



CANADA

# House of Commons Debates

## 40th PARLIAMENT, 3rd SESSION

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### ❖ Criminal Code

**Ms. Francine Lalonde (La Pointe-de-l'Île, BQ)** moved that Bill [C-384, An Act to amend the Criminal Code \(right to die with dignity\)](#), be read the second time and referred to a committee.

She said: Mr. Speaker, I will not have enough time to list everything that has happened and that has been written regarding the right to die with dignity since the debate on Bill [C-384](#) began.

It is a sign, if a sign were needed, that shows the need to decriminalize euthanasia and assisted suicide or physician-assisted dying under certain conditions. My bill has a specific objective. It deals only with people capable of making decisions for themselves who are living in conditions of suffering that cannot be alleviated. But it has the merit of forcing a debate on decriminalization that, in Canada, unlike in the United States, is a federal jurisdiction. I think that studying my bill in committee and passing it after consideration and amendments would at last rid us of the criminal nature of physician-assisted dying by euthanasia or assisted suicide.

The Collège des médecins du Québec could then, freely and without fear, continue the admirable work it has begun on appropriate end-of-life care, including terminal sedation and euthanasia. The Quebec National Assembly could, in all good conscience, refer the study of the right to die with dignity to its Commission de la santé et des services sociaux. Not only is it necessary, but it is urgent to remind ourselves of the degree to which the Criminal Code of Canada hinders a genuine debate on vital life questions that so many people are faced with daily. A number of people who have appeared before the Commission de la santé et des services sociaux have done so. Here are some examples.

Jean-Pierre Béland, professor of philosophy and ethics at the Université du Québec à Chicoutimi, wonders what the problem is when it is accepted that a physician must answer to his code of ethics that requires him to make it possible for a patient to die with dignity.

He goes on to say that it is part of the code of ethics and that we all know that the problem lies with the current Criminal Code. This Criminal Code, which falls under federal jurisdiction, recognizes that any act of euthanasia must currently be interpreted as a criminal act within the meaning of the Criminal Code. In practice, is the patient not thrust into an impasse because the law forces doctors and caregivers to live in the ambivalence

of palliative care language, which preaches independent choice when, in reality, the patient has no choice because he is denied assisted suicide and euthanasia?

There are tonnes of quotes. I have one from a very remarkable document from the Collège des médecins du Québec on doctors, appropriate care and the debate on euthanasia. The following is an important excerpt from that document:

*The status quo makes this research difficult if not impossible. For all sorts of reasons, our society—and doctors are no exception—is in denial not just about euthanasia, but also about death. The current state of the law in Canada certainly has a lot to do with that. In a context where any act aimed at shortening life is considered murder punishable by criminal sanctions, it is rather difficult to have an open and frank discussion on all the care that would be appropriate at the end of life.*

My dear colleagues will agree that the Quebec and Canadian context has completely changed since the motion was unanimously passed by the National Assembly of Quebec.

Those are not my words. We did not see it, but representatives in the National Assembly unanimously passed a motion to establish an ad hoc commission “for the purpose of examining the issue of the right to die with dignity and, if need arises, of the procedural requirements”.

The National Assembly commission has already heard from dozens of specialists, be they doctors, ethicists or people who work in palliative care. The quality of their testimony is incredible.

It has brought a question to my mind. Quebec's parliament came together and undertook a joint consultation with specialists. Then, in August, they travelled throughout Quebec. Quebec's National Assembly commission will come forward with a motion. Given the commission's title, it seems that they will want to determine the conditions for dying with dignity. What will the Parliament of Canada do? It will say that it is in charge of the Criminal Code. On what side of the issue will we be? Personally, I hope we will not be against it.

I hope that the Parliament of Canada will take the time to consult and get informed. Of course, I hope that this will be the case when my private members' bill comes before the House. My bill is specific and limited, but it raises the question of criminalization or rather decriminalization. That is the biggest problem. That is the problem.

Who can repeatedly say with confidence that helping someone in unbearable pain, particularly someone in palliative care—that is definitely unbearable pain—is a crime? Many witnesses speak about helping someone die peacefully, so that they do not suffer. Is that really murder? Is that really a crime? Many of them say it is not. That is exactly my point. Within the three physicians' associations in Quebec, approximately 75% say that the option should exist to perform euthanasia in order to help people die under specific conditions. They want to be able to establish these conditions themselves.

I would like to read excerpts from the brief from the Fédération des médecins spécialistes du Québec:

*From a medical standpoint, the right to die with dignity and quality end of life care are notions that implicitly refer to euthanasia. It was in that context that a working group on clinical ethics, mandated by the Collège des médecins du Québec, or CMQ, in 2006, decided to address the issue. Based on the reflections of that group and particularly because of the CMQ's position, the federation decided to conduct a survey on euthanasia—*

I will talk about that in a moment, but first I would like to read another interesting excerpt:

*More and more people no longer have any moral or ethical objection to the idea of allowing a doctor to administer terminal sedation under extraordinary circumstances. Euthanasia is starting to be viewed as an act of support, the final step in quality end of life care. However, from a strictly legal standpoint, the debate continues. The Canadian legal framework, the Criminal Code, stipulates that any action to end another person's life constitutes murder and is therefore subject to criminal sanctions.*

But doctors work with people who no longer have any hope and who are no longer treatable.

Regardless of the legislative model eventually passed by the National Assembly regarding civil rights, the Criminal Code of Canada should be amended. This is by no means supported by everyone, considering the firm opposition expressed by certain radical groups that strongly support recriminalizing abortion in Canada.

The reflection paper of the Fédération des médecins omnipraticiens du Québec is also clear and precise. It is even philosophical, to some extent.

Due to improvements in health care, people now live longer and it is possible to delay death, sometimes significantly. However, the ability to live longer has a downside because an increasing number of people suffer from degenerative or incurable illnesses, such as Alzheimer's or cancer, which decrease considerably their quality of life. As a result of the evolution in medical technologies and a better understanding of them, people wish to control end-of-life decisions in order to die with dignity. This evolution in medicine inevitably leads to the debate on end-of-life care and euthanasia.

These are not physicians who teach at universities, although they might say the same thing. These are physicians who deal with patients and look after them in their final days.

These texts both contain the results of surveys on euthanasia. This is what the Fédération des médecins spécialistes discovered.

The survey indicated that medical specialists are prepared to hold a debate on euthanasia (84%) and believe that Quebec society is also ready to discuss this matter (76%). In addition, 75% of medical specialists would certainly or probably be favourable to euthanasia within a clearly defined legislative framework, and believe that Quebec society also supports legalized euthanasia, although to a lesser extent (54%).

Passage of a bill legalizing euthanasia by the House of Commons would receive the support of 76% of specialists.

However, our survey tends to confirm that euthanasia is a factor that medical specialists have to deal with in their practice. According to 81% of respondents, euthanasia is often/sometimes (52%) or rarely practised in Quebec.

The FMOQ survey gave similar results. I would add that more than half of all general practitioners believe that euthanasia is carried out indirectly in Quebec at present. 74% of physicians surveyed believe that euthanasia should be a tool available to doctors in order to fulfill the ethical requirement of helping their patients die with dignity.

74% of the respondents believe that new regulatory and legislative frameworks should be adopted to permit euthanasia.

These are but a few of the many accounts I read or heard. I believe there is no longer any hesitation. I know that, increasingly, the position of those opposed is the fear of the slippery slope.

But we cannot, based on this irrational fear—a number of studies have shown that when legislation exists, there is no slippery slope—and based on the slippery slope refuse assisted suicide to people who are dying in pain. That makes no sense, and that is what we are faced with.

### **Mr. James Lunney (Nanaimo—Alberni, CPC):**

Madam Speaker, I would like to remind the member that in law reform, going back to the Supreme Court of Canada in *Rodriguez v. British Columbia Attorney General*, it has been recognized that Canadian society is based on respect for the intrinsic value of human life and the inherent dignity of every human being. That was confirmed by the Law Reform Commission of Canada, which wrote similarly, "In truth the criminal law...serves to underline those values necessary or important to society" and that it is necessary to "reaffirm these values". Thus in Canada the law has affirmed the intrinsic value and dignity of life.

In the member's own province, at least 100-plus doctors, led by doctors Ayoub, Bourque, Catherine Ferrier, François Lehmann, and Josée Morais, and endorsed by 132

Quebec physicians, have spoken out against these measures. They do not want to be put in the position of having to terminate a patient's life.

Does the member not understand that contrary to her intentions, this bill will allow doctors to provide a patient with a lethal injection, making many Canadians vulnerable to a premature death?

**Ms. Francine Lalonde:**

Madam Speaker, I would like to make a few points in response.

First, I will point out that there are 8,000 medical specialists and more than 8,000 general practitioners. Around 100 have signed the letter written by five doctors.

These five doctors had the right to write this letter, but I know that two of them were deacons and another was a member of Opus Dei.

We have a right to defend our religion, but we cannot force our religion on others. I think that in Canada, as attitudes and needs evolve, Parliament should legislate not according to specific religions, but according to the right an individual must have if they are suffering, if they have suffered, and if they are seeking help to die.

When a doctor helps someone die, it has nothing to do with murder. A murder is always a violent act. Helping—

**The Acting Speaker (Ms. Denise Savoie):** Order, please. I will give other hon. members the opportunity to ask questions.

The hon. member for [Mississauga South](#) for a quick question.

**Mr. Paul Szabo (Mississauga South, Lib.):**

Madam Speaker, Dr. Ferrier from McGill University also raises an issue, and I will not read the quote to save time. She basically expresses a concern that doctors would be put in a position where they would have to deliver care as well as euthanasia, and that this would be a conflict in the patient-doctor relationship. In fact, she is concerned that some doctors would not participate, meaning that many people would start hunting around for those who would give them what they want if they could not get it from somebody else. It is going to undermine the system. It is a serious concern.

I wonder whether the member would comment.

**Ms. Francine Lalonde:**

Madam Speaker, I want to thank the hon. member for his question.

The majority of doctors, as I was saying, are in favour of reviewing end-of-life care. In end-of-life care there is a place for sedation and a place for euthanasia.

Like me, doctors are convinced that no one should be forced to help someone die, just as no one should be forced to perform an abortion.

Indeed, one needs to be in tune with these issues, but there needs to be legislation that includes what we consider to be essential safeguards.

My bill—

**The Acting Speaker (Ms. Denise Savoie):**

There is time for one last question.

The hon. member for [Burnaby—Douglas](#) for a very quick question.

**Mr. Bill Siksay (Burnaby—Douglas, NDP):**

Madam Speaker, I want to thank the member for introducing this important piece of legislation, which I will be proud to support when the time comes for the vote on it.

I want to ask her about the so-called slippery slope. There are some people who believe that this kind of legislation that provides an option of death with dignity leads to a deterioration of palliative care and end of life care. However, Arthur Schafer, the director of the Centre for Professional & Applied Ethics at the University of Manitoba, has

studied this and in fact shown that palliative and end of life care get better when this kind of legislation is introduced--

**The Acting Speaker (Ms. Denise Savoie):**

Order. The hon. member has 15 seconds to respond to the question.

**Ms. Francine Lalonde:**

Madam Speaker, I was looking for another study conducted by a university in Oregon on the law in Oregon and the law in Holland. It focused on a number of vulnerable groups, looking for signs of a slippery slope, but it did not find any. In one group where there were more deaths—

**The Acting Speaker (Ms. Denise Savoie):**

Resuming debate. The hon. member for [Ancaster—Dundas—Flamborough—Westdale](#).

**Mr. David Sweet (Ancaster—Dundas—Flamborough—Westdale, CPC):**

Madam Speaker, I am pleased to have the opportunity to speak to Bill [C-384, An Act to amend the Criminal Code](#), which is more commonly known for the issue it tackles: euthanasia and physician assisted suicide. There is no question that the circumstances, pain and emotion surrounding one's desire to even consider euthanasia and assisted suicide are difficult and complex, made all the more poignant by the personal experiences that frame our diverse perspectives.

I must say from the outset that while I fundamentally disagree with this bill, I respect every member of the House and every Canadian who advocates for or against the bill. That is because the circumstances that would bring anyone to contemplate medically assisted suicide, whether it be for himself or herself or a loved one, are very deep, very emotional and very difficult personal decisions.

Throughout this debate we have heard many stories and I am certain that we will hear many more. Each is different and relevant. I do not know if we can ever truly appreciate these until we walk in that particular person's shoes, but please allow me to add my own as well. My mother passed away from a debilitating autoimmune disease called scleroderma. Unfortunately, even today, not a lot is known about this disease.

When death occurs, as was the case with my mother, it is from organ complications after many years of suffering and pain. It is dying from the inside out. My mother's internal vital organs became like stones. Her skin became as fragile as parchment. There were days at the end of her life, I would suspect, although she never spoke to me about it, that she would rather not have lived. They were days that we as her family would rather have not seen her suffer.

However, as heart-wrenching as it was, she found a modicum of serenity and acceptance and we comforted her as best as we possibly could right until the end. My family was blessed by discovering two great champions: my younger sister, Connie Hayes, and my older sister, Suzanne Bryant, who were there day in and day out to care for my mother and bring the family even closer together through this tragic, painful ordeal.

I think we can all agree with the overall objective of ensuring that people with terminal or severe illness suffer less. However, I do not believe that Bill [C-384](#) is the answer. In fact, I have stated before in this place that, in my opinion, Bill [C-384](#) is irresponsible. Frankly, I am convinced that it is diametrically opposed to the Charter of Rights and Freedoms which guarantees individual Canadians the right to life, liberty and the security of person.

I am deeply concerned that Bill [C-384](#) would allow anyone to request medical assistance with suicide or euthanasia without sufficient oversight or regulation. Clearly, no one is going to make that kind of decision lightly, but nor should it be so readily accessible that an irreversible decision could be made too hastily, out of pain or emotion, or out of guilt that someone would be a burden to others.

The flaws with this bill are not with its call to compassion or its appeal for dignity near life's natural end, but with the unintended and, I believe, unmanageable consequences. Moreover, I believe we as parliamentarians have a duty and moral obligation to uphold the value of life. What kind of precedence does this set? At what point on this slippery slope do we stop? Is that really for us to decide?

I would like to quote an article from yesterday's *Globe and Mail*, written by Margaret Somerville, the founding director of the Centre of Medicine, Ethics and Law at McGill University:

*Indeed, one of the people responsible for shepherding through the legislation legalizing euthanasia in the Netherlands recently admitted publicly that doing so had been a serious mistake, because, he said, once legalized, euthanasia cannot be controlled. In other words, justifications for it expand greatly, even to the extent that simply a personal preference "to be dead" will suffice.*

I am also worried that Bill [C-384](#) signals a devaluing of life and I believe that is heading in a vastly wrong direction. These are my personal and emotional views and reasons, but they are also the reasons for many hundreds of constituents who have called, written and emailed my office.

I would like to supplement this by referring to some of the work done by committees and commissions over the years related to this specific topic. I hope they help illustrate and amplify my point that we are treading down a very slippery slope.

We should consider this paragraph from the 1982 report by the Law Reform Commission of Canada on this topic that my colleague referred to earlier. It reads, "There is, first of all, a real danger that the procedure developed to allow the death of those who are a burden to themselves may be gradually diverted from its original purpose and eventually used to eliminate those who are a burden to others, or to society. There is also the constant danger that the subject's consent to euthanasia may not really be a perfectly free and voluntary act".

Therefore, in addition to the lack of oversight in this bill, what is also troubling is the lack of precise language. I have a copy of the bill in front of me and the actual text is only three pages long, in both official languages. It is hardly anything that would tackle something as serious as bringing about medically assisted death.

The bill before us would allow for physician assisted suicide and euthanasia if the subject appears to be lucid and is in severe physical or mental pain and yet there is no definition of what constitutes severe pain or mental pain. I would hate to see an elderly, ill or disabled Canadian, feeling that he or she is a burden to his or her caregivers or to society, request assisted suicide using severe mental pain as a reason.

In tandem with our duty to uphold the value of life, I also believe we must support quality palliative care and end-of-life care for Canadians so that they will never need to think that euthanasia or assisted suicide is the only relief for their suffering or feel that they would be relieving a burden on their family by taking that path. Our ultimate goal ought to be to help ensure Canadians can live life well to its natural end. With the ageing of the baby boomers, this is an increasingly important issue.

A study of palliative care conducted by a Senate subcommittee in 2000, tabled a thoughtful report called "Quality End-of-Life Care: The Right of Every Canadian". The report recommended collaborative development of a strategy to improve palliative and end-of-life care with attention to issues such as support to family caregivers, access to home care, training and education, research and surveillance.

Since then, Health Canada has been working to develop a pan-Canadian strategy for palliative and end-of-life care. While much remains to be done, I believe this can help deal with the very real physical, psychological, spiritual and practical needs of a person who is dying and the person's loved ones.

As we discuss, debate and consider Bill [C-384](#), we must not forget what we can do in these areas of health care to help Canadian families from coast to coast. We need to recognize the work being done in hospice care by so many dedicated doctors and nurses, as well as what is being done by great Canadians in the communities in which we live.

It was such a concern for ordinary Canadians in Hamilton to give quality care, end-of-life care to the people of Hamilton that they raised \$3 million and built the Dr. Bob Kemp Hospice to ensure hospice care was available to people in need.

We are faced today with a problem that continues to challenge our society. The pitfalls are many and the answers are far from clear. In view of this, I would urge members to reject Bill [C-384](#) and signal to all Canadians that we hold life as sacred and do not find the intentional taking of life acceptable whatsoever.

**Mr. Paul Szabo (Mississauga South, Lib.):**

Madam Speaker, before I came to this place, I spent five years on the ethics committee of the board of directors of the Mississauga hospital. I learned a great deal about self-determination, competency, the whole idea of informed consent, the realities of coercion by family members, friends and other people who have conflicts of interest, and the risk that the patient may be competent but not understand the risk of incorrect diagnosis or prognosis and the possibility that circumstances can change after he or she has given consent but then lapse into incompetence. These are all very minor, simple ethical questions. There are many more complex ones. These are just a sample.

Euthanasia involves a physician directly injecting a lethal substance into another person with the person's consent. Physician assisted suicide involves a physician who provides the individual with information, guidance and the means, such as a prescription for a lethal drug, with the intent that the person himself or herself will take his or her own life. That is the difference.

Bill [C-384](#) seeks to legalize both euthanasia and assisted suicide. It purports to provide the right to die with dignity when in fact what it does is it gives the medical practitioner the right to terminate or assist in the termination of life before natural death.

It would change section 14 of the Criminal Code such that a medical practitioner does not commit homicide if he or she aids a person to die with dignity who has given his or her free or informed consent, who has a terminal illness, and who continues, after expressly refusing the appropriate treatments available, to experience severe physical or mental pain without any prospect of relief.

There are some flaws in the bill. I looked at it carefully. My immediate reaction is that it does not restrict this availability to Canadian residents. Anyone could walk into Canada and request euthanasia, which is silly.

The bill does not define terminal illness. It does not define lucidity. It does not define a whole bunch of things. In fact, it requires the patient to be free from duress or coercion, but it does not give any indication of how that might be addressed.

This bill is an amendment to the Criminal Code. It is two paragraphs long.

I have before me the bill of one jurisdiction and it is 10 pages long. Let me highlight some of it. It includes 20 definitions that are necessary to be there so it is operable. Also, under "Written Request for Medication", it has section 2, who may initiate a written request; section 3, the form for written requests; section 4, the attendant physician responsibilities; section 5, consulting physician confirmation; section 6, counselling referral; section 7, informed decision; section 8, family written notification. It goes on. It includes written and oral requests; the right to rescind; waiting periods; medical record; documentation requirements; residential requirements; disposal of unused medication; effect on construction of wills, contracts and statutes; insurance and annuity policies; construction of the act. Under "Immunities and Liabilities" it covers the sanctions of prohibiting a health care provider from participating; liabilities and claims from government authorities; and forms to request. I could go on.

This is a comprehensive bill on a very serious subject. The bill before us for debate is not. Based on my review of the bill and the legislation in other jurisdictions, I have concluded that this bill is seriously flawed, inoperable and irreparable in its current form.

We have to look at the experience of other jurisdictions. It is instructive.

Oregon has had the law for 12 years. In 2009, 93 people obtained prescriptions for the lethal drug, but only 53 actually took their lives. In Washington state in the first 10 months, which is how long it has had the law, 63 people got the lethal drug, but only 36 took their lives. Does it paint a little picture? There are some numbers here.

In all of these jurisdictions people were asked why they were seeking euthanasia or assisted suicide. Ninety-one per cent of them said that it was losing the ability to participate in the activities that make life enjoyable. Eighty-two per cent said they were worried about losing their dignity. Only 23% said they were worried about the pain and suffering. We cannot ask people who are not the patient how they feel about this. We have to ask people who are facing this situation.

It is clear to me the concern about pain and suffering, which is really the only major justification the member has given on this bill, in fact is not the compelling reason that some people request termination of life.

Our health care system is there to meet the needs of all, including the disabled, the terminally ill, the aged and the most vulnerable in our society. We meet those needs through continuing care, palliative care, stroke and geriatric rehabilitation, long-term care, hospices, home care and family medicine. We need to continue to improve that care, not terminate it.

Palliative care workers are very concerned about this bill. Organizations and hospices are doing their very best to give the best possible care in difficult situations. The disabled in our society are obviously very concerned about whether their lives are at risk because someone decides they are not living in dignity.

As well, the legalization of euthanasia and assisted suicide would reduce funding for palliative care, reduce the number of palliative care service centres and reduce the number of palliative care physicians.

There are some slippery slope considerations. I would simply point out that people are not valueless because they are chronically dependent or dying. They continue to be human beings and should be respected and supported in their time of need and, as a result of the loss of a patient's autonomy because the final decision will belong to a physician, not to the individual. I mentioned personal autonomy.

Our experience shows that there is an absolute certainty that errors will occur and that lives of people will be wrongly terminated.

Our social, moral and ethical values, as expressed in our laws, practices and customs, define who we are as a people and as a country. The thought of deliberately taking a human life for any reason is simply incompatible with Canadian reality. The decriminalization of euthanasia and assisted suicide depends entirely on the participation of the medical profession, and it should be noted that the majority of the medical profession is opposed. As I mentioned in my question earlier, it will pit doctor against doctor, depending on whether they support it.

What we really need is a national strategy for comprehensive palliative care to address any gaps in compassionate care services. This also involves an increase in education for doctors and medical students who normally receive little training in the benefits or advancements in palliative care.

For all of those reasons, I am strongly opposed to euthanasia and assisted suicide and I will be voting against Bill [C-384](#). In my view, it is simply wrong to deliberately kill another human being. The miracle of life is inherently dignified and each day is a gift to be cherished.

**Mr. Joe Comartin (Windsor—Tecumseh, NDP):**

Madam Speaker, there is no doubt, having learned from the prior debates on this bill and again this evening, that this is an extremely difficult issue for all of us to confront as parliamentarians.

It is a private member's bill, so it will be a free vote for all members of Parliament, and all of us as individual members of Parliament must make our decisions. I know most of my caucus are opposed to the bill at this time, but there are certainly other members who, in good conscience, will vote in favour of it.

That division in attitudes comes from a philosophical basis, from a religious basis and from a moral basis on both sides of the issue. I have taken a somewhat different approach in my opposition, because I am opposed at this time. I cannot rule out that at some point, our Canadian society should in fact have a provision that would exempt this type of death from the Criminal Code's definition of murder, but we are not there today. I am quite convinced of that. In all good conscience, again for my colleague from the Bloc, I have serious problems with the methodology in the bill. I will come back to that if I have enough time at the end.

My approach is one simply of analyzing where we are as a society, both in Canada and at a somewhat more extended level, in some of the countries and jurisdictions that have introduced the concept of assisted suicide in whatever form or methodology they have done it. In terms of all the work I have done on this, I have come very definitely to the conclusion that it would be premature for Canadian society, at this time, to move down this road. Again, we may never move down this road, but we certainly should not at this time, for two primary reasons.

First, it is quite clear that as a society, we do not have the medical professionals ready, trained and equipped to deal with pain control. One studies the curriculum in medical schools and the position that doctors take when they are out of medical school and practising, whether they are general practitioners or specialists. It is quite clear that the knowledge out there on pain control has nowhere near permeated 100% of our medical profession.

I say this from a good deal of experience in my own community. I believe we have the best hospice in the country. I think it is 25 years old now. One of the programs we instituted about four years ago, or a bit longer, was a mentoring process by a pain specialist, who is now retired. She conducted a mentoring program, funded by the provincial government, for general practitioners. We now have put about 30 general practitioners through that process, educating them. These doctors are practising, some for a good deal of time, but they have to learn, for the sake and benefit of their patients, how to control their pain. It has been very successful.

The director of our hospice tells me that she does not get requests for assisted suicide. This woman has worked in this field for over 20 years in the Windsor area. The hospice is able to provide them with the resources, the pain control and sometimes the setting, so it is not necessary for individuals to have to make that decision of ending their own lives earlier than what would naturally occur. They are able to do that, yet still have full dignity of living out their lives to the fullest, both in time and in quality of life.

The other reason I believe this is premature is we do not have anywhere near the services in palliative care in hospices that we should have. The statistics I have on this show quite clearly that only about 20% of the regions are fully covered by full palliative care in hospices. We have perhaps another 15% or maybe 20% where we have partial coverage. We have a long way to go, and we should be concentrating on that.

I must admit I get to be critical of the government. One thing that happened, not in this current budget but in the two budgets before that, was the money to assist in setting standards for those palliative care centres and hospices was cut. There is no money left in the federal budget for the type of research and the setting of standards that would help the provinces in those areas.

We need to finish building the infrastructure before we move to considering whether we are going to have assisted suicide. We then need to look at other jurisdictions. What has happened there is not what I think we see in the common viewpoint of the average Canadian.

The average Canadian thinks the person who will have an assisted suicide is the stereotypical sufferer of Lou Gehrig's disease, that type of debilitating and terminal illness, those people who near the end of their lives will be unable to do anything to end their lives themselves and so they need assistance. That is the image out there. That is what shows up in the opinion polls.

If we study every jurisdiction that has moved to assisted suicide, that is not the person who is primarily using the system. It is almost overwhelmingly, and I am talking very high percentages, 75%, 80%, 85% of the cases, the frail elderly and, in some cases, younger people suffering from severe disabilities. It is not someone suffering from Lou Gehrig's disease.

Until we are in a position to complete the building of the medical infrastructure that we need to support patients, we cannot go down this road. We have to think about the unintended consequences every time we pass legislation, and this is certainly a classic example of where we end up with an unintended circumstance. We think what we are doing is helping a patient, a citizen of our country, but what we are doing is severely terminating lives of this much larger group in the form of the frail elderly.

Again, I have looked at all the jurisdictions, of which I am aware, where they have legislation. We heard from my Conservative colleague about the minister who moved the legislation through the Parliament in Holland. In 2009 the minister went public, supporting exactly the position I set forth before Parliament tonight. She recognized they did not have anywhere near a full system of palliative care in Holland. She has recognized, by the statistics that are coming out now, that it is the frail elderly who are overwhelming being euthanized. It is not what was intended. This was a consequence that resulted. She has made it quite clear that if faced with the decision today, she would not have marshalled that legislation through her legislature until that system was built.

This is not an easy issue, but it is very clear to me that the bill is so premature. We are at a stage in our development of our society where we can build the rest of that system. It will require some additional financial resources, but it is not great and we can afford to do it. That is what we should do and put off this type of legislation for quite some time into the future, if ever.

#### **Ms. Diane Bourgeois (Terrebonne—Blainville, BQ):**

Madam Speaker, I would like to begin by congratulating my colleague from [La Pointe-de-l'Île](#) for having the courage to introduce such a bill. It is an honour for me to support this bill. I recognize the member's wisdom in foreseeing what is to come.

We will all grow old and at some point we may have to choose what we want to do with our lives. We may have cancer or a degenerative disease and we may have to make a choice. If we cannot do so, we may think back on today's debate.

To consider this bill and its consequences, we must keep a very open mind. All my colleagues who have spoken have provided us with various insights about the consequences of the bill. We are talking about this, and it is a good thing.

I wonder if we are ready not to brush off this bill, to improve it and send it to committee for further discussion. Contrary to what has been said, this bill does not devalue life.

If we read this bill carefully, we can see that it calls for a mechanism leading people to make conscious decisions.

Two members have made false and dishonest comments about the bill. These comments are tainted by religious ideology. They cannot tell me that they have read the bill correctly. Their religious ideology showed through their comments.

My colleague was right when she said that those who usually oppose abortion are predisposed to oppose this bill. People often bring up the protection of life for all manners of things. Some even go as far as to lie to the House tonight to show that they are against the bill. What some members said about the bill is not true.

Now...

#### **The Acting Speaker (Ms. Denise Savoie):**

Order. I believe it is a violation of the Standing Orders to say—

### **Ms. Diane Bourgeois:**

Madam Speaker, I withdraw the word I used. I will simply say that some people go out of their way to misrepresent what the bill is trying to do. I apologize, but I am still of the same opinion.

We all want to die with dignity. I listened to one of our colleagues across the floor who was saying earlier that his mother passed away while in pain, but despite everything, she died peacefully. How would he know? How can he know if his mother died peacefully while she was in pain? She had no choice. Perhaps she would have felt more peaceful if she had had the choice. There was nothing else to help her. I do not know. I think the members was making a gratuitous remark.

Let us talk about palliative care. Yes, there is some very good care, but there are also people who will simply be left on their own at the end of their lives, even if they have good palliative care. Does anyone here know someone who has died of Alzheimer's disease? What happens in the last four or five days of the life of someone dying of Alzheimer's disease? They can no longer swallow and they can no longer think. They are simply left on their own and given cortisone or morphine.

I have before me a text written by Claire Morissette. She died on July 20, 2007. She explains what she was going through during her final days. I would like to read a passage. This is what she wrote about pain.

*Suffering is much like shivering. You shrivel up, your entire body contracts from your scalp to your feet. It HURTS!!! It hurts constantly. The shivering consumes all your strength, all your consciousness, it is exhausting. Think about it: could you stand shivering for ten days, twenty days, two months, years on end?*

*Then relief comes, the shot of morphine. It is like a wave of warmth that releases you from the shivering, blessed relaxation on an open beach. Thank you!!! Oh, thank you!!! That feels so good. But, [with doses like that], you hallucinate, you become confused, half-deranged.*

*While this is going on [listen carefully], the body drains away. Lacking appetite and exercise, you dissolve. In the mirror, you see (no exaggeration) a concentration camp skeleton. You have no buttocks to sit on, your breasts are empty, your knees are unreliable. [In fact, you have to hold a pillow between your knees so you can keep them together.] Your skin shrivels; wrinkles take over. How humiliating. What is worse, because of the medication, your urine, your feces, your flatulence, your breath, your vomit all smell like the end of the world, and, in complete humiliation, you inflict it on the people helping you. If you have to defecate in bed, in a dry bedpan, the stench is beyond description. Then someone else has to wipe your bottom, which is still more humiliating.*

*Is that how we want people to live? Is that dying with dignity? That is truly the end of the road. She goes on to say that making even the smallest movement takes an enormous amount of energy. People watch DVDs and try to get used to it, but when they are really suffering, all they want is to find sleep, deep sleep, unconsciousness, oblivion. Yes, indeed, everyone feels awful about it. Everyone wants to help, to do what they can. But their helplessness is tangible.*

Claire Morissette continues on, saying that people will cry in secret, no matter how hard they try to keep the atmosphere from being too dismal. But their grief is heartbreaking. Is that really allowing a person to live with dignity?

She says that she could die of hunger or she could die of thirst. She knows that she will die, but all she wants is to die with dignity and to be allowed to choose where, when and how she will die.

This bill introduced by the member for [La Pointe-de-l'Île](#) will allow, would allow or would have allowed this person and their doctor to talk about options. All that is requested is our compassion. We would not let an animal die this way. If your dog was

suffering, you would take him to the veterinarian. What about a human who is suffering terribly? We do not give them the possibility—

**The Acting Speaker (Ms. Denise Savoie):**

Order. Resuming debate. The hon. member for Langley has about two minutes before adjournment proceedings.

**Mr. Mark Warawa (Parliamentary Secretary to the Minister of the Environment, CPC):**

Madam Speaker, the seniors that the hon. member just spoke of are not trash. They are treasures.

I would like to state from the outset that I do not support Bill [C-384](#) which proposes the legalization of physician assisted suicide and euthanasia under specific conditions.

The bill raises a number of serious concerns and I propose to outline the ones that I consider the most troubling.

First, Bill C-384 is too broad in terms of its scope. Bill C-384 proposes to amend the Criminal Code to provide an exemption not only for the offence of assisted suicide but also for the offence of murder. These amendments would represent a substantial change in the current state of law on a matter that touches life and death.

The proposed legalization of medical euthanasia and assisted suicide would not only apply to terminally ill patients but also to persons who suffer from severe physical or mental pain without a prospect of relief.

Therefore, under the bill, persons who suffer from depression could request that a doctor help them to commit suicide. They could also request that the doctor carry out the act itself that would cause their death.

When I articulated earlier that Bill [C-384](#) is too broad in its scope, this concern applies to both the fact that it would permit physician assisted suicide and euthanasia, and to the fact that it would allow a vast array of persons to make a request to a doctor for assisted death.

**The Acting Speaker (Ms. Denise Savoie):**

Order, please. The hon. member will have approximately eight minutes when the bill comes back to the House for debate.

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.