C-14 includes the following safeguards: a requirement for a second independent medical opinion; a 15-day reflection period; the ability for a patient to withdraw consent at any time; and a rigorous requirement for documentation at every step, with new criminal offences to prevent any potential abuse.

This government recognizes the need to respect the moral conscience of individual medical professionals. While every patient who fits the medical criteria will have access to medically assisted dying, no individual doctor or nurse will be required to participate if it conflicts with his or her values and beliefs.

● (1545)

[*Translation*]

Some medical professionals have expressed reluctance to refer a patient seeking medically assisted death to a physician who can provide the service because they feel that the referral would make them complicit in the death of the patient.

[*English*]

However, while it is absolutely critical to reflect important safeguards, we must also respect that the people seeking this procedure should have reasonable access.

In Carter, the Supreme Court of Canada recognized that the conscience rights of physicians will need to be reconciled with the charter rights of patients seeking medical assistance in dying. Although much of the necessary balancing will be a matter for the provinces and territories, our government is committed to working collaboratively with provinces and territories to support access to medical assistance in dying while respecting the personal convictions of health care providers.

The federal government will offer support to help ensure that all Canadians have access to the medical aid they need. One approach is a pan-Canadian coordination system for access to medical aid in dying. We can start by reviewing the assisted dying regimes in other countries to see what they have done and assess their applicability to Canada.

[*Translation*]

Closer to home, in Quebec, the act respecting end-of-life care offers other examples. It includes a range of end-of-life care, including palliative care, palliative sedation, and medical assistance in dying. The legislation makes the service broadly available in institutions and at home.

[*English*]

Physicians in Quebec are not required to provide this option, but they are required to notify the institution or local authority of any request and to forward the patient's request form. The institution will then take the necessary steps to find another physician as soon as possible to address the request.

Many people in Vancouver Quadra who have contacted me about the bill have expressed their support for medical assistance in dying. As their representative, I am pleased to support the work of my colleagues, the Minister of Health and the Minister of Justice.

Under the proposed legislation, medical assistance in dying would be available only to mentally competent adults who are eligible for publicly funded health services in Canada, who have an incurable illness, disease, or disability, are suffering intolerably, are in an advanced state of irreversible decline in capability, and whose death is reasonably foreseeable.

Some of my constituents have also expressed concerns about access.

[*Translation*]

Our criteria permit medical assistance in dying for some, but not all individuals who may seek it. We have heard concerns from some Canadians and experts about extending eligibility to mature minors, permitting requests made in advance, and including psychological illness as a sole underlying condition.

● (1550)

[*English*]

I want to let Canadians know that our government has heard their concerns.

[*Translation*]

At the present time, the limited information available on these issues warrants the cautious approach in the draft legislation before us.

However, the government is making a commitment to undertake independent studies on these issues to better understand the risks. The results of the reports will feed into the five-year legislative review set out in the bill.

[*English*]

There are other facets of the challenge of access. As we all know, our country has many remote and rural communities that face challenges in accessing health care services, including access to a physician or other health care provider. Although delivery of health care is a provincial and territorial responsibility, accessibility is one of the five main principles of the Canada Health Act.

[*Translation*]

I am pleased to report that, along with the protection of vulnerable populations, questions of access have been considered and addressed throughout the proposed legislation and in the complementary initiatives.

[*English*]

Let me provide an example. The umbrella term “medical assistance in dying” encompasses both the situation where a provider must be physically present to administer a substance that causes death, and the situation where the provider prescribes a medication that the person can take himself or herself. Having criminal exemptions for both procedures would help to increase access for eligible people and provide choices in the circumstances around which medical assistance in dying is provided.

Second, the draft legislation provides exemptions for both physicians and nurse practitioners to be able to provide this assistance. Nurse practitioners, or those with an equivalent designation, are authorized in many provinces to perform medical functions that are necessary for medical assistance in dying.

[*Translation*]

Exempting nurse practitioners from criminal liability provides the provinces and territories with an additional option to facilitate access to medical assistance in dying in underserved areas.

[*English*]

I will offer another example of how we are working to support access in our health care system. Canadians, experts, and stakeholders have focused on the need to improve access to quality palliative care in Canada, even as we consider how to implement medical assistance in dying. We have listened. Our government is making the commitment to develop, along with the provinces and territories, measures to support the improvement of a full range of end-of-life care, including palliative care.

[*Translation*]

In the context of a new health accord, our government has committed to providing $3 billion over the next four years to improve home care, including palliative care. Discussions with the provinces and territories are already under way.

[*English*]

In the meantime, it is essential that we end the suffering and restore the dignity of Canadians currently experiencing grievous and irremediable medical conditions as soon as possible.

The draft legislation before us acknowledges the need for access, alongside the need for safeguards and protections. With the bill, our government would achieve these objectives and meet the deadlines imposed by the Supreme Court of Canada.

I have confidence that we can put in place a system that meets the needs of Canadians for compassionate care and support at the end of life.

I invite my colleagues in this House, and all Canadians, to contribute their views to this discussion as we continue the process of updating our laws to reflect 21st-century realities. Our door is open, our government is listening, and we are committed to supporting our medical professionals, protecting our most vulnerable, and restoring the dignity of Canadians in their most trying moments.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, the member concluded by asking that we update the law to reflect 21st-century realities. By my count, this is the third issue on which the government is using an argument of dates to demonstrate a particular legislative opinion. We need more than just the dates.

With respect to the legislation before us, I have advocated for two changes.

One is that we have some kind of advance review by a competent legal authority to ensure that somebody receiving this service, or whatever we want to call it, did actually meet the criteria. Without advance legal review, there is no way of actually ensuring that the criteria were met. A person could go from doctor to doctor, or someone else could go from doctor to doctor for them. I want to know what the member thinks about advance review by a competent legal authority.

Also, what does the member think about removing the “reasonable but mistaken” clause, which would allow somebody who takes somebody else's life without consent to escape prosecution if they had a reasonable but mistaken belief that the person did consent?

Would the member accept those two changes? With those two changes, I think many of us would have a much easier time supporting the legislation so that we can meet the timeline.

● (1555)

Ms. Joyce Murray: Mr. Speaker, I want to thank the member for those thoughtful proposals.

There will be a committee process in which these kinds of ideas can be put forward and the committee can hear from expert witnesses. What we do not want to do is put unnecessary barriers in the way of people who are qualified to have this kind of end-of-life assistance.

I do want to say that it would have been helpful if the Conservative Party had done the work on how to follow through on the Supreme Court of Canada's requirement for medical assistance in dying when that Supreme Court ruling came out. There could have been much more discussion in Parliament a year ago, which is what our party called for and the Conservatives refused to do.

[*Translation*]

Mr. Robert Aubin (Trois-Rivières, NDP): Mr. Speaker, I thank my colleague for her speech.

I want to begin by saying how much I appreciate the tone of our exchanges today. It is inspiring and a change from our debates.

My question is quite simple and is on the example my colleague gave in her speech about one of her friends who stopped eating and drinking for six days in order to end his life. Although the Supreme Court's criteria are relatively clear in the legislation, the fourth element is rather vague in my opinion.

We are talking about natural death becoming reasonably foreseeable. Could my colleague provide some clarification on this fourth criterion? If someone meets the first three criteria, would he not be forced, once again, to stop drinking and eating in order to meet the four criteria to get the service he is seeking?

Ms. Joyce Murray: Mr. Speaker, I thank the member for the question.

I can guarantee that my friend's condition was consistent with the criteria of our bill.

[*English*]

As I said in my remarks, with such a short time to deliver on the Supreme Court's mandate in the time frame available, it is important to be cautious on how this is framed. That is what the proposed law would do. It finds the correct balance between safeguards for the vulnerable, the rights of physicians and nurses, and the personal rights of those who wish to have assistance in dying.

We have time moving forward to continue considering situations such as the member has brought forward to confirm that we have the balance right, or make adjustments in the future when the bill is reviewed in five years.

Mr. Arif Virani (Parliamentary Secretary to the Minister of Immigration, Refugees and Citizenship, Lib.): Mr. Speaker, I rise today to speak to Bill C-14. I start with reference to the Supreme Court of Canada's Carter decision, about which we have heard much.

In the opening paragraph of that ruling, the unanimous court said:

> It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician’s assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.

I agree with the Supreme Court. The choice is cruel.

The Supreme Court concluded that the criminal law as it currently stands was not only cruel, it was also unconstitutional. The court found that section 7 of the charter required access to medical assistance in dying, subject to certain safeguards. That is where the House finds itself today.

Let us be clear. The question facing parliamentarians is not whether we can permit Canadians access to medical assistance in dying. That access must be permitted to comply with the charter. The actual question facing us is how to design the access. In terms of design, I believe Bill C-14 strikes the right balance. The balance is between the right, on the one hand, of a competent person who seeks an assisted death in response to a grievous and irremediable condition, as compared to the need to protect the vulnerable from being induced to commit suicide at a time of weakness.

Striking this balance is not simple. Nor is it permanent, and this is an important point. The balance must be calibrated and recalibrated according to changing evidence and the evolution of societal values. Indeed, the Supreme Court's 2015 decision, which reversed the court's earlier ruling in 1993 in Rodriguez, is evidence of this very evolution. However, for now, in terms of where we are in 2016, I am firmly of the view that the bill would strike the right balance.

There is another reason why I rise before members today to speak in favour of the bill. That is because I have spent my career as a constitutional litigator fighting for people's rights, their human rights, their charter rights, their right to equality. Treating people equally means treating people with respect, according them dignity and according them autonomy. The bill would do that. It would give people control over their own lives, including the conclusion of their lives. It would allow those nearing death to pass in a manner of their choosing with less suffering.

In empowering choice, the bill would empower Canadians. It would strengthen us as a people because it is informed by a desire to give Canadians more autonomy and, as a result, greater dignity.

● (1600)

[*Translation*]

For the rest of my speaking time I would like to address two major categories of concern that this bill raises: the criticism that Bill C-14 does not go far enough to make medical assistance in dying available; and the opposite criticism that the bill goes too far and makes medical assistance in dying too accessible.

[*English*]

In this first category, the concerns are that Bill C-14 is not broad enough. They centre on three main components, and we have heard some of them this afternoon and in previous days of debate. For now, it is proposed that medical assistance in dying only be permitted for adults and for those who suffer from more than a mental illness alone. In addition, for now Bill C-14 would not provide for advance directives regarding medical assistance in dying.

The words "for now" are important. The government has committed to an independent study of legal, ethical, and medical issues that are raised by each of these three different categories. This is important. If medical assistance in dying is to be expanded into any of these three areas, it must be done only after a comprehensive study of the benefits and the risks associated with permitting medical assistance in dying in such circumstances.

I was determined to hear from my constituents directly on this important legislation. Therefore, in early April I hosted a town hall in my riding of Parkdale—High Park on the issue of medical assistance in dying. The engaged constituents of my community came prepared with thoughtful and personal reflections, with concerns, and with questions, many of which related to these very three items I just raised.

While the residents and community, like me, are keen to protect and promote the autonomy and dignity of all Canadians, including youth and the mentally ill, the residents of my community also cautioned about moving too quickly in an area where the consequences of a decision were final and irreversible. They noted, for example, that in Belgium medical assistance in dying had been legalized and studied for a period of 12 years prior to medical assistance in dying being made available to minors. The mentally ill, it was noted, would be able to avail themselves of medical assistance in dying under this legislation provided the mental illness was part of the patient's overall medical circumstances and that the applicant was still able to meet all of the general eligibility criteria.

As one who has championed the rights of mental health consumer/survivors in my community, I know it is critical that before embarking on the path of increased access to medical assistance in dying for those whose condition is mental illness alone, we get this right.

As we have said repeatedly, our government believes in enacting legislation that is well reasoned, carefully analyzed, and based, above all, on sound evidence. The proposed independent studies into things like access for minors will help inform this analysis and critical evidence-building process. Importantly, Bill C-14 also contains a provision which calls for a mandatory review of the entire legislation every five years.

As I said at the outset, finding the right balance in legislation of this nature is not permanent; it is fluid. It is a dynamic process which can and must adapt to changing evidence and societal norms.

Bill C-14 is not an extensive enough category. We also find an argument relating to reasonable foreseeability. We heard questions about it this afternoon. Some assert that the requirement to Bill C-14 that a person's death must be reasonably foreseeable is an unnecessary barrier. Such concerns are unfounded. Bill C-14 is actually more permissive than any assisted-dying legislation in North America. In Quebec, an applicant must have a terminal disease. Bill C-14 is more accessible. It would allow medical assistance in dying where death is reasonably foreseeable, looking at the totality of the medical circumstances.

In addition, in each of the four American states that have legislated medical assistance in dying, one is required to have a specific prognosis that an individual has less than six months to live. There is no such temporal restriction in Bill C-14.

Finally, in the category of Bill C-14 not being quite broad enough, some contend that the bill should stipulate, and again we heard it this afternoon, that medical practitioners are professionally bound to provide such service. This criticism misunderstands the nature of Bill C-14. It is an amendment to the federal Criminal Code. It is also misguided jurisdictionally.

Wearing my constitutional hat, it is clear that the federal government has an important role to play in maintaining universal access to insured health services, but the ultimate delivery of medical services is primarily a matter of provincial jurisdiction. Our government, as was mentioned by my colleague, has committed to work going forward with provinces and territories to support access for medical assistance in dying, while simultaneously respecting the personal convictions of health care providers. This approach reflects the balancing that must occur when addressing competing charter claims.

On the one hand, the section 7 claims of those who seek access to medical assistance in dying must be balanced with the freedom of conscience rights that are entrenched in subsection 2(*a*) of the charter. Those are the freedom of conscience rights of health care providers. The Supreme Court recognized this in the Carter decision, in paragraph 132, and this bill recognizes it in the preamble.

The second broad category is that the bill is too permissive.

● (1605)

[*Translation*]

In fact, those who maintain that Bill C-14 is too permissive are the ones who are failing in the fundamental responsibility to protect people who might commit suicide in a moment of weakness.

[*English*]

Requesting medical assistance in dying is not simple. Nor should it be. Requests must be made in writing. This has a meaningful impact. All such requests must be witnessed by two independent individuals. They cannot be a beneficiary in a will or a person charged with the care of the ill individual. A request must then be approved in writing by not one, but two different medical practitioners. Finally, the bill calls for a mandatory waiting period of 15 days in order to allow individuals to reflect on the seriousness of this choice.

The bill goes further. It requires an extensive regime of monitoring, so data and trends respecting medical assistance in dying can be obtained and analyzed by government. This kind of monitoring will ensure transparency, but more important, it will facilitate strengthening safeguards where required.

Finally, I am encouraged by the fact that Bill C-14 not only reflects the significance of choosing medical assistance in dying, but that every choice ought to be an informed one. By this, I am referring to the pressing need to enhance palliative care in Canada, a need expressed to me time and again by residents in my riding of Parkdale—High Park. If we are to ensure that the significant choice of requesting medical assistance in dying is fully informed, it is critical that we work collectively, in a non-partisan manner, to ensure that improved palliative care is readily available.

In conclusion, I reiterate that this proposed legislation is neither too restrictive nor too permissive. It strikes the correct balance, while simultaneously recognizing that with further study and mandatory review, the balance will continue to be recalibrated to reflect new evidence and evolving societal values respecting medical assistance in dying.

Most important, the bill would eliminate the cruel choice that the Supreme Court described in the opening paragraph of the Carter decision. No longer will grievously ill Canadians be faced with either taking their own life prematurely or prolonged suffering until they die. Bill C-14 would give such Canadians what the charter requires, autonomy. It would give them control over their passing in a manner that ensures their dignity. For this reason, I will be supporting this legislation.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Speaker, there is a couple of things I would like to clarify. The member and his colleague who spoke earlier said, pretty unequivocally, that no doctor would be required to participate in this regime. I do not see any protection in Bill C-14 that would assure doctors they would not be required to participate, other than a very vague comment in the preamble talking about that possibility. It certainly does not put ironclad protection in the bill.

The other issue I would like to raise with all my colleagues on the other side is palliative care. We continue to hear their commitment to palliative care. I applaud that. We need better palliative care. I have been working on that years. We can talk about it, but I do not see any evidence in the budget of the $3 billion that was promised to be immediately invested. I am very concerned. We need to get working on this. I want to see an actual firm commitment within the budget so we have something we can take to Canadians that says help is on the way.

Barring that, to offer physician-assisted death without—

● (1610)

The Deputy Speaker: The hon. parliamentary secretary to the Minister of Immigration, Refugees and Citizenship.

Mr. Arif Virani: Mr. Speaker, my hon. colleague has raised two points. One is the issue of doctor participation, and it is broader than just doctors; it is also nurse practitioners. Clearly, in the Carter decision, paragraph 132, the court went beyond the call to specify that nothing in its decision would compel a health care practitioner from being required or compelled to provide medical assistance in dying.

The preamble, as my colleague noted, reflects that same sort of rhetoric. I would put it to him that our party and this government firmly believe in complying with the charter, including all aspects of the charter, including section 2(a), which protects those conscience rights.

On the issue of palliative care, the member is correct. It would be inappropriate for palliative care to be entered into this bill, which deals with a discreet amendment to the Criminal Code. An announcement was made today in question period, and my friend was here to hear it. The minister indicated the amount of monies being allocated for palliative care. I would ask him to put faith in the minister. She is a family physician and has been on the ground providing these services. She recognizes the important need for palliative care to be provided in a robust way so people have an informed choice when they make this significant decision.

Mr. Charlie Angus (Timmins—James Bay, NDP): Mr. Speaker, I listened with great interest to my hon. colleague.

My concern with the lack of action on palliative care is that there was zero dollars in the budget. We have a promise now, but that is another year lost. I find it extraordinary to be talking about the right to die, but not the right to quality palliative care and the role the federal government has to play.

The other area that concerns me is the federal government has major health responsibilities in the delivery of health services to the military, the federal penitentiaries, and indigenous people. Yet, under section 12.1 of the first nations non-insured health benefits, when people are dying and have to be taken out of a reserve for palliative treatment, their loved ones are not allowed to go with them.

It says in federal regulations that the first reason to deny loved ones to be with their spouse at the end of life is compassion. Compassion is the number one rule for denying loved ones a chance to have palliative care. If the Liberals are serious about ending these cruel choices, they will tell that health minister to change the wording in the health guidelines now, so loved ones are never separated at the time of death.

Mr. Arif Virani: Mr. Speaker, as we have indicated, the palliative care financial allotments do not appear in this discreet legislation. The member has raised an issue about whether they should have appeared in the budget. I can assure the member that we are working to renew a lapsed agreement called the Canada health accord, with which the member for Timmins—James Bay will be very familiar.

The previous government simply allowed that to lapse. We do not believe in governing in that manner. We believe in engaging with provinces and meeting with them to understand their needs, and to address them going forward in a robust manner that is consensual, two-way, and that provides the financial supports that are needed by the provinces and territories.

With respect to first nations palliative care in particular, and the very particular issue that the member for Timmins—James Bay has raised, I think it is an important issue. Obviously more important than the issue we are dealing with discreetly here is repairing a woeful and shameful record in respect of first nations peoples, which has existed for generations.

We see that reflected in every mandate letter provided to every cabinet minister by the Prime Minister. That is something on which we are actively working. We have had robust debates about mental health in particular communities, including the community the member represents. However, that is only one part of a broader piece that needs to be addressed.

I look forward to working closely with the member going forward about how to address compassionate care and palliative care, in particular for first nations people, as part of our duty of care to first nations.

The Deputy Speaker: Before we resume debate, I get the sense, especially given the nature of the debate today, of the need for time for members to explain points in questions that they might pose to a speaker who has just presented. We are doing our best. In the five-minute period, it is very difficult to pose much more than two questions and receive their responses. If members make their interventions more concise, obviously more members can participate, but in all honesty and as the presiding officer, the last thing we want to do is cut people off.

We will be as judicious as we possibly can, but if members are able to be concise in their interventions, it would help their colleagues to have more opportunities to pose questions in the five-minute period.

Resuming debate, the hon. member for Saint-Hyacinthe—Bagot.

● (1615)

[*Translation*]

Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP): Mr. Speaker, first of all I would like to say that I will be sharing my time with my colleague from Kootenay—Columbia.

Medical assistance in dying is definitely one of the most important social issues our country and our Parliament will face and have faced in a long time. There is no doubt in my mind that this is the most delicate issue that our Parliament will have to deal with.

I would like to say that I will be supporting this bill at second reading stage even though I feel that we need to amend it.

We have known from the beginning that the NDP will have a free vote on this personal and delicate issue. Therefore, we are not seeking a consensus, but rather we want to continue consulting our constituents and the many experts studying this issue in order to determine what would be the best bill to reflect Canadians' rights.

It is important that we clarify the bill we are studying because it leaves room for interpretation and, above all, it contradicts the Supreme Court's ruling in the Carter case.

We will debate the necessary amendments in a non-partisan manner, but it is important for everyone here in the House to remember why we are voting on this issue. The issue at hand is not whether we are for or against medical assistance in dying. The Supreme Court of Canada was very clear that medical assistance in dying is a charter right. We are here to debate the bill and ensure that it reflects the Carter decision and does not leave anything open to interpretation.

As I just said, the Supreme Court unanimously ruled that competent Canadian adults who are suffering intolerably as a result of a grievous and irremediable medical condition have the right, under the charter, to medical assistance in dying.

The Supreme Court mandated our Parliament, and also the provincial legislatures, to pass legislation that is compatible with the Supreme Court's decision. This decision sent a strong message to update our laws, which are meant to protect vulnerable people and also the health care professionals who help them.

It is important not to politicize this issue or deal with it in a partisan manner. It is also important not to reduce this major issue to a pro-life and pro-choice debate since we know that debates like that can be never-ending.

I am very proud to have been a member of the Special Joint Committee on Physician-Assisted Dying. I worked on that committee with my colleague from Victoria, and I would like to sincerely thank him for his expertise, experience, and wealth of knowledge on this issue. This was my first experience with committee work. I would therefore like to thank him again, along with all of the committee members and the staff who assisted us. It was a privilege for me to be part of that committee because it gave me the opportunity to carefully study the Supreme Court's decision in this regard, and the provincial court decision that preceded it. We also carefully considered the laws in Quebec. I am very proud of the role that Quebec has played in leading the way on this sensitive issue. We also considered legislation from countries around the world.

Our committee reviewed two major studies, which together heard from over 13,000 people and more than 100 organizations. We held 11 hearings.

● (1620)

Sixty-one expert witnesses shared their work with us. Since February 6, 2015, the day of the Supreme Court ruling, every medical organization in the country and every organization that represents people with illnesses or health care professionals has given this sensitive issue very careful consideration. Those speaking on behalf of doctors told us how they were trained up until February 6, 2015. Their careers were based on the duty to heal. Since February 6, 2015, they have become aware that their role is now also to help people avail themselves of their right to seek medical assistance in dying.

During the committee's work, I made a point of meeting with all of the organizations in Saint-Hyacinthe—Bagot with an interest in this issue. I met with representatives of organizations for people with disabilities, user committees, institutions, medical institution representatives, and an organization that works with bereaved families and supports people at the end of their lives. I shared the committee's thoughts with them. I also had a meeting with all of these stakeholders to discuss our committee's report. Everyone who is directly involved in this issue and deals with it on a daily basis was very comfortable with our recommendations.

The role of the committee was to take advantage of this unique opportunity to reflect on all of the aspects of physician-assisted dying. Of course, we know that the government will not take all of our 21 recommendations into account in its bill. As the parliamentary secretary was saying, we do not have a lot of time. However, we should be considering all aspects of this issue. We made one recommendation that generated a lot of questions, our recommendation on mature minors.

Some witnesses told us that, for years, they have been helping young people around 16 or 17 years of age who have lived with incurable diseases for a long time and that those young people achieved a degree of maturity that very few adults achieve over the course of their lives.

Of course, after hearing this sort of testimony, we cannot close the door on that aspect of the issue. We cannot move forward with it now, because studies need to be done. One of our recommendations was that the necessary studies be conducted according to a certain timeline. We should not wait for these young people to end up before the Supreme Court.

As I said, the legislation leaves too much room for interpretation. I believe that, as parliamentarians, we have the duty to ensure that people who are sick do not have to continue to go before the courts to defend their right to physician-assisted dying.

Lawyers told us that we could consider the Carter ruling as a floor. That is what we, as MPs, chose to do. The Conservatives are saying that the Carter ruling should be considered a ceiling. The Liberals decided to go below the Carter ruling and down into the basement with their provision on reasonably foreseeable natural death, and that needs to change.

The Liberals keep telling us that $3 billion has been promised for palliative care. That is only a promise. There was nothing about it in the budget. However, all of the witnesses spoke about palliative care. Everyone in my riding has talked to me about it too. The important thing is to work for the best interests of all Canadians and to allow them to die with dignity.

● (1625)

[*English*]

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Mr. Speaker, with respect to the importance of palliative care, the member referenced that we heard from the government, not only in recent weeks, but for a number of months, in terms of its commitment to palliative care. It is a very important part of the debate, no doubt, and as we continue to debate, a very emotional piece of legislation about which we are all very opinionated. However, one of the things that is very important for us to recognize, when we talk about palliative care, is that there are many different stakeholders—in particular, provinces, first nations, and so forth—that need to play a critical role in the development of palliative care policy.

I wonder if the member might want to provide some comment, from her perspective, as to how important it is that Ottawa work with the different stakeholders to ensure that we do provide the type of palliative care that Canadians from coast to coast want to see?

[*Translation*]

Ms. Brigitte Sansoucy: Mr. Speaker, we must go much further. The federal government must provide leadership on palliative care. It is all very well to promise $3 billion and to promise to talk about it, but there was no money in the last budget to initiate discussions with the provinces and carry out the necessary studies.

I held consultations in my riding, which has one of the largest long-term care facilities in Quebec. For hundreds of seniors, there are only 12 palliative care beds in that institution. That is clearly inadequate. It is not enough to promise $3 billion. There has to be money in the budget, and the government has to get to work on this right now.

[*English*]

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, I thank the member for her remarks.

The member for Parkdale—High Park, I believe it was, is quite correct to say that this legislation would create one of the most permissive euthanasia regimes in the world. That is certainly what I understood him to say, and I think that would be quite correct.

We are limited to some extent, obviously, by the legal environment we are in. However, my concern is that this does not contain the safeguards we need to ensure that there are precautions in place so that someone who took someone's life without consent would be effectively prosecuted.

I want to ask the member if she would support my proposal to remove the reasonable, but mistaken, provision within this bill. I think that would be a substantial improvement.

The bill right now says that people could avoid prosecution if they have a reasonable, but mistaken, belief that someone consented. This would allow people to take the life of a person who did not consent and, yet, escape prosecution if they could at least show, beyond a reasonable doubt, that they had a reasonable, but mistaken, belief.

Would the member support removing that very concerning section, in order to ensure that vulnerable people are protected?

[*Translation*]

Ms. Brigitte Sansoucy: Mr. Speaker, the clause on natural death that is reasonably foreseeable is the most contentious clause in this bill.

Yesterday, Quebec's health minister, Gaétan Barrette, said that the courts would quickly strike down this clause. He even called on doctors to rely on Quebec's law rather than the federal law as drafted. We have a duty to ensure that the law is clear.

In recent weeks, some Quebeckers have starved themselves to death while trying to become eligible for medical assistance in dying. That has to stop. People have to be able to decide to die with dignity. Our law must allow it.

● (1630)

Mr. Pierre-Luc Dusseault (Sherbrooke, NDP): Mr. Speaker, I would like to thank my colleague for her work on this issue.

Could she talk about access to medical assistance in dying for all Canadians, no matter where they live in Canada, as it is now a right protected by the charter as a result of the ruling?

Ms. Brigitte Sansoucy: Mr. Speaker, the issue of access to medical assistance in dying is indeed crucial. Since it is a right, of course it must be accessible. That is why it is important to extend this capacity to other health care professionals.

When it comes to assessing eligibility for medical assistance in dying, physicians take care of that. The riding I represent is 50 kilometres from the nearest urban centre, and some of my constituents do not have access to a doctor. It is therefore important to allow other health care professionals to help people exercise their right.

[*English*]

Mr. Wayne Stetski (Kootenay—Columbia, NDP): Mr. Speaker, I rise today to speak to Bill C-14, an act to amend the Criminal Code and to make related amendments to other acts related to medical assistance in dying.

I support the bill at second reading. However, it does need to be amended.

I will start today with a story. Some years ago, my wife Audrey and I adopted a beautiful sable sheltie dog by the name of Princess Diana of Cornwall. She was named at a time when we lived on Cornwall Drive in Port Coquitlam, and the world was abuzz with a royal wedding involving two people named Charles and Diana.

Princess was a great dog. Unfortunately, when she was about 11 years old, she developed cancer. We were already living in our current home city of Cranbrook, located in the Rocky Mountains area of British Columbia. As the cancer progressed, Princess was living with more pain and discomfort. We consulted our local vet regularly. One day he told us that she was terminal and in a lot of pain and he thought the best thing we could do for her was to end her suffering. He asked us to bring her back the next day. We took her home to say our goodbyes, and the next day I brought Princess back to the veterinarian. He asked me if I would like to leave her with him or whether I would like to stay. I said I would stay. I held her in my arms and watched the needle go into her paw. She lay down and died in my arms. As I stood there with tears in my eyes, I thought that if I were ever in intolerable pain from an incurable disease, this is how I would want to leave this world, with a needle in my paw, lying in the arms of someone I love. I personally became a believer in physician-assisted suicide right there 20 years ago.

I am not suggesting that the death of a pet and that of a human are equivalent, though they certainly can feel much the same, as many who have loved a beloved pet will know. We need to take even more care that we have it right when we are talking about euthanasia through a human lens.

As members know, in February 2015, a unanimous Supreme Court ruling established the charter-protected right of competent adult Canadians who are experiencing enduring and intolerable suffering as a result of a grievous and irremediable medical condition, including a disease, disability, or illness, to access medical assistance in dying. We in the NDP are committed to implementing the Supreme Court order decision with balance and sensitivity, respecting the autonomy of patients, the rights of health care practitioners and vulnerable individuals, and the fundamentally personal nature of this issue to every Canadian; in other words, we need to get this legislation right.

Last week, when I was back in my riding of Kootenay—Columbia, I met with Bendina Miller, the past president of the Canadian Association for Community Living. The CACL was one of the main supporters of the vulnerable persons standard, the purpose of which is to protect the vulnerable in Canada, as Bill C-14, medical assistance in dying, moves forward. While the CACL believes that the bill in its current form takes appropriate steps toward addressing the vulnerability of people living with a disability, it believes some improvements are required to meet the Supreme Court's intent that the legislation must provide fair access to assisted death and also protect vulnerable persons who may be influenced or induced to use the system to die.

The Canadian Association for Community Living recommends five areas of substantive amendment to this draft bill. I will summarize them here.

First, Bill C-14 should be amended to extend the current requirement for judicial oversight until such time as a study of the merits and implications of the bill allows them to be clearly understood.

Second, included in the bill should be an explicit legal requirement to identify, explore, and record the sources of a person's suffering, and an attempt to address the motivations of his or her request for death.

Third, Bill C-14 should be amended to meet the requirements of the Carter decision and should specify that a voluntary request for medical assistance in dying cannot be made as a result of external pressure or any form of inducement.

Fourth, Bill C-14 should be amended to specify that the minister “will” make, not “may” make, regulations regarding the mandatory reporting of information about requests and the provision of assisted dying.

Fifth, it should mandate a palliative care or other professional evaluation to ensure patients' rights to informed consent by having information about the full range of available treatments and supports that could ease their suffering.

● (1635)

The bill should not proceed without an enhanced national palliative care strategy, which is clearly missing in the Liberal government's 2016-17 budget.

Back in November, I had the pleasure of meeting new members of Parliament from all of the parties represented here in the House, except the Green Party. I was struck by how consistent the words were from all of my colleagues. They said they were here to work collaboratively to build a better Canada. It was very encouraging for me as a new MP, because that is also why I am here.

When I am back home in my riding sharing with my constituents what we are doing here in the House, I tell them that we are working on three bills in particular that would fundamentally change Canada, going forward: first of all, proportional representation voting; second, legalizing marijuana; and third, physician-assisted suicide.

This is the first of those three bills to come to the House for debate and further study, and we need to work together collaboratively to build a better future for Canadians. The bill would do three things: maximize one's willingness to live through expanded palliative care, ensure that our vulnerable citizens are protected, and give our citizens the Supreme Court assured right to choose to die in the arms of someone who loves them, if they are experiencing enduring and intolerable suffering as a result of a grievous and irremediable medical condition.

Let us amend the bill collaboratively and give Canadians the best possible outcome on this very important and emotional issue.

Mr. Adam Vaughan (Parliamentary Secretary to the Prime Minister (Intergovernmental Affairs), Lib.): Mr. Speaker, I thank the member for his considered remarks to the House, but I did not hear a reference to the notion or the concept of advance consent. I am curious as to whether he has thoughts on that issue and how those concerns may be addressed in the parliamentary process as this bill moves through committee.

Clearly, some of the other areas we understand as areas that need to be questioned and explored by committee. We accept that and think it is a good legislative process. However, I did not hear those remarks, and I am interested to hear the member's thoughts on that.

Mr. Wayne Stetski: Mr. Speaker, absolutely, I think that is missing from the current version of the bill. I think it is really important to give Canadians the opportunity for an advance declaration of what their wishes are, particularly if they know their disease is leading to a condition where they will not have the ability to make that decision themselves later on. Therefore, I do think that should be in the bill.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, I want to pick up on the question of advance consent, because it has come up a number of times today.

What we heard from the special committee, at least from those who are involved in health care or represent those who are involved in health care, is that it is very difficult to have an advance directive about a very hypothetical situation in which a people do not actually know how they will experience what they will be going through. With an advance consent provision, one may end up with a situation where someone, who at the present time does not want to die, still has their life taken because of something they wrote down earlier, and they may be experiencing those events differently from how they expected.

I want to ask the member specifically with regard to sexual consent. We have a very clear understanding that a person cannot consent in advance. There has to be contemporaneous consent in the context of sexual consent. Therefore, why would we have a different and lower standard for someone consenting to die than for someone consenting to engage in sexual relations?

● (1640)

Mr. Wayne Stetski: Mr. Speaker, I really do not think it is a lower standard. If we have the opportunity to declare our intent ahead of time and put it in writing, that at least gives us some opportunity to have some say over our future. If we reach the point where we cannot consent and we cannot not consent, and then we have no options at all. Therefore, at least having an opportunity to declare our wishes ahead of time is an improvement over not having any choice at all.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Speaker, I really hesitated getting up to ask this question, but my colleague, and I respect him and his work, inferred some similarity between the loss of a pet and the loss of a loved one, a human. I have lost lots of pets over the last 60 years, and yes, I have shed some tears, and I have had this kind of experience. However, to infer that there is even a 1% similarity between losing a pet and losing a family member I think misses the point.

I watched my mother and dad approach death. I watched a brother, who lay unconscious for a month in hospital on life support approach death and die. Five years ago today, my wife suffered an intracranial hemorrhage and two days later passed away. However, not in one of those situations, not in one of them, would I have wanted to end their lives one day earlier.

We need to realize what suffering can teach us as we walk alongside those who are suffering and enter into their suffering. That is what it means to be human. My concern is that if we lose the drive to walk with those who are suffering and lose the commitment to actually do something about palliative care and provide good care for those who are suffering, we are really missing the boat.

I would like my colleague to comment on the lack in the budget of actual hard commitment to really get on with palliative care.

Mr. Wayne Stetski: Mr. Speaker, let me repeat what I said during my speech. I am not suggesting that the death of a pet and the death of a human are equivalent.

We need to take even more care that we get it right when we are talking about euthanasia using a human lens. I absolutely agree that palliative care is critical. We need to make sure that we have a national palliative care strategy to go along with this, but they need to go hand in hand if they are to move forward at all.

The story I told was what convinced me that if I had a choice, I would choose to die with dignity.

Mr. Sean Casey (Parliamentary Secretary to the Minister of Justice and Attorney General of Canada, Lib.): Mr. Speaker, it is my honour to stand to speak in support of Bill C-14, a significant piece of legislation that would allow for the first time in Canadian history the provision of medical assistance in dying across the country.

I believe Bill C-14 directly and thoughtfully responds to the Supreme Court of Canada decision in Carter. This legislation would strike a careful balance between the autonomy of competent adults whose deaths are reasonably foreseeable to seek medical assistance in dying and the protection of vulnerable people through careful tailoring of the eligibility criteria and robust safeguards that are essential to prevent error and abuse.

[*Translation*]

As recognized by the Canadian Medical Association before the Special Joint Committee on Physician-Assisted Dying, one cannot underscore enough the significance of this sea change in Canadian medical practice and Canadian society as a whole.

At present, there are eight jurisdictions in the world, in addition to Quebec, that have adopted precise legal rules on medical assistance in dying: four U.S. states, Colombia, and the European countries of Belgium, the Netherlands, and Luxembourg.

The international community is looking at Canada's leadership on this issue right now, and I commend all hon. members on both sides of this House for their invaluable contributions to this complex and sensitive debate.

● (1645)

[*English*]

Bill C-14 would establish the criminal law rules regarding medical assistance in dying that address issues including eligibility, procedural safeguards, and the framework for a pan-Canadian monitoring system. In addition to the comprehensive legislative response proposed in Bill C-14, the government would undertake independent studies into three key issues that the Supreme Court declined to address in Carter: eligibility for persons under 18, advance requests, and requests for medical assistance in dying solely on the basis of a mental illness.

Allow me today to provide all members with further clarifications on the eligibility criteria included in Bill C-14 and how they respond to the Carter ruling, a question that has been asked numerous times since the bill was introduced.

Under Bill C-14, medical assistance in dying would only be available to mentally competent adults: one, who have a serious and incurable illness, disease or disability; two, who are in an advanced state of irreversible decline in capability; three, who experience enduring and intolerable physical or psychological suffering as a result of their medical situation; and four, whose natural death has become reasonably foreseeable taking into account all of their medical circumstances and without requiring any specific prognosis as to the length of time that they have remaining.

I would emphasize that those are the exact words of the legislation, because there has been some incorrect reporting on what is actually required. It is also important to remember that the criteria must not be read in isolation. Each element mutually informs the meaning and scope of the others. They work together to create a clear picture.

Some people wonder what reasonable foreseeability of death means given that everyone's death is reasonably foreseeable in the sense that death, like taxes, is inevitable for all of us. Bill C-14 expressly states that the person's natural death has become reasonably foreseeable, which clearly indicates that a change in the patient's medical circumstances is required. The patient is now on a path toward death, but previously he or she was not. A healthy person's death is not reasonably foreseeable unless the person experiences a change in his or her medical circumstances.

Mr. Speaker, at the outset of my remarks, I neglected to inform you, but I do now, that I will be sharing my time with the esteemed member for Fredericton.

The concept of reasonable foreseeability is also well known in law, and assessment depends on the context. In the context of medical assistance in dying, it would require a real possibility of the patient's death within a period of time that is not too remote from circumstances that can be predicted within a range of reasonable possibilities. Again, the legislation expressly states that a specific prognosis as to the time the patient has remaining would not be required. Because everyone's trajectory toward the end of life would be unique, this criterion was carefully crafted to provide maximum flexibility to medical practitioners so that they may assess the overall medical circumstances of a patient on a case-by-case basis. The overall medical circumstances, as opposed to any particular type of condition, are what matters when the objective is to give Canadians the option of a peaceful medically assisted death instead of having to endure a prolonged or painful one.

As recognized by medical standards and guidelines on prognostic indicators, there are many factors that may contribute to a patient's being assessed as approaching the end of life, including the presence of an advanced, progressive, and incurable disease, but also completely different factors, such as age, the general frailty of the patient, and risks of death from complications of other conditions that may not be fatal on their own, but which can jeopardize the life of someone who is otherwise weakened.

As recently recognized by the Canadian Medical Association, the requirement that natural death has become reasonably foreseeable would provide clearer guidance than the court's use of "grievous and irremediable" in that it would indicate , and I quote the CMA representative, that the condition should be "towards the end of the spectrum", but does not mean "terminal or that death is immediately on the horizon".

If we consider the Carter ruling itself, the Supreme Court expressly stated that the scope of its declaration was intended to respond to the factual circumstances of the case, and that it made no pronouncement on other situations where physician-assisted dying may be sought. Bill C-14 would directly respond to the factual circumstances of both Kay Carter and Gloria Taylor, who were both in decline and suffering while on a trajectory toward the end of their lives without it being certain when exactly they would die.

The Supreme Court did not define the term “grievous and irremediable medical condition”. It rather acknowledged that it was Parliament's task to weigh and balance the perspective of those who might be at risk in a permissive regime against those who seek assistance in dying. This is exactly what Bill C-14 does. It defines eligibility in a manner that is consistent with the Carter ruling read in its entirety, and provides necessary clarity on the assessment of eligibility.

Some have expressed concern over the lack of express protection for conscience rights of health care providers. The legislative objectives of Bill C-14, which are clearly stated in its preamble, include respecting the personal convictions of health care providers while also recognizing the provinces' jurisdiction over various matters related to medical assistance in dying. Balancing the interests of medical practitioners and those of patients is such a matter. Importantly, nothing in Bill C-14 would compel health care providers to provide any assistance that may be contrary to their conscience rights. More important than legal protections in a statute book are the concrete and practical actions that are directly aimed at supporting conscience rights of practitioners. In this regard, the Minister of Health has offered to work in collaboration with the provinces and territories on the development of an end-of-life care coordination system to help respect the providers' conscience rights while facilitating patients' access to care including assistance in dying.

Some have expressed concern that the safeguards in the bill are not sufficient. The proposed safeguards are generally consistent with and perhaps even a little stronger than the safeguards found in other medical assistance in dying regimes around the world.

● (1650)

The trial judge in Carter considered voluminous evidence on the efficacy of these regimes, and the evidence persuaded her that the risks to vulnerable people could be adequately managed under such systems. We are equally confident that these safeguards would guard against abuse and error.

I believe the proposed legislation is the right way forward on medical assistance in dying for Canada at this time and is a principled response to the Carter decision. I would urge all members to support second reading of Bill C-14.

Mr. Martin Shields (Bow River, CPC): Mr. Speaker, I appreciate the presentation on the debate today. One of the areas I am concerned about with the bill is that in rural Canada it can be a challenge to identify two physicians or two nurse practitioners. Outside the large urban areas there are a smaller number of doctors and often not even a nurse practitioner. Even if we had those four, it would quickly become identifiable who those people were, and that could be a severe challenge in rural communities. The only other alternative then is referrals. Again, those are the people who become the referral that people go to.

That is a question I have with this legislation. I am very concerned about the limited number of medical people who would have to be involved in this process outside the major urban centres.

● (1655)

Mr. Sean Casey: Mr. Speaker, it is that very concern that was borne in mind when the decision was made to extend the exemption with respect to medical aid in dying to nurse practitioners. We see more and more in the country, with doctors being abundant in major centres and not so much outside of major centres, that much of the load has now fallen to nurse practitioners. That is the very reason why they are included.

Access is important with respect to any charter right. The member raises a very valid concern and the specific attempt to address it is with respect to the inclusion of nurse practitioners.

Ms. Georgina Jolibois (Desnethé—Missinippi—Churchill River, NDP): Mr. Speaker, I have a question about access to adequate medical services and access to nurse practitioners or doctors. Where I come from, in my riding, most reserves and communities do not have that privilege when we talk about the national palliative care strategy. I am very concerned because where I come from we do not even have access to a nurse. How can the government ensure that we can have this meaningful discussion in a broader context to help people die with dignity?

Mr. Sean Casey: Mr. Speaker, clearly, the last two questions point out the unevenness of access to medical services right across the country.

Today in Parliament we are debating an act to amend the Criminal Code. The government's response to the Carter decision was both legislative and non-legislative. The legislative measures are the ones we are debating now, but in terms of non-legislative measures, there is a commitment of $3 billion in home care, a significant part of which would be palliative care.

This legislation alone would not resolve the inequality in access to medical services across the country. We acknowledge that. It cannot do that. That is something the government has to continue to strive to accomplish through the negotiation of the health accord and through working with provinces for a palliative care strategy and for medical coverage in rural and remote areas.

Mr. Nick Whalen (St. John's East, Lib.): Mr. Speaker, I would like to thank the member for his comments and reasoned commentary on this.

I had the good opportunity of having a round table last week with the Newfoundland and Labrador coalition of pensioners and seniors associations. To a person, they were favourable of the approach we have taken with this legislation. There was one issue that really hit to the crux of what they felt might be far enough or not far enough in the legislation. That was with respect to advance care directives. They also had a concern with respect to determining in advance whether or not one's condition would become intolerable. They were also concerned about the ability of provinces to have appropriate registries in place to handle that type of medical care.

I would ask the member if he agrees that this integrative approach of going incrementally toward medical assistance in dying is the proper way to go, or if he feels we should go even further at this stage.

Mr. Sean Casey: Mr. Speaker, I thank the member for St. John's East for the question and also that he used part of his constituency week to consult with his constituents. That is extremely important. It is something that I did as well.

The government has clearly proceeded carefully. Given the compressed time frame that we were given by virtue of the inaction prior to the election and the deadline imposed by the Supreme Court, I believe that this is the prudent course. The preamble of the bill and the non-legislative measures indicate that there will be a further, more detailed, thorough, and more drawn-out examination of the more sensitive questions, and I think that is the best solution for Canada at this time.

● (1700)

Mr. Matt DeCourcey (Fredericton, Lib.): Mr. Speaker, with the Supreme Court's decision in Carter, Canadians were given notice that medical assistance in dying would effectively become legal in Canada. It was, hence, the responsibility of the government to put forward clear rules around who is eligible to obtain medical assistance in dying, what safeguards must be followed to protect vulnerable individuals, and to create a monitoring regime to ensure accountability, transparency, and public trust in the system. Federal legislation was also important to ensure that a consistent approach to medical assistance in dying would be available across Canada.

Bill C-14 is the result of extensive consultation over the past year with individuals, groups, and experts at home and abroad. It takes into account a range of interests, including personal autonomy and safeguards to protect the vulnerable. It also recognizes the diverse and personal ways in which individual Canadians arrive at the question of medical assistance in dying. It balances individual rights and informed conscience, and respects the professional ethics and conscience of physicians and medical practitioners.

This legislation also addresses and proposes broad action on an aspect of end-of-life care where Canadians, regardless of their views of medical assistance in dying, have clearly indicated that they want action, chiefly, palliative and hospice care. I had the pleasure yesterday to take part in Hike for Hospice in sunny Fredericton and I am proud of the overwhelming support demonstrated by community members for such a worthy and important cause.

As we address an issue as delicate as medical assistance in dying, we cannot act without a full and intentional movement toward expanding all options of end-of-life care. The government has made clear that as part of a multi-year health accord, financial resources to improve home care, including palliative care, will be of primary importance. Also, as we launch Mental Health Week today in Canada, we must recommit our efforts to providing greater care and support for those suffering from mental illness and deliver on clinical and community-based approaches that will allow greater access to mental well-being for Canadians who suffer from mental afflictions.

[*Translation*]

On December 11, a Special Joint Committee on Physician-Assisted Dying was tasked with reviewing recent consultation activities. The committee also consulted with Canadians and stakeholders and made recommendations on the framework of a federal response to the Carter decision. The committee met 16 times, heard from 61 witnesses, received more than 100 briefs, and tabled its final report to Parliament on February 25.

[*English*]

I would like to extend my thanks for the work of the committee, as well as for the individual commitment demonstrated toward this issue from each and every committee member.

I, too, have heard from hundreds of people in the riding I represent, and have sought out wisdom and advice from leaders within the disability community who are calling for assurances that those with vulnerabilities will be safeguarded from outside influence in their personal decision-making; from the faith community, including trusted mentors and friends, who have encouraged me to reflect upon my own informed conscience in rendering a decision on this important matter; from the medical community, including leading voices, who have called for a sage and measured approach to the development of a framework around medical assistance in dying; and from those seeking a more liberalized approach, who may be dissatisfied with the framework that is proposed in front of us.

I have listened, I am listening, and I will continue to listen to people in the riding I represent. I have reflected, I am reflecting, and I will continue to reflect upon this important decision that will change the way Canadians consider end of life.

I approached this question like many others, with great humility, understanding that in a pluralistic society as rich and diverse as Canada's there will undoubtedly be those who feel that this legislation does not meet their world view. I wish to extend my empathy and understanding to them, and let them know that I, like all my colleagues, will continue to do my best for them.

I believe the ministers charged with crafting this legislation and the government as a whole have also approached this question with great sensitivity. The approach being taken is emblematic of a government that has listened to citizens, and will continue to listen to the wide diversity of opinion on this personal and challenging decision.

With this in mind, I wish to express my general comfort with the legislation before us. I would like to take the time to explain in greater depth the elements of the legislation and what it means for Canadians.

● (1705)

[*Translation*]

First, to allow access to medical assistance in dying in Canada, the Criminal Code would need to be amended so that doctors, nurse practitioners, and those who assist them can help eligible patients die without the risk of being charged with assisting a suicide or committing a homicide. There will also be safeguards to ensure that those who receive medical assistance in dying are eligible for it, can give their informed consent, and voluntarily requested assistance in dying.

[*English*]

A voluntary and informed request must be submitted in writing by the person in the presence of two independent witnesses, and a second medical opinion is required. No one aside from the person wishing to receive medical assistance in dying can make that voluntary request. This approach holds that the right to choose medical assistance in dying belongs only to the competent adult who would receive it. This is also necessary to protect vulnerable people.

A person who wants to access medical assistance in dying would have to meet the following criteria. They would have to be a mentally competent adult of 18 years or older. They would have to have a serious and incurable illness, disease or disability, be in an advanced state of irreversible decline of capability, and experience enduring and intolerable suffering as a result of their medical condition. They would, in effect, have to be on a course toward end of life. Death would have to be reasonably foreseeable.

The proposed legislation holds that mature minors would not be eligible nor would people suffering solely from a mental illness. The government is, however, proposing an independent study of the legal, medical, and ethical issues related to medical assistance in dying for mature minors, for those suffering from a mental illness, and around advance directives.

[*Translation*]

Again, the bill includes protections to ensure that patients are eligible and have given their informed consent. There would be a mandatory waiting period of at least 15 days, and patients could withdraw their consent at any time.

[*English*]

Also, there is nothing in the proposed legislation that would compel a health care provider to provide medical assistance in dying or to refer a patient to another practitioner.

The proposed approach to this most difficult of questions does its best to recognize individual choice for adults who are suffering intolerably and for whom death is reasonably foreseeable. It seeks to affirm the inherent and equal value of every person's life. It has the goal of protecting vulnerable people and reaffirms society's goal with regard to preventing suicide. It is an approach that recognizes where we are as a society and as a people advancing in the world. It is respectful of the divergent voices of Canadians and it demonstrates flexibility in its ability to reassess and examine the issue of medical assistance in dying in the weeks, months, and years to come.

I wish to thank my constituents who have reached out to me on this important matter and the many more who, I know, have wrestled with this question internally.

Know that this Parliament and I will do our collective best to serve each one's interests and those of their neighbours on this and on all important matters.

● (1710)

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, this member and the previous member referred to the “flexibility” of this legislation. Flexibility may be a good quality to have at a dinner party, but it is not much of a virtue in the context of legislation. Flexibility does not help physicians who are going to have to look at this legislation and decide if something is legal or not. Let us not call it “flexibility”; let us be clear and call it “ambiguity”.

I wonder if the member would support at least clarifying the ambiguous criteria, because the more he talked, the less I understood.

He talked about death being “reasonably foreseeable” and said that one has to be on a course toward end of life. Again, we are all on a course toward the end of life.

What prevents the government from amending the legislation to actually, in a very basic and sensible way, define what we are talking about? Ideally it would put in the word “terminal”, because that is what is implied but not said—and if it is not said, then it is not in the legislation.

Could we get some clarity around what these things actually mean?

Mr. Matt DeCourcey: Mr. Speaker, I thank my colleague across the aisle for his question, although I would caution him to advance with some modesty in the commentary he uses to talk about this sensitive issue.

As I explained, I did have the opportunity to consult with medical practitioners, with leading voices, about where they saw this legislation fitting into what we needed to accomplish as a government in response to Carter.

My general reflection of these conversations has been that the medical field is, by and large, comfortable. Of course there will be those who will not see this within their own world view, and that is where the flexibility in this legislation exists: to ensure we meet the rights of those adults who are suffering intolerably to access medical assistance in dying while also recognizing the conscience of practitioners who will be providing the service.

Mr. Charlie Angus (Timmins—James Bay, NDP): Mr. Speaker, I listened with great interest to my hon. colleague. I think what is disturbing me in the tone of the debate today is that there is an impression being created by the Conservatives that somehow the great moral crusade here is to actually defy the Supreme Court ruling. The Supreme Court ruling made a decision that has really tied the hands of Parliament. I may not agree with how it arrived at it or I may not agree with the fact that it has limited our ability to consult with Canadians, but one thing I am very aware of is that this right already exists now. It is already being practised by the courts, and if Parliament does not frame clear legislation with clear limits, there will be a legal vacuum come this summer in which the fears that my Conservative colleagues are raising may well be much more realized by other parties who step forward and go to the Supreme Court to say Parliament has failed in its fundamental duty to act.

Given the constraints put upon us by the Supreme Court, I would like to ask my hon. colleague what he feels will happen if Parliament does not come up with this bill to meet the timeline of the Supreme Court and leaves that legal vacuum that would exist across this country?

Mr. Matt DeCourcey: Mr. Speaker, I think the best way I could reply is by explaining to my hon. colleague the advice that I have been given, again, from people in the medical community, people in the vulnerability community, and all those who have first-hand experience in trying to deal with end-of-life situations.

They have all impressed upon me the need for this Parliament to move with legislation that is caring, that is compassionate, that is smart, that recognizes in fact that the Supreme Court has already decided upon this issue, and that it is up to us as legislators, as parliamentarians, as leaders in our community, to come up with appropriate legislation that would best meet the collective interests of Canadians.

I cannot speak in specifics of what might happen, but I do know, in consultation with those who do have insight into vacuums in the legal and medical system, that it is not something we want to see here in Canada.

Hon. Peter Kent (Thornhill, CPC): Mr. Speaker, I will be splitting my time with the member for Durham.

I think it is important for Canadians to realize that the legislation before us is neither the alpha nor the omega in the continuing conversations Canadians are having about physician-assisted death. The Supreme Court forced this legislative moment on reluctant politicians with the Carter decision, but the conversation has been simmering, occasionally percolating, for decades in hospital intensive care wards, doctors' offices, around family dinner tables and at the bedsides of loved ones, from holy pulpits and at congressional retreats, medical schools and law schools, from theist philosophers and from the atheist sort. Most personally, the conversation has been conducted within ourselves, in our own minds, in both sickness and in health.

If the proposed legislation before us is neither the beginning nor the end of our ongoing conversation about physician-assisted death, what is it? Where exactly are we?

First of all, I think it is abundantly clear that we are definitely not where the Supreme Court told us to go. The legislation before us, which I believe will easily pass the House, and should as well the Senate, is only an interim step that will almost certainly very quickly lead us again to the Supreme Court.

The official opposition has set as its highest priority safeguards to protect the most vulnerable in society as well as the conscience rights of physicians and other health care professionals. We are pleased that the government accepted recommendations from the Conservative dissenting report from the special joint committee to exclude minors, to include stringent safeguards to protect those with underlying mental health challenges, and to recognize the risks involved with advance directives, which I will come back to in a moment. However, there are still concerns with the proposed legislation before us.

First, a point that has been and will be raised by colleagues many times, and I believe on both sides of the House, is the lack of specified conscience protection, an assurance that medical practitioners and institutions may decline participation in physician-assisted death. However, I do not believe that should be a problem, because I do not believe there will be a shortage of physicians willing to assist those patients who meet the criteria for assistance.

Also, there are the concerns, again raised by many of my colleagues, on the need for greater provisions for prior review, for consideration of underlying health issues, and for the effect of possible psychological disorders on patient decision-making. I believe those matters should be thoroughly reviewed again in committee.

As well, many of my colleagues have expressed concern with the extension of the Supreme Court's specific direction that physician-assisted death be performed by medical doctors to also include nurse practitioners. We know the government's logic in broadening the responsibility is to provide for remote areas where qualified nurse practitioners now carry out many of the services traditionally provided by MDs. Again, I believe the legislation needs more specificity in this area. I firmly believe that many nurse practitioners are qualified, capable, and willing, but perhaps the legislation should explicitly state that nurse practitioners be engaged only as physicians of last resort in circumstances where no medical doctor is available.

I also recognize the widespread concern and resistance to the vague nature of such phrases within Bill C-14 as “reasonably foreseeable”. I personally accept such imprecise conditions because I realize that as magnificent as modern medicine is today, prognoses regarding the time of a final breath or a final heartbeat are still often only educated guesses. This is certainly worthy of further examination at committee.

Finally, one of the most important shortcomings in convincing Canadians to accept Bill C-14 is in the government's unkept and—I will be perfectly frank—broken promise on palliative care.

The Liberals made a campaign commitment to invest $3 billion in long-term care, including palliative care. The importance of access to palliative care in end-of-life decision-making was one of the few unanimous points of agreement in the special joint committee's report.

● (1715)

We as parliamentarians can rush to meet the Supreme Court deadline of June 6, but at the same time, the government has a clear duty, a moral obligation, to put in extra effort to expedite fulfillment of that promise to expand the availability of accessible, affordable, acceptable palliative care for all of those who, for reason of conscience, faith, or choice decide not to avail themselves of physician-assisted death.

I firmly believe that choice must be extended, as I believe the Supreme Court clearly meant it to be in the Carter decision, to patients suffering from the specific diseases and conditions that formed the basis of the Carter decision: the brutally imprisoning final stages of spinal stenosis; the choking, smothering final stages of ALS; and the unrelieved pain of irreversible but interminably long final stages of progressive multiple sclerosis.

While I am on this point, I remarked earlier on the need to recognize the risks involved in advance directives for diseases such as Alzheimer's, dementia, and the like. That said, I believe advance directives must eventually be allowed in physician-assisted death.

I consulted with many individuals and groups in my riding of Thornhill in recent months and beyond. I greatly respect—profoundly respect—the advice and interventions of various faith communities, social agencies, and medical institutions and their concern over the need for greater protection of the most vulnerable.

My personal decision, which will determine my vote on this legislation, is a product of three individuals and their experiences. In my previous life as a journalist, I followed closely the unsuccessful legal crusade of Sue Rodriguez as ALS steadily increased its deadly grip and her rhetorical question posed to Canadians: "If I cannot give consent to my own death, whose body is this? Who owns my life?"

In the previous couple of Parliaments I became close with another thoughtful, courageous Canadian, a fellow member of Parliament, the Hon. Steven Fletcher, Canada's first quadriplegic MP, re-elected three times and just last month elected to the Manitoba legislature, who did not give up after his life-changing accident 20 years ago. He met immense challenges and he overcame them.

However, in two private members' bills tabled two years ago, which I seconded, and in testimony before the parliamentary committee this January, Steven made a powerfully convincing argument for self-determination to one day make a final decision. He said such a law would be based on an individual's own morals and ethics while stressing that there should be no pressure on that person from society, family, friends, or the institution they may be in.

I was also powerfully informed and persuaded by the tragically tortuous passing of my brother-in-law, Rik Davidson, a brilliant academic, through Alzheimer's. Should such an ending be diagnosed for me, I assure the House that an advance directive would be composed, and either under law or not, it would be fulfilled.

Finally, as a cancer survivor, I have had many hours of reflection, during treatment and since, to ponder the issues involved in this debate on a personal level. I am fortunate that modern medicine, faith, and an incredibly supportive wife and family have left me—for now—clear and happily continuing my late-life adventure as a politician.

I am honoured that I can participate in this debate to argue for the passage of Bill C-14, eventual broadening of this legislation's provisions, and immediate government action to expand palliative care facilities and services, because I passionately believe that the issue before us ultimately comes down to choice: the free choice of a competent adult individual to choose between accessible, affordable palliative health care and the constitutional right to physician-assisted death.

● (1720)

Mr. Adam Vaughan (Parliamentary Secretary to the Prime Minister (Intergovernmental Affairs), Lib.): Mr. Speaker, the issue of advance consent or advance care directives was spoken to in the presentation to the House of the hon. member. My question is about how the timing in that regard could be spoken to in amendments to this legislation.

How would the hon. member see advance care directives provided at the age of 20 when the person will encounter difficulties maybe 30, 40, 50 years later? Alternatively, upon diagnosis of a situation and immediately entering into advance care directives, how would the hon. member model timetabling around that so as to review the person's decision before the ultimate act is pursued?

Hon. Peter Kent: Mr. Speaker, I thank my colleague for a very thoughtful question, one that has been asked many times in recent months as the Supreme Court deadline has loomed. There are a great many accounts written by Alzheimer's patients with significant medical and academic ability, who compose diaries from the time of diagnosis and their observations of steadily diminishing capacity.

There is a point, supported by an Alzheimer's patient in the final stages, and I would be surprised if they would allow that they themselves, even though they might be unaware, continue to that final stage. The burden on family, friends, and the medical institutions is overwhelming. The period of 15 days obviously does not work, but there are some worthy accounts which can be referred to. There was a great personal diary in *The New York Times* Sunday magazine a few months ago about an academic who was provided with mail order barbiturates from Mexico to be prepared when she realized she was in the last stages of fully controlling her life and her situation.

I think physicians and experts in this area could provide us with answers to the member's question.

● (1725)

Hon. Michael Chong (Wellington—Halton Hills, CPC): Mr. Speaker, I want to thank the member for Thornhill for his thoughtful views on the bill and for his personal stories relating to the bill.

In his speech, he mentioned that he did not believe the bill was compliant with the Supreme Court. Could he tell the House in what ways he believes the bill is not compliant with the Carter decision?

Hon. Peter Kent: Mr. Speaker, the reality is that the three parties to the Carter decision would not be assisted by Bill C-14. I listed the three conditions: spinal stenosis, ALS, and multiple sclerosis. All three of these particular afflictions would require additional legislative provision. I believe that is why the legislation will be back before the Supreme Court to order an extension of its provisions.

[*Translation*]

Mr. Pierre-Luc Dusseault (Sherbrooke, NDP): Mr. Speaker, I thank my colleague for his speech.

I would like to know what he thinks about the government's decision to use a different definition than the one set out in the Carter decision. The Supreme Court's decision used the term grievous and irremediable medical condition. Although the government was well aware of what was in the Supreme Court's decision, it decided to use a different definition.

What does my colleague think about the uncertainty this could create in the legal system and especially in our health care system?

Hon. Peter Kent: Mr. Speaker, I thank my colleague for his question.

[*English*]

I think the answer is politics. As we have seen characteristic of the Liberal government in recent weeks and months, it is reluctant to reach difficult decisions. There is an attempt to keep everyone happy on every file, with procrastination and avoidance of the tough decisions that need to be taken. I think this is another case, such as with pipelines, military missions abroad, the environment. However, in this case, risk aversion has basically brought the government to enter a piece of legislation which does not go, as I said, where the Supreme Court ordered us to go.

Hon. Erin O'Toole (Durham, CPC): Mr. Speaker, I would like to start by thanking my colleague, the member of Parliament for Thornhill, for a very thoughtful presentation in this House.

A debate on Bill C-14 is an example of this House of Commons at its best. Canadians do not send us here to have unanimous agreement on issues of the day. We are here to represent our ridings, the constituents who have sent us to Ottawa. We belong to political parties. We have different leaders' roles. However, we are Canadians who bring an experience and a point of view to this chamber.

Infrequently, we share that view in the personal stories that people bring to the House of Commons. Today, on the difficult subject of Bill C-14, I learned of my colleague's perspective and personal experience with a member of his family, his personal experience covering the Rodriguez case in the 1990s as a journalist, and how that has combined to formulate his position on assisted dying or euthanasia. Members should welcome that.

It is unfortunate that we do not have a full House for important debates like this. We get so busy, but it is important for us to learn the perspective that each of us brings as a member of this chamber. We are not sent here to be surrogates for other interests or to run polls. We are sent with the judgment to try to look at legislation from the lens of our own experience, education, and background. Many members have brought that to this floor today, and I applaud them for it.

I have looked at Bill C-14, and I have struggled with it. Certainly this is a place where there are two sides on this issue, maybe broken down even more than that. However, there is compassion at the heart of both sides, and that is what is often forgotten in this debate. Why I say this should be the House of Commons at its best is that the Supreme Court of Canada recognized the role of Parliament to clarify the law with respect to euthanasia in a way that is thoughtful and complies with its direction in Carter. This is indeed one of the important debates that we should not fear in our House of Commons. We should ensure that we take part vigorously and share perspectives, as my friend from Thornhill has.

I have looked at Bill C-14, not just as a member of this chamber but also as a lawyer. I have reviewed the case law going back on this some 20 years. I have also reviewed it as a father of two children, a husband—I know my wife is watching today—and the son of a strong woman who died from cancer when I was nine. My most formative memories of my mother Mollie are in her palliative stage of that disease. Of course, all of these things combine to formulate my position on Bill C-14 and what I feel is the government's position with respect to Carter.

However, I am using my speech today to talk about some of the concerns I have with the bill. I will start with a Supreme Court of Canada quote from Justice Sopinka:

> Regardless of one's personal views as to whether the distinctions drawn between withdrawal of treatment and palliative care, on the one hand, and assisted suicide on the other are practically compelling, the fact remains that these distinctions are maintained and can be persuasively defended.

Within the Rodriguez decision in 1993, the Supreme Court struggled with the role of the state at end of life in euthanasia or assisted dying. It struggled with whether that role should be passive with respect to palliative care, treating and helping and comforting and limiting pain at end of life, or whether the role of the state should be an active role at end of life.

Justice Sopinka, in the majority court in 1993, said that the bright line of the active versus passive could be persuasively defended. That was the language of the court. Canadians remember, as my friend from Thornhill did, the tragic circumstance of Ms. Rodriguez and her compassionate arguments with respect to that. Bill C-14 is about the role of the state. It is not suicide alone, and that is why we have to have legislation that both accepts the Carter decision but brings us to a position that Canadians can be comfortable with, that persuasively defends it.

● (1730)

The second quote I will use is from Carter, paragraph 117, as to why the court found the position of the trial judge to be compelling. It states:

> We agree with the trial judge that the risks associated with physician-assisted death can be limited through a carefully designed and monitored system of safeguards.

At paragraph 120, it went on to state:

> We should not lightly assume that the regulatory regime will function defectively....

What the Supreme Court did was to allow this Parliament to come up with a regulatory regime to function effectively. The importance of that function is to ensure that what both courts said, the court of the Sopinka decision and the unanimous court of today in Carter, is that the decisionally vulnerable should be safeguarded. That was clearly part of the direction of both courts. This key element, and the aspect of what I consider to be the challenge for an ironclad regulatory regime, the slippery slope argument, is where I find Bill C-14 to be failing. That is why I am not supportive of it.

In the Carter decision, the court said that it was not in a straitjacket because it rejected euthanasia in the Rodriguez decision, and it looked at it in light of recent charter decisions. However, it is looking to Parliament for a system that does not allow the decisionally vulnerable, those impacted by a terrible diagnosis, under the strain and stress of an illness, to at a moment want to take their life and have the state play a role in that. Both courts recognized that these are vulnerable Canadians who need to be safeguarded. My concern is that this would not take place within this legislation before this chamber.

If we look at the great work that members of the all-party committee did, from the aspects of the all-party committee recommendations to what is before us in Bill C-14, the bill actually reflects more of the work done by the Conservative opposition on that committee. However, it certainly shows an indication of where the regulatory regime regarding assisted death would go. At some point in the future, it will likely include mature minors, and it will likely include people afflicted with mental illness, because that was the recommendation of the all-party committee.

As a veterans advocate for years before I joined Parliament, and having the privilege of being the veterans minister, I have met dozens of veterans who would have been decisionally vulnerable when they were suffering from depression, post-traumatic stress disorder, or another operational stress injury, but who are now leading productive lives as mothers and fathers. Some have returned to their role in the military. Many are actually advocating and helping other veterans.

Therefore, I am concerned with a regime that indicates that is where it will go. I know that Bill C-14 does not contain those provisions. However, the slippery slope element, which both the Sopinka courts and the McLachlin courts considered, show that is what we should anticipate in a few years. Although this House of Commons is well-intentioned, with an impossible regulatory regime, unable to look at every situation, I think the persuasively defended bright line has not been accomplished in Bill C-14.

Another example I will provide is that the Carter family themselves have expressed concern with Bill C-14. However, the Minister of Justice, in her thoughtful remarks in this chamber, which I appreciated, suggested that both appellants would have been provided for with respect to their assisted death under Bill C-14. That is not according to the family. The minister had to use language relating to a condition that can become “reasonably foreseeable” of death. Therefore, even the distinction between the named plaintiff in this case, the position of the family and the people who advocated for them, is at odds with Bill C-14 and the position of the justice minister.

● (1735)

If anything shows the fact that there is already a slippery slope and a very difficult framework to set, I am concerned that this has been rushed and it will not defend and safeguard against the decisionally vulnerable.

Could Bill C-14 be improved or, if Parliament could take more time, could it address this issue that confronts this place with Carter? In my weighing of all of the issues, as I said, as a parliamentarian who tries to draw upon my own experiences, as everyone does in this place, I do not think Bill C-14 can do that. I still feel that the persuasively defended bright line accomplished in the Sopinka decision has not been met by Bill C-14. In addition, many of the concerns providing the slippery slope that the Supreme Court in Carter raised have not been addressed by Bill C-14 either.

However, I have appreciated people sharing their points of view on this important issue. Parliament should not fear important debates. Members should come here in a respectful and thoughtful tone.

● (1740)

Mr. Adam Vaughan (Parliamentary Secretary to the Prime Minister (Intergovernmental Affairs), Lib.): Madam Speaker, putting aside the fact that we are under a deadline because of inaction by the previous Parliament and that an extension has already been sought at the Supreme Court, the issue that concerns me is this notion that people with psychiatric conditions, post-traumatic stress disorder, I think, was the issue raised, would be able to avail themselves far too easily of physician-assisted dying.

Does the member not reflect upon the provisions around requiring attending doctors or medical personnel to assess the psychiatric condition of the individual seeking this? Are those not the safeguards that would prevent an unfortunate circumstance from being pursued based on psychiatric conditions which were present when the request was made?

Are those safeguards not significant enough to prevent a mistake from being made and could they not be strengthened with further conversation in committee?

Hon. Erin O'Toole: Madam Speaker, even his framing of this, that mistakes can be made, sort of shows that it is very difficult for Parliament or any sort of regulatory regime, or the professions themselves, to set certainty. In fact, one of my main concerns with Bill C-14 is that it essentially kicks the issue back to the courts by using a reasonable foreseeable standard, which is kind of the linchpin of our common law.

When it comes to the case of a veteran with PTSD, there is no reasonable foreseeable end to that person's life at all, provided there is proper intervention. I have talked to military members, lower ranks and higher ranks. When the black dog, as Winston Churchill described it, hits people, they do think their own only option is to end their lives. However, I have met veterans who are now helping dozens of other veterans because they have found a path to wellness through a whole variety of programs and have made the decision to err on the side of help and not on the side of tragedy.

The very fact that the special committee put mental injuries, many of which can be treated, in the framework for euthanasia shows how difficult it will be to find the right balance.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Madam Speaker, I want to underline that there has been some discussion here about psychological suffering. The legislation very clearly includes psychological suffering as a criterion and subsection 241.2(2) talks about physical or psychological suffering being a criterion. The member, quite rightly, illustrates how having these provisions could create a more permissive environment for suicide more generally. We have heard his concerns about veterans. The member for Winnipeg Centre has spoken quite eloquently about the effect of some of this in the aboriginal community.

Would the member agree with me that we should simply remove the reference to psychological suffering from the legislation? It would be cleaner and clearer if we were to talk specifically about physical suffering and would not create some of these problems that he and others have raised.

Hon. Erin O'Toole: Madam Speaker, I would like to thank my friend and learned colleague who has provided a lot of perspective on this. That one issue needs to be addressed at committee or immediately with respect to Bill C-14, because it shows that already the legislation and the framework is flawed.

Going back to my earlier comments, this is a difficult circumstance, where, as parliamentarians, we are faced with compassion on both sides of the issue. Provided we have shared time between the member for Thornhill and myself, who may disagree on the final elements of what we see missing in Bill C-14, it shows the gravity of this decision, why we should have this debate, and why more members should be here to share their personal views with respect to concerns on either side.

● (1745)

The Assistant Deputy Speaker (Mrs. Carol Hughes): We are now at the five-hour mark for this part of the debate. Now we are going to the 10-minute debate and 5 minutes of questions and answers.

Resuming debate, the hon. parliamentary secretary to the Minister of National Defence.

Hon. John McKay (Parliamentary Secretary to the Minister of National Defence, Lib.): Madam Speaker, I was quite encouraged by the previous two speakers and their internal discussion on this issue. It does show that within parties, and I know within our party, there is considerable debate about this issue.

I found trying to assemble my thoughts to be quite difficult as it does go to the heart of our beliefs, our values, and our experiences. Sometimes, frankly, they are not reconcilable beliefs or values.

First, I take the opportunity to compliment the government on allowing a free vote. That is particularly important on this side of the chamber. In a debate such as this, it is very important that members feel complete freedom to speak freely, to vote freely, and to, as much as possible, minimize the partisan jabs that go on in this place. Because this is a free debate and a free vote, it actually strengthens this vote. It is, after all, important that we reflect the consensus of Canadians. They put us here, and they are the ones who we are to reflect.

In this perpetual dialogue between Parliament and the court, it is important that we establish a standard of deference for both institutions, both of which are critical to our freedoms and our democracy. Because this is a free vote, I believe it will therefore strengthen Parliament's expression on Bill C-14.

Some have said today that this decision flows from the Carter decision, and indeed Bill C-14 before us is a response to that decision. However, I would argue that the debate predates Carter by at least several decades as Canada unwinds itself from its Judeo-Christian heritage.

The sixth biblical commandment says simply “thou shalt not kill”. One way or another, it has formed the basis for our legislation and our jurisprudence for the last 4,000 years. In religious and secular terms, it is the doctrine of the sanctity of life.

The last time the Supreme Court dealt with this issue was, as has been mentioned many times, in the Rodriguez decision. At that time, Mr. Justice Sopinka spoke for the majority when he said, “This argument focuses on the generally held and deeply rooted belief in our society that human life is sacred or inviolable.”

He then goes on to reference section 7 of the charter and states that it is rooted in “the profound respect for the value of human life”, which is the right to life and the right not to be deprived therefore except in accordance with the principles of justice.

My own views, frankly, parallel Mr. Justice Sopinka, and in part explain why I do not support capital punishment. The reason I do not support capital punishment is that so often we get it wrong. Similarly, my views are pro-life, which I know is a minority view. I try to be, in my own philosophical way, as consistent as I can be.

What has happened for the justices to do what is an about-face, and disavow their own decision? I know that some will say that the charter is a living tree, but still this is a very significant change of position and even a disavowal of their previous decision in a space of less than 25 years.

In my view, it is the rapidity with which Canadians have disavowed their Judeo-Christian heritage on the sanctity of life and have substituted a test of the functionality of life. Life has to be functional in order to have meaning. Life for its own sake, let alone being created in the image of God, does not meet the test of functionality.

● (1750)

I appreciate that images of people in great suffering are felt deeply by us all and, as the previous speaker said, there is compassion on both sides of this argument.

I do hope the government means what it says in the preamble:

> And whereas the Government of Canada has committed to develop non-legislative measures that would support the improvement of a full range of options for end-of-life care, respect the personal convictions of health care providers and explore other situations—each having unique implications...

I would be distressed if this were mere lip service, but I have some confidence that the money set aside will in fact start to address some of the situations where people find themselves in end-of-life situations with very few, if no, alternatives. I think as we as a society age, this is going to become more and more of a critical issue.

However, concerns have also been raised by those who represent vulnerable communities and their concerns are legitimate.

Jurisdictions that have gone down the route of assisted suicide have, frankly, a bit of a spotty record. Once institutionalized, there seems to be upward pressure on the numbers and expansion of categories and cases which seem to fall outside of even the most generous interpretation of the law. It is perfectly understandable that there will be expansionary pressure. Indeed, it is a certainty that those who want individual autonomy as the value that is above all other values will challenge this legislation. That is a guaranteed certainty.

However, for those who cannot speak for themselves or for whom consent is problematic at the best of times, there is a worry that the categories of “assistance” would be expanded. I know this sounds like a slippery slope argument, and that is only because it is.

There is an absolute certainty of judicial challenge, regardless what the Government of Canada puts forward, how this Parliament votes and possibly explains the reluctance of the previous government to engage.

While I support Bill C-14 as the best that could be offered up under these circumstances and therefore will vote for it, I would have liked to have seen a couple of other measures included.

First, I would have liked to have seen a panel approach, rather than the one that is offered up. In Ontario, we have declarations of medical competency. It is based upon a panel of one doctor, one lawyer, and one other.

It makes sense to me that leaving the process exclusively in the hands of health care professionals will inevitably create a bias to the questions doctors ask about health concerns rather than procedural concerns, consent concerns, and ethical concerns which lawyers, ethicists, and others focus upon.

It seems to me that if a panel of mixed professionals is required for mental health competency, which is after all a reversible decision, then a panel of three mixed professionals should be the norm in a decision that is not reversible. It also may go a long way to alleviate the concerns of “doctor shopping”. It would lead also to a consistency of approach across the country.

The second measure is conscientious objections. I have heard the argument that no health care professional can be compelled to participate, and it might even be true. I think we can solve that quite easily by simply stating that explicitly in the legislation.

Finally, there has been a lot of negative commentary about the right of religious groups to comment on this bill. It might be pointed out that rabbis, imams, pastors, priests, nuns, and so on, have literally sat at bedsides millions of times as people have passed. They have every right to give their opinion and they bring with them literally thousands of years of experience.

● (1755)

I would like to finish with a quote from Jean Vanier, which I obviously will not get to, but I know you will want to hear in the response to questions, Madam Speaker.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Madam Speaker, the member made some very insightful remarks. I certainly agree with him on many of the points he made in terms of how Bill C-14 needs to be improved, the panel oversight, some protections for conscience rights, and those kinds of things.

My question relates to the legal profession. I am not a lawyer, so I will ask my colleague who is a lawyer. He commented that in the Rodriguez decision in 1993, the Supreme Court decided that the social good was of higher importance than relieving the suffering of one individual. That ruling was affirmed again in the Latimer case in 1997.

I wonder if my colleague would comment on what he thinks changed in terms of the law that created a situation where the Supreme Court would reverse itself on a fundamental issue when from my perspective, I do not see that any laws have changed.

If he has time, I would love the hon. member to give the Vanier quote.

Hon. John McKay: Madam Speaker, I am not sure the law has changed all that much. I do think societal conditions have changed, and I think there is a value shift that is going on from a communitarian view of life to a personal autonomy view of life. I think that actually is expressed by Jean Vanier, a philosopher, a theologian, a humanitarian, the founder of L'Arche, and a former Royal Canadian Navy officer, who said:

> A society which discards those who are weak and non-productive risks exaggerating the development of reason, organisation, aggression and the desire to dominate. It becomes a society without a heart, without kindness—a rational and sad society, lacking celebration, divided within itself and given to competition, rivalry and, finally, violence.

I do not think we are there, but frankly, those are concerns that have been expressed and I think they are concerns that bear being listened to.

Mr. Charlie Angus (Timmins—James Bay, NDP): Madam Speaker, one of the concerns we have as New Democrats is the issue of finding a balance on this legislation.

It was put forward and put upon the House by the Supreme Court. It has laid down a set of rules that we have to respond to, but if we are to move in that direction, the obvious question is, where are the standards for palliative care across this country?

There are many areas under provincial jurisdiction, but the federal government plays an important role in the delivery of health care and the federal government also has a major responsibility in areas of its own jurisdiction, and we have seen a lack of action.

We moved through the last Parliament a national palliative care strategy, but we saw no movement from the government in the budget. We are now hearing on this day that we are discussing medically assisted death that they will come forward at some point with all kinds of money, but there is nothing there now.

We have Motion No. 46 that will be coming before the House about establishing a coherent national palliative care strategy, working also to improve the EI benefits for caregivers so that families are given support, and also calling on the federal government to establish standards under federal jurisdiction.

I ask my hon. colleague what he believes the role of this Parliament is on moving forward with palliative care at this important time.

Hon. John McKay: Madam Speaker, I thank my hon. colleague for his work in the last few months with the people in Attawapiskat.

He puts the question in a very pointed way. We are in a bit of jam. We have a limited time frame in which to actually pass legislation which affects the Criminal Code.

When the Minister of Health answered a similar question in question period earlier today, she said that she is absolutely committed to putting forward a palliative care strategy. I am prepared to accept her at her word. Knowing her personally, knowing her personal background, knowing her integrity, I am perfectly at ease with accepting her word on this and her seeking out funds in order to put money behind that strategy.

I think the hon. member has raised a pretty legitimate issue, and we would all be a lot more comforted if we were doing this legislation in the context of a tabled palliative care strategy.

● (1800)

Hon. Michelle Rempel (Calgary Nose Hill, CPC): Madam Speaker, Canada is a secular state, but we are not, however, an amoral state. Our morality is defined in the shared set of values that sustain our pluralism, and our freedom of speech enables civil society to explore and frame what we define as right and what we define as wrong.

The law and policy that parliamentarians set also have the effect of shaping social norms. In this, I ask my colleagues in considering this bill to consider our responsibility as parliamentarians in defining the morality of our country. This is a sacred connection between us and the Canadians we represent.

The introduction of the Canadian Charter of Rights and Freedoms guarantees certain political rights to Canadian citizens and civil rights of everyone in Canada from the policies and actions of all areas and levels of government. It also greatly expands the scope of judicial review in Canada.

The Supreme Court of Canada ruling on physician-assisted dying, or the Carter ruling, touches the core of our nation's morality in that it discusses the sanctity of human life and how we should, as a nation, best respect it. It places the onus on Parliament to respond with a new legislative framework to address the issue of physician-assisted dying per the scope of the ruling. It also places an onus on Canadians to actively participate in one of the most transformative debates that Canada has had in a generation.

The Minister of Justice, in her speech on this bill, stated:

> From the start, we have known from the Supreme Court of Canada's unanimous Carter decision, that it is not about whether or not to have medical assistance in dying; it is about how we will do it.

I disagree.

The debate in this place that the Carter ruling has spurred is about how we respond to the ruling, not simply how to allow physician-assisted dying to occur. This is material because the Carter ruling does not allow us to abdicate our responsibility to decide whether physician-assisted dying should occur or in what context it should be allowed.

To be clear, with this bill the government has chosen to respond to the Carter ruling by allowing physician-assisted dying to occur in the context defined therein. It could have responded to it in many ways, including the invocation of the notwithstanding clause of the charter.

My concern with the government's approach to the Carter ruling is multi-faceted, but particularly troubling to me is that much of its rationale for its response seems to be that the Supreme Court has forced Parliament to allow a framework for physician-assisted dying.

In this matter of deep concern and sensitivity to all Canadians with all viewpoints on this issue, this is not a sufficient enough explanation to show the government's intent over time as to how approaching broader questions related to physician-assisted dying should be addressed.

I say this not simply as an indictment of the government, but as a cause for reflection for us all. While the Carter ruling came out over a year ago, all of our political platforms and national debates were largely silent on approaches to this issue during the last federal election campaign.

While parliamentary panels and committees did a remarkable amount of work in a short period of time, similar legislation in Quebec took nearly six years of public engagement to draft and pass, and even then, Quebec's National Assembly was divided.

There are issues the government has touched upon in relation to the Carter ruling which I do not believe Canadians have given us a clear mandate to legislate upon.

I also believe that the bill in its current state would leave provincial legislatures and medical associations with unresolved legislative issues leading to a balkanized patchwork of legislation and processes related to this issue.

While I appreciate that the government must respond to the Carter ruling in a shortly defined period, I am concerned that the government has not clearly specified its preliminary positions on many issues raised in the joint committee report and in tone has resigned itself to the inevitability of future charter challenges on this legislation.

In this context, I respectfully urge my colleagues here and the government to deeply focus upon our responsibility as parliamentarians to respond to the Carter ruling with firmness and clarity and to do the following.

First, change the timing of the parliamentary review of this legislation to two years after coming into force as opposed to five years, and to develop a strategy to actively engage a wide range of Canadians in this discussion.

This would promote us as legislators and our electorate to embark upon a fully informed discussion on how to best provide end-of-life care and ease of suffering to Canadians, with the hope of engaging more Canadians on issues that arose in the joint committee report, which I do not believe we have a clear mandate to legislate upon and are beyond the scope of Carter. This early review would also allow Parliament to assess the efficacy of the government's proposed safeguards. The review of this legislation should also be held on a regular, as opposed to a one-time, basis. The requirement of an annual report to Parliament regarding the government's response to the Carter ruling would also be helpful.

Second, the government has signalled the need to study issues of use of advance directives in physician-assisted dying, availability of physician-assisted dying to mature minors, and the definition of conditions beyond the scope of the Carter ruling under which physician-assisted dying would be available in the future.

● (1805)

To date, the government has not described the framework, the timing, nor the scope under which these studies would occur. This needs to be rectified immediately, hopefully with the input of members from a broad range of the community. Further, the government should commit to taking policy responses to these issues to the electorate before allowing them to come to pass.

Third, the bill is silent on direction regarding conscience rights of medical practitioners and faith-based care facilities in being required to provide physician-assisted dying to patients. In this, we are forcing the issue to be decided by provincial legislatures and by medical associations. This silence is an abdication of our responsibility to the electorate, as the Carter ruling clearly outlines the need for Parliament to respect the charter rights of both patients seeking physician-assisted death and the conscience rights of health care providers. I also have concerns regarding the selection of a panel approach to approval, as opposed to the way the bill currently outlines the selection.

Fourth, I am concerned the government's response to the Carter ruling to date is simply this bill. This fails a significant component of the Carter ruling. The ruling in its conclusion relies upon the assumption that a legislative framework allowing physician-assisted death would ensure that physicians properly inform patients of their diagnosis and prognosis and the range of available options for medical care, including palliative care interventions aimed at reducing pain and avoiding the loss of personal dignity, prior to allowing physician-assisted death to occur. In this, I believe Canadians have the responsibility to ensure that the range of options available to patients in this situation is robust and in every situation enables people to lessen their suffering while living.

In saying this, I in no way diminish the legitimate right for patients to choose the path of their end-of-life care. However, our country will have failed them if our response to the Carter ruling simply focuses on legislative mechanisms to allow physician-assisted death to occur rather than also placing a significant new emphasis on increasing and improving the range of available options for patients facing grievous and irremediable medical conditions.

Our response should also be clear about the limitations we would place on further expansions to the scope of access to physician-assisted dying. This includes a formal response from all levels of government, civil society, non-governmental organizations, Canada's faith community, and individuals to talk about and address the following: the mental anguish those facing grievous and irremediable medical conditions experience; how to support those who provide care to those who are suffering; reducing barriers to access to end-of-life care, including isolation, availability, and cost; reducing the stigma of mental health issues in Canada, and providing care and compassion to those facing this issue; ensuring a culture in which suicide is normalized does not arise, and ensuring strategies for suicide prevention are prioritized; ensuring that medical professionals have robust and comprehensive training on end-of-life care; developing and funding a comprehensive palliative care strategy to be implemented at the same time the bill comes into force; ensuring that physician-assisted dying does not evolve in our society as a promoted response to a diagnosis of a grievous and irremediable medical condition; and engaging research institutions and granting councils in a discussion on how to fund and manage research related to end-of-life care, and ensuring that what we have learned is effectively translated into public policy and clinical practice.

This discussion should not be treated as static, and a mechanism to address the success of programs and initiatives, in coordination with provinces and territories, health care providers, civil society, and the public at large, to address these issues on a regular basis should be immediately implemented.

Our collective response must first and foremost come from a place of compassion for those who are suffering. Our response must recognize the spirit of the Carter ruling in that Canadians ultimately have the right to choose their path of care.

However, we cannot abdicate our responsibility to respond to these issues to the courts or to other levels of government, nor should we see a legal framework in which physician-assisted dying occurs as a comprehensive response to the Carter ruling. Instead, we should ensure that our response is comprehensive, is clear and thoughtful, and is backed by a mandate from Canadians. Our covenant with our electors and the respect for the sanctity of life demand nothing less.

● (1810)

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Madam Speaker, I listened attentively to many of the comments the member made. There were several ideas which ultimately have a lot of validity. I have listened to the debate today, and she and other members have been very willing to share their many opinions on the legislation and justifiably so.

We have been fairly clear about wanting to get the legislation to committee. We are all very much aware of the Supreme Court of Canada deadline which is looming.

I would ask if the member would at the very least recognize the importance of getting the legislation to committee, where members like herself and others could share their thoughts on how they might improve the legislation. At the same time, they could provide Canadians from different parts of our great nation the opportunity to provide direct input to our standing committee.

Would she not support getting the bill to committee as soon as possible so we could actually get that feedback, especially given the deadline from the Supreme Court of Canada and the fact that we also have to get the bill through the Senate of Canada?

Hon. Michelle Rempel: Madam Speaker, while I appreciate that the government does have a timeline in which to respond to the Carter ruling, I also find its response to be lacking for the reasons that I have outlined in my speech.

[*Translation*]

Mr. Pierre-Luc Dusseault (Sherbrooke, NDP): Madam Speaker, I thank my colleague for her speech.

However, how can she tell the House that it is not our duty to abide by this ruling and to grant this right? The court stipulated that medical assistance in dying is now a right guaranteed by the Canadian Charter of Rights and Freedoms.

As legislators, how can we refuse to grant a right that was confirmed in the Supreme Court decision?

What does she want us to do if she does not want us to abide by the court's decision and understand that this is now a charter right that must be granted to all Canadians?

[*English*]

Hon. Michelle Rempel: Madam Speaker, as I outlined in my speech, the options afforded to us as parliamentarians with regard to a Supreme Court ruling are many. The government has chosen to respond with this bill and I do not feel that the government has responded adequately in terms of providing a concurrent framework on palliative care outlining how. For example, the Liberals talked about studying an expansion of the Carter ruling in terms of situations in which physician-assisted dying would occur.

I believe it is incumbent upon the government to clearly communicate this prior to a vote happening in the House of Commons. I do not think it has done that to date. I certainly think there is a little more work to do on this before it is an adequate response to the Carter ruling.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Madam Speaker, my colleague has outlined many of the concerns that many of us in the House have. Throughout debate today we have heard government members assure us that conscience protection is included in Bill C-14. I do not share that optimism because I do not see it here, other than in the preamble, and it is actually along with the intention to expand physician-assisted dying to minors and people with psychological issues. That is a pretty weak commitment.

My bigger concern is that the bill is totally silent on protection for health institutions. We know that many hospices in Canada have been started with the express purpose of improving the quality of life for those approaching end of life and many of them are supported by very generous donors. If we are to insist that those institutions now need to participate in physician-assisted dying, I have concerns that we will end up losing a lot of health care facilities in our country. I am wondering if my colleague would share any comments on her views on protection for institutions.

● (1815)

Hon. Michelle Rempel: Madam Speaker, the Carter ruling is quite clear in the need to acknowledge both the charter rights of patients in choosing their end-of-life care and the charter rights of medical practitioners. I do not believe that the bill has adequately done that. It will leave it to the provinces and medical associations, and I feel this is an abdication of our responsibility as parliamentarians.

Ms. Yasmin Ratansi (Don Valley East, Lib.): Madam Speaker, I appreciate this opportunity to discuss the Government of Canada's commitment to establish a framework for medical assistance in dying.

On April 16, I hosted a town hall meeting for the residents of Don Valley East on this matter. As we know, this is a very emotional and personal matter. It was important for me to listen to my constituents' concerns and to ensure that their concerns were heard. Some of my constituents wanted dementia and Alzheimer's to be included, others wanted advance directives, and some wanted protection for the vulnerable.

In order to ensure that there is no confusion on what this bill is all about, I am taking this opportunity to speak on the matter.

Being part of the Abrahamic tradition, I had to park my own beliefs and listen to my constituents and ensure, as a parliamentarian, a balanced approach. Some of my constituents thought that this bill does not go far enough. Others felt that we should not allow it. To help my constituents have a say in this matter, I have asked them that when this bill goes to committee to make a submission to the justice committee.

The Supreme Court of Canada's decision in Carter has significant implications for provincial and territorial governments, and touches many Canadians in a very personal way. A number of individuals have already been granted exemptions by provincial superior courts to access medical assistance in dying. This is in keeping with the conditions set out by the Supreme Court's decision to extend the timeline for its ruling to come into effect to June 6, 2016. It is now time for us to establish a legislative framework for medical assistance in dying to legally become part of the options available to Canadians at their end of life.

Bill C-14 would provide Canadians with greater autonomy over their health care at the end of life, while also providing protection to health care providers and to individuals who may be vulnerable. It would provide provinces and territories with a strong foundation for implementation.

Canada is not the first to implement medical assistance in dying. In Europe, for example, three countries have legislated access to medical assistance in dying: Belgium, the Netherlands, and Luxembourg. In the United States, four states have legislated access.

Where Canada is unique is in the jurisdictional complexities we face. In Canada, the federal government has exclusive jurisdiction over criminal law. However, health care is a shared jurisdiction between the federal, provincial, and territorial governments. Primary responsibility for the provision and delivery of health care services rests with individual jurisdictions. The provinces are responsible for hospitals, the delivery of health care, and regulation of the medical profession, among other things.

As provinces and territories bear ultimate responsibility for the implementation of medical assistance in dying, the scope of the federal legislation has a significant impact on them.

[*Translation*]

That is why our government has been working collaboratively across governments, while at the same time respecting jurisdictional roles and responsibilities.

[*English*]

When health ministers met in January, they came to an agreement that a robust and consistent regime across the country is in the best interests of Canadians. Health Canada has also engaged in ongoing discussions with health officials in the provinces and territories to hear their views on many aspects of this important issue.

● (1820)

[*Translation*]

By establishing national eligibility criteria and safeguards, this bill will help ensure consistency across the country as well as respect the underlying criteria of the Canada Health Act.

[*English*]

The proposed legislation will set out who is eligible to receive medical assistance in dying and the safeguards that must be adhered to for medical practitioners to be protected from criminal responsibility.

Provinces and territories cannot modify these Criminal Code exemptions through their own legislation or regulations.

[*Translation*]

However, the provinces and territories can legislate or introduce policy measures with respect to aspects of medical assistance in dying under their jurisdiction. This could include identifying any special training for offering medical assistance in dying, specific forms to be filled out, or how the cause of death should be recorded.

[*English*]

However, in order to respect the principle of accessibility upheld in the Canada Health Act, provinces, territories, and regulatory bodies would need to consider the implications that any additional guidelines or regulations would have for patient access.

The bill gives the Minister of Health the authority to make regulations about the information to be collected and the processes for collecting it. Working with provinces and territories will be critical to determining how a pan-Canadian monitoring mechanism can be put in place, the types of information to be collected, and the reporting requirements among other elements.

In reviewing the bill, I see that the government has taken into account the concerns of some health care providers; that is, the protection of their conscience rights. The Supreme Court was clear that providers should not be compelled to provide medical assistance in dying. However, the government is also aware that the exercise of such rights may constitute a barrier to access for those who are seeking it.

To address these issues, the government will work with provinces and territories to support access to medical assistance in dying, while respecting the personal convictions of health care providers. This could include, for example, a pan-Canadian system that would facilitate access for patients to willing providers of medical aid in dying.

[*Translation*]

Throughout the consultations on medical assistance in dying, we heard loud and clear from Canadians calling for more resources for quality palliative and end-of-life care.

[*English*]

With Canada's aging population as well as growing rates of chronic disease, we must consider ways to support the improvement of a full range of options for end-of-life care. This includes better integration and expansion of access to services at home, including palliative care.

Medically assisted dying is a complex and important issue for Canadians and requires collaboration across jurisdictions to ensure that we have a framework that fits within our uniquely Canadian context.

I would therefore like the bill to go before committee where our collective thinking and robust consultation will hopefully result in a better bill, which is satisfactory to all. I think the bill at least provides a foundation for our continued collaboration.

● (1825)

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Madam Speaker, I enjoyed listening to the member's speech. She did something interesting at the beginning where she referenced her personal religious beliefs coming from the Abrahamic tradition. We have heard a number of Liberal members reference their personal religious beliefs, but then also say that they are going to have to in some way park those beliefs.

When I think about the relationship between faith and reason, I am often drawn to think of one of Plato's dialogues called Euthyphro and I would commend it to the reading of hon. members. It discusses the question of the origin of goodness; in particular, is a thing good because it is declared so by religion, or is a thing declared good by a religion because it is intrinsically so? I think most of us would agree that religions declare things good or bad because they are so intrinsically. They do not render a thing good or bad by declaring them so.

It is one thing for the member to ignore religious convictions, but it is another to ignore the underlying realities and truths that those things express.

I want to ask the member to further comment on that dynamic. I want to ask her if she believes in the universal immutable human dignity as a reality, not just as an arbitrary confession. Does the member believe that to be a reality and will that be expressed in the vote she makes on the bill?

Ms. Yasmin Ratansi: Madam Speaker, for me and for the religious beliefs of all of the Abrahamic tradition, life is sacred. However, what we are talking about here is people who have unbearable diseases, and the Carter case is very clear. As people with religious convictions, we have to ensure that Parliament observes the laws of the land and observes the Charter of Rights and Freedoms. My assessment is that, if we are to move forward with this bill and help our constituents and Canadians live with dignity, we should let this bill go before committee and listen to other concerns and then come up with a robust bill.

Mr. Charlie Angus (Timmins—James Bay, NDP): Madam Speaker, I have been listening with great interest, and this is a profound discussion that we are having tonight. The issue in terms of what people are able to access at end of life has been put before this House, not simply because of the Carter decision and not because of, as some colleagues have said, a narrow rewriting of the legislation. However, if we are going to rewrite this legislation, we have to deal with the huge shortfalls in end-of-life care for those who are wanting to live—the palliative-care needs of the sick and their families. Yet only 16% to 30% of Canadians are able to access quality palliative care. Only four provinces even have a palliative-care framework. It is the responsibility of the federal government to work with the provinces, and also to put the money on the table to say that palliative end-of-life choices are going to be available. However, we saw zero money in the budget from the current government.

If this bill is going to be in place in June, we are going to be in a situation in Canada where people will have technically the right to end their life if they are facing intolerable suffering, but they will not also share the same right to access quality health care for their family if they are living in under-serviced areas and patchwork areas. I am asking why the current government has not stepped forward in advance of this legislation to start dealing with the huge shortfalls we are facing in palliative care.

Ms. Yasmin Ratansi: Madam Speaker, palliative care is an important aspect. I believe, when I was doing my presentation, I made palliative care part of the comprehensive framework that we have to work with. There are cases in one of the states where it is the Cadillac version of palliative care. Those people who have the Cadillac version of palliative care are the first ones to want assisted dying. I do not mean to say that we should not have palliative care. It is extremely important, and choices are important. However, to have a robust and very strong bill, we need to send this bill to committee and work around it.

● (1830)

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Madam Speaker, a report in *The Globe and Mail* on April 24, 2016, says 13-year-old Sheridan Hookimaw killed herself on the banks of the river that winds through Attawapiskat. The sickly girl had been flown out for weekly medical appointments. She wanted to end her pain, and in the process, she set off a chain reaction not only in her community but in communities right across this country, which we are still dealing with today.

This debate strikes at the very heart of the meaning of life, it strikes at the heart of bureaucracy, and it strikes at the heart of how we care for the most vulnerable in our society. I have been told over and over again that this situation is different, that there is no connection.

In the indigenous world view, everything is interconnected. It is holistic, meaning that when a change is made in one place, the impact will be felt elsewhere, and the two cannot be separated. In the western world view, often we compartmentalize things. We believe that we can play, that we can control certain situations, that we can effect change here and not see change in other places. Above all, we have come to believe ourselves able to predict and control all, to control the future. This does not mean, though, that we should not take action.

The impact of this bill on people in Toronto may be very different than on the people in Nunavik or Attawapiskat. Our role as parliamentarians is to place ourselves in the moccasins of others, to place ourselves outside of our own experiences, to see the world through another cosmology and other world view, and to see the impact that our decisions may have on others.

We are making profound changes in concepts surrounding life, which cannot be undone in the future. In the indigenous tradition and philosophy, we are required to think seven generations into the future. If I am wrong and there is no connection between Attawapiskat and physician-assisted dying or suicide, if the average person does not see a connection and communities do not see a greater stress, then I will gladly say I was wrong; but if there is an impact, which is caused by the valorization of suicide, then what?

When the House passed amendments to the Criminal Code on other issues in our criminal justice system, who would have thought that indigenous peoples would now make up 23.2% of the prison population? It seems that madam justice is blind to the suffering of many of her fellow citizens. We have equal laws, and yet the treatment and effects are unequal across our country. We make laws often for the average person, but the impact is felt most by those who are on the margins of society.

Even though we have the Gladue rulings in our justice system and cases where we are supposed to take into consideration someone's upbringing, someone's past, unfortunately, those are not reflected in our justice system. Therefore, how can we be assured that the changes we are making today in the House will not have an equally detrimental impact on others?

My earliest memory, one of my strongest memories, is as a little six-year-old boy. My mother had just lost a house. We were in tough economic times in Calgary, Alberta, and she could no longer support us. She was a single mom, and she went off on the road looking for work. She decided at one point she could no longer raise me or my little brother by herself and she needed help, so she went to her ex-husband, my father. My father was a residential school survivor, an alcoholic, and a member of gangs. We knew all these things.

We knew he had a terrible temper. We were told this as young children, and we were very scared as children. We were dropped off at his place, with his parents, my grandmother and grandfather, and we were very upset. It is the only time that I remember my brother peeing his bed, because of the stress, because my mother had to find work because of economic stresses in her life.

I remember climbing a tree in the back yard and wrapping a rope around my neck at the age of six. This is a true story. People often think it cannot be true, but this happens in our country, like the case of the 13-year-old girl in Attawapiskat.

● (1835)

I wrapped that rope around my neck and thought, “Should I jump off into this universe, which is before me?” It was in that back yard that somehow I made the decision to climb down out of that tree and unwind that rope from around my neck.

If in my life I had seen, or I had known, that my grandmother had somehow used physician-assisted dying or physician-assisted suicide, or others in my family had completed the irreparable act, then it would have made it much more difficult for me to continue.

We might not think the impact will be there, but we do not know. We assume we know these things. We are deciding the future of a few for the end of a few.

In the case of Sheridan Hookimaw, as a society, we are unable to provide the necessary care, the love and the protection. We have failed our most vulnerable.

The Canadian Webbian bureaucracy was unable to respond to the needs of a 13-year-old girl. How can we be sure that it will now be able to respond to the needs of all in the future in our societies?

This debate is about life itself. Indigenous people never knew of suicide. It was unheard of in indigenous communities. Yet it now continues to plague our communities, and the spirit of suicide seems to always be there.

Life is not easy. It is about struggle, about fighting for another day. If indigenous peoples had committed suicide, then we would not be here today for all the trials and tribulations we have faced.

I participate in one of the high ceremonies of the indigenous custom and tradition of the Plains Cree. It is called the sundance. It is a four-day ceremony, and for three days and three nights, no food or water shall pass my lips. I pierce my body to sacrifice myself for others, in prayer for them. I do this not for myself, not to ask for something for myself, but for others.

In the sundance, in the sundance lodge, my Sundance Chief David Blacksmith talks about the spirit of suicide, how it is coming to take our young and is starting to take our old people, how it is affecting our society, how it is destroying our sense of community, and I have to listen to it. I have to be moved by the words he brings, because the people surrounding me in the sundance have all been affected by it.

We are placing ourselves now outside of nature. Nature itself is hard, to strive, to struggle, to see another day. It is a struggle that is noble. Now placing the tasks in the hands of the state removes us from nature, telling the state that it will now be the one who will be enabling us to do these things; someone else will be deciding, bureaucracy will now be deciding.

Others may feel that they are a burden. Others may say that they are a burden. I think there is something noble in sacrifice and in striving in the struggle for life itself, to hold someone's hands in the final moment, to have to grow up and not simply say, “I am going to hand it off to someone else to look after, but that I will stand there or I will sit there, holding your hand at that exact moment. Even in your final breaths, even though it may be difficult, we will continue on”.

Perhaps this is just another step on the road of moral relativism that we are in nowadays, but even our judiciary cannot serve as a balance between the different societies making up Canada. We are in a sorry state. We have truly entered a new age, one of the throwaway culture where all boundaries are starting to crumble.

Finally I would like to say, in the words of Elder Winston Wuttunee, “If you cry, your children will die”. It is dangerous to abandon one's self to the luxury of grief. It deprives one of courage and even of the wish for recovery.

From an indigenous perspective, I look at this bill and I cannot support it, because it leads to a place where I do not believe we are looking out for the interests of all people within our society. It is not allowing us to fully comprehend the needs of everyone who makes up Canadian societies, but really, it is taking us down a path that is very dangerous, and we do not know where it ends.

Let us be very careful in this House, and take the time that is necessary as we make our decisions.

● (1840)

Mr. Todd Doherty (Cariboo—Prince George, CPC): Madam Speaker, I would like to thank my hon. colleague for sharing his views on this.

I know I will be reprimanded for this, but I am disappointed by the disrespect that one of his own colleagues made while he was speaking, by walking not once but twice directly in front and making noises, while he was trying to give that heartfelt presentation.

I have considerable concerns with the bill, and my comments are neither for nor against, but on the timing, the time we have to debate it and the rush to get the legislation through. Quebec took six years to, hopefully, get it right.

I have an adult child who is 28 years old. She presents herself as mature and is beautiful, but cognitively, she is developmentally challenged. My concern is that there are not enough measures in the bill as it exists today that would protect the cognitively challenged. It says a “competent” adult has the right to make this request. Who determines that adult is competent to make that decision, and are there enough safeguards in place for those who are cognitively challenged?

Mr. Robert-Falcon Ouellette: Madam Speaker, not being a lawyer, I am not sure. However, I know once we start doing a process, once we have gone down this path, we cannot go back. We need to take time to look at Quebec and see what happens there, how it plays out in that jurisdiction, before we start elaborating in other jurisdictions.

I understand that there are people who are suffering, but I do not think we have dealt properly with the suffering that goes on in many communities. We have not taken the time to really understand or to make sure that they feel protected.

I do not have a lot of comments to offer the member, but it is a concern as well.

Mr. Charlie Angus (Timmins—James Bay, NDP): Madam Speaker, it was very unfortunate that my colleague invoked the name of young Sheridan in the House in this debate. She did not die because she was suffering from an incurable illness like Lou Gehrig's disease. She died because of lazy indifference from federal and provincial officials, from poverty, and the fact that we do not have mental health workers. It took months to get her body home through the bureaucratic red tape, as the family could not deal with the trauma.

What we are dealing with here is our obligation before the Supreme Court. This is our job. However, it is extremely dangerous and unprofessional to invoke the suffering of those children as a way to say that we are not doing our job here.

We have a job to do before the Supreme Court, but we also have a job for those children, so a young child like Sheridan will never ever be denied mental health services because some official says we will not give it to them, or that they are going to have to live in a squalid shack because some official will not sign off on the housing agreements. Those are fundamentally different.

Knowing the family and what these children have gone through, it is very unfortunate that my colleague has used those stories to somehow conflate these two issues, which are fundamentally different.

Mr. Robert-Falcon Ouellette: Madam Speaker, unfortunately, perhaps the member fails to understand indigenous philosophy, which is about the interconnectedness of everything. The member may believe that these are unconnected events, but in fact they are connected. We could debate about the definition of the bill. We could say "medically assisted dying" or "medically assisted suicide". Our use of terminology is very important. If we use "medically assisted suicide", it has connotations to it that people will understand. I am sure at some point that people will be banging on the doors at some emergency wards and saying they are suffering, they want to end it, and ask for help.

I apologize if I offended anyone in invoking the name of the young girl, but her name is in the newspapers and her case is well known. If we cannot speak truth in this place and use the truths that are out in society here in the House of Commons then where else will it happen?

● (1845)

The Assistant Deputy Speaker (Mrs. Carol Hughes): Before we resume debate, I want to remind people that when others are speaking it would be good to allow that person to speak without going back and forth. I want to make sure we keep that level of respect here in the House.

Resuming debate, the hon. member for Calgary Shepard.

Mr. Tom Kmiec (Calgary Shepard, CPC): Madam Speaker, as I rise today to speak about the grave implications of Bill C-14, I am reminded of the Yiddish proverb, which says: "From fortune to misfortune is a short step; from misfortune to fortune is a long way". I am afraid that the legislation being brought forward by the current government is a short step to misfortune, and the path with proper safeguards would be a long one.

This is a difficult subject, but the floor of the House of Commons was made to debate weighty subjects, to define how we live in our Confederation, to seek out the objective truth, and to legislate wisely.

However, the House has addressed the issue several times over the last decades. In 1983, the Law Reform Commission of Canada recommended against legalizing or decriminalizing euthanasia or assisted suicide. In 1993, the Supreme Court dismissed the challenge by Sue Rodriguez on the Criminal Code prohibition of assisted dying. In 2006, Bill C-407, a bill that would have allowed physician-assisted suicide in certain circumstances, died on the Order Paper in that Parliament. We can see in the chronology the hesitancy to legalize assisted suicide, and for good reason.

Bill C-14 would impact how Canadians view the worth of their lives and the lives of their loved ones. The safeguards we put in place must protect Canadians from abuse when it comes to physician-assisted suicide, and that is something all Canadians can agree on. We must ensure that, as far as possible, the legislation we craft mitigates the harm inherent in legalizing the killing of human beings.

Additionally, I remind my fellow parliamentarians that the ruling of the Supreme Court in Carter v. Canada directly contradicts the Supreme Court's 1993 decision in Rodriguez v. British Columbia. In that ruling, the Supreme Court was clear when it stated that section 241(b) of the Criminal Code of Canada was in fact constitutional. It reads:

> Every one who...
>
> aids or abets a person to commit suicide,
>
> whether suicide ensues or not, is guilty of an indictable offence

At that time, it was ruled that the Canadian Charter of Rights and Freedoms confirmed its legality.

Millions of Canadians believe that the Supreme Court erred in its interpretation of sections 1 and 7 of the charter. Despite this, I recognize that the court made a unanimous decision. Therefore, the question before us is no longer whether assisted suicide should be legalized or not, but rather to conform with the Carter decision in what the contents of the legislation should be, as well as the safeguards. That is the matter before us.

Many of my constituents have reached out to me with concerns about the direction that this legislation is taking. Bill C-14 would fail to provide stringent limits. It would fail to keep the deadly wolf of abuse and misapplication at bay.

Constituents like Alexia Blackwell wrote to me that, "Legislation must clearly spell out the protections provided by the Charter of Rights and Freedoms so that caregivers and their organizations will be protected from coercion or discrimination."

Canadians must have access to palliative care before and alongside physician-assisted suicide so that their first end-of-life option can always be a peaceful, compassionate, and natural death.

Palliative care provides compassionate and ethical end-of-life care for those suffering intolerably as a result of a grievous and irremediable medical condition. It must always be presented as an alternative to physician-assisted suicide.

I would also like to note that in 2014, the House voted in favour of a motion brought forward by the hon. member for Timmins—James Bay, which read:

> That, in the opinion of the House, the government should establish a Pan-Canadian Palliative and End-of-life Care Strategy...ensuring all Canadians have access to high quality home-based and hospice palliative end-of-life care...

That is the sort of care we should be working towards.

A very important safeguard, and one that I feel has only been partially addressed by the bill before us, is the conflict of interest that is bound to arise if we do not ensure that physicians are prohibited from benefiting directly or indirectly from recommending or performing physician-assisted suicide. I say this because, like millions of Canadians, I firmly believe that no person in Canada should profit from death. Since physicians in Canada are paid directly by their provincial health authorities, they cannot be placed in a situation where helping a patient choose physician-assisted suicide, or an extensive palliative care plan, or a chronic disease plan could be influenced by a consideration of monetary gain.

Similar prohibitions on physicians profiting for performing the physician-assisted suicide procedure exist in other jurisdictions that have now legalized the procedure, including Germany, Switzerland, and Oregon. These laws exist for good reason. As much as we may not like the idea, it is possible for unethical physicians to promote the idea of assisted dying over other health care alternatives if they stand to benefit from it.

The Dutch government, concerned over accusations that the practice of euthanasia was being abused, undertook studies in 1990, 1995, and 2001. Physicians were guaranteed anonymity and immunity from what they revealed in regard to violations of the guidelines. Therefore, the findings of these studies are indicative of what was going on in the practice of their profession.

It quickly became apparent that half of Dutch doctors had no hesitation in suggesting that their patients consider euthanasia, which compromised the necessary voluntary nature of the process. In addition, 50% of these cases were not reported, according to a study by researchers from the University of Ghent in Amsterdam.

● (1850)

Even more alarming was the fact that a quarter of the physicians said that they were terminating the lives of patients without an explicit request from the patient. Another third of the physicians said that they could conceive of doing so; they were not just thinking that they could do so.

We must not be naive about the possibility of coercion. That is why I am asking the government to amend paragraph 241.2(6)(b) and delete “other than standard compensation for their services relating to the request”, thus making the assisted-suicide decision and the provision free of any financial consideration.

Another issue I have heard brought up frequently is the lack of definition for the phrase “intolerable suffering”. I have heard a lot of talk about this particular issue. Should the definition of suffering include those struggling with mental illnesses, those struggling financially perhaps, or those who suffer from intense boredom? We should be protecting people from their suicidal desires rather than enabling them. After all, is that not the whole point of the excellent mental health initiative called Bell Let's Talk campaign, which we all support?

We cannot simultaneously work to end depression and suicide while also creating legislation that would allow people to request assisted dying simply because their situation has led them to consider their personal suffering intolerable or their death reasonably foreseeable. Realistically, this would fundamentally change the practice of psychiatry, the central focus of which is to develop good mental health that prevents suicide and shows persons the value of living and the inherent dignity of their condition.

Considering this incoherency, we must ensure that requests for physician-assisted suicide are considered objectively by a judicial review body that ensures the request is voluntary, well considered, informed, and consistent over time. This regulatory body must ensure that consent is actually being given by the patient requesting the physician-assisted suicide, and that all requests are reported to this body. The need for this sort of regulatory body is evident when we consider other jurisdictions where physician-assisted suicide is legal.

According to a study published in the *Journal of Oncology Practice*, over 500 people in the Netherlands are euthanized involuntarily every year. In 2005, a total of 2,400 deaths by euthanasia or physician-assisted suicide were reported, representing 1.7% of deaths in the Netherlands. There were 560 of these deaths that occurred without proper documentation of consent. In Belgium, the rate of euthanasia deaths that occur without explicit consent is three times higher than it is in the Netherlands.

Speaking of ambiguous requirements, it is the inevitability of life that it must end. From the moment we breathe our first breath outside our mother's womb, it is reasonably foreseeable that we will die. That is another vague, confusing term that at best fails to provide any meaningful guideline for physicians or their provincial colleges as they evaluate individual requests. Another vague term is the definition of medical practitioner as a person entitled to practise medicine under the laws of a province. This is problematic because that definition changes from province to province. In my home province of Alberta, it includes osteopaths, also known as chiropractors.

When deciding whether to provide assisted dying, physicians can follow their conscience without discrimination. No one should be compelled or coerced to provide assistance in suicide. I held a round table last week with participants who were for and against assisted suicide. I asked the question, regardless of whether people were for or against, what part of the bill they believed was most critical. They said it was protection for conscience. The people want an extension to protect the ability for people to say no based on moral and ethical grounds.

We must be very careful that Bill C-14 will not force Canadian physicians with deeply held religious, moral, or ethical beliefs about the sanctity of human life to go against both their conscience and the Hippocratic oath. I believe that section 2 of the Charter of Rights and Freedoms that protects freedom of conscience and religion, as well as freedom of thought, belief, opinion, and expression applies here. Further, what is the point of any of these rights if we cannot express them through action or inaction without state coercion?

I could go on about the ways that Bill C-14 would go far beyond the recommendations of the Supreme Court, how it lacks the strict safeguards referred to in Carter, or the broadly worded definitions that are a problem. I could speak of the irresponsibility of poorly defining the person who is eligible to undertake or to perform assisted suicide.

This bill is based on badly reasoned and inadequately researched recommendations from a committee that failed to seek proper input from a broad diversity of Canadian beliefs and opinions. The National Assembly of Quebec got it right by allowing for six years of debate, through three different assemblies, to study and consider all of this.

To finish, I urge the government to move significant amendments to this legislation or drop this bill entirely and table a better one. The path back from the misfortunes of this bill is too significant to get it wrong.

● (1855)

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Madam Speaker, I am sure the member is somewhat familiar that this decision was made by the Supreme Court well over a year ago. The previous government virtually did nothing to address the issue. It had a panel, and I recognize that, but it fell far short in trying to come up with any sort of legislation. We had opposition days to encourage the Conservative government to take action, but it chose to do nothing.

In hindsight, does the member believe there was an obligation on the former government to at least advance the issue in a more timely fashion? By doing that, who knows where we might be today. However, at the very least, we need to recognize the restraints we are currently under with the Supreme Court of Canada. We still have to go through the Senate. Does he believe there will be value in getting this to committee so we can talk about the many ideas we are hearing today and listen to what Canadians have to say in the hopes that—

The Assistant Deputy Speaker (Mrs. Carol Hughes): Order, please. We have to give time for the answer so other people can ask questions as well.

The hon. member for Calgary Shepard.

Mr. Tom Kmiec: Madam Speaker, I was worried that the member had almost become mute after the Manitoba election results.

The previous government called national consultations and started the process of hearing from Canadians on what they wanted to see in the bill. It is an excuse to say that the timetable is so short. A few months have gone by since October 19. The current government could have tabled a bill and we could have considered it. We would have had much more time for a fulsome debate.

The answer is simple. The government should have simply tabled a bill back in December or January to get the process started. The Liberals knew the deadline and they knew when would be too late. Instead, they have chosen to table a bill so far along the process that requires us to have shortened debate and a shorter review time.

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Mr. Speaker, I heard a lot of agreement, but I want to reflect on the correspondence I am getting from people in my riding of Nanaimo—Ladysmith.

One writer said, “I want to have the choice how and when I am ready to die. It is not simply a matter of providing palliative care facilities, but we should definitely have more and better hospice care in people's homes as well as residential hospice within the community. I consider it a basic human right and though it is of essential importance to me in my senior years, I believe that people of all ages should be supported in facing their own end.”

This is an issue that has gone on for a long time and my sense is this Parliament and people are ready to decide. However, following up on my colleague's comment across the aisle, the Conservatives had opportunities to consult, but slowed and slowed.

I think all parties recognize that the Quebec leadership on this issue, so far as thorough and complete consultation, is to be admired. After the Carter decision and while they were still in power, why did the Conservatives not take the initiative and do the consultation we needed?

● (1900)

Mr. Tom Kmiec: Mr. Speaker, obviously I was not a member of the government in the previous Parliament, but the Conservatives called for national consultations, appointed a panel and heard from Canadians on what they wanted to see in the bill. Again, the current government could have tabled a bill in December or January and kicked off the process in the House to ensure we would have enough time to get it to committee, have a fulsome consideration of section by section and leave enough time for the Senate to also contribute to the debate.

We can debate whether the timelines were good or not, but they are what they are. We have until June 6 to report back and have a bill that is passed by both Houses of Parliament. The most important thing is the content of the bill. That is what we are debating. We are not debating whether the timelines are appropriate. It is the content, the safeguards and conformity with the Carter decision that are important.

Mr. Raj Grewal (Brampton East, Lib.): Mr. Speaker, I rise today to speak to Bill C-14, an act to amend the Criminal Code and to make related amendments to other acts regarding medical assistance in dying.

I would like to start by saying that I value and recognize the deeply personal and difficult nature of this topic for many across our great nation. We all know at least one person who has passed, or may pass, in intolerable pain. It is difficult for families to witness their loved ones suffering, but more so for the patient who has no control over his or her situation and believes he or she should have a choice for a peaceful death. This, my friends, is the reason we need to have this discussion and pass this legislation.

Many of our colleagues on both sides of the House and in both chambers have worked diligently over the last few months on the Special Joint Committee on Physician-Assisted Dying in order to help create a comprehensive framework that upholds the essence of the Supreme Court's decision as a result of the Carter case. This decision balances different interests and protects vulnerable persons. I would like to thank all of our colleagues on the joint committee, their staff, library analysts, the clerk, and all of the witnesses who appeared and sent briefs to the committee.

This is not an easy topic on which to give, hear, or read testimony day in and day out, and for many it can take an emotional toll. At the same time, witnesses who contributed to the consultations should be commended for being a valuable part of Canada's history, as we shape this nation's law to allow our citizens to die with dignity.

Just last year, a provincial and territorial advisory group on medical assistance in dying was established, with most provinces and territories participating, led by Ontario. This shows the need for and interest in adapting our laws to allow for death with dignity.

Included in this report is the unequivocal call for amendments to the code to allow for assisted dying by regulated health professionals and to protect these professionals while they do it. We look forward to working with these territorial and provincial partners. It is also why, as part of our budget, we have put a multi-year health accord forward, with the federal government's commitment to providing $3 billion over the next four years to improve home care and palliative care.

On February 6, 2015, the Supreme Court of Canada unanimously declared that the Criminal Code prohibitions against physician-assisted dying were unconstitutional when considering competent adults who clearly consented to die, who were suffering, and where death was reasonably foreseeable. I would like to quote a vital part of that SCC ruling. It states:

> It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician’s assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.

This highlights the core of this issue, and the special joint committee showed it understood the Supreme Court's points. The report of the committee illustrates this, and I will quote from it. It states, "Our response to the Carter ruling must be focused on the needs and wishes of patients. The Committee was unanimous in recognizing the overarching need to have safeguards to protect the vulnerable.”

Therefore, the objectives of this legislation are comprehensive and adequately balance all the core elements of the discussion on this topic, some of which are: recognizing personal autonomy and dignity; recognizing inherent and equal value of every life; setting out eligibility for competent adults where death is reasonably foreseeable and who are suffering intolerably; balancing different interests, including personal autonomy toward the end of life and the protection of vulnerable persons; and encouraging a consistent approach across Canada.

● (1905)

Bill C-14 incorporates the points made by various stakeholders, including doctors and nurse practitioners, patients and families, civil rights groups, leading experts, faith-based groups, provincial and territorial governments, and more.

To enable access to medical assistance in dying, the Criminal Code will be changed so physicians, nurse practitioners, and those who help them can provide eligible patients assistance in dying without the risk of being charged with assisted suicide or homicide. There will be safeguards to ensure those who receive medical assistance in dying are eligible, can give informed consent and can voluntarily request it. The foundation will be laid for the Minister of Health to make regulations to establish a process for monitoring and reporting on the use of medical assistance in dying. It is crucial that the ability to provide assistance in dying is not limited to physicians.

Nurse practitioners are an important part of this framework if we are to provide all Canadians with equitable access to a peaceful death. Nurse practitioners have the authority to deliver many of the same medical services as family physicians. They can assess, diagnose, prescribe and treat patients. They can act independently in every jurisdiction, except Quebec, where they practice under the authority of a physician. That is why they are covered under Bill C-14.

In order to ensure the safety of all vulnerable persons, we have included the following safeguards that must be respected: a medical opinion to ensure the patient meets all of the established criteria; a second independent medical opinion; a request in writing or by proxy before two independent witnesses; the right to withdraw the request at any time; a 15-day waiting period, unless death or loss of capacity is imminent; and, consent must be confirmed immediately before medical assistance in dying is provided.

As a government that values the power of evidence-based decision-making, the provisions regarding monitoring will be critical for transparency and public accountability of medical assistance in dying, as well as to evaluate whether the law is achieving its goals of respecting the autonomy of eligible persons to choose medical assistance in dying while protecting vulnerable persons and the conscience rights of health care professionals.

Nearly all jurisdictions that permit a form of medical assistance in dying have established monitoring systems for these purposes. The government would work with the provinces and territories in developing these regulations and in establishing an interim system until a permanent process is in place. As the legislation stipulates that there must be a parliamentary review in five years, the data collected from monitoring will be essential to improving the law.

There are those who say this legislation does not go far enough. We have listened carefully and appreciate their input and passion for a thorough framework for medical assistance in dying. It is their tireless advocacy which will ensure that we have the best possible legislation regarding this very sensitive issue.

With that being said, at this time not enough is known about the risks or benefits of medical assistance in dying for minors. We could certainly use more time to study this, as well as advance requests when mental illness is the sole underlying medical condition for requests.

These are important parts of the issue that cannot be written in hastily. They will be studied independently once this bill is passed so we meet our responsibility as a government to protect all vulnerable persons from any potential abuses or error.

To conclude, we do not have an easy task ahead of us. However, most things worth doing are not easy. We each have been elected to make difficult decisions and work hard to do what is best for our constituents and all Canadians. Canadians have spoken loudly on this issue, and we know that a majority of them support medical assistance in dying. We owe it to them to vibrantly debate and pass this legislation in order to allow Canadians a choice in how they end their lives.

● (1910)

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, the member wrapped up by referencing opinion polls. Of course, we know Canadians support strong safeguards, including conscience protection. There will be some form of assisted suicide in this country going forward, but Canadians want to see us do the hard work of putting in safeguards.

The member talked specifically about the court decision. He would know that when the court granted the four-month extension, it put in place a system by which people could still, in the interim, seek euthanasia or assisted suicide, but they needed to go before a judge to do that. The court in its wisdom understood the need for some kind of system of legal review.

With ambiguous criteria, the absence of advanced legal review, and allowances for people to go from doctor to doctor until they get the right outcome or the outcome they want, this is not a system for ensuring that any kind of meaningful check occurs at all.

Would the member agree with me, and agree, frankly, with the direction the court seems to have given us when they granted the extension, that we should have some kind of system of advanced legal review by competent authority, and it would not have to be onerous, to ensure that whatever criteria are in this legislation are actually met in every case?

Mr. Raj Grewal: Mr. Speaker, the government has laid out a clear framework to ensure that the most vulnerable people in our society are protected. For mentally competent adults who are in an advanced state of irreversible decline and capability, have a serious and incurable disease, and for whom death is reasonably foreseeable, there will be not one but two medical opinions by independent witnesses.

We have also stipulated that we will be working with the provinces and territories to ensure that we have regulations that are in the best interests of all Canadians.

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Mr. Speaker, we want the bill to move forward. We want this medical service to be accessible to all. We also want to get the details right.

During the election campaign, the leader of the Liberal Party issued a statement that told us that he believed the Supreme Court made the right decision and that Canada's laws must be consistent with the court's ruling, because that is the right thing to do.

If experts who testified in the Carter case find that in fact the outline of the bill is not consistent with the court's direction and ruling, will the Prime Minister and his party still support the direction of this legislation, or will they bring forward amendments at committee in order to bring it in line with the Supreme Court ruling? Will they seek a reference to the Supreme Court to ensure that their proposal is completely charter-compliant?

Mr. Raj Grewal: Mr. Speaker, Bill C-14 represents a direct response to the Carter ruling. It sets out a framework to ensure that we have assisted dying in this country within a framework that ensures we protect the most vulnerable people from abuse.

On second reading, the Attorney General said the government will be putting forward, publicly, the documents that examine the charter impact of the bill for all Canadians and this House to look at as well.

We will be working with the provinces and territories to ensure that we have regulations to protect this framework, because this is a very sensitive issue for all Canadians. This bill is a great response to the Carter ruling, and the parliamentary review after five years will ensure that this issue keeps building forward.

● (1915)

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Mr. Speaker, I heard the member talk about the details for the physicians and nurse practitioners making decisions.

I am wondering if the member would agree that the legislation puts the onus on the provinces, and in particular, the regulatory bodies. By doing so, it opens the doors for different regulatory decisions across Canada and these will not be uniform and consistent across the country.

Mr. Raj Grewal: Mr. Speaker, my hon. colleague is well aware that health care is a joint federal and provincial jurisdiction, and as a federal government, we have to work with our partners, the provinces and territories, to pass this legislation and set a framework.

We clearly stated that we are willing to work with our partners to ensure that in Canada our confederation works best for all Canadians, especially on issues such as physician-assisted dying, and that we have the best interests of Canadians at heart.

[*Translation*]

Mr. Charlie Angus (Timmins—James Bay, NDP): Mr. Speaker, I am very proud to take part in this debate as the representative for the people of Timmins—James Bay.

This is a historic debate for our country. The issue of medical assistance in dying is very complex and very personal. As parliamentarians, we have a duty to work together, strike a balance, respect the Supreme Court ruling in Carter, put in place the necessary protections for vulnerable individuals and seniors, and, lastly, introduce a national plan in order to guarantee access to palliative care.

[*English*]

At the beginning of this discussion, I think it is very important to put on the record that none of us come into this discussion with any level of moral superiority. This issue affects every single one of us. It affects our families. We cannot discuss this issue without putting it through the prism of our own personal lives and the lives of the people we know.

During this very time that the discussion has been going on, I was in the hospital with someone very close to me. The doctors said that there was nothing more to be done, they would have to go to hospice, and there were only days left. This person who is very close to me said that if they only had days, they were getting their hair done and were going to buy some nice shoes, $600 shoes. Being from a Scottish family, that was quite shocking. They said if they only had days, they were going to go out and have a nice dinner. Those days have turned into weeks.

Every day is a miracle. That is something we need to recognize. The power and the will to live is so incredible. We have to support it. We also have to recognize those who are living with intolerable pain, and be respectful of those whose hopes for the future are so crushed by debilitating illness. It puts us in a very special position, to be careful.

I want to say at the outset that I respect the importance and supremacy of the Supreme Court in our country, but I think it made a fundamental error and mistake in its treatment of the Canadian people. I think it was responding to what it felt was the last government's refusal to respond on a number of court decisions, so it put a firm timeline on Parliament to act.

It would have been fair for the Supreme Court to recognize that in October there was an election, a new mandate, and a new government. That government should have been given the opportunity to take this discussion across the country. This discussion should not be dealt with simply within this Parliament. This discussion should be a mandate that every Canadian is able to participate in. It is very unfortunate, and nobody will ever accuse me of giving the government a free pass, but the government's hands have been tied in a very unfortunate manner, in that we have to have this legislation passed by June.

For those who are very concerned about this legislation and in listening to some of my Conservative colleagues, I would warn that if Parliament does not act and if Parliament does not set the parameters for this legislation, we will then see a legal vacuum. The decisions on medically assisted death are already being made by the courts across this country. They are stepping into the vacuum that exists now.

It is incumbent upon us to respond. It is not good enough to say that we will fight this, that it is not the Supreme Court's job, and that Parliament should take back control. People can say whatever they want, but at the end of the day if we do not act by June, there will be a legal vacuum in this country. I would tell any of my colleagues who are very concerned about this legislation to just watch what happens in a legal vacuum, where others go back to the Supreme Court saying that they want to expand the rules much further.

Where does that bring us? One of my concerns is that if we are going to talk about the right that people have, the constitutional right, wherever they are in this country, to end their life if they are in medically difficult circumstances, how can we have that discussion without saying that people also have the right to quality palliative end-of-life care?

Across this country, only 16% to 30% of Canadians are able to access quality palliative care. Only six provinces have palliative care definitions under their framework. In fact, only four provinces actually even have a palliative care framework. There is a patchwork across this country.

● (1920)

We respect, within the House, that much of the health care services are delivered through the provinces, but the federal government has a fundamental role to play in working with the provinces. This is why the New Democratic Party pushed in the last Parliament for a national palliative care strategy, respecting the provincial and territorial jurisdictions but working to find ways of establishing proper palliative services. Pretty much every parliamentarian voted for that, yet we have seen no action. We have seen no action from the present government, which is a fundamental mistake if we are talking about having this legislation in by June.

Today is the first day I have ever heard someone from the government talk about their election promise that was supposed to be $3 billion. Well, that $3 billion is not happening now. Again, we are putting that to some time in the future. That is not acceptable. I have heard people talk about cruel limited choices and compassion, but it happens all the time. If people living in a rural area in Northern Ontario are sick, and their children live in Alberta or B.C., they have to make some pretty tough decisions on their own. I have dealt with them in my office, and that lack of access to quality palliative care is heartbreaking.

The New Democratic Party has pushed Motion No. 46 in this new Parliament, which calls for the establishment of a pan-Canadian palliative end-of-life strategy. It has already been supported by Parliament, but we have not seen any action on it. We are asking for that to be moved now, to re-establish the secretariat on palliative and end-of-life care, with dedicated funding. That could have been done in this budget and it could still be done now to implement a national awareness campaign on end-of-life care so that people can have this discussion. I have been hearing lots of talk about how important it is to have this discussion in the House, but the federal government can play a role in furthering the discussion.

The other area is EI benefits for compassionate care so that people are able to look after their loved ones. Finally, there is a huge area of jurisdiction under the federal government, where it delivers health services to indigenous people, people in the military, and people in prisons.

Section 12.1 under the federal health act says that under no circumstances whatsoever, when someone is dying on a reserve and is being flown out for their final hours, will their spouse be allowed on the plane with them. They are to die alone. Under section 12.1 of these standards, it says it cannot be appealed. The first rule in the health standards says under no circumstances will compassion be accepted. That could be changed tomorrow. The health minister could stand up and say it is an unacceptable, cruel standard that the federal government would allow an elderly person to die alone without their life partner there, and that they would have written into the legislation that under no circumstances would compassion be considered a reason for letting someone be with them when they die. What kind of nation are we, if we think that is a perfect bureaucratic standard? It is not.

Therefore, if we are going to have this discussion about allowing people with incurable suffering to make that choice, and if we are going to make it available nationally, then it is incumbent upon the House to say that every family that has a loved one who is suffering will have the support they need, because how we come through death as a family is how we find ourselves. We either come out through these deaths stronger and closer together, or sometimes we see families breaking apart because of the strain that is put on them by a system that has failed them again and again, and when they needed it in the most vulnerable moment in their lives.

I am asking my colleagues. We could rise to a higher level in the House. We could rise to what we are called to do, which is to establish a vision for our nation. This is an opportunity, but it is going to have to move beyond simply this legislation. It is going to have to be done in conjunction with a plan for palliative care across the country.

● (1925)

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Mr. Speaker, I appreciate many of the comments on the issue of palliative care. As a former health critic in the Province of Manitoba, I spent a good number of hours meeting and talking with individuals who were very much concerned about the need for expanding palliative care. This is an issue that all provinces, as they try to deal with their provincial budgets, have to come to grips with. It is not an easy issue.

The Minister of Health and the Prime Minister have made the commitment, and we want to demonstrate strong leadership on this file. We are talking about $3 billion. We are talking about the issue of a health care accord renewal. The last time that took place was back in 2004.

There is an opportunity for us as parliamentarians to recognize that we need to invest in palliative care, but at the same time would the member not agree that it is absolutely critical that in demonstrating this leadership we also need to work with our provincial stakeholders and others to ensure that we are providing a service, so that it does not matter what region in the country, there is some level of basic palliative care for all Canadians?

Mr. Charlie Angus: Mr. Speaker, certainly the reason we passed the palliative care strategy in the last Parliament was that one of the key first lines was to work in conjunction with the provinces and territories, but we have not seen that action. There was no action on the call for establishing the palliative care strategy. We can talk about it, but unless we establish a palliative care strategy or unless we put in the secretariat, this is just talk.

Yes, it is $3 billion, but there was nothing in the budget. There were zero dollars in the budget to deal with the shortfalls in health care.

My colleague can shake his head all he wants, but an election promise does not make palliative care. Palliative care is made by political will, and political will needs someone to stand up and say in a budget or a throne speech that we will establish that secretariat and we will make this happen.

So far, today has been the first time the Liberals have announced it. Lo and behold, guess what we are discussing. We are talking about medically assisted death and suddenly there is all this will on the other side. However, that will is the power of the government.

I would ask the Liberals, where were the dollars for health care for first nations under their jurisdiction when we got zero dollars to augment the huge shortfall? On palliative care, the Liberals can talk all they want, but they are going to have to put the structures in place and they have not done it yet.

Mr. Jim Eglinski (Yellowhead, CPC): Mr. Speaker, the hon. member mentioned quite a bit about the vacuum that may come about if this does not happen. I would like his opinion on what would happen if this House votes the bill down.

Mr. Charlie Angus: Mr. Speaker, I think it would be incredibly irresponsible if we told the Supreme Court that we have taken our opportunity to respond to it and we are not going to do it. Is the Supreme Court going to sit around and say that is perfectly reasonable? The Supreme Court will say that we had an opportunity to draft legislation with clear rules and clear limits, and in that vacuum other decisions will be made.

There will be groups that will come forward and will challenge the Supreme Court and say that they saw the Carter decision and they do not think it goes far enough and they want to establish further rights. Those rights would be established because Parliament has made it known under the mandate. I believe that we should have had more time, but we do not have more time. If we are telling the Supreme Court that we are not going to take our responsibility here in the House to draft legislation, in that vacuum, a lot of steps are going to be taken and members of Parliament are not going to be able to do anything except get up and make their Standing Order 31 statements to rail at the Supreme Court once again.

It is our responsibility; we have that duty, and we can do it now. I would say we all work together, because we are all in this together. We have to come out with legislation. Otherwise, that vacuum is going to be, potentially, very socially difficult and maybe destructive.

● (1930)

[*Translation*]

Mr. Denis Lemieux (Chicoutimi—Le Fjord, Lib.): Mr. Speaker, it is a great pleasure to take part in this second reading debate of Bill C-14 on medical assistance in dying in Canada.

I had the privilege of being a member of the Special Joint Committee on Physician-Assisted Dying, and I supported all of the report's recommendations.

However, as many members have acknowledged today, medical assistance in dying is a complex, sensitive, and extremely personal issue.

Ever since the Supreme Court handed down its ruling in Carter last year, Canadians all across the country have been contributing to the discussion. The issue continues to be the subject of serious debate and deliberations all around the world, everywhere from the United States to Europe, Australia, and New Zealand.

In virtually all parts of the world, deliberately ending someone's life and helping someone end his or her own life are serious crimes that carry harsh penalties.

However, as many people know, Canada is not the only jurisdiction to legislate and authorize medical assistance in dying. Four U.S. states, specifically Oregon, Washington, Vermont, and California, along with Colombia, and three European countries, specifically Belgium, the Netherlands, and Luxembourg, have a legislative framework that allows some form of medical assistance in dying.

I listened to more than 60 expert witnesses during the meetings of the Special Joint Committee on Physician-Assisted Dying, and I was deeply moved by the testimony of the Hon. Steven Fletcher; Benoît Pelletier; Jean-Pierre Ménard from Quebec; Dr. Cindy Forbes, president of the Canadian Medical Association; and Dr. Monica Branigan of the Canadian Society of Palliative Care Physicians.

Last week, though, I got a call at my constituency office from Bibianne Gauthier, the mother of Jean Truchon. After our conversation, I was able to put a face to a real request for medical assistance in dying.

After meeting Ms. Gauthier and her son Jean, I decided to share this real case with my colleagues in the House and read the letter that Jean Truchon wrote to his health care team on January 20.

I would like the House to know that I personally got permission from Jean Truchon to read this letter in Canada's Parliament. I am also doing this at the request of Mr. Truchon's parents:

"I am 48 years old and I have had cerebral palsy since birth. I spent 22 wonderful years living in an apartment.

On March 11, 2012, my life was turned completely upside down when the medical team at the Centre hospitalier universitaire de Montréal diagnosed me with inoperable degenerative cervical disc disease. That day, I reluctantly put one foot in the grave and I have every intention of putting the rest of my body there on September 1, 2016. I had to resign myself to living in a home and despite the good care I am receiving and my efforts to adjust to the situation, I simply cannot imagine living much longer under these conditions.

My question is this. Since I believe that I do not meet the eligibility criteria for medical assistance in dying [in January of this year], I intend to refuse to allow the staff to feed me or give me water, as I am unable to feed myself. I am asking that my doctor at the centre be authorized to administer a drug to at least relieve the pain.

I look in the mirror and I no longer recognize the man I once was. That is when I say, 'What is the use in living like this'. Sometimes I think you do not have be at the end of your life to experience the intolerable suffering that I am currently experiencing. Doctors have told me that eventually I will become incontinent. The thought of it is too much to bear. I still have too much dignity to live like that.

● (1935)

At one point, I was in bed and no one responded when I pressed the call bell. I had to relieve myself in bed. It was then that I understood that life in an institution was not for me. I know that other people living a similar life in similar circumstances make different choices. However, in my case, I made the carefully considered decision that 2016 would be my last year.

I realize that dying before my parents is not the best way to go because it defies logic. However, I cannot take it anymore. My family and my friends are aware of and respect my decision even though they do not agree with it, because they are going to lose me. They understand all my struggles, and I thank them for their understanding.

I have considered a more dramatic form of suicide, but the fear of surviving and being in an even worse condition prevents me from doing it. Furthermore, to ease my family's pain, I am choosing to leave in a more honest manner by having them at my side. The antidepressants I have been offered, together with an explanation of their potential benefits, will never give me back the use of my arms or change the prognosis of physical decline. In good conscience and of my own free will, I have refused the medication, which will not give me back the will to live what would seem like an artificial life.

If this letter results in a more objective awareness of those who are suffering and are not at the end of their lives, I will have achieved one of my objectives.

Since I have no expectations that my case will be eligible for medical assistance in dying, I am also appealing to the CIUSSS bioethics committee to allow my treatment team to respect my choice and to allow me to receive the comfort care and the medication required to alleviate my suffering when I stop my feeding.

Thank you for taking the time to read this letter."

The letter was signed by Jean Truchon.

This extraordinary 48-year-old man is just one of the faces of medical assistance in dying in Canada, but as I read about Jean's courageous decision, I felt that the committee had made good recommendations in its report.

The Minister of Justice consulted all of the existing legislation around the world to draft the government's legislative response to the Carter decision.

The bill sets three eligibility criteria: individuals must be competent adults who are in an advanced state of irreversible decline; they must have a grievous and irremediable illness or disability, and their medical condition must cause them enduring and intolerable suffering; and their deaths must have become reasonably foreseeable, taking into account all of their medical circumstances.

The bill also has a non-legislative component. It provides for further study of three specific topics: mature minors, advance requests, and mental illness.

I am also pleased to see that Bill C-14 includes solid safeguards to prevent mistakes and abuses. I would like to reiterate them: the patient must get an opinion from two independent doctors and the request must be made in writing; the patient has the right to withdraw the request; there is a 15-day waiting period; and consent must be confirmed immediately prior to the administration of the medical assistance in dying.

In closing, I would like to encourage all members to read the document entitled “Legislative Summary of Bill C-14: An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)”, which was tabled in the House by the Minister of Justice. It contains important information on the international laws and regimes that influenced the government's approach to medical assistance in dying in Canada.

The government wanted to learn from the experiences of other jurisdictions. The approach it plans to take is broader in scope than that of the United States, which gives access to medical assistance in dying only to people with an incurable disease. The approach the government is considering gives the option of a peaceful death to everyone approaching the end of his or her life, not just those suffering from incurable diseases. At the same time, it eliminates some of the risks that may be associated with a broader regime. The government has also committed to continue examining these more general issues and will continue to observe what is being done elsewhere in the world in terms of medical assistance in dying.

I urge all members to support this bill and send it to committee, thereby responding to our Supreme Court's request to legislate in this area.

● (1940)

[*English*]

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Mr. Speaker, I appreciate the many fine words from my colleague, and I would like to ask him a question.

The government has brought this legislation forward because of the Supreme Court of Canada ultimately doing what Liberals believe is the responsible thing to do, with the strong leadership from the Prime Minister's Office to the ministers responsible for bringing forward the legislation itself; but one thing we are often being told about is the importance of not only the legislation but the whole issue of palliative care.

I am wondering if the member might want to take the opportunity to emphasize, from his perspective and his constituents' perspective, just how important palliative care is as part of this whole debate.

[*Translation*]

Mr. Denis Lemieux: Mr. Speaker, I thank my colleague for his question.

When I sat in the special joint committee, it really struck me how the issue raised by the Carter decision really forced us to reflect on the quality of palliative care in Canada.

That is why I was thrilled to hear that the Minister of Health had announced plans to invest an additional $3 billion over the next four years to improve palliative care. As we said in committee, medical assistance in dying must not replace palliative care. That care constitutes end-of-life care, and medical assistance in dying should be considered part of palliative care. I am therefore very proud of our government's decision and the decision taken by the Minister of Health.

Mr. Gérard Deltell (Louis-Saint-Laurent, CPC): Mr. Speaker, I too would like to commend my colleague, with whom I served on the special committee struck by the government. The committee was made up of MPs and senators from all political parties.

I would like to know my colleague's thoughts on the text of the bill. It uses words that have raised many questions in Quebec and all across Canada regarding what is reasonably foreseeable: a reasonably foreseeable death. The Quebec legislation clearly states that care must be provided to people who are reaching their end of life.

Is the member comfortable with the term “reasonably foreseeable death”, or would he prefer a definition that is closer to the one used in Quebec, in other words, “end of life”?

Mr. Denis Lemieux: Mr. Speaker, I thank my colleague for his question.

I understand my colleague's points, and I have often heard him use those words in the media in the past few weeks. What Canadians need to know is that the point my colleague raised is one of the four criteria required for access to medical assistance in dying. It is important to explain to Canadians that there is not just one criterion for obtaining medical assistance in dying, but four.

I will take this opportunity to remind my colleague from Louis-Saint-Laurent about what he said this morning in response to a question from our colleague opposite. I was so sad to hear it. According to the member from Louis-Saint-Laurent, cases like Mr. Truchon's, which I talked about just now, are unintended consequences. That is what he said in response to my colleague.

I want the member to know that I really disagree with him. I invite him to talk to Mr. Truchon's parents. He will see that Mr. Truchon and his family are altogether remarkable and are not trying to abuse the system in the way that the member for Louis-Saint-Laurent suggested this morning.

[*English*]

Ms. Rachel Blaney (North Island—Powell River, NDP): Mr. Speaker, I know from personal experience how hard it can be to be with people who are at the end of their life. I have actually been with people who have starved themselves to precipitate their end of life more quickly.

One of the concerns I have with this bill is that it would limit people who have health issues that are unbearably painful but whose end of life is far away in some cases. My question is this. How does the member think this would work with this bill, and how can we support people who have done the due diligence, have independent thought, and are ready to go when they are in unbearable pain?

● (1945)

[*Translation*]

Mr. Denis Lemieux: Mr. Speaker, I thank my colleague for her question.

I look at the situation that Mr. Truchon and his family are in, and I see the law in Quebec. Mr. Ménard told us that he would certainly have drafted Quebec's law a little differently in light of the Carter decision.

Today we are asking ourselves a big question in relation to the bill we are debating that was introduced by the Minister of Justice. Mr. Truchon's family is a real-life example. Will they have to watch their son suffer for five, seven, eight days, or will our bill enable them to witness a gentle death that lasts four or five minutes?

[*English*]

Mr. Mark Strahl (Chilliwack—Hope, CPC): Mr. Speaker, it is always an honour to stand in this place and participate in the debate, no matter what the subject matter. There are some debates that are more important than others, and I would venture to say that parliamentary historians will not be poring over the *Hansard* of the latest budget implementation act in five, 10, or 50 years from now. However, the debate we are taking part in today is not just any debate. It matters. How we as a Parliament, as a group of elected representatives, respond to it will have a profound impact on our society and on the value we place on life in the months and years ahead.

We are here to debate Bill C-14. The short title of the bill is the medical assistance in dying act. I would suggest that this title downplays the decision that we as parliamentarians are being asked to make. Bill C-14 would remove the criminal prohibitions for killing a person, or helping that person kill himself or herself, in certain situations. That is the harsh, stark reality of what we are dealing with in this bill. It is not just another medical procedure that we can sterilize with antiseptic and non-offensive language. This is a serious matter. It will result in a fundamental shift in Canadian society, and making the language more palatable and less jarring does not change that.

We are here because of the Supreme Court of Canada's Carter decision. While the court had previously ruled that the Criminal Code provisions on euthanasia and assisted suicide were constitutional and did not violate the charter, last February it reversed itself and struck down sections of the Criminal Code. It gave Parliament until June to come up with a law that respects its ruling and places restrictions on when and where euthanasia and assisted suicide can take place without criminal penalty.

The Council of Canadians with Disabilities and the Canadian Association for Community Living have produced an excellent commentary on the court's decision, warning that persons with disabilities, including people with serious mental and emotional disabilities, have been put at serious risk. They have also provided these sobering statistics:

> ...in Belgium, the number of Assisted Suicide deaths has increased an average of 47.77% annually since 2003, and in the Netherlands it has increased 64.13% since 1995, with no end in sight to this increase.

They have called upon Parliament to “place crucial safeguards on the Court’s judgment to limit access to assisted suicide”.

Unfortunately, the joint parliamentary committee report on assisted suicide went the other way, suggesting that doctor-assisted suicide should even be made available to minor children and those struggling with mental illnesses. As a result, Conservative MPs on the committee filed a dissenting report recommending stronger protections for the vulnerable. Thankfully, most of their recommendations have made their way into Bill C-14.

I have heard from hundreds of my constituents who oppose assisted suicide and euthanasia. They fundamentally believe that the Supreme Court's ruling and this bill will lead us down a slippery slope. Some oppose it on religious grounds, believing in the sanctity of life at all stages. Others oppose it for a variety of logical or ethical reasons.

I have also been contacted by some constituents who support the concept of euthanasia in principle and in certain circumstances. Having myself watched a number of family members and friends ranging in age from 13 to 85 die from cancer over the last few years, I understand the desire to ease the suffering of those we love as much as possible at the end of their lives. I believe that, instead of considering euthanasia and assisted suicide as a desired way to provide relief to dying patients, the federal government should be doing more, in concert with the provinces, to promote and expand comprehensive palliative care services right across the country.

Indeed, we voted nearly unanimously for expanded palliative care services and a plan in the last Parliament. During the election campaign, the government promised to inject $3 billion into palliative care. However, its budget did not include a dollar of funding or a mention of it coming anytime soon. The Minister of Health referenced her commitment to palliative care again today in question period. However, words are not enough. We need action, and it should have been a companion to this legislation, not an afterthought.

I want to talk about my main concern with assisted suicide as it relates to this bill and the ruling by the Supreme Court.

We need to continue the national conversation about improving our mental health system of care, which is currently failing too many Canadians. Mental Health Week starts today. The Canadian Mental Health Association is encouraging us to get loud on ending the stigma around mental illness.

● (1950)

Many of us have participated in, and will participate in, events this week to do just that. We put on green ribbons. We have attended champions of mental health dinners. We celebrate those who have spoken out and shared their stories of overcoming the darkness in which they have often lived for years. We beg people struggling with mental illness to reach out. We tell them that help is available, and it is. We grieve whenever individuals take their own life as a result of their mental illness.

Indeed, we have had many debates in the House, with heartfelt speeches by members on all sides, trying to figure out how we can best support those struggling with mental illness. Why did we do that? It is because we believe we must provide hope for those who are suffering. We believe that every life is worth saving and that those with mental illness can be treated, helped, and hopefully made well again.

We are told we should, as parliamentarians, separate assisted suicide from suicide brought on by mental illness. We should not be under the impression that we get to choose whether these two issues will be conflated or not. If assisted suicide becomes normalized, we should not be surprised if societal attitudes on other types of suicide change as well.

I recognize that mental illness is currently excluded from permissible cases for assisted suicide or euthanasia, but the government has said it will be embarking on further studies to look at the unique implications of situations where mental illness is the sole underlying medical condition. Indeed, Liberals mentioned their intention to move forward on this study at the technical briefing on Bill C-14.

Why would the government want to study this matter further if not to bring it forward as a future amendment to the bill? We cannot allow the door to be opened even a crack to allow for those suffering from mental illness to be able to access physician-assisted suicide.

I recently spoke to someone who was diagnosed with bipolar II disorder about the bill. This person attempted to be well with every tool available, and shared the following with me:

> My disease is a challenge every single day of my life. Sometimes I work to keep the symptoms at bay from minute to minute. Suffering is a given. And yet, I have much joy and hope, so much to live for. But what if I get really sick, what if I can not manage for an extended period and fall into a deep unbearable depression? Do I need to write an advanced directive to my doctor, asking them explicitly not to allow me access to euthanasia? To ask them to help me fight for my life, even if I can't do that in my moment of total despair?

We need to say it loud and clear that suicide is not the answer for mental illness, whether it is medically assisted or not.

I know that my time is short, so I will move on to another concern I have, and that is the possibility of having two nurse practitioners to sign off on assisted suicide or euthanasia requests for a patient. Nurse practitioners play a vital role in many remote, rural, and northern communities, but when we are dealing with a matter this serious, this permanent, with these types of consequences, I believe that not only should two doctors be required to sign off but that there should be a requirement for a psychological examination or independent oversight from a social worker to be done on patients before they can access assisted suicide or euthanasia.

This would provide an additional level of protection to ensure that patients are truly capable of making decisions with respect to their health and that the request to end their life was not made as a result of external pressure as is mentioned in section 241.2 of the bill.

Finally, Bill C-14 does not enshrine the legal rights of medical professionals such as doctors, nurses, pharmacists, and caregivers to opt out of providing assisted suicide services or referrals if their personal conscience, beliefs, or ethics do not permit them to do so. This is a critical flaw.

As the bill does not adequately protect vulnerable people and does not adequately protect the conscience rights of medical professions, unfortunately, I cannot support it.

● (1955)

Mr. Adam Vaughan (Parliamentary Secretary to the Prime Minister (Intergovernmental Affairs), Lib.): Mr. Speaker, I listened with interest to the presentation and appreciate that these issues bring back memories and experiences that are extraordinarily personal, and I do not mean to move into those areas unduly, so I hope the member can forgive the question.

In situations where, quite clearly, individuals are exerting an individual right and an individual choice, I wonder if the member could reflect upon what right we have to impose bureaucracy, layers of decision-making, additional voices, and additional concerns into people's lives when they are trying to make a choice for themselves about the most personal decision they may ever have to make.

Mr. Mark Strahl: Mr. Speaker, I accept the question in the spirit in which it was given.

I think what the court has called on us to do is to set limits. It has not thrown the door completely open. It put its own conditions on grievous and irremediable conditions, and when and where this can be accessed. The court in its ruling has asked Parliament to specifically consider when and where assisted suicide, euthanasia, can be accessed. I think that is what we are doing here today.

There has been debate throughout the day. Some believe the bill does not go far enough in terms of its permissiveness, and others, like myself, believe that it is not tight enough around the court ruling. We are going to have a variety of opinions here, but that is exactly what we are doing. We are talking about what limits we believe should be placed on assisted suicide and euthanasia, because that is what the court has asked us to do.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Mr. Speaker, we have moved 180 degrees, from a criminal activity which was under the Criminal Code to now, where actually we can kill somebody and call it assisted suicide, and at the same time get the health care to pay for it.

I wonder if the member would comment about doctors and nurses who have an ethical or moral gauge within their own soul that will not allow them to do this. Would the bill protect them?

Mr. Mark Strahl: Mr. Speaker, I would certainly argue that it would not. There is mention of conscience rights in the preamble, but we have seen before that the preamble is not the meat of the bill. It does not have the same effect that it would if it were in among the provisions of the bill.

I have spoken with many medical professionals since the bill came out, since the Supreme Court ruling came out, and there is grave concern about participating in this sort of scheme. I want to be clear that sometimes there is a religious bent, but often it is an ethical bent. It is people who have spent their entire lives, gone to school, sometimes for over a decade, to help save lives, who are now being told that part of the medical system is to provide assisted suicide or euthanasia services, and they are morally or ethically opposed to doing so.

I do not think the bill goes far enough in protecting those people from opting out of the system, and it is one of the reasons I will not be supporting it.

Mr. Todd Doherty (Cariboo—Prince George, CPC): Mr. Speaker, I really appreciate the debate. Again, I will go on record as saying that I fear we do not have enough time to have a lengthy debate, but I do appreciate the comments from both sides.

My comments are neither for nor against at this point. However, it says informed consent being given, but in the bill itself there is no advance directive. The very people whom the bill could help, such as someone suffering from advanced stages of ALS, Lou Gehrig's disease, may not be able to give that consent at the time. Is there not a concern, and how can we rectify this as we move forward?

The deadline is speedily approaching. Does my colleague share the same concerns?

● (2000)

Mr. Mark Strahl: Mr. Speaker, quite frankly, I think that is one of the unfortunate things that has happened in this debate. Due to the timing of the dissolution of Parliament for the election, there were several months lost when we were not debating this in the chamber. There were many months lost when this was not on the national agenda.

To now rush the bill forward, as we are compelled to do, I cannot think of a bill that deserves more time, more thought, and more debate than the bill before us, yet we have an arbitrary deadline that has been set by the court. That is truly the most unfortunate part of this debate, and one which I hope we do not live to regret.

[*Translation*]

Mr. René Arseneault (Madawaska—Restigouche, Lib.): Mr. Speaker, I thank you for giving me the opportunity to share my thoughts on Bill C-14.

I had the privilege of sitting on the Special Joint Committee on Physician-Assisted Dying. Along with the members of the committee, made up of 11 of our colleagues and five senators, I believe I can say that I was right in the thick of things, when it came to testimonies and opinions from the various stakeholder groups, experts, and everyday citizens.

The debate on medical assistance in dying is an emotional one. That is because it deals with the last of the taboos of any society, namely to plan one's own death and, in a way, to get help organizing it.

Whether you are religious, secular, atheist, philosophically liberal, or ideologically conservative, every opinion on medical assistance in dying matters. In the wake of the Carter decision, the diverging opinions and our deepest moral values now seem to torment us. Either side of the argument on medical assistance in dying is a source both for concern and for hope. This issue leaves no one indifferent, but above all stirs the most sincere and honest emotions.

That is where we run the risk of losing sight of the purpose of the debate. In fact, medical assistance in dying, regardless of our personal values, is not something that any of us must impose on or deny anyone else. I urge all my colleagues to keep in mind that medical assistance in dying is now an individual right recognized by the Supreme Court of Canada, a right that is no one's business but the individual's and, at the same time, a right that does not force anyone to compromise their deepest individual moral convictions.

Morality, taboos, planned death and the emotions this stirs must not cloud the rationale of the Carter decision. If we eliminate our individual morality from the analysis of the Carter decision, then it is rather simple.

First of all, two sections of the Criminal Code are affected, namely section 14 and paragraph 241(*b*). These provisions prohibit a person from counselling or aiding another person to commit suicide.

Second, as a result of these Criminal Code provisions, a person suffering from a grievous and irremediable illness could prematurely end their life, knowing that no one could help them die when they are no longer able to commit suicide because of the progression of the illness. In short, the prohibition in the Criminal Code provisions I mentioned could lead a person with an irremediable illness to take their own life early, even though they are still enjoying a certain quality of life, because they foresee that they will no longer be able to do so themselves at a later date.

Third, section 7 of the Canadian Charter of Rights and Freedoms states that everyone has the right to life. In Carter, the Supreme Court cited this principle in stating that a person suffering from a terminal illness cannot be deprived of this right. In other words, medical assistance in dying will maximize the time the person has left to live. That is the objective of Bill C-14, which amends the Criminal Code of Canada in order to allow medical assistance in dying.

In its wisdom and with a unanimous decision, the Supreme Court of Canada is showing us the way so that we can amend section 14 and paragraph 241(*b*) of the Criminal Code, which currently violate the right to life, liberty and security of the person guaranteed by section 7 of our charter.

The principles in Carter that must guide us in developing Bill C-14 are found in paragraph 127 of the decision, a paragraph that I invite my colleagues to read carefully because it will require our attention when we debate this matter.

● (2005)

The Supreme Court of Canada stated:

> [These sections] are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

Also in paragraph 127, the Supreme Court of Canada stated:

> The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought.

I will support this bill at second reading, but I must confess that I hope the committee can re-examine the bill and try to fine-tune it, because I have some concerns.

For example, this bill may suggest a rather restrictive approach with respect to Carter, especially since the bill contains words that are not in this decision. For example, subsection 241.2(2) states: “A person...[has] a serious and incurable illness, disease or disability”. The word “incurable” never appears in the Carter decision, and that may seem a bit too restrictive.

The bill also refers to an “advanced state of irreversible decline in capability”. The words “advanced” and “decline” do not appear in the Carter decision and could be interpreted as rather restrictive language.

Another one of my concerns has to do with the fact that, right now, this bill seems to disregard any advance requests for medical assistance in dying. Since the Carter decision suggests that there may be other requests in other exceptional circumstances, I believe that it is quite likely that people with a grievous and irremediable medical condition may also experience a deterioration of their cognitive and intellectual faculties.

I think that perhaps the committee should re-examine the possibility of an advance request so that someone with Alzheimer's or brain cancer, for example, is not prevented from giving informed consent to medical assistance in dying the second time because of the deterioration of his or her mental and cognitive abilities.

On page 6 of the bill, in paragraph 241.2(3)(*h*), it reads:

> immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying.

It seems that this paragraph is rather strict, given that people who are terminally ill could lose consciousness or that their intellectual faculties could be impaired because they are being heavily medicated. They therefore might not be able to consent to the medical assistance in dying the second time.

Those are some of my thoughts on the bill. I hope that the committee responsible for studying it will reflect on these comments.

● (2010)

Mr. Gérard Deltell (Louis-Saint-Laurent, CPC): Mr. Speaker, it is once again my turn to commend my colleague from New Brunswick, whom I respect and hold in high esteem. In committee, we worked together a great deal and did so positively and constructively. I got to know him, and I believe the feeling is mutual.

Earlier, our colleague mentioned that there are words in the bill, such as “incurable" and “advanced state of decline”, that were not in the Carter decision. There are also words such as “minors” and “reasonably foreseeable” that were not in the Carter decision. Why am I raising the subject of “minors”? Because that was touched on in the majority report. As for “reasonably foreseeable”, that is not clear enough to us.

I would like to hear my colleague's thoughts on the debate that has been going on across Canada for a few weeks now about how to define “reasonably foreseeable”.

Mr. René Arseneault: Mr. Speaker, my colleague from Louis-Saint-Laurent's question is an excellent one.

The words “reasonably foreseeable” can cause some confusion from a legal point of view. What is reasonably foreseeable? There are many ways to interpret those words. It is true that those words do not appear in the Carter decision and that removing them from the bill would be a good thing.

My colleague often referred to the Quebec version of the law, which is about the moment when a person is at the end of his or her life. The words “end of life”, however, can also cause confusion from a strictly legal point of view. When does end of life begin? Is it 24 hours before a person dies, a week before death, a month before death, or is it the moment when a doctor confirms that no treatment can save that person's life?

The committee needs to take a close look at those words to ensure there is no ambiguity that could open the door to a legal challenge.

[*English*]

Ms. Rachel Blaney (North Island—Powell River, NDP): Mr. Speaker, in the backgrounder, the government refers to having equal access. I am curious as to why the provisions to protect the personal convictions of health care practitioners are not included directly in the text of this bill.

[*Translation*]

Mr. René Arseneault: Mr. Speaker, I am not sure I understood my colleague's question correctly.

The independence of doctors is not included anywhere in the bill. Doctors can in fact be independent, because two doctors are needed to approve the consent when a competent adult is seeking medical assistance in dying. This is actually referring to two doctors who are independent in relation to the person seeking medical assistance in dying. If I understood the question correctly, that is what I think.

● (2015)

[*English*]

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Mr. Speaker, I appreciate the fine comments made by my colleague.

I have raised the issue of palliative care a great deal today. As we go through the debate on this legislation, a lot of members have been talking about the importance of palliative care. Could the member provide some thoughts from his constituency on the whole issue of palliative care? This has been thoroughly discussed as we have debated this bill. Does the member have any thoughts he would like to share with regard to this issue?

[*Translation*]

Mr. René Arseneault: Mr. Speaker, I thank my colleague for his excellent question.

He definitely must have read the report produced by the Special Joint Committee on Physician-Assisted Dying, which recommends taking a long, hard look at palliative care and developing a policy on the issue.

Because of the Carter decision, time is of the essence. To respond to the Carter case meant responding to medical assistance in dying based on the charter and the Criminal Code, which prohibited medical assistance in dying. Palliative care was not the crux of the debate in Carter, although everyone seems to agree that we need to think carefully about this service and provide it for Canadians.

[*English*]

Mr. Nathaniel Erskine-Smith (Beaches—East York, Lib.): Mr. Speaker, “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice”, so says section 7 of the Canadian Charter of Rights and Freedoms.

In February of last year, the Supreme Court applied those words to strike down the criminal prohibition against assisted dying.

As a matter of policy, this was a welcome decision. Blanket bans are an ill-advised form of regulating conduct that is not inherently wrongful. The criminal law is a blunt instrument, often imposing costs beyond the benefits it seeks to achieve and it should be resorted to sparingly.

An optimal policy involves nuanced legislation that protects those at risk without preventing others from making their own choices and directing their own lives as they see fit.

In response to the Supreme Court's decision in Carter, the government has drafted Bill C-14. The government states correctly that it is no longer a question of whether to legalize assisted dying but how we should do so. In other words, relitigating Carter is a futile exercise when the Supreme Court has already spoken, unanimously no less.

Still, it remains useful to understand how we got to where we are. If we are to adequately address the court's concerns, we should have a complete understanding of those concerns. Having studied section 7 of the charter in depth, I would like to first briefly explain what the Supreme Court requires of us on this issue.

Section 7 of the charter provides the right to life, liberty, and security of the person qualified by the principles of fundamental justice. A violation of life, liberty, and security of the person is only unconstitutional if there is also an infringement of a principle of fundamental justice.

The court has stated that those principles are to be found in the basic tenets and principles of the legal system. The key principle to understand on this issue is over-breadth, or what we refer to as “minimal impairment” under the classic Oakes test under section 1. If a law infringes life, liberty, and security of the person, over-breadth requires the law to be reasonably necessary to achieve an important government objective.

In Carter, the court first determined that the blanket criminal prohibition against assisted dying engages life, liberty, and security of the person. In the court's words:

> Liberty protects “the right to make fundamental personal choices free from state interference”.... Security of the person encompasses “a notion of personal autonomy involving control ...over one's bodily integrity...”.

Second, the court determined that the blanket prohibition was over broad. The purpose of the legislation, as defined by former Justice Sopinka in the earlier Rodriguez decision, was “...the protection of the vulnerable who might be induced in moments of weakness to commit suicide ...”. In the court's view, the absolute prohibition on assisted dying went too far. While protecting vulnerable people is the law's object, it caught people outside of this class: those who are competent, fully informed, free from coercion or duress, yet choosing to end their lives.

We are now faced with new legislation, Bill C-14.

Our first job is to assess whether this legislation meets the criteria set by the Supreme Court. To answer this, we must first assess the government's objective, now a dual objective: one, to provide a means by which those subject to grievous and irremediable suffering can die with dignity; and, two, to protect those who wish to continue to live from coercion or undue influence.

Is this legislation reasonably necessary to effect these twin purposes? The answer is, unfortunately, not a resounding yes. It is a resounding almost.

I have real concerns, for example, that limiting access to those for whom death is “reasonably foreseeable”, however one seeks to define that term, would have precluded one of the applicants in the very Carter decision from accessing the new regime.

There is no evidence presented by the government that limiting access to terminal illness is necessary to protect the vulnerable, provided other safeguards are put in place, and it is an open question whether this provision is constitutional.

As one constituent aptly put it, “What Bill C-14 says is: I can express a desire to die when I'm terminally ill, but if I'm not considered competent, it won't count; I can express a desire to die when I'm competent, but if I'm not considered terminally ill, it won't count.” This should be remedied before we pass this legislation.

The remainder of the law may well fall within a range of reasonable options and therefore be charter-compliant, but that cannot possibly be what we aspire to in the House. We may have been tasked by the court to address the constitutionality of the current laws, but we are tasked by Canadians to go beyond that. The law we put forward should not simply fall within a range of reasonable options. It should be the best possible law we are capable of drafting.

I have met with many constituents over the last number of weeks and months to discuss this issue. In early April, for example, we hosted a town hall on the topic. It is, rightly, a sensitive topic for many.

● (2020)

My constituents' views and opinions have informed the following thoughts, all of which revolve around the importance of choice.

First, my constituents overwhelming favour advance directives. I appreciate that this is a complex area. It is one thing to assess an advance directive regarding a permanent coma and another thing to assess an advance directive regarding differing degrees of dementia. However, simply because a matter is complex or difficult does not mean we should not attempt to address it. I believe we need to look at advance directives more seriously and that many of the worries regarding stale decision-making can be resolved by sunset clause provisions.

As former Chief Justice Lamer said in Rodriguez, the legal system should not deny consent but should seek to ensure that such consent “is as independent and informed as is reasonably possible”. With appropriate safeguards in place, witness requirements, competency assessments, informed consent through advance directives should be respected.

Second, my constituents overwhelmingly favour placing assisted dying within the context of end-of-life health care overall. Under our charter, access to assisted dying cannot depend upon the availability of palliative care, but, as a matter of policy, for there to be a real choice, we should invest significantly in palliative care options. The $3 billion promise for home care investments is a good start, but it is only a start.

Third, choice depends upon competency and capacity. A competent adult should not be defined by age, but by capacity to understand and to choose.

Fourth, a small but vocal group of constituents have asked for choice for doctors, the right to conscientiously object. It is important for the government to acknowledge the deeply held beliefs of some doctors and we must do our best to reconcile those beliefs with the importance of providing access to assisted dying across our country. It is reasonable to respect doctors' choices, at the outset a cautious approach, providing patients with a public list of participating health professionals across the country.

Fifth, and finally, a similarly cautious approach regarding mental health is also warranted. The foundation of the court's decision was autonomy and dignity, and mental illness, including depression, can impinge upon fully informed and free choice. The law does not require anyone to choose life or death, but allows Canadians to make that deeply personal choice for themselves. For some, the right to life precludes assisted dying, but for others, including former Justice Cory, the right to life includes the right to death.

I will support this legislation at second reading and I hope it will be improved at committee.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Mr. Speaker, I fully agree with what the member opposite said about the need for palliative care as an option. Therefore, could he comment on why it is not part of Bill C-14 and why the word does not even appear in budget 2016?

● (2025)

Mr. Nathaniel Erskine-Smith: Mr. Speaker, I was also perplexed that we did not see palliative care options in budget 2016. We have made a commitment to spend $3 billion on home care, as I understand it, although I am not spending the money personally or individually, so I cannot make that choice on my own.

However, I do know that we are committed to working with the provinces, first and foremost, to establish a new health framework. I am convinced by this government that we are committed to investing in home care through that framework.

Mr. David Tilson (Dufferin—Caledon, CPC): Mr. Speaker, the member gave an excellent presentation. In fact, I have listened to all the speeches that have been given so far and they are all excellent. Some are for the legislation and some are against. Almost all members speaking for or against the legislation have said that they have some serious concerns about the legislation. The problem is that the Supreme Court of Canada has already extended the time once and the next date is June 6.

The fact is that we are all admitting that there are serious concerns with this bill. It has been studied by a committee of members of Parliament, a committee of the Senate, and the justice committee is reviewing it now as we speak. Should we be rushing through with this? This is a very serious issue. We all agree that this bill is not perfect and we can do better. Therefore, the question is whether we should be asking for yet another extension so members of Parliament and the Senate can spend more time on this subject.

The Speaker: Before I turn to the hon. member for Beaches—East York for his reply, I want to take this opportunity, since the hon. member for Dufferin—Caledon has made mention of the excellent speeches we have heard this evening on this topic from both sides, and I appreciate his comments in that regard, to say that I appreciate the tone of this debate and the desire of all members to take part in it in a very serious and respectful way.

The hon. member for Beaches—East York.

Mr. Nathaniel Erskine-Smith: Mr. Speaker, we have had a parliamentary committee do incredible work getting a report out after holding hearings that would have taken months and months on end in a very short time span. We have legislation before us that requires fixes, yes, but in the main part addresses the Supreme Court's concerns.

I do not believe an extension is necessary. I do not believe it would be granted if sought. I believe it is incumbent upon this House to act expeditiously and get this legislation passed.

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Mr. Speaker, I appreciate the member's particular focus on the absence of advance directives in the legislation. I share his concern. I would like to explore that a little more with the member. Perhaps he could shine a light on why this might have been missed and how we could fill the gap.

In paragraphs 13 and 14 of the Carter decision, the Supreme Court referred to the cruel choice that is posed to legally competent patients facing degenerative diagnoses, and those who have to choose between taking their lives prematurely or losing capacity later on. The member referred to that in his speech. The solution proposed by the all-party committee, which I salute, was to allow them to record their wishes while legally competent, and then through an advance directive, which would be subject to the same stringent medical and legal safeguards as the instantaneous request that is more identified in the legislation that is before us.

I am hoping the member can shine a light on why his government ignored that very specific and very constructive recommendation.

Mr. Nathaniel Erskine-Smith: Mr. Speaker, I do know that the Canadian Medical Association has raised concerns and red flags with respect to advance directives. I expect that that worry has led my government to proceed more cautiously.

We can note that the parliamentary report in and of itself provided for advance directives, but limited to where individuals had been diagnosed. Even among advance directive advocates, and in looking at that parliamentary report, we can in fact go further. I personally think we ought to go further.

While, unfortunately, those advance directives did not find their way into this legislation, my hope is that parliamentarians across the aisle and on this side of the floor can work together to ensure that we protect fully informed choice, whether one is terminally ill or not, whether one has been diagnosed or not, through advance directives.

● (2030)

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Mr. Speaker, I will preface my comments tonight by saying it is not my intent to offend anyone, but I do believe that this is the time for plain speaking.

This bill is about choices and it is about rights. Although I resent that the Supreme Court has ignored 15 rulings of Parliament that said we did not want to bring in any law on this subject, I respect that we have to bring one in by June 6. Of course, if we do not bring one in, I am not sure that the consequence is worse than this rushed Bill C-14. As I understand it, if we do not bring in legislation, we remain in the circumstance we are today, where there is the precedent of the Carter decision but no law in either direction for or against.

I said that the bill is about choices and rights. First, let us talk about choices. If I want to kill someone, myself, my baby, or someone else, this is a choice I can make today in Canada. Each one has consequences not just for me, but for many others. If I kill myself, my insurance will not pay out, and that will affect my family. They will also deal with, hopefully, the emotional trauma from the shock of missing me.

If I kill my baby pre-term, I have to live with that, and the father of the baby has to deal with it, but otherwise, there is currently no consequence.

If I kill someone else, I risk imprisonment. I understand that the Carter decision is trying to ensure that even people who cannot pick up a gun themselves can choose to get assistance in killing themselves.

However, their choice does have an impact on others. It has an impact on the health providers who are opposed to participating and whose rights of religious freedom and the right to refuse to participate are not adequately protected in this current version of Bill C-14.

It has an impact on the taxpayer, who will be paying for several doctor consults, and if some of the suggested amendments come into place, additional psychiatric reviews or judicial reviews, as well as the drugs to do the deed. When we kill ourselves, we pay for the bullets or the rope.

Let us look at how this legislation addresses the Carter decision. Keep in mind that the Carter decision limited the scope to those who are over 18, terminally ill, and can give consent. I do not see anywhere in the Charter of Rights and Freedoms that we have the right to die, only that we have the right to live, so certainly the Carter decision, in my view, is flawed.

However, the decision limited the scope to those over 18, terminally ill, and with the ability to give consent, so I find it incredible that this bill before us is looking to study extending this right to mature minors, to those with psychological only conditions of suffering, and those who do not qualify as mentally competent to give consent.

I was a youth leader for over 30 years, and I have known young people who broke up with their boyfriends and girlfriends and who took their own lives. These were tragedies that could have been avoided if hope and counsel had been provided. However, there will be many more lives taken before their time if we allow mature minors to ask for assisted death.

This is a dark path. We should not be studying it or even considering it.

[*Translation*]

With regard to the studies on whether people who are mentally ill should be able to request medical assistance in dying, I am asking that the bill be amended to ensure that it does not provide for that possibility at all.

Many people suffer from depression, but it is treatable. I know many people who take anti-depressants and medications that come with a warning that possible side effects may include suicidal thoughts. If we start killing people who are not actually dying, it is akin to murder.

For those who want to give their advance consent to be killed later, I ask them: why wait? Why not let them choose suicide when they are still able to commit suicide, rather than letting someone do it for them? They are not choosing to commit suicide in the beginning because they want to live as well and for as long as they can. That is why Canada needs good palliative care.

● (2035)

[*English*]

In my riding of Sarnia—Lambton, we have excellent palliative care. St. Joseph's Hospice has a wonderful staff, and we have the co-operation of Bluewater Health, the VON, community care, and so many other organizations, along with palliative care specialists who give the end of life dignity and meaning.

However, because palliative care is not completely funded in Canada, the hospice has to undergo significant fundraising of some $1.4 million each year. Government funding covers only 43% of the costs. Food, building maintenance, program coordinators, day hospice, and crisis support are not covered.

The cost of palliative care at home or in hospice is one-quarter of the cost of palliative care in acute care facilities. However, Bill C-14 would not do what it so simply could: amend the Canada Health Act to make palliative care a covered service so that all Canadians would have the end-of-life care that would cause them to choose life. Yes, of those who have good palliative care, 95% of them choose to live as long as they can and as well as they can. That is something missing in this bill.

Now that we have talked about choices, let us talk about rights. Most people who want to kill themselves can pick up the gun, or take an overdose, or hang themselves, or whatever. We are not talking about a huge percentage of people who cannot pick up the needle or swallow the pill. We are talking about a very slight minority of people. On the other hand, we have millions of health care workers, doctors, and nurses who for reasons of religion or otherwise do not want to participate in the killing of people, yet this bill says nothing about that. The rhetoric when the bill was presented said that health care providers would be able to refuse to participate or refer. However, based on the history of broken promises, I would want to see that one in black and white in the bill to be sure that the intent to protect the rights of health care workers is captured.

[*Translation*]

Let us move on to the subject of taxpayers' rights. When an individual decides to kill himself, he pays for his own bullets or pills. Now, the bill seeks to transfer that burden to taxpayers, who will have to cover the cost of medical consults and associated administrative formalities. I am opposed to my tax dollars being used to kill people.

I believe that, if people want to kill themselves, they should have to pay for the entire process. Some may say that killing people costs less than taking care of them, but that is a slippery slope, is it not? It creates a situation where we may start calculating the price of keeping people alive. In time, death may become a way to save money.

That was the case in all of the other countries that have implemented similar legislative measures. Belgium, the Netherlands, and Denmark all started out with strict guarantees. However, these guarantees were hard to implement and were eventually set aside.

After that, it became easy and practical to get rid of vulnerable and undesirable members of society. The percentage of deaths rose from less than 1% to 6%. I do not believe that there is enough accountability in this bill and I would like to see improvements made in that regard.

[*English*]

As I said, this bill is about choices and rights. I believe the bill does not do enough to protect the rights of health care workers, the young, and the vulnerable. I believe the choice to kill oneself should come with consequences, which are not well laid out in this bill, such as forfeiting of insurance and the cost of the deed for starters.

I am recommending that the bill be amended in committee to document the protection of health care workers' right to refuse without retribution, to capture the duty of the requesting individual to cover the cost of the process, and to remove from the scope of this bill the studying of mature minors, advance consent, and those suffering psychologically.

● (2040)

Ms. Karina Gould (Parliamentary Secretary to the Minister of International Development, Lib.): Mr. Speaker, I would like to begin my comment with something that the previous speaker mentioned. He said that he appreciated the tone and the level of respect that this debate has taken.

My hon. colleague began by saying that she was not going to offend anyone, or that she hoped not to. However, it is incredibly important to recognize that this issue is deeply personal. It is something that affects many different people. Therefore, to put medical assistance in dying in the way that it was painted, I think is deeply offensive to many of my constituents and people across this country. There is a certain level of respect that needs to be offered to those individuals who are seeking this assistance. They are at a point where they are suffering so immeasurably and so severely that we need to respect that decision and ensure their voices are being heard. That is what this bill addresses. It is important to remember that there are many safeguards within this bill that protect vulnerable individuals.

Because she talked about choices and rights, I am wondering what my colleague would say to someone who is suffering so immeasurably that this is the choice that he or she would make.

Ms. Marilyn Gladu: Mr. Speaker, I would repeat that there are different opinions on this issue. While we want to protect the views of those who would choose this way, there are many who are offended by that choice. We need to recognize that. That was my intent in bringing the message.

Mr. Bev Shipley (Lambton—Kent—Middlesex, CPC): Mr. Speaker, one thing I can say about my colleague from Sarnia—Lambton is that we always know where she stands. Quite honestly, this debate is about just that. She certainly would not offend anyone, because we either live or we die. Let us be frank about it. The Supreme Court has given medical people the right to kill people. That is what has happened.

I did not see anything in this bill with respect to the following. Let us say that there are people who are terminally ill and are dying of severe cases of cancer. They might not die of the cancer; rather, they could die because of the poison that is given to them. I am wondering what the death certificates would say in terms of the cause of death. If we are to track any of the statistics, if we do not have some indication of what they actually died from, then we lose track of what this bill would accomplish.

Ms. Marilyn Gladu: Mr. Speaker, my understanding of the way it is intended to work is that if someone does request assisted dying, the cause of death would be listed as the pre-existing condition as opposed to assisted suicide. Therefore, I agree that this will cover up the tracks of how often this is happening. All of the countries that have implemented legislation like this began with good intent and good process. However, people were not following the rigour, so the data tracking was difficult. Eventually, they opened it very wide, which is my concern with this legislation.

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Mr. Speaker, I wonder if the member could provide some comment. She was a part of the government for a number of years. The Canada health care accord that was signed back in 2004 was allowed to expire. Year after year, we in the opposition argued that the Conservative government of the day should have done something with respect to the renewal of that health care accord. It is a bit much to listen to the Conservatives saying that we are not doing enough in terms of palliative care, because palliative care no doubt would have played a very important role in any future health care accord. If we think of the future of health care delivery, would she not agree that palliative care has to be a major component of that?

Ms. Marilyn Gladu: Mr. Speaker, I absolutely do agree that palliative care has to be a fundamental part of health care as we go forward.

I heard questions earlier tonight that asked when end of life starts. Palliative care experts will tell us that even up to a year before death, in some cases two years, there is an advantage to good palliative care, the kind that does not just occur in the hospitals but in hospices and in home care. Therefore, I encourage the current government to do what it can to implement the promise it made in the budget.

● (2045)

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Mr. Speaker, I can assure the member that the Liberal government will do what it can in terms of administering a palliative health care policy from coast to coast to coast. It is something we have believed in for many years and ultimately have been advocating for. Therefore, it is with pride when I look to the current Prime Minister and the Minister of Health when we talk about how we are going to see an investment in palliative care.

Before I talk more about palliative care, I want to talk about why we are here today.

It was a Supreme Court decision, a unanimous decision, which needs to be highlighted, where all of the judges came to the conclusion that Canadians suffering intolerably have the right to request assistance to end their suffering. We respect that decision. The issue before us today is, if Canada should have medical assistance in dying, how do we make it available? In essence, that is the issue before us today.

It is important that we recognize that this decision was made in February 2015. The government of the day sat back and did virtually nothing. It took a change in government, when Canadians spoke on October 19, and then a number of weeks that followed. We had the first Liberal-appointed cabinet in the last decade, and part of the mandate letter was to deal with this issue.

We do not have a choice. The Supreme Court has made this decision. We have a responsibility as parliamentarians to act on that court decision.

We have seen an incredible amount of effort put in by members of the Special Joint Committee on Physician-Assisted Dying, who worked virtually around the clock, seven days a week, with Senate colleagues. They did a phenomenal job in terms of getting us into the position of where we are today, which is debating the bill at second reading.

Hopefully, sometime this week, we will see the bill pass second reading. Parliamentarians, many of whom have talked about all sorts of ideas, will be able to make their presentation or express their thoughts at the committee stage, and at the same time allow stakeholders and individuals to share their incredible experience. At the end of the day, if we can improve this legislation, I can assure members that the Government of Canada is open to doing that. We are not fearful of accepting amendments, if in fact it can improve the quality of the legislation.

Within the legislation, members will find that there is an automatic review mechanism. After four years from this legislation becoming law, it will be reviewed by Parliament. I believe that is the responsible thing to do.

As parliamentarians, I would suggest we all have a role to play in terms of looking at how we are going to get this legislation through in a timely fashion. Not only does it have to pass the House and go to committee, it also has to get through the Senate, and it is important that it be done by June 6. We need to do this, because it is one of the ways we ensure that there are standards across the country so that void can be be filled.

We can look at what the legislation would actually do.

Access to medical assistance in dying would only be available to those who meet certain conditions. One, they must be mentally competent adults who are in an advance state of irreversible decline and capability. Two, they must have a serious and incurable illness, disease, or disability, and are experiencing enduring and intolerable suffering caused by their medical condition. Three, it must be those whose death has become reasonably foreseeable, taking into account their medical circumstances. We believe this meets what the Supreme Court of Canada has asked of us.

● (2050)

Obviously, it is a very emotional issue. We all have stories that we can reflect on. In 1999, I was at my father's deathbed. Thanks to good palliative care, I was able to be there at his time of passing. I appreciate the importance of pain management. He was in what I would classify as a fantastic facility. It allowed my father to end his life in a very positive fashion. Having a wonderful relationship with those he truly cared about and loved was very important, not only to me but to my family.

Prior to his going into Riverview Health Centre, I remember that we could barely communicate with him because of the intense pain that he endured. Once he was in the loving and caring hands of our health care professionals in a palliative care unit, with proper medications and painkillers, the difference was night and day. I remember saying to the doctor that we were going to have to look at having him come out, believing that he was getting so much better.

Our health care workers do an incredible service to Canadians. We need to recognize that. We should not be fearful that the legislation is going to obligate a doctor, a nurse, or a nurse practitioner to do something that goes against who they are, or that they are going to be penalized for that.

We have had those assurances, whether it is a charter of rights assurance or assurances from the ministers directly when they brought this bill forward and addressed it. The assurances are there. We are going to provide a service that is necessary. It is the right thing to do.

This is not something that is coming from one political party or one faction of society. It has gone through the court process. Nine Supreme Court judges ruled unanimously. We believe in Canada, and we believe in the rule of law. We recognize that this legislation is necessary.

As I indicated, there is always the opportunity to look for ways to improve the legislation. I am anxious to see it get to the committee stage, and to see if there is anything that could come out of the committee that would make it a better piece of legislation.

I have had the opportunity to listen to a good portion of this debate. I want to emphasize how important it is that we continue to look at palliative care and the potential that the Government of Canada has to show leadership on this issue, much like the current Prime Minister demonstrated leadership by getting in this legislation in its current format and getting the Special Joint Committee on Physician-Assisted Dying working together to bring us to where we are today.

We want to see the same sort of leadership, and I believe it is there, on the issue of palliative care. We do need to see strong national leadership on that issue. That is why I was very glad when the Minister of Health made a $3-billion commitment to palliative care.

Let us not kid ourselves; it will not be easy. I was a health care critic at the provincial level. If we are going to try to implement a program that is going to be universal so that it does not matter what region of the country people are living in, it will require a great deal of sitting down with our provincial counterparts and other stakeholders, in particular our first nations, aboriginal communities, to come up with how we can shape a world-class palliative care system.

Let us not kid ourselves; it is not going to be an easy challenge. That is why I am very grateful for the sense of commitment, whether it is coming from the PMO's office or from the Minister of Health in regard to making sure that, number one, there are financial resources to follow the commitment; and number two, that there is a feeling that in order to achieve it, we have to get people sitting around the table. That is something that is truly different this time around from what it was under the previous administration.

● (2055)

This government believes in working with other levels of government and believes in working with people. I believe that ultimately that is going to make the difference.

Today we debate this very important issue that all Canadians are very much concerned about. All Canadians have an opinion on it. It is such a privilege to express what I believe is what a majority of my constituents would want me to do on this issue and I feel very proud in terms of what this government has been able to accomplish in a relatively short period of time.

Mr. Martin Shields (Bow River, CPC): Mr. Speaker, I appreciate the member and the speaker before him for thanking us for the tone of this debate and the non-partisan and impersonal debate it was, although it got a little more personal with our colleague there.

A question I asked earlier was answered in a different way and I will try again. One of the things I see in the document deals with two doctors and two nurse practitioners that will be put in the role of signing or agreeing with the documents. In the rural areas I am familiar with having that many doctors and nurse practitioners can be a challenge. The answer I got was, “That is why there are a lot of nurse practitioners.” In the rural areas I am familiar with there are more doctors than nurse practitioners. There are not many nurse practitioners.

We come down to the challenge in rural areas of those people being known. It is very tough in a smaller community for medical staff to be labelled with that kind of a role. How would my colleague deal with this in rural areas, realizing that nurse practitioners in some areas are not as plentiful as they are in other areas?

Mr. Kevin Lamoureux: Mr. Speaker, I note that nurse practitioners for all intents and purposes, even though they have been around for many years, it is only in the recent decade or so that we have seen provinces looking at how we could potentially expand the roles of nurse practitioners.

I realize there are a lot of sensitive issues in regard to health care and the delivery of health care services, which include doctors in many rural communities. The more remote, the more difficult it can be, but there are also many rural communities that have a fairly healthy situation with doctors.

The answer to the question likely lies in working with our health care professionals and different stakeholders like our provinces to see if the concerns the member has raised could possibly be dealt with. I do not have the short answer, but hopefully that will assist him in getting a better understanding of where I am coming from on that issue.

Mr. Alistair MacGregor (Cowichan—Malahat—Langford, NDP): Mr. Speaker, I appreciated the parliamentary secretary's speech. In the Carter ruling of the Supreme Court of Canada when it held up the appeal, it defined a competent adult person as one who clearly consents to the termination of life and has a grievous and irremediable medical condition that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

In Bill C-14 under proposed paragraph 241.2(2)(d), the legislation specifically mentions that a natural death has to be reasonably foreseeable. I want to know the member's opinion on that specific section of the bill. Does he believe that complies with the Carter ruling and is the government prepared to refer this legislation at some point down the road to the Supreme Court to make sure that we do not have future charter challenges?

Mr. Kevin Lamoureux: Mr. Speaker, as the legislation stands currently, I am fairly confident that it meets the requirements of the Supreme Court of Canada's decision. Having said that, I would remind the member, as I indicated during my remarks, that once we get to the committee stage there will be the opportunity to hear expert witnesses and the individuals who have written the legislation. Many of these questions could be put right to the table.

A lot will depend on how the ebb and flow of the committee goes. It is not to say that I do not know the specific answer, but I would feel far more comfortable given the makeup of the committee and I know the types of effort that people have gone to in looking at the actual wording. A little change in a word could have a fairly profound impact in terms of how the legislation is actually interpreted.

It is best that we understand what is being said in our intent and then we have to rely on the professionals and the individuals who are drafting the legislation and working with the different stakeholders to make sure that we get it right. I am confident that at the end of the day we will get it right.

● (2100)

Mr. Adam Vaughan (Parliamentary Secretary to the Prime Minister (Intergovernmental Affairs), Lib.): Mr. Speaker, I thank members for pursuing this issue not just from some excellent legal scholarship, and we heard that tonight with presentations from my colleagues, but also talking about the impact their lives have had on how they assess the legislation before us.

I too will reflect on my time on this planet, dealing with the challenges of watching a loved one pass away. In this case it was my mother. It was 20 years ago this past January. After a very determined 15-year battle with cancer, she succumbed. Part of the process involved palliative care at the end, which was excellent. However, it was too much for her at one point and she called her three children around, my two sisters and myself. She said, “Kids, I've had enough.” She pulled her oxygen mask off and said, “Don't revive me. I love you. Goodbye.”

We had been dealing with three or four months, it is almost impossible to measure the time, of watching my mother struggle on to make sure that all the kids were there to say goodbye, and saying goodbye to loved friends and family. Clearly, after 15 years, she had had enough.

We sat there by the bedside and watched as life started to leave my mother's body. For myself, who had been in the city and was taking care of her at the end, most persistently on a daily basis, it was too much for me. I could not take it anymore. I left the hospital room knowing that I had said my goodbyes and this was the end. When I came in the next morning, there was my mother sitting up in bed saying, “Well, that didn't work.” Palliative care continued for weeks afterward. It was a palliative care that got more fragile, more painful, and a greater hardship for her and for us to deal with, but in the end she passed away.

She had a do not revive order. As we talk about this issue, we have found ways in the country before to assist people in making decisions, even when they are not in a place to make those decisions.

That is what we are struggling with today. How do we find a more proactive and more informed way of doing this when different dimensions and different diagnostic tools come into play, and different eventualities are being considered?

What we are trying to figure out here is how to extend the do not resuscitate orders into a new sphere of medical assistance. That is the essence of what we are trying to do. It strays into other areas. I have heard it in these debates that the legislation is fine but it does not do X or it does not do Y, which are really topics for other pieces of legislation. We are not focusing on what we are trying to get done right here.

The bill responds to the Supreme Court, as we are compelled to do constitutionally. I do not resent it. It is an extraordinary responsibility to respond to the Supreme Court when it assesses our laws to be lacking or the needs of our population not being met. What we are trying to do is to get a perfect letter through a defined letter box and making sure it clears that letter box.

People in our country are suffering and families are suffering as we debate this. I appreciate the sentiment from many people in the debate to try to get the legislation perfect. It deserves to be perfect. We all strive to make it perfect. However, we cannot let perfection get in the way of what is needed and what is good. There is goodness in the bill, because it does limit people's suffering. Have we done enough on palliative care? Of course not. Have we done enough on the quality of life? Of course not. Have we done enough on medical research? Of course not.

Death is still a very difficult subject for far too many of us. However, Bill C-14 responds to the court's challenge in a very particular way, and the committee will try to make it better. I trust it will come back to the House with a better bill. I hope we can get the bill to committee as soon as possible so it has the space to work on that perfection, rather than us pursuing our task of trying to perfect the criticism of the bill. We need to get the bill to committee so it can be studied, some of the language refined, some of the opportunities better understood, and some of the restrictions better defined. We need to get it to committee quickly.

● (2105)

However, we have to resist being afraid of this bill because it would start to do things that we have not contemplated, such as the slippery-slope comments we had, where we are worried about what happens with person X and person Y in five and ten years' time if these conditions change. We have to look at the legislation that is in front of us, we have to deliver it to committee with criticisms attached, and then we have to trust ourselves as colleagues, as parliamentarians engaged in this issue, to try to and hope to deliver a better bill for the next reading and then on to the Senate for its work and for its resolution.

Let us not kid ourselves. There will be no bill passed in this Parliament that will not be challenged at some future date at the Supreme Court. There will be no new thinking or new idea or new circumstance that does not demand of us to revisit this bill in one, two, three, five, or ten years from now. We have lived on this planet for thousands of years and never perfected the art of dying. It is a tough issue. It is a hard issue. If we lose sight of the fact that our inability to come to terms with that promotes and prolongs the suffering of individuals, we will have truly failed as parliamentarians. We are being asked to make a tough call. This legislation would define what we think is a good judgment and would define what we think is a good approach to this.

I can hear good ideas emerging. However, the debate being called for by many quarters about improving palliative care did not need this bill for that call to be made. We should have been perfecting palliative care years ago. The call to ensure that vulnerable people are better protected and their quality of life is better protected did not need this bill for that debate to happen. Vulnerable people should have been spoken to and their needs addressed long before this bill was ever presented.

However, to use those as roadblocks to end suffering is unconscionable in my perspective, and we have to respond to the deadline that has been imposed upon us by a court that has already been asked to extend that deadline once and already has referenced the suffering as a reason not to extend it again. We have a duty, and we have a duty tonight and over the next few days to get this bill to committee as quickly as possible, and then to listen to what we have said to one another in these last few hours. I do not think anybody has presented a concern that is not of value and does not inform our ability to talk about this bill in more pronounced ways and more reflective ways, and that is good.

Let us amend. Let us lean into the parliamentary committees that we have here. Let us trust one another to fix good ideas and make them better ideas. That is what the committee process is supposed to be about, and that is something that I trust will happen. Let us measure the impact of this debate through that process and ensure that our voices and the voices of our constituents are heard in this debate and also heard in the legislation as it moves forward. At the end of the day, let us be honest with ourselves. We will be revisiting this issue the minute it gets royal assent. We will revisit it because life brings us these challenges as surely as it brings us death. We have to be, on these sorts of issues, smart enough to trust one another, compassionate enough to learn from one another, and at the end of the day, disciplined enough to ensure that this Parliament works for those who are suffering, those who are vulnerable, and those who want to live out their last few days with dignity.

My mum taught me a lot about life by the way she died, and I am sure it is a story that all of us have learned from loved ones as we have watched them move through very difficult times. However, I also remember my mum saying, as she was sitting there, that she loved us and it was not just her suffering she was trying to manage, it was ours. Therefore, it is not just our difficult decision we are trying to manage here today; it is the country's difficult decision.

I trust all members to take that seriously, but I also trust them to support us as we pursue palliative-care improvement, as we pursue the opportunity to improve the lives of vulnerable people in this country, and as we seek to deliver choice to people about how they move forward, with support when they make mistakes but understanding when they get it right.

I hope we can get it right with this legislation. I hope the committee gets it right, and I hope the next debate about this finds even more consensus.

● (2110)

Mr. Todd Doherty (Cariboo—Prince George, CPC): Mr. Speaker, I want to thank the hon. member for Spadina—Fort York for his comments and for sharing his experiences with the House.

The hon. member mentioned trust a number of times, about getting it right. With a decision and legislation that bears the gravity that this does, I again go back to the time that we are spending discussing this—this is not a debate; it is a discussion—trying to make sure we get it as close to right as possible. The balance of power rests on that side of the House, and I would think that the public and perhaps those down the street in the Supreme Court can see that we are having those discussions and that, at this point, if the government went across the street and said it needs more time, I would hazard a guess that it would allow that.

Whether it is a notwithstanding clause or just asking for another extension, would my hon. colleague across the way at least say that true leadership would be asking for a bit more time for us to have this great discussion?

Mr. Adam Vaughan: Mr. Speaker, I was in the House last session when Liberals were in opposition and we moved a motion to speed this debate up to give us that time, and it was defeated. I do not think it is our privilege now, having already gone to the Supreme Court and asked for an extension, to prolong other people's suffering. We have a responsibility to act.

This issue has been in front of us for a lot longer than the bill has been in front of us; the committee spent time on it and did extraordinary work exploring this issue and laying the groundwork for the legislation; and there was work done in the previous Parliament, although not nearly fast enough.

The issue is that we have to accept, as parliamentarians, that we do not produce perfect legislation. We never will. We are just people giving it our best effort. On this bill, where a free vote has been offered to all parliamentarians on this side of the House, and I assume on the other side, we are in the position of trying to make this work. The deadline we have been given by the Supreme Court is the right decision.

It is time to act. It is time to end the suffering for some and provide clarity for others, so I do not think the responsible thing to do is to ask for a delay. We must make a decision, and then we must revisit this issue when problems arise again, because, as surely as we stand here today, they will.

Mr. Daniel Blaikie (Elmwood—Transcona, NDP): Mr. Speaker, I want to thank the hon. member for his compelling speech. The one piece that stood out to me is more of a process issue.

He talked about the need to get this bill to committee so that it can be improved. That is something I would like to see. I could go on about some of the things that I do not think the government got right in this bill, but given that a special committee did a lot of great work on this and issued a report, and the government legislation does not really reflect much of anything that came out of that report, why should we have confidence that the government is going to respond appropriately to the next committee that looks at this bill?

Mr. Adam Vaughan: Mr. Speaker, I am tempted to quote one of my favourite movies and say, “You have to have a little faith”.

The committee that laid the groundwork for this legislation, the bill that is in front of us, explored a lot of issues; and at the end of the day, the justice minister presented a bill, which in the opinion of the government, gets the issue fundamentally right as it relates to the Supreme Court. It takes away some of the other issues, says that this is core of what we need to do, and leaves it to Parliament to improve upon it. We need to seize that, as parliamentarians, as an opportunity to show how Parliament can work collaboratively around, in particular, difficult issues.

The challenge we have is to find ways to address some of the ideas we want pursued, not just through this specific piece of legislation. Advance consent is an issue for me, or the different names that it is given, like advance care directives. It is a fundamental part of what is missing in this bill, and I want to see that really seized upon by the committee. The palliative care component, the duty of care to people with vulnerabilities, all of those issues are other issues we need to bring to the House, and we need to bring the same level of creativity and compassion to those issues.

We get locked into this notion that governments must present perfect legislation or, otherwise, it is thumbs up or thumbs down. Parliament is not supposed to work that way. We come here representing parties and our constituents, and we have to bring all of that to bear on legislation each and every day, not just simply vote party colours all the time. That is part of the freedom we need to explore in Parliament and one that our leader has put on the table and is trying pursue, and we need members' support to make it happen.

● (2115)

The Deputy Speaker: Before we resume debate, I want to make a brief comment to all hon. members. First, I want to compliment members, as we have heard earlier today, on some very heartfelt interventions from all sides of the House on this particular issue, a very human and emotional issue that is before the House.

The chair occupants are doing their best to accommodate members and are trying not to cut them off. We are down to 10-minute speeches and five-minute periods for questions and comments, which generally only leaves us enough time for two interventions during that five-minute period.

We will do our best, but if members happen to notice that there are a good number of members rising on questions and comments and wish to keep their interventions concise, that would allow more members to participate in that five-minute question and comment period.

We will be as judicious and fair as we can in making sure that all members have the opportunity to finish their points, and so on.

Resuming debate, the hon. member for North Island—Powell River.

Ms. Rachel Blaney (North Island—Powell River, NDP): Mr. Speaker, today this House stands to discuss Bill C-14. As we do so, we must seriously consider this important responsibility. The Supreme Court decision has been made. The job in this House is to create legislation that would provide clear boundaries moving forward.

In February 2015, the Supreme Court of Canada concluded that the absolute prohibition on assisted suicide violated the charter rights of Canadians suffering intolerably with grievous and irremediable medical conditions who, being adults and assessed as competent decision-makers, would otherwise seek medical assistance in dying on their own terms.

In response, the joint special committee of Parliament was tasked to consult with experts and Canadians who reflect the diverse perspectives on this issue. It reviewed the Supreme Court's decision in the Carter case and the 400-page judgment of the B.C. Supreme Court that preceded it. It studied Quebec's new assisted dying law, as well as the reports of two major panels on medical aid in dying, which together heard from 13,000 Canadians and more than 100 organizations. The committee then held 11 hearings, called 61 expert witnesses, and received more than 100 written briefs from groups across Canada.

I have read the report and want to thank the committee for the great work it has done, resulting in 21 recommendations on a legislative response. These recommendations demonstrate balance and sensitivity, respecting the autonomy of patients, the rights of health care practitioners and vulnerable individuals, and the fundamentally personal nature of this issue to every Canadian.

I have also been listening to the constituents in my riding of North Island—Powell River, where people are very concerned. Many from my riding are worried that there is not enough support for palliative and end-of-life care. They want to know that the vulnerable will be protected and they want to know that those who suffer greatly can decide to die with dignity. I have had many letters from my constituents, and I know there will be many more. This is a subject that deserves much discussion in each riding across Canada.

Bill C-14 is also a very personal one for me. Years ago, I was a volunteer for a hospice and watched many people die. I remember being present for people who were in so much pain and who wanted the release of death so badly that starving themselves became their only solution. I remember the agony of the people and their families who just wanted a safe release from this pain.

I also sat with people who fought every day for one more. Their desire to continue in the face of such pain was tremendous.

After volunteering there for years, I left knowing that death is an intensely personal process and that honouring people and their families through it is so important.

Today, I want to talk to Bill C-14, the Liberal government's legislative response to the Carter case.

The Liberal bill has raised new concerns and leaves many questions, for me, unanswered.

There is consensus among academics, health professionals, faith communities, and the public that Canadians deserve better end-of-life and palliative care treatment.

The federal government has a role to play in working with the provinces and the territories, as well as first nations, Inuit, and Métis communities, on finding strategies that work.

We have a critically important opportunity to enhance the services across the country, yet the government was missing in action in the budget on palliative care—even after promising $3 million for home care during the campaign. Holding the government to account on the promise of that motion remains one of our top priorities as we assist in the legislative response to the Carter decision.

This bill refers to palliative care in its preamble; yet while introducing this bill, the government made no new commitments to palliative care. The people of my riding want to see this investment happen.

The NDP took a significant step forward in the last Parliament when a motion brought by the member for Timmins—James Bay to establish a pan-Canadian palliative and end-of-life care strategy earned nearly unanimous support of the House of Commons.

Palliative care is about patient- and family-centred physical, psychological, and spiritual care.

Everyone dies, every family has to deal with the loss of a loved one, and these traumatic moments are made more difficult and more expensive when there is no access to quality palliative care. With an aging population, it is crucial that the federal government provide leadership now.

● (2120)

The government backgrounder refers to the following system to ensure equal access:

> The government is proposing to work with provinces and territories on the development of mechanisms to coordinate end-of-life care for patients who want access to medical assistance in dying. This system would help connect patients with a physician or nurse practitioner willing to provide medical assistance in dying, and support the personal convictions of health care providers who choose not to participate. It would also respect the privacy of those who are willing to provide this assistance. This system could also offer other end-of-life care options to both patients and providers.

However, this is not mentioned at all in the bill. This leaves a lack of clarity and room for poor decisions. It is important to respect the health care practitioners' freedom of conscience while at the same time respecting the needs of the patient.

Having seen the previous government's agenda being held up in the courts time and time again, Canadians expect a government to be thorough. Now is the time to strengthen the bill against charter challenges by resolving contradictions with the Supreme Court ruling in Carter. Canadians have waited long enough. Let us get it right the first time.

It is not a partisan criticism either. The co-chair, Conservative Senator Ogilvie, told the *Hill Times* that the law as it has been introduced will be challenged in courts, and he is disappointed that the government did not take more of the committee's recommendations.

This is not a case where good enough legislation is good enough. This is a life and death issue, so let us get the right legislation.

The people in my riding are concerned about safeguards. They know the value of life and want to make sure that some lives are not considered less valued than others. I could not agree more. I have members of my family who have severe mental illness and who are differently abled. They are precious to me, and I would not wish them gone from my life.

Right now, Bill C-14 would legalize medical assistance in dying for competent adults 18 years of age or older who meet the following criteria: serious and incurable illness, disease or disability; in an advanced state of irreversible decline in capability; experiencing enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

There are also requirements for two independent medical practitioners or nurse practitioners to confirm each criterion. The request must be in writing where possible and witnessed by an independent adult, and a 15-day reflection period must be observed. To help protect people in vulnerable situations, the witness to the request cannot be a beneficiary under the will of the patient, someone who may benefit from the patient's death, or directly involved in providing care to the patient. The two physicians or nurse practitioners must also be independent from one another. Safeguards must be there to provide the support that patients and their families need during this painful time.

We know that this is a difficult issue that touches many in a personal way. There are many issues to discuss, and we hope to see them discussed. Therefore, I will be voting in support of the bill, but I know that it is going to a special committee, and when it returns to the House I hope to see many more changes made.

Many speakers today are expressing their profound disbelief that Bill C-14 would deny Kay Carter, one of the two women on whose behalf this case was brought to the Supreme Court, suffering from serious and incurable but non-fatal conditions, the right to choose medical assistance in dying.

According to many experts, their only remaining recourse to meet the bill's final criterion would be to starve themselves to near death, as we have seen people do in Quebec, in order to meet the province's eligibility criteria. I have seen this in action, and it is a dreadful way to die.

Going forward, New Democrats will consult with experts and people affected as we study this legislation very carefully. As Amy Engel wrote, “I want to be someone strong and brave enough to make hard choices. But I want to be fair and loving enough to make the right ones”.

● (2125)

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Speaker, the member referred to page 7, numbers (5) and (6), which talk about independent witnesses, and the independence of medical and nurse practitioners, ensuring that there is no business relationship, and there is no potential financial benefit from having someone have their death hastened.

Certainly, I agree with these principles that are here, but my concern is that, while they are here, a person could say that, yes, they are independent and all of those things, but there is no method of verifying whether or not that is in fact the case.

I wonder if my colleague would support the idea of a prior review, either a tribunal or judicial review, or some panel which would oversee and verify the facts that are stated.

Ms. Rachel Blaney: Mr. Speaker, this is part of the realities we are facing.

We know that some of these decisions have to be done in partnership with the provinces which will have certain authority and responsibility in this process.

I think it goes back to that bigger question of making sure there is the support, so that we do not have a patchwork framework across the country. We want to make sure that the services make sense, and we want to make sure that we ask these hard questions.

I am hopeful that the work done in committee will answer some of these questions for us in a good way, and that we will see that process unfold in our relationship with the provincial and territorial governments.

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.): Mr. Speaker, palliative care is, indeed, a very important issue.

There are many people here who believe the bill goes too far. There are many others who do not believe it goes far enough, and I fall generally in that camp. I think we could do a lot more, but I appreciate the compromise presented in this bill.

The member for Spadina—Fort York who spoke earlier is correct in that anything we do will face further challenges. For better or for worse, I do not believe this file is ever going to be completely closed. It is too close to the hearts of too many people. I think all members can agree with that.

The member wants to resolve a number of conflicts she sees between the bill and the Supreme Court ruling. I am wondering if the member plans to submit amendments to achieve that very thing at committee, and if she agrees that the committee process is the best way to address these issues within the tight timelines we face.

Ms. Rachel Blaney: Mr. Speaker, I hope that the committee will continue the work when the bill gets there.

One of my frustrations is that many of the thoughtful recommendations that were brought forth by the last committee were not put into this bill.

I would like to see a review of the wonderful recommendations that were already made, and to make sure that we do not repeat the work that was already done.

● (2130)

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Mr. Speaker, this is a difficult topic, and I am generally in agreement with what the member has put forward.

We heard earlier from the parliamentary secretary to the Prime Minister that there would be a possibility for amendments. I am wondering whether the hon. member for North Island—Powell River has considered amendments from her party, and whether we have any indication that the Liberal government will in fact entertain amendments that come from opposition members of Parliament.

Ms. Rachel Blaney: Mr. Speaker, it is very important that all voices be heard strongly in this process.

For me in the work that I am doing, speaking with my riding has been very powerful. People are concerned. People are very supportive. Some people are very unsupportive of this process.

It is important that the government continue to do its work, to make sure that the voices are heard, so that the voices of the ridings across this country are heard.

[*Translation*]

Mr. François Choquette (Drummond, NDP): Mr. Speaker, I want to congratulate my hon. colleague on her excellent speech. It was very well delivered and very well explained. Truly, I could not have done better.

I also want to thank my hon. colleagues from Saint-Hyacinthe—Bagot and Victoria for their excellent work on this special committee to arrive at the findings we have here.

What struck me most in my colleague's speech was the issue of palliative care. The NDP worked very hard to put in place a palliative care strategy. In my riding, we have Maison René-Verrier, which does excellent work for people who, sadly, are at the end of their life. It is very important to support those people, to be very close to them, and to help them get through this stage we must all go through.

I would like my hon. colleague to say a bit more about the importance of providing palliative care. Unfortunately, the Liberal government still has not delivered on its promises on palliative care.

[*English*]

Ms. Rachel Blaney: Mr. Speaker, that is an excellent question.

Palliative care is so important. We do have an aging population, and as people get to that part of their life, they want to know the services are there for them. I represent a vast riding with many rural communities. We face many challenges in helping people stay in their communities for a period of time as they age.

Having a Canadian strategy that really engages the provinces and territories to work collaboratively to meet the needs of constituents across this country is imperative. We have already had a vote on a motion that the member for Timmins—James Bay presented and that was nearly unanimous.

In this House, we know palliative care is important. I hope we continue our work to make sure that service is delivered.

Mr. Chris Bittle (St. Catharines, Lib.): Mr. Speaker, I am pleased to have an opportunity to participate in the second reading debate on Bill C-14, the proposed legislative approach to medical assistance in dying in our country.

This is a historic bill, and it tackles an issue that is of great interest and importance to many Canadians. It is also one that raises divergent and deeply held personal views, which is why broad consultations with a variety of groups and organizations were essential before reforms could be developed and considered by Parliament.

Members are aware that a special joint committee of the House of Commons and the Senate recently studied this issue, in January and February of this year, and in the context of that study, had the opportunity to hear from 61 witnesses and consider over 100 written briefs.

Other recent consultation initiatives were undertaken by the federal external panel on options for a legislative response to Carter in Canada, from July to December 2015, and the provincial and territorial experts advisory group on physician-assisted dying, from August to December 2015. Each panel met with representatives of dozens of stakeholder groups and received numerous written submissions from key organizations, including the medical sector, disability rights groups, legal and civil liberty organizations, and faith groups. Furthermore, many of the organizations that were consulted held extensive consultations with their own membership, some over the span of years, and shared the benefit of those with these panels.

Of course, we are also indebted to the years of consultations undertaken by the provincial government in Quebec leading up to its own legislation in this area. The extensive work that those in Quebec undertook was carefully considered, and I thank them for their leadership on this issue. It informs this proposed legislation as well.

The broad and in-depth consultations that have occurred over the past year across this country have undoubtedly enriched the policy development process that has led to the introduction of Bill C-14. I am pleased to see in the document entitled “Legislative Background: Medical Assistance in Dying (Bill C-14)” which accompanied the bill and was tabled in this place by the Minister of Justice, that the development of the proposed legislation was informed by the evidence before all levels of court in the Carter case by available Canadian and international research, social science evidence, governmental reports, and parliamentary studies.

That document also tells us that it was informed by the experience of existing international medical assistance in dying regimes around the world, as well as by numerous recent consultation activities on medical assistance in dying, including the work of the special joint committee, the federal external panel, the provincial-territorial expert advisory group, the work of the Canadian Medical Association and the College of Family Physicians of Canada, as well as the work of the provincial colleges of physicians and surgeons.

The consultation process has been robust and comprehensive. This has provided an opportunity for a variety of stakeholders from diverse perspectives to share their views and to reflect the views of other stakeholders who may not necessarily share their point of view.

I would like to briefly outline the considerations that some of the key stakeholders have raised with respect to this issue. One of the key stakeholder groups on this issue, given the active role they will be playing in response to requests for medical assistance in dying, is the medical profession, and by that I mean the various types of health care providers, such as doctors, nurses, pharmacists, nurse practitioners as well as their regulatory bodies.

The importance of this issue for the medical profession was underscored by a representative of the Canadian Medical Association who appeared before the special joint committee and testified that medical assistance in dying is a difficult and controversial issue for the medical profession, that it represents a sea change for physicians in Canada.

Many of the people who spoke from the perspective of the medical profession emphasized the need for clarity in the law so that health care providers are crystal clear about what is permissible and what is not permissible in providing medical assistance in dying, and that federal legislation is needed to ensure national consistency.

I am pleased that the proposed legislation responds to that request for clarity and consistency. Bill C-14 comprehensively sets out who can do what and to whom, and which safeguards are to be complied with. Moreover, as it is a proposed amendment to the Criminal Code, it would apply equally across Canada.

The unanimous decision of the Supreme Court of Canada in Carter focused on the role physicians could play in medical assistance in dying. I am pleased to see that in Bill C-14 explicit exemptions are also included for other types of health care providers, such as nurse practitioners, pharmacists, or other persons who would assist a medical practitioner or nurse practitioner with a request for medical assistance in dying.

● (2135)

This is responsive to the wealth of information received from representatives of nursing to pharmacist organizations in the course of various consultations.

Another important request that was raised by the medical profession was the need to respect the conscience rights of health care professionals who may object to providing medical assistance in dying. I would highlight that the bill makes explicit reference in the preamble to respecting the personal convictions of health care providers.

I will also note that the government has committed to working with the provinces and territories to support access to medical assistance in dying by connecting willing health care providers with patients. To me, this strikes an appropriate balance between supporting patient access or respecting the conscience rights of health care providers, as well as the jurisdiction of the provinces and territories.

Lastly, the medical profession, among other stakeholders, expressed a strong desire for a national monitoring system for medical assistance in dying. I am very pleased to see that Bill C-14 would empower the Minister of Health to make regulations to establish a federal monitoring system, with the associated requirements for health care providers who would be responsible for handling requests for medical assistance in dying to provide information for the purpose of that monitoring.

Several key stakeholders, and in particular disability rights groups, raised the necessity of robust safeguards to protect the right to life of every person in our country. This of course includes people who are ill, elderly, or disabled. Some national disability rights groups also indicated that stringent safeguards were needed to ensure the voluntary nature of a request for medical assistance in dying, free from any pressure or coercion, and based on informed consent, the heart of which was ensuring the patient had the capacity to make the decision in question.

The consultations that have occurred thus far, and the ones that will continue over the coming week, are crucial to ensuring we get this bill right. I am very much looking forward to the testimony that will be presented before the Standing Committee on Justice and Human Rights this coming week, a committee of which I am a member. I am eager to gauge the opinions of all sides of the debate on medical assistance in dying. I look forward to working with my committee colleagues to bring this bill back to Parliament and have a sound framework in place by the June 6 Supreme Court of Canada deadline.

Parliament has debated the issue of medical assistance in dying on several occasions over the past two decades. Each time, it was not able to support amendments to the Criminal Code to make this a reality for Canadians. The time has come to make this change. I believe this proposed legislation should be passed. I agree with the legislative background paper the Minister of Justice has tabled, and its statements that this proposed legislation strikes an appropriate balance between the autonomy of those seeking access to medical assistance and the interests of vulnerable persons in our society. I would urge all members of the House to support the second reading of Bill C-14.

● (2140)

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Speaker, I want to thank my colleague for pointing out that a few times tonight reference has been made to "when this bill gets to committee". It in fact is in committee right now, and the committee has started its work. I understand it has had four hours of study already, and it will continue that tomorrow.

My colleague referred to broad consultation a number of times. He referenced the expert panel. We have the expert panel report. Unfortunately, the Liberal government chose not to accept any recommendations from the expert panel. Therefore, we are somewhat limited with respect to broad consultation.

Also, in terms of broad consultation, a number of groups requested to appear before the joint committee that were not allowed to be present simply because of the time pressure. Therefore, to use the term "broad consultation" is a bit of a stretch. However, I certainly hope that in the next week of study at the justice committee there will be broader consultation.

My colleague referred to the fact that this should apply equally across Canada. I wonder if he would agree that if we can apply the access to physician-assisted dying across Canada, we could also at least ensure conscience right protection for physicians and other medical health practitioners, as well as institutions that offer health care, be applied equally across Canada.

Mr. Chris Bittle: Mr. Speaker, the consultations have been broad. The joint committee heard from over 60 witnesses and received over 100 different briefs. Over the next week, my colleagues and I will hear from 42 witnesses. We have yet to determine the number of briefs that we will receive, but I expect it will exceed the number of witnesses who we are hearing. We are getting a broad variety of opinions from faith groups, medical associations, individuals, and bar associations.

The other issue that my hon. friend brought up was conscience rights, and whether they can be enshrined. This is a Criminal Code amendment at its core. This law would not compel physicians to do anything. We have to respect the jurisdiction of the provinces and the provinces regulate medical professions and so do the independent colleges of physicians and surgeons and colleges of nurses, and so on and so forth. We have to respect the rights of the provinces to legislate in that regard.

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.): Mr. Speaker, the member for St. Catharines is right, that the process is not over. There are more people to hear from, more studies to be done, more details to be hashed out.

Would the member like to remind our colleagues what the results of not passing Bill C-14 would be? The Carter decision does not provide us a deadline after which the status quo remains. There are real world results for this being defeated. Would the member like to address the real world effects of this bill not passing?

● (2145)

Mr. Chris Bittle: Mr. Speaker, the Supreme Court has been clear. It has set for us a deadline of June 6 to pass legislation. This is not a matter of whether medical assistance in dying is to be legal; it is to establish a framework.

I am concerned that should we go forward there will be a vacuum in which there is no regulation. We must act. The Supreme Court has given us an extension of time. We have the time in which to do it. I know it may seem that we are a bit rushed, but we are willing to work extra hard on the justice committee to ensure it gets back to this place in the appropriate amount of time. However, it is imperative that we get this work completed, and get it to the other place so that vacuum does not exist.

[*Translation*]

Ms. Marjolaine Boutin-Sweet (Hochelaga, NDP): Mr. Speaker, earlier an hon. member talked about respecting provincial jurisdictions.

Does the government know how it is going to ensure that the practice will not be too different from one end of the country to the other? In other words, how will it prevent fragmentation while respecting provincial jurisdiction?

[*English*]

Mr. Chris Bittle: Mr. Speaker, I believe the bill is set up in an appropriate way that it would allow for the provinces to set up with their own colleges and with their own regulations on how medical assistance would be provided. As the hon. member knows, the provision of health care services in the country is the jurisdiction of the province. We respect that and the bill makes provisions for that. The minister has stated that she looks forward to working with the provinces to assist in a framework across the country.

[*Translation*]

Mrs. Sylvie Boucher (Beauport—Côte-de-Beaupré—Île d'Orléans—Charlevoix, CPC): Mr. Speaker, every one of us has their own story, experiences, destiny, and perspective on life and death.

However, no one, and I mean no one, can be indifferent to the bill we will soon be voting on. It is important to respect the personal and private opinions of all our colleagues on both sides of the House.

Just 15 years ago, we might never have had this discussion or this debate. Quebec paved the way with its end-of-life legislation. After more than six years of countless meetings and many discussions, and not without much debate involving all of society, members of Quebec's National Assembly passed the bill, which became a reality for Quebec.

One of my former colleagues in the House, the Hon. Steven Fletcher, introduced two bills on this issue in 2014, thus laying the groundwork for national reflection. In 2015, the Supreme Court also struck down the Criminal Code section that prohibits a doctor from assisting someone to end their life in very specific circumstances.

There is little time left before the Government of Canada puts in place a Canadian law to provide a framework for medical assistance in dying.

A special joint committee was struck, and six weeks of meetings, discussions, and testimony followed. The committee then tabled a report in the House of Commons. In response, a bill was drafted. Now we need to work together to make the bill law.

We must take Canadians' opinions into account. This is not a partisan issue. This is a social issue that should bring people together. First and foremost, we must protect the most vulnerable members of society. It is the Government of Canada's duty to legislate on this very difficult matter. This bill touches our core values. We will never achieve unanimity.

Even so, we have to address concerns that have been raised about a subject that is still sensitive and emotional for all of us. It is our duty to have a frank and open discussion to move the debate forward in response to the Supreme Court of Canada's request.

I think we need to set aside any emotions we might be feeling in connection with such a personal and sensitive subject. We must ensure that the legislation includes guarantees to protect the most vulnerable members of our society as well as the conscience rights of doctors and other health professionals.

As legislators, we must have an open discussion that respects who we are, and we must be free to vote in accordance with what we believe deep down.

We must also make some amendments to ensure that there is an excellent framework for this legislation.

We must respect the rights of the ill, but we must also respect the right of doctors to say no. There is currently a grey area that leaves room for interpretation by the provinces. We must be united as a country on protecting doctors, pharmacists, and institutions. I am talking about all health care personnel.

The Government of Canada must ensure that the people who make use of this legislation are making a clear and informed choice and have all of the information they need to make an informed decision.

There are some concerns, especially in the details of the bill, with respect to the fact that nurses have the same decision-making power as doctors in providing medical assistance in dying.

● (2150)

I remind members that Bill C-14 on medical assistance in dying is the government's response to the Carter decision. In this decision, the court ruled that people have a right to medical assistance in dying if they are adults, if they are suffering from a grievous and irremediable medical condition, and if they have given informed consent.

It is important to consider what “informed consent” means. It must be clearly defined, to ensure that the Canadian public is fully aware of what is involved.

We must also consider and propose solutions for people who want to live, in spite of their illness, and for those who want to be with their loved ones even though they realize they are at the end of their life. I think it is very important that we invest much more in palliative care.

We are talking a lot about medical assistance in dying, but I get the impression that in this debate members are forgetting about the most important thing, and that is the ill person. There is little or no reference to those who will never make use of this legislation.

On a more personal note, I too have had to think carefully about this issue. I carefully weighed the pros and cons. I looked to my own experiences for answers to my questions. I searched my past. I looked at myself in the mirror and thought about my views on life and death. I saw the face of my father, who was stuck in a wheelchair for over six years. Not a day went by when he did not shed some tears. How many times did he tell me that he would rather die than be there, paralyzed, unable to walk or be completely autonomous?

However, I also thought about the time when, of necessity, I ended up supporting my friend Rachel through the terminal stage of her illness. She had AIDS, but she wanted to live at all costs, despite the illness that was consuming her.

Then there is me, both a legislator and a human being, who must, in all honesty, reflect logically on what I myself would do if I were at the end of my life and had to make a choice. There is no obvious answer. However, I dislike aggressive therapy, and everything is already there in black and white.

This debate has forced me to think beyond death itself to accepting it and to the grieving process that is necessary either for the person involved or the loved ones.

The medical assistance in dying legislation is not perfect. There are some things that need to be redefined and a few amendments to incorporate, but we have to keep in mind that the Supreme Court is pressing us to pass legislation by June 6. That is why I am voting in favour of this motion, in order for the bill to go back to committee and for the committee, which is duly appointed, to study the provisions and ensure that all Canadians are protected. They are what matter most here.

● (2155)

[*English*]

Mrs. Celina Caesar-Chavannes (Parliamentary Secretary to the Prime Minister, Lib.): Mr. Speaker, I want to thank my colleague for her impassioned speech on this topic, and especially the examples of her father and friend. I thank her for sharing that with us.

I would ask my colleague to comment further on the importance of this legislation, in particular for other members of communities who are contemplating this important decision in their lives.

[*Translation*]

Mrs. Sylvie Boucher: Mr. Speaker, I think that this is a social bill. As I said, we must leave partisanship aside and listen to what Canadians want us to do as legislators. A lot of people have concerns about this bill because they do not believe it is sufficiently well framed. That is why if we are required to do this, I want it to be drafted in such a way that it respects all Canadians. This bill must include safeguards for those who are going to use it. Those safeguards are just as important for us, the legislators, but they are especially important for Canadians.

[*English*]

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Mr. Speaker, I thank the member for personalizing the conversation in relation to family members. It is appreciated.

Coming back to the issue of palliative care, I want to thank the Conservative members of the special committee who put a focus in their dissenting report on the importance of palliative care and the failure of successive governments to implement that.

I want to flag again the work that my colleague from Timmins—James Bay is doing on the palliative care issue and the fact that he was able to get the House to agree. It was a rare moment of close agreement a couple of years ago.

I am hoping that the member can talk a bit more about what steps the House and the government might take to bring some of those recommendations around palliative care to fruition.

[*Translation*]

Mrs. Sylvie Boucher: Mr. Speaker, I would like to thank my colleague for her question.

We are talking at length about medical assistance in dying, but the need for palliative care is also great. I used to provide support for people who were dying and suffering. We need palliative care so that people who wish to continue living despite the illness consuming them can live in a supportive environment where they are properly cared for and find relief from their illnesses.

Some of them want to live more than anything, whereas others want to die. We have to look at both sides of the coin. We should have this debate because it is not a partisan debate but rather a societal debate.

● (2200)

Mr. Gérard Deltell (Louis-Saint-Laurent, CPC): Mr. Speaker, we were very pleased and moved to hear our newly elected colleague, who has also served in other sessions. It is clear that she is experienced.

Are people in my colleague's riding talking about this issue? What are they telling her?

Mrs. Sylvie Boucher: Mr. Speaker, I would like to thank my colleague for his question.

Yes, they are obviously talking to me about this issue. I see both sides of the issue, and they are very well defined. When I visit the urban part of my community, people tell me that they are in favour of this bill. When I visit the rural part, people are starting to ask some good questions that make me think about the importance of representing both parties in this bill: the people who are at the end of their lives and the people who want to live. That is what is missing in this bill. Quite frankly, palliative care has been forgotten. Therefore, I am hearing one thing from the urban population and another from the rural population.

As legislators, we want a law that benefits all Canadians, whether they have the right to die or not.

[*English*]

Hon. Larry Bagnell (Yukon, Lib.): Mr. Speaker, I am happy to rise on this very important debate. It affects all of us, including my wife Melissa, my seven-year-old daughter Aurora, my four-year-old son Dawson, me, and everyone. Not all bills affect every Canadian, but this does. It is a very critical debate.

When this first came up in the House, I voted against it, because sadly there is much elder abuse in Canada, people who take advantage of those with less capacity. I encourage all legislatures, all four levels of government in Canada, all government workers, and all journalists to do everything in their power to work to eliminate elder abuse. That includes the protections needed in this particular bill.

I was also not comforted by what happens in some European countries with legislation. Many people are assisted in dying without their consent.

I have now been convinced by six items. First is the great care that was put into the protection provisions of this bill. There are two doctors or nurse practitioners, totally independent from each other, who are needed to approve the consent.

Informed consent is needed, and again at the time that the act will be carried out. The person must be suffering from intolerable pain. They must provide written consent. They must be in the process of dying, and there must be a 15-day waiting period.

There must be a five-year review of this bill, with the additions that many people might be suggesting during this debate.

Also, I have been convinced by the overwhelming support of my constituents who have contacted me, saying that people should have assistance in choosing the time to end their intolerable suffering.

I have also been convinced by the government's strong conviction, ensuring that there is good palliative care, so that the lack thereof is not what forces the choice of this other decision under this law.

I am also convinced by the cautious approach the government has taken to ensure that such a major life-and-death decision is done right.

Finally, I am convinced that there will be no sanction against health care workers who do not want to participate. I talked to a very experienced medical administrator who suggested that it could be up to 90% of doctors who would choose not to participate. For the provincial and territorial governments, that will provide an administrative challenge for those very small communities that may only have one practitioner.

I have asked my constituents, through the newspaper, to give me feedback. I received very heartfelt thanks and heartfelt views on all sides of this legislation, similar to what I am sure the other 338 members of Parliament have from many of their constituents. Of course, they were not all the same.

I have not had any bad experiences, as a number of MPs have had. However, I was moved by the sad stories of those who did, primarily with family members.

I remember a call from a mayor who told the story of the terrible suffering of a family member. It had gone on far longer than was ever needed. There was no benefit to the person. They did not want to be there.

I remember a call from another friend in a very similar situation. They exposed the myth that it was important not to do this in order to have family gathering together for a peaceful end. They outlined how that is a myth because at the end, in that particular case, the person was in so much pain and it was so distracting, the person did not want to or have the ability to see or gather with anyone.

I had feedback from another constituent whose father and other relatives had Alzheimer's disease. It was a terrible end that they did not want to have, and it could have been ended earlier.

Other constituents gave a large number of different views. One person said that if we allowed such suffering to go on in an animal, we would be charged. Another person talked about their husband who had a rapidly deteriorating disease. He wanted to die at home with family and could not. The doctor explained how that was not possible. They had a terrible painful experience in the hospital for their last few days.

● (2205)

On the other side of the issue, I had a nurse contact me who is totally against the bill and did not think we should proceed with it.

Then there were two views related to the people who are left behind in these situations. There were a number of people who, when in this terrible pain and suffering, did not want the suffering of their relatives and friends to go on. They wanted to terminate their lives so there would be no suffering left for their family and friends. On the other side of the coin, a person suggested we did not want to deny family and friends the wonderful ability to care for that person to the end.

Another person suggested that we have to make sure that all publicly funded health care facilities must allow this.

I also had a suggestion from someone who works with seniors, wanting an advance directive, similar to what is in the Yukon Care Consent Act for end of life that exists right now.

In summary, a majority of my constituents were in favour of assisted dying. Some were against it, like a woman from the small community of Haines Junction. Of those in favour, a number of them want some of the suggestions that people have talked about here today. Many were in favour of having advance directives. I would say that is the biggest amendment they would like to occur at second reading.

I want to close with a couple of suggestions for the committee to wrestle with. First is the advance directives. If people have a debilitating disease, they have to give informed consent at the very last minute, but they may not be able to, as they might not be in condition to do so, so it defeats the whole purpose. Perhaps it should be allowed only for those who are not capable at the last minute so that, as has occurred in the past, people with advance directives who in the end did not want them carried out are not taken advantage of.

The second biggest suggestion was related to the description of foreseeable future. On one side it may provide the flexibility that people want to make the right decision at the right time. On the other hand, it may not be enough definition. Medical workers want more definition, so they are not caught on the wrong side of a criminal law suit.

I had a student ask me an interesting question: what if a person suffering from an insufferable physical disease also has a mental illness and therefore could not give the informed consent? I am glad the committee will further study mental illness. I had a number of people suggest that mental health, Alzheimer's, and even mature youth need to be dealt with.

I want to thank my constituents and members of the House for this very non-partisan, thoughtful debate on this life-and-death situation for all of us. Hopefully, in the end we will find the combination that gives the most peace to the most Canadians.

● (2210)

[*Translation*]

Mr. Bernard Généreux (Montmagny—L'Islet—Kamouraska—Rivière-du-Loup, CPC): Mr. Speaker, my colleague gave an excellent speech. He described his riding, which is very big like mine. Actually, I think his riding is even bigger than mine.

Rural regions often have difficulty obtaining services. In my opinion, offering palliative care would be one way to make up for the lack of services available to people who need help at the end of their lives. I would like my colleague to talk about how increasing services and care at centres designed for that purpose fits in with this bill.

[*English*]

Hon. Larry Bagnell: Mr. Speaker, I definitely agree with the member. I am very happy that the minister is so committed to palliative care, which is an important part of this whole process, so that a person does not have to make a decision on assisted death just because good palliative care is not available.

My mother had wonderful palliative care in B.C., and I would hope that is available to all Canadians.

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Mr. Speaker, I would like to discuss further with the member the comments he has heard from his constituents around conscientious objection from health care providers and practitioners.

New Democrats in the all-party committee made a clear recommendation that no health care worker should ever be compelled to participate in assisted dying and that they should be legally shielded from unfair consequences resulting from that personal decision.

Despite my intention to support the bill at second reading and send it to committee, there is still concern that there are no legislative measures to enshrine that recommendation, although we are hearing from the government that it may be interested in non-legislative options.

I would be interested to hear whether the member has further ideas about which side of the regulation that issue might fall and whether he shares my concern that it would be better, for the sake of health care providers, to lock in those protections and guarantees.

Hon. Larry Bagnell: Mr. Speaker, none of the health care people I talked with were concerned that their protection was not in the bill, but I certainly hope the committee does look at it.

Mr. Sean Casey (Parliamentary Secretary to the Minister of Justice and Attorney General of Canada, Lib.): Mr. Speaker, I thank my colleague, the member for Yukon, for his remarks. Clearly, he has consulted widely through his community and through his riding.

There are a couple of points arising, one is with respect to medical directives.

There has been a lot of discussion around medical directives, but the international experience, certainly in the Netherlands, is that even where they are allowed, most of the time medical practitioners are reluctant to rely upon them; and so, we would be very much forging new ground in that regard in a very compressed time frame. Perhaps the member would like to give us some reflections in that regard.

The second point, I think, relates more to his riding; that is, in this legislation, there is something that is fairly unique to Canada, which is an enhanced role for nurse practitioners. The goal of the government certainly was, by allowing an enhanced role for nurse practitioners, to ensure access or to provide greater access for rural and remote communities. Perhaps the member would like to comment on whether that is important in an area like Yukon.

● (2215)

The Assistant Deputy Speaker (Mr. Anthony Rota): In 30 seconds or less, the hon. member for Yukon.

Hon. Larry Bagnell: Mr. Speaker, in 30 seconds I cannot deal with the advance directives other than to say it is very important that the committee deal with this in depth. That is why I am glad that, failing that, it will be taken up in the five-year review of the bill.

With respect to nurse practitioners, yes, in places like rural areas, there are huge, vast areas, larger probably than any country in Europe, that do not have a single doctor. So, nurse practitioners are increasingly playing a very important role. I think that is why the government included them in this legislation.

Mr. Alistair MacGregor (Cowichan—Malahat—Langford, NDP): Mr. Speaker, it is an honour to rise in the House today to continue the debate on Bill C-14.

I truly believe that this debate we are having, and the quality of the debate I have heard throughout the day, is going to be a watershed moment for our country. It is certainly going to be one for the history books, because through a charter challenge, the Supreme Court is forcing us as a legislative body, as a country, to fundamentally examine the meaning of life, the meaning of death, and how we as a society treat those two very difficult concepts.

Death is a hard subject to talk about. Humans have, for thousands of years, struggled with the concept and how we deal with it. Many of us turn to spirituality to find answers, and others are more matter of fact. In any case, the debate concerning life and end of life has reached Parliament's doorstep, and it is up to us as parliamentarians to carry the torch and do that subject the honour and justice it deserves.

As a rookie member of Parliament for the great riding of Cowichan—Malahat—Langford, I have been receiving correspondence from my constituents. I must say to the constituents who are watching the debate today that I have never been prouder to be an MP for their area. The tone in which they have written me, whether they disagreed with the legislation or supported it, has been incredibly respectful.

Of the concerns that I have seen from constituents, some want to see more protection for health care workers. They are concerned that freedom of conscience and freedom of religion are not respected enough in the legislation. However, others do not think that the bill goes far enough. They have looked at the ruling from the Carter decision and compared the provisions of Bill C-14 with it and have found it lacking.

I have heard other hon. members in the House say that, no matter what bill comes out at royal assent, they do see challenges in the future, but it is up to us as parliamentarians to do the best we can with the time we have.

Speaking of the bill, I am going to support this legislation at second reading, because I think we have something to work with. To do honour and justice to it, we must send it to committee so that we can have a more fulsome look at its provisions, and we can hear from witnesses. Furthermore, we must take the recommendations from the special joint committee and see if some of those recommendations can be adequately applied.

I support this legislation, because I believe in a patient-centred approach. I realize that my support of this legislation will cause some of my constituents distress. It is one of the challenges of being an MP. It is balancing the views of one's constituents with one's own personal values. This is the eternal struggle that each and every one of us finds in the House every single day.

However, I believe that, if we are talking about values, one important concept to look at is to not impose one's values on someone else, but to respect a person's values. If a person's values means that he or she is choosing a way out to end suffering that we as healthy people can only imagine, well then we must respect that choice. I fundamentally believe in that.

Looking at the Carter decision, the Supreme Court ruled that it had to be a competent adult person who clearly consents to the termination of life and has a grievous and irremediable medical condition, including illness, disease, or disability, which causes enduring suffering and is intolerable to the individual in the circumstances of his or her condition.

Section 7 of the charter says:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

The court found that the prohibition on physician-assisted dying infringed on the right to life, liberty, and security of the person in a manner that is not in accordance with the principles of fundamental justice, and that is why we are here today.

Of the recommendations of the special joint committee, there are three in particular that I want to look at. In a 10-minute speech, to look at all 21 is rather impossible, so I will start with recommendation 7, which dealt with advance directives.

● (2220)

There was a recommendation that advance directives be allowed, but unfortunately, Bill C-14 only makes mention of advance directives in the preamble. The preamble committed to exploring it, but there was no firm commitment in the legislation.

The other recommendation I want to look at is number 10 regarding freedom of conscience. The preamble, again, committed to non-legislative measures in this particular area. There is a template that the government could have followed. There is precedent in protecting freedom of conscience and freedom of religion. It goes all the way back to 2005 when Parliament passed the Civil Marriage Act.

For the reference of all MPs in the House, I will note that section 3 of the Civil Marriage Act states, “It is recognized that officials of religious groups are free to refuse to perform marriages that are not in accordance with their religious beliefs.” Section 3.1 says, “For greater certainty, no person or organization shall be deprived of any benefit, or be subject to any obligation or sanction, under any law of the Parliament of Canada solely by reason of their exercise”. There was a template and hopefully this is one area that the committee can examine further.

The other recommendation I want to look at is number 2. That was basically following the Carter decision. It states, “That medical assistance in dying be available to individuals with terminal and non-terminal grievous and irremediable medical conditions”. Unfortunately, the text of the bill, referring specifically to proposed paragraph 241.2(2)(d), reads, “their natural death has become reasonably foreseeable”.

This is one section where I do not know why the government wrote it in, because it goes against what the Carter decision specified and it goes against what the special joint committee recommended, yet it is here. I see nothing but problems with this. I see future charter challenges.

We owe it to Canadians to get this bill right the first time and not force people to go through the courts for several more years, only to have this legislation dumped back in our laps again. It is the same with advance directives. There will be people who get a diagnosis of dementia. We all know the end result of having Alzheimer's and they will ask why they are being excluded and why their advance directives are not being respected.

I would like to talk a bit about palliative care. I know it is a subject that has been talked about a lot in the House. The reason is that when this bill receives royal assent in June, it is going to be the law of the land. Palliative care is in such a sorry state in so many jurisdictions in Canada right now that I do not want Canadians to be living in a hospital bed somewhere with substandard care and thinking their only way out is to end their lives. That is why we talk about palliative care with such urgency, because once this bill becomes the law of the land, that is what some Canadians may think is their only option. We have to treat it with the urgency that it deserves.

I would now like to talk a bit about the great work that the member for Timmins—James Bay has done. It is very important to recognize that a previous motion in the House of Commons was passed with all-party support in 2014, yet here we are in 2016 still talking about it. I would love to have seen some firm dollar commitments in the budget. Until we see that, all we have is talk. We need an absolute pan-Canadian palliative care strategy. I was honoured to walk in the Hike for Hospice on the weekend in my riding. A great bunch of people in the community came out for it.

I would like to end on the concept of empathy versus sympathy. Up until this point, our country has had a sympathetic viewpoint on this whole issue and true empathy means that people step outside of just feeling sorry for people and actually perceive the world through their eyes. That is what this legislation aims to do, to see the world through the eyes of someone who is suffering from a condition. We have no idea what it is like and that is what everyone needs to be doing in this country, being more empathetic and trying to provide true support.

● (2225)

I will end there. I am thankful for this opportunity.

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.): Mr. Speaker, the member has added one more to a long list of excellent speeches here today from all parties. Congratulations on that.

There are many conflicting emotions and opinions for so many people on this issue. I want to congratulate the government for taking those different viewpoints, balancing them with one another and with the requirement of the court ruling, and coming up with this excellent piece of legislation.

Would I like it to go further? Yes, I would. Personally, I would like to see the right to assisted death by a living will—that is advance approval—included as the member referenced. I also know that not everyone agrees with that for a variety of completely valid reasons. Indeed, many of our colleagues would like this bill to be more restrictive on certain points.

I congratulate also the special committee on such tremendous work and on producing such a comprehensive report that looks at these substantial and substantive nuances and conflicts. In the context of all the circumstances before us, the government has done the best possible job of balancing all of these different perspectives to get this bill in within the imposed and very rapid deadline.

I wonder if the member agrees that even on the points where he may disagree, the government has achieved a real working compromise that moves us forward as a country on this extremely important issue, and that the risk of doing too much and then having it fail outweighs the benefits of having a bill that would do everything the more progressive among us would like.

Mr. Alistair MacGregor: Mr. Speaker, I will agree with the member that the timeline is not ideal. Here we are on May 2, and June is next month and that is the deadline. This bill still has to make it through committee, come back for report and third reading, and go through the Senate before the Governor General signs off. In that time, we have not had much time to do the proper work, but we have to deal with what we have.

As for the certain clauses that the member was talking about, I just wish that the government had listened a bit more and followed the special joint committee's recommendations. Specifically with proposed paragraph 241.2(2)(d), that was a glaring oversight. However, again I do welcome its going to committee and I hope we have amendments that do it justice.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, based on what the member and others have said, it seems there is a consensus emerging, at least from the different opposition parties, about the need to have clearer and better protection of conscience. The Liberals say this is important to them. Why not put it in the legislation, exactly as the member talked about, using the model of the Civil Marriage Act?

I would caution the member on putting too much stock in the special joint committee. I know the member was not part of that process, but my big concern was that there was a real bias in terms of the witnesses who were able to present and the witnesses who were not able to present. Just one example is that we had three separate panels from the organization Dying with Dignity. However, many intervenors on the other side of the issue, people who actually intervened in the Carter decision and presented to the federal expert panel, were not able to participate in the special joint committee. I understand, from what I have heard so far, that the justice committee is looking at a more balanced group of witnesses and I really appreciate that. However, I would caution the member to consider the process that led to that result, and hopefully we will see a more balanced group of witnesses from the justice committee.

On the issue of advance directives, the big problem with advance directives is that those are used in very specific situations where the outcomes and all the elements can be predicted in advance. The problem is that it is very difficult to predict what exactly will happen to someone undergoing one of these illnesses or how the individual will respond to it. I wonder if the member can talk about the problems of using advance directives when there is not certainty at all about the kind of process that a person is going to go through or how that person is going to experience that at that time.

● (2230)

Mr. Alistair MacGregor: Mr. Speaker, I recognize that everyone in the House to some extent has had personal experience with the loss of a loved one. For me, it was my wife's grandmother, who was suffering from dementia. Had we stepped back a few years with her when she was present and cognizant and if she had been able to peek into the future and look at what her life would end up being, she might have wanted a different path. It is very hard to witness someone going through that who has lost the mental faculty to make a decision on his or her own.

I agree with the member. It is a very thorny subject, but I believe it is one that absolutely deserves a closer look. Someone who has a diagnosis of dementia is going to look at section 7 of the charter and is going to say, “This is failing me.” He or she is then going to take it to the Supreme Court and I am pretty sure that the Supreme Court will rule in that person's favour. It is up to us to grapple with this issue now.

Mr. Kyle Peterson (Newmarket—Aurora, Lib.): Mr. Speaker, I rise tonight to comment on Bill C-14. Before beginning, I want to commend all members of the House for so far treating this debate with the sensitivity it warrants. This is without doubt an issue that evokes much passion on both sides of the issue. This debate at its essence pits the sanctity of life against the inherent autonomy of the individual. I think it may be a worthwhile exercise to go back in time, not just a little but back a few decades so we can attempt to put the current debate into some legal context.

The common law crimes of attempting suicide and assisting suicide were codified in Canada when Parliament enacted the Criminal Code in 1892. Eighty years later, in 1972, the House repealed the offence of attempting suicide from the Criminal Code based in part on the argument that a legal deterrent was unnecessary in those circumstances. However, the prohibition on assisting suicide remained. This prohibition is found currently in section 241 of the Criminal Code. This in my opinion is the fundamental shortcoming of our current law.

Currently, able-bodied Canadians can take their own lives without any legal consequences. Those who physically cannot are currently discriminated against from doing so. This brings us to Carter, a unanimous decision of the Supreme Court of Canada that overturned the 1993 case of Rodriguez. Carter holds that, among other things, the Criminal Code prohibition against assistance in dying found in section 241 is unconstitutional on the grounds that denying disabled people the right to assisted suicide is contrary to the Charter of Rights and Freedoms.

The current legislative prohibition found in the Criminal Code was held to be over broad in that it prohibited physician-assisted death for a competent adult person who, first, clearly consents to the termination of life, and second, has a grievous and irremediable medical condition including an illness, disease, or disability that causes enduring suffering that is intolerable to the individual and the circumstances of his or her condition.

This leads us to where we are today. The court decision requires strict limits that are scrupulously monitored. This government is proposing a framework that considers different interests, including personal autonomy toward the end of one's life, the protection of vulnerable persons, and conscience rights, all values that are deeply important to Canadians across this country.

The debate regarding medical assistance in dying is important to each and every one of us for different and for deeply personal reasons in many cases. For all Canadians this is a difficult and profoundly sensitive issue tied to their life experiences and personal beliefs.

I have heard many of my constituents share with me their opinions on the bill, some of whom face difficult and sometimes unimaginable health challenges. Just today, I received an email from a woman in my riding suffering from a slow-moving form of ALS. Gradually this horrible disease has taken her voluntary muscle control, making it difficult for her to sign her own name, to speak, and to even form the most basic sentences.

In her own words to me she describes the situation as thus, “Our hearts continue to pump. We are aware of everything happening to us and around us, but become unable to do the simplest things for ourselves. We cannot predict our lifespan”. She urged the House, through me, to reconsider the issue of advance directives. This is one Canadian who will be directly impacted by Bill C-14, one Canadian of many.

● (2235)

Members may ask why I relay this story. It is because Bill C-14 clearly states that a requirement for assisted dying must be that natural death is within the reasonably foreseeable future. For many Canadians, suffering and looking toward the future of only further pain and suffering, there is no clear, distinguishable path to death, but this should not diminish their choices. For some, without this choice in the future, it can feel like a loss of comfort, a loss of safety and a loss of autonomy.

Additionally, this past weekend I had the opportunity to sit with a few of my fellow members of Parliament from York region to listen to important concerns and questions relating to Bill C-14. With an open mic, this event not only provided the opportunity for the participants to express their views and opinions on medically assisted dying, but also allowed me a great opportunity to meet and discuss on a more personal level with the people in my community who would be directly affected by the results of this debate.

While these discussions are important, it is equally important that a person does not come to end-of-life decisions lightly. Oftentimes the decision follows years of personal deliberation and what I can only imagine would be the most difficult conversations of a family member and those closest to them.

For these reasons and many others, Bill C-14 cannot and should not be taken lightly. While there will always be those who believe the bill does not go far enough, others believe it goes too far.

The Supreme Court of Canada unanimously decided that Canadians suffering intolerably had the right to request assistance to end their suffering. The bill respects that decision. However, I would encourage all members to engage with their constituents on this important matter and bring that informed advice to committee.

Medical assistance in dying represents a significant change in the Canadian medical landscape, and this government has conducted consultations with many experts. Physicians have indicated that they would be most comfortable providing this option to patients approaching death as another option alongside palliative care, withdrawal of treatment or palliative sedation. These options are all individually important and are woven into the bill to ensure that patients are served and equally protected, as well to limit any risks to the physician.

As this government engages with the provinces and territories to support the development of a pan-Canadian monitoring system to collect and analyze data, monitor trends and publicly report on medical assistance in dying, I ask that we all take time to consult with our constituents.

While I am open to the government's Bill C-14 and will support it to move it to committee, I do feel some amendments may be necessary. We, as legislators, are not doing our jobs if we are not open to continually hearing from Canadians and engaging in meaningful consultations and dialogue, especially on an issue as important and fundamental as this one.

I urge all members to also support the bill. I thank the Speaker for allowing me to rise to speak on such an important topic and share my perspective.

● (2240)

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, the member talked about the possibility of amendments. I would like to suggest one amendment and hear his comments on it.

We have these criteria in the bill, but the criteria only mean something if there is some kind of assessment in advance. If the only assessment of each case is retrospective, then there is very little way of adjudicating if someone is actually meeting the criteria. There is no way of protecting the vulnerable, because even if there is some suspicion of a problem, the person is already dead.

Our first priority should be to protect people who do not consent, who do not want this, from being pushed into it.

Would the member agree with me that a simple system of advanced, legal review by some kind of cognizant authority is necessary to ensure that people who do not consent do not have their lives taken inadvertently? It could be a judge, or a consent and capacity board, and the model could vary from province to province.

Mr. Kyle Peterson: Mr. Speaker, we have a rare opportunity to hear from the member for Sherwood Park—Fort Saskatchewan, and I appreciate his question in this House. It is an important question.

I think everyone here agrees that we would all be very disappointed if we enacted a law that resulted in people having their lives terminated without their consent. I agree with the member that, as long as the mechanism in place could still be processed quickly without further suffering to the patient, it is a safeguard that should be in the system. We want to ensure that we are aligned with the Supreme Court that the patient consents to the termination of his or her life. I am happy to support whatever we need to do to ensure that is in the legislation.

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Mr. Speaker, although the hon. member for Newmarket—Aurora is not in the position of being a parliamentary secretary or a minister, as a member of the majority Liberal government my question to him is this. Does he have any sense of whether the committee will be open to amendments and whether the governing party will allow amendments?

I have had the very depressing experience today of watching Liberal members being forced to vote for a motion that I pleaded them not to vote for. It is the first time I have had a very strong sense that perhaps the respect for individual members of Parliament and the ability to bring amendments at committee, reflecting the will of the committee, may be more circumscribed than I would have hoped.

Mr. Kyle Peterson: Mr. Speaker, the member is correct that, like her, I am not a minister of the crown or a parliamentary secretary. However, like her, I am a Dalhousie law graduate and have a complete respect for the legal process. I think, for the legal and law-making processes to work well, committees must have the ability, the power, and the capacity to make amendments when that is the will of the committee or the House. I trust and I have faith in the justice committee that it will be not only willing but able to do so at the committee stage.

Mr. Martin Shields (Bow River, CPC): Mr. Speaker, I appreciate the member's contribution to the discussion this evening. One of the challenges I find with this legislation is from my past experience when I was on a board that was attempting to design do-not-resuscitate orders with doctors. It took us a couple of years before they finally agreed to it, and it turned into four levels, not one, of do-not-resuscitate orders. What we then found was that the doctors still found a way to not implement them. They said that we as a board had decided on the policy but that they did not want to implement it.

My question to my colleague is this. We have 10 different provinces and territories. How will we deal with a profession that really does not want to implement this particular process?

Mr. Kyle Peterson: Mr. Speaker, I do not necessarily share my colleague's pessimism with respect to the ability of our provinces to implement processes that may or may not be derived at the federal level. I also do not necessarily agree that they may not want to implement them. If there is a robust consultation system in place with the provinces, the medical associations, and the health professionals in all of the provinces, by working in consultation, knowing full well that whatever process is in place has to be in line with the Supreme Court of Canada, I am convinced and optimistic that we will be able to come up with a reasonable process that ensures that doctors and health professionals are protected, and that the rights of the patients are protected at the same time.

● (2245)

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Mr. Speaker, I appreciate the respectful tone and the way in which all members in this place are approaching an issue which I know could divide us. It touches on the sanctity of life, on issues of great importance to all of us, and on the question of human suffering that so distresses all of us. It interprets a Supreme Court decision. Bill C-14 is a bill that requires a sobriety, a sensitivity and a respectful dialogue as we approach it.

Other members have reflected on what they have learned from their constituents. I need to share the story of what happened to me when I became the member of Parliament for Saanich—Gulf Islands. I was someone who would not have been comfortable with this bill. My constituents may be the most active group of people working for Dying With Dignity.

There are two Dying With Dignity chapters in Saanich—Gulf Islands. I was visited by members from the Salt Spring Island chapter. I was visited by members from the Victoria chapter. Over time, I realized that perhaps my riding had been sensitized to this issue, because Sue Rodriguez lived in my riding.

Her death in 1994 touched all Canadians, as we realized that she tried so hard to get relief from the courts, permission to have a medically assisted death. In the end, it was not possible through the legal system. We all remember her quite courageous and tragic death.

At the time of the court telling Sue Rodriguez that she could not find access to legal medically assisted death, she said, “If I cannot give consent to my own death, whose body is this? Who owns my life?”

These are profound questions that hang in the air still. Some of us might answer that none of us own our own life, that our lives belong to the creator. Some of us may say whatever one believes, each of us has the right to make our own decisions. Those people who might believe one aspect through faith have no right to deny someone else the decision that he or she wants to take, to plan for a death with dignity.

In the course of listening to my constituents, particularly through a series of town hall meetings over the last five years, and through questions and comments that have come to me through the mail, I became persuaded that my job as their member of Parliament was to support access to medically assisted death.

Then my life experience as a lawyer kicked in, and I was very relieved when the Carter decision came down. I thought that at long last we now had legal clarity on this matter, and that Parliament could begin to resolve the issue through the work in Parliament. The issue has been through the courts so often that I felt that we were now in a position as lawmakers and legislators to deal with the decision in Carter.

Just to remind members, the Supreme Court said that the Criminal Code sections that prohibited physician-assisted death violated section 7 of the Charter, and therefore:

> ....are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

The court was clear in this decision that we were not speaking of any possibility that one person could make a decision for medical assistance in dying for anyone else. This is a personal decision. The Supreme Court has said that a competent adult person can make this determination. What the court set out as the conditions that would justify medically assisted death was a grievous and irremediable medical condition.

I was disappointed in Bill C-14. I felt, after looking at the report of the special committee, that the legislation would likely anticipate where the court would go in future rulings, and avoid protracted court cases as Canada figured out how we would accommodate medical assistance in dying.

● (2250)

The bill, in not fulfilling even the conditions set out in the decision of the Supreme Court in Carter, would lead to more litigation and more suffering for people who now see that the Supreme Court of Canada has said that to suffer in situations like this violates their charter rights. If we pass Bill C-14 as it is currently drafted, Parliament would be denying them their charter rights going forward.

Other members of Parliament have mentioned this. We know that the legislation is attempting to balance very difficult issues to ensure that there are robust safeguards—and we have had conversations about whether they are sufficiently robust—the sanctity of life, and the protection of vulnerable persons.

This bill is close to getting it right, but where I am really baffled is in the decision not just to say “irremediable” but to insist, as others have noted, that one of the conditions in section 241.2(2)(d), is that their natural death has become “reasonably foreseeable”. I am afraid that is quite baffling, given what the Supreme Court told us we must do. The “irremediable” situation was not described as incurable or terminal. That is a deficiency in the legislation and one that will not just disappoint people who are suffering, but also calls into question the wisdom of this place in interpreting the Supreme Court of Canada's decision to protect charter rights.

Many have spoken about this second area as well. As I read it I thought that this cannot be right, that this must just to be bad drafting, that they cannot mean this. In going through all the conditions, yes, there are safeguards there. There are independent medical practitioners, more than one, and there is not undue influence of any kind. Not to go through every element of it, but as we have to go through quite a protracted process to make a legal declaration, and it would be fulfilled by independent witnesses, one has to go through all of this and then, after all that, at 241.2(3)(h) we find that immediately before providing the medical assistance in dying, the person would be given the opportunity to withdraw the request, ensuring that the person gives express consent to receive medical assistance in dying.

This is gravely disappointing. Those who take the decision that they want medical assistance in dying are now denied that, if their situation is one where we cannot reasonably foresee their natural death and where at the moment they have planned for and gone through this protracted process to ensure that they would have medical assistance in their death, now must be of sound mind to reassert and have the capacity to reassert that they have confirmed this is what they wish. This would surely deny many groups of people who would look to the court decision in Carter as their way of knowing that they would have the right to choose to die with dignity with the assistance of a medical professional.

Many have mentioned these deficiencies in Bill C-14. There are others that have been raised by the British Columbia Civil Liberties Association, as a co-litigant in the Carter case. I am not out of sympathy with those, but perhaps those could wait for another time.

I do not see how Parliament could decide to wait for another time in ensuring that the legislation we pass now is in conformity with the instructions we received from the Supreme Court of Canada.

Calling on my background as a lawyer, as well as my commitment to my constituents, I look at Bill C-14 and ask how we could pass something that would once again be found by a court to violate section 7 charter rights for those Canadians who have met the test in Carter, but would fail the test in Bill C-14. It is an enormously difficult question.

I have enormous respect for all the voices I have heard in the House in this debate at second reading. I will vote for the bill at second reading, but I hope we are prepared to fix its deficiencies in committee.

● (2255)

Mr. Sean Casey (Parliamentary Secretary to the Minister of Justice and Attorney General of Canada, Lib.): Mr. Speaker, I always appreciate the thoughtful remarks from the member for Saanich—Gulf Islands.

However, I want to push back a little on her suggestion that this is bound for unsuccessful litigation and ask her these three questions. Would she agree that the court in its decision did not define “grievous and irremediable”? Would she agree that it was open to Parliament to provide such a definition? Would she agree that at page 98 of the decision, the Supreme Court said it would give a great degree of deference to any complex regulatory scheme that is put in place by Parliament to respond to the decision?

Ms. Elizabeth May: Mr. Speaker, I return the compliment to my friend, the member for Charlottetown and parliamentary secretary. I enjoy working with him as well.

However, in answering his question, while the court did not define “grievous and irremediable”, it is a logical leap, which I will not take, to imagine that the court was not considering the specific case in front of it. In other words, the case of Kay Carter dealt with someone who was in a grievous and irremediable situation, but her natural death was not foreseeable at that moment. The facts set before the court that led it to make this ruling was that there was a violation of charter rights, not in the abstract, but for the plaintiff, the litigant, before them. It described her condition as “grievous and irremediable”. In that, it did not insist that we know or that her doctors know that her natural death was foreseeable. In other words, the facts set in this case did not require a terminal illness.

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Mr. Speaker, I want to thank my colleague for her thoughtful remarks, although I may disagree with her on some of her conclusions.

Would she agree that there needs to be better protection within the legislation to ensure that should their conscience not allow medical or health care practitioners who are providing end-of-life care to go down that path, that they should have the freedom not to participate?

Second, in terms of the potential future of this regime, in whatever form it ends up taking, is she concerned at all about the impact on the potential lack of trust between patient and doctor? What would this do to the patient-doctor relationship in terms of trust, especially for those who are elderly, who may be facing end-of-life decisions?

Ms. Elizabeth May: Mr. Speaker, I do not think there is any dispute—well, I should not say there is no dispute—between the hon. member and myself. It is only right that a health care professional would have the ability to say that they would not want to assist in a situation like this.

As for whether I think this would call into question the relationship between a patient and their doctor, I do not see that it would. I believe that doctors who are not prepared to assist in this way will make a recommendation to the patient that they find somebody who is prepared to do it. They know they need to get independent medical advice from more than one medical professional.

I have great respect for the medical profession. I cannot imagine the medical profession urging someone to consider an option such as medical-assisted dying if that is not something the individual, on their own, has chosen because they are in a situation of grievous suffering and they wish that for themselves. I do not see it contaminating the doctor-patient relationship.

● (2300)

Mrs. Celina Caesar-Chavannes (Parliamentary Secretary to the Prime Minister, Lib.): Mr. Speaker, before I begin, I would like to acknowledge the Minister of Justice, the Minister of Health, and the parliamentary secretaries and their teams for their work on this important legislation, and to thank them for their efforts. I would also like to thank the chair and members of the Special Joint Committee on Physician-Assisted Dying, the witnesses they heard from, and the countless Canadians who took part in consultations right across the country. This is not an easy topic for discussion, and I commend all involved for their thoughtful, compassionate, and thorough work.

The Carter decision set out a clear objective for parliamentarians to come up with a legislative framework that allows Canadians who are suffering intolerably the right to request assistance to end their suffering. Bill C-14 is the government's answer to this critical objective, and I stand here today, proud to support this important legislation.

I have heard from constituents on both sides of the issue, some who flatly oppose allowing any access to medical assistance in death, and others who believe the legislation does not go far enough. I have also heard from people who applaud the thoughtful work on this bill and have reached out to me to express their gratitude.

In this regard, it is important to note and to reiterate what has been mentioned many times in this chamber. With this legislation, our task was not to determine if physician-assisted dying was necessary, but to determine how best to move it forward. This is an important consideration and one that is worth repeating.

Of paramount importance to me in reviewing this bill was to determine if it properly considers different interests, including balancing the right to personal autonomy at the end of life with the need to ensure robust protection for the most vulnerable in our society. I believe that this legislation achieves this balance and that it rightly takes the necessary steps to ensure that the rights of all are respected.

With respect to personal autonomy, this legislation responds to the objective mentioned earlier that was provided to us by the Supreme Court of Canada, that Canadians who are suffering intolerably have the right to request assistance to end their suffering.

I am not a lawyer, and as such will not speak to the legal ramifications of this bill. As well, I cannot speak with authority on the constitutional nuances of this bill. However, as a person of faith, it was critically important to me that subsection 2(a) of the Charter of Rights and Freedoms, which grants Canadians the freedom of conscience and religion, was considered and protected.

A couple of weeks ago, I had a meeting in my office with members from the St. John the Evangelist Catholic Church in Whitby. While they understood that the objective for us in this chamber was to come up with a legislative framework for medical assistance in dying, they were gravely concerned about protecting the conscience of medical professionals. They wanted some assurance that the conscience of the health care provider was protected.

Balancing the rights of medical providers and those of the patient is generally a matter of provincial and territorial concern. However, our government is committed to working with the provinces and territories to explore options to facilitate access and care coordination while recognizing the personal convictions of health care providers.

Having worked in health care based research for the bulk of my professional life, I have had the opportunity to work closely with health care professionals in a variety of capacities. It is very important to me that any legislation put forward respected the rights and personal convictions of care providers. I am very pleased to see that this legislation makes mention of this while acknowledging that safeguarding those convictions requires an ongoing conversation with the provinces and territories.

● (2305)

The robust considerations and protections for the most vulnerable in our society inherent in this legislation are also of particular importance. This legislation sets out the criteria for the determination by medical professionals as to whether or not a patient suffers from a grievous or irremediable medical condition. These criteria include that they have a serious and incurable illness, disease or disability; are in an advanced state of irreversible decline in capability; the state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and that their natural death has become reasonably foreseeable.

As a mother of three children and MP for the bedroom communities in my riding of Whitby, I was pleased that the legislation also includes strict eligibility requirements that protect minors. Careful thought and consideration are required to understand and assess a minor's ability to make a decision involving the termination of his or her life. I applaud the decision to further study this aspect of the legislation and look forward to being actively involved at that time.

Additionally, this legislation would ensure that those who make a request for assisted dying do so without coercion, having provided informed consent, and given the opportunity to, at any time and in any manner, withdraw their consent. These safeguards are fundamental to Bill C-14. The bill provides safeguards to ensure that individuals can remove consent. The requirements that the request be voluntary and that the person must decide for himself or herself that he or she wants medical assistance in dying is as equally important as the requirement to have the ability to remove consent.

I am proud that this government has listened to stakeholders from across the country and has committed to ensuring that all Canadians have access to quality end-of-life care, including palliative care. Our $3-billion commitment to improving and expanding access to home care is another critically important step and I look forward to seeing continued progress on this vital portfolio in the months ahead.

Finally, I would like to thank and acknowledge my colleagues in the chamber for the thoughtful, measured, and respectful tone struck during this debate. This is not an easy topic of discussion. It is one that challenges us to examine our fundamental beliefs about life and death. I commend all for their work on this file.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, it is good to hear the member talk about how she sees the protection of conscience as very important, but I would simply ask, why not protect it in the legislation? There is, of course, a precedent for this. We have talked about the Civil Marriage Act including protection for conscience at the federal level. A similar model could be used.

Essentially, what we are being told by the government is that we are talking about it, so why not just take the government's word for it. Taking the government's word for it just is not good enough. We want to see conscience protection included in the legislation.

Also, does the member clearly understand that the protection of conscience includes the right to choose not to refer? There has been some confusion about that by some other members. Respecting an individual's conscience includes the right to not only not provide a service but to not be complicit in providing the service by using a formal referral. Physicians do not have an objection to providing information, of course, and facilitating the orderly transfer of records, but there is a big difference between that and a formal referral. I would appreciate the member's comments on that as well.

Mrs. Celina Caesar-Chavannes: Mr. Speaker, with respect to the right of a physician not to refer, as I said in my comments, this is for the provinces and territories to determine, with the help of the government, to respect the conscience rights of physicians.

The question about referrals did come up in my riding. Many were concerned about that. I hope that consideration is part of an ongoing conversation with the provinces and territories and medical professionals.

● (2310)

[*Translation*]

Ms. Marjolaine Boutin-Sweet (Hochelaga, NDP): Mr. Speaker, given that the member is the Parliamentary Secretary to the Prime Minister, does she have any more information she can give us regarding the funding that will be allocated to palliative care?

As she knows, no funding was allocated for that purpose in the latest budget, nor are there any new commitments set out in Bill C-14. Can she give us a little more information in that regard?

[*English*]

Mrs. Celina Caesar-Chavannes: Mr. Speaker, as the Minister of Health has stated many times in this House, she is in constant dialogue with the provinces and territories to renew the health accord. There is a commitment of $3 billion in the budget to look at end-of-life care, including home care and palliative care.

Mr. Garnett Genuis: Mr. Speaker, as a follow-up to my previous question, to put a finer point on it, the current policy of the College of Physicians and Surgeons of Ontario is to require referral if something falls within the standard of care, or in an emergency or urgent situation, to actually require the provision of that service. This is not something that can wait for further consultation, because if this legislation passes, then right after June 6, or whenever this would take effect, it would be required in Ontario for physicians to either refer or potentially to provide this service.

If the member accepts the value of protecting conscience, recognizing that this could be the reality and the outcome in her riding once this legislation passes, would she not support immediate changes to this legislation which formally and directly would ensure the protection of conscience in that legislation?

Mrs. Celina Caesar-Chavannes: Mr. Speaker, I do respect the fact that there are jurisdictional boundaries with respect to what we can and cannot legislate. The provinces and territories have jurisdiction over this particular aspect and the government will continue to work with the provinces and territories to ensure that the conscience rights of our medical professionals are taken into consideration with respect to this bill.

[*Translation*]

Mr. Luc Berthold (Mégantic—L'Érable, CPC): Mr. Speaker, this evening, I have the pleasure of being here with my colleagues to speak about the bill on medical assistance in dying.

This is a major issue and I must admit that it gave me a greater understanding of my new role here as the member representing the people of my riding, the new role that I am playing in the House of Commons for our country.

From the beginning, there has been a lot of talk about the budget, transportation, deficits, terrorism, and all sorts of other topics that are all equally important to our country. However, rarely does a bill generate as much uneasiness and discomfort among our constituents as the bill we have before us today.

Not a day has gone by since January that I have not spoken about medical assistance in dying with the people of my riding of Mégantic—L'Érable. Quite honestly, I expected people to give me strong, clear answers. However, it has been quite the opposite. After speaking with people even for just two or three minutes, I have seen that they know how important this issue is, but they hesitate to voice their opinions on it.

I think that, as a member of Parliament, my role is to take a position in accordance with my values and beliefs, all the while representing the will of those who did me the honour of electing me to Parliament.

I must say that I have not yet made up my mind about this issue. Every time I find myself leaning to one side, I hear arguments that make me once again question my views.

This is a complex issue that touches people's hearts and strikes at the very core of their values. A bill about medical assistance in dying is not like any other bill. This is a bill that makes us take a look at ourselves and our lives. We immediately think about our parents, our grandparents, our brothers, our sisters, our friends, and ourselves. Suddenly, a bill that is being discussed in Ottawa, far from my riding, becomes something very personal to the people I talk to.

Allow me to give an example. How would we react if one of our loved ones was suffering at the end of their life and their last moments were unbearable? Most of us have had experience with this. We have been in this type of situation, supporting a loved one at the end of their life. Most often, these people we care about are suffering from a cancer that can cause horrible suffering. No one, absolutely no one, wants to see a loved one suffer.

I want to share my own experience. My father died of throat cancer after a difficult eight-month battle against this terrible disease. He was not even 50 years old. Those were difficult months. I think that we all went through something similar in our own lives, when we had to support someone we loved dearly through a very difficult time.

When that stage begins, we do not realize that it is the final stage of that person's life. When doctors set out to treat that person, we do not expect it to be the beginning of the end, so we begin a healing process with our loved one, and we work hard with that person because we love them and we want to fight and win the war on cancer.

At the end of that war, when my father knew that medicine could do nothing more for him, how would I have reacted if someone had suggested ending his life? I do not know because I was one of the last people in my family to tell him he could let go and give up the fight. I did not want him to go even though I knew deep down that it was the only way out for him.

Fortunately, my father received palliative care that minimized his suffering in his final moments. My mother and my brother showed great courage. They were by his side in his final moments because they lived in the same city. I was farther away and saw him on weekends. All of those people and his family members were by his side until the end.

● (2315)

I am certain that he is looking down on me today and that he is very proud to see me here in the House of Commons. My story is that of thousands of Canadians. It is the story of our will to live, and it is the story of our relationship with death.

Soon, I will have to vote on Bill C-14. I will have to decide how our country will respond to the Supreme Court decision that gives some Canadians the right to choose medical assistance in dying. I will repeat that I have not yet made my decision.

I recognize that people who are dying must be able to die with dignity. Dying with dignity does not necessarily mean obtaining medical assistance in dying. Dying with dignity means being able to die surrounded by your loved ones whenever possible, receiving medical treatment that is respectful of one's last moments and, above all, not suffering too much.

I was shocked to learn in the course of the legislative process that not all Canadians have access to palliative care. More than 60% of Canadians who are dying will not have the support required to take this last step in dignity. Even before I take a stand on medical assistance in dying, I believe that we have a duty to change this.

I hope that the goal of members of the House is not to do everything they can so that as many Canadians as possible choose to make use of medical assistance in dying. In fact, I am convinced that it is not. The Supreme Court has ordered us to quickly regulate the use of medical assistance in dying and to set parameters for the entire process. Which Canadians will be given access to medical assistance in dying? How will the most vulnerable members of our society be protected? Who will help the sick people and authorize the use of medical assistance in dying? How will the people who are involved in the dying person's choice be protected?

Over the coming weeks, I am going to show Bill C-14 to my constituents. In a few days, I am going to set up a meeting with a community organization in my riding called Le Havre, which is an aid and support group for people with mental health problems. We are going to hold a round table to talk about medical assistance in dying, the end of life, and people's decision-making abilities. I hope that these discussions will give me a better idea of the choice that I should make in a few weeks.

Fortunately, although it was definitely short on time, the Special Joint Committee on Physician-Assisted Dying managed to ensure that we heard from many groups and citizens to gather their views. I did not attend all the meetings, in fact I attended only one, but it made an impression on me. I will come back to that later.

I want to thank all of my colleagues in the House and the Senate who contributed to the work of the committee. There is no single response to the Carter ruling, because no two situations are identical. The goodwill of everyone allowed parliamentarians to consider two reports, including a dissenting report tabled by our colleagues, the members for Louis-Saint-Laurent, Langley—Aldergrove, Kitchener—Conestoga, and St. Albert—Edmonton. I am pleased that Bill C-14 takes a lot of inspiration from my colleagues' report, because it more closely reflects my concerns at this stage in my own personal thinking.

As I already mentioned, this is not about a race to allow medical assistance in dying. We need to make sure we protect Canadians' charter rights, whether that involves seeking medical assistance in dying or protecting those who will have to face that difficult choice, whether they want to or not, in the coming years. In the current situation, I think Bill C-14 should have been based more on the dissenting report, because the bill does not go far enough to protect vulnerable individuals, their families, and health professionals. What are its main principles? As my colleague from Louis-Saint-Laurent mentioned earlier today, it is about the protection of minors, people with mental illness, and the conscience of doctors and other health professionals.

The bill should apply only to people who are at the end of their lives. The option to receive palliative care is also important to Canadians. Steven Fletcher mentioned something to the joint committee. He said, “The further you move away from the Carter decision, the more likely it is that you're going to step into provincial jurisdiction. When you make that step, I predict you'll go into constitutional darkness, never to be found again.” We have to make the right decision, an informed decision. I think that the dissenting report shows us the way. Soon I will have to take a stand, and I hope that my constituents will help me with that.

● (2320)

[*English*]

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): Mr. Speaker, I appreciate the comments by my friend across the way, but I am confused about the emphasis on palliative care with the deadline that is presented to us, which is June 6.

If we were going to venture into palliative care and incorporate it into the legislation, we would have to have talks with the provinces that would actually be delivering the palliative care. The first thing we would have to do is define what proper palliative care would be, and that would become confusing because in some cases there would be family members available and in other cases there would not. I had a case in my own family with two grandmothers over 100 years of age whose children were in their eighties. I am not sure whether a definition could incorporate them into that.

Given the deadline we have and the involvement with the provinces, how would my colleague suggest that we possibly approach the palliative care question?

[*Translation*]

Mr. Luc Berthold: Mr. Speaker, in an ideal world, we would have the time to do things in order. Unfortunately, the Supreme Court imposed a deadline. I think that the choices when it comes to end of life are comprehensive choices. We cannot just offer people medical assistance in dying without also offering them the possibility of dying gently, with dignity, and with palliative care. We must offer both options to Canadians.

As to how to do that, it is a judge who decided to force our hand and make us proceed more quickly. We must do everything in our power to make palliative care available. It is our duty as members of Parliament.

● (2325)

[*English*]

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, with respect to palliative care, one of the proposals we have heard is to have a right to palliative care put into this legislation. We could not fully operationalize it today, but we could introduce a right that people could expect to have. That would fit really well with this.

[*Translation*]

This bill provides no conscience protection for doctors and nurses. If Parliament supports this bill, doctors in Ontario will not be able to opt out of performing euthanasia, and it is possible that some doctors will leave the profession. I urge the government to include conscience protection for doctors in this bill.

Does the hon. member agree with that?

Mr. Luc Berthold: Mr. Speaker, obviously, we cannot ask anyone to go against their values. We cannot force a health care professional to participate. As stated in the dissenting report, the act must protect the freedom of conscience of doctors, health care professionals, and all those who will be called upon to participate in this process.

That is an excellent question, and the answer should be obvious. I do not see how the opposite could happen, unless there was a new case before the Supreme Court because we would have unfortunately failed in this exercise.

[*English*]

Mr. John Aldag (Cloverdale—Langley City, Lib.): Mr. Speaker, I rise in the House today in support of Bill C-14, an act to amend the Criminal Code and to make related amendments to other acts, also known as medical assistance in dying. In January, I was appointed to the Special Joint Committee on Physician-Assisted Dying and I was honoured for the opportunity to be part of this important discussion in Canadian society.

Over the span of a couple of months, my fellow committee members and I spent a lot of time working to understand the complex issue of medical assistance in dying. We discussed, we debated, and we even disagreed on a few issues, but in the end we drafted a report that I thought was the best possible solution for this complex social and legal issue.

Drafting any legislation can be difficult, but it becomes especially difficult when its title includes death or dying. It is a topic that most of us are sensitive toward and many have difficulty confronting.

Within the special joint committee we dealt head-on with a number of difficult issues and were immersed in them for six weeks. We reviewed reports by the provincial and territorial expert advisory panel on physician-assisted dying. We heard from health care regulatory bodies throughout Canada and the federal external panel on options for a legislative response to Carter v. Canada, to name a few.

We had the challenging task of grappling with the major issues touched on by Bill C-14, which include the availability of medical assistance in dying for mature minors or for patients with mental illness, advance consent, conscientious objection, and inevitably ensuring that adequate safeguards were in place to protect the vulnerable.

On February 25, the special joint committee reported back to Parliament where the Minister of Justice and the Minister of Health took the report into consideration and began drafting Bill C-14, which is what I am here to discuss today.

Bill C-14 reflects a number of recommendations made by the special joint committee and these include six main points: allowing both euthanasia and assisted suicide; making it available to permanent residents of Canada, so as not to encourage what some have coined as "suicide or death tourism"; requiring a written request for medical assistance in dying; requiring two witnesses during the time of request; requiring confirmation from two doctors or nurse practitioners that the person making the request meets all of the criteria for medical assistance in dying; and requiring a mandatory statutory review.

The key message I have taken from this very difficult discussion that I was part of and that Canadians are now joining, is that this has to be a patient-centred discussion. I encourage all parliamentarians to set aside personal values and beliefs and focus on what is in the best interests of patients. Medical assistance in dying is, and should only be, about the patient.

Upon reflection on our committee work, I now realize that the committee managed to develop a higher level of comfort with this difficult topic than is held by most Canadians at this point in the public discourse on medical assistance in dying. I am glad to see that the government took the overarching perspective of Canadians into consideration and is willing to use this legislation as a stepping stone for further studies and future revisitation.

In the past few months I have hosted and co-hosted medical assistance in dying town halls. I have spoken directly to my constituents. I have listened to the concerns of my constituents and of many Canadians around the country, and just last week, there was a demonstration for Bill C-14 held at my constituency office. I have heard the positive, the negative, the concerns, and the support, and although I fully support this legislation, I believe there are a few voids that have yet to be filled.

First, during the demonstration last week, important criteria, or better yet lack of criteria, of the bill were brought into question. How does one maintain safeguards when dealing with non-medical personnel? Bill C-14 ensures protections are met for non-medical personnel who participate in medical assistance in dying, including those who aid a person at that person's explicit request to self-administer a substance prescribed as part of the provision of medical assistance in dying, by amending section 241 of the Criminal Code, and introducing proposed section 227 to allow medical assistance in dying if the appropriate conditions are met.

However, what is being done to ensure that non-medical personnel are in fact following the guidelines required by medical assistance in dying? For instance, right before the time of administering the lethal prescription, a patient must be asked whether they would like to continue with medical assistance in dying, but how do we know that these independent individuals are in fact asking this question, among others? How do we know that the individual will not take advantage of the situation or the vulnerable position that the patient is in? These are questions my constituents would like to see addressed.

Second, I recently spoke to someone who was heavily involved in the Carter v. Canada case, who was wondering whether Kay Carter herself would have qualified for medical assistance in dying given the legislation being discussed today. I have read articles stating that she would have been, because she met the criteria for eligibility. However, would health care practitioners consistently agree that Kay Carter would indeed have qualified under this legislation?

● (2330)

The part that I am finding difficult to grasp, for Kay Carter and many others, is the ambiguity of the criterion for imminent death. How do we know that individuals would not be turned away from the service of medical assistance in dying because of the vague nature of this criterion? Who would be responsible for deciding the criteria for imminent death? Will there be inconsistencies in the definition of imminent death? How will we, as a society, address these?

Last, the hard timeline between the date of request and the day on which medical assistance in dying would be provided was yet another point of concern. Many constituents have expressed concerns that this may lead to the hastening of death because the timeline is simply too short. The special joint committee had recommended a flexible waiting period, which would depend on the nature of the illness as opposed to just an imminent death. It was suggested that imminence and competence not be the only factors in determining the timeline, but much rather the rapidity of progression and nature of the patient's medical condition be used when determining the reflection period.

These are a few pieces of the proposed legislation that my constituents and I feel need to be clarified and tightened before the final legislation is created for June 6.

However, I also want to acknowledge that the legislation has done a great job in addressing a number of concerns that have been conveyed by my constituents and many others. For instance, the first misconception I would like to clear up is that Bill C-14 does not address the conscientious objections of medical personnel. It does. There is nothing in the proposed legislation that would compel a health care provider to provide medical assistance in dying or refer a patient to another medical practitioner. Balancing the rights of medical providers and those of patients is generally a matter of provincial and territorial responsibility, and we need to respect that. However, that being said, the federal government has committed to work with the provinces and territories to support access to medical assistance in dying while respecting the personal convictions of health care providers.

Bill C-14 also recognizes the autonomy of persons who have a grievous and irremediable medical condition that causes them enduring and intolerable suffering and who wish to seek medical assistance in dying, while recognizing the importance of protecting the vulnerable and ensuring adequate safeguards are in place.

Over the past four months, I have encountered a wide variety of perspectives about this complex and difficult issue. Some have been extremely restrictive, while others have been extremely permissive. Some believe the legislation would go too far, while others believe it would not go far enough.

I believe Bill C-14 is an important first step in Canada. It is cautious, even conservative legislation, but it will provide a necessary first response to the Carter decision along with a commitment to continue studying the effects and revisiting important issues of medical assistance in dying in the future.

Ultimately, when it comes to Bill C-14, I would like to see the voids found within the legislation addressed prior to June 6, and I intend to support Bill C-14. I encourage my colleagues on both sides of the House to support the rights of Canadians, and to put patients first by supporting this bill.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, I think the hon. member respectfully engaged in some obvious sleight of hand with respect to the conscience provisions that are not in this legislation. He has said that it is a misconception to say that this legislation does not address conscience, but then he says there is nothing in the legislation that would directly infringe conscience. The fact is that the legislation does not contain conscience protection.

The member is right that it would not require the infringement of conscience, but it does not contain conscience protection. The effect of the absence of conscience protection is that in the province of Ontario at least, and perhaps other provinces, as soon as this legislation takes effect and euthanasia will enter the standard of care, physicians will be required to either refer or even, in certain situations, will be required to provide. The member should know that this would be the clear effect of this legislation. He should acknowledge that.

Again, if the member thinks conscience is important, why does the government not put forward amendments which would actually ensure the protection of conscience? Let us stop this slippery game about the language. If we all agree that conscience is important, why do we not firmly protect it in the legislation?

● (2335)

Mr. John Aldag: Mr. Speaker, as was stated by one of my colleagues earlier, the comment is that the provinces and territories will end up dealing with this issue of conscientious objection. The colleges will need to deal with referral. I have spoken to people within my home province of British Columbia, and the sense is that the provincial and territorial jurisdictions will need to be involved, and that is the appropriate place to address conscientious objection within this topic of medical assistance in dying.

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Mr. Speaker, I want to thank my hon. colleague for Cloverdale—Langley City. Again, it is a marked departure from previous debates in this place to hear so many members of the governing party speaking clearly of their own concerns about government legislation.

I would ask my hon. colleague if he has a sense of whether the government, the minister, the committee, will have the right and expectation of being able to accept amendments, if that becomes the decision of the committee operating independent of control by the Prime Minister's Office or the minister.

Mr. John Aldag: Mr. Speaker, I believe very much that we have a good piece of legislation. As I said in my comments, it is a starting piece for a very difficult subject.

Our government has been very clear that we have legislation that has been put forward. We are in the consultation stage right now. We are having this debate. I believe that if compelling arguments are brought forward, they will at least be considered as the final legislation comes forward. I will be watching, along with my constituents, on what the final bill looks like.

Mr. Michael Levitt (York Centre, Lib.): Mr. Speaker, I want to thank the hon. member for his speech, and I also want to add my voice in congratulating the members of this House for the tone of the debate this evening on what has been a rather late night.

Like all members of this House, I spent the last week in my riding of York Centre, where I had the opportunity to hear from a number of my constituents on this issue and on this bill. What I heard most was that it strikes a balance. I heard from people across the spectrum, who phoned or came into the office, that it is striking a balance, that there is work to be done, but that they feel this is a solid place to start as we head to the committee phase.

From my point of view, the advance directive provisions, dealing with individuals with mental illness, and many other things still need to be looked at.

I would ask the member what he feels are some of the things that the committee can be examining in this next phase, because I believe that the House should pass the bill and send it to committee.

Mr. John Aldag: Mr. Speaker, I would encourage the committee to listen to the comments that are being put forward, both the questions and concerns, and attempt to have witnesses who can address those, as the special joint committee had done. Then we will be able to weigh through the evidence, as we are about evidence-based policy, and see how the recommendations can be made to perhaps strengthen Bill C-14.

● (2340)

[*Translation*]

Mr. Joël Godin (Portneuf—Jacques-Cartier, CPC): Mr. Speaker, I am probably one of the last to speak today, since it is almost midnight.

Since this is my first long speech, I would like to take this opportunity to thank the 105,000 voters I represent. Not all 105,000 of my constituents voted for me, but more than 44% of the people of Portneuf—Jacques-Cartier did. I thank them.

Members win election campaigns, but we never do so alone. It is a family affair. Family is important to me. I would like to take this opportunity to thank my wife, Isabelle, who happens to be here this week. She is not in the gallery because it is late, but I appreciate her being here in Ottawa. I also want to thank my children, who are currently asleep. Charles-Antoine and Ann-Frédérique participated in my election campaign and sacrificed quality time with their father during the campaign. I want to thank them.

Last year, 2015, was a very difficult year for me. Talking about it is very emotional for me. There was an election. The 338 MPs here campaigned, but unfortunately, as fate would have it, my father passed away right in the middle of the campaign, on August 19. Unfortunately, he will never see me here in the House. He would probably have been very proud. My mother died in May. Both of my parents died in the same year, in 2015. I had two loyal volunteers up there watching over me. Sadly, my mother died of cancer like so many Canadians. We all have our story. I am sharing mine today. My father and mother died in 2015, but the year ended on a high note because I was elected.

My mother was diagnosed with cancer two years before she died. That is why I am taking part in this evening's debate, because I supported my mother through her illness. She passed away on May 1, 2015. She lived through that agony, and I would call it agony, but she was serene. She had some good times in those two years. She enjoyed the gatherings we had during those last two years. I saw her smile. I saw her stay positive. I saw her become a fighter. Unfortunately, on May 1, at 6:50 p.m., I had the unfortunate experience of finding her in her hospital bed after she had died. She had just begun palliative care. Unfortunately, it happened just a few minutes before I entered the room. That is why this debate is so important to me. I supported her. She did not really have the opportunity to improve her condition, which deteriorated really quickly.

The principle behind Bill C-14 is to allow Canadians to die with dignity. What is the definition of "dignity"? Dignity can be described as the respect, consideration, or regard that someone or something deserves. Human dignity is the principle whereby no person should ever be treated as an object or as a means, but rather as an intrinsic entity.

Out of respect, I can say that my mother was treated with dignity. She was treated with respect throughout her agony. She was respected until the very end. The law did not exist. Is this law really necessary? The Supreme Court requires us to make a decision, pass a law, accept a law and enact it. However, what worries me about this law are the parameters. It is important to understand that we must allow people to have access to medical assistance in dying.

● (2345)

However, human nature being what it is, it is difficult to take rights away from people after implementing a law that is too broad in scope. I therefore invite parliamentarians and the committee that will be examining the bill to be thorough and restrictive.

Let us begin by talking about the definition of "reasonably foreseeable". I would like to inform the House that according to my life expectancy, I will die in 2044 at the age of 79. That is reasonable and foreseeable. That means we have a problem. This term is not defined clearly enough. It is not specific enough. The definition is too broad.

The Supreme Court of Canada gave us the mandate to determine the criteria for defining grievous and irremediable medical conditions. Why are we afraid of using science to define these criteria? Science can determine whether someone is at the end of his or her life. We are afraid to use words like "terminal". A word like that does not really leave room for interpretation. If science tells a person that his or her condition is terminal, then it means that it is terminal and that that person should expect to die in the near future.

I would encourage the people who will be assessing the legislation to be very specific. We need to restrict access to this procedure. In my opinion, the first criterion should be that access is limited to people who are, unfortunately, terminally ill. I want to emphasize that safeguards should be put in place to restrict access to medical assistance in dying. We need to set very strict and restrictive parameters.

Doctors are there to save lives. They need to abide by the Hippocratic oath. Nurse practitioners are also being added to the mix. When they went to school, they did not expect to have to take any action that would result in death. We are talking about professionals who want to treat people to help improve their health. Why are we asking them to do the opposite? Are we going to ask other groups who work in hospitals to engage in this type of intervention? The nursing associations that I consulted were very surprised to be given this new responsibility and be part of this debate.

Some argue that there are regions that do not have access to doctors. If there are no nurse practitioners, who are we going to ask? The bill provides for a 15-day waiting period. To my knowledge, in this very beautiful country of Canada, the second-largest in the world, we are never 15 days away from treatment by doctors. We must not hand over the responsibility of carrying this out to a professional body other than the medical profession.

Do my colleagues know that a person other than nurse practitioners and doctors can go around with the famous drug that ends life? Clause 4 of the bill clearly stipulates:

> No pharmacist who dispenses a substance to a person other than a medical practitioner or nurse practitioner commits an offence under paragraph (1)(b) if the pharmacist dispenses the substance further to a prescription that is written by such a practitioner in providing medical assistance in dying in accordance with section 241.2.

That is dangerous. People will be able to walk the streets with a drug that kills. We must also protect our seniors. They are vulnerable people. Heirs, insurance policies, caregivers, and families can take advantage of seniors. Let us protect our seniors. Let us be restrictive and put safeguards in place to impose as many limits as possible.

There is a centre called Cité Joie in my riding. I can understand that people reach the point of exhaustion. The centre offers respite. I can tell you that I have seen people there with extraordinary smiles.

● (2350)

I cannot bear to no longer see such happiness. We have to support these people. We cannot give them that possibility. I have much to say. However, in closing, I would like to inform the House that I have not made up my mind about the final bill. I am asking the committee that will study it to put more restrictive provisions in the bill so that we can believe in life and we resort to the legislation only at the end of life.

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.): Mr. Speaker, I appreciate the personal story and the comments by my colleague from Portneuf—Jacques-Cartier. This is a very personal, emotional and important debate. Like me, he is a new MP, and he was not here when the Carter decision was handed down.

However, I am somewhat frustrated by the fact that nothing was done in the four months that passed between the time that the Supreme Court ruling was handed down and the end of the 41st parliament.

Since we were given such a short deadline, does my colleague believe that passing the bill at second reading would improve the situation, even if he is not satisfied with the conditions, or would he be happy with the void created by the failure to pass the bill at third reading, in the event that the changes he wants were not accepted?

Mr. Joël Godin: Mr. Speaker, we cannot change the past, but we can change the future.

We, the members of the opposition, are here to work with the government members. I do not want partisanship to enter into this debate, because this issue is too important for that.

Now, can we move forward on this bill? I very much appreciate my colleague's question, and I am not here to obstruct this bill. I respect my colleague. I am here to work with all parliamentarians so that all Canadians, whether in my riding or my colleagues' ridings, will be satisfied with our work and how we are representing them on this non-partisan file.

Mr. Gérard Deltell (Louis-Saint-Laurent, CPC): Mr. Speaker, facts are facts.

A year ago, when the Supreme Court directed Parliament to legislate, we did not really have a choice. The Supreme Court knew it was an election year. Parliament therefore had just three months before the fall election was called.

During that time, the government, under the leadership of the right hon. member for Calgary Heritage, struck a committee of three independent Canadian experts to study the situation. It is a lie to say that the former government did nothing. The committee produced a lengthy report with several recommendations. It was a great help to the parliamentary committee that produced the main report and the dissenting report. Those are the facts.

We talked about this for six years in Quebec. Here in the House of Commons, we have limited time. Nevertheless, is the member listening to his constituents, and are his constituents talking to him about this very sensitive subject?

Mr. Joël Godin: Mr. Speaker, I thank my colleague from Louis-Saint-Laurent, who has a lot of experience, especially on this issue. He had the privilege of working in the Quebec National Assembly, and he participated in the debate over six years. As he said, it is rather odd that we are taking six months, while Quebec took six years. It is no wonder we are here so late this evening. As parliamentarians, we are working extra hard.

I obviously meet with many constituents in my riding. They all want to discuss this very sensitive topic. There is no standard opinion on this issue, and no one blindly agrees. It is important to listen. As I mentioned in my speech, everyone has had a different experience with death, whether it is the death of a friend, family member, or child.

This is therefore a very emotional issue, and my constituents talk to me about it. I listen to them and ask questions to ensure that I am representing them well. When we vote on this bill in the House, I will make a decision that I think best reflects the beliefs of the people of Portneuf—Jacques-Cartier.

● (2355)

The Assistant Deputy Speaker (Mr. Anthony Rota): There being no further members rising for debate, pursuant to order made earlier today, the debate is deemed adjourned and the House stands adjourned until tomorrow at 10 a.m., pursuant to Standing Order 24(1).

(The House adjourned at 11:55 p.m.)

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