Second Session – Forty-First Legislature

of the

Legislative Assembly of Manitoba

Standing Committee on Legislative Affairs

Chairperson
Mrs. Sarah Guillemard
Constituency of Fort Richmond

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MANITOBA LEGISLATIVE ASSEMBLY
Forty-First Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON LEGISLATIVE AFFAIRS

Monday, November 6, 2017

TIME – 6 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mrs. Sarah Guillemard (Fort Richmond)

VICE-CHAIRPERSON – Mr. Greg Nesbitt (Riding Mountain)

ATTENDANCE – 11 QUORUM – 6

Members of the Committee present:

Hon. Mr. Goertzen, Hon. Ms. Squires

Mr. Allum, Ms. Fontaine, Mrs. Guillemard, Ms. Klassen, Messrs. Michaleski, Nesbitt, Piwniuk, Swan, Teitsma

Substitutions:

Mr. Isleifson for Mr. Michaleski at 7:09 p.m.

APPEARING:

Mr. Andrew Micklefield, MLA for Rossmere

PUBLIC PRESENTERS:

Mr. Cory Ruf, Dying with Dignity Canada
Mr. Larry Worthen, Coalition for HealthCARE and Conscience
Mr. Mark Kristjanson, private citizen
Mr. Randy Goossen, private citizen
Mr. Alewyn Vorster, College of Physicians and Surgeons of Manitoba
Mr. Frank Ewert, private citizen
Ms. Beverly Rutherford, private citizen
Ms. Barbara MacKalski, private citizen
Ms. Kristin Harris, private citizen
Ms. Mary Shariff, private citizen
Mr. Albert Chudley, private citizen
Mr. Anthony Nakazato, private citizen
Ms. Valerie Wadephul, private citizen
Ms. Ann McKenzie, private citizen
Ms. Patti Fitzmaurice, Roman Catholic Archdiocese of Winnipeg / Archdiocese of St. Boniface
Mr. Donald Peters, private citizen
Ms. Julie Turenne-Maynard, Catholic Health Association of Manitoba

WRITTEN SUBMISSIONS:

Jennifer Savoie, private citizen
Jayson Barkman, private citizen

MATTERS UNDER CONSIDERATION:

Bill 34 – The Medical Assistance in Dying (Protection for Health Professionals and Others) Act

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Madam Chairperson: Good evening. Will the Standing Committee on Legislative Affairs please come to order.

Our first item of business is the election of a chair–Vice-Chairperson. Are there any nominations?

Mr. Doyle Piwniuk (Arthur-Virden): I nominate Mr. Nesbitt.

Madam Chairperson: Mr. Nesbitt has been nominated. Are there any other nominations?

Hearing no other nominations, Mr. Nesbitt is elected Vice-Chairperson.

This meeting has been called to consider Bill 34, The Medical Assistance in Dying (Protection for Health Professionals and Others) Act.

Before we get to the presentations, we have a special request to undertake. Presenter No. 5, Cory Ruf of Dying with Dignity Canada, and presenter No. 1, Dr. Barbara MacKalski, have asked to make their presentation by telephone. The House leaders have been informed and already agreed to this request, and we have arrangements in place to accomplish this. We will call the two presenters in order we received the requests, with Mr. Ruf first, followed by Dr. MacKalski.

I would ask if it is the will of the committee to entertain these two presentations first, and then move on with the other presentations? *[Agreed]*

On the topic of determining the order of public presentations, I will note that we have out-of-town presenters in attendance marked with an asterisk on the list. With this consideration in mind, in what

order does the committee wish to hear the other presentations on Bill 34?

Mr. Andrew Swan (Minto): Madam Chairperson, we can keep with our usual practice and allow the out-of-town presenters to go first.

Madam Chairperson: Is this the will of the committee? *[Agreed]*

I would also like to inform all of you in attendance today that, if necessary, the Standing Committee on Legislative Affairs will meet again to consider Bill 34 tomorrow, November the 7th, at 6 p.m.

Finally, I would like to inform all in attendance of the provisions in our rules regarding the hour of adjournment. A standing committee meeting to consider a bill must not sit past midnight to hear public presentations or to consider clause by clause of a bill, except by unanimous consent of the committee.

Written submissions from the following persons have been received and distributed to the committee members: Jennifer Savoie, Jayson Barkman. Does the committee agree to have these submissions appear in the Hansard transcript of this meeting? *[Agreed]*

Before we proceed with presentations, we do have a number of other items of points of information to consider. First of all, if there is anyone else in the audience who would like to make a presentation this evening, please register with the staff at the entrance of the room.

Also, for the information of all presenters, while written versions of the presentations are not required, if you are going to accompany your presentation with written materials, we ask that you provide 20 copies. If you need help with photocopying, please speak with our staff.

As well, I would like to inform presenters that, in accordance with our rules, a time limit of 10 minutes has been allotted for presentations, with another five minutes allowed for questions from committee members. Also, in accordance with our rules, if a presenter is not in attendance when their name is called, they will be dropped to the bottom of the list. If the presenter is not in attendance when their name is called a second time, they will be removed from the presenters' list.

Prior to proceeding with public presentations, I would like to advise members of the public regarding the process for speaking in committee. The proceedings of our meetings are recorded in order to provide a verbatim transcript. Each time someone wishes to speak, whether it be an MLA or a presenter, I first have to say the person's name. This is the signal for the Hansard recorder to turn the mics on and off.

Thank you for your patience.

Bill 34–The Medical Assistance in Dying (Protection for Health Professionals and Others) Act

Madam Chairperson: We will now proceed with public presentations.

We will now call Mr. Cory Ruf, and as soon as we have him on the phone, our recording staff will put the presenter live for the room.

Please proceed with your presentation, Mr. Ruf.

Mr. Cory Ruf (Dying with Dignity Canada): Okay, thank you very much.

Good evening. My name is Cory Ruf, and I am the communications officer with Dying with Dignity Canada. I thank the Standing Committee on Legislative Affairs for allowing us to participate in this meeting.

Dying with Dignity Canada is the leading national organization committed to improving quality of dying and defending Canadians' end-of-life rights. We work to break down unfair barriers facing suffering Canadians who wish to exercise their right to medical assistance in dying, or MAID. We also work to ensure that the rules and regulations surrounding MAID are fair and compassionate, and that they ultimately comply with the Charter of Rights and Freedoms and the Supreme Court's 2015 decision in Carter v. Canada.

***** (18:10)

Before I delve into our specific concerns about Bill 34, I would like the committee members to imagine themselves in the shoes of a Manitoban who might explore a request for MAID. Individuals who request MAID are some of this country's most vulnerable, physically compromised patients.

According to numbers released by Health Canada, the 30 Manitobans who accessed MAID in the first six months of 2017 had an average age of 75. In 70 per cent of those cases, cancer was the primary underlying condition.

Now, picture yourself as a 75-year-old who is facing a second, third, or even fourth round of cancer treatment and has decided that they have had enough. Maybe you're staying in a hospital, in a personal-care home or still living on your own. You are aware of your right to MAID and would like to be assessed for it. You're not sure how your doctor feels about MAID, but you have no idea how you'll get your questions answered without going through them.

How the doctor or nurse practitioner responds could ultimately determine whether or not this 75-year-old person has access to their right to MAID. Right now, provincial regulation only requires conscientious objectors to, at a minimum, provide the patient with a publicly available resource that gives information about MAID. That could be a pamphlet, an address for a website or the phone number for a service that provides information on MAID.

Navigating the health-care system is challenging enough for the young and able-bodied among us, so imagine the burdens facing the 75-year-old cancer patient whose condition is rapidly declining, who is bedbound, and who may not be able to use the Internet. Maybe they don't speak English or French as a first language, or they have difficulty seeing, hearing or speaking.

As a society, we must ask ourselves whether it is acceptable for their doctor, the person most responsible for their care, to say when it comes to finding someone who will answer your questions about MAID, you are on your own.

If passed in its current form, Bill 34 would communicate that it is okay to tell desperately ill Manitobans that they are on their own. It reinforces provincial regulation that fails to provide a backstop for vulnerable Manitobans, and it would handcuff the College of Physicians and Surgeons of Manitoba should it decide that its current policies on MAID unfairly privilege the views of objecting physicians over the rights of vulnerable patients.

In particular, the ambiguity of the language in Bill 34 raises major concerns. It proposes a ban on regulation that would require clinicians to aid in the provision of MAID. But what does aid mean in this context? Certainly, filling a prescription or providing a MAID assessment would qualify.

But what about connecting a Manitoban who has questions about assisted dying with a provincial MAID team? What about giving accurate, non-judgmental information about MAID to a patient who asked for that. Does that constitute aid?

If interpreted broadly, this provision could suggest that physicians have absolutely no obligation to ensure that patients in their care have access to the compassionate treatment that they seek and to which they have a right. In the most dramatic scenarios, this legislation could even communicate to objecting clinicians that they do not have to do the bare minimum that the college currently expects of them; that is, if they believe that providing a patient with a publicly available resource constitutes aiding in the provision of MAID. This would be unconscionable.

Clinicians do have a right to conscientious refusal. However, protecting that right need not and, indeed, must not obstruct Manitobans' right to MAID.

Thankfully, there are models that exist that strike a fair balance between these rights and interests. In Ontario, the College of Physicians and Surgeons requires doctors who object to MAID to provide patients who request it with what is called an effective referral. An effective referral can come in many forms and, according to a CPSO fact sheet, there are a number of ways in which clinicians can satisfy the effective referral requirement without communicating directly with a MAID provider.

For example, they could notify a third-party agency or provincial care co-ordination service, which would then put the patient in contact with a participating clinician. Alternatively, they could establish a willing point person in one's practice team to handle all requests for MAID, and that person would make contact with a MAID provider or third-party agency. These are just a couple of examples.

What should also be noted is that satisfying the effective referral requirement does not mean that the physician endorses MAID, nor does it mean that the referral will necessarily lead to the provision of MAID. The key here, though, is, and I quote, that the referral must be made in a timely manner so that the patient will not experience an adverse clinical outcome due to a delayed referral. End quote.

If a request is not acted upon quickly, it risks forcing the patient to live longer in a state of intolerable suffering. A patient could also lose capacity while they're waiting, rendering them ineligible to access MAID under the current federal law. After all, time is of the essence for patients who request MAID.

In the first half of 2017, one in three Manitobans who made a formal request for MAID died before their assessment could be completed. Unlike the CPSO's effective referral policy, Bill 34 fails to provide a backstop for these vulnerable patients who are at risk of falling through the cracks.

It privileges the interests of objecting clinicians over the rights of desperately ill Manitobans. It offers employment protections for health-care professionals who refuse to participate in MAID without extending those same protections to clinicians who, as a matter of conscience, feel a duty to provide this essential service. In addition, it handcuffs the college in its ability to create and enforce regulation that ensures the safety and personal autonomy of suffering Manitobans.

These issues are complex, and yes, they call for us to reconcile competing interests and beliefs. But as you consider changes to this bill, we urge you to strike a fair balance, one that doesn't lay the heaviest burden on the shoulders of the most vulnerable person in the process. Their rights, their interests and their choices must come first.

Thank you.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for the presenter?

Hon. Kelvin Goertzen (Minister of Health, Seniors and Active Living): Only to thank you for joining us by this means here tonight. I know it's a little unusual for us to do this, but I appreciate that you've made the effort and that the committee has made the effort to allow it to happen via teleconference.

Floor Comment: I'm sorry, I can't hear you. I can hardly hear you.

Madam Chairperson: Okay, go ahead again, Mr. Ruf. We didn't acknowledge you before you spoke.

Mr. Ruf: I'm sorry, I'm having a lot of difficulty hearing you.

Madam Chairperson: Can you hear us now?

Mr. Ruf: I can hear you now.

Mr. Andrew Swan (Minto): Mr. Ruf, thank you for presenting tonight. I'm one of the MLAs, and I'm the opposition NDP Health critic. I thank you for presenting tonight.

The Manitoba committee system is–it's very open and very democratic, allowing anybody to present. It also gives us an opportunity, after we've heard what people have to say, to ask the minister questions. And you did raise some questions about what you believe is ambiguity. I realize you won't be able to hear the rest of the presentation, but we will have a chance perhaps to get the minister just to clarify some of the things that you have raised as concerns on the record, which will help anybody who needs to look at the bill in future. So I want to thank you for your involvement this evening.

Mr. Ruf: Thank you.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation, Mr. Ruf.

Mr. Ruf: Thank you very much.

Madam Chairperson: I will now be calling upon Dr. Barbara MacKalski, and as soon as we have her on the phone our recording staff will put the presenter live for the room.

***** (18:20)

Okay, so apparently, Dr. MacKalski has been called into an emergency procedure and we will try again a little bit later.

So I will now call upon Larry Worthen, Coalition for HealthCARE and Conscience.

Mr. Worthen, do you have any written materials for distribution to the committee?

Mr. Larry Worthen (Coalition for HealthCARE and Conscience): I do, and I've given them to the Clerk. I'm not sure they're ready yet.

Madam Chairperson: Okay, please proceed with your presentation.

Mr. Worthen: Madam Chair, thank you for the opportunity to present to the Standing Committee on the topic of Bill 34.

I'm presenting the following brief on behalf of the Coalition for HealthCARE and Conscience, which is a national network of organizations which was formed to protect conscience rights for individuals and institutions with the legalization of assisted suicide in Canada.

The coalition represents 10 organizations, including 5,000 physicians across Canada. We are in support of Bill 34 and commend the Manitoba Legislature for this legislative initiative. In other provinces, most notably Ontario, the regulatory body

has passed a policy that requires effective referral for MAID. Because of this, our Ontario members are concerned about their continued ability to be able to care for patients.

Now our members understand that MAID has been permitted through the recent Supreme Court of Canada decision in Carter and in federal legislation. We are not seeking to turn back the clock or obstruct patient access to the procedure. We simply ask that once a patient has decided to pursue MAID, we not be forced to participate in placing him or her at risk in this way. Participation includes providing MAID, assisting in the provision of it or making arrangements for the patient to receive it, as in a referral. A referral is a recommendation that a patient under our care should access this procedure and is morally equivalent to performing the procedure.

It is a denial of our solemn responsibilities to God and our neighbours. In this respect, Catholic, Evangelical and Orthodox Jewish theological experts support this view. Other religious groups are also concerned, such as Muslims, Sikhs and Hindus. Other members of our coalition who do not have a religious background are also concerned because of their adherence to the Hippocratic Oath or their personal creed. These standards of medical care have been in place for millennia.

Our primary motivation is the good of our patients. Doctors and nurses know from experience that a request to die can be a cry for help. Loneliness, isolation, poverty, disability or mental illness would lead anyone to question the value of life. It's important to note that in a recent Ontario case called the AB case, a judge has circumvented the clause in the federal legislation requiring death to be reasonably foreseeable. This exposes members of the disability community to premature death. So many times, for many patients, the proper care and supports have helped people overcome these challenges to lead a meaningful life. We have seen relationships restored, milestones celebrated and lives lived when at first there appeared to be no hope. And we have also seen treatments that despite all odds have led to months and even years of prolonged life.

When we are required to participate in the destruction of that life, we're being asked to close the book on a patient when there may be many more chapters to be written. We would not force a patient to prolong their life against their will, but it is also not right that we should be forced to participate in the death of a patient that goes against the very reason we became doctors and nurses in the first place.

Even physicians who are theoretically in favour of assisted suicide are having emotional difficulty following through, as we have read in a recent article in the National Post. Provided that we have adequate conscience protection, we can be a benefit to the health-care system by being there for patients who choose to live despite their challenging circumstances.

Now, what is our primary concern? Without conscience protection like this in other provinces, we are concerned about our ability to be there for our patients. Our concerns are well founded. The College of Physicians and Surgeons of Ontario has experts who insist that conscientiously objecting physicians will have to leave family medicine, palliative care and other specialities and move to a small number of specialities like pathology or cosmetic surgery. Winnipeg ethicist, Dr. Arthur Schafer, who was chosen by the government of Ontario to sit on the provincial-territorial expert advisory committee on physician-assisted death, has publicly stated that conscientious objectors should go into specialities, such as sports medicine, that affect–or that avoid end-of-life care. A prominent Canadian medical ethicist, Dr. Udo Schüklenk from Queen's University, has publicly advocated for a morals test to be applied to medical school applicants to screen out those with conscientious objections. This year, two Ontario medical schools had questions in their admissions process requiring students to act against their conscience.

In this climate, doctors that have conscientious objections to participating in MAID are concerned that they are being squeezed out of medicine. Last week at a public meeting in Nova Scotia, the college registrar stated that physicians who refused to refer for euthanasia for conscience reasons would be disciplined for professional misconduct.

Canada is a country in which pluralism allows us to live and work within a diverse community of ideas and perspectives. Both provincial human rights legislation and the Charter of Rights and Freedoms protect people from that kind of discrimination based on religion, conscience or creed. When policies like those in Ontario are enforced, our values will eventually no longer be represented in the profession or welcomed in health care, a system for which

people of faith and conscience have been founding pillars.

Now, is there a way to provide patient access without sacrificing conscience rights? Now, there are many examples. You need to know that no foreign jurisdiction that has legalized assisted suicide has required doctors or nurses to participate against their will. And there is no indication that in any of these jurisdictions this has caused a crisis in access. Many provinces, like Manitoba, have come up with innovative options. This legislation recognizes that assisted suicide is different than an appendectomy or plastic surgery, as it is essentially killing a patient.

The Supreme Court in the Carter case said nothing in their decision would compel physicians to participate in assistance in dying. The court said, quote, "a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief." The court affirmed that the Charter rights of patients and physicians will need to be reconciled. A commonly held definition for the word reconciled is to coexist in harmony. We suggest that the Manitoba model strikes the correct balance, providing access while providing conscience so that the two can exist in harmony.

I want to just take a moment and talk about how people can get access in Manitoba. When a patient requests MAID, our physicians–our member physicians' primary concern will be to determine the source of the suffering and to try to address it with the patient. Our doctors are willing to discuss all patient options. Once the patient has contacted the MAID team for their assessment, our doctors can provide care in all other matter unrelated to MAID. There is no need to disrupt the therapeutic relationship.

***** (18:30)

Patients could access MAID assessments in the following ways without forcing their physicians to act against conscience. In the office, one would think that if a patient can get to the office, then the patient has been able to make an appointment with their doctor and would also be capable of calling Health Links to request an assessment from the MAID team. In addition, people in the community would have family members, friends or other caregivers who could assist them in making the call or on their behalf.

If an office outpatient is so sick or debilitated they're physically unable to call Health Links, then, really, they should be admitted at the hospital, which one of our members would be pleased to do, provided that it was not an admission specifically for MAID.

We also have to remember that in order to qualify for MAID, the patient must be competent. And in addition, conscientiously objecting physicians can disclose their position on these issues with their patient far in advance so that the patient could make the contact with the MAID team for an assessment prior to a serious decline in the patient's condition.

Now, if the patient is at home and they're really, really sick and they're unable to make the call on their own, well, then they would likely be part of Home Care. And normally, in Home Care, each patient has a care co-ordinator who is the primary person responsible to co-ordinate his or her home care. If the patient or the family members are unwilling to contact the Health Links line for an assessment, a conscientiously objecting physician could suggest that the patient or the representative contact their care co-ordinator to arrange that assessment.

If the patient happens to be in a facility that permits MAID on the premises, and they're unable to contact the MAID team on their own, then the conscientious objector could report their conflict to their medical director who could facilitate a complete transfer of care within the facility from one caregiver to another. Complete transfers of care are a routine matter in most facilities, so this would allow anyone who was unable to make the contact themselves to basically have a new caregiver who could make the contact on their behalf. In facilities that do not permit MAID on the premises, then there is the option of the complete transfer of care from one facility to another.

Bill 34, along with the implementation of these strategies, would provide patient access while allowing conscientiously objecting physicians to continue to serve their patients without affecting the therapeutic relationship or patient care.

Madam Chairperson: Mr. Worthen, your time has expired for presentation. Thank you for your presentation.

Do members for the committee have questions for the presenter?

Point of Order

Mr. Swan: Point of order. I wonder if there's agreement by the committee just to let Mr. Worthen finish his presentation, because we see he's almost at the end of his text.

Madam Chairperson: Is it the will of the committee to allow Mr. Worthen to finish his presentation? *[Agreed]*

* * *

Mr. Worthen: I apologize, Madam Chair, for being so long-winded.

Our doctors have the well-being of their patients as their primary concern. We appreciate that the Manitoba college and the Legislature recognizes our commitment to our patients, our integrity and our service and that there is a commitment on the part of the government to create a health-care system that is pluralistic, diverse and supportive of conscience and religious differences.

Thank you for your time and your attention.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for the presenter?

Mr. Goertzen: Only, Mr. Worthen, thank you for coming here tonight and making your presentation. I think you travelled from some distance. I appreciate you being here and providing the information that you have.

Mr. Swan: Mr. Worthen, I thank you for presenting to us tonight. Just to remove any suspense that might be in the room, the opposition NDP caucus is supporting Bill 34. We do have some concerns, though, not with what's in the bill, but I suppose with what's not in the bill. I just want to address one of those things with you.

You've given us examples where an individual might want to get more information on assistance with ending their life because of their suffering, and you've given two examples of facilities that permit that to happen on the premises and those that don't.

In your presentation, you've said that a conscientious objector could report their conflict to the medical director who could facilitate a complete transfer of care to another caregiver within the same facility, program or service. If there is a medical health professional who has a valid conscientious objection, do you have any difficulty with there being a policy saying that they should report that conflict to the medical director within that hospital or that personal-care home to ensure that information is given to the patient? Is that a problem for you?

Mr. Worthen: I think one of the difficulties–we certainly reviewed the legislation. One of the challenges here is that–and we've definitely had a lot of discussions in Ontario and other provinces. One of the difficulties here is if we try to lay down all of the scenarios that could possibly occur, we would–it would result in legislation that would be very, very extensive. And–but I can say, to answer your question directly, that the proposals that we made in Ontario for amendments to Bill 84 included a requirement to do just what you suggested.

Mr. Swan: Thank you, Mr. Worthen.

And the other scenario I just want to address is facilities that do not permit medical assistance in death on the premises. Your point is the patient be 'kimply' transferred to a facility that permits that to occur.

How is a patient who's in a facility supposed to get any information, then, if no one's going to provide it to them? *[interjection]*

Madam Chairperson: Mr. Worthen.

Mr. Worthen: I'm sorry. Pardon me.

I can tell you that practically none of our 5,000 doctors that we represent would have any difficulty providing the patient with the information that they require. Our doctors want to talk with their patients about this. If a patient comes forward to the physician and is feeling like they want to end their lives, obviously they're suffering terribly, and that's an important thing for them to discuss with their physician. So our–none of our doctors would have any difficulty in terms of discussing this with the patient.

And with the system you have in Manitoba, the patient–if the patient is outside of a facility, they can simply contact and get an assessment directly. If it's within a facility, then we have the option of a complete transfer of care.

The scenario that was put forward by Dying with Dignity, which they love to put forward, is, in my view, very fictional. There–if we all work–if the system works well, it's possible to create a system

that will provide access without delay while at the same time protecting conscience rights.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation.

I've had a request from Mark Kristjanson, private citizen, No. 8 on the list. A family emergency has arose, and he has requested to present next. Is it the will of the committee to grant this request? *[Agreed]*

I will now call upon Mark Kristjanson, private citizen. Mr. Kristjanson, do you have any written materials for distribution to the committee?

Mr. Mark Kristjanson (Private Citizen): I don't.

Madam Chairperson: Okay. Please proceed with your presentation.

Mr. Kristjanson: So I'll apologize in advance if my unstructured comments are not as organized and as succinct as they ought to be, and you are very welcome to interrupt me if I'm going on too long.

I'm a family doc. I have practised for about three decades. I work in a number of fields. I do some hospice care. And I attend a ward of profoundly developmentally disabled patients at St. Amant. And I do some work at CancerCare, serving in two roles there: seeing patients in the Urgent Cancer Care Clinic, where we attend patients who are suffering acute complications of their disease or their chemotherapy or their radiotherapy; and I also participate in a really neat project called UPCON, and we develop educational materials and programming for primary-care providers where there's an intersection between oncology and primary care.

And I'm grateful that you are considering Bill 34 and that there is support for this bill. My own concerns with respect to what would happen if Bill 34 were not passed into law is that I personally would be very vulnerable in the sense that I can lose my career because I do literally regard people as sacred, and I know that I could not, and won't, even if I lose my career, I'm not going to commit an evil against a fellow human being. And I regard the intentional destruction of another person as, in and of itself, an evil thing to do. I know that many people don't share that view. I understand that my views may be at the extreme end of the spectrum. But I know I just–I can't and won't kill people. And I won't make referrals for that.

***** (18:40)

I should say, and this is in concert with what Larry Worthen was just saying, is that, you know, for those of us that have practised for as long as I have, even though I've never made an abortion referral, and I've made it clear to my patients I never would, none of my patients ever had difficulty accessing abortion when that's what they wanted. And they all knew they were welcome to come back and see me, and none of my patients ever left me because of my stance on that, and I never abandon them, and certainly my viewing of my fellow human being and my patient as sacred doesn't incline me to abandon them in any sense of the word, and there are mechanisms in place in the cultural milieu and formal mechanisms whereby patients can access abortion, and you know that's going to be the same thing with euthanasia. There's–there won't be, in a practical sense, any abandonment to people accessing MAID.

I'm grateful that the MAID team we have right now consists of very reasonable, thoughtful, prudent people who aren't careless with the way that they discharge their duties, and I'm very grateful that our College of Physicians and Surgeons has taken such care to reasonably accommodate all of the players in this. But I'm also aware that there are people like Jocelyn Downie, you know, an academic lawyer, who engages in ongoing lobbying in favour, of what I'm sure she sees as a legitimate concern for patient autonomy, in favour of euthanasia rights, and I don't want our college to be swayed in the direction that the Ontario college was.

I have great respect for the care that the college has taken in elaborating and articulating the current position they have, and if the law does nothing more than secure that position I'll be very grateful, and that's really all I had to say.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for the presenter?

Mr. Goertzen: I want to thank you for at least three things. One is for taking care of people in difficult and vulnerable times of their lives. You expressed that, I think, with great compassion. I think we could tell the compassion that came through in your presentation. I also want to thank you for mentioning the MAID team as being a group of people who do serve with compassion as well and I think it's added balance that you've mentioned that, and of course the College of Physicians and Surgeons, which I think

has also done good work in trying to strike the right balance for its members as well.

So, if I had to sum up your presentation, I would say it was compassionate and balanced, and I appreciate that very much.

Mr. Swan: Yes, well, Dr. Kristjanson, thank you for presenting tonight, and we all wish you well. As we know, you've got other things you have to get to.

I just wanted to raise one thing. You did talk about the role of the College of Physicians and Surgeons of Manitoba. I have had a chance to look through the provisions in the code of conduct, and do you think that what now exists with the College of Physicians and Surgeons is a reasonable protection of the conscience of individuals like yourself but also a balance of the very difficult issues that are involved in medically assisted death?

Mr. Kristjanson: Can you perhaps state again the question? I'm–I missed it.

Mr. Swan: Yes. I've had a chance to look at the code of conduct of the College of Physicians and Surgeons, which sets out the rights of members of the–of your profession, but also, you know, what obligations they have. Do you think that the work that the college has done is a fair way to balance what we know is a difficult issue? *[interjection]*

Madam Chairperson: Mr. Kristjanson.

Mr. Kristjanson: Sorry. Yes, I do. I–yes. Thank you.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation.

I have also been requested to switch numbers nine and three, so Dr. Randy Goossen and Kristin Harris have decided to swap–has asked us to change their places on the list. Does the committee agree with the request? *[Agreed]*

So I will now call upon Dr. Randy Goossen. Mr. Goossen, do you have any written material for submission to the committee?

Mr. Randy Goossen (Private Citizen): Yes, I do. Thank you.

Madam Chairperson: Please proceed with your presentation.

Mr. Goossen: Honourable Chair and committee members of the Legislature, I really appreciate the opportunity and thank you for the chance to speak about Bill 34.

My name is Dr. Randy Goossen. I have been trained both as a family physician and a psychiatrist, and I come from Mennonite heritage. Along with over–and I believe this number should be 10 to 14,000 others that have sent letters to you, their representatives–I am here in favour of Bill 34, which supports physicians of conscience who choose not to participate in MAID and legislates that, in the future, they will not be expected to do otherwise, including having to refer patients.

Many ask why is Bill 34 necessary when, at present, the College of Physicians and Surgeons of Manitoba has stated that physicians need not to participate. Well, the reason is–I'm going to hopefully talk about, is the story of my father, will answer this question.

My father was a conscientious objector in World War II and was made an example of in spite of the fact that he was protected by the BNA Act of 1867 that allowed for individuals to not go to war because of their faith. When Mennonites moved to Canada, provisions had been made to guarantee their pacifistic stance and that it would be honoured. Although some Mennonites chose to go to war, and others went to CO camps, my father, who was a devout and godly man and a conscientious objector, felt that he could serve his country without killing. He did what he felt was right, even though it might cost him dearly.

He was eventually brought before a judge in southern Manitoba who decided to prosecute him for his beliefs. He was stripped of his teaching certificate and was sentenced to 12 months imprisonment and hard labour at Headingley jail. During the procedures, my father and others were asked various questions to determine their CO status. The question of whether they had bought war bonds was just–was asked by the judge. It ended up that there was no right answer. If you bought them as a CO to support your country, you were seen as being pro-war. And, if you didn't, you were seen as a disgrace to your country, as a teacher and a public servant. Either way, your answer was used against you. The judge also asked the what if question. What would you do if some enemy would attack your mother or sister and misuse and maltreat them, and you just stand there and not defend them? This was a difficult question for my father, who answered something to the effect that he would do all that he could to help, but he would not kill.

The point is this: Although at present the College of Physicians and Surgeons in Manitoba–has done a great job, by the way–respects physicians' rights not to participate in MAID, there is no guarantee that this will not change in the future. The way it is written at present leaves some of my colleagues in a difficult position. They in no way want to participate in something that they feel goes against their conscience, particularly the end of a patient's life, because even referring to MAID in their minds is participation. We see these selves as part of the profession that has, for thousands of years, clearly declared the importance of doing not–doing no harm.

My father lost his teaching certificate, and my colleagues see that there is potential that, in the future, they could lose their licences too. The question of making a referral or not usually brings up the question of patients' rights to access. The issue here isn't one of access, as access is readily available to anyone who requires MAID, either through family advocates and other professionals. Physicians of conscience will not abandon their patients as they see it–their responsibility to explore and understand their patients' concerns regarding end-of-life suffering and challenges, and their calling to assist them through difficult times, no matter. They are well aware that, if necessary, the transfer of care could easily be accommodated to another colleague willing to take over the management of the patient seeking the services of MAID.

Access for MAID has been secured. What has not been secured is the freedom to practise in a way that follows one's conscience. There is no other jurisdiction in the world that demands the need for a referral to a MAID service from physicians. The experience in Ontario, where I used to practise, has shown the militancy against physicians of conscience, where one ethicist suggested that a person's stance on MAID should be used as a screening tool as to who would be appropriate to be accessed in medicine.

***** (18:50)

And, by the way, I would just say that my father wanted to be a doctor. In those days they had quotas: a number of Jews, a number of Mennonites, and although he eventually accepted a teaching position at a school, his medicine acceptance came through and he decided to stay–stick to his first commitment instead of going into medicine.

Speaking as a psychiatrist, I see how vulnerable many people are when affected by their medical and psychiatric challenges. Even without a definitive psychiatric diagnosis, individuals can negatively be influenced by a sense of burden they hold in relation to their families. One wonders how it is that access to MAID is given so much attention rather than the need for access to palliative care.

In conclusion, Bill 34 does not impede the right of patients to accessing MAID. Bill 34 reminds us of the importance of physicians calling to be able to follow their ethical beliefs while addressing the various medical and psychiatric challenges that their patients face.

My father's freedom was unjustly taken away many years ago even though he was guaranteed freedom of conscience under the BNA Act. His rights were stripped including the licence to teach. He was sent to prison, both in Headingley and in Brandon, without cause. And this is why I am here today. Though a man of grace and kindness, having come through a trial of faith, my father's loss and grief and despair now has a purpose. And what is that? The purpose is that others not be robbed of the privilege to practise in good conscience.

It was many, many years later that the Manitoba government apologized to my father, sealing the fact that they had done him an injustice, and as a token of apology they gave him back his teaching licence.

Bill 34 is the right thing to do. It sends a message that we respect all people, those who choose MAID and those who follow their conscience when it comes to MAID. Thank you.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for our presenter?

Mr. Goertzen: Please don't apologize. That was very meaningful, and I appreciate you not only relaying your own personal family history, but also talking about history and how while at certain moments in time it feels conscientious rights are protected. Those dynamics can change, and it is important to have something more specific to hold those rights.

And so I appreciate you relaying both your personal family connection and the historical perspective, as well.

Mr. Swan: Mr. Goossen, on behalf of our NDP caucus, I want to thank you for coming down and making a presentation to us. We hear many important presentations at a very open committee here and like this, and we appreciate that.

One of the comments that you made in your presentation is why are we talking about MAID, why don't we talk more about the need for access to palliative care.

You're now standing in front of a committee of legislators. Are there things that you would like to tell the committee about things that you think Manitoba can do better when it comes to providing palliative care?

Mr. Goossen: Thank you so much, and I appreciate your words.

I think what's important to recognize is that throughout Manitoba and in various parts of Canada, palliative services are not available. And I think that, when we look at resources that are going towards the needs for individuals who are suffering and the supports that could be provided, I would really encourage the committee to consider particularly our province in areas where palliative care isn't available what could be done around that. So that would be my big flag to wave. Thank you.

Ms. Judy Klassen (Kewatinook): Thank you so much for sharing your father's story. It really touches my heart. And I was really glad to learn that he got his teaching licence back and that he was apologized to. So thank you.

Mr. Goossen: Thank you so much for this opportunity.

Madam Chairperson: Thank you.

I will now call upon Dr. Alewyn Vorster.

Dr. Vorster, do you have any written materials for distribution to the committee? *[interjection]*

Please proceed with your presentation.

Mr. Alewyn Vorster (College of Physicians and Surgeons of Manitoba): Thank you very much.

Good evening, and thank you for the opportunity to present our concerns from CPSM. I am Dr. Alewyn Vorster. I am the past president of the College of Physicians and Surgeons of Manitoba, which is CPSM. And the CPSM's working group, I was the chair of the such-mentioned working group. That group developed our standard of practice pertaining to the provision of medical assistance in dying, MAID.

CPSM is very grateful to have this opportunity to share our thanks for the work this government and its predecessor did to promote the ability of the Manitoba patients to access MAID. Both governments have worked very hard to support the creation of a provincial MAID team.

Minister Goertzen has kindly and publicly supported the CPSM's standard of practice regarding MAID. Both the Manitoba MAID team and the CPSM standard of practice regarding MAID are recognized across Canada as leading best practices.

We understand that the intent of Bill 34 is to make clear that members of a regulated health profession have the ability to refuse to provide MAID on the basis of their personal convictions. That is consistent with the CPSM's standard of practice in relation to the provision of MAID. However, CPSM is concerned that Bill 34, as currently written, could unintentionally result in harm to patients if its provisions are not clarified. CPSM is particularly concerned for patients who are disadvantaged, who may not have friends or family or access to a computer or the physical ability to make a phone call. CPSM wants to protect vulnerable patients.

We are concerned that physicians may interpret Bill 34 in a way that they believe they can deny services to a patient or deny timely access to an information resource about MAID. This is at the very time when a patient is contemplating an extremely difficult decision. Patients eligible for MAID are especially vulnerable, as you all know, as they are suffering from a grievous and irremediable medical condition that is incurable. They're in an advanced state of irreversible decline in capability that causes them to–enduring physical and psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable, and their natural death has become reasonably foreseeable.

Our primary concern is that health-care providers may misconstrue Bill 34 as giving those who conscientiously object to MAID the right to refuse to provide a patient with timely access to a resource that will provide accurate information about MAID, or abandon their patients who wish to explore MAID or avail themselves to MAID by

refusing to provide medical care that is unrelated to MAID, such as treatment to alleviate pain.

The CPSM urges this committee to recommend that Bill 34 should not proceed in its current form. Bill 34 should be amended to clarify the phrase, aiding in the provision of medical assistance in dying, does not entitle a provider who conscientiously objects to MAID to refuse to, again, provide timely access to a resource that'll provide accurate information about MAID, or abandon a patient by refusing to provide medical care unrelated to the actual provision of MAID.

The background is there on our CPSM's standard of practice. As the regulatory body for all physicians in Manitoba, the CPSM has developed its standard of practice which sets out the minimum expectations of all members regarding MAID. The standard was developed by a diverse group of members, with expertise in various related aspects of medicine, including palliative care, oncology, psychiatry, health care and hospital administration. The working group worked diligently and scrupulously to ensure that the standard achieved an appropriate balance in the relation to respecting physicians' personal convictions and their ethical responsibilities to their patients.

***** (19:00)

The CPSM's requirements in relation to members' personal values and beliefs about MAID were arrived at following extensive consultation with our membership and stakeholders. They are the result of a great deal of effort on the part of our working group, which was composed of members who both supported and opposed MAID. The requirements represent an appropriate balance between the competing interests of all involved.

The CPSM has worked closely with stakeholders to ensure resources about MAID are readily available by phone or the Internet, such as complying with the CPSM's minimum requirements set out in the standards is not onerous. It can be as simple as giving a patient the phone number or the website for the MAID team. The CPSM's minimum requirements as they relate to members' personal values or beliefs about MAID require that every physician who refuses to refer to a–to refer a patient to another physician or to personally offer specific information about the medical assistance in dying on the grounds of conscience-based objections must, among other things, provide the patient with timely access to a resource that will provide accurate information about medical assistance in dying and continue to provide care unrelated to medical assistance in dying to the patient until that patient's services–or, sorry, that physician's services are no longer required or wanted by the patient or until another suitable physician has assumed responsibility for the patient.

The CPSM is particularly concerned that sections 2(3) and 3(1) of Bill 34 may be interpreted broadly to apply to section C of the CPSM standard, which sets out our requirements of a physician who refuses to refer a patient to another physician or to personally offer specific information about MAID because of a conscience-based objection. We have heard from government representatives that their position is that aiding in the provision of medical assistance in dying does not include providing information on how to obtain MAID. Aiding in the provision of MAID is intended to be some type of active participation in its actual provision. Our concern is that others will interpret it more broadly. Furthermore, there's no guarantee that the courts will interpret these provisions in the same manner as what we understand is the government's position, as stated above. Rather than having a protracted and expensive court proceeding, we urge that Bill 34 be amended to clarify the scope and intent of the phrase aiding in the provision of medical assistance in dying, so that physicians and others clearly understand the parameters of the law.

In order to protect patients, the CPSM is most concerned that the requirements contained in our standard be preserved so that no patient is abandoned at this time of critical need. Patients need to be protected by making it clear that all CPSM members are required to provide the patient with timely access to a resource that will provide accurate information about MAID and to continue to provide care unrelated to MAID to a patient who is seeking MAID. No patient should be abandoned because of the patient's choice to explore the possibility of or the eligibility for MAID.

So, in summary, on behalf of all patients in Manitoba, the CPSM is asking the committee–that the committee recommend that Bill 34 be amended to provide clarifying language within Bill 34 that would leave no ambiguity that the existing minimum CPSM requirements, as set out in our standard of practice, do not conflict with Bill 34. The CPSM is of the opinion that the CPSM's standard balances respect for healthcare providers' personal convictions and their ethical responsibilities to their patients. Its provisions should be preserved by ensuring there is

no potential legislative impediment to the CPSM requiring that all physicians adhere to its standard regarding MAID.

On behalf of patients in Manitoba, the CPSM thanks you for this opportunity to share this with you, our desire to ensure that no patient is abandoned at a time when they are facing an unimaginably difficult decision. Please amend Bill 34 for the sake of Manitoba's patients.

Thank you very much.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for the presenter?

Mr. Swan: Dr. Vorster, thank you for coming out and presenting and thank you for the work that you and the college have done in putting together a code of conduct and rules and regulations that I think everybody is in agreement with.

One of the things that happens at a committee like this is after all the presenters are done, I'll have the chance to ask the minister some questions. Would it be of assistance to you if we're able to go through the very concerns that you have and the minister was to put his position on the record, as it was? Is that something that you think would be helpful to this process?

Mr. Vorster: Thank you very much, Mr. Swan. If the minister so wishes, I'm just a visitor. Sounds like a good plan.

Mr. Swan: If I can just follow up with that. And you have set out for us at the bottom of page 2 of your presentation two minimum requirements that the college requires of physicians. One is to provide the patient with timely access to a resource that will provide accurate information about medical assistance in dying and continue to provide care unrelated to medical assistance in dying to the patient until that physician's services are no longer required or wanted by the patient or until another suitable physician has assumed responsibility for the patient.

Those are the obligations the college believes that physicians should follow. Question I have is: do you think it'd be appropriate for us to confirm tonight that these provisions do not run afoul of what's contained in Bill 34?

Mr. Vorster: I do think that it is important because of the fact that we feel that it is a little broad the way it is described in Bill 34. We have no problem with members providing or objecting to provide MAID. It is the issue of the aid that we feel is a little broad in the specific perspective. And then, of course, as you mentioned, on second component, it's very easy, and I can think of multiple examples of abandoning a patient, and I think that is absolutely essential that that is covered, as well, in the message.

Mr. Goertzen: Thank you very much for being here this evening. I know it was relatively short notice. I appreciate you coming.

We've had this discussion a few times in the past, as you know. And I hope that the presentations that you've heard before you were able to come to the podium gave you some comfort, as well, in terms of what many of your own members feel, and then that certainly it's not their intention, from those we've heard and those who represent larger groups, to do anything such as what you indicated your concerns are. But to save maybe some of the suspense until midnight, I've already indicated to you and publicly that this legislation is intended to confirm what the college is currently doing. We think it's the right balance. I've said that to you publicly–or said that to you privately and said it publicly, that the college's resolution in terms of ensuring that referrals don't have to be made, but information is provided is the right balance. We've augmented that with ensuring there's facilities who do not want to participate, do not have to participate, but there needs to be a policy for transfer, and this bill holds that, we believe, holds that balance for the future. I have a good working relationship with the college of physicians. I believe that we've struck the right balance, but I don't know who might be on the college in the future where that balance might be upset. And so this legislation is to ensure that that balance is held for the future.

Mr. Vorster: We are in total agreement with Bill 34, except that we are asking for the amendments. The relationship that we've shared with you is a wonderful relationship, and we say thank you for that. We had some very good meetings. We all want the same thing. We want patient safety, there's absolutely no doubt. And, if we think of patient safety, we just heard Dr. Goossen gave a wonderful talk about his father who was obviously a vulnerable patient, and I think a vulnerable patient is really what we're looking after, but what we should be looking after and what we should be helping with is Bill 34,

as well, and that is why we're asking for those amendments. Thank you.

Madam Chairperson: Thank you very much for your presentation.

Committee Substitution

Madam Chairperson: I would like to inform the committee that under rule 85(2), the following membership substitution has been made for this committee effective immediately: Mr. Isleifson for Mr. Michaleski.

Thank you.

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Madam Chairperson: I will now call upon Dr. Frank Ewert, private citizen.

Mr. Ewert, do you have any written–

Mr. Frank Ewert (Private Citizen): I do.

Madam Chairperson: Okay.

Please proceed with your presentation.

***** (19:10)

Mr. Ewert: Madam Chairperson, honourable members of this standing committee, thank you for allowing me to address you on Bill 34.

I believe this bill, which I support, is not only important to me as a physician, but of huge importance to our society where we hold most dear those foundational values–freedom of conscience and religion–that go to the core of what it means to live in a free and democratic society.

It was in August of 1970 that I, along with 75 other medical students who were to become the class of '74, stood to vow to uphold the Hippocratic Oath, also called the Declaration of Geneva, 1948. I was young and idealistic, filled with gratitude and hope for a future where I would be allowed to serve my fellow human beings. I pledged to consecrate my life to the service of humanity. I pledged to practise medicine with conscience and dignity, and that the health and life of my patients will be my first consideration. I pledged to maintain the utmost respect of human life from its conception. And, even under threat, I will not use my knowledge contrary to the laws of humanity.

These words resonated with my own deeply held moral beliefs. That was then, and this is now. My core values have changed, but–have not changed, but the core values of society have changed. And I view it as particularly lamentable that the core values accepted by my profession have changed as well. Back in 1970, I ventured to say that none of us would have even remotely conceived that physician-assisted suicide and euthanasia would become part of medical practice. Hippocrates and his associates would have found this anathema to the ethical practice of medicine. And this view has held for the better part of 2,500 years.

June 17, 2017–2017, Canada joined a very small group of countries in the world that have legalized physician-assisted suicide and euthanasia. It is unfortunate that it has been given the descriptor of a–medical assistance in dying, or MAID. I think this term is ambiguous and imprecise. Palliative care physicians provide assistance and care to the dying every day, MAID ends palliative care. MAID is more precisely the medical act of inducing death. But it is the law, and patients do have a right to access euthanasia, and I'm not here to argue against what the Supreme Court and the Parliament of Canada have decided. I'm here to express my fears and concerns for the effects this federal law may have on me and other doctors, nurses, pharmacists and other health-care workers who, on conscience ground, cannot and will not participate in MAID.

My patient's wish to be euthanized should not become my command to be the one to kill him, or aid him to take his own life. Why do we need a particular law to protect our conscience rights? No doubt you are aware that the Supreme Court of Canada and the federal Bill C-14 both acknowledge conscience rights, as given in section 2 of our Constitution, to be recognized in the implementation of this new federal law. We need Bill 34 because the federal bill left it to the provinces to implement this law, and provinces have left it to the provincial regulators–the colleges of physicians and surgeons–to work out the implementation details.

In Manitoba, our College of Physicians and Surgeons have acted honourably and acted in the spirit of the Supreme Court decision and the federal law. It has made it clear that, on the basis of conscience, no one must–has need to provide MAID. This does not mean that we can be untruthful to a patient who requests this option, nor try to act as an obstacle to a patient's access. This does not mean that we would ever abandon our patients or refuse to continue to treat them or care for them to the extent they allow us. It does not mean that we would withhold any chart documentation that the patient would request to be handed over to a MAID team.

It does, however, mean that our patient must know where we stand on the basis of our conscience on the issue of MAID and know that, although they have a right to MAID, that we will not be part of the process for them to have MAID. The way this was achieved was by providing a direct pathway to the MAID team that the patient, or a designate, could easily access directly without any physician referral. If the patient, by way of physical disability, was not capable of accessing the MAID team, his care, in whole or in part, would be transferred to another physician or health-care provider who would be willing to help the patient process the request.

Manitoba's approach made us think that our conscience rights were protected. Then we saw what was happening in Ontario. Their College of Physicians and Surgeons decided to enact a solution to what should have been a non-existent problem.

They decided physicians wouldn't provide MAID themselves, they must find someone who would. They used the term effective referral and ethicists on both sides of this issue have agreed that giving the so-called effective referral is the moral equivalent of doing the act.

Suddenly we realized our conscience rights in Manitoba might not be as secure as we thought. Regulatory body memberships that govern our profession and oversee MAID are replaced on a regular basis through elections and appointments. A future board could easily adopt the position of the Ontario college regulators. Appeals were made to this government and to their credit, they listened and we have Bill 34.

What are the likely effects if our conscience rights are not protected? For me, there seem to be only two options: I could betray my deeply held beliefs and violate my conscience, or I could leave a profession I dearly love and feel called to. Why are conscience rights so important? Conscience is the moral decision-making capacity we all have. It is the ability to differentiate right from wrong. It is the guardian of our most deeply held beliefs. Conscience beliefs are not irrational and they cannot be easily dismissed.

Now freedom of conscience is not the same as freedom of choice. I choose where I live, what party I support, where I give my charitable donations. Our conscience does not give us unfettered choice. In freedom of choice, I am sovereign, I choose. With conscience, I am subject, I am bound by its dictates and conscience will not be denied. If I violate it, if I act against it, if I tell it lies, conscience will have its revenge. I will suffer deep moral harm, my integrity will be fractured, and my integrity is what I trade on with my patients.

My patients not only count on my competence, they count on me to be honest, and truthful, and trustworthy. If I trade on my integrity to save my job, will my patients appreciate me more and see me as being just pragmatic? They may, but they may also wonder what other parts of my integrity are negotiable.

I want my patients to be able to trust that I would never do anything to harm them. I want them to know that I adhere to the Hippocratic Oath as given in the Declaration of Geneva. I want them to know I refuse to have my–leave my conscience beliefs at the door.

The other option for me if my conscience rights are denied would be to leave–or be forced out of the profession. This path, we would, I believe, diminish my profession and society. Do we as a society really wish to expunge all people of faith or of no faith from the health-care profession who hold beliefs that prevent them from participating in MAID? And doesn't a patient have the right of choice to be treated by a physician who is a conscientious objector to MAID?

I believe this bill and Manitoba's legislators are in a position to make a strong statement on the importance of conscience rights protection by passing this bill. I believe Manitobans strongly believe in the importance of ensuring conscience rights protection.

I believe this to be true of people of faith as well as people of no faith. I also believe this to be true for those who support MAID as well as those who are opposed to it. This bill acknowledges and affirms the most fundamental freedom of any truly free and democratic society. Thank you.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for the presenter?

Mr. Goertzen: Doctor, I want to thank you for being here this evening and for making the case strongly for conscientious rights and for balance.

I think you speak on behalf of many Manitobans. My office has received 14,000 letters in support of the legislation as of about a couple of hours ago, and

they're still coming in, so I think it speaks well of Manitobans' desire to see conscientious rights protected.

Thank you.

Mr. Swan: Doctor, thank you for coming down to present to us this evening. In your presentation, you gave your view that the College of Physicians and Surgeons has acted honourably and acted in the spirit of the Supreme Court decision and the federal law in balancing very different concerns. Are you satisfied with the way that the college has both put protections, but also put some obligations on physicians in dealing with this very, very difficult issue? *[interjection]*

Madam Chairperson: Dr. Ewert.

Mr. Ewert: Sorry. Yes, and I am, and I would be if I could be reassured that this board never changed and they never change this position. But we know the way the college regulators–how it functions, that it could change. What's true today may not be true for them tomorrow.

***** (19:20)

Mr. Andrew Micklefield (Rossmere): Yes, thank you for your presentation. Did I–excuse me. Did I hear you correctly say that if there was–you were in a situation where you would be forced to participate in MAID that you would contemplate even leaving the profession?

Mr. Ewert: Yes, I would. Now, you can say as you–if you look at me and my age, that I'm nearing the latter part of my career, and it's not–and it doesn't have a huge impact in many ways, but I could not countenance ever taking a person's life. It would go against everything I've ever believed in. So, yes, I would not do it.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation.

I will now call upon Beverly Rutherford, private citizen. Ms. Rutherford, do you have any written materials for distribution to the committee?

Ms. Beverly Rutherford (Private Citizen): I do. Thank you.

Madam Chairperson: Please proceed with your presentation.

Ms. Rutherford: Thank you, Madam Chairman and the honourable minister, and, Dr. Vorster, thank you for coming and presenting as you did.

My name is Beverly Rutherford, and I'm a family physician. I graduated from medicine in 1980, and at that time, recited with my classmates the Hippocratic Oath. In this, I committed to do my utmost to respect life from conception to death, and above all, to do no harm.

In my years of caring for patients, I have looked after many with serious, debilitating illnesses and conditions, and I've always done my best to offer cure when available, comfort and alleviation of suffering when possible and always to stand by in support offering compassion and care in the dying process.

I've cared for many dying in hospital, at home or in palliative care facilities. In this time, many patients and their families request an end to further investigations and treatment, accepting a natural death and being offered palliative care if they so choose it. This is not euthanasia, but simply good, patient-focused medical care. I have never had anyone request euthanasia, physician-assisted suicide or medical aid in dying.

However, if I were, I would not be able to participate, as this goes against everything I believe in and negates the purposes for which I went into medicine. We are not God and have no right to take a life. This does not mean that I would in any way obstruct a patient from accessing MAID, and would make sure that they knew how to access the information regarding it.

A colleague of ours, Lee Isaacs, a family physician in Winnipeg–but spending–he spent most of his career in Ashern as a solo GP there–wrote a letter to the editor of the Free Press, September 8th.

I'm going to quote this article: Christianity has opposed suicide for 2,000 years. Thou shalt not kill has been the governing principle. Ethics–and I would add–include morals–are not overturned by majority votes, opinion polls or even court decisions. From the earliest church fathers to the 20th century theologians such as Karl Barth, Christianity has condemned suicide unequivocally. In 1950, in the aftermath of the Nazi horror that carried, that supported eugenics and euthanasia to their ultimate extremes, Barth wrote: If a man kills himself without being ordered to do so by God, then his action is murder.

I believe that the reason that this has been accepted by so many of late in the situation we're in is the belief by the vocal few that human

autonomy is the fundamental moral value and that–the fundamental moral value–and that it trumps all others. They believe that one's life, like one's body, one's property, is one's own to use and to dispose of as one sees fit. I would argue that orthodox Judeo-Christian belief and doctrine would reject that whole line of thought. Both Jews and Christians, regardless of the extent in which they differ from each other and their own–within their own diverse communities share a sense of dependence upon their creator who has endued human life with intrinsic and inherent value.

I'm not Jewish, but I'm going to quote a presentation of Reform rabbis who authored the Responsa Committee's statement on euthanasia in 1997. They gave three reasons for remaining faithful to the traditional Jewish understanding of the issue: We see no good reason, first of all, to abandon the traditional Jewish teaching concerning the inestimable value of human life; second, we do not believe that the existence of pain and suffering constitute a sufficient Jewish justification for killing a human being in the name of compassion; third, we are uncomfortable with arguments for assisted suicide that proceed from judgments concerning quality of life.

I am very concerned with patients who are already feeling isolated, worthless, that they are not contributing to society, that they are a burden to the health-care system or to their families, and which, I would add, is a very large segment of our population, would fit that description. I'm concerned that such widespread discussion of euthanasia and MAID will push them into considering something that, in the past, would not even cross their minds.

We need to do everything possible as a society within our families and communities and within the health-care system to affirm their inestimable value as human beings separate from their function or utility.

I am also involved with teaching medical students. I am very concerned for them, that their entrance into the medical field is concurrent with not just with the legalization of physician-assisted suicide, but that they are also being taught about the MAID process in Manitoba with little, if any, discussion or dialogue or question as to whether this is something that they should choose to be involved in.

I do not believe that this is an issue of doctors' rights and therefore our conscience protection versus patients' rights to the care that they are requesting. We do not offer medical treatments which we deem to be hard–harmful, even if requested by a patient, and we are not a heartless group of uncaring physicians and health-care providers.

The Christian tradition of providing health care to the poor, the suffering, the marginalized, setting up hospitals and clinics in places in the world where there is none, putting their own lives at risk, treating leprosy in the past, HIV and Ebola virus more recently, and the Mother Theresas of the world, all of these attest to the falseness of that criticism which has been raised against us in the media.

In closing, I strongly encourage you to support Bill 34 as it is one step in the right direction, in that it acknowledges that not all health-care providers accept that physician-assisted suicide is acceptable and that there will be protection for those who choose, due to their conscience, to refrain from involvement in this process. Thank you.

Madam Chairperson: Thank you for presentation. Before we move to questions from the committee members, I have been informed that Barbara–Dr. Barbara MacKalski is available for her telephoned presentation.

Is it the will of the committee to hear from her next? *[Agreed]*

Are there any questions from committee members?

Mr. James Teitsma (Radisson): I just wanted to thank you for coming out this evening and presenting your thoughts and views on this particular issue. They're not unique and I can assure you that they've been heard. Thank you.

Mr. Swan: Dr. Rutherford, thank you from our NDP caucus for coming down and presenting.

I'll ask you the same question I asked Dr. Ewert just a minute ago. I've had a chance to look at the provisions in the code of conduct of the College of Physicians and Surgeons. I've also listened to their presentation tonight.

Do you have any difficulty with the balance that the college struck in protecting the conscience of practitioners, but also setting out some basic requirements for what you do when someone comes to you that may be interested in this? Do you agree with the college's position?

Ms. Rutherford: I have. I must admit hearing Dr. Vorster's concerns now raises more concerns for me. If he is not happy with this bill and the provisions of it and what he would like added to that, I'm not entirely sure; my hearing's not great, so with him speaking forward I could not hear everything he was saying. But, to date, yes, I was very happy with our college's response, in contrast to Ontario's and the fallout of that. Thank you.

Madam Chairperson: Seeing no further questions, thank you for your presentation.

***** (19:30)

I will now call on Dr. Barbara MacKalski, No. 1 on the list. And as soon as we have her on the–okay. Dr. MacKalski, can you hear us?

Ms. Barbara MacKalski (Private Citizen): Yes, I can hear you very well, thank you.

Madam Chairperson: Excellent. Please proceed with your presentation.

Ms. MacKalski: First of all, I would like to thank all the members of the committee for the honour and opportunity to present in support of Bill 34. I am a doctor and a specialist in internal medicine and gastroneurology. After completing my training at the Mayo Clinic, I chose to return to my hometown of Brandon, Manitoba, and as such I'm deeply committed to our province.

I present today as an individual, as a physician and as the daughter–as a daughter who recently accompanied her father through a long and difficult end-of-life journey. So I have been there on many levels.

Conscience protection enshrined in the law is critical to the harmonious and ethical practice of medicine in the diverse culture in which we live. And while there continues to be opposition to MAID–or, physician-assisted suicide–patients, regardless of their viewpoints, strongly favour conscience protection for health-care professionals, including students, residents, doctors, pharmacists, nurses, health-care attendants who are vulnerable in many situations.

Bill 34 protects health-care professionals from moral distress and prevents the potentially sad situation of a professional forced to choose conscience over a career in health care. In our society, healers of diverse cultures and religious beliefs are necessary. Doctors may, in a free society, justifiably hold moral objections to MAID based on religious factors. However, even more universal are ethical concerns rooted in the Hippocratic Oath. Indeed, there pronouncements against physician-assisted suicide from the time of Hippocrates.

The principles of beneficence, which means to act in the patient's best interest, to do good; nonmaleficence, which means to minimize or do no harm; social justice; fairness; the inherent dignity of every life and the protection of the vulnerable must be balanced with another ethical principle: that of patient autonomy. And we as doctors really deal with this every day. This applies to common situations, such as when a patient–when a physician declines writing an illegal prescription or advises against an investigation or a surgery requested by a patient, because it's not indicated.

Based on these ethical principles, the American College of Physicians issued a position statement opposing physician-assisted death–and actually, I wrote in my written report September 19th, 2017, but the official position paper is October the 17th, 2017. These views are also shared by the British college of physicians, and are shared by numerous physicians in our country, although we do not have a consensus statement.

Patients are entitled to a doctor of integrity and honesty who will not violate conscience. Patients deserve a doctor whom they can trust, who recommends what she or he deems the best care plan.

I quote a Dr. Yang from the journal of the American Medical Association, one of the most prominent journals in the medical world, and it's 2016: Physicians are members of a profession with timeless ethical responsibilities. They are moral agents and merely providers of services, and hence, physicians everywhere believe in conscience protection, and not just physicians, but our nursing colleagues and our patients.

Therefore, Bill 34 is a necessary safeguard for all health-care professionals who choose not to participate in MAID.

I wish to congratulate our legislators of all parties for their foresight and wisdom on this crucial matter. And I am very proud to belong to this province tonight as we discuss this very important bill.

Madam Chairperson: Thank you for your presentation.

Are there questions from the committee members for the presenter?

Mr. Swan: Dr. MacKalski, can you hear me alright?

Ms. MacKalski: I can hear you.

Mr. Swan: Okay, thank you. I'm the New Democrat Health critic and our caucus is supporting Bill 34. I just want to thank you for your participation tonight. You haven't heard all of the other presentations, but it has been, I think, a very–it's a very useful evening for members of the committee to hear what Manitobans have to say. And I want to thank you for joining us tonight. We understand you're having a busy evening and we appreciate the perspective that you've brought to this discussion.

Ms. MacKalski: Thank you for your kind words.

Mr. Goertzen: Thank you, Dr. MacKalski. My name is Kelvin Goertzen, I'm the MLA for Steinbach and the Minister of Health. You're presenting by phone in a beautiful room in the Legislature. There are probably close to 100 people who've been listening to you, and we're surrounded by pictures of past premiers, so we are in the heart of democracy. And I think much of what you spoke to today talked about democratic freedoms, talked about conscious rights, and I think you spoke eloquently and we are better for you having joined us in this form and fashion through the telephone and we appreciate your presentation.

Ms. MacKalski: Thank you.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation.

Ms. MacKalski: Thank you very much for giving this–me this honour and for allowing me to participate by phone. I am most grateful.

Madam Chairperson: Thank you.

I will now call upon Kristin Harris, private citizen.

Ms. Harris, do you have any written materials for distribution to the committee?

Ms. Kristin Harris (Private Citizen): I don't.

Madam Chairperson: Please proceed with your presentation.

Ms. Harris: Can everyone hear me? It's a bit quiet back there, so.

My name is Kristin Harris and I'm a family physician, a little bit younger than some of the others who have spoken so far. I graduated from med school in 2009, actually in Alberta, and did my residency in Chilliwack, BC, and worked in Calgary and Kenora, and then came back to Winnipeg where I grew up. So I'm back home now and I thank you for the opportunity to speak with all of you today.

I'd like to applaud the government in putting forward this bill that would protect the rights of physicians and others who, whether because of their conscience, their religion, or the Hippocratic Oath, do not feel that it's right to participate in medical assistance in dying, or MAID. I believe this bill is necessary because while the College of Physicians and Surgeons in Manitoba may support physicians now, this may not always be the case, as we've heard.

Currently in Ontario, as we know, you've heard tonight, they have a different perspective and physicians feel jeopardized and feel that their job is on the line and they have to choose between conscience or their work. No other jurisdiction where MAID is legal requires mandatory participation or referral, and I don't think that we need to provide referral. I don't think we need to be like Ontario where they're mandating referral.

Worries about patients not being able to access MAID is commonly cited as one of the biggest concerns for those who are pushing for mandatory referral by physicians. In jurisdictions across the world that do not require referral, we have not seen a crisis with regards to access.

In Canada, MAID is fully accessible to anyone without a referral. We do not need to force physicians to go against their conscience and morality as human beings. It can be hugely distressing for anyone to feel like they may have to compromise their integrity and morals. Even some on the MAID team find the experience to be emotionally distressing at times, so imagine how much harder it would be for someone who doesn't support MAID to be asked to go asked to against what they believe.

***** (19:40)

As a country that values diversity, I think we should be accepting and supportive of our differences, not trying to eradicate them. Patients are diverse, and so are the doctors and other health-care workers who serve them, and it's in our diversity that we are strong.

Furthermore, the Charter of Rights and Freedoms protects people from discrimination based

on religion, conscience, and creed. Patients have rights, but so do physicians. Whether they agree with their physician's views or not, most patients want a physician who they know will stay true to their morals and beliefs and who maintain integrity. I, nor do my patients, want a physician who will compromise what they believe in.

I wanted to share a little bit about access, but it's already been mentioned tonight. There's many ways that–if a patient can access MAID, and I don't think–I think oftentimes there's an unrealistic patient that's put forward. You know, this person who's living in isolation, who has no one and who can't call or can't come into your office or can't go anywhere. But I don't think that's a realistic patient from my experience.

Most people have someone–whether it's a friend or a family member, a neighbour–someone who's involved in their life, and if they're accessing me, they can either call, or someone who's bringing them to see me can call for them to access care. So I really don't think access is an issue.

I'd like to sort of differentiate, as well–I think that we're all willing to provide information for how to access MAID or to a place where they can access MAID. However, I know I wouldn't feel comfortable referring directly to the MAID team, because in essence, I feel like they're the ones that carry out that act and if I don't feel it's right for my patient, I would have a hard time referring directly to the MAID team. However I would feel comfortable referring to a third party like Health Links who would be willing to give them the information they need. And I by no means would want to obstruct their ability to access that, and I would be able to freely give them that information for Health Links. And I think most of my colleagues would feel comfortable with that.

And by no means do we want to abandon our patients. I haven't heard of one person that I've talked to who sympathizes with–sort of my thoughts as well–who would want to abandon their patients. We are–we want to support our patients and it's just that in this–with regards to MAID, it's not something that we can support due to our conscience, as you've heard.

Now that MAID is legal, I feel–I fear for more older and more vulnerable patients who may feel pressured or coerced into choosing MAID. It is often impossible to fully understand the psycho-social dynamics at play. And with the outcome of MAID being so final, I think the stakes are high and many physicians would prefer to err on the side of caution.

I never want to be involved in killing a patient who may be feeling coerced. I also see that many times, people change their minds. In the midst of suffering, people often can only see the negatives and may desire suicide or MAID. However, if helped successfully through their suffering, they overcome these challenges and go on to lead very meaningful lives. And I think it's sort of a separate topic, but it was asked tonight, you know: What supports for palliative care are there, or what supports to sort of support these patients through this time might there be.

I think mental health is huge and most of these people who are choosing MAID, it's because of their feeling of loss of control or so many other issues that–where the root is more the mental health. And you see it from the time of children all the way up in age, and I think we need much more support for mental health and that which develops resiliency and just people being able to work through their struggles and work through and have a different perspective about their pain and struggle.

Despite MAID being legal, the act itself, whether requested by the patient or not, is an act of killing a patient, which may be–many find unconscionable. I want to be able to come alongside my patients during their greatest need rather than facilitating their death. I prefer to fight for and with them to ease their suffering.

I also think it's important to point out that just because something is legal or available does not mean that it's beneficial or even in our best interests. I'm sure every physician has a story about a patient's request that was not in their best interest and may have even been harmful to them. Physicians are not robots that just blindly do whatever patients desire. A physician's knowledge and experience and their duty to do no harm are important factors when decisions are made.

Of course, as outlined above, if a patient is not satisfied with the care by their provider there are other avenues through which they may seek alternative care. Because MAID is such a controversial topic and because we should be upholding the Charter of Rights and Freedoms, we should be allowing physicians to decide for themselves whether they want to be involved, and should not penalize them if they choose to abstain.

Physicians who conscientiously object are by no means abandoning their patients. It's quite the opposite. We want to stay by our patients helping them through their distress, both physical and mental, right until the natural end.

I believe this bill would help to support the diversity we celebrate in Canada and shows respect for everyone involved, patients and their health-care providers included. Thank you.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for our presenter?

Mr. Goertzen: Thank you. I think you helped dispel a couple of myths that have–maybe were here before the committee started. One is that this isn't generational, and so you represent a variety of different doctors coming forward from different graduating classes and different decades, and so we thank you for that.

I'm glad you've come back to Manitoba to practise, and so certainly thank you for that. Alberta's loss is our gain. And also I'm glad that you've re-enforced the issue of access. I think that there was some misconception prior perhaps of the committee and maybe even within the college that there was a desire to limit access. I think the doctors who are practising but who have a concern about conscientious protection understand that the laws been–have been determined. Access has to be provided, but that the balance of rights should be to ensure that individuals who have a conscientious objection need to have that protection, not just today as it exists within the college, but in the future for future colleges as well.

So thank you for those things.

Ms. Harris: Thank you.

Mr. Swan: Ms. Harris, thank you for coming down and presenting to us tonight. I want to pick up something that the minister was talking about.

I've asked a couple of physicians who come down tonight if they agree with the way the college has balanced the rights to conscience by physicians, but also the rights–or the right to patients to have their physicians provide certain things,

From your comments you've said that you have no difficulty providing patients with timely access to a resource, a third party like Health Links, that will provide accurate information, and that, of course, you would never abandon a patient just because they want to get more information on that.

So is it fair to say you're agreeing with the balance that the college has taken in setting out both the rights of physicians but also the obligations of physicians?

Ms. Harris: Yes, I would agree. However, like I stated, I think as long as the mandatory provision to other resources isn't directly to the MAID team. I think as long as they're sort of a third party that is just a generic place where people can access information, I would feel comfortable with that.

Ms. Klassen: Thank you.

One of the concerns I caught that you brought up with the perhaps patients would be coerced into passing on. My worry is that what is there to prevent that from happening? Would you then be able to speak up to the MAID team and say there is this possibility that the patient's being coerced?

Ms. Harris: Yes, I would feel very comfortable speaking to the MAID team if I had concerns. I would hope I'd want to speak with them to advocate for my patient, because I don't want to see someone unjustly choose death if they're feeling like a family member or a friend is sort of pushing them into that. I would feel very comfortable speaking with the MAID team about that. And I would hope that the MAID team is very aware of that scenario, and that that happens and that they be–err on the side of caution rather than sort of just–and I think they do err on the side of caution, but just–I think that's important.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation.

I will now call upon No. 10, Mary Shariff, private citizen.

Ms. Shariff do you have any written submission for distribution to the committee?

Ms. Mary Shariff (Private Citizen): I do.

Madam Chairperson: Please proceed with your presentation.

Ms. Shariff: I just really would like to thank the opportunity–thank you to have the opportunity to come and speak this evening.

***** (19:50)

I just want to tell you a little bit about myself. I'm a professor of law at the University of Manitoba. I've been looking at the issue of MAID for a number of years, and my expertise is in actually comparative laws with respect to MAID and I was an expert witness on comparative laws in the Carter case.

I'm just here to speak about three issues–speak to the bill and look at three issues. And I'll follow basically the handout that you have. So if you would like to follow along in the materials, that's fine.

So the three issues I'm going to talk about is that conscience protection with respect to MAID legislation is standard fare, it's nothing unusual. The second issue that I'll speak to is that its–actually seems to actually operate as a form of safeguard in the MAID regimes in the other jurisdictions, and then the third thing I'm going to talk about tonight is the Manitoba college guidelines.

So, on the first issue is that conscious protection regarding medical assistance in dying is a key component of MAID regulation in all the jurisdictions that permit assisted death. So that would include the Netherlands, Belgium, Luxembourg, Colombia, Oregon, Washington, Vermont, California, Colorado, Washington D.C. as well as Quebec.

In the American states–so the ones that I just listed off–the assisted death laws in the United States clarify there is no duty to participate, whether by contract or by law, in assisted death, nor are there any requirements to refer. Participation is entirely voluntary, and that's actually captured in all those laws. It's an opt in. The other part of the American laws is that they actually protect, and this is in bill–the bill. They protect physicians from–and other health-care providers from disciplinary action for refusing to participate in good faith compliance with the provisions of the statute.

In the Netherlands, Belgium and Luxembourg, these are the first jurisdictions–first countries that actually passed the MAID laws, and all these MAID laws in these three jurisdictions, which I'll call the Benelux countries, they're all very similar. All recognize that doctors have no obligation to participate in MAID. For example, in Belgium–and the Belgium law is actually very close to what our Canadian MAID law looks like. It's very, very similar. In the Belgium law, it states that no physician may be compelled to perform MAID, nor may other persons be compelled to assist, right? And I think that's an important piece, because the bill that you have before you is not just about physicians but it's other health-care providers as well. So this is consistent with Belgium. Furthermore, in the event of a refusal, the Belgian act only requires the physician to inform the patient of the refusal in a timely manner, explaining the reasons for the refusal and then to transfer those–the patient records upon request. Luxembourg follows this same pattern.

The Belgium legislation was passed in 2002, Luxembourg legislation was passed in 2009 and those conscience-protection provisions have not been changed. So they've not had an issue. So, again, conscience protection in the issue of MAID is standard fare.

One of the things about Manitoba, it's really interesting as a person who actually researches and studies comparative laws, is that Manitoba is a leader on this issue. And I think that's very important to think about, because, as we've heard tonight from some of the presentations, and especially talking with–dealing with the college, very early on, WRHA made MAID accessible through a central access point. And through the WRHA website, phone lines, Manitoba Health website and so on and so forth and through the MAID team, there's access. So this approach by the WRHA is not only relevant to conscience but also key for monitoring and control and public safety.

What else will I say here? Now, on the second issue, that conscience protection actually forms part of a safeguard, and you might want to take a look on the handout, because I'm going to read from this particular paragraph. Drawing from the Belgian experience–and, again, I'll reiterate that the Canadian MAID law, very similar to the Belgium law. Okay? So, if you take a look at the Belgium law, and probably you already have, you'll see it's very, very similar. And again, that law has been in place, and the conscience-protection provisions have been in place for 15 years. In Belgium, it is one of the most liberal MAID regimes that you will find out of all the jurisdictions. And from Belgium–there's MAID specialists there that are recognized–internationally recognized practitioners who specialize in MAID, that their perspective is from their experience, that critical voices are an essential and critical part of end-of-life care.

I'm going to read this quote. This is from a recent paper by Paul–Dr. Paul Vanden Berghe, who is a MAID physician as well as a palliative care doctor, which is a bit of a controversial thing that I just said, but this is how it reads: In all

communication, special attention is given not to convey the implicit message that a palliative care professional is only a true professional if they can't go the full way in matters of euthanasia. Whether as a physician, nurse, psychologist, social worker, spiritual-care giver or any other member of the palliative care team, the law states that no health-care professional can be forced to be involved in the act of euthanasia. Every professional has the right to set their own ethical limits. What is expected of them is that they indicate these limits clearly, forthrightly and, above all, in a timely manner. From our experience, it is actually recommended that critical voices remain present in the team, as it advances in the decision-making process.

Okay? So the critical voice, when it comes to requests for MAID, is an important component of this–sort of the overall safeguard process.

On the third issue, with respect to the Manitoba College of Physicians and Surgeons, bylaw No. 11, standards of practice of medicine, schedule M, which is the–schedule M is the MAID provisions–and they're–I've appended all of this to your handout. Again, Manitoba has had very, very strong leaders on this issue. Post-Carter and pre-federal legislation, the Manitoba College of Physicians and Surgeons turned its mind to the regulation of MAID and its implications for physicians and patient care. The college addressed the MAID procedure in its standard of practice with a view to both participating and non-participating physicians. And with the MAID–with MAID provision in mind, the college sets out what it calls minimum requirements. And these include, on the grounds of a conscience-based objection, a physician who receives a request about MAID may refuse to provide it or personally–personally–offer specific information about it or refer the patient to another physician who will provide it.

The standard then–and I've appended it in your materials there–goes on to describe, among other things, that a refusing physician must promptly inform the patient of the objection and provide the patient with timely access to a resource who will provide that information. And there's a number of other items in there that talk about–continue to provide care and then transfer records, if authorized to do so or on request. I think it uses the language of authorization.

Not only has the WRHA already provided that MAID information access point, the processes described by the college with respect to the exercise of conscience is consistent with the other jurisdictions that have legalized MAID. It is also consistent–and this part's kind of interesting–with the pending MAID legislation that is coming–that's being reviewed in Victoria, Australia. It's a new bill. It's gone through the first reading. It's at second reading. Actually, I think it passed one level already. And they've already had the benefit, then. What they've had is the benefit of learning from the Canadian experience. And in the Victoria legislation, they've also expressly set out the right to refuse to participate or provide information. And it's an interesting bill, and I would recommend to take a look at it.

So just to close, I would encourage you not only to consider conscience-protection legislation with respect to MAID, but also to really pay attention to what the college has come up with. Pay attention to the knowledge and the expertise, the amount of time that they have put in over a number of years. And it looks like they've got the balance right. And now this would be to enshrine that in the provincial legislation.

And I think the bill that you have before you is a really good bill. It has just the right flow to it and I think it's just a matter of a few tweaks and you could put the college provisions right in there.

And then I guess the last point I'll make is to please consider palliative care. It is part of the MAID safeguards. It's supposed to be–whether or not we have it, it's actually put there in the federal legislation as the patient to be informed of their palliative-care options. If there are no palliative-care options, I'm not sure exactly what that's supposed to mean. Not only did Belgium and Luxembourg, when they passed their MAID legislation–pass they–passed MAID legislation at the same time, they also created a right to palliative care, and they passed palliative care legislation. And so did the country of Colombia, when they legalized MAID, they also created a right to palliative care, as well as the province of Quebec in their legislation. So I would encourage you to think about the role of palliative care as well.

***** (20:00)

Thank you.

Madam Chairperson: Thank you for your presentation.

Are there questions from the committee members?

Mr. Goertzen: Yes, thank you. That's an excellent presentation, particularly the focus on the legal aspects of it. I think both my friend from Minto and I were particularly interested in that, and I appreciated the suggestion about perhaps–and it might form a future amendment–but about being more specific about the college's policies within the legislation.

This is, I think, more than enabling legislation, but it is specific legislation. But I appreciate that suggestion and maybe that, if it doesn't make it in this round, might be something to look at to the future about enshrining the college's–because I think everybody agrees here this evening that the college has struck the right balance and–but there's concern about what that future might look like, as colleges change and environments change. But perhaps enshrining the college's language right into the bill would make some sense, so thank you very much.

Mr. Swan: Dr. Shariff, I want to thank you for coming down. To date myself, I'm so old that Cliff Edwards taught me comparative law at Robson Hall. Yes.

I want to echo what the minister said. I mean, we've heard tonight–is support for Bill 34. We've also heard a position put forward by the college that they want to clarify that the requirements that are placed on physicians, even if they exercise their conscience, perhaps could be clearer. I'm hoping that, before the night is over, we'll be able to sort that out.

Do you think that those would be useful things to enshrine in legislation, or do you think that that could be taken care of by the minister making a very clear comment on the record that there is protection for what the college has already put into place?

Madam Chairperson: Ms. Shariff.

Ms. Shariff: Sorry.

Sorry. It's been a long day–grabbing my face there. Okay, so, I think what the college has set out in–and you've got, actually, a copy before you there. A few pages in, on the minimum requirements–could be enshrined in legislation. I think the way the language reads and what's actually contained in there is actually in a lot of other legislation, in MAID legislation directly in the legislation. First of all, describing the conscience-based objection, of course, and then going on to say timely information, providing them–staying–you know, staying with the patient and then providing the patient's information or medical record upon request. These are very standard kind of provisions, so I think it is the kind of thing that could be captured in legislation.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation.

I will now call upon No. 11, Dr. Albert Chudley, private citizen.

Dr. Chudley, do you have any written materials for distribution to the committee?

Mr. Albert Chudley (Private Citizen): I do.

Madam Chairperson: Please proceed with your presentation.

Mr. Chudley: Thank you, Madam Chair, and to the legislators and the committee here and the honourable Minister of Health. I really appreciate the opportunity to express my support of this important bill that is publicly being considered this evening. I congratulate the government and legislation–legislators for enshrining this protection of health-care providers who refuse to provide or aid in the provision of medical assistance in dying on the basis of their personal convictions.

I come from the experience gained as a physician for over 43 years since I graduated. I practised in specialties of pediatrics, neonatology and medical genetics. Apart from my specialty qualifications and teaching in those specialty areas, I taught at the undergraduate, graduate and post-graduate levels for 37 years, but I also did participate in teaching medical and clinical 'ethits'–ethics to undergraduate medical students in the Faculty of Medicine for over a decade.

I retired from my medical practice recently, and I'm–I currently hold the title of professor emeritus at the University of Manitoba. I did not renew my medical licence, and have been without a medical licence for six days as of today. Although my retirement from clinical practice was not an easy decision, it was, in part, motivated by the fact that I will be spared from having to practise medicine at a time in which some of my colleagues will be participating in ending a person's life.

My world view and perspective is through the eyes of the great physician, Jesus. I'll be speaking in support of Bill 34 with the following considerations: (1) why is the bill necessary; (2) what about the patient; and (3) a recent vignette that would hit the press particularly on the weekend.

Legislation will legally protect health-care workers from discrimination or discipline for failing to carry out MAID activities. This is true for physicians, nurses, pharmacists, health-care aides, medical and nursing students, or other health care-related disciplines or students that may be asked to participate in MAID.

I hope that the legislation will also protect discrimination against students applying for or being interviewed for admission to a health professional program based on their views not to be involved in MAID activities.

The bill will set an important standard for all other provincial legislators or regulatory bodies to consider or follow. All of Canada is watching how we address this important issue.

So what about the patient? Well, protecting rights of health-care workers does not diminish the rights of patients who choose to consider the MAID option. Manitoba has established a MAID team that is quite readily contacted by the patient, the patient's family, a member of the health-care team or patient advocates regardless of where they live in the province.

And just as an aside, I went on the Internet and I found three sites that I got the phone number to call without any difficulty.

Although I can only speak for myself, I do not believe that protecting the rights of health-care providers who refuse MAID involvement is abandoning patients. There is the options of transfer care, either complete transfer or partial transfer as could be negotiated with the patient, and this remains an option in these circumstances.

Based on the experience of assisted dying in other jurisdictions, the typical patient opting for MAID is not an individual dying in extreme pain, begging and pleading for death to come quickly. In these medical and palliative care circumstances, there are medical procedures and medications that can properly control the pain.

In some circumstances, pain management results in higher doses of opioids or other pain-control medications that sometimes can compromise the patient's underlying condition and could lead to respiratory failure and sometimes death.

Some have argued that this is no different in this circumstance than MAID, as the result is the same, except that the death process without MAID takes longer.

In clinical and classical medical ethics this is referred to as the double effect whereby in some circumstances, in order to achieve the goal of pain relief, unintentional death happens. Intention is the difference here. So the intention is to keep the patient comfortable, not to end their lives. With MAID, the intention is to end a life.

So, finally a short vignette. There were a series of articles in the local press and a recent program on national radio concerning an elderly man with a terminal illness in a Winnipeg hospital who was purportedly denied access to the MAID team for several months. Many disparaging remarks were made regarding his care team in that place and the lack of attention by the institution and staff to his pleas to end his life.

His wife visited him regularly and daily. She did not, or would not, contact the MAID team herself on behalf of her husband, although, apparently, she was aware of how to contact the team.

After the MAID team provided a recent psychological assessment, his underlying diagnosis of ALS was now apparently in doubt and, in their opinion, he was not ready.

This all comes from this great pool of knowledge and truth, the Winnipeg Free Press, from the Saturday edition.

***** (20:10)

So the diagnosis was in doubt in their opinion and he admitted to being lonely, though, and was bored and he believed he was wasting his life and wasting resources. He did very recently experience and enjoy visitors though, who shared good memories with him, as described in this report. And I think everybody should go back to this Saturday posting. It was really heartwarming to see that.

It's reassuring that the MAID team has followed the–their–the proper protocol, but it is disconcerting that some seniors because of the MAID option may now feel pressure, or perhaps even a duty, to end their lives before their appointed time.

Thank you.

Madam Chairperson: Thank you for your presentation.

Do committee members have questions for the presenter?

Mr. Swan: Dr. Chudley, on behalf of our NDP caucus, first of all thank you for coming down to present tonight, and secondly take our best wishes for a very happy and fulfilling retirement.

Of course you've been a medical practitioner, you also took time away from your practice to teach at the Faculty of Medicine. So we certainly appreciate you doing that. Of course, this is a fairly small community and it's practitioners like yourself helping out at the university that do make a difference.

So thank you for presenting to us tonight.

Mr. Goertzen: Yes, I echo my friend from Minto's comments on thanking you for your practice, Dr. Chudley. I'll probably be accused of losing doctors in Manitoba tomorrow after you've announced your six-day retirement, but you served our province well, I know, for many years.

And I appreciated your comment particularly about the college, and I think that speaks to, you know, the evolving nature of this. And you raised the concern about the possibility of somebody not being able to actually access medical school because of their personal beliefs. And you know, that's a different field of thought that people might have to give consideration to at some point.

But I think it speaks to the fact that this is evolving, this is sort of new to Canada, and relatively new generally. And it requires us to continue to think in different ways and to continually be careful to protect those conscientious rights for those that are practising, or perhaps those who want to practise.

Thank you.

Mr. Chudley: Thank you. I agree.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation.

I will now call upon Anthony Nakazato, private citizen.

Dr. Nakazato, do you have any written materials for distribution for the committee?

Mr. Anthony Nakazato (Private Citizen): Yes, I do.

Madam Chairperson: Please proceed with your presentation.

Mr. Nakazato: Thank you, Madam Chairperson.

I am here to make a presentation in favour of Bill 34, The Medical Assistance in Dying (Protection for Health Professionals and Others) Act. I'm a pharmacist and I've been practising for approximately 30 years; 26 of those years have been in the health-care facility here in the city of Winnipeg.

Early in my career, I had the opportunity to practise on the palliative-care ward and was involved in the care of patients in the end stage of terminal illnesses. Many of these patients had pain, some had poorly controlled pain or the fear of poorly controlled pain. However, once my colleagues and I were able to assess them, assess these patients, we were able to recommend a medication regimen for pain or other symptoms that they were suffering–for the management of these symptoms. And after all of this, the vast majority of these patients were able to achieve improved pain control, improved symptom control. And this enabled them to pass away of natural causes, or naturally.

My thought is that, if the medical assist–if medical assistance in dying had been available at that time, some of these patients may have requested it out of fear that their symptoms could not be managed and that they would have to suffer uncontrolled pain or otherwise. In this way, I believe that palliative care was able to control their symptoms and alleviate their fear so that the consideration of euthanasia was removed.

Further, it has been my experience that those with terminal illnesses, what they really want is someone to be beside them as they journey through the process of dying. And palliative care and those who practise palliative care are those that who do just that for these patients.

I believe that the diagnoses of a terminal illness does not necessarily have to mean that the patient is condemned to suffer a slow and painful process that leads to death, and that by offering palliation, the patient is not abandoned by health-care workers or the health-care system.

And so it is these experiences and my own personal convictions that bring me to believe that there needs to be a law so that health professionals and others who hold conscience-based objections to medical assistance in dying can be supported in offering alternative course of care and so that patients who choose to proceed with medical assistance in dying can receive that service from a health professional who is not in a position of conflict because of conscience-based objections. And

so, in this way, protections are put in place for both patient and health professional.

Thank you, it is with the utmost respect that I make this submission to the committee.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for the presenter?

Mr. Goertzen: Thank you for being here and for reminding us that among the many voices who have offered support tonight and through their letters that–it's not just doctors, of course–we've heard from many nurses and you representing the pharmacists' profession. We appreciate that there are a number of different health professionals who are impacted by this and who seek protection from the legislation. So thank you very much.

Mr. Swan: Yes, well, thank you, Mr. Nakazato, for coming down and presenting, and, as the minister has said, you're the first pharmacist who's presenting to us, and I think that that's an important perspective.

I know that from reading the federal law and observing how things work in Manitoba, the doctor or nurse-practitioner asking for a prescription of the dose that would assist in ending a patient's life, at that time they must advise the pharmacist that this is what this is going to be used for.

I was able to find online the Ontario code of conduct for pharmacists making it clear that no pharmacist has to comply with that or fill that prescription. I couldn't find the Manitoba standard. Do Manitoba pharmacists have that same protection within their code of conduct?

Mr. Nakazato: Thank you, yes, I believe that it is present. I did look at it–or, look for it myself on the college of Manitoba–Pharmacists of Manitoba website. As I recall, it's somewhat hidden, and it's kind of an old statement. Maybe it goes back a few years. But I believe that that protection does exist.

Mr. Swan: As we've talked about tonight, and I think that everyone around the table agrees that Manitoba's approach in having what's called a MAID team, a collection of health-care professsionals who are involved in this, I presume–you may or may not know, but–would they have a pharmacist or a small group of pharmacists that they would usually deal with to request the dose of a prescription?

Mr. Nakazato: Yes, it's my understanding that there are pharmacists on the MAID team. Yes.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation.

I will now call upon Valerie Wadephul, private citizen.

Ms. Wadephul, do you have any written materials for distribution?

Ms. Valerie Wadephul (Private Citizen): No, unfortunately I don't. I was not given that much time to prepare and I've had a crazy weekend. So I'll do my best.

Madam Chairperson: Please proceed with your presentation.

Ms. Wadephul: Madam Chair, ladies and gentlemen of various titles, I'm grateful for this opportunity to be here and listen with you to this evening's presenters and to share my thoughts on the issue of Bill 34. I cannot remain silent but must support the health-care workers in our province.

***** (20:20)

The first presenter that we heard over the phone from Dying with Dignity, he said that–imagine somebody 75 years old in negative circumstances. I'm closer to 75 than you may realize, and that could have been me. If I imagine myself in dying, painful shoes, I know that I can have painkillers that can be effective. I would prefer my family to want to be with me, to love me as long as my body continues to live.

When we love someone, we want to be able to love them as long as possible. The moment of death is so final. To hasten the time when we can no longer love our family members is not really MAID. I think MAID is a misnomer.

I have a girlfriend who died about six months ago. Her name was Lorna, and she died at the palliative care at St. Boniface Hospital. She did receive MAID. She had medical assistance in dying. She, herself, was dying and she had medical assistance in giving her comfort, painkillers, all the care she needed and loving care. That is MAID. I personally believe that that–MAID is a misnomer. It really should me MAIK because what has been–come into our country with euthanasia and physician-assisted suicide is medical assistance in killing, not in helping somebody to die.

We do know that people in a coma can often be conscious of all that is happening in their proximity. If I were in my dying coma state, I would like to hear my family recalling happier times that we shared, rather than hear them say I wish she'd go already. Maybe we should get the doctor to give her a shot and we'd be rid of her. That's not love. That's not love.

Doctors become doctors and nurses become nurses usually because they want to help heal and protect life, our most precious possession. You may–some of you may remember Peter Warren, used to be on the radio, and I'll never forget one time. I only–sometimes you hear something once and you never need to hear it again; you never forget it. They were talking about this very issue and a young man phoned in and he said my mother had a mysterious illness, they didn't know what it was and she was very sick in the hospital. And he said every time I'd go to visit her, she'd beg me to help me to kill myself. And he says, I couldn't do it. I just–I felt, like, mom, don't ask me to do this. Do you realize what you're asking me to do? But she still tried to talk him into it. And he didn't. And what happened was she got better. They didn't know why, but she got better. He was so grateful that he didn't listen to her. But she felt it was her right to go because she was so ill, so sometimes this right should not be given to people. Unfortunately, there are doctors who easily support medical assistance in killing but many, thank God, still do not.

I ask you, for a moment, to imagine yourself in a position where you are being requested to do something totally against your conscience. I'll pause a moment so you can imagine such a scenario. Think of a scenario like this. Can you maybe close your eyes and imagine what you might be asked to do that would be totally against your conscience? Sometimes it's hard to find something but I hope you have.

Okay, you've been asked to do this objective thing. You explain to the requester why you find this action to be repugnant to you. You debate back and forth a bit and still disagree. Then you are ordered by this person that you must carry out that action, totally against your inner self. You are expected to do it anyhow. How do you feel? What if you'd lose your job if you disobey? How do you feel? Does this feel like justice?

As you may know if you have researched the issue, places where these euthanasia and assisted suicide laws have been enacted–there have been some abuses in the application of these laws. Euthanasia is supposed to mean a good death. A good death is one where one is surrounded with love and caring, which is what proper palliative care is. Manitoba can be proud of some of its end-of-life hospice and palliative care facilities. Let us be proud to respect the conscience rights of health-care workers as well as pharmacists.

Please support Bill 34. If our health care loses health-care workers who respect the sanctity of life, we'll be left with a health-care system filled with workers who do not respect the sanctity of life, my life and yours. Is this the kind of health-care system we want to live under? It is bad enough that the Hippocratic Oath is no longer mandatory in our country. We need to retain and respect the conscience rights of very dedicated people by enacting Bill 34.

We must not forget, at one time, two of the main hospitals in our city, St. Boniface, where I was born, and the Misericordia, were faith-based hospitals before the health sciences grew so large and complex. But they were the two main hospitals. I'm old enough to remember that.

We have heard many fine medical professionals here today who believe social justice and fairness would be–and they would be in great moral distress if this bill passes. We must also remember most countries in the world have not agreed that physician-induced death is a desirable action to adopt into law.

I realize that we have an elected governing party and members labelled opposition. May I point out, an opposition party need not oppose just because they wear the label. When they see good bills put forth such as Bill 34, they should wisely and freely support it.

I thank you for listening and for laughing when you were supposed to.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions?

Mr. Goertzen: Thank you for your presentation. I spent a bit of time in opposition myself, and I'm glad that time's over. For now, anyway.

The–I will say, for the opposition, the opposition has indicated that they're supporting this bill, so I–

and the Leader of the Opposition indicated that a few days ago, so I appreciate that.

You mentioned two points that I'll just quickly touch on, and others have mentioned it too, palliative care. And in Canada, we don't do a good enough job of palliative care. That's just not Manitoba; that's every province. We need to do better. We need to ensure that people don't feel that they have no other choice. And, sort of, that's something I'd like to see improved in Manitoba, but across Canada as well.

The other–and that's a–that's largely a government responsibility. The thing that you talked about that isn't so much a government responsibility is being able to be there in those last moments with families that care. I've been lucky. I have a loving family, and I hope that I'm a loving father to my own son and to my wife. But there are many who don't have families, and it's a call to all of us not as government, but as individuals–as humans–to not only be good family members, or to sometimes be good family to those who we aren't actually related to.

So thank you for that.

Madam Chairperson: Ms. Wadephul–Mr. Swan.

Mr. Swan: Yes, on behalf of our NDP–

Madam Chairperson: Oh, Ms. Wadephul, there is five minutes of questioning.

Ms. Wadephul: Oh, I thought you were–I thought nobody had any questions. Okay.

Madam Chairperson: Okay. Mr. Swan.

Mr. Swan: Yes, on behalf of our NDP caucus, I want to thank you for coming down.

As I think you've got the sense tonight, the committee process in Manitoba is a very open and a very democratic one, and we want to thank you for coming down and sharing your views on this bill.

Thank you.

Ms. Wadephul: I really appreciate that I live in Manitoba and that I have had this opportunity. And it was my MLA who told me, you can go down here, and I thought, I've got to because this is such a serious thing, even for all of you sitting there.

I'm a lot closer to 75, but it–the time comes quicker than you realize. Thank you.

No more questions?

Madam Chairperson: No. Thank you very much for your presentation.

***** (20:30)

I will now call upon Dr. Ann McKenzie, private citizen.

Dr. McKenzie, do you have any written materials for distribution to the–

Ms. Ann McKenzie (Private Citizen): No, I don't.

Madam Chairperson: Please proceed with your presentation.

Ms. McKenzie: Thank you. I really appreciate the opportunity to be here and speak to you, Madam Chairperson, Mr. Goertzen and committee, and I was really delighted to hear all these excellent presentations from so many wonderful presenters.

So I will be brief and personal. I do want to support Bill 34, and I'll give you some reasons why I'm in favour of the bill, and then I'll tell you some quick stories to illustrate further.

I'm an emergency physician at a community hospital in Winnipeg, and I've been doing this type of work for over 35 years, and all of that time I've worked to protect the lives of my patients, treating illness, relieving pain, providing comfort where possible, and sometimes withdrawing active care at the request of a patient or family while, of course, providing comfort care. But I have never intentionally caused the death of patient. As a medical student 40 years ago, as a number of other people have mentioned, I made a promise in the Hippocratic Oath to protect life and never to take any part in doing something to end a patient's life. And I want to continue to keep that promise.

So far I have not been asked by any patient for medical assistance in dying, but I thought a lot about how I would respond to that request. And, first of all, I'd want to make sure that that patient was physically comfortable, because some of these people are really in dire distress, and it's hard for them to have a discussion about anything. And I'd want to listen to their fears and their concerns and see if we could address them because, with good palliative care, many patients are able to continue fairly comfortably with life until their natural death occurs and relief of symptoms can bring a very different and a more hopeful perspective.

For a patient who's still interested in medical aid–medical assistance in dying, I could direct them to the various avenues provided by the WRHA–and people have talked about how the access to that is pretty easy in this province–and then their questions could be answered. But I would not be comfortable in making a direct referral to the MAID team. However, I wouldn't stand in the way of somebody who wanted to access it.

So I remain committed to providing compassionate care for my patients to the best of my ability, and I would continue to be committed to that care whatever a patient's views on medical assistance in dying, whether they decided to access that or not, until their care was transferred to another physician.

I think there's been quite a bit of discussion already about what the College of Physicians and Surgeons has brought forth, and I am really pleased. In fact, I was very, very relieved to first hear what the college had decided about it because it was something that I was really, really worried about. So I'm glad to have their support, and I'm delighted that the Province wants to bring in this bill to support those of us who have conscientious objections to medical assistance in dying and being involved in it.

So those are some reasons, and now just some quick stories. The first one's about my dad. He died peacefully early last year, and this was before MAID was available in Manitoba. He must have thought a lot about this, though, because he was a medical ethicist. He actually ran the medical ethics program for the medical school for many years. I don't know if he would chose–would've chosen that way to end his life. However, he received excellent palliative care, and he died comfortably and peacefully with his family around him. And I wish that every patient were able to leave this life so comfortably at the time of their natural death. However, I fear that vulnerable patients might lose valuable time with their loved ones by choosing assisted suicide before they've accessed all the available palliative care. So I'm not comfortable referring patients directly for MAID.

The next story is very emotional for me because I am a suicide survivor. I lost my 19-year-old son to suicide four and a half years ago, and, of course, the loss was devastating for our family and for my son's many friends. One deeply disturbing thing was the premeditated nature of the act of suicide. A healthy, brilliant, beloved young man, he made the choice to leave us, and he's gone from this world, and we will never be the same. So it's not surprising that the idea of having anything to do with physician-assisted suicide is pretty horrifying to me.

The third story is about an elderly patient that I saw a few months ago. Her sister had cancer, and she'd asked the MAID team to end her life. My patient had supported her sister's wishes and had been present when she died. She had not expected to be traumatized by the experience, but she was. The premeditated nature of the procedure was one thing that was very upsetting for her. She was having nightmares and other symptoms of PTSD. I haven't seen any research on the effects of being present when a MAID death occurs, but I'd be interested to know if it's being studied, and again, I'm not comfortable being involved in any way in such a premeditated death.

So, in conclusion, I want to support Bill 34, and I believe that it will ensure that I and many other health-care professionals with conscience concerns can, in good conscience, consider–continue to provide excellent, compassionate care to keep patients comfortable to the end of their natural lives while in good conscience not providing medical assistance in dying.

Thank you so much for this opportunity.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for our presenter?

Mr. Goertzen: Thank you for your service as a medical professional. More specifically, thank you for coming tonight and sharing a personal story. I've heard many presentations, hundreds, maybe thousands, over my time here and every once and a while I'm struck at the courage that it takes to come before a legislature and speak to MLAs, but to speak so personally and to speak about your personal experience. That takes a lot of courage. And we are MLAs who represent different parties but we're Manitobans, and as Manitobans I think all of us can say our heart goes out to you and we are sorry for your loss, but thankful for your courage to come and speak about it tonight. Thank you.

Mr. Swan: Yes, on behalf of our NDP caucus, thank you for coming down and making a very thoughtful and very moving presentation. As you've heard, my usual question has been to ask about the college's position, but you've already answered that. It is a political committee, so I just have to ask which

community hospital you happen to work at as an emergency room physician.

Ms. McKenzie: I'm afraid to say this. I work at Concordia emergency, long we–may we be open, please.

Thank you, Mr. Swan.

Ms. Klassen: Thank you for that. As–you know, I want to say sorry about your son. I've had many suicides in my own family. I know that the loss, the pain, doesn't get better, but the coping skills, they come. So I really appreciate that and bringing the perspective on the post-traumatic stress and we'll definitely make sure that we hold this government to account and make sure that those studies are taking place. So, I thank you for sharing today.

Ms. McKenzie: Thanks.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation.

I will now call upon Patti Fitzmaurice, who will be presenting on behalf of the Archdiocese of St. Boniface as well as the Roman Catholic Archdiocese of Winnipeg.

Ms. Fitzmaurice, do you have any written materials for distribution to the committee?

Ms. Patti Fitzmaurice (Roman Catholic Archdiocese of Winnipeg / Archdiocese of St. Boniface): I do.

Madam Chairperson: Please proceed with your presentation.

Ms. Fitzmaurice: Thank you.

I am the social justice co-ordinator for the Roman Catholic Archdiocese of Winnipeg, and prior to this position I was a practising lawyer, and I only mention that because regardless of how much I try, my experience in that profession has tended to influence the way I present things. So it comes more as a explanation than anything else.

I'm here representing the Archdiocese of Winnipeg and the Archdiocese of St. Boniface. Archbishop Gagnon of the Archdiocese of Winnipeg and Archbishop LeGatt of the Archdiocese of St. Boniface–both would have liked to have been here to speak to this community, but, unfortunately, their schedules wouldn't permit it.

***** (20:40)

Both the archdiocese as well as the Roman Catholic Archdiocese of Keewatin-Le Pas, the diocese of Churchill and the Ukrainian Archeparchy of Winnipeg strongly support Bill 34. We recently undertook a letter-writing campaign to show the Manitoba Legislature our support. Speaking for myself and the Archdiocese of Winnipeg, I personally received from our parishioners 4,400 letters that were then forwarded to the MLAs. Some of those letters were signed on behalf of a whole family or on spouses, but I counted them as one, so the support was actually even greater. And I'm also advised that some sent their letters directly to their MLAs and some by email, which I didn't figure into that account. I was told that, on behalf of the archdioceses in Manitoba and as well as other organizations, that over 10,000 letters were sent to MLAs and the honourable Minister of Health has mentioned that it's more in the neighbourhood of probably 14,000 letters.

I want to just briefly explain that conscience rights are extremely important and fundamental to Catholics. And I'm not going to go into a detailed thesis as to why this is, but conscience rights are really a foundation of our faith. Catholics believe everything we are and have comes from one God, and as God created everyone in His image and likeness, there is true dignity in all men and women. It–and in that sense, we aren't supportive of medically–medical assistance in dying and we wish to protect the conscience rights.

It's–it is essential that we as human beings be free to act in such as way as to seek what is true and good. We discern what is true and good through our holy scripture and the doctrine and teachings of the church. Ultimately, we seek the voice of God to lead us in the direction of what is good and to avoid what is evil. That voice, we believe, is heard in the conscience. And we then fulfill our quest to live a moral life by bearing witness to the dignity of human beings.

The conscience is our core, our sanctuary, where we are alone with God. Our conscience is the way in which we reason and recognize the moral quality of the act which we are about to perform. In all we say or do, we are obliged to follow faithfully what we know to be true and just. We believe that a person has a right to act in conscience and has the freedom to make moral decisions and that people must not be forced to act contrary to his or her conscience.

And I share this, mainly because I can't speak for anyone else but Catholics, but I shared this belief as an example because I–there is a tendency to 'trivalize' conscientious rights and the conviction that people hold to them. I think there's a belief that it's easier to explain it away or to lessen the importance of a conscientious right in our society today. But I think that by showing you how essential it is to Catholics to believe in our faith and to act upon our faith, we're showing how conscientious rights are so extremely important, and that by the doctors who have spoken tonight, I think you can also get the impression, as well, at how much agony, distress and trauma it would cause for a person to be forced to act against what they truly believe in the core of their being.

Now, I'm aware freedom of conscience isn't the same as freedom of religion, but they're related, the conscience rights. Freedom of conscience in our democratic society is the freedom to have, hold and act upon one's conscientiously held beliefs. And I'd mentioned the Universal Declaration of Human Rights, that holds that all human beings are born free and equal in dignity and rights, and human beings are endowed with reason and conscience and should act toward one another in the spirit of brotherhood; that everybody has the right to freedom of thought, conscience and religion; and that everyone has the right, in private or in public, to manifest his religion or belief in teaching, practice, worship or observance.

Conscience rights aren't only based on religion. In R. vs. Morgentaler, Madam Justice Bertha Wilson stated: It seems to me, therefore, that in a free and democratic society freedom of conscience and religion should be broadly construed to extend to conscientiously held beliefs, whether grounded in religion or secular morality. And I, again, I mention that today because in my opinion there is a tendency, unfortunately, to just dismiss conscientious belief and especially if it's stated in religious terms.

But, having said that, the Supreme Court, again, stated that values that underlie our political and philosophic traditions demand that every individual be free to hold and to continue to manifest whatever beliefs and opinions his or her conscience dictates, provided only that such manifestations do not injure his or her neighbours or their parallel rights to hold and manifest beliefs and opinions of their own.

And so we come in our society to the point of having to balance rights. And, in the Carter case which allowed for the medical assistance in dying, it also mentioned the need to uphold freedom of 'relatious' and conscience, but didn't go any further. Our federal legislation does not address freedom of religion and conscience. So we're left with a situation where we have to balance what the Supreme Court of Canada has allowed in medical assistance in dying with the right of health-care professionals who are looked upon to assist in the suicide of another person, to refuse to so assist.

The Manitoba government has provided a means in which those who seek medical assistance in dying can obtain it. It has allowed for teams of health-care professionals to diagnose, assess, and provide the services. Bill 34, we feel, balances the access Manitobans have to medical assistance in dying with the right of health-care professionals not to be involved if their conscience or personal convictions do not allow them to do so. We feel that the bill is important. As I state in this brief: even though the Manitoba College of Physicians and Surgeons have provided guidelines, we feel that a broad legislative bill or law would be able to protect the conscience rights of our health-care professionals. The college can change its guidelines without the input of Manitobans, and we have seen–and it's been referred to this evening–different guidelines being provided by Ontario, where the rights of the physicians and surgeons to have freedom for following their conscience has been limited.

The people in Manitoba who submitted the letters from their MLA–to their MLAs come from all walks of life and have shown that freedom of conscience should be protected by law and by their Legislature. Furthermore, the college of physicians only regulates its members, and not other health-care professionals, so therefore, the bill obviously extends to more.

We believe that those who seek medical assistance in dying will still get the assistance they seek if they meet the requirements. However, as it stands now, without passing legislation, those who have a conscientious belief or conviction that to in any way be a part of inducing death is abhorrent to them may be in a position of choosing between their profession or their conscience. For Catholics, there would be no choice; the profession would lose. Those who felt their conscience or conviction would not allow them to participate would also avoid the calling to be a health-care professional. Manitobans would all lose. Our health care in general would

suffer. The fundamental rights of Manitobans would not be balanced and it would not be fair and just.

There is a need for clarity and certainty in the protection of freedom of conscience, and we implore and pray that this committee will recommend Bill 34 as it is now for passage into law.

Thank you.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for our presenter?

Mr. Goertzen: Thank you very much for your presentation on behalf of the Archdiocese of St. Boniface and the Roman Catholic Archdiocese of Winnipeg. I appreciated, again, the legal perspective that you brought, in particular, the need to protect conscientious and religious freedoms. I think too often, people view the Charter of Rights and Freedoms as a hierarchy of rights, and it's not. It's a series of rights that often butt up against each other and try to demand the same space. And I think in the Carter decision that was particularly true.

This legislation, we believe, brings the right balance when it comes to rights, to–enshrines the balance that is–currently exists with the College of Physicians and Surgeons and will ensure that that balance remains not as a hierarchy of rights, but as a equalization of rights for those who are affected by it.

So thank you again for your presentation. And thank you for the letters. And I'll be busy signing letters in response.

***** (20:50)

Mr. Swan: Yes, I'll–Ms. Fitzmaurice, thank you very much for coming down to present the brief on behalf of the Archdiocese of Winnipeg and the Archdiocese of St. Boniface, and our NDP caucus thanks you for presenting it to us.

Ms. Klassen: I just want to say thank you for the letter-writing campaign. I know I've received a lot of letters myself from my communities, so it was a great initiative that you guys thought of and I really appreciate, and I have already sent off all my responses to the communities that participated in that. And I'm just grateful that it enabled me to fight for the position to be able to support the bill within the Liberal caucus.

It was well known that Dr. Gerrard, though, already supported the bill. It just gave us that extra edge that we needed, so I appreciate that.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation.

I will now call on Dr. Donald Peters, private citizen.

Dr. Peters, do you have any written materials for distribution to the committee?

Mr. Donald Peters (Private Citizen): I do.

Madam Chairperson: Please proceed with your presentation.

Mr. Peters: Madam Chairman, members of the committee, I deeply appreciate this opportunity to speak to you. I kept trying to talk myself out of this, but I couldn't live with myself.

I am a retired physician. My specialty was anaesthesia. I used drugs all the time, always to bring relief to patients. Now, I strongly support Bill 34. I have personal reasons. I'll mention those first.

I believe in the sanctity of life until the last breath. Also, as has been mentioned by many others, I took the Hippocratic Oath at a time when it contained this statement: I will neither prescribe nor administer a lethal dose of medicine to any patient, even if asked, nor counsel any such thing.

I know there are physicians currently practising in Manitoba and we've heard from many who feel the same way, and to do others would violate their conscience.

I would urge our MLAs to pass Bill 34, even though Canadian citizens enjoy freedom of religion and that in Manitoba, our College of Physicians and Surgeons supports conscience rights, we've already heard it mentioned several times that Ontario, it's taken a very different direction and it has gone to the point where physicians could be sanctioned or even lose the right to practise if they don't perform or refer patients for this service.

Now, this bill applies not only to physicians, but has been mentioned to nurses, pharmacists, and other health-care professionals where participation would violate their conscience.

Now, I feel there's more than my personal perspective on this, and I'm going to do a projection to the future. Take it for what it's worth, and this is

based on my experience in medicine over the past number of decades.

First of all, even though currently three strict criteria are required for a patient to have access to MAID, three additional circumstances are already being put forward consideration to qualify for medical assistance in dying. These are for mature minors, people with mental or psychiatric disturbances, and those who would like MAID included in their advanced care directive. I'm only going to focus on the second one, patients with mental illness or psychiatric disorder.

Consider this: All of us at points in our life become discouraged. At such points we have a somewhat reduced interest in our life. Now, sometimes it's more than just discouragement. It can be frank depression, which varies from mild to severe. The reality is that in most instances, with the passage of time or medical therapy or changing circumstances, people recover.

Now, I want to share two personal cases that I was involved with which make me feel that MAID is not a solution to this problem.

The first case was that of an angry, discouraged young man who was very depressed. He decided he would end his life by taking a gun to his head. He failed, but he did blow off his nose. I became involved when he came for reconstructive plastic surgery. The young man I saw was friendly and clear-headed. Had he succeeded, he would've not have had a second chance. Now, with disfigurement, he was prepared to go on with his life.

The second case was that of a middle-aged businessman. He was successful. He was coming in for surgery. When I reviewed his chart, there were two things that caught my attention. The first was the fact that he was a paraplegic–sorry, a hemiplegic, which meant he had no use of his legs and, secondly, he had a gunshot injury to his head when he was a young man.

So, after I'd finished examining him, I said, would you mind telling me about that gunshot injury when you were young? He just smiled and said, you know, young men of their 20s sometimes do stupid things. But think about it–here was a man who suffered severe disability, but he was able to go on with his life. If MAID became available for people with this disorder, there would be no second chance.

The second situation I want to mention–and this is not conjecture, this is reality–that already there is at least one ethicist at Queen's University who's advocating that when students apply to enter medicine, that they be questioned on their position on MAID, and if they're opposed to it, they should be barred from entering medicine.

Well, think what that means down the road. When our children and our grandchildren are facing serious medical challenges, will there be any physicians around who have the position that they are there to treat, comfort, but never harm?

And, therefore, I strongly feel that we need to pass this legislation now. Thank you.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for our presenter?

Mr. Goertzen: Thank you very much for your medical service and for your presentation tonight. And you mentioned, again, the application to medical school. That was an interesting–that's an interesting development in what I know will be a developing issue, medical assistance in dying. It's one of the challenges when courts make laws, is that there's not a lot of policy discussion that sometimes happens around it before that, and then the Parliament is left to fill in some of the blanks, and we see a lot of things that are–continue to evolve around this.

So you've raised that; other presenters have raised that as well, and I appreciate that, and it might be instructive for future discussion.

Mr. Swan: Yes, Dr. Peters, I just want to thank you for coming down and presenting. I know it's been a while now you've been sitting in your chair, and I appreciate you for staying around and coming up and giving us your perspective on what we all agree is a very, very important issue.

Madam Chairperson: Thank you very much for your presentation.

I will now call upon Dr. Julie Turenne-Maynard, CHAM, Catholic Health Association of Manitoba.

Dr. Turenne-Maynard, do you have any written materials for distribution?

Ms. Julie Turenne-Maynard (Catholic Health Association of Manitoba): Yes, I do, and he's passing it.

I just want to make a clarification: I'm not a doctor. I'm the executive director of the Catholic Health Association of Manitoba.

And for those who don't know it, CHAM is a volunteer provincial association comprised of Manitoba Catholic self-governed health and social service organizations as well as the representatives from the five archdioceses in the province of Manitoba.

So we provide a forum for our members to exchange ideas and best practices, and we develop shared strategic initiatives that support our collective ability to strengthen the healing ministry of Jesus.

So, with respect to CHAM's position on Bill 34, our members believe that the content of the bill as proposed has profound implications for all who work in health and personal-care facilities in Manitoba, now and in the future, both individuals whose practice in these settings is overseen by regulatory body and those whose work is overseen by employers and directed by institutional policies.

The matter of whether or not health-care professionals and others involved in the provision of health care may be exempt from co-operating with the provision of MAID based on a claim of conscience remains a subject of both professional and public debate. While we recognize that this debate will and cannot be exhausted this evening in this setting, CHAM wants to put forward some brief reflections on why and how Bill 34 represents a just compromise. We have managing disagreement in circumstances where extinguishing disagreement is unlikely.

***** (21:00)

We're of the view that Bill 34 reflects the spirit of the February 2015 Supreme Court's decision in Carter v. Canada, which states, and I know you're familiar with the statement, but I'll say it anyway: "In our view, nothing in the declaration of invalidity we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament and provincial legislators." However, we note that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, a religious belief. In making this observation, we do not wish to pre-empt the legislative and regulatory response to the judgment. Rather, we underline the Charter rights of patients and physicians will need to be reconciled.

CHAM is of the view that the government of Manitoba, understanding that the provision of health care is undertaken by multiple parties, both regulated health-care professionals and other health-care workers, has prudently crafted legislation to address the legitimate interests of all providers in a manner that need not undermine the interests of persons wishing to request access to medical assistance and dying. We are of the view that the balancing of the legitimate interests of providers and patients is ethically necessary and possible.

We're also of the view that a legislative response, in addition to the current positions of regulatory bodies, addressing the matter of conscientious objection to the provision of medical assistance in dying by its members, prudently achieves this needed balance.

CHAM supports the balance that government is trying to achieve through this bill, and, if we ask what's at stake, a decision to act or not to act for reasons of conscience represents a judgment or a conclusion individuals, who are moral agents, reach in an answer to the question: May I, should I or must I co-operate with a request made of me?

The matter of co-operation is at the heart of claims of conscience, a claim that requires each of us to sort out or evaluate the threshold between acting in support of requests that don't undermine our core or identity or conferring beliefs over against acting in support of requests that do undermine our core identity and conferring beliefs.

Conscientious objection is an individual's judgment that it would be unethical for him or her to act in a certain way. It's not a judgment about the person making the request. Acting conscientiously is the most fundamental of all moral obligations. Given what's at stake, a legislated response that offers protection of conscience, provides social policy that balances the interests of others have in pursuing access to medical assistance in dying. It avoids the pitfall of an either-or decision by either party.

So, in summary, Bill 34 legislation is prudent. It's not about settling the differences but rather the managing the differences that can't be resolved. It's not about the requester; it's about the person who's being asked to act. It adds clarity and assurance for those who want to conscientiously object, who are not members of regulated bodies, and Bill 34 addresses the compromise about how, in a democracy that values respect for persons, that the

parties are not arbitrarily subjected to the will of one another.

So we definitely support this bill. Thank you.

Madam Chairperson: Thank you for your presentation.

Do members of the committee have questions for the presenter?

Mr. Swan: Yes, well, thank you, Ms. Turenne-Maynard, for coming down and presenting on behalf of the Catholic Health Association of Manitoba. Again, I think it's been a very positive and very important committee meeting tonight, and I thank you for your addition to our discussion tonight.

Mr. Goertzen: Thank you very much. I think it's fitting that you, I believe, are the end of the public presentations.

Catholic Health Association of Manitoba does tremendous work in Manitoba. It's an important part of the health-care system, I've learned, over the last 18 months–it feels longer, but I guess it's been 18 months–is complex and multifaceted, and it takes many different groups and organizations and individuals to make it work well. And, certainly, the Catholic Health Association is a part of that. So thank you very much for your presentation and for your continued work in the community.

Ms. Klassen: I just wanted to say thank you for your presentation.

Madam Chairperson: Seeing no further questions, thank you very much for your presentation.

That concludes the list of presenters I have before me. Are there any other persons in attendance who wish to make a presentation on it? Seeing none, that concludes public presentations on this bill.

*** * ***

Madam Chairperson: We will now proceed with clause-by-clause consideration of Bill 34.

During the consideration of a bill the table of contents, the preamble, the enacting clause and the title are postponed until all other clauses have been considered in their proper order. Also, if there is an agreement from the committee, I will clauses in blocks that conform to pages with the understanding that we will stop at any particular clause or clauses where members may have comments, questions or amendments to propose.

Is that agreed? *[Agreed]*

Does the minister responsible for Bill 34 have an opening statement?

Mr. Goertzen: Now, I want to thank all the presenters who came here tonight. Some came from a great distance. Some phoned in from further away, and I think it demonstrated the best part of our public presentation process that we have in Manitoba, which is unique in Canada.

I recognize the vast majority of presenters here tonight were–are in favour of the bill and, certainly, the overwhelming number of respondents that I've had in my office by letter, email or otherwise have also expressed their support for the legislation.

But I also know that it's not an easy issue, that anytime we're dealing with whatever you call it, euthanasia, medical assistance in dying, assisted suicide, people call it different things. It is a difficult issue. It's a difficult thing to talk about. It's a difficult thing to confront. It's a new legal reality in Canada and every province is struggling in its own way to get the balance right.

I think that Manitoba, and I will give credit to the college and those who have been involved in this previously, have gotten the balance essentially right, and we want to keep it that way.

Our government has made it clear that we support conscientious rights. We want to ensure that that continues in the long term even as the legal field around this issue and other issues shift as legal fields always do.

I know that there's been controversy and I'm not a stranger to controversy these days, but there's been controversy around the issue of providing medical assistance in dying, to use the term in faith-based institutions. We've made it clear and I've made it clear to the minister that we will protect the rights of those institutions who do not want to for faith or other reasons provide the procedure in their facilities, but there needs to be policies in place and that goes to access. There needs to be access and our government is dedicated to ensuring that that balance is maintained. We have made it clear to this legislation that those medical professionals, not just doctors, but nurses and pharmacists and others perhaps who do not want to participate in the procedure, need to have their rights protected, but not at the expense of access. And so where there have been issues and questions about access we've acted upon that. That, I think, is also the balance and

goes to the question that was raised by the college of physicians on this issue.

So the balance isn't easy, but I think that compared to other provinces we have met that balance better than most. I think that we have found a way in a difficult environment to give those medical professionals the assurance that they need that they won't have to participate in medical assistance in dying. We have, I think, found a way to give those institutions who have a faith-based history to give them the assurance that they will not have to have the procedures on their facilities, but they've come away, too, in terms of the assessing of individuals.

And so in many ways it's the best of Manitoba, is the way to find and try to balance the rights of everyone. The Charter is not a hierarchy of rights, they're competing rights. In Manitoba I think we respect that and we recognize that, and there are competing rights on this issue. But we cannot let the rights that are either faith-based or conscientious rights for other reasons be lost in this debate and they will not be lost in this debate under our government. But we will ensure, as the law requires, that there is access because we are law-abiding citizens and the government will follow the law.

***** (21:10)

So I appreciate very much the presentations that have been brought here tonight. I think it speaks well of everyone who presented. I think it speaks well of this Assembly that we've agreed to move forward on this legislation. And I know it won't be the last time we debate this issue, because there will be things that we can't foresee sitting at this committee room here, at 10:30, on a Monday night, but what will come in the future. And it might be left to future legislators to make that debate, but I hope that they'll look back at this committee hearing and the presentations that were made and see that, in Manitoba, we believe in protecting rights and we believe in balance and we believe in following the law. And tonight was, I think, the demonstration of all those things that make Manitoba a great province.

Madam Chairperson: We thank the minister.

Does the critic from the official opposition have an opening statement?

Mr. Swan: Yes, thank you, Madam Chairperson.

I do want to thank–acknowledge and thank everybody who came out to present tonight, and I'm actually moved by the number of people who are still present well after 9 o'clock to hear us moving through what's called the clause-by-clause discussion of the legislation. And I'll–spoiler alert, I'm going to ask the minister a couple of questions based on what we've heard and get him simply to confirm a number of things which were raised primarily by the College of Physicians and Surgeons that I think can just give some clarity to what the bill is intended to do.

As I said in debate on this bill, the legislators–there's 57 of us, all of whom come from different backgrounds, who may have a different face–or no faith, as the case may be–and we all may have different views on this particular issue. We know that the federal government passed legislation after the Supreme Court spoke, and Bill 34 is an effort by the government to try to deal with what I think we can all agree is a very, very difficult issue.

Our caucus is supporting Bill 34. We agree with conscience protection. As I think you will understand from some of the questions I've asked presenters tonight, we don't know that access has been given the same importance by this bill. It's not a reason not to vote for the bill, but we think that we can ask a couple of questions to clarify that tonight.

Obviously, it's a difficult issue for anybody; for physicians, obviously, who are providing care to individuals; other health-care professionals; and also for patients and for families. And, certainly, my family has gone through–have–both my father and father-in-law, who suffered from illnesses that eventually took their lives. That's not easy. I learned more about the palliative care system and hospitals than I ever really wanted to, not knowing that Health critic was going to be in my future. I know that many members of our Legislature and, certainly, everybody sitting out there in the gallery tonight feels very strongly about this. And I really want to thank the minister and all of my colleagues around this table for what I think has been a very, very important and a very productive evening.

So, with that, we're ready to move into clause-by-clause consideration of the bill with a couple of questions that I'll be asking the minister as we go.

Madam Chairperson: We thank the member.

Clause 1–pass; shall clauses 2 and 3 pass?

Some Honourable Members: Pass.

Some Honourable Members: No.

Madam Chairperson: I heard a no.

Mr. Swan: Yes, well, as promised, I have a couple of questions for the minister.

We've heard concerns by the college that there are some provisions of this bill which are ambiguous. As both the minister and I learned or, hopefully learned in law school, one of the ways to deal with that ambiguity is to put some clear statements on the record at a committee hearing such as this one.

One of the concerns raised by the college–or one of the statements made by the college in their presentation is, and I quote: We've heard from government representatives that their position is that, quote, aiding in the provision of medical assistance in dying, end quote, does not include providing information on how to obtain MAID. Aiding in the provision of MAID is intended to be some kind of active participation in its actual provision, end of quote.

Can the minister just confirm that, indeed, that is the government's intention, that medical assistance in dying has to be something beyond simply providing information on how a patient can obtain MAID in Manitoba?

Mr. Goertzen: It's beyond the provision of information. In Manitoba, the college, through its policies–its thoughtful policies–that came up that were developed by consultation requires that medical professionals provide information, how to get information, essentially, a phone number to call, as an example. The college does not require referrals. We support that. We do not believe that medical professionals should have to make a referral either to the MAID team or to another physician to have the procedure done. The college's current policy is that a phone number or like information be provided is a reasonable balance, and there's nothing in this legislation that upsets that balance and I think it only confirms the college's position.

Mr. Swan: I thank the minister for that.

At the bottom of page 2 of the submission of college, the college lays out minimum requirements as they relate to members' personal views or beliefs. We appreciate that the college only regulates physicians, that nurse practitioners may also be involved in the MAID team and they have their own college which has set out its own requirements. We also appreciate that there can be pharmacists who may be asked to prepare the prescription to assist in ending a patient's life.

The CPSM's requirements are stated as follows and, again, I quote, provide the patient with timely access to a resource that will provide accurate information about medical assistance in dying and continue to provide care unrelated to medical assistance in dying to the patient until that physician services are no longer required or wanted by the patient or until another suitable physician has assumed responsibility for the patient.

And what I think the college is looking for and I think it would be helpful, can the minister simply confirm that that requirement imposed by the CPSM members is not inconsistent with what's contained in section 2 and 3 of Bill 34.

Mr. Goertzen: In my understanding from legal counsel, that it is not inconsistent, and I think we heard from doctors and others today that the provision of care outside of MAID is not a concern and that almost universally the provision of information in terms of how to access other information related to MAID, whether it's Health Links or a like phone number, is something that's been the reasonable compromise in Manitoba. Certainly, medical professionals in Manitoba do not believe they should have to make a referral and we support that and we believe the legislation supports that.

Mr. Swan: To bring the circle complete, if nurses, pharmacists, other regulated professionals have similar requirements to what the college has created–after what we can agree was a lengthy process of consultation and discussion–that, again, in the minister's view would not be inconsistent with what's contained in Bill 34.

Mr. Goertzen: I believe that the professionals that the member has referenced are equally as protected under the legislation, as would doctors be.

Mr. Swan: I thank the minister for those responses.

Madam Chairperson: Clauses 2 and 3–pass; clauses 4 through 6–pass; preamble–pass; enacting clause–pass; title–pass. Bill be reported.

The hour being 9:19 p.m., what is the will of the committee?

Some Honourable Members: Committee rise.

Madam Chairperson: Committee rise.

COMMITTEE ROSE AT: *9:19 p.m.*

WRITTEN SUBMISSIONS

Re: Bill 34

I would like to thank the Standing Committee on Legislative Affairs for the opportunity to express why I support Bill 34.

I am a proud nurse of 29 years. Although medical professionals all work together to assist and care for patients and their families, it must be acknowledged that there is a medical hierarchy. Still today, the physician is considered the leader of the medical team. It is intimidating for a nurse, a medical student or even a patient to challenge the physician or health care leader.

Over the past year, I have spoken with many peers, patients and families about how troubled and compromised they feel about MAID. The Nursing World Organization defines moral distress as, "When one knows the right things to do, but institutions make it impossible to pursue the right course of action." Today in health care, moral distress is real. The health care providers are feeling cornered into compromising their values and later suffer in silence and alone. It is unacceptable for many of us to actively or intentionally assist with the giving of a lethal injection with the sole intent of ending our patient's life. This is contrary to everything nursing embodies.

I urge you to support Bill 34, a conscience clause for health care workers.

Respectfully,

Jennifer Savoie, RN
Winnipeg, Manitoba

Re: Bill 34

To Whom It May Concern:

Thank you for considering Bill 34 as a way to protect doctors and other health care providers that currently do not want to be involved with Medical Assistance in Dying otherwise known as MAID. As I sit on my coach, shortly after watching the Jets game, I think back to how we got to this particular place in time. I find it interesting that just two to three years ago medical professions, as a whole, were in almost unanimous agreement that we should not be involved in any form of physician assisted suicide. We should, as a body, try to alleviate suffering, give high quality palliative care, and do our very best to treat those who are dying with respect and dignity. I am not saying that everyone agreed, but I sure was not aware of a big movement of physicians lobbying for MAID or rallying in the streets for this "human right" to become a standard in medicine. Fast forward to 2016 and 2017 and I read articles in the paper and online that lead me to believe that some ethicists want doctors and other healthcare workers that do not participate actively or passively in MAID (not even two years old yet) to pick another specialty or quit their job. Some go as far as suggesting that perhaps they should not have even gotten into medical school in the first place!

What happened?

I listened to CBC's "The Current" on November 3, 2017. Dr. Arthur Schafer said that there "has never been a physician in Canada, to my knowledge, who has been fired based on conscious ethical objections". His point is that we do not need this bill as no one has ever been fired in the past. To me his statement implies that conscious objectors should not be worried about there jobs. This is interesting as I read an article on the CBC website (July 2016) that states, referring to Dr. Schafer, "A Manitoba ethics professor says doctors vehemently opposed to physician-assisted death should consider changing careers." Dr. Schafer was quoted saying that some doctors who are fundamentally against MAID perhaps "shouldn't be practicing as a doctor".

My point is, on one hand we are led to believe that we should not worry about legal protection because we don't need it. Yet, on the other hand, we are sent the message that we should probably look for a different job if we do not actively or passively participate in MAID, something that was illegal just two short years ago. All this to say, Bill 34 is necessary to protect myself and many of my colleagues who believe we are better at helping patients in pain, addressing their fears and needs, talking to them, and being doctors that we wanted to be in medical school. Doctors that help patients live and do not assist them in dying. Do not get me wrong, I believe that most of the doctors on the MAID teams love their patients and want to give them dignity and provide for them many of the same things I want to provide. We disagree however, in how that is enacted for our patients. I have seen many patients that expressed interest in dying or even attempted suicide. Most of these patients were very happy that a health care provider, friend or family member convinced them that life was worth living. These are the patients that convince me that

participating in MAID, even with those close to death, is not what we should be doing for our patients.

Not wanting to be involved in MAID does not make me a worse doctor nor does it make me someone that should choose another career. It makes me a Canadian doctor with an opinion that should be respected and listened to, just as I have done for those who are in favour of MAID. I can help patients with compassion and still be a conscientious objector and this should be okay in Canada in 2017. There are ways that our society can provide MAID without forcing conscientious objectors to participate. We have many wise people in this province that can think of ideas in which access to MAID is not hindered while respecting those with different opinions.

In saying this, I have to say that Manitoba has actually done a pretty good job of protecting physicians of conscience. In some ways, however, my concern lies with nurses, pharmacists and my other healthcare colleagues who do not have the same present policies of protection that our college provides for us physicians. What we need now is legal protection for all those who object to MAID for ethical reasons. Health care workers should have the right to consciously object without fear that their college will sanction them or that their college's position will change in the future. This would help ensure that there will never be a doctor or health care worker who is fired due to their ethical objections to MAID. Dr. Schafer seemed to think that the fact that no one has been fired for conscientious objection is a good thing, and to this I agree. Surely we can all agree to this.

As long as I can, I will try to help my patients live a better life, care for my patients, wake up in the middle of the night for my patients, alleviate suffering for my patients, try to prevent disease in my patients, and love my patients. I will never abandon my patients. For many legitimate reasons I believe that MAID is not something we should be doing as doctors so I cannot be part of a process that ends my patient's life. Please support this bill.

Sincerely,

Jayson Barkman MD CCFP (FPA)