CRIMINAL CODE

BILL TO AMEND—SECOND READING—DEBATE CONTINUED

On the Order:

> Resuming debate on the motion of the Honourable Senator Wallin, seconded by the Honourable Senator Tannas, for the second reading of Bill S-248, An Act to amend the Criminal Code (medical assistance in dying).

Hon. Stan Kutcher: Honourable senators, I rise today to speak in support of Bill S-248, introduced by Senator Wallin in this chamber, a bill that would allow for the provision of advance requests for medical assistance in dying, or MAID, for competent persons who wish to avail themselves of this method of asserting their end-of-life choice.

I will not repeat the well-researched and clearly presented information provided by Senator Wallin on what we know about Canadians' opinions regarding advance requests or her discussion about Audrey's Amendment and the details of this bill. I will focus my remarks on a number of key items that I hope will be considered at the committee that studies this important legislation. Before I do that, I want to echo two key points that Senator Wallin addressed in her speech.

First, it is clear that this bill amends the Criminal Code to allow for advance requests. It is permissive, not prescriptive. There is nothing in this bill that compels or directs any person to seek MAID using an advance request.

Second, this bill does not promote MAID as an alternative to palliative care or a remedy for access to needed services and supports. As Senator Wallin put it, "MAID is not an alternative to poverty or treatment or support or family." I agree with both of these considerations.

That said, let me begin my contribution to this debate by considering what an advance request for MAID is and, equally important, what an advance request for MAID is not.

We can think of an advance request for MAID as a request made by a competent person, for MAID, in advance of a loss of decision-making capacity, to be acted upon under the circumstances outlined in the request after the requester's loss of decision-making capacity, following the requirements set out in federal legislation.

• (1610)

This consideration has a number of key components that can assist us in thinking critically and compassionately about advance requests for MAID. It can help identify areas that need careful attention as safeguards and standards are constructed to help manage the application of advance requests.

I will focus on four areas:

First, an advance request is not a directive. MAID providers are not obliged to provide MAID simply in response to a request. They must still follow their professional guidelines, best judgment and all legal stipulations in responding to an advance request. Thus, the request itself must be clear, specific and stipulate the conditions under which it is to be considered by the MAID provider.

Second, the request must be made by a competent person, and as such, a clinically and legally defensible determination of competence should accompany an advance request.

Third, the advance request must be made voluntarily and be well considered. That means that the request cannot be the result of undue influence or coercion and that the person making the advance request has demonstrated that they have considered relevant information prior to them making the request.

Fourth, the request has been made in due consideration of the impact of the passage of time. It should be regularly updated so that the MAID provider has reasonable comfort that the request is current.

Before going into these four areas in more detail, I will address what an advance request is not and consider what some kinds of conditions are that we may expect that advanced requests would be made for.

An advance request is different than an advance directive. Advance directives already exist, are well established and are common in many different aspects of medical care. Senator Mégie raised this important issue in a question to Senator Wallin.

While an advance request for the federal regime for MAID would be governed by the Criminal Code, advance directives are governed by provincial/territorial regimes for other types of health care. Most frequently, they are given in the context of a choice or refusal of treatment.

For a personal example, when my elderly mother began to experience numerous and compounding health challenges, my brothers and I had many very emotionally problematic conversations with her about what kinds of treatments she would accept and what kinds of treatments she would not accept. These were difficult.

We wrote down her decisions and we all signed off on them. We made sure that we provided evidence of her cognitive capacity at the time of our discussions. We also all came to an agreement on substitute decision making. When the time came — and it did — we provided her medical team with her directives. They followed them.

I am certain that for many in this chamber, this is a situation not unknown to you. It can be very uncomfortable because it deals with the reality of the upcoming death of a loved one. But it is supposed to be uncomfortable because if it were not so, we would not be loving and caring people.

The same discomfort should and does arise in all of our discussions about MAID. Discomfort is a necessary part of this journey.

Advance directives can include preferences for treatment and stipulations for refusal of treatment. As such, they are logical extensions of the doctrine of informed consent for treatment and refusal of treatment.

They can range widely, from accepting palliative sedation while concurrently not accepting antibiotic treatment for a potentially life-ending infection to directing a "do not resuscitate" order, to refusing all foods and fluids administered via a feeding tube or by mouth, known as voluntarily stopping eating and drinking, or VSED, which usually — and we've lived through this — results in death in 7 to 10 days.

Thus, while an advance request for MAID is not the same thing as an advance directive, these different concepts share the acceptance of personal autonomy as it pertains to advance decision making, and we are underpinned by the doctrine of informed consent and the right to choose and refuse treatment, even if that choice results in or hastens death.

While it is anticipated that most advance requests will be made in the context of neurodegenerative diseases such as Alzheimer's disease, other kinds of illnesses may also trigger an advance request. For example, a primary brain tumour, such as glioblastoma multiforme. GBM, as it is known in the medical community, is the most invasive type of brain tumour and is not curable.

People diagnosed with GBM typically live 10 to 22 months from the time of diagnosis. While most people are cognitively intact when diagnosed, decision-making capacity can decline very rapidly. End-stage GBM can include severe headaches, inability to swallow, delirium, hallucinations, delusions, loss of control over bodily functions, seizures and loss of consciousness. Knowing this reality, an individual may consider making an advance request for MAID at the time of diagnosis.

The challenge that this condition illustrates is that it is not possible to predict with any degree of certainty how long a period of decision-making competency will be in place before the changes — which can occur rapidly — happen, leading to an inability to consent to MAID even if that is the person's end-of-life choice.

Incidentally, this uncertainty can lead to a person deciding to access MAID before they want to, a situation that is horribly unsatisfactory, to say the least.

Let us now return to the four points that I made arising from the definition of an advance request.

First, the issue of clarity, so that everyone, including the MAID provider, is certain about what the wishes of the competent person making the request are. It's the wishes of the competent person.

Here, in my opinion, it is necessary to ensure that the request is made in written form and is specific to what the individual making the request considers to be their threshold that will trigger a MAID request. The request should provide as much information as possible for others to be able to clearly understand the conditions under which MAID can be administered.

Statements such as "when I am no longer able to enjoy life" or "when I am not able to make my own decisions" or "when I can no longer recognize my family" should not be put forward as situations for MAID consideration. Specificity is needed. For example:

> I would like to receive MAID under the following conditions, even if I am not in pain and regardless of what others think about how my life is going: if I can no longer recognize any member of my family at any time of their visits for a period of two months; OR if I can no longer toilet myself for a period of one month; OR if I do not know where I am, what day it is and what month of the year it is, daily, for a period of one month.

What is important to stress here is that these conditions are specific and are what the individual considers to be intolerable to them. They will vary from person to person and are not conditions that a third party decides.

Furthermore, if the individual is willing, family members and others can participate in the discussions as to what conditions the individual considers to be the threshold for MAID when the advance request is being developed. With such specificity, fulfilling the advance request for MAID becomes clearer for the patient, clinician and family members alike.

• (1620)

My second consideration was that the request be made by a competent person, and, as such, a clinically and legally defensible determination of competence should accompany an advanced request. This means that the advanced request for MAID should include an assessment of competency provided by a qualified clinician, and a note describing the assessment and its results should be signed, dated and affixed to the written advance request. For example, a clinical interview plus a mini-mental state examination could be considered to fulfill this condition.

That safeguard is useful to avoid later questions as to whether the person making the advanced request was or was not competent to do so at the time the advanced request was made.

Third, the advance request must be made voluntarily and be well considered. That means the request cannot be the result of coercion, and the person making the advance request has demonstrated they have considered relevant information prior to making their request. This issue may be addressed in the legislation or it may be addressed in clinical guidelines that need to be developed to assist patients, their families, clinicians and MAID assessors.

In my own professional experience in conducting numerous patient decision-making assessments, the issue of clarifying that there is no undue coercion is always part of how such assessments are done. If the clinician is not certain about coercion, the usual practice is to seek a second opinion from a colleague. If there continues to be uncertainty, further investigation may be required to clarify the situation.

Perhaps this is the issue that Senator Batters was trying to address with her questions to Senator Wallin about two independent witnesses whose purpose was to confirm that the advanced request was made voluntarily.

The Hon. the Speaker: I'm sorry to interrupt you, Senator Kutcher, but the time has expired. Are you asking for five more minutes?

Senator Kutcher: I am.

The Hon. the Speaker: Is leave granted, honourable senators?

Hon. Senators: Agreed.

Senator Kutcher: Thank you.

Legislating two independent witnesses, as this bill does, may add an additional safeguard to mitigating the possibility of coercion. Alternatively, or as a complement to that, there could be guidelines embedded in standards of practice for MAID providers. These, and other options, need to be closely examined at committee.

My fourth consideration was that the request has been made in due recognition of the impact of the passage of time so that the MAID provider has comfort that the request is current. Proposed paragraph 241.2(3.22)(b) of the bill addresses this issue, requiring that an advanced request be no more than five years old. Senator Wallin has told us that the five-year timeline was chosen following consultations with various stakeholders, but that she is not wedded to that number. Personally speaking as a clinician, I would suggest a shorter time period, perhaps two years. However, whatever the window chosen, it would be essential that the updating be signed by the individual, clearly confirming the specificity of the intolerable suffering criteria for that individual and that a clinical assessment of decision-making capacity be appended to the update.

Honourable senators, this is an important piece of legislation, and it requires our careful and critical consideration. I recall in our debates during Bill C-7 that one reason presented for not legislatively addressing the issue of advance requests was that this issue had not had sufficient study in committee. Colleagues, now is the time for us to do just that.

Thank you, *wela'lioq*.

Some Hon. Senators: Hear, hear.

(On motion of Senator Martin, debate adjourned.)

RCMP'S ROLE AND MANDATE

INQUIRY—DEBATE CONTINUED

On the Order:

> Resuming debate on the inquiry of the Honourable Senator Harder, P.C., calling the attention of the Senate to the role and mandate of the RCMP, the skills and capabilities required for it to fulfill its role and mandate, and how it should be organized and resourced in the 21st century.

Hon. Marty Klyne: Honourable senators, this item is adjourned in the name of Senator Busson, and I ask for leave of the Senate that, following my intervention, the balance of Senator Busson's time to speak to this item be reserved.

The Hon. the Speaker: Is leave granted, honourable senators?

Hon. Senators: Agreed.

Senator Klyne: Honourable senators, I rise to speak to the inquiry commenced by Senator Harder on December 2, 2021, regarding the future of the Royal Canadian Mounted Police. It's an important discussion, and, by many accounts, one that is long overdue. I hope it's a discussion that leads to a clear and realistic picture of our RCMP and a bright future for the organization.

The RCMP is the most unique police force in the world. It's our national police force; it's our federal police force; and in some jurisdictions, it's the provincial or territorial police force, or the municipal police. It is also an international police force through its involvement in INTERPOL.

Depot Division, the RCMP Academy, is considered one of the most elite police training academies in the world. From 1885 to 1920, Depot was the headquarters of the North-West Mounted Police and then the Royal Northwest Mounted Police. Not only has every member of our national police been trained at Depot since the inception of the North-West Mounted Police in 1873, Depot has also trained police and investigators of many stripes from around the world.

Mounties in their dress uniform are collectively one of the most recognized symbols in the world, dressed in the red serge, Stetson hats, Strathcona boots with spurs and midnight blue stirrup overalls with a yellow stripe down the legs. Like Canada's multiculturalism, two official languages, the maple leaf, our Parliament buildings, maple syrup and the Rockies, the RCMP is a symbol of national identity.

We also know that those who serve in our national police force act with courage every time they put on the uniform, sometimes making the ultimate sacrifice in the line of duty. Last month, the death of Constable Shaelyn Yang in Burnaby, B.C., was a tragic reminder.

• (1630)

Suffice it to say the RCMP has an important place in our country's complex history and in our national culture, as well as in keeping us safe. However, there are concerns with our RCMP. There are questions about its mandate, its focus and its conviction to uphold the RCMP's core values. All of this lends itself to a question around the RCMP work environment, the influence of systemic racism, numerous cases of failure to adhere to proper protocols and decades of physical and sexual harassment, not to mention the difficulty in recruiting applicants and cadets. These concerns give rise to an overarching question