



Fourth Session, 40th Parliament

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REPORT OF PROCEEDINGS  
(HANSARD)

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SELECT STANDING COMMITTEE ON

**HEALTH**

**Victoria**  
**Wednesday, July 15, 2015**  
**Issue No. 17**

LINDA LARSON, MLA, CHAIR

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**SELECT STANDING COMMITTEE ON  
HEALTH**

Victoria  
Wednesday, July 15, 2015

*Chair:* Linda Larson (Boundary-Similkameen BC Liberal)

*Deputy Chair:* Judy Darcy (New Westminster NDP)

*Members:*  
Donna Barnett (Cariboo-Chilcotin BC Liberal)  
Dr. Doug Bing (Maple Ridge–Pitt Meadows BC Liberal)  
Sue Hammell (Surrey–Green Timbers NDP)  
Richard T. Lee (Burnaby North BC Liberal)  
Dr. Darryl Plecas (Abbotsford South BC Liberal)  
Jennifer Rice (North Coast NDP)  
Bill Routley (Cowichan Valley NDP)  
Dr. Moira Stilwell (Vancouver-Langara BC Liberal)

*Clerk:* Susan Sourial



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MINUTES

# SELECT STANDING COMMITTEE ON HEALTH



Wednesday, July 15, 2015  
11:00 a.m.  
Birch Committee Room  
Parliament Buildings Victoria, B.C.

**Present:** Linda Larson, MLA (Chair); Judy Darcy, MLA (Deputy Chair); Donna Barnett, MLA; Dr. Doug Bing, MLA; Sue Hammell, MLA; Richard T. Lee, MLA; Jennifer Rice, MLA; Bill Routley, MLA; Dr. Moira Stilwell, MLA

**Unavoidably Absent:** Dr. Darryl Plecas, MLA

1. The Chair called the Committee to order at 11:03 a.m.
2. The following witnesses appeared before the Committee and answered questions regarding Dying with Dignity:
  - BC Civil Liberties Association
    - Josh Paterson, Executive Director
3. The Committee recessed from 11:50 a.m. to 11:54 a.m.
4. The Committee reviewed the Sub-Committee's Terms of Reference.
5. **Resolved**, that notwithstanding the motion adopted on March 26, 2015, the Sub-Committee of the Select Standing Committee on Health shall convene at the Parliament Buildings or in Vancouver and shall report to the full Committee by November 30, 2015 its recommendations on the specific matter referred to it. (Judy Darcy, MLA)
6. The Committee adjourned to the call of the Chair at 11:56 a.m.

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Linda Larson, MLA  
Chair

Susan Sourial  
Committee Clerk



WEDNESDAY, JULY 15, 2015

The committee met at 11:03 a.m.

[L. Larson in the chair.]

**L. Larson (Chair):** Good morning. We are pleased this morning to have Josh Paterson with us from the B.C. Civil Liberties Association to do a presentation to this committee.

I'll just very briefly ask each of the members here to introduce themselves for Josh's benefit and for the record.

**B. Routley:** Bill Routley, MLA for Cowichan Valley.

**J. Rice:** Jennifer Rice, MLA for North Coast and northern and rural health critic — opposition spokesperson.

**S. Hammell:** Sue Hammell from Surrey-Green Timbers, critic for mental health and addictions.

**J. Darcy (Deputy Chair):** Judy Darcy, MLA for New Westminster, opposition spokesperson on Health and Deputy Chair of the committee.

**M. Stilwell:** Moira Stilwell, MLA for Vancouver-Langara.

**L. Larson (Chair):** I'm Linda Larson, MLA for Boundary-Similkameen.

**D. Barnett:** Donna Barnett, MLA for Cariboo-Chilcotin.

**D. Bing:** Doug Bing, MLA for Maple Ridge-Pitt Meadows.

**R. Lee:** Richard Lee, MLA for Burnaby North.

**L. Larson (Chair):** Thank you.

I'll turn it over to you, then, Josh. You go right ahead.

[1105]

### End-of-Life Care

**J. Paterson:** Well, thank you very much to all the hon. members here. I really appreciate the invitation to present to you today on the traditional territories of the Xwsepsum and the Lekwungen people.

The B.C. Civil Liberties Association — some of you may be familiar with us. We're based in Vancouver. We're Canada's oldest and largest civil liberties and human rights organization. We are non-partisan. We are independent. We work on advocacy, law reform, litigation and education at the national and the provincial level, and we've been doing that since 1962.

The decision in Carter and Canada was the BCCLA's case. We litigated it all the way from B.C. up to the Supreme Court of Canada. So it is with particular pride that we are now engaged with the B.C. Legislature as well as the federal government to discuss the aftermath of what is, for us, the biggest victory in our history and certainly one of the most important Charter decisions the courts have ever rendered, in that unlike many of the other Charter decisions, this one has an implication for every individual. Whether you would ever choose to access physician-assisted dying or not, every single person in the country now has a newly recognized right that they didn't have before.

The Supreme Court obviously broke with a long-set precedent in the Rodriguez case back in February when it ruled that there was a constitutional, Charter-protected right to physician-assisted dying in Canada. The judgment was resounding. It was unanimous — so unanimous, in fact, that they just signed it off "The Court." None of them took individual credit for it. They were all so bought-in to the judgment that they signed it simply "The Court."

What it does is it recognizes that physician-assisted dying is to be treated as a medical service in this country, that it is a right that people have and that the federal government, through the Criminal Code, cannot criminalize physicians who provide this treatment to people.

Now, I'm not going to belabour what the judgment itself said and what their reasoning was. I know that you've already heard from, for example, Dying With Dignity Canada, colleagues that we work with very closely on this, who would have explained some of that to you.

I am going to focus on a few parts of the judgment that I think have implications for what governments, federal and provincial, will be doing in the aftermath. But I do want to, at the outset, just quickly summarize.

The court, in its very first paragraph, said something that was very powerful. They said, and I quote for the purposes of *Hansard* from paragraph 1 of the judgment:

"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."

Of course, the Supreme Court in its ruling made it so that Canadians no longer have to face that choice by eliminating the criminal prohibition on physician-assisted dying for a narrow range of people. Those people are competent adults who make a free and informed choice completely voluntarily, who have a grievous condition and who are experiencing irremediable suffering that is intolerable to that individual. All of this has to be assessed by a physician.

It's not someone who's just not feeling well. It's not someone who is seized with some sort of transitory illness. It has to satisfy all of these conditions so as not to

be a crime under the Criminal Code of Canada when a physician assists. Now, that doesn't stop the federal government from going further, if it so chose, to extend this right to other categories of ill people. But the judgment itself was narrow in its effect.

Why did the court rule that? They ruled that on a few bases. One is the right to liberty, that people have the right to make fundamental choices about their health, about matters affecting their bodily integrity, and that the criminal prohibition against physician assistance in dying was an infringement of liberty.

[1110]

It was also an infringement of the right to security of the person, because it forced certain individuals who did not have the ability to take their own lives to suffer longer than they otherwise would. It was seen to be the effect of the Criminal Code — in fact, government action — that was causing the extension of that suffering, making it a violation of the Charter of Rights and Freedoms.

Finally and interestingly, it said that the criminal prohibition against physician-assisted dying actually violated their right to life. Here was a provision that had been put in place presumably to protect life, which of course is a key aim of governments and is one of the underpinnings of the constitution. But the evidence showed that what it was doing was causing people who knew they were going to meet some sort of end that, for them, was lacking in dignity, that would be characterized by inconceivable pain, to take their own lives when they still could do so, even though they might have weeks, months, even years left to enjoy their life reasonably enough, to spend with their families and their grandchildren.

During that time they would not have the physical capacity any longer to take their own lives. They would not be able to ask anyone to do it for them. Those people were actually seeing their lives shortened if they made that choice, and the Supreme Court of Canada found that that violated the right to life.

Now, I want to point out that the court didn't say that some people's lives are worth less. They said it is because we value the lives and the autonomy of people suffering in these conditions that they need to be granted this right. They need to have the right to make decisions for themselves.

The court affirmed the evidentiary findings made by the trial judge that in all of the other jurisdictions that practise this, the evidence is that it can be done in a safe manner that protects vulnerable people and that those concerns being raised didn't have any support in the evidence.

What does this mean for B.C.? Despite what some people have been saying, there isn't actually going to be a federal legal void when the judgment comes into effect on the expiry of one year from the judgment. The court said that parliament and provincial legislatures may enact laws — they were very clear on this — "should they so choose."

If no action is taken by the federal government, all that will happen on February 7, 2016, is that it will no longer be a crime for a physician to assist someone to die who meets those criteria that are set out. It would be free to provinces, to regulatory bodies, to colleges of physicians and surgeons, to the colleges of pharmacy to come up with the appropriate regulations that they feel they need to do.

The federal government, of course, has said they intend to pass legislation, that they intend to correct the Criminal Code so that the wording reflects the judgment. They say they are going to embark on a consultation process through the summer and taking us through the election in order to do that. We continue to await that announcement that we've heard is forthcoming from Justice Canada.

What we say will happen at the expiry of that time is that physician-assisted dying will be regulated in the same manner as other health care matters, that the provincial and territorial laws that apply to health care and the standards of the medical profession that govern all other kinds of informed consent around end-of-life care will simply apply to physician-assisted dying in the same way. We think that that's a sensible approach and that it's actually one supported by the evidence that was before the Supreme Court of Canada and the Supreme Court of British Columbia.

There was tons of evidence. There were tens of thousands of pages that we put forward, binder after binder, affidavits from people all over the world — ethicists, practitioners, patients, people who were suffering from different kinds of illnesses. The Supreme Court went through all of the evidence that the Supreme Court of B.C. had looked at, and they found that they could not find any error in the Supreme Court of B.C.'s evidentiary findings, so all of those stood.

The trial judge here in B.C. had taken the view — you can find this at paragraph 63 of the Supreme Court judgment — that she would have needed to find that there was an absolute prohibition on this practice if there was any evidence that physicians were unable to assess competence, that they were unable to assess voluntariness, that they were unable to basically govern this practice so that it didn't result in the so-called slippery slope, a casual termination of life just any old time.

[1115]

She said: "If I were to find that evidence to be true, then I couldn't make this ruling." She didn't find that evidence to be true. She expressly rejected those possibilities despite tons of effort on the part of the federal government to introduce evidence to that effect. None of the federal government's evidence was preferred over our evidence. After reviewing the evidence, she concluded that a permissive regime with properly designed safeguards was capable of protecting the vulnerable from abuse and error.

At paragraph 106 of the judgment she "found that

it was feasible for properly qualified and experienced physicians to reliably assess patient competence and voluntariness and that coercion, undue influence and ambivalence could all be reliably assessed as part of that process." She found that "it would be possible for physicians to apply the informed consent standard" that medicine uses in every other possible treatment — that they could apply that to this treatment and that that would be adequate.

She found, at paragraph 107, that there was no evidence of a risk to vulnerable populations and no evidence from the jurisdictions around the world that allow physician-assisted dying that people with disabilities were at heightened risk of accessing the service. They were accessing at no greater proportion than other members of the population who wanted to access PAD, PAD being physician-assisted dying. There was "no evidence of inordinate impact on socially vulnerable populations in the permissive jurisdictions." There just simply wasn't any "evidence that a permissive regime in Canada would result in a 'practical slippery slope.'"

At paragraph 115 they reference this: "Based on the evidence regarding assessment processes in comparable end-of-life medical decision-making in Canada, the trial judge concluded that vulnerability can be assessed on an individual basis, using the procedures that physicians apply in their assessment of informed consent and decisional capacity in the context of medical decision-making more generally."

Now, I highlight this because this is where the rubber starts to hit the road in terms of what jurisdictions and regulatory colleges will do following the judgment. We have evidence, found at the Supreme Court of B.C. and based on tons and tons of documentation, affirmed by the Supreme Court of Canada, that the standards we have in place right now for informed consent give us what we need in order to safely regulate this practice.

It is our position that for parliament and legislatures and the colleges considering what to do, physician-assisted dying can and should be treated like other medical decisions and governed by the established norms of informed consent law, which have shown themselves, through evidence, to be perfectly adequate as a framework for other end-of-life medical decisions. There is no need for an elaborate system of difficult-to-surmout checks and balances. Indeed, any government erecting such a system would run the risk of a constitutional challenge.

What this next phase is really about is figuring out what that regime is going to look like in each of the provinces and territories. We really welcome the opportunity to work with legislatures and parliaments across the country in order to find our way through this. In doing that, we emphasize that there must be no barriers created that would make it difficult for people to access. Obviously, they need to be assessed by their physician. Obviously, they need to meet the criteria that are set out.

There have been proposals for multi-month waiting periods, proposals for having to say it four times over, three times verbally and twice in writing. Those aren't the precise bounds of the kinds of proposals that are being made, but other kinds of proposals involve these kinds of hoops to get through. We've seen in other controversial procedures in the past panels of doctors and having to get multiple approvals and all these kinds of things. We don't think that the evidence supports that. We don't think those kinds of measures are appropriate.

[1120]

We are very concerned that PAD be accessible across Canada so that people don't suffer from a lack of access in certain parts of the country. We would like there to be consistent standards nationwide, recognizing that health care is a provincial jurisdiction. We would find it problematic if people in some provinces or within certain regions of certain provinces, for one reason or another, didn't have reasonable access to what is now a constitutional right.

The federal government has said to us at BCCLA, as have the federal opposition parties, that they don't consider access to be a federal responsibility, that their job is the Criminal Code.

While it's certainly open to federal and provincial Health Ministers to come up with some standards — and those conversations could be had — we don't expect Parliament to be legislating to guarantee a certain level of access anywhere in the country. What we know is that people have a right. Because health care is provincial, that's now going to fall to the provinces.

We say that physician-assisted dying really ought to be a private matter between a physician and patient like other treatment decisions at the end of life, governed by the established norms of informed consent law. We think that provincial governments now have the responsibility to make sure that insured persons, within the meaning of provincial and territorial health insurance legislation, are able to access this right as they are able to access other treatments.

One thing we say that goes beyond the scope of the judgment, although it is not precluded by the judgment — it just wasn't part of the decision; it wasn't part of the facts that we pled — is that we do think it's consistent to allow physicians to act on advance directives in requesting assistance in dying, when they later may no longer be competent.

If we proceed on the theory that we want to maximize people's enjoyment of their lives, we think that someone ought to be able to say: "Look, when I get to a certain point, this is what I want to have happen, but not a moment sooner. I want to enjoy my life to the very last, and when that last bit slips away, this is what I would like to have happen."

It seems consistent to us. It's consistent with the rights that are established in the judgment. We think that ought to be a part of anything coming forward. That might not come from the federal legislation. It may be something that the colleges or the provinces have to look at.

As in other cases of end-of-life care, if there's some doubt about someone's capacity, if there's some doubt about someone's competence, then of course that ought to be assessed. There are specialized capacity assessments already available, already done for other kinds of medical procedures that would be appropriate to be done here.

We don't see having to check if the physician has any reason to doubt that someone understands what they're asking, is willingly doing it as opposed to being pressured. We don't see any reason why there couldn't be some kind of assessment in those sorts of circumstances.

We think that if, for whatever reason, a physician or series of physicians refuses to provide it to someone who is competent, they should have some way of appealing that or somewhere to go to make sure that they are able to be assessed so that a determination can be made as to whether they are able to access the service.

**L. Larson (Chair):** Josh, if you don't mind at this point, watching the clock and knowing that there are lots of questions around the table, would it be all right to go to the group here and let them ask you some questions?

**J. Paterson:** It would be quite okay. But I still had two more minutes. There was one last point that I kind of wanted to make. Maybe my.... I was timing. But that's okay.

**L. Larson (Chair):** Yeah, I'm sorry. I had 20 minutes on my clock, and I thought we started just after....

**J. Paterson:** Forgive me. I stop-watched it.

**L. Larson (Chair):** Okay. Much more efficient than me watching the clock on the wall.

**J. Paterson:** That's okay. I don't mind. I can come back to it in questions and answers. Obviously, I'm in your hands, Chair.

**L. Larson (Chair):** I would like to get through some of these questions regardless of where we're at, because that clock tells us we have to be done in a while.

**J. Paterson:** Fair enough. I will come back to these other points in questions.

**L. Larson (Chair):** Definitely.

**J. Darcy (Deputy Chair):** Thank you very much, Josh. Very helpful presentation, and building on the discussion we had earlier with the folks from Dying with Dignity.

There isn't a legal void. The issue is access to care, which is a responsibility of the provincial government within the terms of the Canada Health Act, fundamentally.

[1125]

**J. Paterson:** That's right.

**J. Darcy (Deputy Chair):** So individuals who want to access this right could be anywhere in a continuum of health care, without getting too complicated. They could be at home and being cared for in the home. They could be in palliative care. They could be in residential care, a hospital, any of a number of places, and be dealing with a number of different health care providers. And they could be in an acute care hospital, of course.

If the provincial government is responsible for ensuring access, and equal access, what is the responsibility, then, at a provincial government level? I understand that there are the regulatory issues for the colleges, but what are the responsibilities, then, of the provincial government that's responsible for delivering care and ensuring access?

**J. Paterson:** Thank you for your question, Ms. Darcy. One of the things that may cause some barriers to access for some people is the right of physicians to conscientiously object. And we stand by the right of physicians to conscientiously object to providing this service. In fact, it's explicit in the judgment. We've said that all along.

What we say about conscientious objection is that a physician who does conscientiously object should have a duty on them to indicate to a third party, whether it's to some body that's created, whether it's to the regulatory college, whether it's to the Ministry of Health or the local health authority or whatever. Some body needs to be contacted by them, not for the physician to refer but to say, as is a requirement across conscientious objection law in medicine, "I have objected," and inform the patient briefly of the reason for their objection.

We do not want to impose on physicians. Others do, and that's their right to have that view. We do not think that physicians should have the obligation imposed upon them to refer to another willing provider.

What we would imagine happening then is that that third party, with the consent of the patient, has got to contact them, and they'll try and work something out. We see it as a reasonable accommodation for the conscientious objection that can be done without too much problem for the patient.

Where it might come and affect the province, though, is if you had communities where every doctor objected — some smaller community or a one-doctor town, these kinds of things — then how does that patient get access? We say there will be some obligations that fall to the province in terms of providing access where we accommodate those doctors, those individuals.

I think generally, as a matter of health policy, that there is going to be an obligation on the province to ensure that there is a reasonable level of access to this kind of treatment for everyone in the province who wishes it. It's not for me to tell the Ministry of Health.... I can't imagine right now exactly how all that ought to be done, but

there's going to be some sort of superintending obligation on the province to make sure that people can reasonably access this, irrespective of where they happen to live.

There may be resource implications to that. There may be various different kinds of policy implications to that for the Ministry of Health. But we think that there is a positive obligation on the province to ensure that this treatment is accessible, just like other medical care that's provided for under the Hospital Insurance Act that hospitals have got to provide this, and under MSP that MSP has got to provide certain kinds of care. We see it in that same vein.

**J. Darcy (Deputy Chair):** I just want to understand. If the physician does not have an obligation to refer as someone objecting on conscientious grounds, you're saying the province needs to have some agency, some place where people can go. But whose responsibility is it? How will that patient be made aware of where they can go, and whose responsibility is that?

[1130]

**J. Paterson:** The particularities of that would, of course, need to be worked out. One way you could imagine doing it....

There are already statute-established health authorities for every region of the province. Perhaps that's the place that a physician notifies: "Hey, look. I cannot help this patient any further." Then it would incumbent on the health authority — as quickly as possible, not dithering about, not getting lost under a stack of papers — to see to it that that patient is connected with a willing provider that's reasonably accessible to them.

That would be one way of doing it. A province might choose to make the college do that. Another province.... They are already preparing for this in Quebec. In the Quebec legislation it is the executive director of the local health authorities that does it. It could be analogous to that. But something needs to be there in order that patients are not abandoned and to make sure that physicians are not in a position where they're being forced to provide the service or to provide a referral.

**L. Larson (Chair):** Donna, did you have one that you wanted to...?

**D. Barnett:** It's on a different topic. Back to the right of the patient, if the patient is not coherent enough, could their power of attorney then take the responsibility to work with a physician?

**J. Paterson:** Under the judgment as it stands, it will not be permissible. If the federal government did only what the Supreme Court has told them to do, it would not be permissible for anyone else, any substitute, to make a decision for that person. It needs to be someone's own

choice. That's what the case was based on, so that's what the law now says.

In terms of advance directives, oftentimes how those work is that there's an advance directive in place but there's still a substitute decision-maker, and they have to kind of execute on the advance directive. Where there was an advance directive in place, that's specified — not just "I give power of attorney over to this person for my health decisions" but "I choose physician-assisted dying under this circumstance." Then we think that ought to be respected.

There is a whole other conversation about: "Well, what about people in this kind of situation?" Right now the judgment doesn't address that. Governments, of course, could choose to grapple with it, but it's not part of the judgment as set out.

**L. Larson (Chair):** It seems right now, on that topic, Josh, that even though it's supposedly a legal document, and like you were saying, it must be the person themselves — perhaps, once they're diagnosed and they know what's coming — that makes some sort of a legal document that says: "This is what I request at this point when I'm into this stage."

That is challengeable at the current time, is it not? Isn't that what a lot of the issues that we see very public end up as? The person isn't able to speak for themselves, and someone else is able to challenge and say: "Well, I don't want that to happen to this person." Is that a legal issue, a legal loophole somewhere — that we don't recognize and respect those wishes?

**J. Paterson:** I think it is problematic. We all know of the case from the Fraser Valley where the individual is responding to spoon-feeding. She did everything possible that she thought she needed to do to make clear what her wishes were, and the court hasn't upheld them because the law currently is binding them.

I think looking at that decision and what the impediment was there would be a worthwhile project for the Legislature to undertake in order to ensure that people in that situation are not caught in the way that they are and to make whatever tweaks would be necessary to ensure that when these things are clear and valid, and so on and so forth, someone can say: "Look, I don't care if I respond to a spoon being placed by my mouth." I think there might be some work to do there for sure.

**L. Larson (Chair):** That one does concern me.

[1135]

**S. Hammell:** I just want to go back to the notion of referral. There are other procedures that could be questionable in terms of ethics or morals of physicians. What is the direction to them at this point in time? I'm thinking of.... If a doctor does not want to do an abortion, is

that a referral position? Can they say: "I'm just not going to refer you"?

The other one that comes to mind is vaccination. There's sometimes some kind of ethical decision-making for a doctor or other people around vaccinations. Do they have a right not to refer when you take your child for a vaccination? There are probably others that don't come to mind.

**J. Paterson:** Sure, there are all kinds. I can speak to that.

Different provinces do it differently. In B.C. the College of Physicians and Surgeons of British Columbia has professional standards and guidelines on access to medical care that address conscientious objection. What the B.C. requirement is on doctors, coming from the college, is that physicians can make a personal choice not to provide treatment, based on their values or beliefs, but physicians have to provide patients with enough information and assistance to allow them to make an informed choice for themselves.

We would endorse that too. Even a conscientiously-objecting physician cannot say.... It should not be considered good practice for them to simply button up and not mention this other option to people. They need to provide full information for patients to make decisions.

What the college then says, though, is that this right to object "includes advising patients that other physicians may be available to see them, or suggesting that the patient visit an alternate health care provider. Where needed, physicians must offer assistance and must not abandon the patient." They go on to say that physicians shouldn't get into a long discussion of their personal beliefs, shouldn't try to convince the patient one way or another. We would endorse all that.

But the BCCLA would not go as far as the college has gone currently. This is pre-physician-assisted dying. We wouldn't go as far as that. We would say that you don't have to point out another physician if you don't want to. We would say, however, that you do need to register your objection. That is a pretty standard feature of conscientious objection in medicine.

Alberta does very much the same thing. Ontario has taken a different approach. They've said.... Some on the committee might be aware that the college there has imposed a duty of effective referral to a non-objecting, available and accessible physician. A group of doctors and dentists — a religious association of doctors and dentists — is actually challenging that, judicially reviewing the college's decision to the Divisional Court of Ontario. So that's going to be a live question, whether the college has the right to go that far.

We wouldn't support the college going that far. That's consistent with our position of being a patients' rights organization and the premier secular defender of religious freedom in this province. So we have to balance these things out.

As far as institutions go, talking about referral, what does an operation like St. Paul's do — or denominational hospitals anywhere in the country? In some places the denominational hospital might be the only one in town. In Vancouver, and in B.C., the premier palliative care facility for the province is in a denominational hospital.

This is a very interesting one. We say that conscientious objection is a carefully qualified claim, in that respecting it depends on whether it's practicable to provide a reasonable accommodation. We don't think that it is a reasonable burden to impose on patients who are in palliative care at St. Paul's to all of a sudden have to leave the community of care that they have there.

The whole point of palliative care, for example, is to develop an environment where you feel comforted, where you feel at ease, and all of a sudden we're going to say to someone: "Well, look, if now you decide — and maybe you hadn't thought of it before — that you'd like to access physician-assisted dying, you've got to go across town." Even that trip across town to VGH might be unduly onerous. You could well imagine some families not asking questions, not pursuing the option.

[1140]

We say that it's.... It's a clear principle of constitutional law. In a case called *Eldridge* the Supreme Court of Canada recognized that providers of public health care — whether a hospital that's owned by the government or not, whether it's run by a religious association or not — are carrying out a function of the government and that, in so doing, they have the duty to respect the Charter and to provide medically necessary services that are carrying out a core governmental objective.

If you look at St. Paul's, going back over several governments, governments recognize that it is a core part of the public health care system, both for the Lower Mainland and for the province. More of their patients come from outside of Vancouver than from inside.

The government cannot escape its duty by contracting out services to a hospital, whether or not they were already there. We wouldn't say that.... Obviously, any physician within the hospital would retain the right to conscientiously object, but a publicly funded hospital that's integrated into the system should not be able to have that right. We would say that, yes, that is violating the religious freedom rights of the board of directors who are governing the hospital but that it is an acceptable and justified violation in order to protect the right of the patient in those situations.

**L. Larson (Chair):** We've got a couple more questions still.

**D. Bing:** Thank you for your presentation, and I hope you will give us the last two minutes of your presentation later.

**J. Paterson:** Oh, I've been covering it off in my answers. I've been very tactical in the way I've been answering.

**D. Bing:** That's great. As you were saying, health care is a provincial responsibility, yet we do need, it seems to me, national standards. What you were describing of what they're doing in Quebec just made me realize that every province can have their own system, and we'll have a patchwork of policies and standards across the country. That's one thing. I wondered if there should be maybe a federal-provincial conference where the Health ministries could all work out similar policies.

The other thing, I think, is that the important factor in this is the physicians. We're asking them to provide the service, yet they have not been consulted at all in this. I think that, again, every province has their own college and body that looks after this. I think that they should be part of the conversation. They should be included in any discussion. That could be discussed at the federal-provincial level.

**J. Paterson:** I agree wholeheartedly both with the idea that it would be great if provinces and territories and the federal government would get together and figure out what national standards ought to be and also that doctors need to be involved in the process.

The Canadian Medical Association has already engaged in a consultation of its membership. They've produced a fairly lengthy report and proposal that they're offering. It's on their website. They're offering it to all comers. It's a draft proposal right now, until their meeting in Halifax in August.

Last year at their annual meeting in Toronto they endorsed the idea of physician-assisted dying. This year they hope to endorse a whole set of recommendations around it, including a virtually identical conscientious objection concept to what I've just elaborated to you — referral to a third party to be identified; they don't specify — but that there has to be access to it, on and on and so forth. They suggest more things like there've got to be timelines and there have got to be various different things that we wouldn't endorse.

Clearly, physicians and their national advocacy bodies are trying to grapple with this. Doctors of B.C. — I co-presented on a panel with the past president of Doctors of B.C. out in White Rock last month. It's clear that they're grappling with it too. I mean, doctors are going to have to be part of the conversation. Pharmacists, for that matter, are going to have to be part of the conversation. They dispense.

Everything that I've said about conscientious objection we would apply equally to pharmacists, that individual pharmacists and pharmacies ought to have the right to conscientiously object, subject to: there's got to be a way for patients to access this stuff.

Some jurisdictions have it so that it is not you waltzing into Shoppers Drug Mart to get the drugs on a prescription but that the doctor him- or herself is the one who obtains the drugs necessary to perform the treatment, thereby taking patients out of the equation and out of the embarrassment or the privacy violation of having to go to their pharmacist and deal with this.

**R. Lee:** Thank you for the presentation. My question is on the informed consent — if someone is competent to make that decision, and then later it's found that he or she may not be competent near the end of life. At that point, whose decision? And the timeline — when should the decision be made to carry out that decision if there has been consent?

**J. Paterson:** When can the decision have been made?

**R. Lee:** No. The decision probably has been made, and there may be an agreement. But then if the person becomes incompetent in terms of making decisions, who will carry on and say at which point the of end of life should be executed?

**J. Paterson:** In the case of an advance directive, which I've discussed, it would be up to whoever is the designated person under the advance directive to see to it that the wishes of the patient are carried out. That might happen at a point at which a patient were no longer competent. I mean, that would be the whole purpose of having the advance directive.

For those who have left no indication of what their decision might be, it's much more tricky. The judgment does not talk about others being able to just decide what to do. Now, it is already the case that some physicians engage in other kinds of practices — for example, the withdrawing of care, the withholding of certain things to people who are suffering those sorts of situations. There are a lot of questions around that kind of stuff, but that is not what was covered in the judgment. It's up to the provinces to do what they see fit about those kinds of situations.

This case at the Supreme Court hinged on the liberty interest and on the making of a choice — someone's autonomy right to make their own choice. That doesn't apply in the situations where someone hasn't made their own choice. There may be other considerations that one would be concerned about but not the liberty interest, not that autonomy interest.

**L. Larson (Chair):** Josh, thank you very much.

**R. Lee:** Can I have a follow-up question?

In our province we have the representation agreement kind of thing. Could this decision be part of the representation agreement so that in the later stage it won't be challenging the court or that kind of thing?

**J. Paterson:** Well, I'm not an estates lawyer. My expertise doesn't really go to what an agreement would have to cover, who needs to sign off on it and what notary you have to go to. All that kind of stuff is really beyond my expertise. You'd have to invite another witness for that. I'm sorry.

**L. Larson (Chair):** Thank you very much, Josh. I hope you did capture the last of your....

**J. Paterson:** I did. The only other....

**L. Larson (Chair):** Is there a final statement you'd like to make?

**J. Paterson:** Sure. Why not? We think that record-keeping is really important if we're going to understand how all of this is working. So we would suggest in whatever system came to be that there be appropriate oversight, that somebody is at the college, is at the Ministry of Health collecting data so that we know how it's working.

There are a few other interesting things that legislatures ought to just keep in mind. Life insurance — no one should be prejudiced in terms of their ability to make a life insurance claim because they've accessed physician-assisted dying. Do there need to be some sort of amendments to provincial insurance legislation on that? I'm not sure. Already most life insurance policies cover suicide if it's two years out of someone having bought the policy. In Oregon what they do is they just list the underlying illness as the cause of death to deal with that.

There's lots more we have to say about it, but I think that gives a sample of the kinds of things that the province may need to think of.

**L. Larson (Chair):** Some very good ideas there. The committee will discuss it and make recommendations. I really appreciate you taking the time this morning to come and talk to us. I'm sure that if anyone has further questions, they'll be able to contact you if they like.

**J. Paterson:** My pleasure. I will leave some cards over on this end — I won't come around; I know you've other business — so if anyone wants them, they'll be here.

**L. Larson (Chair):** All right. Thank you. I appreciate that.

We'll just take a five-minute break here, and then we'll carry on.

The committee recessed from 11:50 a.m. to 11:54 a.m.

[L. Larson in the chair.]

#### Subcommittee Terms of Reference

**L. Larson (Chair):** Okay, thank you everybody.

As we had too fine a timeline on our subcommittee to look at the dying with dignity type of aspect of the submissions, I would like to put a motion on the floor to extend that timeline.

[1155]

If you've got it, Judy, would you perhaps read the motion?

**J. Darcy (Deputy Chair):** I'd be happy to.

I move: "Notwithstanding the motion adopted on March 26, 2015, the Subcommittee of the Select Standing Committee on Health shall convene at the Parliament Buildings in Victoria or in Vancouver and shall report to the full committee by November 30, 2015, its recommendations on the specific matter referred to it."

**L. Larson (Chair):** Any discussion? Is everyone all right with that?

Motion approved.

**L. Larson (Chair):** Any other business that anyone wanted to bring up today?

Judy and I will get together with Susan and take a look at the timelines. You realize you do have a meeting scheduled in your calendar at the beginning of September in Vancouver for the full committee, but you will hear from us on next steps from the subcommittee as well.

Can I have a motion to adjourn?

Motion approved.

The committee adjourned at 11:56 a.m.

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