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question de mourir dans la dignité**

Le jeudi 14 octobre 2010 — Vol. 41 N° 11

Consultation générale sur la question de mourir dans la dignité (11)

**Président de l'Assemblée nationale:
M. Yvon Vallières**

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Commission spéciale sur la question de mourir dans la dignité

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(Neuf heures trente-quatre minutes)

Le Président (M. Kelley): À l'ordre, s'il vous plaît! Je constate le quorum des membres de la Commission spéciale sur la question de mourir dans la dignité, donc je déclare la séance ouverte en rappelant le mandat de la commission.

La commission est réunie afin de procéder à la consultation générale et aux auditions publiques sur la question de mourir dans la dignité.

J'imagine, Mme la secrétaire, il n'y a pas de remplacements?

La Secrétaire: Non, M. le Président.

Le Président (M. Kelley): Parfait. On a une autre journée fort chargée aujourd'hui, et c'est une journée où la traduction simultanée est disponible. Alors, si j'ai bien compris, le poste 1, c'est en anglais, et le poste 2 est en français. C'est bien ça? Alors, pour les personnes qui veulent avoir accès... parce que les témoins vont, dans la plupart, aujourd'hui, s'exprimer en anglais, mais on va être capables de poser nos questions en français.

So we have a linguistic balance today. There is simultaneous translation available to allow people to testify in English, but we'll have translations so members of the commission can pose their questions in French and...

Without any further ado, we will pass to our first witness, who is Professor Margaret Somerville, from McGill University. Professor Somerville, welcome back, because you testified earlier on when we had our consultation with experts in the spring, so welcome back before the commission.

Auditions (suite)

Mme Margaret Somerville

Mme Somerville (Margaret): Thank you, Mr. Kelley. And I'm not going to have anything new to say, but it's a privilege to be here and to be able to address you again. I understand that I have 15 minutes. Is that correct?

Le Président (M. Kelley): Roughly.

Mme Somerville (Margaret): Roughly. OK. Well, what I'd like to point out is that it used to be easy to make the case against euthanasia when we were largely a homogeneous Judeo-Christian based society. You simply said: Well, thou shall not kill. And it was much more difficult to make the case for euthanasia in those times. And today the situation is reversed. It's very easy to make the case for euthanasia. It's simply a matter of saying: This is my life. And whose death is it anyway? And I've got the right to self-determination and autonomy, and this is what I want to do. And who are you to tell me that I can't do it? Very often, that's followed by: You're trying to impose your religious beliefs on me.

And it's hard now to make the case against euthanasia. But I think that there is a very, very, very strong case against euthanasia. And because it's hard to make, most people don't understand what it is. One of the reasons for that is that the strongest case against euthanasia lies in the institutional and societal level. And the arguments against euthanasia, often there's no visual images of them. For example, what would legalizing euthanasia do to the world of the future? How will our children, great-great-grandchildren die if we legalize euthanasia now? What would legalizing euthanasia do to the institutions of law and medicine? And you can't wheel society... put it in a wheelchair and wheel it on to a television set and show what would happen.

I've studied this area for around about 35 years and have followed the developments and, as you know, there's a book that I've written which goes up to 2002. Since that time, I've written quite extensively on euthanasia, I continue to study it and I participate in debates all over the world. I've just come back from Australia about two weeks ago, where I was involved in the Australia-New Zealand Palliative Care Conference, which had a very large section on euthanasia and physician assisted suicide. And the Australians are facing exactly the same type of questions as we are facing here.

So, what would legalizing euthanasia... Let's say, first of all, due to our institutions of medicine and law, we would have to change our law to say that it is sometimes acceptable — and now I'm going to use a very strong word that people object to — to kill a patient, because that's really what you would have doctors doing with euthanasia. People object to that word, but I would argue to you that if we can't call something what it really is and still feel that it's justified, then maybe there's something wrong with what we're doing. And what I think that word does is that it raises our moral intuitions that there is something wrong in what we're doing.

And if you look at the literature, you find — particularly, for instance, in some of the literature on the military — you find that people have got a... we have a natural instinct not to kill other humans. And so, for example, when the Americans were sending their soldiers into close hand-to-hand combat in Vietnam, they actually psychologically deprogrammed them so that they would be able to kill another human in close contact. And we really... I mean, I often wonder if that's the reason that so many Vietnam veterans are in such bad shape today. So we do have to wonder about that.

● (9 h 40) ●

We also have to ask: What would it do to our physicians, what would it be like for our medical students? Can you imagine standing up in front of a medical school class and saying: Now, here's today's lesson on euthanasia? This is how you go about it. And it would affect the whole ethos and the whole ethic of medicine, nursing, health care professions, which, for thousands of years, have had this rule that you do not kill your patients. And, indeed, society has had that rule. So, one of the things that we have to

ask is «Why suddenly now do we think this is a good idea?». And I think the reasons are largely at the societal level and that's why I think we need to address those.

And I would put to you that the clinching case against euthanasia is this, that if you look at the most fundamental norm or value on which our type of societies are based, it is that we do not kill each other. No matter how compassionate and merciful a person's reasons for carrying out euthanasia, it still alters that norm that we don't kill each other to one where we don't usually, but sometimes we do. And I don't think we can afford that as a society.

And an editor of *The Australian* newspaper — this was during my time in Australia just recently — wrote that we'd cross this threshold at our ethical peril. Once it's crossed and killing is sanctioned, the question becomes: What are the terms, conditions and safeguards on which it can be carried out? «Given the frailty of human history, does anybody doubt the scope and scale for abuses?»

And, indeed, I think you can see the expansion of justifications can not be prevented from looking at the 30-year history in the Netherlands. Now, it's an interesting question that people say, well, you know, it's not abuse, but it depends what constitutes an abuse and it depends whether what would be an abuse sort of under one set of rules becomes a justification under another set of rules. And that's what you can actually see in the Netherlands. When the Netherlands first legalized euthanasia, which was in 1973, through a court decision, it was that this was only for competent, consenting adults who were terminally ill, with unbearable suffering and who repeatedly requested euthanasia over a period of time.

Now... So doing something that didn't comply with those requirements would have been an abuse. And in fact, as you... I'm sure you've heard a thousand times, the Remmelink inquiry in 1990 and the subsequent follow-up in 1995 showed that around 50% of the physicians involved in euthanasia didn't follow all of the requirements. But now the amazing thing is that not one of those original requirements still applies. Now, for instance, with the Groningen Protocol, parents of disabled newborn babies can request euthanasia for their baby. Children between the ages of 12 and 16 can have euthanasia with their parents' consent. It's been the reports on people being euthanized who have not consented or don't even know that's what's happening or who are incompetent.

I was surprised, I was looking at the figures yesterday, and the figures for the Netherlands were much, much higher than I had ever realized. I usually use a conservative figure around 500 cases a year, but the figures I saw yesterday were in the thousands. And certainly, that's just a new report out, which you've probably seen, from Belgium which has only had euthanasia legalized for two years, and that showed that of 208 cases that they followed, 142 had consent, but... I think it was 66 who didn't. So, I mean, that's huge, that sort of... at least two thirds of the cases, and that's in a new system that's just being implemented.

As well, as you probably also heard, the Dutch have a provision for legislation by the people, like the American legal system does. So, if you get a certain number of signatures on a petition, it goes into Parliament, and the Parliament has to consider whether it will make it law. There's recently been a petition put in that there should not need to be any justification for euthanasia other than the person's wish to have it provided that they're over

the age of 70, and it's called the «tired of life» provision, that you would be allowed to have euthanasia if you're tired of life. And I was speaking with some Dutch legal health lawyer experts, a few weeks ago, and they told me that the petition got 100,000 signatures, and so, you know, I think that's really worrying. I don't think that's to be celebrated, it shows that euthanasia is a good thing. I think that once you introduce it and it's absorbed into being the norm, it is unstoppable.

And the other thing which I would have thought I would have known, because it's the kind of work I do, is that, about 10 days ago, I saw a report that in Belgium they were doing organ transplant retrieval after euthanasia. And I don't know whether anybody has talked to you about that, but I phoned Dr Frank Delmonico, at Harvard University, because he's the head of the International Transplant Association, you know, he's the immediate past president, and he said: Yes, that is correct, and I have here articles that show... that report on the cases where the combination of euthanasia and retrieval of organs for transplant after euthanasia.

My intuitive reaction to that was that there was something radically wrong with that, that this... that just the fact that you had intentionally killed somebody and then you thought it was acceptable to take their organs, I mean, it was... it's like making them into objects. It's dehumanizing them, I feel, in that way. And the film *Never let me go*, that has just opened in Canada, is extremely interesting in that regard. As well, when you put... when you bring in that we have an aging population, you've got scarce and expensive health care resources, you add euthanasia to that and you've got a lethal, I believe, a lethal combination.

So, what we can summarize is that the anti-euthanasia position — and this is my position — is that euthanasia is never justified, because intentionally killing another person, other than in the rare circumstances where that's the only way to save human life, as in justified self-defense, is never morally acceptable and is not ethically acceptable. The position of a lot of people who support euthanasia is that you can have euthanasia on certain conditions. Therefore, they would see in some conditions it would be justified. And the position of an increasing number of people is: You really don't need a justification other than that the person wants it and consents to it.

As well, you will see that the procedural... if you were to legalize it and you put in procedural safeguards, both the Netherlands and Oregon show that those safeguards are ineffective. The Oregon is often touted as being some way that shows that it can be regulated properly. But if you really look into what is going on in Oregon, what you've got is selective reporting and inadequate reporting to know what is really going on. And in that respect, there is a very interesting article in the *Michigan Law Journal* reporting on it in detail, written by Herbert Hendon, who is a Dutch physician, who is a psychiatrist who specializes in treating people who might commit suicide, and Kathleen Foley, who is probably the leading palliative care specialist in the United States, who's the head of palliative care at Memorial Sloan-Kettering and was also the president of the George Soros Project Death in America.

● (9 h 50) ●

So, in conclusion, what I would argue to you is that for a whole wide range of reasons, it would be a sad day for Québec, a sad day for Canada and, I think, a sad

day for the world and certainly for the world of ethics if you were to recommend legalizing euthanasia. And, by the way, I point out that I use that term to include physician assisted suicide because I think that there is no difference. There is a difference legally, but there is no difference in terms of the ethics that are involved. So the euthanasia debate is a momentous one, it involves our individual and collective past, the ethical, legal and cultural norms that have been handed down to us as members of families, groups and societies, it involves the present, whether we'll change those norms in the future, the impact this would have on those who come after us. And in debating euthanasia, it is far from sufficient to look at what happens at the individual level, and whether you've got some... our compassion should go out to them, some poor dying persons who feel that this is the only way they can handle their situation. We are not, as individuals, isolated items. As humans, we also have to live in families, societies, and we have to have solid ethical shared values on which we base those societies. And quite frankly, I think, this is the single biggest challenge to whether we can maintain those values and maintain that societal cohesion. That's why, I think, the euthanasia question is so extraordinarily important.

And instead of dying in dignity, which is the slogan, as you know, of the pro-euthanasia groups, and as I entitled the submission I made to you, I think our goal should be to allow people to live in dignity up until they die a natural death. Thank you.

Le Président (M. Kelley): Thank you very much, Professor Somerville. Mme la députée de Hull.

Mme Gaudreault: Merci beaucoup. Alors, si je pose la question en français, Mme Somerville, vous allez pouvoir répondre en anglais. Pas de problème. Alors, toujours un plaisir de vous entendre. Vous êtes une experte dans le domaine, vous avez utilisé le sujet depuis 35 ans. Alors, vous êtes une source d'information précieuse pour nous.

On vous a découverte au Parlement, au début de l'année, maintenant, on vous retrouve à nouveau. Vous avez peut-être pu lire quelques échanges que nous avons eus avec les personnes qui sont venues nous rencontrer. Le débat est très polarisé, les gens sont très en faveur ou très opposés à la légalisation. Alors, votre position, elle est très claire.

Je voudrais vous entendre par rapport... J'ai apprécié que vous précisiez que vous aviez la même position au sujet du suicide assisté parce que, pour nous, il y a une différence, en tout cas, pour moi, il y en a une, ce n'est pas du tout la même... ce n'est pas la même demande à mon avis. Et le risque de la pente glissante à mon avis est un peu plus prononcé lorsqu'on parle d'euthanasie que lorsqu'on parle de suicide assisté. Je voudrais vous entendre par rapport à l'arrêt de traitement. Quelle est la différence, si une personne décide: Aujourd'hui, moi, j'ai la sclérose latérale amyotrophique, je suis allée sur Internet, j'ai vu les étapes qui m'attendent et j'ai rencontré les gens, les membres de ma famille et je ne veux plus prolonger ma vie, je veux mettre un terme, j'ai la chance d'avoir un respirateur et je peux, au moment opportun, le retirer? Est-ce que cette personne-là est avantagée par rapport à une autre parce qu'elle peut faire un arrêt de traitement?

Mme Somerville (Margaret): Well, when you withdraw life support treatment, the person doesn't die from

the withdrawal of the life support treatment. The person dies because they've got a failed respiratory system and that can't maintain their life. And throughout Canada, of course, including Québec, what we know is people have got the right to refuse to be touched. The right in the Civil Code of Québec, the right to inviolability, therefore not to be touched without their free and informed consent as the Code provides, so, that's... And then, there we see a case in Québec City of Nancy B., where the Code affirmed that, yes, that was the law, and throughout Canada that law is followed. So that's not a problem. So, what you're doing there is you're respecting the person's right not to be touched and including through the respirator or whatever it is that you're doing to treat them. And they die from natural causes which is, you know, what we argue in the anti-euthanasia situation. Obviously everyone is going to die. The question in the euthanasia debate is not if we die, everybody dies. The question is how we die and what means of dying should be prohibited.

And so, what I'm arguing to you is that the means of intentional killing or intentional assistance with killing yourself, that's what assisted suicide is, doesn't just involve that individual and doesn't involve a natural death. You die from either the lethal injection in euthanasia or you die from the poison that is intentionally provided to you so that you can kill yourself. And once you've got that, what we call an ethics complicity, then you have to look at both the ethics of that complicity in that person's dying and you have to ask what are the full span of consequences from it. Now, what you can then do is look at the consequences at, at least, three levels, and sometimes we look at four. The first level is the individual level, and, for the person involved, a lot of people say: Well, it's no different for them, they're going to die any way, they want to die sooner, so let's accept that.

That might not even be true because, there, if you talked, as you have, to thousands of them probably, palliative care specialists, and also you look at the very extensive literature for example on what people are actually wanting to know when they ask: Will you help me kill myself or will you kill me?, very often, they're wanting you to say: We love you, we want to care for you, you're not too much of a burden. You can also look at the work, I hope you have, of Dr Harvey Chochinov, who is a Manitoba psychiatrist, who specializes in psychiatry of dying people. And you can see... He and his team of researchers have recently evolved a protocol that's called dignity therapy, this has been published in the medical literature, and it's amazing, I mean, we now know there's lots of things that we can do to help people, that's what palliative care is about.

But once you start to say that the State will authorize somebody to give that person the means to kill themselves or authorize our physicians to kill them, you've got a different ball game. You've got society involved, and therefore you've got to look at the other levels, which are the ones that I briefly alluded to in my opening remarks, you've got to look at the institutional level, that is: What does that do to the institution of law, that it's authorizing this? What does that do to the institution of medicine that is going to be involved in this? What even does it do to the institution of the family, that you've got family members involved in it? And then you've got to look as well at the societal level. What does that do to what we call the societal cultural paradigm? And that's the shared story that we

tell each other in order to bond to each other as members of the same society. And it's the collection of stories, myths, beliefs, attitudes, principles, ethics, etc., that we say: Yes, I agree with you. I mean, one of the reasons that we've got problems in the so-called cultural wars at the moment is that we've got competing stories about what story should be the base of our society. And I think that an extraordinarily important element of our shared story is the value that we respect each individual human life but, in addition to that, that we respect human life in general. And you can't do the latter if you institute euthanasia and assisted suicide.

There's a very interesting French case on the respect for human life in general. The French have sort of developed this sport that was called dwarf throwing. I don't know if you've heard about this. And what they were doing was that they'd get a person who was... the medical term for it is achondroplastic, that got short hands and short legs, you know, they're the little people, they often call themselves the little people, and what they would do, they'd have two big, strong men and they'd start fairly close to each other and they'd throw the dwarf from one person to the other, and the first person who dropped the dwarf lost the game, and... Anyway, somebody took these guys, who were doing this, to court and said: This was not acceptable in French society, that it showed values that were contradictory to what the French thought. And the defense came forward and they brought some of the dwarfs in, and a dwarf, so, got up and said: But I love this, I consented to this, I want to be part of this sport. And what the court said was really important and interesting, it said: It doesn't matter if you want to do it, it doesn't matter if you consent, this is contrary to respect for human life in general, to make a human person a ball, a tool, an object that you would do this with.

And so I think the same thing ought to apply in euthanasia, that even if the people say: Well, I want this, I consent, we have to ask: What does that do to our respect for human life in general? Because what we do to them doesn't just affect them, it affects our most important institutions and society. And just on the institutional level, you know, in a society that's more or less religious, you've got religion to carry the value of respect for human life. In a society such as ours, which is secular, the two institutions that carry the value of human life, our society as a whole are medicine — it doesn't kill — and law — it prohibits killing. And that's what you're going to change if you institute euthanasia or assisted suicide.

● (10 heures) ●

Le Président (M. Kelley): M. le député de Marquette.

M. Ouimet: Merci, M. le Président. Alors, bonjour, Mme Somerville. Je vais adresser mes questions au Pr Somerville en anglais.

I must confess you've played with my mind a good part of the summer and this early fall, because...

Mme Somerville (Margaret): Well, that's reassuring.

M. Ouimet: No, no, in a positive way, of course. Part of me and probably part of my colleagues is the same thing. Part of us want to open up on an individual basis for compassionate reasons, and then we fall into the line of arguments that you have developed, and that holds us... holds me back anyways for the present time.

But there's... On a fact, on factual issues, we have heard people say that the slippery slope arguments are more fiction than fact, are more myth than fact. Could you sort of tell us, you know, trying to get a good grasp on all the arguments we have been hearing regarding slippery slope? Is it true? Is it factual? And where could you refer us for us to get solid documentation on that so that at least we can clear that out of the way?

Mme Somerville (Margaret): Well, you see, the interesting thing about that question, it's really again what I referred to. It's when people say: The slippery slope is a fiction, what they mean is that what they would consider an abuse is not very common. But what has happened in the Netherlands is that what would have originally been considered an extraordinarily serious abuse, for example giving a lethal injection to a newborn baby at the parents' request, is now legal. So, I would say that that's a very strong example of the slippery slope.

And indeed, the woman who was the vice... I think I forgot what the exact term is, but she was like the vice-president of the Dutch Parliament. And she was the main person who pushed the legislation through the Dutch Parliament to legalize euthanasia. And very recently she's come out and said that, if she had known where it would go, she never would have done that.

I think the other thing that you can look at is, well, this paper from the *Canadian Medical Association Journal* that I referred to, which shows that, out of 208 deaths, 142 were at the patient's request. But 66, there was no consent. No request, no consent.

And you get the same thing here, I mean, I've brought the paper here. You get exactly the same thing from the Groningen Report, which was done in... Sorry, not the Groningen, the Remmink Report, which was done in 1990. This is a piece that I've got, which is June the 21st 2010, so it's very recent. And it has a diagram accompanying it. And I looked at these figures and I thought: These figures can't be correct. But I haven't... I went... then I went actually to this book, which is excellent. This is the book by Foley and Hendin. And I looked up the figures in this, and they more or less correlate.

So, these are the figures taken from the Dutch Government's report, which was done by people who were not antieuthanasia. So, you know, that's often a good test to see whether they're probably true. What this says is that, in 400 cases, doctors provided patients the means to kill themselves. In Holland, assisted suicide is not the usual mechanism used. In 2,300 cases, doctors killed upon request, so that would have been your standard euthanasia with consent. In 1,040 cases, doctors actively killed these patients without the patient's knowledge or consent. And, in 4,941 cases, doctors administrated lethal morphine overdoses without the patient's explicit consent. Now notice that says «lethal morphine overdoses». It's not just necessary pain relief treatment.

As well, there is literature that showed where people have done research on the doctors who carry out euthanasia, and you get responses like: I took their request for all necessary pain relief treatment as being a consent to euthanasia. Well, that also, I think, is a gross abuse.

The other thing is that, when you look at the literature, you find that certainly not all Dutch doctors are willing to use euthanasia. And what the literature says is

that, in the big hospitals, there's usually one, or two, or maybe three doctors who do most of the cases of euthanasia.

Now I think that you also have to ask why might that be. I mean, what I would speculate is that those doctors might be desensitized. In fact, I once chaired a debate in which doctor Peter Admiral was one of the participants. He's a Dutch doctor who is very pro-euthanasia. This was in 1989, so this is a while ago. And he got up and he said: I personally have carried out 1,200 cases of euthanasia. Now, he wouldn't have known those patients, they certainly wouldn't... by no means his patients. And somebody from the audience said: But, you know, how could you do that? Didn't you find it difficult? And he said no. He said: I'm an anesthetist, and it just involved giving the first half of an anesthetic where you paralyze the person, because they were using curare at that point. And he said: I'm not giving the second half, not resuscitating them.

And I think... And, as well, if you look at the surveys, the... Well, I know the current English figures, they have just done a survey. Something around about 79% of doctors... no, 75% of doctors are adamantly against euthanasia, and 79% of the general population are in favor of it. But, you know, one of the things that we know is that even doctors — and that was exhibited here in Quebec — don't know what euthanasia is. They think that giving adequate pain relief is euthanasia. It's not. And palliative sedation, when it's used properly, is not euthanasia.

And, in fact, I would... As I've said before, I ended up on the front page of *The Ottawa Citizen*. It had a headline that said *Ethicist Recommends Jailing Doctors*. So, I got into terrible trouble with the doctors, and the reason was that I'd said that I personally would take a prosecution, a criminal prosecution against any doctor who failed to give adequate pain relief.

And I don't know whether anybody has told you, but, just in the beginning of September, we had the International Association for the Study of Pain meeting here, in Montreal. And on Friday there was a summit and the... Have you heard about this? And what is being approved in principle, but we're still working on the final draft, is called the *Declaration of Montreal*. And it declares that there is a fundamental human right to adequate pain relief treatment. And I've been privileged to be involved in helping with that project.

Le Président (M. Kelley): Very quickly please, because we're way over time.

M. Ouimet: Very quickly. How do you explain the highest court of the country, in Rodriguez, the verdict is 5-4, very close? And the Bar, in the brief that they've tabled in front of this Commission, review the literature in the U.S., in Great Britain, in Canada, and, speaking of jailing, the doctors say: Every time there's been an attempt to convict a doctor who has, on grounds of compassion, shortened the life of a patient, the doctor has always been acquitted. And they say, you know, the jury is a representation of the people and of the social conscience of the people at that given time.

● (10 h 10) ●

Mme Somerville (Margaret): Well, I think that, as we could see, for instance, in the Latimer case here in Canada and these other cases, in an individual case and facing a person who's in terrible pain and suffering, I can

understand how you could think: I've got to do something about this. But what we should do about it for the sake of society is not kill that person but relieve their pain and suffering, including, if necessary, by palliative sedation. And the very fact that the doctors are willing to break the law I don't think is at all reassuring. I think it's the opposite, because it means that, whatever safeguards we put out on this, all we're going to do is extend the circumstances in which that's likely to happen.

I mean, the other thing that I haven't had time to talk about is what this does to people who will be patients. I mean, we know that, in the Netherlands, old people are frightened of going to hospitals, frightened of being put in nursing homes. Apparently, they're going across the border to Germany, because Germany, because of its past and the horrors of the Nazi era, has got very strict rules against any of this. And I just... I think that of course our heart goes out to these people. And, at a compassionate level, we say: I want to do everything I can to help you. But the wrong thing to do is to help... is to say: Well, then let's legalize euthanasia. I just think it's wrong.

Why did the Supreme Court do that? Well, at the time, the Chief Justice, who was Antonio Lamer, I worked with him on the Law Reform Commission of Canada as a consultant to the Commission for some time, and he was a very liberal secular kind of guy, you know, so I wasn't at all surprised. In fact, in his judgement, what he says is that you've got a right to commit suicide. Now, that he actually expressly says that, he's the only judge that says that, but what that would mean is, if you brought somebody into an emergency room after they'd attempted suicide — now I'm not talking about a terminally ill person, I'm talking about a 16-year-old heartbroken girl — you've got a duty not to touch them. If they've got a right to commit suicide, you've got no right to prevent them from doing that. So, I mean, I think we have to be very careful with some of those judgements.

And as well the judges... It's true a lot in our society. I mean, the kiss of death in our society is that somebody says to you: Oh, you're saying that because you're religious. And I think the judges, they even made an express statement in the Rodriguez case that they were acting simply on the principles of law and not of religion, theology, philosophy. I've forgotten the range of things. But I think people, inevitably, their values come from a very wide group of sources, and that they... and that we have to be very careful not to dismiss them because we don't like the source of their values. And, in fact, there's a wonderful case, it's called the MacKenzie case, in which a judge sits that out very clearly. It's a British Columbia Supreme Court decision.

Le Président (M. Kelley): Mme la députée de Joliette.

Mme Hivon: Oui, bonjour. Bienvenue à nouveau. Je vais aussi poser mes questions en français. Dre Somerville... Pre Somerville, Dre Somerville. Vous êtes tout ça, vous êtes plein de choses.

Mme Somerville (Margaret): C'est toute la même chose.

Mme Hivon: Oui. Je veux juste... Évidemment, on est ici pour confronter les points de vue, et là on a eu

plusieurs jours d'auditions. Et, juste sur l'argument de la peur, je veux juste vous soumettre ça quand vous parlez des gens aux Pays-Bas, parce qu'ici on a eu des personnes âgées, quelques-unes, dont Mme Raphals, qui avait à la fin quelque chose comme 87 ou 88 ans et qui nous a dit, pour sa part, qu'elle avait très peur d'aller à l'hôpital et qu'elle, elle voulait rester à la maison parce qu'elle avait très peur qu'entre les mains d'un médecin elle perdrat tout contrôle sur les derniers moments de sa vie, parce qu'elle deviendrait quelqu'un qui pourrait, en fin de vie, être l'objet d'une sur-médication. Pas de crainte, de peur de mourir, au contraire. Elle, elle dit: Moi, je veux être capable, jusqu'à un certain point, de décider et de garder le contrôle jusqu'à la fin de ma vie et de pouvoir dire avec ma famille: Là, j'en ai assez, laissez-moi partir et aidez-moi à partir, le cas échéant. Donc, je voulais juste porter ça à votre attention.

Moi, ce qui me frappe dans le discours des éthiciens beaucoup, c'est: on a les éthiciens qui nous parlent des messages qui seraient envoyés à la société. Par ailleurs, il y a beaucoup de citoyens qui viennent nous voir, de gens aux prises avec des maladies, de proches. On le voit aussi dans des sondages. Même le Barreau nous dit qu'il faut considérer l'ouverture. Le Collège des médecins dit aussi que l'euthanasie pourrait être vue, l'aide médicale à mourir, comme un soin ultime de compassion, de soulagement de la douleur.

Et, moi, ce que je me demande, c'est — je suis très intéressée de vous entendre là-dessus: Quel message on envoie à une personne, d'une part, mais aussi à la société plus largement quand, face à quelqu'un qui souffre physiquement, moralement, en fin de vie, et qui demande qu'on mette fin à ses jours de manière répétée, et à qui on dit: Bien, écoute, il existe quelque chose, il existe la sédation terminale, donc on est face à un cas où n'est pas capable de te soulager parfaitement, mais il existe la sédation terminale, donc on va t'endormir, on va arrêter au besoin l'hydratation, la nutrition jusqu'à ce que tu meures, parce que c'est la manière ultime de soulager ta souffrance... Et cette personne-là, avec ses proches, dit: Non, moi, ce n'est pas ça que je veux. Moi, ce n'est pas ça, ça me fait créer un angoisse incroyable de savoir qu'on va m'endormir et que je ne saurai pas pour combien de temps, pour combien de jours, et que ma famille aussi va devoir vivre ça. Et quel message on envoie à la personne, à la société et aussi à sa famille qui, elle, aimerait qu'on entende la personne qui dit: Écoutez, plutôt que de m'endormir pour une semaine ou deux semaines, je voudrais qu'on m'aide maintenant à mettre fin à mes souffrances pour moi, pour mes proches aussi?

Mme Somerville (Margaret): Well, there is sort of a saying that I want... the family can — and this is putting it crudely — the family hopes the person dies to put the family out of its suffering, and I just think that's the wrong thing to do. And indeed, in the paper that I mentioned that's in the Michigan law journal, by Foley and Hendin, they describe a case where exactly that happened. And it was under the Oregon legislation. And the old lady, in the morning, said: I wish I could die. And they said: Well, what about this afternoon? And with that she took the medication in the afternoon. And they examined this case and said, you know, it was a situation where they should have been great warning bells of inappropriate use of the suicide provisions.

But, when you started of to speak, you talked about this old lady wanting to have to have control, and

a normal human reaction to fear is to reduce... is to try to take control over the circumstances that arouse that fear. And it's what the psychiatrists and psychologists call terror reduction mechanisms. And so one of the things that euthanasia could do is to act as a terror reduction mechanism. You can't avoid death, but you feel that you can take control over by controlling the manner, time and place in which you die. And it might well act to alleviate some people's fears in those ways, but what I argue... I mean, I don't deny some of the things that euthanasia could do, I think we have to accept that those things are true. But the question is: Is it overall a good thing to do? And I argue that, even for utilitarians who don't have any innate objections to killing another person in these circumstances, that even for them the harms that legalizing euthanasia would do still far outweigh any benefit. And the whole point is that, for those people, the dying persons, as you mentioned, you can use... I don't use the term «terminal sedation» because I think that's another confusion with euthanasia. I use the term «palliative sedation». Then, it's a proper, authentic part of palliative care and it should be available. I'm assuming you have, but, if you look at the literature and you look, for example, at Dr. Chochinov's research for one, and you see, for instance, when people asked to be killed, very often, some 12 hours later, they say: No, no, I don't want that.

Dr. Bernard Lapointe tells an amazing story of a young man that he had in the Royal Victoria palliative care unit. And this young man was... he was 28. He was dying of AIDS and he had Kaposi's sarcoma all over him, this terrible skin cancer that comes with AIDS. And Bernard said that every morning he would go to see this young man, and the young man would say: Please kill me, I want to die. And Bernard asked one of the volunteers, an older man aged about 75, if he would take on this young man as one of his patients that he would visit, and the old man did. And Bernard said that, for about a week or 10 days, he noticed that the young man had stopped asking: Please kill me. And so he went to see... On the next time he went to see the young man, which I think he did every day, he said: You haven't mentioned that for a while. And you know what the young man said? He said: No, I don't want to be killed now because I've got a friend. I mean it was so sad. This young man was from South America, had no relatives or family here. You know, for him, it was a tremendously stigmatizing disease.

So I think that we've got to be aware of the people suffering and we've got to do everything that we can to alleviate that. But the one thing I think we shouldn't do is intentionally kill them, and because of all the other harm that that would do. And that's really what I'm arguing here.

● (10 h 20) ●

Mme Hivon: Juste peut-être pour dire, la question de Mme Raphals et la question de la peur, en fait c'est assez anecdotique. C'est juste que je voulais juste mettre ça en parallèle parce qu'on nous dit des fois qu'il y a des gens aux Pays-Bas qui ont peur d'aller à l'hôpital pour certaines raisons, parce que l'euthanasie existe, alors qu'ici il y a des personnes âgées qui nous disent: J'ai peur d'aller à l'hôpital parce que ça n'existe pas. Alors, je voulais juste faire un petit clin d'œil avec ça.

Mme Somerville (Margaret): Yes. But it's not just fear of going... of old people's fear of going to hospital

if we institute euthanasia. Dr. Philip Nitschke is currently here in Canada and he was, as you know, he's a big advocate of legalized euthanasia. And it was legalized for 11 months in the Northern Territory of Australia in 1997, and they had a public health crisis among the aboriginal population because the people themselves would not come to doctors or hospitals and they wouldn't bring their children for immunization because they thought that the children were going to be killed. So, you know, there is other fears associated with it as well.

Mme Hivon: Comment expliquez-vous sur la question de la sédation? Moi, de ce que j'avais compris, la différence entre sédation palliative et terminale, c'est que les médecins employaient le terme «terminale» quand il n'y avait pas de retour, en quelque sorte, c'est-à-dire quand la sédation était vraiment utilisée jusqu'à ce que mort s'ensuive, en quelque sorte, alors que la sédation palliative permettait toujours de dire: On va vous endormir pour 24 heures peut-être puis on va réévaluer vos symptômes dans 24 heures. Et c'est que les médecins en soins palliatifs utilisent beaucoup l'argument évidemment de la sédation terminale, comme ils nous disent — mais je peux comprendre les nuances que vous faites — pour dire qu'il y a comme toujours un moyen.

Par ailleurs, le Collège des médecins se questionne à savoir si, à un moment donné, quand on fait une sédation terminale en enlevant l'hydratation, l'alimentation, versus une dose létale... Quelle est vraiment la différence? Le Barreau, ce qui nous a surpris aussi parce que les avocats sont en quelque sorte les spécialistes de l'intention, nous ont dit qu'ils avaient de la difficulté à voir une différence d'intention entre les deux. Et je dois vous dire que les gens qui viennent nous voir, les gens de la société civile en général, ont aussi de la difficulté à voir une différence entre les deux.

Donc, d'un point de vue, je dirais, global, comment nous, comme législateurs, on peut dire qu'il y a une différence fondamentale entre ces deux choses-là quand même le Barreau, même le Collège des médecins et les gens voient vraiment une similarité entre les deux?

Mme Somerville (Margaret): Well, the idea of determining what the intention is a daily event in courts across the country. I mean, to take a very sort of a stark example, if you drive your car down the street and you hit somebody and you kill them, you obviously had no intention to kill them. On the other hand, if you drive your car down the street and you want to kill your ex-husband, and you do so, you've got an intention to kill him. So, that... Well, it's true, you know. And that makes a huge difference. In the first case, there may be no legal liability at all if you weren't driving negligently. In the second case, you've got a first-degree murder charge.

And so this idea that you can't distinguish the intention and it's too difficult to do is one of the platforms of the pro-euthanasia people, because they... And a lot of their arguments actually rely on confusion whether it's a pain relief with intentional killing or whatever. And I think that you can distinguish those things. When you give a sedation which is indicated and there are no guidelines being drafted as to... — for instance, there's one group of guidelines being drafted in Mount Sinai Hospital in Toronto — as to what the indications for palliative sedation

are, and you follow those, and a reasonable doctor would think that palliative sedation was needed as the only means to relieve the person's pain or suffering, then you use it. And that is proper palliative care treatment, it is not intentionally killing. And that's very different from what you do when you give a lethal injection.

Now, as to the lawyers, I think one suggestion to them would be that they should be... that, if they want euthanasia to be legalized, they should be... a group of them should be designated as the people who will carry out the euthanasia. That's actually been suggested in the literature because there's a... one of the arguments being, you know, all the problems in letting doctors do this, that people become afraid, etc. And so in one article in a journal called *Perspectives in Biology and Medicine*, which is a very prestigious journal out of the University of Chicago, there is an article called *Legistrothanatory*. I think I referred to it in my submission. And in that it was suggested we should have especially trained group of lawyers who would do this.

And I think you will find... I think that's the other thing. When you can talk about sort of in a detached manner and you're not going to be the person who is doing it, then I think you have a different emotional reaction. And we also know this from research that, when physicians have intervened on a person so that they have bonded emotionally in some way to that person as their patient, they find it much more difficult, for instance, to withdraw a respirator than if they have decided initially that there's no point in putting them on a respirator. They find the second decision much easier because they haven't bonded in the same way.

But, you know, I really think the one thing to emphasize as well is that we have got to be very careful whether we're treating the patient and doing what's best for the patient or whether we're treating the family. There's a difference between sitting besides someone's bed and wishing that all of this suffering was over and actually doing something to make it over, which is what euthanasia is.

Mme Hivon: Je comprends. Dernière question, mon collègue y faisait référence, toute la question de expériences étrangères. Évidemment, votre point de vue est un point de vue qu'on entend beaucoup. Certains, eux, disent qu'il n'y a pas de pente glissante parce que des études montrent que les personnes les plus vulnérables, soit âgées, handicapées, ne sont pas des gens qui ont plus recours à l'euthanasie que d'autres. Et l'autre élément dont ils nous parlent beaucoup, c'est le petit nombre en Oregon, je crois, 0,8 % ou tout ça. C'est sûr que, nous, on regarde ça avec énormément d'intérêt et d'attention. Je dois vous dire qu'on note toutes les études et on creuse tout ça.

Moi, je veux juste comprendre une chose: Pourquoi, d'un point de vue éthique ou, je dirais, plus sociétal, les sociétés comme les Pays-Bas, la Belgique, l'Oregon qui ont ces législations-là depuis le début des années 2000, je pense 2002 en Belgique, 2001 aux Pays-Bas, Oregon quelques années aussi, pourquoi, s'il y a des preuves de dérapage, il n'y a pas de mouvement pour revenir en arrière, arrêter ça? Il me semble que ce sont des sociétés avancées qui ont des gens éduqués. Il devrait y avoir des mouvements de recul, des gens qui sont outrés de ce qui se passe. Pourquoi, malgré ce qu'on nous dit qu'il se produit, il n'y a pas de tel mouvement et qu'on ne revient pas en arrière?

Mme Somerville (Margaret): I don't know whether there are movements to try to reverse this. I can't tell you. I do know that the media in most of our Western democracies are very pro-euthanasia. And we know as well that younger people tend to be more pro-euthanasia than older people.

In this book, in the chapter by Herbert Hendin, who is the Dutch psychiatrist, he gives a very interesting explanation of how euthanasia first got legalized in the Netherlands. He says that... The Dutch society, he describes it as being divided into three silos, and each silo kind of set up its own shared values, and that the society as a whole didn't have that one base for the society, and that the people who were the pro-euthanasia people, who were the... kind of the «let's change all of our traditional values» group, in the cultural wars, very often, so that you can describe them as the secular based group, they were dominant in Parliament and were able to get this legislation through. And he said that the Dutch have a policy. I've forgotten how he put it, but it's something about let's be conciliatory... Oups! That's the word he uses. He says the Dutch society is compartmentalized, and compartmentalizing differences is seen as avoiding direct engagement and maintaining consensus within respect of autonomous groups.

So I think you really have to... there's a lot of things that you have to understand. It's a bit like doing comparative law. You can't just look at the legal provision and say: Well, that's the same as ours, because unless you understand the whole history and basis of that, you're not going to really understand how... either where that law came from or how it functions in the society in which you're looking at it. So, I don't know, I mean, I think it'd be great if they did an about-face. I don't know whether they will or not.

• (10 h 30) •

Le Président (M. Kelley): Just one final question. Your colleague, Richard Deschamps, came from the Faculty of law at McGill and spoke to us...

Une voix: ...

Le Président (M. Kelley): Pierre, sorry. Pierre Deschamps came and spoke to us about the experience in British Columbia, where six years ago they put into place directives for Crown prosecutors under certain circumstances, with a kind of check list, not to prosecute, because these are cases that... This Latimer case is a whole different, because that's a parent, it's not a doctor, so I think we leave that one aside. In the six years, have your fears of abuse come to pass, in British Columbia? Have the fact that there are, in certain circumstances... It's not decriminalized, it remains a crime, it remains part of the Criminal Code. But the Crown prosecutors in British Columbia have decided that in certain circumstances it's acceptable, and I don't know what the exact legal expression for that is, but there is a certain tolerance. So has your question of abuse come to pass in the six years that this has been the case in British Columbia?

Mme Somerville (Margaret): I don't know, Mr. Kelley, because I haven't seen these statistics from British Columbia. I don't know how many — do you know? — how many cases they've had presented to them and how many they've decided to... should be prosecuted.

That is a different... that is certainly a different way of going about this situation in that... those are the normal rules of prosecutorial discretion. But you'd have to watch as well that those were not abuse. But it's a different kind of abuse. It would be that there was not a prosecution where there ought to be a prosecution. That happens an awful lot.

I mean, currently, I'm quite involved in looking at the Assisted Human Reproduction Act in Canada, and we know that it's being flagrantly violated, where the penalties are between \$250,000 and \$500,000 fine, five years in jail or up to 10 years in jail. And somebody who phoned the RCMP about this, because surrogate mothers are being paid, embryos are being sold, sperm and ova donations are being paid for, all of which are crimes in Canada, currently no prosecutions, and the RCMP apparently told the person they spoke to, and the RCMP said: Oh! we're not interested in that.

So, I mean, yes, that can happen that you can have a failure of prosecution. And I think then, of course, it's up to the attorney general of the province to decide whether that's a flagrant violation of what should be happening or not. That, I think, is... it relates to this issue, but it's less heinous than legalizing this. I mean, that's... The first thing, I think... The first thing I would say is we don't let's legalize it. And then, you know, there are other mechanisms that are being used, providing they are being used legally and wisely. Then maybe that's part of our normal justice system.

Le Président (M. Kelley): Perfect. Thank you very much for your second contribution to our reflection.

I will suspend for a few seconds. Je vais suspendre quelques instants. And I will ask the representatives of the Côte-des-Neiges Presbyterian Church to take place at the table. On va suspendre quelques instants.

(Suspension de la séance à 10 h 35)

(Reprise à 10 h 37)

Le Président (M. Kelley): Alors, la commission reprend ses travaux. Our next witness is Rev. John Vaudry, from the Côte-des-Neiges Presbyterian Church.

Côte-des-Neiges Presbyterian Church

M. Vaudry (John P.): Thank you very much, Mr. Chairman. I want to thank you for the invitation to meet with you today. And also want to thank you for taking on this task. Given the very sensitive, difficult, nature of the subject, I don't envy your job.

In some ways, I wish I had gone before Dr. Somerville. I think she has taken all of my points. But I'll just say them, I guess, in different words, so I'm going to stick to my script pretty much, to keep me within the time frame.

I did have a colleague who was going to come along, Dr. Victor Gavino, but he is leaving for Africa tomorrow, so I'm here by myself.

And I'm representing the Côte-des-Neiges Presbyterian Church, which is a 146-year-old Protestant congregation in the Côte-des-Neiges area. It was originally Scottish and rural. It is now very much urban and multiethnic. We don't presume to speak on behalf of all Presbyterians or all

Christians or anything like that, but imagine that quite a number of people... religious people of different religions probably would agree with many parts of our position.

May I say at the outset that I'm not entirely comfortable with the name of your committee. It seems to me that the very name, «death with dignity,» gives a bias. And maybe other people have said this, but it has long been a slogan of the pro-euthanasia movement. And so I think something more neutral would have been better. It's almost like a committee studying the ethics of abortion being called a committee on a woman's right to do what she wants with her own body. So, I think a more neutral title would have been better.

Of course, all the terms have their problems. «Euthanasia,» a word invented in the 17th century, simply means «good death», and it could apply to many different situations. The term «mercy killing» makes it clear that killing is involved, and I'm using the word too, and suggests that those who perform it believe they are acting from motives of compassion. The term «assisted suicide» has been called a deceptive expression since it often really still involves one person killing another.

• (10 h 40) •

Definitions are important, and the definition that I would take today is from a scholar named Luke Gormally, who said: Euthanasia is the intentional killing of a patient in the course of medical care, when the patient is believed, by a doctor, to have good reason to be killed because of his or her present or foreseeable mental condition and quality of life. And maybe at the patient's request, that would be voluntary or not, involuntary or even involuntary. And again I would stress, as Dr. Somerville did, the word «intentional» is «intentional killing of a patient». And I think that needs to be stressed, because there's a wide-spread confusion among many people, among the general public, I find... some of my own parishioners. A number of people appear to see little or no distinction between, say, a lethal injection, which is intended to kill, and the use of medications to control pain, that may also hasten death.

But there is a great deal of difference between what I want to have happen and what I foresee may happen if I take certain steps to follow a certain purpose. To take an example, public speakers, and I know this from experience, know that the talks they give will not only inform and stimulate, but will, in many cases, induce boredom, bewilderment and/or misunderstanding. Speakers do not intend these things, but they know that they probably will accompany the giving of their talk. Nevertheless, the reasons for giving the address outweigh these consequences, and so they go to the microphone. In a sense, they allow the consequences although they do not desire or will them.

Let me just try to expand a bit on the points that our church submitted in its brief. We mentioned first the age-old respect for the sanctity of human life. And another way to put this might be to speak of the intrinsic or objective worth of every person. And this is a basic value enshrined in law that each man or woman is of worth simply because he or she is. It is not that our life is of value or has dignity because we feel it does or because someone else sees some utility in it. Our human dignity and worth is a given. It's not that some lives are worth living but others are not. All lives have value. It is a matter of being rather than doing. And this means that the young, vibrant, skateboarder possesses worth as does the elderly man who can't

remember his name. Human dignity belongs to the middle-aged woman rushing downtown to get to her office and to the terminally ill cancer patient in palliative care. The mentally handicapped child has as much right to be alive as a university professor or a member of the National Assembly.

Of course, as a pastor, I do think in religious terms, and, in theological terms, humans are of infinite value because they are created in the image of God. The «*imago Dei*» underlines all our rights as people.

The acceptance of euthanasia, it seems to me, implies that some lives have no worth, and so killing them can be justified. And we need to see this as a major reversal in our moral values concerning protecting the life of the innocent. Dr. Somerville has written that our most important, fundamental, norm is that we must not kill each other.

Second, euthanasia brings a drastic change in the role of the physician. And I think this is extremely important that she is now seen not only as a healer but also as a dispenser of death. And, from the time of Hippocrates, the doctor has been charged with the noble task of healing the sick. To turn the doctor into a killer — let's be quite clear that there is no third thing, partway between homicide and natural death — is to abandon the entire medical tradition of Western civilization. In the words of a Scottish theologian, the incongruity of the physician as an agent of death could hardly be greater.

Recently, I read a chilling essay by Leo Alexander, who was a psychiatrist involved in the Nuremberg trials in the late 1940s. It's a classic essay entitled *Medical Science Under Dictatorship*. And he tells how, quote, «subtle shift in emphasis in the basic attitudes of physicians» of Germany in the early 20th century made Hitler's euthanasia directives possible in the 1930s. It began in a very subtle way, and there was a kind of slippery slope.

Dame Cicely Saunders, pioneer of the hospice movement in Britain, which provides palliative care for the terminally ill, speaks movingly of the need for patients to be able to trust their care givers. «Making voluntary euthanasia available would present people with an intolerable dilemma,» she says, «when they need support to take courage and trust us never to think they are a burden.»

Thirdly, there is a reason to fear that voluntary will gradually become involuntary euthanasia. Of course, you can even raise questions about just how voluntary such voluntary euthanasia would be, and this is a difficult thing, but there can be subtle pressures that are brought to bear. A danger, perhaps, of relatives applying undue pressure on the sick, specially if there is a considerable inheritance or a large insurance policy involved. Could not society, including family, friends, even medical staff, bring subtle pressure to bear on a patient? How easily a person might come to feel he is old, sick, useless, and a burden to the health care system, that therefore he ought to get out of the way. As Cicely Saunders comments, «a right to die could all too soon become a presumed duty to die».

Sir Norman Anderson, former director of Advanced Legal Studies at the University of London, wrote that, «if voluntary euthanasia were ever to be made legal, there would soon be a demand for further concessions. It would not be long before the argument would be heard that paralysed, incontinent, and semicomatose elderly persons would certainly sign the suitable form if only they were to have a sufficiently lucid interval.» So, why should not their relatives do for them what they would wish to do

for themselves? The next step would be to authorize an official to do this, so that the relatives would not have the emotional burden of making the decision. It is human nature that, when we are given an inch, we take a mile, so why should we think that we are so superior that we would be able to resist such a development?

Experience of the Netherlands has been mentioned already, today. It should be a cautionary tale. Voluntary euthanasia has been legally tolerated there since, I guess, the 1970s, and it is well known, these days, that involuntary euthanasia is being practiced by Dutch doctors. Just recently, the 4th of October, Dr. Antoine Boivin, writing in *La Presse*, stated, «En 2005, aux Pays-Bas, les médecins ont provoqué intentionnellement la mort de plus de 1 000 personnes sans leur demande explicite ou sans rapporter leur geste aux autorités.»

Lastly, we live in times when palliative care has made great strides in alleviating pain and suffering in its care for the whole person. Naturally, we all dislike pain, and many of us fear we shall die in great pain. Of course, it's not true that all terminally ill people have pain. I understand that among cancer patients there're a considerable number who do not have pain. My mother died within the past year, of a lymphoma, and gradually weakened, but did not report pain. There is pain for some people, and, in the majority of cases, it can be controlled by means of medications such as morphine. I must confess I was startled to read Dr. Alexander's remark that, «the development of effective analgesics and pain-relieving operations has taken even the last rationalization away from the supporters of euthanasia». That was written in 1949. We have surely come a long way since then in pain control.

In conclusion, one wonders why, despite all the advances in medicine and in care for the dying, there is such a demand today for euthanasia. No doubt there are several factors involved, not least social changes such as the loss of community, an increased individualism, the adopting of a more secular world view. Perhaps people feel they would be gaining a measure of control over their life and death if they could set the time of their own death.

The truth is, of course, we can never completely avoid or escape a sense of helplessness and dependence at the close of life. It will be there to some extent. We will have to depend on family, friends, medical staff, clergy, and others for care and support. This need not be viewed as a loss of dignity, and indeed it can prove to be a meaningful time for the patient and for those around her.

As a Christian, I think of Christ, who himself endured dreadful suffering as he approached what must have seemed to those who were present an appallingly undignified death. Yet, at that point in his life, he was still able to interact meaningfully with his mother and with others, as the seven last words from the cross attest. So, I would urge you, on behalf of our Church, to stand firm, to resist the popular but misguided thinking... clamors for euthanasia and assisted suicide to be legalized. Do not take us down a road that, as a society, we may one day regret. Thank you very much.

● (10 h 50) ●

Le Président (M. Kelley): Thank you very much, Reverend Vaudry. Perhaps I'll just comment first of the question of the title of this committee. People have said the legislative process is a little bit like making sausages, is something that it's best not to know too much detail about.

But there was a motion passed in the National Assembly, which predated the creation of the committee. So, the members around this table were left to enact a motion that had come to us from the floor of the National Assembly, with unanimous support of all the parties, which talked about quite clearly the right to dying with dignity.

And that's a debate that I think is more closer to the debate you were saying, so we couldn't wander too far away from that motion, but we decided we didn't want to make it a right, because I think a right becomes a much more charged debate. So, the title was left to provoke a debate. We look across the province, we have 300 people that want to appear before this committee, we've received over 6,000 people who have answered an online survey, so I think it's succeeded in what you want any title to do, which is to provoke a debate.

And, if it's seen as one taking sides in the debate, that's not our intention, as I say. But on the other hand we were subject to a motion that was adopted by the National Assembly, and we, you know, operated within that. So, I think that — just to make things clear — that we didn't choose that because it's associated with a certain movement or another movement, that wasn't our intention at all, but we're also working within the parameters of a motion that came to us from the floor of the National Assembly, and, subsequent to that, the members of the committee were chosen, and away we went.

And maybe my first question...

M. Vaudry (John P.): ...I was concerned, that's helpful. I figured it probably was a motion, that it wasn't your own choice, exactly.

Le Président (M. Kelley): No. As I say, it predated our existence, so...

Une voix: ...

Le Président (M. Kelley): O.K. Mme la députée de Joliette.

Mme Hivon: Et, juste sur la question du titre, parce que je pense que c'est important aussi, en fait, voyez-vous, il y a... moi, je trouve que ça a sa vertu aussi, parce que la notion de dignité, pour certains, est une chose, pour d'autres, est une autre, et en soi ça aussi suscite le débat. Et d'un point de vue comme de l'autre il y a des gens qui nous font part de leurs points de vue en disant que, pour eux, mourir dans la dignité veut dire qu'il ne peut pas y avoir d'euthanasie, et, pour d'autres, c'est le contraire. Et le dernier point, c'est qu'on voulait un titre assez général pour que ça comprenne tous les soins de fin de vie, pas seulement la question de l'aide médicale à mourir, mais les soins aussi. Fin du débat.

Le Président (M. Kelley): You know, just, I think, because the question comes up, and it wasn't our intention to take a title that was in any way... It was just to open it. It wasn't a committee on, you know, assisted suicide, it's not a committee on euthanasia, it's looking at end of life in a larger sense, that's all.

M. Vaudry (John P.): My point is simply that it has been a slogan for a long time, and so I think that...

I mean, I accept what you say, and it certainly has provoked the discussion, but I think one could argue it seems to be biased in a certain direction.

Le Président (M. Kelley): But, anyway, I assure you it's not, and it wasn't our intention, so....

M. Vaudry (John P.): ...OK. Yes.

Le Président (M. Kelley): But, just on a first question, in your first point you talked about, you know, a natural death, and, you know, this is something that comes up time and time again. But I think... isn't there room for a reflection that natural death is a more and more rare occurrence? I'm always touched when I go to Québec City, because when I walk along Aberdeen Street, I can see the apartment where my father was born, as my father was born in an apartment. But that's all gone now, and birth is a highly medicalized event for most Québec women, that happens in a hospital.

And equally a natural death is something that... half a century ago most Quebecers would have died at home, you know, with a visit of their clergyman, a visit of their family doctor... We had a Dr. Major, yesterday, who came to... and he's a senior. I don't know exactly how old Dr. Major is, but he came from the era of home visits, you know, doctors, the black bag, arriving on your doorstep. And that was a different way of organizing medical care. I'm not an expert to say whether it was a better way or a worse way, but it's different. And we live in a different time now, and a lot of these questions are more complicated, because there is a lot of medication, there're a lot of treatments, there're a lot of things, artificial respirators and other things, that these questions maybe aren't quite as clear-cut anymore. And trying to find the line...

You spoke about intent. And Dr. Somerville just spoke about intent. But I'm still... If someone is plugged in, and, by unplugging, that person's life ends, some of those fears you raised about a large inheritance or a big life insurance policy remain there. But 20 years ago, as a society, we changed the Civil Code, and those kind of rights to end treatment or refuse treatment are now permitted. And has there been abuse? Have there been all sorts of people unplugging mom and dad to get inheritance? That's not my... I don't have proof of that, no one suggested that and anything else.

So, I just wonder about some of these sort of fears because end of life is more complicated. You had an experience with your mother. Both my parents died of cancer, and I found that end of life more... you've lots of choices, you know. I want this treatment, want that treatment. You talk it over with a parent who is heavily medicated, who doesn't really know. I don't know... history doesn't really help me decide whether this treatment or having this operation, in terms of the fact that you know the number of days left for the parent are finite... Is this a good idea, drag them downtown to the hospital for another five weeks of radiation therapy? Is this a good idea or not? I don't know.

I mean, that's what we're confronted with, now, so, this notion of a natural death, I understand it in the abstract, but we live in a society where natural death is a pretty rare bird, right now, and as it made some of these ethical issues more, and not less, complicated.

M. Vaudry (John P.): Well, I acknowledge that certainly we're living in a much more complex society, and there are all these various means that we didn't have, and we've a lot of questions we didn't face, generation or so ago. I still think there are some important distinctions, though. I mean, I think there... When I say «a natural death,» I guess I mean one that is brought on by the illness or whatever it may be, but that is not deliberately induced by somebody else. And I don't think, you know, withholding treatment or refusing treatment, for example, is in the same category as euthanasia. I think there are those distinctions.

My mother had the opportunity to... I suppose she could have taken some kind of chemotherapy. She was 84 years old, and one physician friend of hers advised her that you might live a little bit longer, you might have another month or so, but you also might be very, very sick, and you have the right to just decide you're not going to do it. And she decided to do that and lived out whatever days she had. I don't see... So, I would say that was a natural death. And then she also chose... made some decisions about it too. But that would be quite different from giving an overdose of morphine or whatever.

Le Président (M. Kelley): No, I mean, I don't know the answer to my question. That's why I throw it out, because it seems to me, you know, we take a lot of comfort, but, you know, letting someone starve to death, that's fine, because in certain circumstances feeding someone is a treatment. I have a right to remove the feeding tube. I'm still trying... I struggle with it, and I don't know what the answer is. But that's a natural death, but, instead of having the person starve to death, I put an injection of another medication in patients that are usually medicated to the gills anyway on a lot of other substances.

That that's ethically wrong, I'm still having trouble finding where these lines are. And, what the doctors... the College of physicians and surgeons said to us, at the beginning of this whole operation, there're these gray areas that they're not certain, and, I think, as members of a committee, we're trying to struggle with and that by letting someone, you know, remove feeding, giving them water is refusal of a treatment, and with that we're all very comfortable. But, if I do something a little more proactive, that's the end of the world, and I'm... That's a lot of these areas that, I think, what the questions of the Members... at least, this Member of the committee is struggling with.

● (11 heures) ●

M. Vaudry (John P.): I guess you have to take those things... I mean, I'm not a doctor.

Le Président (M. Kelley): Nor I am.

M. Vaudry (John P.): No. I guess you'd have to take them on a case by case basis where, to remove a feeding tube from one person might be a very intentional way of killing that person, letting him actually starve to death. But, in another case, my understanding would be that it would be more in the line of... it is kind of a treatment, it's not going to do any good, and in fact it's going to do harm to continue with that intubation. So, you remove it, the person doesn't starve to death, he dies of the cancer or whatever it is that is working on him. And I saw this recently, I was thinking about your commission while visiting a gentleman, about the early part of the month,

in the Jewish General, who is in this very position. And he was in pain, but then the doctors would come and give him some medication, he would calm down and he would be okay until the pain was wearing... or the medication wore off, and then tried again. And they did it at a certain point, removed tubes, everything was shutting down, he was really dying.

So, I think there is... I had a quote and... if I can just find it, it's from a noted physician, Lord Horder, who said: «The good doctor is aware of the [distinction] between prolonging life and prolonging the act of dying.» Now, it may seem like a gray area, I am sure, at times; but that's always been in our medical tradition that people have been able to discern when they're doing one and when they're doing another.

Le Président (M. Kelley): Thank you very much. My colleague from Laurier-Dorion.

M. Sklavounos: Thank you, Mr. Chair. Reverend Vaudry, thank you for being present and thank you for your views. I just want to reiterate, I feel more comfortable starting this way, saying that I am definitely part of no movement and the choice of the title was intended to be neutral. Even though we have... You're not the first person to have commented that it could be perceived differently, And Dr. Somerville, my professor, right before you, made the same comment.

I just want to maybe explore a couple of things. I thought the question of President Kelley was actually fantastic, a good one, but I want to take down maybe another angle, take another angle with you.

There is a fundamental problem that we face, in Québec society, with suicide, and just your run-of-the-mill, if you want, suicide. And the classic example we hear about is... that we use when we... to differentiate here is the heartbroken adolescent who's lost the love of his life and wants to jump from a bridge. And some people have come forward and have said that, if we were to explore the road down euthanasia and assisted suicide, we'd basically be shooting ourselves in the foot with respect to all the investment, time, effort, campaigns, help lines, everything we're trying to do in Québec where there is a serious problem, and nobody denies that.

I want to know, from your point of view, whether there is any distinction... I mean, I do understand and everybody is welcome here, and I feel it's important to say that people of faith, although we have a pretty good idea what you're going to say before you show up, you are as welcome as anybody else and your opinion is as valid as anybody else. And at least, I want to make sure that you understand that from my point of view.

Dr. Somerville said that too, that we shouldn't pass judgment on where people derive their values from, and I'm 100% in agreement with that. Do you see some kind of distinction? Because, I... We've had people come and argue that it would be discriminatory to open up to one of these categories of people just because people would be sick and said, while you're willing to look at the question differently just because someone is sick or maybe dying, whereas you're not willing to look at the question that way for the young guy who wants to jump off the bridge because he just lost his girlfriend? Do you see a distinction, do you see a similarity? Is the fact that that illness and

an inevitable imminent death somewhere not an intervening factor that's important, that causes us or should cause us to analyze it differently?

M. Vaudry (John P.): Well, if I understand the question: is there a difference between suicide and, say, physician assisted suicide or euthanasia? Well, yes, I would think that there is, very clearly. I mean... I really don't agree with either one. I would want to try to prevent people from committing suicide, and I think there is an ethical, moral problem there. But, certainly, in euthanasia or... I mean, that is certainly somebody deliberately killing another person with assisted suicide. If it's true assisted suicide, then the person is helping the person to do it himself, and so we're back to suicide again. The fact that the person is ill... while we have sympathy for the person who's very ill, but we'd... I guess we've got sympathy for the person who is heartbroken as well. So, I'm not sure that I really see the difference between those two things. I don't know if that's what you're getting at, but...

M. Sklavounos: I'm just...

Le Président (M. Kelley): Very quickly.

M. Sklavounos: I'm just... Oh yes, we just have a little bit of time. What's your best argument for someone who comes to you and says: I'm a non-believer; so, you're not going to get me, for example, with any of the arguments that you'd convince maybe a member of the Church or something with? What's your best argument? Is it the one that Dr. Somerville made about the message we send out and social order, etc.? What's your best argument?

M. Vaudry (John P.): Well, I guess, on one level, yes, I would say that we really do, then, fundamentally change our way of looking at life, at the treatment of sick people. Our whole values would be turned upside down, I think, by legalizing euthanasia, then saying that it is permissible to kill some people, that it's not that every person has a right to life. So, I think that, yes, that would be one of my strongest arguments, and I guess also I would say that I really think that it's not necessary, that we have measures in place in our hospitals whereby we can, to a very, very large extent, control people's pain and help them, and I think that the better way to go is along the lines of palliative care and fostering more of a sensitive community, perhaps.

Le Président (M. Kelley): Mme la députée de Joliette.

Mme Hivon: Merci, M. le Président. Bonjour, merci beaucoup d'être parmi nous aujourd'hui. Si on fait cette commission-là de manière aussi étendue et qu'on se promène dans huit villes au Québec, c'est pour entendre, évidemment vous l'aurez compris, le plus grand nombre d'opinions et d'experts, de gens de la société civile, d'organisations, de citoyens et aussi, évidemment, de groupes comme le vôtre qui défendent des valeurs, aussi, religieuses. Donc, merci beaucoup d'avoir pris le temps de poser ce geste citoyen et qui, selon moi, est très précieux dans notre démocratie.

Moi, je voulais revenir justement à des questions de valeurs, de compassion et de dignité aussi, parce qu'il

y a un certain affrontement dans le débat. Pour certains, au nom de la compassion et de la dignité, certaines choses devraient être prévues par le législateur et, pour d'autres, c'est l'inverse, le statu quo doit être maintenu.

On a eu les représentantes des infirmières qui travaillent pour l'association NOVA, avant VON, qui nous ont dit que, dans leur pratique, essentiellement ils travaillent avec des gens en fin de vie, donc en soins palliatifs à domicile, et que, de leur expérience, environ 30 % des gens en fin de vie, en maladie terminale, expriment, à un moment ou à un autre, le désir qu'on mette fin à leurs souffrances et donc de mourir. De ce nombre-là, on explique qu'avec des bons soins, avec un accompagnement serré, avec de l'aide, aussi, psychologique, on réduit à environ 7 % les gens qui continuent à demander qu'on abrège leurs souffrances, par exemple avec une aide médicale à mourir.

Moi, je dois vous dire que, depuis que j'ai commencé les travaux, seulement dans mon entourage et dans mes amis, trois personnes m'ont parlé que leur père, leur soeur, leur mère étaient aux soins palliatifs et que, dans les derniers jours de leur vie, toutes leurs énergies étaient concentrées, dans chacun de leurs moments d'éveil, à demander qu'on les aide à mourir, des demandes répétées, insistantes, auprès du personnel médical et auprès des proches de la famille.

Vous pouvez comprendre qu'aussi on a eu des personnes qui sont venues devant nous et qui nous ont raconté des histoires similaires. On a eu la famille Rouleau dont le père, l'époux, ou le fils, selon la perspective, était dans une situation où il avait une maladie dégénérative très grave et, lui aussi, toutes ses énergies étaient concentrées à ça parce qu'il souffrait puis il ne pouvait pas voir la suite des choses. Et, dans ce cas-là, c'est particulièrement triste parce qu'il a décidé de mettre fin à sa vie parce qu'il avait trop peur des prochaines étapes, et ça a été très difficile pour la famille, qui est venue témoigner devant nous.

Alors, moi, je veux savoir, face à des situations comme ça qu'on peut dire exceptionnelles, mais je dois vous dire que, nous, avec les travaux qu'on fait, on entend plusieurs témoignages, des gens viennent nous parler des expériences, on se dit, au nom des valeurs de compassion et de sauvegarde de la dignité, qu'est-ce qu'on fait avec ces gens-là pour qui la compassion et la sauvegarde de la dignité est synonyme d'abréger leurs souffrances?

● (11 h 10) ●

M. Vaudry (John P.): Well, I would want to say that a person who opposes euthanasia is not necessarily a person who lacks compassion. I would hope that all of us have a concern for those who are very ill or who are in pain. It's really kind of a question, I guess, of how we then deal with that pain. And... Again, I'm not a medical person and I can't speak with any great knowledge about pain control, and so on, but I really believe the way to go would be to use medication. Now, it might mean increasing the dosage; a person might need a great deal of pain medication. And, yes, it's true that may indirectly hasten the person's death.

But again, I come back to saying that it would not be your intention, your intention is to relieve the pain. The other is... It's just something that is likely to happen, but you are not willing that or desiring that. But the thing would be to relieve the pain, and I just believe that surely there are ways to do that. But I'm not speaking as a medical person, or that we can work also on developing better ways. Maybe that's another thing.

Mme Hivon: En fait, ce qu'on me dit du corps médical, c'est que, quand on est dans des culs-de-sac comme ceux-là, ce qui reste, c'est la sédation terminale, donc la sédation jusqu'à ce que la personne meure, en fait. Parce que, comme vous voyez, ces personnes-là, ces cas-là seraient des cas où toutes les énergies de la personne sont concentrées sur une chose, c'est-à-dire d'arrêter la souffrance et de mourir — ou d'arrêter l'agonie. Parce que des fois ce n'est pas des douleurs physiques, c'est une anxiété incontrôlable; et donc, c'est d'endormir la personne.

Moi, je veux comprendre, de votre point de vue, comment ça... Évidemment, les personnes qui viennent nous voir et qui défendent un point de vue différent du vôtre nous disent: Moi, ce n'est pas vrai que c'est ça, la solution, de dire: Je veux être endormie jusqu'à je ne sais quand, jusqu'à ce que mort s'en suive et que je dois décider que c'est ça, la manière de mettre fin à ma souffrance. Pour ces personnes-là, c'est un non-sens de les surmédicamenter ou en fait de les mettre dans un état d'anesthésie générale. Donc, j'aimerais juste comprendre, vous, de votre point de vue, avec les valeurs qui sont les vôtres, comment ça a, pour vous, un sens différent que, en fait, de donner une injection finale à quelqu'un?

M. Vaudry (John P.): I guess I still would see that as a treatment and that it is... I mean that... and it certainly doesn't sound very appealing to anyone concerned, but I would think that this is something that maybe is a last resort. But it's done as a treatment rather than with the intention of hastening the person's... or bringing on the person's death. I think, again it comes back to intention. I guess it might seem to be... it might appear to be very much the same thing. It might be hard to see how it's not just a kind of a gray...

Mme Hivon: Mais c'est quelque chose avec quoi vous pouvez être à l'aise à cause de la question de l'intention qui serait différente.

M. Vaudry (John P.): I believe so, yes. Yes. Yes.

Mme Hivon: Merci beaucoup.

Le Président (M. Kelley): On that note, Reverend Vaudry, thank you very much for coming. As, I think, half of the protestant contingent in Quebec's National Assembly, I think we're two, so... but thank you very much for your contribution to our work and our reflection.

M. Vaudry (John P.): Thank you very much. Thank you.

Le Président (M. Kelley): Je vais suspendre quelques instants, and I would ask Mr. Gus Olsthoorn to take place at the «table des témoins».

(Suspension de la séance à 11 h 16)

(Reprise à 11 h 19)

Le Président (M. Kelley): Alors, la commission reprend ses travaux.

Our next witness, as the first of many citizens we'll be hearing from today, speaking on his own behalf and

not on behalf of a group or an organization, is Mr. Gus... Olsthoorn?

M. Gus Olsthoorn

M. Olsthoorn (Gus): Olsthoorn.

Le Président (M. Kelley): Olsthoorn. A good Irish name, anyways.

M. Olsthoorn (Gus): Dutch name.

Le Président (M. Kelley): I know it's a Dutch name, and we've heard an awful lot about the Netherlands in the last few weeks...

Des voix: Ha, ha, ha!

Le Président (M. Kelley): ...of all sort of things. All I know is that I once bicycled from Amsterdam to Brussels and it's a beautiful part of the world, so...

M. Olsthoorn (Gus): Indeed!

Le Président (M. Kelley): ...there you go. So, a presentation of about 15 minutes, followed by an exchange with Members of the committee.

● (11 h 20) ●

M. Olsthoorn (Gus): Thank you very much, ladies and gentlemen, for hearing me today on the subject. And I understand that it is related to end-of-life issues, not just helping people to die. I just want... A preamble to my talk: I modified my talk a little bit from what I presented, but, as the names implies, Olsthoorn is a Dutch name. In the early '50s, my parents took a boat from Holland to Ontario and raised seven kids. And, about 17 years ago, my father, who I never knew to be sick, even taking Aspirin, contracted pancreatic cancer, and he passed away in seven months. He had one treatment of radiation and that was more for... psychological rather than medical.

As you know, pancreatic cancer is a very strong, aggressive cancer; so, at 66, he died. My father did not go to the hospital, he was in a bed at home, the nurses came on a daily basis to assist my mother and sister in looking after my father, and he was on a constant morphine drip and he withered away. He was not himself, he wasn't there when he died. And, when my mother called to say: Your father passed away, I say: Thank God that's over! It was long enough, and the suffering is over, so... I understand the question from Mme Hivon; it's gut wrenching. It is a gut-wrenching thing when it comes time to letting go, and... I don't really want to speak to that today, I'm sure you've heard many stories and are going to hear more stories about that.

I want to talk today a little bit about principles that I hope that this committee will support when their report's done. Just one last anecdote: about two months before my father died, he told me something he had never told me before. He said: «I know I never told you, kids, that I loved you, but I always did and I wanted to... I showed it... I thought I showed it by the way I worked.» And how hard he worked, and he did work very hard. But, if his life hadn't been ended earlier, I would have never heard him say that. So that's somewhat of a poignant point to me.

I titled my talk *Principles to Die For* and I want to summarize it with five key principles that I think are essential for not only this commission, but for Canadians and for any civilized society.

End-of-life issues. It is no exaggeration that end-of-life issues are plagued with great emotion and sentiment that often cloud better judgment. After all, what decent human being would want anyone to suffer? However, decisions based on emotions are often regretted as the bigger picture is often overlooked in the heat of those emotions. Perhaps the biggest picture is to be gained when we see human life from God's perspective, a unique and sacred gift, created in His own image. Or do we see people as just one of the many life forms on Earth, with no special inherent value? We kill and eat millions of animals. We euthanize those animals that are unwanted. Yet, is this how we are to treat our fellow human? Is this in keeping with God's command to love our neighbor as ourselves? How we view each other ultimately rests on how we view God. So, why not simply euthanize people when they no longer can contribute to society? Why not dispose of them as unwanted dogs? And the threat and temptation to treat others that way is very strong, and only our shared belief in the sacredness of human life will prevent us from sliding down the road to this despotic level that unfortunately is not so rare.

The cost of living. A utilitarian society that views people only in terms of money will ultimately make decisions based on economics. Surely it is far cheaper to dispense an extra dose of drugs to speed up the dying process than provide special care for perhaps many years. What will prevent us from putting a price tag on human life? Without a deep commitment to the intrinsic value of each human life, eventually only the rich will be able to pay for their lives. The poor will be some of the first to go. What will prevent our society from reaching those depths? How much money will you or I need to stay alive? This, then, must be the first principle: human life is sacred and must be treated as such.

A lesson from capital punishment. In order to gain some perspective on end-of-life issues, it might be worthwhile to learn a lesson from how our country has dealt with capital punishment. Our country, among others, has banned capital punishment outright, even for those who have committed the most grotesque and heinous crimes against our citizens, based on a singular idea: we have outlawed capital punishment because of the perceived possibility that an innocent person might be put to death. As a consequence, we have declared to any would-be murderers that, regardless of how many innocent people they kill, how many women they rape, how many children they molest, their life is protected. We guarantee it in advance. All this, based on the possibility that one innocent person might die.

Applying this then to end-of-life issues, it would seem very appropriate to also decide that, since we cannot guarantee that an innocent person will not be put to death, we must also outlaw euthanasia and assisted suicide. To do otherwise would be highly hypocritical, for, in the former instance, we protect all murderers for the sake of one innocent, while, in the latter, we would be willing to put to death many innocent for the sake of the few for whom it might be justified. The second principal therefore is this: we must not put anyone to death, for there is always the possibility that an innocent person might die.

The exception should not be the rule. We have become adept at postulating worst-case scenarios in trying to establish rules from them. Many have heard of the unlikely situation where a number of people are adrift in a boat at sea but there is only enough water for a few days. The question is asked to... to what each participant would do if they were in that situation.

Unfortunately, these extreme exceptions are used to set precedents for the rule. For example, since we do not want to deny a woman who has become pregnant through rape access to abortion, we have effectively avoided making any laws at all regarding abortion and have washed our hands of the matter without consideration to how many innocent lives might be terminated. The same will undoubtedly happen with euthanasia. We would become so torn up with how to ethically end a life of a person in great suffering that we will simply wash our hands of the death of anyone with life-threatening illnesses. So, rather than protecting the life of its vulnerable citizens, the government will look the other way while innocent people are essentially murdered. How can our government guarantee that this scenario will not happen if we have already dropped all laws regarding abortion?

As Mr. Justice Sopinka stated in Rodriguez versus Canada, assisted suicide is ungovernable. It is not possible to devise safeguards which could adequately protect the vulnerable. Those who are most likely to ask for euthanasia are those who are most vulnerable to pressure from family members and the health care system and fearful that they will become burdens to both. The third principle is this: we must not make rules based on exceptions to a rule.

Hypocrisy. Hunters are repeatedly taught that, if they are not sure what they are hunting is a deer, they must not fire their weapon to prevent the accidental death of a fellow human. Why then do we not apply the same logic to other life issues? So, let me contrast two controversial issues: capital punishment, which we banned outright because an innocent person might die, or abortion is permitted outright, even though innocents do die.

Why do we go out of our way to protect murderers when we go out of our way not to protect our future generation? Is there not a double standard here?

So, with regards to euthanasia and assisted suicide, which will we choose: to protect life or promote death? If we are not sure that innocent people will die, we must ban the practice outright. There is no other way to protect us.

The fourth principle is this: we must be a society that protects life at all costs.

The challenge of a secular society. Modern Québec society has declared itself secular. By that, I mean it has decided to exclude God from the paradigm of modern existence. It falls then upon society to act as God instead. Thus, when faced with issues of great significance such as end-of-life issues, it has chosen to act alone and assume a role that has not turned out too well for societies that took on that burden.

● (11 h 30) ●

Thomas Jefferson understood well that acting as God is fraught with great risk. That is why he included these words in the Declaration of Independence of the new United States of America: «We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights;

that, among these, are life, liberty and the pursuit of happiness.» One will note especially the right to life, not death.

Mr. Jefferson understood full well that it was not the State that granted these unalienable rights, but that the State's role was to ensure that the rights conferred by the Creator were protected. Many tragedies have befallen societies, especially in the 20th century, where governments took upon themselves the role of creator and assumed that the State itself was the endower of rights. It became an easy thing thereafter to believe that since the State had given those rights, it could also take those rights away.

The late Nobel Prize winner Aleksandr Solzhenitsyn, when asked about the millions of people who had perished in Russia during the Soviet era, and I understand there's about 70 million people who had died during that period of time, stated: «Men have forgotten God; that is why all this has happened.» It is no small thing to make decisions regarding the lives of people and to leave God out of the question.

Why God matters. One of the most fundamental questions humans can ask is summarized as: Did God make man or did man make God? If God did indeed make man, then man is accountable to his Creator. If man made God, then man can do whatever he wishes as he is accountable to no one save himself. As someone has said, without God, everything is permissible. History is rife with those who believed themselves to be above any accountability. By force of arms, terror and deception, these dictators manipulated and massacred millions. For as long as they were in power, they were untouchable. The lust for power, wealth and prestige has corrupted many a good man and led many, also deluded, to their destruction and great remorse. Those or these, standing in the ashes of destruction, have asked: How did this happen? The answer is simple: Man had forgotten God. Is Quebec destined to do likewise? Arrogance and pride are marks of a society on the verge of making great and deadly errors. Instead, learning lessons from so many others, we should humbly seek God for wisdom and direction so that we might do what is right in His eyes. End-of-life questions demand this kind of humble attitude. The last and possibly most important principle therefore is this: we must never forget that we are all accountable to God.

So, in summary, the principles are this: number one, human life is sacred and must be treated as such; secondly, we must not put anyone to death, for there's always the possibility that an innocent person might die; thirdly, we must never make rules based on exceptions to a rule; fourthly, we must be a society that protects life at all costs; and finally, we must never forget that we are all accountable to God. Thank you very much.

Le Président (M. Kelley): Thank you very much. We will start with an exchange with members of the committee. Mme la députée de Mille-Îles.

Mme Charbonneau: Merci, M. le Président. Good morning. You don't need it.

M. Olsthoorn (Gus): OK, thanks.

Mme Charbonneau: I might stumble on a couple of words, but I guess you can hear me out. In your memoir,

you say, or you stop at a certain place where you say «the cost of living». I have a hard time with the cost of living. The mission we have is not to look at the cost of living. The mission we have is: Should we hear the people who ask us to die? When they come to us and they deliver their experience, they don't tell us they don't believe in anything. They specially don't believe in pain, in suffering, in agony. They believe that they have the right to a natural death, which is not permitted to everyone. Natural death is something, actually, today, something that we cannot say, since... If we take your father as an example, he didn't have all those treatments that changed him and made him die before his body decided to die. You saw him leave, you saw the difference. When people ask us — in their belief, because Québec is a place where it's wonderful because we have so many people with different beliefs — so, when people go to their doctor and say: I had enough. I had a good life. I have people that love me. I have accomplished and decided that I don't want to go through the pain that is waiting for me, even though most of that pain will be relieved, I don't want to go through that. I wish to choose, to end it in another way. My family and I have decided a date, a certain ritual, a good supper, good wine, laughter, remembering. But when that supper will be over, I wish I could leave with serenity, I wish I could leave in calm and with the loving family that I have. Why can I not have that choice? Why do I have to wait that the pain and the illness that I have gain everything, and then I get to die? What do I get to answer to that person?

M. Olsthoorn (Gus): Well, of course, you postulate one of the things I brought up before, as you brought up an exception, and many people do not die like that, you know, thankfully, many people don't.

I've seen enough people who... I remember another guy, Karl Scherb was his name. When I saw him, he was so emaciated, he was... I think of somebody who came out of the Holocaust. It's terrible, it's tragic. But I think, as a society, we need to say: We guarantee life, we do not guarantee death, death will come to everyone. So the principle we have to stand on is that we will protect life. Obviously, you cannot prevent suicide, you cannot prevent people who want to jump off a bridge and kill themselves. I had a colleague or a fellow student who shot himself because his wife had left him. Did he have the right to do it? I don't think so. He did it, and the rest of us were greatly shocked, over such a thing as just his wife left. I mean, obviously he was depressed and despondent, but society, as a culture, as a value, people... we say: We protect life, we want people to enjoy life as much as possible, right. But I don't think we should ever come to the place where we're going to tell people: OK, now you can die, now you can't die. We should never come to that place where we will give permission to people to die.

Mme Charbonneau: I'm going to stop you right now. I'm going to tell you why: I'm going to explain to you an exception, or why maybe we should listen to exceptions, because we heard all sorts of experiences, and the role that we have — and I guess you understood — we have to confront people that are against with...

A family came to us and said that the father shot himself. He chose, because he knew that nobody else could do it, to kill himself. The children were telling us

that they were deprived of that precious moment where a father can say to their children: I'm leaving. There were... The wife was deprived of that last morning where she left for work and didn't know, because he didn't want to tell her, he didn't want to make her a partner in that crime. So she said... the family came to say: If he had a date, if he had that right, then we would have had him longer, because he would have known that at a certain moment that exception would make him a father longer than when he had still his hands and his feet to kill himself.

So, when you say we should be careful to exception, that's what they said for an opposite reason. They said: You should be careful to exception, because we would have had him longer if he'd had the right to die. So...

M. Olsthoorn (Gus): In one sense, I find what you said very chilling.

Mme Charbonneau: It is.

● (11 h 40) ●

M. Olsthoorn (Gus): But it almost implies that one day we're going to have... we could have suicide clinics — right? — where you set a day and you walk into this clinic and, in a nice comfortable surrounding, you say goodbye to all your friends and relatives and somebody injects you. To me that is repulsive to think that, you know, under State sanction, we're now going to be putting people to death, and the reasons, well, of course expand from somebody who is desperately ill and, you know, they're in terrible suffering, right, to, well, maybe we should expand the boundaries a little more to somebody who has just suicidal depression, you know, has suicidal depression tendency or just had decided: It's my right, I don't want to live anymore, and you, the State, have to pay for my death. Right? But let's make it easy for everybody and let's set a date. I find it horrifying. I don't know what else to say.

Mme Charbonneau: But that doesn't answer the fact that exception could exist, exception situations.

M. Olsthoorn (Gus): Oh! There are exceptions definitely. I mean, people who want to end their life and... you know, if someone was to put it to me and said: You see your father, he has few days, weeks to live. All you have to do is press this little button, and we can speed this up. I'm not sure what I would have done. Emotionally, I would have probably said: You know, he's not going to get any better. My sister kept telling him: Oh! You're going to get better, dad. You're going to get better, dad. He was half the size that he started out. I'm not sure what I should have done, but that was an exception. We should not make a rule saying that now everybody has the right to push the button and speed up somebody's life. That's what I'm concerned about. It's that we take these exceptions and then we pass rules to saying how people can kill each other, you know. Exceptions have to be exceptions. Thank you.

Le Président (M. Kelley): M. le député de Marquette.

M. Ouimet: Merci, M. le Président. Thank you very much for your presentation. You drew some interesting parallels with capital punishment in your presentation.

I found that very interesting. And it prompted me to wonder like where does the... Our society has recognized the right for a lady, a woman to terminate a pregnancy. And I was wondering where that sort of fit in your system of values, decisions being made decades ago. And, based on the principles you were enunciating... and I said, you know, I wonder how that fits into your system of values.

M. Olsthoorn (Gus): Well, that's a very good question, and I do have opinions on that. I recently became a grandfather, about six months ago. I also have four sons myself and present at all their births. I find it hard to think that two hours before my sons or grandsons were born that they were not human. Or, should I say, maybe a month before they were born, they're no longer human. Or maybe two months before, they're no longer human, they were not human. At one point... At what point does human life start?

And some people... And I understand the Québec National Assembly unanimously voted for unrestricted abortion on demand, which... unrestricted access to abortion for a woman, which... We know that the viability of human life outside of the womb happens 22 weeks. So, to tell me that there's somebody who'd say that it's OK to kill a child a month or week before they're born, somehow it's OK and they're... That's why my reference to... We have made no laws, we've actually abolished all laws regarding abortion in Canada simply because we got so caught up in the rights of women that we totally forgot about the right of the next generation. I find that... Who's speaking for my grandson? Who's speaking for them before they're born?

I know it's a tough issue too but again I don't see... If we come to the place with... regarding abortion and we said... whatever, woman and doctor decide, and we don't have anything to do, right, we're going to come to the same place regarding euthanasia. It's too complicated, too emotional, too... Let's just leave it to the doctor and, you know, the patient, or family and patient. Then it will no longer become murder, it'll just become one of those unregulated things.

Le Président (M. Kelley): The Member for Laurier-Dorion.

M. Sklavounos: Thank you, Mr. Chair, Mr. Olsthoorn. Great people are Dutch. My spouse is Dutch. I just wanted to say thanks for coming out. Thanks for sharing your time with us. Just very quickly, my conception. I like to think of my conception of society in Québec as a society that's neutral and not necessarily secular. And why I'd like to clear that up is I think «secular» kind of becomes a belief in itself, and when you call a society «secular», it kind of means that everything else is not on an equal footing. I prefer to see Québec culture, you may disagree with me, Québec society as neutral, neutral meaning that society stays out of those issues as much as possible. I may be wrong. It's my conception. At the same time, it's not because issues such as abortion or other issues have been decided in Québec that people who are against, etc., are... their opinions have less value or should not be expressed.

I want to explore another issue with you, though. I come from a culture of people who were taught that you fight till the end. You don't give up. No matter what the odds are, 300 against 10,000, you fight till you're the last guy. You go down. You don't give up. It's just not taught in our culture.

But I have this movie scene in my mind, that keeps coming back to get me. It was one of the Vietnam movies. I don't know if it was *Full Metal Jacket* or *Platoon*, and one of the soldiers stays behind because he's got to go to the bathroom, and the guys, the rest of the platoon, the rest of the unit moves up and, at some point, he hasn't been... he doesn't come back. So they go back looking for him and they basically see him on the ground, and he's been ripped apart. His intestines have been literally ripped out. And the guy is in serious pain, I mean, I actually felt the pain watching the movie. Good movie. I don't remember which one it was, though.

And he says... he looks, and you see the guy saying: Kill me! Kill me! I'm in pain. And, if I remember correctly, it was a very, very difficult moment, because you felt the pain of his comrades, who are sitting above him, and...

Une voix: ...

M. Sklavounos: Yeah! I mean, these guys have sworn to protect each other, and defend each other, and watch each other's backs. Yet the guy's on the ground and he's suffering. And, if I remember correctly, at some point, very quickly, he turns around, he puts a bullet in his head and he walks away. Like I say, I prefer saying... You know, I come from a culture where, you know, we're taught to battle till to end no matter what the odds are. But I have difficulty seeing that guy put an end to his buddy's pain with a bullet in the head, when he was suffering, as just an animal; a killer. I have difficulty just simplifying it like that.

Can you help me with that a little bit, or... Is it just the same thing, saying there are exceptions and sometimes it's easier, but as a society we don't want to go down the road of the exception because, as in the case of abortion or something, we start with exceptions and then it becomes generalized, and we lose control, or do you have something else to help me with that? Because that's an image i'm battling with.

M. Olsthoorn (Gus): Well, your question is... I would see it as the exception. I mean, I'm sure you've never run across somebody who was in the imminent stages of death or you could have put a bullet in their head. I'm not sure if I wouldn't do the same thing, knowing that it's an irretrievable situation. You can't get out of it. But, when you come out of that situation, you still maintain that I am for life. I'm for life. I'm going to the end. But at some time the end comes awkwardly. It doesn't come cleanly. It would be nice to just say: O.K. Well, it's over. Fine. Everybody, go home! But it doesn't happen like that.

So then you come to this, you know, this grey area, here, where... You know, somebody says... I would come down to... If you have choices to make, and there are equal choices on either side, you know, you just simply have to make one of the two choices. It doesn't really matter. And I think you're looking for... What I'm afraid of is that because of these exceptions, these gut-wrenching things, that we're going to end up making rules about everything and no longer respect that life is worth living, life is sacred. We need to support life until it can no longer be supported. That's what I would hope that the commission ends up saying: We stand for life and we're protecting life.

● (11 h 50) ●

M. Sklavounos: We have that argument done and we're... That argument has been noted and many have

made it. I'm not going to ask you another question, because we have no more time, but I understand that point.

Le Président (M. Kelley): Mme la députée de Joliette.

Mme Hivon: Oui. Je vais poser mes questions en français. Merci beaucoup pour votre présentation. On veut entendre spécifiquement des gens comme vous qui ont une opinion, qui sont des citoyens et qui veulent nous en faire part, alors merci.

Moi, je veux revenir — justement vous venez de terminer avec ces propos-là — sur l'idée de protéger la vie. Vous avez dit qu'il fallait protéger la vie à tout prix. Vous parlez du caractère sacré, fondamental de la vie. Mais vous savez aussi sans doute que l'autonomie de la personne est une valeur qui a pris beaucoup, beaucoup de place dans notre société, dans notre droit, dans nos règles.

Et j'aimerais savoir, au nom du principe que vous défendez et que vous nous invitez à défendre, de la protection de la vie à tout prix, comment vous vivez avec le fait que maintenant, dans notre Code civil, on prévoit clairement qu'une personne peut refuser tout traitement, une personne en parfaite santé peut refuser une transfusion sanguine même si sa mort va arriver dans les heures qui viennent, une personne qui a toutes les chances de s'en sortir peut refuser d'entreprendre un traitement, peut demander d'être débranchée, parce que c'est vu comme un traitement. Comment vous réconciliez ça, comme l'évolution qui a été faite dans notre réflexion de société, avec ce que vous défendez du principe sacré... du caractère sacré de la vie?

M. Olsthoorn (Gus): I believe that if a person with all their faculties has decided that «I do not want this medical treatment», such as someone with cancer who says: I do not want chemotherapy, I do not want radiation treatment, then they do certainly have that right. We're not... You know, the society doesn't... in the case they force somebody against their will to take treatment, I don't think people... We have this right to terminate.

The other point is that I think, though, society has to say that our value, our Canadian value is to protect life, protect it no matter where until... you know, until it starts, until it ends, right, we are there to protect it. My concern is that it'd become a value of this society, Québec society, that we are maintaining life at all cost. When I mean all cost, it's in the sense of... that we should not be attaching a dollar value to it because once you start doing that then it becomes who has the most money. What if we don't have money? What if we can no longer afford certain treatments?

Mme Hivon: Certains ont avancé l'argument sur la question justement du caractère sacré de la vie puis la protection de la vie à tout prix, se questionnaient à savoir... C'est certain que la valeur d'autonomie a beaucoup de place et ce n'est pas un principe que personne remet en cause, mais c'est de savoir où on trace la ligne entre l'autonomie et, je dirais, le bien commun ou les craintes qui peuvent être exprimées si on permettait à l'autonomie d'aller jusqu'à avoir une aide médicale à mourir.

Et certains nous ont dit que, si on prenait le principe vraiment de la primauté de la vie, du caractère sacré de la vie au pied de la lettre, il faudrait s'inquiéter beaucoup plus du fait qu'on permet à quelqu'un, par exemple

pour des croyances religieuses, de refuser une transfusion sanguine plutôt que de permettre à quelqu'un à qui il reste une semaine à vivre et qui est agonisant de demander qu'on abrège ses souffrances. Quand on prend ça du point de vue de la protection du caractère sacré de la vie, qu'est-ce que vous répondez à ça?

M. Olsthoorn (Gus): I'm sure you have heard many people. I'm not sure I have an answer on the balance between personal autonomy and respecting the sacredness of life. They almost and sometimes seem to be clashing with one another which I think you're struggling with, and I heard your prior question and I can understand that it is extremely difficult and somebody asked you to come up with an answer. I'm not sure that there is an answer. I mean, even Mr. Kelley expressed the same thought. We're here charged with coming up with some kind of answers.

I come back to my point about, you know, a hunter. If you're not sure that, you know, you're going to put an innocent person to death, we should always side on the side that's protecting the innocent, that, you know, establishes rules that protect these people. So that's why I'm advocating that we do not institutionalize euthanasia or assisted suicide. It's going to happen. I don't think there is any way that anybody could prevent it. Right? But we need to instate laws that prevent it. That's why I believe our federal Government had decided not to advance a bill regarding assisted suicide and euthanasia because there are just too many risks, and as... for Justice himself said: «It's ungovernable». How do you... Where do you set the rules? And I think, while you're asking the question, you already realize there are no real solid clear-cut rules.

Mme Hivon: Et justement pour continuer sur la question des craintes, parce que, de ce que je comprends, c'est que vous craignez qu'il y ait en quelque sorte des dérapages ou qu'on ne soit pas capables de mettre des limites. Et je veux comprendre: Est-ce que votre crainte vient un peu d'un manque de confiance dans le corps médical qui serait ouvert à des pressions et mettrait fin à la vie d'une personne sans que la personne ne le demande? Est-ce que ça provient plutôt du fait que le législateur déciderait que tranquillement il faut élargir, élargir, élargir sans faire des débats importants, je pense, comme celui qu'on prend le temps de faire aujourd'hui, ou est-ce que ça vient de vos concitoyens puis de la société en général, puis vous vous dites: Les gens n'ont plus de valeurs, et donc, si on ouvre la porte pour des cas très, très, très exceptionnels, ce ne sera peut-être pas les médecins, ce ne sera peut-être pas les législateurs, mais ça va être les citoyens qui vont mettre une pression incroyable pour faire sauter les balises, et donc ni le législateur ni les médecins ne pourront résister à ça?

M. Olsthoorn (Gus): I think the fear comes from all three. My parents are from Holland, so I'm well aware of the situation in the Netherlands. Human nature being what it is, history has shown that people can do unimaginable evil. My mother was saying that in Holland, she lived in... during occupied Germany for five years. She's saying that the Dutch doctors were noted for their resistance to supporting the German... the Nazi doctors and their experiments and their, you know, putting the Jews to death, etc. They were noted for their resistance and yet, 50, 60 years later, they're one of the leaders in doing the same thing

that the Nazis were doing. Human nature is like that, society changes, and I fear for that, you know.

Mme Hivon: Je ne suis pas certaine que les gens des Pays-Bas seraient d'accord avec votre affirmation qu'en pratiquant l'aide à mourir ils font la même chose que les nazis. Je veux juste peut-être relever ça parce qu'il faut quand même essayer ici de ne pas faire en sorte que nos amis néerlandais ou que la Hollande soit vue comme une société qui n'a absolument aucune valeur, et tout ça. Je ne sais pas si votre affirmation est vraiment ce que vous vouliez dire, là?

M. Olsthoorn (Gus): I'm just saying and reiterating what my mother had told me, that... She said that Dutch doctors were opposing the Nazis and, you know, things like abortion and euthanasia, putting the terminally ill to death, they were noted for their resistance to that. And yet it seems to me that the Netherlands is a leader in putting, you know, assisted suicide and euthanasia and these types of... My point is that the values of the Dutch doctors had flipped, had switched 180 degrees in such a short time. Obviously not all doctors and not all Dutch people, I know there are many good doctors... but I know that Holland is a much more liberal country than Canada or the United States. So, obviously, they're not Nazis, I'm not trying to say that, but...

Mme Hivon: Merci.

Le Président (M. Kelley): On that note, thank you very much for your contribution today. I will suspend our work until 1:30. Je vais suspendre nos travaux maintenant jusqu'à 13 h 30.

(Suspension de la séance à 12 heures)

(Reprise à 13 h 33)

Le Président (M. Kelley): Alors, la commission reprend ses travaux. Je vais rappeler le mandat de la commission. La commission est réunie afin de procéder à la consultation générale et les auditions publiques sur la question de mourir dans la dignité.

We have our next group before us, which are four citizens: John McCallum, John Fossey, Glenn Fossey and Ross Anderson. And I believe it's Mr. McCallum who will start. Oh, it's John Fossey. OK. And as I say, for the moment, go ahead and testify in English, and then you may need the headsets later on, when you may be asked questions in French. But for the first part, please, you don't need them to begin with.

**MM. John McCallum, John W. Fossey,
Glenn Fossey and Ross Anderson**

M. Fossey (John W.): Thank you, Mr. Kelley. We're very glad to be able to speak and very impressed by the sincerity of your setup here, that... I can see that it's a real effort, and it has been going for sometime, I think, you had some 100 or more...

Le Président (M. Kelley): 102.

M. Fossey (John W.): 102. And it will be, what, 200 and something when you finish?

Le Président (M. Kelley): Almost 300.

● (13 h 40) ●

M. Fossey (John W.): Almost 300. It's very impressive. And we would just say that we respect what the Government is trying to do. In fact, we respect Government, it's of God, God has instituted Government, and we obey its laws as much as we can, even stopping on stop signs, and things like that. But we respect Government, except where it might be against the conscience in which case God has to be obeyed rather than men. But that would be something that would be faced in the issue involved, for instance, taking arms, and so on. And so our members... And we represent Christians. We represent, we would hope, Christians universally or across the world, that is persons who believe in the Lord Jesus, persons who have the spirit, persons who don't fear death, because it's just the passage into another world where Christ is, he's gone before. So that's what we represent.

Our submission is very simple, really, you ought to read it, it has a preamble, and then there's a submission, and it's based on the Scriptures. Now, we heard lots of submissions or lot... say, some submissions — we were here... I was here this morning. Then, basically, what we are hearing is that there's a general reluctance to base the issues involved in life and death — dying, or living, with dignity — to base the issues on the Scriptures. So we appeal to the commission Members just to bare with us on that. Because that's our stand. We believe that God has given the direction as to how we should be and that there's an answer in the Scriptures to every question. Now, whether we have the answers, we will see, but there is an answer for persons that are dependant on the Scriptures and on the spirit of God.

So what we would say is that we have a faith based on moral presentation today, and we haven't heard too much of it. We heard even church groups give their presentation and we don't see the simplicity of a moral approach, very rare. And so that's our stand, it's a life and death matter that we're talking about. And, when it comes to life and death, then we cannot leave out of it Christ's death, because he's God's man and he was rejected. He suffered from the hands of men, cruelty of Roman powers, cruel men of Rome. He suffered rejection from his people. He suffered physically, he suffered at the cross. But then, above all, he suffered at the hand of God. Why? Because a sacrifice was needed, and the only sacrifice that would appease God's judgement was the sacrifice of the Holy Son of God. And so we don't apologize for this approach because we know that God is a compassionate God, we know that he's a loving God. We know that he has provided force, he doesn't want us to die a death without hope. He's given us hope. And we would just like to get that across that we have to respect that.

And so what we are saying here is that we think the moral approach has been overlooked. You say: Well, everybody doesn't believe it, and that's why I think everybody that we've heard utmost even wanted to go the route of what's moral, because people don't believe it, and you want to appeal to everybody. Well, God is like that; he doesn't leave anybody out. He's without prejudice and without any distinction, whether it's language or color, or sex, or whatever it is. God's appeal is to all men. And Christ

came in order that all men might be saved. And it is that... what I believe is that God will have the victory, he's going to have the majority of persons in heaven, he's going to have the victory. And we want to be on his side, not on the side of the devil. Christ is gone beyond where the devil could get him, he's in heaven now. He's still a man, you know? He's a man with feelings as a man. And he's interceding for us, and he loves us, and he doesn't want us to die without hope.

And so we have all these questions of distinguishing between giving care to the extent of lethal injections or not lethal injections, and we have all these questions about the distinction, you know, between how to care for persons, do the right thing. I believe the Scriptures have the answer.

And so I spoke about the cross, you know, the cross of Christ. We have crosses all over the place, you know, but as the cross of Christ is the center of God's thinking for man, it was before time began that God had the cross in mind. And everything looks forward to it, and everything since then looks back to it, and everything is based on what that was done there. The blood of Jesus Christ, the one who died and shed his blood, the blood of Jesus Christ cleans us from all sins. Do we believe it? Do we believe it or do we think we have another answer, you know? But that's the answer. And so we're Christians, and we believe it's right to be a true Christian, and we believe that we would speak for all Christians.

There is an instinctive background to people, I believe, in this country, in this province, that would recognize the rights of God. And so it's the rights of God that come up when it comes to the question of dying. Have I the right to take it into my own hands? Have I the right to give it to doctors to do it? Have I the right? I don't think we have the right. It's not morally right.

So any legislation that we're talking about here, what is going to be presented by this distinctive commission to the Government eventually, what is it going to be? You've listened to all these... and that will be 200 and something, you've... And, you know, the sincerity of the commission is very impressive. But what is it going to be? Is it going to be something that honors God or is it going to be something that dishonors God? Is it going to be something that honors the Church or is it going to be something that the Church would be, should we say, not supporting? What we do, and what Government does, has to be what God can support.

And so, you see, we have plead with the commission. If you're not being sure up to now, well, be converted. If you feel that there's something, well, be convicted, reconvicted about it, you know. And then, if you're convicted, be convinced about it that this is the way we must not allow Government to legislate euthanasia or assisted suicide. Now, the previous speakers in the room before tried to distinguish between the two, but it's a question of what's morally right, you see. And that makes it very easy to answer; it's not morally right to take your own life. It's not morally right.

One man wanted to do it and he was a Roman soldier. And his charges had disappeared, or thought he had... he thought they had. And he was going to kill himself because he knew that the Roman power would be against him. And he cried out, and Paul says, «Do thyself no harm.» See, that's the answer to somebody who wants to suicide: don't do yourself any harm.

So there's many questions, I'm sure, that the commission would have, we'll try and answer them. But don't go the route that is happening everywhere where the rights of God are not being recognized, and I don't mean by persons, I mean by governments. Don't go that route, it'll be a black mark against Québec to do that. That's my feeling. Don't go the route of legalizing euthanasia or assisted suicide, it's morally wrong. That's all, I think, I could say at this time.

Le Président (M. Kelley): Thank you very much, Mr. Fossey. We'll pass now to a period of exchange with the Members of the Committee. Obviously, as a democratic body, we have certain other principles that are also important. It's very difficult, because whenever you're at the intersection of faith and government and civic society, there are other principles that come into place as well. One of them is: as parliamentarians... We have a diversity of faiths in our society. And I didn't bring it up this morning with one of the witnesses, but Thomas Jefferson very deliberately chose the word «the Creator», and not «God», when he was talking about certain unalienable rights, because Thomas Jefferson had a different perspective on God than perhaps yourself would have and other people. So I think we have a challenge, in an increasingly diverse society, to come up with policies, to come up with points of view that try to reflect the diversity of opinions, because, in a democratic society, that's one of our challenges as well.

And I was just wondering, it's one of the things that, as this debate goes forward... Modern medicine and the advances in technology have made some of these questions a lot harder to answer than maybe 30 years ago. Because we positively play God, in the sense that there are now things that I can do to artificially prolong life, that if things were left alone, nature would have taken its course, but I can put you on a respirator or I can put a tube into your throat so that you can breathe longer. Those are just but two of the many examples we've heard before this Committee this day.

So does that make some of these moral choices more complicated to make for societies, for individuals, for families? Because we hear people that come to us with stories... When you say, «do no harm», well, often those decisions that are taken in a positive way to prolong life create great deal of pain and agony for the patients and for the people who watch someone close to them suffer. So, in a way, has our technology made some of these questions harder to answer?

M. Fossey (John W.): I don't think so. Any prolonging of life gives God more opportunity to complete His work in my soul. And it also gives opportunity for the family to get close to them, and comfort them, and to form links that they've might never had. We mustn't make a law that just goes by the worst cases. We've got to make a law that's morally right. And it's not morally right to put someone to death, but it is morally right to help them to live the longest they can so that they can be formed for God's world. Is that understood?

Le Président (M. Kelley): Well, I hear you, but, you know, you're... You said that... «Do no harm.»

M. Fossey (John W.): Right.

Le Président (M. Kelley): And, if artificially... if I let God's will be done, the person will pass away. But I make a decision to interfere with God's will, in a certain way, as I say, in a positive way, and I'll put you on a respirator or I'll put... find something that will keep you alive when naturally you would have died. And sometimes that can lead to those sort of things that you're talking about, if someone is lucid, if someone is not in pain or suffering. That may prolong life in a positive sense, but it may just prolong the suffering and the agony. And it may be someone that is so heavily medicated that they can't talk to their family, they can't talk to anybody. So, in that sense, I'm just trying to understand if we're not muddying the waters a great deal with some of this technology we...

And some of the home doctors that have come before us said that, at times, we have treatments that are useless. That was their word, «inutile». And that quite surprised me because that's a great cost to society, and if it's not improving the quality of life of the person, where do we draw lines? And I think a lot of the work we're doing as a committee... And one of the things we're finding is what we call our technological progress, not our moral progress — that's another debate, I'll leave that to you — but our technological progress... Have we not made some of these questions a lot more complicated to answer?

• (13 h 50) •

M. Fossey (John W.): But, you see, what you just said is: I want to do this, I want to prolong their life, I want to do this, I want to give... put them on a respirator. I want to do this. That's you, that's not the patient.

Le Président (M. Kelley): The medical... I mean, the process does. I'm not saying it's me who decides that, but I'm just saying: This is what happened and this is the testimony we... sometimes it's with patient's consent, sometimes the patient is unconscious, his decisions are taken for them. There're a whole subcategory of who is taking the decision. But it does muddy the waters, no?

M. Fossey (John W.): No. It might be to some, but, you see, what we say is that if it is determined beyond all doubt that there's absolutely no hope for a patient, and you're saying, well, the profession can take... continue his life by giving medecine or whatever, but if it's determined that there is no hope, the attending physician, following the patient expressed desire, OK, or last will and testimony, might decide to end the life support, you see, that's a decision that the patient makes. Or, if the patient can't make it, then the relatives or the power of attorney that has the power of attorney will make it on their behalf.

But it has to be known that that's what the patient wants. So his conscience is in charge, he is in charge of that. And if he is not able to do it, then his relatives who know could do it for them. So you say it's more complicated, I think it's more beneficial, because it gives the patient, the sick person more chance to be formed for God's will, even in the suffering. Do you want to say anything about that, Mr. McCallum?

M. McCallum (John): I'm just listening to all your saying, Mr. Fossey, and I'm just thinking of the Scriptures, Luke 23. There were two men on the cross alongside of Christ, and one of them, in these last few moments of his

life, he said: «This man has done nothing amiss. I'm getting all that I deserve, I'm a sinner.» But God gave him that opportunity, in these last few moments, to commit himself to Christ. And the way I see what you're speaking of and building up to his... If I, so to speak, pull a plug on someone who, even in unconsciousness, to my looking at it, is working out something with God and God with that man or woman, do you know what you're doing? Do you know what you're doing? You maybe cutting off the possibility that that person lives eternally with Christ or goes under judgment of God, as a God who addresses only righteousness in his judgment. I wouldn't like to have that responsibility. That's all I'm thinking.

M. Fossey (John W.): Yes. And, you see, that man on the cross, he had the opportunity to say to his neighbor: «We indeed justly; Dost thou too not fear God?» He had the opportunity to be an Evangelist in his last moments. So don't, as Mr. McCallum says, take the step of cutting it off yourself, for them.

Le Président (M. Kelley): Mr. the Member from Laurier-Dorion.

M. Sklavounos: Merci, M. le Président. Thank you so much for your presence today and your presentation. It's a complicate issue. I think everybody's opinion is welcomed and I don't think we should start off in any way by rejecting anybody's opinion based on where they derive their values from. And you're very welcomed to be here.

And I'm trying to work within the logic. I was also raised a Christian, baptized Christian. I'm battling with the concept of compassion, because... I used an example earlier, for a gentleman who testified before us, of a situation where someone who believes in life and who wouldn't in any way, under different circumstances, want to harm somebody... And it could be someone they care about. And I used the example of a movie in... two friends soldiers, and one is grievously wounded and in horrible pain, and begs his friend, colleague, to put an end to his suffering, because he's suffering and he's in extreme pain. And I have difficulty, for some reason, in a situation such as that... And I used earlier a movie scene, and, in the end of the movie scene, the soldier turns around and he actually ends his life, he fires a bullet into his friend. And it was very clear that they were friends, they were almost brothers and they would have done anything to protect each other. But in this particular circumstances, this man was suffering.

I don't know why — and, you know, my thoughts and my beliefs are very complex, I don't even care to get into them, because they're still a little bit confused — I have difficulty condemning, condemning the guy who turned around, and he put that bullet in his friend in order to stop him from suffering. I have difficulty... Just personally, I'd have difficulty judging him, I'd have difficulty as a judge condemning him, I'd have difficulty if I were substituted for the person who decides who goes to heaven and who goes to hell. I'd have difficulty even excluding him if the decision were up to me. Can you help me with that? Why is it that I can not clearly say: He has done something wrong. There is a side of me that refuses to throw the stone at that guy.

M. Fossey (John W.): Well, as to whether he goes to heaven or not, that is something that...

M. Sklavounos: I'm 100% in agreement that it's not you who's going to decide.

M. Fossey (John W.): Well, you used the word, that's why... I mean, whether he goes to heaven or not, either of them, either of them, the one that pulled the trigger or the one that was killed, has nothing to do with that situation. It has to do with whether he has accepted Christ as his savior, as simple as that. That's the only basis on which you go to heaven, not the basis of somebody praying for you or to anybody. It's, «Do you believe on the Lord Jesus Christ as the only man that has been accepted by God?» Only man. And His work is complete, absolutely complete. That's the basis of going to heaven, that's simple. And it's so simple that... people don't want it. Too simple!

M. Sklavounos: But, this example of mercy killing, or compassionate murder — we can call it a million things — is that a sin? Is that... Does your faith or the belief system and the Bible, does it make room for that kind of action, for that kind of... Or are these... You know, I mean, what...

M. Fossey (John W.): Glenn, you could answer that.

● (14 heures) ●

M. Fossey (Glenn): I would say not. Christ is here. When Christ was here... You were talking before about our modern technology prolonging life. It's very good that Christ, when he was here, he walked on the Earth doing good and healing those, it says, healing many, that was what he was here for. So, as far as finishing off, he met ones who were in terrible suffering. One woman was in terrible suffering for 12 years, it says, wholly unable to lift her head up, and she touched Christ and she was immediately made straight. So, you might say, «Well, this prolonging of life is been of God.» Until a modern society, it's been of God that we've been able to develop technologies to prolong life. And you might say, «Yes, it could come a stage when we have to say: Well, we've done all we can, we can't continue with the respirator or whatever, it's not going to make any difference.» And then what you may well find is that they might live a few minutes, and then God will come in himself and take the person. But it won't... it's not a question of... To me, there's a big difference between that and willfully administering something that will end that person's life. I'm not sure if that makes sense.

M. Sklavounos: I'm understanding. There's no more time?

Le Président (M. Kelley): No more time, so...

M. Sklavounos: OK. Sorry. Thank you.

Le Président (M. Kelley): Mme la députée de Joliette.

Mme Hivon: Merci beaucoup. Je vais vous poser mes questions en français. Je suis juste curieuse, dans un premier temps, de savoir ce qui a fait en sorte que vous

quatre vous êtes réunis pour proposer ce mémoire. Est-ce que vous faites partie, je ne sais pas, de la même paroisse, d'un même groupe dans votre Église? Est-ce que c'est autre chose? Juste... On aime savoir, les gens, un peu comment ils ont eu de l'intérêt pour la chose, comment ils ont décidé de se présenter ensemble.

M. Anderson (Ross): Nous faisons partie de la même Église.

Mme Hivon: O.K. Parfait. O.K., merci. En fait, un des enjeux majeurs avec lesquels, nous, on doit composer et qui nous cause beaucoup, beaucoup de réflexions et de questionnements, c'est tout l'équilibre dans la société actuelle entre la valeur de l'autonomie de la personne et la valeur de protéger la vie, le bien commun, les messages qu'on veut envoyer à la société de manière globale versus le droit à l'autodétermination, l'autonomie, les choix que la personne peut faire pour elle-même. Et j'aimerais vous entendre, parce que vous avez des valeurs très claires, je peux vous dire que c'est très clair, c'est très limpide pour nous, très facile de vous suivre, morales et religieuses. Et j'aimerais donc savoir comment vous conciliez un peu ça dans l'état actuel de la législation.

Par exemple, je vous donne un exemple, mais, de manière globale, ça m'intéresse aussi de vous entendre sur la conciliation entre ces deux valeurs-là. Mais l'exemple que je veux vous amener, c'est: dans le Code civil, on a décidé, et c'est un principe de common law aussi, mais dans le Code civil c'est clairement dit que quelqu'un peut refuser tout traitement, même si sa mort va arriver. Donc, vous connaissez l'exemple typique d'un témoin de Jéhovah qui refuserait une transfusion sanguine pour des motifs religieux, même s'il est en très bonne santé par ailleurs, et qui va mourir. Quelqu'un peut décider de manière tout à fait lucide d'arrêter la dialyse, de ne pas avoir de dialyse et de mourir parce qu'il ne veut pas un traitement, même s'il est relativement jeune. Et par ailleurs on a les personnes en toute fin de vie pour qui la mort est imminente mais qui agonisent et qui ne peuvent pas abréger leur vie. Et c'est beaucoup la question de l'autonomie, évidemment, qui a fait en sorte que le Code civil a intégré toutes ces notions-là et que maintenant la pratique médicale est telle que l'autonomie de la personne, en matière de refus de traitement, est vraiment considérée comme une valeur, je dirais, primordiale.

Comment, vous, avec vos valeurs à vous, comment vous réagissez à ça?

Le Président (M. Kelley): ...that one.

M. Fossey (Glenn): I see a huge difference between someone who... if someone personally refuses treatment. Bien, si quelqu'un refuse le traitement médical, il n'y a rien qu'on peut faire, comme on ne peut pas... Est-ce qu'on peut comme les forcer? On ne peut pas vraiment les forcer à prendre ça sans... Qu'est-ce qu'on va faire, les attacher? Tandis que quelqu'un qui... si on l'aide à mourir, c'est de demander au gouvernement de... Je vois une immense différence entre donner quelque chose pour l'aider à mourir que de ne pas donner quelque chose parce que la personne insiste.

Mme Hivon: Vous savez qu'avant le paternalisme médical était très, très présent. Donc, le médecin, la

philosophie générale, c'était que le médecin savait ce qui était bon pour vous. Votre consentement, ce n'était pas nécessairement fondamental. Donc, on pouvait dire: Voici ce qu'on va faire, on va vous donner tel traitement, tel traitement.

Maintenant, ça a changé. C'est pour ça qu'on parle qu'il y a eu une évolution. Le paternalisme médical n'est plus quelque chose qui est supposé être présent, puis c'est vraiment le consentement qui est au cœur de la relation médicale normalement, le consentement du patient.

La raison pour laquelle je vous demande ça, c'est que... Puis ce matin on a eu d'autres personnes qui aussi parlaient un peu dans la même lignée que vous que le principe de la protection de la vie doit être fondamental. Et le paternalisme médical provenait un peu de ces valeurs-là de société où la vie, la primauté de la vie était la valeur sacrée au-dessus de tout, et qu'il pouvait y avoir... même si une personne estimait que le traitement médical, elle ne le voulait pas, on lui donnait parce qu'il fallait protéger la vie à tout prix. Maintenant, il y a comme un équilibre ou des choix de société qui ont été faits par rapport à l'autonomie. Et je comprends donc que, quand on est dans une situation comme ça, vous admettez, en quelque sorte, qu'il y a des limites à la protection de la vie à tout prix au nom de l'autonomie de la personne.

M. Fossey (Glenn): Oui, c'est certain que nous allons tous mourir. Alors, comme vous dites, il y a une limite. Je comprends bien ça. Mais, quand on parle de l'intervention, et c'est ça que nous faisons, dans le traitement médical c'est l'intervention, je pense que, pour nous, on parle de la volonté de Dieu. O.K.? On ne peut pas vraiment... Ce qu'on peut faire, c'est de...

Sorry, I better say it in English, yes. It's just that we're speaking about God's rights. And, in God's rights, as far as intervention goes, we can't willfully take someone's life. If somebody refuses the treatment, that's their... we can't exactly... Maybe that's sort of another... that's another story, you might say. But now to legalize willfully taking somebody's life, to me, will be a terrible mistake that we'll regret.

Mme Hivon: Puis ma dernière question: Beaucoup de gens qui sont venus ici qui ont une opinion à l'opposé de la vôtre nous disent qu'on ne peut pas faire en sorte que les valeurs des uns deviennent la loi des autres et, en quelque sorte, que des valeurs religieuses et morales de certains, qui sont tout à fait légitimes, fassent en sorte que la société dans son ensemble, le législateur, le Parlement décident que ces valeurs-là doivent dominer, même si des gens dans la société ne les partagent pas, et que ces valeurs-là seraient la base d'une interdiction, par exemple, d'une ouverture à ce qu'ils demandent une aide médicale à mourir. Et évidemment ça se pose ici, dans le débat actuel, mais ça se pose dans une panoplie d'autres débats dont on ne fait pas l'économie, au Québec comme ailleurs. Donc, qu'est-ce qu'on répond à ces gens-là qui disent que tout le monde ne partagent pas ces mêmes valeurs et que pourquoi on devrait privilégier des valeurs qui en fait les empêchent d'avoir accès à quelque chose mais qui ne nuiraient en rien à quelqu'un qui ne voudrait pas avoir accès à ce même droit? Les questions classiques, mais on veut vous entendre.

M. Anderson (Ross): Je vous dirais qu'en ce qui concerne imposer les morales ou les valeurs de quelqu'un,

un groupe sur le monde en général, je dirais que, oui, on n'a pas le choix. C'est pourquoi nous avons la loi criminelle. Et ce qu'on parle aujourd'hui, c'est le bon et le mal. L'euthanasie, c'est le mal. C'est de faire le mal à quelqu'un. C'est pourquoi jusqu'ici ça a fait partie de la loi criminelle, que c'est carrément contre la loi. Ce qu'on regarde, c'est si on enlève ça puis on le permet.

Alors, dans la société, on n'aura jamais le choix, il faut imposer les valeurs sur la population en général. Et ce qui est primordial dans cette question pour les gens du gouvernement, c'est: on parle d'une question de bon et mal. Et, si on permet les médecins de passer à un acte passif... passif à actif, c'est à ce point-là que nous avons traversé la ligne. Est-ce que ça fait le bon sens?

● (14 h 10) ●

Mme Hivon: Je comprends. Merci.

Le Président (M. Kelley): It's left for me to say thank you very much to Mr. McCallum, Mr. Fossey, Mr. Anderson, Mr. Fossey. Sounds like a law company or something like that, or a group of accountants. But thank you very much for sharing your positions with us today. We...

Une voix: ...

Le Président (M. Kelley): No, no, no, I was only making light of a very...

M. Fossey (John W.): ...and I just say, «Don't allow the law to disregard God's rights, and recommend a law that respects the law of God, the Christian conscience, the medical profession, the Church, and do what's morally right.» Bring that and you'll have God's support.

Le Président (M. Kelley): Message received.

On that... Je vais suspendre quelques instants. And I would ask Barbara Bagshaw to take her place at the witness table.

(Suspension de la séance à 14 h 12)

(Reprise à 14 h 14)

Le Président (M. Kelley): Alors, la commission reprend ses travaux. Our next witnesses are Barbara and Heidi Bagshaw. So, without any further delay, it's your turn.

Mme Barbara Bagshaw

Mme Bagshaw (Barbara): Thank you very much. Thank you for giving me the opportunity to speak today. I'm sure you're all aware that you have an awesome power, and also with that goes an awesome responsibility.

My name, as we just said, is Barbara Bagshaw. I'm the mother of six children and the grandmother of 23, with two more on the way, so I'll be the grandmother of 25. And I brought my daughter Heidi with me for moral support.

I'm not an expert in the field of medicine and I'm speaking simply as the mother of a family. I gave up my career as teacher of Home Economics when my first child was born and, together with my late husband and two youngest children, I came to Canada in 1966.

When I first read about this special commission on dying with dignity, my heart sank. I felt compelled to

respond because I don't want my children and grandchildren living in a society where euthanasia and assisted suicide are legalized.

Whereas the family forms the basis of society, the family cannot do everything, and that is why we have schools, and hospitals, and universities. This problem, at first, the problem is that it looks like... it looks as though it's a case of compassion, that euthanasia is a compassionate act. Which one of us doesn't feel heartbroken to watch a loved one or even a complete stranger suffer? Hard cases make bad laws. We simply can't use misleading vocabulary when dealing with such a profound subject. We are talking about life and death, things that go to the very core of our being, that affect every single one of us, regardless of color, creed or language. There is no dignity to be found in deliberately killing an individual, a human being. We no longer execute criminals in this country. It wasn't called the death penalty for nothing.

Even a child will tell us. If you place a young child in front of a human being, from whatever... of whatever age, they will tell you, «This is a human being.» It's like *The Emperor's New Clothes*. We have people who are trying to say, «Well, this is less than human.» If your IQ is below, say, 40, then you're not a human being. But a child can even tell us this, «This is a... These are human beings.»

Our hospitals have been places where the sick and dying are cared for. Are we going to make them places where the sick are cared for and the dying killed? As we become old and frail, as we inevitably will, in spite of all our best efforts, are we going to have the added burden of being terrified of going to the hospital where we might be killed?

None of us wants to be a burden in old age, but aging is a fact of life. I remember when my late husband was alive. He died when he was 60. And every year a letter would come from his company, inviting us to go to a retirement planning course. It was a six-week course, state of the art. And he used to say, «Oh, it's not for me.» And I'll let it go. And then one year I said, «Danny, whose name is on this envelope? Could we take the course?» So, we took it, and thank goodness we did, because I learned a lot in that course. We talked about pension plans, and retirement, and how we would feel as old people.

But we have a tendency to think that we are not going to grow old. I remember telling my grandmother, «I will not grow old.» And I used to look at old people and the way they walked and the way they behaved, and I used to think, «I'm not going to let that happen to me.» Well, believe you me, I can understand them the older I get. We simply have no way of preventing old age.

Many people are not clear about what euthanasia is and is not. Euthanasia is the deliberate administration of a substance or the performance of a procedure with the deliberate intention of causing death. To put it simply and honestly: deliberately killing a person. None of us wants to suffer pain, but, with the advances in pain management over the past years, it's possible to alleviate almost all pain. If people felt loved and with some care and compassion, if their pain is removed, they're not going to be asking for euthanasia.

• (14 h 20) •

Recently, I saw an interview on television with Michael Douglas. You probably all know Michael Douglas and that he's suffering from a severe form of cancer. I don't

know whether it's terminal or not. And I think it was with Jay Leno, and he said to him, «Michael, is there anything I can do for you, anything?» And after a moment he said, «Yes, give me a hug.» We are all in need of unconditional love.

Even if we have no relatives and even if all our friends have died, at least until now we could count on the care of doctors and nurses if we ended up in a hospital. We need to be able to trust our doctors. I've heard a few doctors who have spoken at these hearings and they have presented excellent reasons why we simply cannot legalize euthanasia and assisted suicide. I sincerely hope that, if I end up in a hospital at the end of my life, I have the good fortune to be under the care of such doctors, doctors who are true to the Hippocratic oath and who will do the best to alleviate any pain I might have without killing me intentionally.

And where are the doctors who advocate euthanasia and assisted suicide? I haven't met any and I hope not to meet them, if in fact they exist, because killing people deliberately goes absolutely 100% against what the doctors are there for.

As I mentioned earlier, it looks like compassion to free someone from pain, but we have to kill the pain without killing the patient. And, besides, compassion for who? Often it's the caregivers and the family who suffer more than the patient. They're the ones who need help and assistance. It isn't easy to watch someone die from a terminal illness. I've done it and I'm sure many of you have, too. I have friends who live in different areas in Montréal who have received help from their local CLSCs with friends or relatives who were dying, and, without exception, they've had nothing but high praise for the quality of professional care that they received. We need more palliative care and more home care assistance.

If euthanasia is legalized, are there any of us so naive as to believe that there won't be abuses? The only safeguard is simple: Don't kill anyone deliberately. Period. If even one person is killed by mistake, it's one too many. Don't we have suicide prevention? If someone comes to us and we know that they want to commit suicide, obviously they have serious problems, and we should use the modern medicine to help them psychologically and in every other way.

My mother died in 1959 from breast cancer. She was 50 years old, and the cancer had spread to her stomach. She had two surgeries and she received radiation treatments at Christie's Cancer Hospital in Manchester. After that, she wanted to stay at home, and so that's where we had her, at home. She was bedridden from September 1958 until her death, in February 1959. We were given painkillers for her, at first in the form of tablets and then ampoules of morphine which we have to give by injection. I never had to do it, but my father showed me how. We had strict instructions about the frequency with which to give this medication. I was at college at the time, but I used to go home at the weekends and do the groceries, and do as much as I could to help. And we also had the help of friends and relatives. But we lived in the country. We had no car and no telephone. We were surrounded by fields.

At no time would my mother have requested euthanasia. It simply wasn't an option. She would have been horrified at the very idea.

My father came to Canada in 1969. He'd been headmaster of his school in England and he taught grade

seven here for several years. In 1999, he suffered a massive stroke which left him unable to speak and almost totally paralyzed. He had the use of one arm. At first, he could feed himself. He was legally blind prior to the stroke. At the time of the stroke, he was living at CHSLD Lachine. And, prior to the stroke, he used to do the crossword with a lady who lived there. She was there because she had polio as a child and she was crippled. Together they wrote three books, unpublished. My father used to tell the story, and she used to write it down. After the stroke, she visited him almost every day.

I used to visit on the weekends and tell him all that was going on in our family, which is plenty. I could see from the expression in his eyes that he understood what I was saying. He tried to speak, but the words wouldn't come out, because that part of his brain that connects the speech... He just couldn't speak.

Since he didn't give me the power of attorney, I had to go through the Public Curator in order to manage his affairs. When my father had his stroke, I arranged his funeral, because the doctor said he would die. Sadly, it was my husband who had that funeral. He died of a massive heart attack. He was 60, and he worked till the day he died. He came home from work on the Friday evening, we sat down to eat supper, and he put his hands out and he had a heart attack.

So, my father lived for four years after the stroke. He died in 2003. And one day I received a call from the CHSLD asking me to go because my father was in pain. I could see that he was passing blood because he had a catheter. And I had to sign a form so that they could give him a painkiller. They told me that they could send him to the hospital, but, if they sent him to the hospital, he would have to undergo tests that would cause more pain. And, if he had surgery, he would probably die in the course of the surgery. They told me that they could take care of him where he was, at the center, and so that is what I decided, that he would stay at the center. And he died some days later.

When I thanked the head nurse for all the care that he had received, she told me: It's not the best, but it's the best that we can do. And she also told me that none of the patients on her floor had bedsores. My father was 94 when he died, and I'll be eternally grateful for the care.

I could go on about this subject for a long time, but, like all truth, the answer is simple: Don't kill anyone deliberately. Period. That is the only effective safeguard against wrongfully killing anyone. You only need to look at countries where this has become accepted, and there have been mistakes. Once we accept that it's out of the question to kill, we can get on with what is really important: taking care of the sick and dying of all ages, training doctors, training more doctors and health care workers.

We hear so much about the aging population, now increasingly about elder abuse. Could it be that money isn't the base of our concerns? Money can always be found for what's important. I do decorative painting, and I took some courses, and I met a lady there that has become a good friend of mine. Her husband is CEO of a big cosmetic company, and this company decided that one of the lipsticks, all the proceeds from one of their lipsticks would go for helping with AIDS, research into AIDS and treatments. She told me that they made, over a period of years, \$20 million. So, money is always there to be found.

As I said in my brief, we live in possibly the best place in the entire world. We could become leaders

in the way we treat the sick and dying. We aren't going to see rallies of the infirmed elderly marching in front of the National Assembly. Let's face it, it's not a glamorous cause.

I would like to make a strong suggestion that people make a notarized will to the effect that, if there is even a remote hint that they die as a result of euthanasia, their relatives get none of their assets. At least that way, the family will make sure that it doesn't happen.

● (14 h 30) ●

Instead of debating this subject, I would like to see the emphasis put on teaching children to have compassion from an early age. I think, for example, of air cadets who visit the veterans' hospital in Sainte-Anne-de-Bellevue. They go and talk to the veterans, and it's beneficial both for the young men and for the vets. They play bingo together. We used to have... Actually, also at that veterans' hospital, there must be men who are suffering from severe injuries and are severely crippled, but they have a lot of care and attention. So we don't hear of them committing suicide and asking for euthanasia. I remember there used to be... at the Lakeshore Hospital, there used to be young women, they used to go... they were candy strippers and they could help out. But I don't see them anymore. I don't think this program is there. But at least they became sensitized to the elderly, they became sensitized to the suffering and... of all ages. But I think that was a very good way to sensitize them to the needs of others.

I know a grandfather who makes an enormous meal and he takes it to a shelter for the homeless. And he takes his seven, nine and 10 year-old grandchildren with him, grandsons, they are boys. And they help to distribute the meal. They're doing this, not to be kept busy, but because they're needed, and they know it. They're providing a service, and they're seeing poverty. What better way to help children learn self-esteem. There's no talk here of being bored. They haven't the time to be bored. And the grandfather makes sure that they do lots of fun activities as well.

If we don't teach children to have compassion and look beyond themselves to see the needs of others from an early age, we can't expect them to suddenly become compassionate, unselfish, loving adults, able to give some of their time to caring for others. I want my grandchildren to grow up, to be mature adults, to live life to the full, knowing how to accept the joys and the sorrows that make up every life.

As I said in my brief, the sweet never fills to overflowing, and the bitter never lasts forever. In other words, we have to accept the human condition. Just as we don't choose the day on which we will be born, we don't know the day on which we will die. Human life in all its forms is precious. So that's all I have to say. And if you have any questions, I'll do my best to answer them. And, I said before, I'm not an expert. And thank you very much for listening to me.

Le Président (M. Kelley): Thank you very much, Mrs. Bagshaw. And really, as we said all along, part of the goal, part of the reason we're doing this, not just in Québec City, but across the province, is to make sure that citizens have a chance to speak out because, of all subjects that parliamentarians can look at, this is one that touches us at the most sensitive moment of our lives, the end of our days. So thank you very much for your comments.

Mme la députée de Mille-Îles.

Mme Charbonneau: Merci, M. le Président.
Good afternoon.

Une voix: ...

Mme Charbonneau: Oh! You won't need them. I should be OK. If ever I stumble on a word, you can correct me or ask me to say it again. I read your memoir with a lot of attention. You didn't deliver it the same way you wrote it, but I could follow you. In a part... At page 3, you say: «Are there any of us so naive [...] to think that», and then you talk about the slippery slope that could occur. We had some doctors that came and talked to us and told us that we shouldn't be so naive to think that it doesn't exist, that sometimes compassion for the people who are hurting exists.

So when you say: «I didn't hear them» or «I don't think there are some», there are some that say they are not against helping people to die. They didn't use euthanasia or assisted suicide. They used the words «helping people to die». Do you think, by helping people, compassion is not at the right place?

Mme Bagshaw (Barbara): We're getting into details here. But, for example, I had a choice when my father was dying. He could have gone to the hospital, and they could have prolonged his life. But I didn't choose that. We don't have to take extraordinary measures to keep people alive. But what we don't have to do is kill them deliberately. For example, when my mother was dying, the doctor could have given her an overdose. Well, he didn't do that. He gave us strict instructions. He wouldn't give an amount that would have killed her. I mean, it would have removed the problem from us. It would have been much easier for us but we wouldn't have done that because...

Mme Charbonneau: Permit me to go to somewhere maybe a bit difficult and, if it's... you tell me. Let's put us in the situation of your mother. What do you think your father would have said if, at one point, she would have said: I had enough. I'm suffering. The medication you're giving me is not enough to keep my head, to be alert, to be with you and to go through this. So help me finish it so that I don't have to suffer, so that you don't have to see me, maybe, suffer, but mostly I don't have to suffer, help me deliver myself, and I cannot do it because you have the morphine, you have the medication? Do you think at that moment, because we're talking way back, do you think at that moment a thought would come to say: It's true, she's asking to leave and she had enough and, by a way or another, the husband can choose to do it or not to do it? I'm not talking about the doctors. Your family had all the responsibility. So do you think at that moment a thought would come to say: Let's help her to leave?

Mme Bagshaw (Barbara): I can tell you with 100% certainty that my mother would not have asked to die. I can tell you she would not. And if she was... like the doctor would say: You know, these pills can be given every two hours and on no condition whatsoever are you to give it before that. But if she was in agony, my father would have given it to her. In fact, he did, but she didn't die. But, I mean, we can't judge. We're talking about extreme circumstances and we can't legalize these things because, if

we do, there will be abuses. There have been abuses. And, you know, Stalin said: «The death of one man is a tragedy; the death of millions is a statistic.» And he would know. We've got to be careful with this.

Mme Charbonneau: M. le député de Marquette.

Le Président (M. Kelley): My colleague for Marquette.

M. Ouimet: Thank you very much. Thank you for your presentation. I'd like to take the discussion, give it a different perspective and wear my hat as a lawmaker. We've been told by physicians, some representing an association of physicians, that in actual fact, perhaps a debatable issue, but in actual fact, euthanasia is being practiced in some of our hospitals in the province at the current time, has been practiced for weeks, months, years and will be practiced. We know that as a given fact.

We also know that in cases where charges had been laid against doctors for killing patients, 99% of the times, if not all the times, the doctors have been acquitted by a jury. We know that as a reality. Are we better off as lawmakers to close our eyes and close our ears on what we know is happening or should we give it some form of direction and some conditions and circumstances and circumscribe as perhaps the province of British Columbia has done and intervene and say: «These are the extreme cases where it can happen»?

● (14 h 40) ●

Mme Bagshaw (Barbara): As someone who spoke before me was saying... or I think it was Mr. Kelley who said that: We're dealing with difficult circumstances because of the technology that has been developed. And so it's possible to be able to prolong life. But I think what we have to do is distinguish — and this is why I insisted on it — exactly what we mean by euthanasia. No one is compelled to put someone on a respirator. You can refuse, you don't have to. You don't have to take extreme measures to keep someone alive against their wishes by using extraordinary means. So we have to define exactly what is meant, and it's very difficult sometimes to make these decisions and that's why... As I said, I'm not an expert, it has to be the doctors to do that. My son used to work at the Lakeshore Hospital and he said... one of the doctors said: The problem here is not that we're killing people, but that we're not allowing them to die. So we don't have to take the extraordinary measures to keep a person alive at all costs, to put a 90-year-old on a respirator when a young person is coming who could benefit from that.

And also, one of the factors involved is cost. It can be very costly to keep someone alive in extreme situations. And that is one of the considerations that has to be looked at. We're not obliged to do these superexpensive procedures to keep people alive, but it's the thing of saying... Well, I'm thinking, for example, of someone who has terminal cancer and goes into the hospital, and a doctor says: Well, you know, she's got like six months, well, you know, let's take her out of it now. Is this to save hospital beds? But I know, I know people that have been in this situation and they've been given a choice: You can go to a palliative care center, you can go home or you can stay at the hospital. They give them the choice. But they're not... I mean, they have not been euthanized.

M. Ouimet: But imagine the worst possible scenario, five, six, seven days to live at best, severe agony. Nothing can possibly happen to change the situation. The patient had expressed in a living will that if ever those circumstances were reached, that person would like to be assisted in terminating or, you know, putting her out of her agony, and the family is begging that. And it happens in hospitals, what we're told. As lawmakers, should we sort of put guidelines around it so that we can avoid perhaps abuses or should we close our eyes and let it continue? As I think the Canadian Medical Association, perhaps not in those very terms, but said: Let doctors make those decisions, when the door is closed, you know, between patient and family and doctor in that hospital.

Mme Bagshaw (Barbara): You're talking about the law here. As I mentioned, hard cases make bad laws. How many people are we talking about? Because of a few cases, are we going to make a law that puts the whole... the rest of society at risk? That's the problem. We can't make those kinds of... we can't make those loopholes.

M. Ouimet: Thank you.

Le Président (M. Kelley): Thank you. Mme la députée de Joliette.

Mme Hivon: Oui. Merci. Je vais vous poser mes questions en français. Merci beaucoup de votre présentation très claire, très articulée, convaincante. Nous, voyez-vous, si on vous pose des questions, je dirais, parfois difficiles ou on semble vouloir pousser, c'est que, nous, on doit se les poser, et on aime que les gens nous aident dans notre réflexion et les citoyens qui prennent le temps d'écrire, qui prennent le temps de venir devant nous, on l'apprécie énormément, et c'est pour ça qu'on veut faire un bout de chemin avec vous.

Moi, je dois vous dire qu'il y a quelques... on a tous chacun nos éléments qui nous causent plus de problèmes, plus de questionnements, qui font qu'on réfléchit à des trucs qui nous choquent plus dans tout ce qu'on entend. Moi, il y a deux choses que je voudrais vous soumettre. La première, c'est quand on dit que c'est exceptionnel. Ça se peut que ça soit relativement exceptionnel, parce que je pense que la vie est très forte et que la majorité des gens vont vouloir vivre, se battre jusqu'au bout, jusqu'au dernier souffle. Mais je ne sais pas si c'est si exceptionnel qu'il y ait des gens, en fin de vie, qui veulent arrêter de souffrir, qui veulent qu'on mette fin à leur agonie, parce que depuis qu'on a commencé les travaux, un, on a entendu plusieurs personnes qui font face à des maladies dégénératives importantes, qui ont de la douleur, qui se projettent dans l'avenir et qui aimeraient ça, qui... Peut-être que rendus là ils ne le voudront pas, mais qui se dirigent vers des situations qui leur causent énormément d'angoisse, parce qu'ils savent que la douleur, l'angoisse, l'anxiété ne pourront pas complètement être contrôlées nécessairement.

On a aussi des gens qui nous rapportent des situations très, très difficiles avec des proches qui, dans les derniers moments de leur vie, demandaient de manière répétée à mourir. Donc, oui, je pense qu'on peut peut-être dire que c'est exceptionnel, mais je dois vous dire que, si c'est si exceptionnel, les exceptions, on en entend quand même beaucoup. Ça, c'est un élément que je trouve

troublant, parce que la législation et l'action du gouvernement, c'est aussi pour l'exceptionnel, c'est aussi pour protéger des fois les minorités. La médecine est faite de tas de recherches pour des maladies exceptionnelles parce qu'on essaie justement d'y aller au cas-par-cas et de faire en sorte que chaque personne soit considérée globalement, qu'elle soit considérée avec tout ce qu'elle a, sa maladie, et tout ça. Donc, ça, c'est un élément, je pense, auquel il faut réfléchir.

Et l'autre, moi, c'est: Si on garde un peu le flou actuel, le fait qu'on s'en remet, ce qui se défend aussi très bien, à l'exercice de la médecine comme elle se fait, la relation entre le patient et le médecin, le fait qu'on se dit: Ça ne va pas si mal dans l'état actuel des choses, puis on peut avoir confiance que les médecins trouvent toujours un moyen, en fin de vie, d'essayer d'éviter le plus de souffrances possible. Moi, il y a une question d'équité qui m'accroche, là. C'est que la personne qui par exemple va avoir une agonie très difficile, puis elle va avoir une relation avec un médecin qui va se dire, un petit peu comme mon collègue disait: Dans le fond, en fin de vie, entre les portes closes, et on a des médecins qui nous ont dit ça, au bout du compte, ce qui se passe dans les portes closes, dans des situations un peu de cul-de-sac, on ne le sait pas, parce que ça relève de la relation patient-médecin.

Cette personne-là, donc, qui, en quelque sorte, a la chance d'avoir un médecin qui va l'écouter jusqu'au bout, essayer de répondre à ses besoins jusqu'au bout, versus celle qui n'a pas ça en fin de vie, qui est face à un médecin qui... pour lui, c'est comme ça et tant pis, il y aura de la souffrance s'il faut qu'il y ait de la souffrance, ou la personne qui est à la maison, seule, qui reçoit des soins à la maison, d'une infirmière, puis qui, non, n'augmente pas les doses... Quand vous parlez tantôt de les donner plus rapidement, elle, elle dit: Non, non, c'est ça qu'on m'a dit, c'est ça que je fais, versus la personne dont c'est le conjoint qui s'occupe puis qui dit: Bien, là, je vais un peu forcer la dose parce que ma femme me dit qu'elle n'en peut plus.

Comment, nous, qui essayons de réconcilier tout ça, de réconcilier l'exceptionnel qui n'est peut-être pas si exceptionnel, de réconcilier le fait que peut-être le flou est bénéfique pour certains, mais peut-être qu'il ne l'est pas pour d'autres, comment on approche ça comme membres du Parlement?

Mme Bagshaw (Barbara): First of all, it's not charitable to let a person suffer incredible pain. So the doctors will give painkillers in order to alleviate that suffering. And they have painkillers that they can use to alleviate pain, almost all pain. When a patient reaches a stage where they can't get rid of the pain, they can induce sleep. In fact, I heard a doctor... I looked on the Internet and I read some of the... what some of the doctors had said, and this is what one of them said. He said: We can take away the pain, and then, in the event that we can't, we can induce sleep. And I believe that's what should be done.

And if you're giving the painkiller in order to get rid of the pain, that's one thing. But giving a deliberate overdose to kill the patient is quite something else. And that's what we have to make sure doesn't happen. And that's why I said it's very important to understand what is euthanasia and what isn't. We can kill the pain without killing the patient, but we can't deliberately... It's in the intention. You can't deliberately kill a person. That's euthanasia. That's what we're talking about. That's what can't be legalized under any circumstance.

Le Président (M. Kelley): M. le député de Deux-Montagnes.

• (14 h 50) •

M. Charette: Merci, M. le Président. Mesdames, merci. Effectivement, un témoignage très, très, très clair, concis, précis, avec une seule question qui me vient à l'esprit: au tout début de votre témoignage, vous avez évoqué le serment d'Hippocrate. Plusieurs médecins l'ont évoqué ici, devant nous, au fil des semaines, au fil des mois, mais avec différentes interprétations. Et je vous en propose une et vous me dites ce que vous en pensez.

C'est un texte qui a longtemps guidé et qui continue à guider les médecins encore aujourd'hui, mais en même temps c'est un texte qui a été écrit il y a de cela plus de 2 000 ans, 2 500 ans ou à peu près, et qui a été rédigé en fonction des valeurs d'une époque, en fonction des principes d'une époque. Ce texte aurait été avant... ou précurseur de l'évolution de la société que les gens à l'époque ne se seraient pas reconnus à l'intérieur de ce texte-là.

Donc, une question simple... fort simple: Est-ce qu'une société peut évoluer? Est-ce qu'on peut revoir certains schèmes de pensée? Est-ce qu'on peut évoquer des changements en fonction de l'évolution d'une société? On a reçu le Barreau, il y a quelques jours, maintenant quelques semaines, sur le côté de Québec, et la question a été posée au Barreau. Donc, des gens spécialisés au niveau de l'interprétation de la loi, notamment, et la question, elle était simple: Si éventuellement le Québec devait assouplir ses règles en matière d'euthanasie, en matière de suicide assisté, est-ce que ce serait une révolution en soi ou tout simplement une évolution?

Et de façon très convaincante, sinon unanime, les gens devant nous ont dit: Pour le Québec, ce serait le fruit d'une évolution. Au fil des ans, avec la reconnaissance de l'autonomie, avec la reconnaissance du droit de refuser des traitements, il y a eu des pas qui ont été faits et, pour le Québec, ce serait tout simplement une évolution normale que d'assouplir les règles qui sont actuellement en pratique.

Donc, autant pour le serment d'Hippocrate que pour la société québécoise, est-ce qu'il est concevable que l'on puisse évoluer, est-ce qu'il est concevable que nous puissions changer notre perception, à savoir quelque chose pouvait être perçu comme mal à une certaine époque et devenir, sans dire normal, acceptable à une autre?

Mme Bagshaw (Barbara): We're dealing in a time when people won't accept truth. We have to accept that there is such a thing as absolute truth. And matters of life and death go to the very core of our being. So, yes, there is a lot of progress, but human nature hasn't changed. Humanity hasn't changed. We're all born, if we're lucky enough, in this day and age, because of technology, to get born in the first place, we're born and we die. And we're human beings. And that doesn't change. And it never will change.

And if you legalize euthanasia, you're going to get a society like they have in Holland, where people are afraid to go to the hospitals, where people have even moved away because they don't want to have to end up being euthanized, and where people have been put to death who didn't want to be put to death, and whose relatives have found out after the fact that that's what happened to their parent who was in the hospital.

So it's not progress. Yes, yes, we have to embrace progress, but only when it's really progress. But there are

some absolutes and this is one of them. This is probably the most important subject that you'll ever have to deal with. There is no other topic of more importance than this one. And I hope that you're going to really study as you are doing.

I commend you for the work that you're doing and the way in which you're conducting these hearings. And I'm grateful for you allowing me to speak although I must say I'm not a speaker. I mean, I came in fear and trembling. You know, I spent hours thinking and working on this to come up with a... But really and truly, all the hours that I've spent, all the time I've spent and all the efforts you've all spent, it boils down to a simple fact, it boils down... Don't kill. Simply. Don't kill people intentionally. If you do it, you're opening the doors. It's the thin end of the wedge, particularly when we have a population that is aging. We've got baby boomers, but hopefully some of these baby boomers will donate some of that money that they must have to palliative care and to programs that are going to help doctors better understand pain control. That's what we need. We need lots of effort and time put into palliative care, into training doctors, into training health care workers.

And above all, we need to teach our young people to have compassion. I've heard people say: Well, this relative of mine, you know, they're dying. They'll probably die next week. But I booked this trip and I'm going on it whether my spouse comes with me or not, that's beside the point. I've heard people say that. We're living in a generation where people are becoming very self-centered. And this is why I put my emphasis on teaching compassion from a very early age. It is amazing how helpful even little children can be in a family. It is amazing, the things that they can do. And the sense of self-esteem, you know, if they can help make a meal, if they're allowed to do these things. We should be putting programs into helping people have compassion. I hope that helps.

Le Président (M. Kelley): All that's left to say is thank you very much for your contribution to our reflection today. I hope we weren't that intimidating because really our goal... as I say, we've decided to go to eight different cities, this is an addition to all our responsibilities in Québec City. But we think it's very important to hear the voice from as broad a cross section of Québec population as possible. So thank you very much for your contribution. Sur ça, je vais suspendre quelques instants, and I'll ask Julie Bonneville to take place at the witness table.

(Suspension de la séance à 14 h 58)

(Reprise à 15 h 2)

Le Président (M. Kelley): Alors, la commission reprend ses travaux. Our next witness is Julie Bonneville. So, it's now your turn.

Mme Julie Bonneville

Mme Bonneville (Julie): Thank you. Good afternoon, everyone on the panel. My name is Julie Bonneville. I am a public elementary school teacher with the Riverside School Board. And put me in front of a group of students,

and I will speak and make a fool of myself, but put me in front of some adults, and I get a little bit nervous.

Le Président (M. Kelley): ...not... we're not that mean, honest, Mrs. Bonneville. We're...

Mme Bonneville (Julie): OK. We've just watched on the television the exciting story of those 33 miners that were rescued from under deep within the earth, and we're amazed at the human spirit that drives people to not give up on other people. So, I urge you... First, I want to urge you, everyone here... You are in such a good position, you've heard so much testimony from people, palliative care experts, doctors, etc., who have probably given many really good suggestions of how to improve palliative care, here in Québec, how to improve the lives of the handicapped, terminally ill and the elderly.

I urge you to compile a list of all those good suggestions that they have made and to do your best and put your heart into trying the implement all those suggestions, those positive suggestions for improving palliative care. And if you do that, you will do something so positive that you will never even dream of the impact for good that they will have. And I urge you to compile this list, but not including assisted suicide and euthanasia. I felt it was important to come and speak today. And I want to make it very clear that my view is that I think that euthanasia and assisted suicide are inhumane for a number of reasons that I want to speak about a little bit.

One, I back up my view with the Hippocratic oath, which, you know, is... How can we, you know, throw out hundreds of years of wisdom? People have lived by that wisdom for hundreds years. Things don't last that long unless they're very good, you know. He says: «I will prescribe regimens for the good of my patients according to my ability and my judgement and never do harm to anyone. I will not give a lethal drug to anyone if I am asked...»

I feel that, legalizing euthanasia and assisted suicide, we will be changing what medicine is. Is an architect's job to knock down buildings? I urge you to compile this list of good palliative care to improve what we already have.

I back up my view with my personal experience in taking care of my two elderly parents. I live with my dad and my mom. And my father has a form of Parkinson's. It's supranuclear palsy. And for the last six or seven years he's been losing very slowly his speech, his ability eat by himself, he can't walk — he can take about six steps and he stops. He takes about six steps every couple of days, because I make him — and to do his daily toilette independently.

He never complains. He's my hero. He has to ask me for every... me and my mother for, you know, every humiliating things that he needs. And he's my hero, because, whenever he's asked how he is, or how he slept, or how he's feeling, he always says, in his slurred voice, «Very well!»

And he has never asked for death, and this, because he's surrounded by love, he's surrounded by love. So that's the key. If we can surround people with love, improved care, I believe they're going to stop asking to die.

You are in such a great position, all of you here, because you've heard from experts, the best Québec has. I saw some of the people on the list, you know, this team, that team, these are experts. And, you know, I assure you, if you make a list and... the position that you have, as you can implement these things, you will be doing a great good

that we will see 100 years ago... 100 years from now, a beautiful thing that will be here 100 years, 200 years from now, the improved serenity at life of people that are aging, handicapped people, the terminally ill, improving their lives, giving them hope.

I back it up with, well, with reports of citizens that are being euthanized before being consulted, in a few countries where euthanasia and assisted suicide are legal. I don't know what the percentage is, but I think if even there's one case, it's too many.

I back it up with the... in the animal world, the kingdom... you know, the world of nature, animals. We don't see animals practicing mercy killing on each other. It just seems to go against the laws of nature. So, I urge you, I urge you to do a great good and compile a list of things that we can do to improve and make these people happier.

I back up my view... Well, I want to say that I sympathize with the pain and suffering that can seem endless for certain elderly persons or individuals with a debilitating illness. You know, I live with one.

It's a fact that the field of medicine has advanced pretty far, so that pain can be managed and controlled in most cases from day to day.

Worst-case scenario, someone is suffering and is begging you to help them to die. If I was a medical specialist, and a patient asked me to help them to die, I'd do what any good suicide prevention team would do. I would counsel them. I would realize that their wish could change from day to day. Their psychological state is certainly not the normal. I would, you know... You know, why would I treat a terminally ill person any differently, perhaps, when they're feeling suicidal, than we would treat a younger, healthier...

Get an 18-year-old who's talking about suicide, alarm bells are ringing. Let's go and help them. We've got to help them, we've got to counsel them, we have to give them more care, we have to get experts in there helping.

No. Counselling, love, affection, the same should be case for terminally ill and handicapped, otherwise it could be discrimination. Please, please, implement. Do your best to try to put into place the good suggestions that we've had about how to improve the lives of the elderly, handicapped and terminally ill, and make them feel loved.

I fear the legalization of euthanasia and assisted suicide would open the door to abuse and people taking in the law into their hands.

● (15 h 10) ●

And my dad... I'm thinking about my dad. When I told him, the other day, where I told him I was coming here on Thursday. He wanted to know... And my mother said: Oh! yes, you know, and he wanted to know more. And I told him why. And he was sad for 24 hours, and I don't know why. I don't know why he was sad, but he was sad.

I would hate that, for people like my dad, that there was an atmosphere of... if euthanasia was so easily available, they, who put very real financial and psychological pressures on their families, if they would feel that: Gee, maybe I have a duty to choose to die. I would hate for that to happen to anyone like my dad or anybody else. So, I think that the rights of some people end where other people's rights begin. So, please, instead of favoring legal euthanasia, please join me in encouraging the improvement — you have such a good opportunity to do that, you're the ones... — improvement of quality of life for the suffering, handicapped and terminally ill. And, once people are getting care and affection, they will stop asking to die.

And I just call your attention to a New Hampshire doctor. I just saw this article here, somewhere, OK? And there's this... a doctor in New Hampshire, Ira Byock, director of palliative medicine at Dartmouth-Hitchcock Medical Center in New Hampshire. He «urged physicians at the conference to focus on suicide prevention with some of their terminally ill patients. Byock recounted the examples of a couple of his patients who had expressed a desire to end their lives, but who then changed their views when provided with more comprehensive palliative care.»

So please, instead of favoring legal euthanasia and assisted suicide, join me in encouraging the improvement of the quality of life for the suffering. Yes. That's all that I wanted to say.

Le Président (M. Kelley): Thank you very much, Mrs. Bonneville. We'll pass, now, to a period of exchange with members of the committee. My colleague from Hull would like to ask the first question.

Mme Gaudreault: Merci beaucoup, M. le Président. Alors, je ne sais pas si vous avez besoin de la traduction...

Mme Bonneville (Julie): ...mais je vais répondre... ou je peux répondre en mauvais français.

Mme Gaudreault: Non, vous pouvez répondre en anglais, il n'y a pas de problème.

Mme Bonneville (Julie): OK.

Mme Gaudreault: D'abord, merci beaucoup d'avoir pris le temps de venir nous rencontrer. Vous savez, on le répète souvent, que, cette commission, justement, on veut vous donner une voix, pour pouvoir entendre le témoignage de tout le monde. Tout le monde regarde... a un regard sur la question d'après son expérience personnelle, et c'est pour ça que c'est important d'entendre la diversité des vécus.

J'ai travaillé, dans une autre vie, bénévolement dans une maison de soins palliatifs. J'y ai vu toutes sortes de belles histoires, comme celle que vous racontez, que vous vivez en ce moment avec vos parents. Pour vous, vous y trouvez... pour vous, vous y grandissez, dans cette expérience auprès de vos parents malades, et ça confirme votre position par rapport à l'euthanasie, la légalisation de l'euthanasie et du suicide assisté.

Mais il y a d'autres témoignages que nous recevons, qui nous présentent les mêmes arguments que vous mais qui militent en faveur de la légalisation du suicide assisté et de l'euthanasie. J'ai souvenir de la famille Rouleau, que nous avons rencontrée il y a quelques semaines ici, à Montréal, et c'est la conjointe d'une personne qui souffrait de sclérose en plaques et qui, en désespoir de cause devant aucune autre option, a voulu se donner la mort lui-même. Il a tenté de se suicider. Il a réussi parce que, bon, on l'a transporté à l'hôpital, mais on lui a laissé le libre choix, et il a pu vraiment terminer ses jours dans la nuit.

Mais sa conjointe nous a dit qu'elle avait beaucoup discuté avec lui de son désir de vouloir mettre un terme à ses souffrances et à sa vie. Et elle se disait complètement contre. Elle ne voulait rien entendre. Mais elle a avoué qu'avec le vécu, le quotidien, les discussions, la compassion, qu'elle avait changé d'idée et qu'aujourd'hui, vraiment,

elle était venue ici, comme vous l'avez fait, pour militer en faveur de la légalisation du suicide assisté.

Est-ce que vous, si toutefois vous pouvez imaginer que vous vous retrouviez dans la même situation, est-ce que vous pensez que vous pourriez, vous aussi, changer d'idée?

Mme Bonneville (Julie): Non, je ne peux pas. Parce que je sais ici, dans ce système solaire, la prochaine galaxie, any galaxy, you'll always see a sign that it's wrong to fill a syringe with a lethal dose and to put it into somebody to stop their life. I don't see a contradiction there. I...

Mme Gaudreault: Même si ouvrir votre cœur signifiait d'accepter que la personne que vous aimez le plus puisse mettre un terme à ses jours.

Mme Bonneville (Julie): I don't think I would be doing them a service. He would...

Mme Gaudreault: OK.

Le Président (M. Kelley): Mme la députée de Mille-Îles.

Mme Charbonneau: Merci, M. le Président. You started to... You said two things at the beginning. The first thing, I will reassure you, for most of us, when we have a teacher in front of us, we're as nervous as you are, because we're all children who had teachers.

The second thing you said really touched me, because we were here the first day this week — I always get «mardi» and «jeudi» mixed up in my English, so let's say «mardi» — we were here, and, when I got home, I was three minutes away of the first miner. I was really touched. And I think you're right to say that somewhere in the world men were trapped, and we didn't let them down. We really wanted them to survive and to get out. And the first one got out, and I think most people watching that TV were crying, because it was something to see, something to really live, and I think we're all going to remember when that thing got out of earth and we saw that miner come out. But those men wanted to live, they wanted to survive, and the people helping them, who invented that machine to get them, wanted them to live too.

We're talking about people who are asking to die. We're not talking about people who are not asking or are not... The people we saw — and you can put them in a «catégorie» that says «Exceptional» — but the people we saw were loved, had a life, just said: I want to. I did it, I bought the T-shirt, I'm happy. Now, I want to pass to something else. And, if there's something else after, I want to see it now. And they said what you said. They said: When the right of someone starts... or stop my right, my right to ask and to get relief, liberation and to get to die. And that's what we get here. We get people that say: Don't do it, because you can't do it, you can't go there. But we have people that say: We don't want everybody to die. I just want myself to die. So, what do I say to that exception?

Mme Bonneville (Julie): OK. Well, can I just restate it? Are you talking about people that are... you know, their mental state is not the norm, because of their illness, their psychological state is not the norm, and people who

could change their mind? Are we talking about asking a health professional to fill a syringe with a lethal dose and put it in someone to intentionally stop their life? I don't see a contradiction there.

Mme Charbonneau: I'm going to tell you. We saw people with all their head, their heart. They had all their intelligence, they weren't depressive, they had a proof of life and of love, and they even brought it with them, they brought relatives. And I'll go further in saying some of them even thought that there was something unfair because they couldn't unplug something. Some people can unplug or stop a treatment and then die, but the people we saw couldn't. They couldn't stop something, they couldn't unplug something, they couldn't do anything else but wait. So...

Mme Bonneville (Julie): But are you talking about... like a case where someone has an illness that's taking its natural course, and should not be prolonged with extraordinary means like a ventilator, and someone else who's in a lot of pain, is saying... asking a health professional to fill a syringe with a lethal dose and intentionally stop their life? I don't see the contradiction. I don't see it.

Mme Charbonneau: I get it. Thank you. C'est bon.

Le Président (M. Kelley): Mme la députée de Joliette.

● (15 h 20) ●

Mme Hivon: Oui. Merci beaucoup pour votre présentation, Mme Bonneville. Peut-être, pour poursuivre... C'est une question difficile, mais on vous pose les questions difficiles qu'on se fait poser et qu'on se pose. Si votre père, dans les derniers moments de sa vie, là — vous savez que la fin est imminente — vous demandait quotidiennement de mettre fin à son agonie, de mettre fin à une vie... Peut-être que ses douleurs physiques seraient bien contrôlées — on ne le sait pas. Il y a différentes personnes qui nous disent que parfois, pour certaines maladies dégénératives, c'est plus difficile. En général, il y a effectivement un bon contrôle de la douleur — mais qu'il aurait une douleur existentielle, une souffrance existentielle, une anxiété très importante et qu'il vous demandait: La plus belle chose que tu pourrais faire pour moi, ça serait d'arrêter mon agonie. Peut-être que, connaissant votre père, c'est complètement impossible. Imaginez quelqu'un d'autre de qui vous seriez proche, mais... Juste imaginer le scénario.

Et puis là, au début, vous vous dites: Bien non, c'est un désir qui est sûrement passager. On va mieux contrôler la douleur, augmenter les calmants. On va faire venir un psychologue qui va évaluer s'il y a une dépression, peut-être donner des antidépresseurs, puis tout ça. Mais, à votre grande surprise et à votre grand désarroi... Parce que je pense qu'on parlait de la famille Rouleau, tout à l'heure, dont le conjoint finalement s'est enlevé la vie. Cette personne-là, elle était très, je dirais, déstabilisée du fait que son conjoint lui disait qu'il voulait mourir, qu'il souffrait trop, qu'il n'y avait plus de sens... puis tout ça. Mais vous êtes prise pour recevoir ça. Puis c'est comme un geste de confiance, en même temps, parce que votre proche s'ouvre à vous en vous disant ça. Puis les jours passent puis la demande demeure. Qu'est-ce que vous diriez à votre père ou à un proche parent qui vous ferait cette demande-là? Après quoi...

Mme Bonneville (Julie): Pouvez-vous répéter la question juste un peu plus court, mais... Parce que je ne sais pas... je n'ai pas tout à fait suivi. Juste un peu plus court.

Mme Hivon: Avez-vous... O.K. C'est beau.

Mme Bonneville (Julie): Merci.

Mme Hivon: Admettons que votre père est dans les dernières semaines, je ne sais pas, de sa vie. Et puis à chaque jour il prend ses énergies pour vous dire: J'en ai assez. That's enough. Je voudrais que ça s'arrête maintenant. J'ai trop de douleur, d'anxiété pour ce qui s'en vient. Pour moi, cette agonie n'a plus de sens. Et vous êtes sa fille. Donc, vous dites: On va prendre ça un jour à la fois. On va revenir, avec l'équipe soignante, les médicaments. On va s'assurer qu'il n'y a pas de dépression, tout ça. Mais votre père continue, jour après jour, à prendre son énergie pour vous dire: Ce que je voudrais vraiment, là, c'est que ça s'arrête maintenant. Qu'est-ce que vous faites?

Mme Bonneville (Julie): OK. Well, I'm just going to tell that maybe my father is an exception, but he has a great philosophy, he...

Mme Hivon: ...and... je ne pense pas que votre père est une exception, pas du tout. Je fais juste vous demander des cas qui nous sont soumis.

Mme Bonneville (Julie): OK. But my father, his philosophy... he uses his pain, he uses and he offers up his pain, and it gives him some meaning. And, well, I think, at the end of his life, if he was on his death bed, it would be very nice when all his brothers and... Not all my brothers and sisters keep enough, you know, touch in... with him as they should, I think. It would be... you know... to have them all around his death bed and then, you know, some things... there're going to be some things amended... would be a very beautiful thing. And I don't think that my dad would ever, in his right... you know, in his life, in his proper mind, to ask someone, a health professional or one of us to fill a syringe with a lethal dose of something and intentionally stop his life. That's just inconceivable to me.

Mme Hivon: Merci.

Le Président (M. Kelley): M. le député de Deux-Montagnes.

M. Charette: Merci, M. le Président. Bonjour. À mon tour d'avoir le plaisir d'échanger avec vous pour une seule question: Est-ce qu'il se pourrait que votre opposition, l'opposition de certaines personnes à l'euthanasie et au suicide assisté soit reliée au poids des mots «euthanasie» et «suicide assisté»? Ce sont des mots qui sont lourds de sens en eux-mêmes. Est-ce qu'on pourrait arriver à voir des concepts plutôt que des mots, c'est-à-dire intégrer cette réalité-là dans une offre de services médicaux, voir ces concepts-là comme un recours parmi d'autres, pas un recours privilégié, mais un recours parmi d'autres, à la disposition de nos soignants, à la disposition de nos médecins?

Mme Bonneville (Julie): Well, I mean, I believe in calling a spade a spade, and, if we ask a health

professional to intentionally stop someone's life, I call that something. And I think it's wrong, I think it's inhumane. And I don't think, in the long run, it's really... I think it's a terrible thing. And I think people who are suffering, they get a certain strength that we don't, and I think many of us, we suffer a lot when we see them too.

But I urge all of you, really... I know a lot of these things are... I see people recording everything, so take the good suggestions that you have gotten to improve their lives and make them happier, and you will have done a enormous, enormous good that you will never, ever... You probably... You won't realize how far goes the impact of it because they won't, you know, they won't all get together and say: Let's throw them a party. They won't all, you know, march up here and say thank you, because they can't. But you'll know that you did a great good. Yes.

M. Charette: Finalement, je vous parlais d'une seule question. Je vais y aller d'une deuxième, suite à votre commentaire. On a un défi qui est assez colossal, celui d'entendre effectivement plusieurs personnes, des personnes avec des vécus, avec des réalités qui sont souvent très différentes, sinon avec des positions qui peuvent être contradictoires. Et c'est là tout le défi. Et aujourd'hui, l'invitation qu'on aime lancer, c'est difficile de la lancer parce que généralement, d'un témoignage à l'autre, on a des positions différentes. Souvent, au niveau de la gestion de l'agenda, on aura des gens qui sont un petit peu plus favorables à une certaine décriminalisation — j'emploie le mot — ou sinon à un certain assouplissement des pratiques, ensuite un groupe qui, lui, sera opposé. Le hasard a voulu qu'aujourd'hui les différents témoignages sont assez uniformes au niveau des orientations. Et, sans dire que c'est un dommage, parce que c'est un réel plaisir de vous entendre, mais souvent on lance l'invitation aux gens qui ont un point de vue, soit pour soit contre, de rester pour le témoignage d'après ou on leur demande s'ils ont bien entendu le témoignage qui précédait, et ça permet d'illustrer le dilemme ou sinon la complexité du travail qui nous revient.

Vous nous disiez tout à l'heure, là, qu'on avait une tâche qui était colossale. Oui, elle est colossale parce que les expériences qui nous sont partagées sont très, très diverses. Sans que ce ne soit une question, je vous demande uniquement de prendre la mesure du défi qui nous revient, parce qu'il est colossal. Les décisions qui seront prises... En fait, la commission n'a même pas de pouvoir de décision. Les recommandations, ultimement, qui seront faites au gouvernement seront le fruit d'une réflexion assez intense, mais le défi est colossal. Donc, il ne faut pas présumer, à ce moment-ci, qu'une position est arrêtée. Au contraire, les témoignages nous renversent souvent, un à la suite de l'autre, parce que chaque groupe peut avoir des arguments qui sont convaincants. Mais je trouve dommage, pour vous et pour celles et ceux qui vous ont précédée aujourd'hui, pour celles et ceux qui vous suivront aujourd'hui, qu'ils n'aient pas la possibilité d'entendre une réalité différente de celle qui est la leur. C'est un commentaire bien plus qu'une question.

Mme Bonneville (Julie): OK. Mais... I would like to thank... I'm grateful I live in a country where I can come and express my opinion at a panel like this. And I'm counting on you.

Le Président (M. Kelley): And we thank you very much for your contribution to our reflection.

We're a little bit ahead of schedule. On est un petit peu en avance de notre horaire, alors je propose une pause, 10 minutes. On va recommencer à 15 h 40. Alors, on va suspendre quelques instants.

(*Suspension de la séance à 15 h 29*)

(*Reprise à 15 h 46*)

Le Président (M. Kelley): Alors, la commission reprend ses travaux.

Avant de céder la parole à notre prochain témoin, on apprend une triste nouvelle, le décès de Vera Danyluk, qui a été longtemps maire de ville Mont-Royal, qui était également la présidente de la Communauté urbaine de Montréal. Alors, je pense, c'était une femme extraordinaire dans la vie municipale, ici, à Montréal. Et, surtout à son arrivée, moi, je me rappelle, il y avait très peu de femmes impliquées, au niveau municipal, en politique. Alors, je pense, ça a pris du courage additionnel pour une femme de s'imposer dans l'arène municipale. Alors, c'est une très triste nouvelle. On savait que Mme Danyluk était gravement malade, alors ce n'est pas une nouvelle qui surprend nécessairement, mais, je pense, c'est triste quand même. Et je veux juste exprimer à ses proches, au nom de la commission, nos condoléances, parce que Mme Danyluk a fait une grande contribution à la vie publique, politique au Québec.

Sorry about that, to start off with a... but it was just something that a journalist just spoke to me about, and it's very sad news about the passing of Vera Danyluk. So...

Our next witness is Mme Natalie Valle. So, without any further ado, it's your turn.

Mme Natalie Valle

Mme Valle (Natalie): Thank you very much. I would just like to start thanking you all. I'm aware a little bit of the hard work that it must imply for you to be listening to all of these hearings on a topic that's very difficult and that touches the heart and lives of so many people.

In June of 2008, on Father's day, my sister called to tell me that my dad had been diagnosed with stage 4 cancer. What his family doctor had thought to be an inflamed sciatic nerve had been a cancerous tumor which, because of a misdiagnosis, was allowed to develop for years such that, within the span of one month, it had radically transformed my father's life. A few weeks after his diagnosis, the anesthesiologist confirmed my mother's worst fears: the cancer was far too advanced to be treated — nothing could be done: the amount of chemotherapy that it would take to kill the cancerous cells would kill my father as well.

Thankfully, my mother is a fighter and a realist. A fighter because she decided that she would do everything she could, day by day, to help my dad survive the cancer; and a realist because she was aware of the fact that human beings, even doctors, can make mistakes. While she trusted the anesthesiologist's prognosis, she did not think it was the last word. He might, based on his medical science, conclude that my dad had no chance, but, while he was still alive, of course there was hope, and that meant there was a chance.

My father's life was turned upside down. In May of 2008, despite the pain from his supposedly inflamed sciatic nerve, my dad was working, driving, gardening, etc.

I had spent the weekend of May 16th to the 18th with him, and I saw how he was in pain, and that, because of his lower back, everything was more laborious. Aside from that, however, he was leading a normal life. But, in June, he was bedridden, unable to walk on his own, and in need of help to carry out the most basic functions, including going to the bathroom, with all the embarrassment that might suppose.

• (15 h 50) •

Last month, I was with him because we were actually celebrating my birthday, and he spontaneously, at that moment, shared with us that, at the worst moment of his illness, when he felt least in control of what was happening, he was completely unsure as to how things would develop and he wanted to die. He wanted his life to end, even if that meant ending it himself. His reason? It wasn't the pain — my dad's quite strong — and he felt that, even if the pain wasn't controlled, he had — and at times it was, you know, unbearable, he thought he could cope with it — and it wasn't even the drop in his quality of life. I guess my dad is just very gifted in adaptability, but he felt sure that he could find a way to make the best of his new situation — really, our new situation. His reason, actually, for wanting to end his life was his fear of being a burden. Despite the limitless support of my mother and the readiness of each of his four children to see him through this illness, my dad was scared of making other people suffer, and this became his greatest weight — the realization that he was becoming a burden for others.

Our culture places a very high value on independence and autonomy. And this can be very positive. Each person, of course, has a right to their opinions, to their choices, their preferences, and independence is certainly a good thing, as is autonomy. Both indicate our capacity to assimilate information, reflect upon it, make our own decisions, which, of course, develop into opinions, convictions and actions. However, it is interesting to note that independence and autonomy go hand in hand with a culture also characterized for its individualism, materialism and consumerism and, I would also add, it's misled compassion.

My father did not kill himself nor did he ask finally to be killed. What changed his mind? Well, he thought about it a little more and he thought to himself: If I kill myself, where am I leaving my wife and children? What message am I sending them? He recognized that, while he had the right to make his own decisions, to exercise his autonomy, his autonomy was not the only value at stake. It was not absolute. His choices would have direct consequences on other people, consequences that would make their suffering easier because they would be faced together, or more difficult to bear because my father could have opted out and left us to deal with our own loss.

Advocates of euthanasia and assisted suicide, from what I understand, present three main reasons for their stance: the patient's inability to cope, a drop in the quality of life, and autonomy or freedom of choice. In their eyes, all three of these reasons are indexes of dignity. The first two reasons, ability to cope and quality of life, are very personal and subjective. That's why I don't want to go into them, I think that they need to be looked at case by case. On top of that, both of those, quality of life and ability to cope, are not fixed measures. I think that they are dynamic. Your ability to cope can vary and so can your perception of quality of life. I'm just thinking of our own personal circumstances where, you know, one day we can

wake up and we feel ready to take on the world and an added bit of pressure is actually a stimulus, and, within 24 hours, we can feel the total opposite. So, we realize that ability to cope can fluctuate. Even in the case of my father, for example quality of life, you know, was... there was a drastic change, and what, for him, one month before falling ill, might have been impossible to bear, for example not being able to lift himself out of bed or turning over on his own, let alone walk around the house and, as I said, you know, he goes to the bathroom, it seems impossible to deal with. But, once that was his reality, he was able to find strength, and even tenderness that he did not know he had within himself and also in his relationships. And, in fact, I think that all of us discovered how much our relationships were worth.

So, I'd like to focus on the third reason, which is autonomy, cause I really think ultimately it comes down to autonomy. And, in addition, autonomy is more theoretical, right, and, in a sense, it's more objective and that makes it a little easier to debate it.

While my father was struggling to adapt physically, emotionally, psychologically, financially and socially to his — but also — our new circumstances, across the Atlantic, in a small town nestled in the Apennine Mountains, his mother was living her final days. At home, in her bedroom, accompanied by her husband, her son and the care of her two daughters, who washed her, nourished her, attended to her person in her home, she died. She died with pain, yes. She died in absolute dependence on her caregivers. She died in peace, surrounded by those she loved most. And, most importantly, she died with dignity. She died without apologizing for needing help, without the slightest fear of being a burden, because the thought of being one never crossed her mind nor those of her family members.

My grandmother had given her family everything she was able to give. So, it was a natural response for them in turn to tend her every need when she was no longer able to care for herself. She saw no shame in that: it was what was due to her as a person, as a wife, as a mother and as a grandmother. When I spoke with my aunts to thank them for all they had done for my grandmother, they were surprised. At this point, my father was still very ill and they... I could see they were wondering: Why is this person... why is she thanking us? Because, to their mind, they had done what they were supposed to be doing, and they were very happy to have done it. They were just thankful that my grandmother had lived a full life. And, in fact, I think that my gratitude made them even wonder... if I was taking good care of their brother, that is, my father.

Reflecting on my family's experience, it became clear to me that autonomy is a human value that most people would recognize, while its exaggerated exultation is a more recent cultural phenomenon. What was almost entirely a non-issue, a mere fact of life for my grandmother, was actually an obstacle, a source of angst, a threat to the life of my father.

What is meant by autonomy? Well, autonomy can be said to be independence, freedom of choice, being able to undertake activities without seeking permission from an illegitimate controlling body, it is making the choices you want to make. But autonomy is not the person nor is it as important as a person. You need to exist, among other things, in order to be autonomous. Autonomy is just one quality, among others, of a living human being.

It is arguable that autonomy has become the supreme value of our culture in Québec. By a way of anecdote, I was a bit surprised and, to be honest, also a little disappointed when I was speaking to a friend of mine who had just given birth to her daughter three months earlier and she was telling me how she was training her daughter to become independent. I thought, well... starting very young. Somehow, over the course of the past decades, autonomy has become directly linked to dignity, such that lost of autonomy is understood to be a lost of dignity, and this, with very serious consequences, especially for the weaker members of our society. And we are all part of the same society.

Upon what basis can we claim that needing other human beings implies a lost of dignity? Every child, from birth until adolescence, is physically, financially, emotionally and socially dependent. And, if any of you were parents, you might say: Until the age of 30. And we ask ourselves: Do they lack dignity? Does a child lack dignity because of his dependence? At all times, we, human beings, are dependent, at least emotionally, socially and psychologically. Isolated and absolutely alone, can any one of us aspire to be fulfilled and well balanced? Isn't the capacity to cultivate enduring relationships much more a sign of dignity than mere independence or individualism?

Looking at the basic facts of how we come into the world and live our lives, it is no surprise that we need others at the end of our lives as well. In Mitch Albom's best-selling and well-loved book, *Tuesdays with Morrie*, he quotes his dying professor: « "In the beginning of life, when we are infants, we need others to survive, right? And at the end of life, when you get like ne, you need others to survive, right"? His voice dropped to a whisper. "But here's the secret: in between, we need others as well." » It is much more human to need others and to be needed by others than to be absolutely autonomous. How is our culture encouraging this solidarity which is a fact of life? After all, society rests on the cultivation of the person's social dimension, and I think it was mentioned earlier the whole episode we just witnessed in Chile, and we can imagine how that experience will have strengthened the social bond so much in the whole country.

● (16 heures) ●

Granting the right to be killed or to assisted suicide on the basis of autonomy in one case makes it impossible to deny it in any other case. That is why, in Holland, where it began as a restricted palliative measure for the terminally ill, suffering, in the words of the Dutch Government, «hopeless and unbearable pain», has become policy for those suffering from pain in all stages of life, including newborns who will not die simply from withheld treatment, and so, must be euthanized. Obviously, there's not much autonomy there. Most currently, a movement is under way allowing those over the age of 70 who are simply tired of living to have access to euthanasia and assisted suicide. On that note, it should also be mentioned that the restrictions are hardly restrictive. How else do you explain the findings of the Dutch Government-initiated study, the Remmelink Commission, let by Dr. Van der Maas, at the Erasmus University in Rotterdam? Just to cite one of their findings: in 1990, there were 1,000 people whose lives a doctor had deliberately ended without a clear and explicit request from the patient. The possible exceptions to patients who had never requested euthanasia — in plain

terms, had never requested to be killed — are justified by the Dutch Government by claiming that this occurs in other countries as well.

This is hardly reassuring, and certainly not the model I would like my Government to follow, and definitely not the kind of health care I would like my father or anyone else to receive. And here you can just imagine the situation of my parents when this anesthesiologist, meaning all the good in the world, told my mother that my father had no chance. I mean, of course, someone with a lot of experience, with a lot of scientific training saying that, it has a big impact. And my mother, I mean, she could have thought, «Well, then let's just end it easily for everyone», and opted for euthanasia. And now my dad is very well, working, gardening, driving, everything else.

Clearly, then, the autonomy of a few individuals who clamor for the right to die, that is the right to be killed, should not be allowed to prevail over the autonomy of others or determine the cultural course of an entire nation. And such decisions do determine culture.

In the questionnaire put together by the Select Committee Dying with Dignity, a series of questions, Nos. 11 to 13, I believe, are asked regarding the role of law. With the consideration, I would... it seems to me, that law should simply mirror what society wants, I would argue that law shapes what society thinks, and this is what will happen with laws surrounding the end of life. I ask myself why my father, who, like his mother, had done everything for his family, felt he was becoming a burden and had no right to place this burden on his family while my grandmother would not even have been able to think in those terms. The right to die or rather the right to be killed very quickly becomes the duty to die or rather to be killed.

Leaving aside for a moment the complexity of human suffering and the compassion due to those who are suffering, the insistence on the right to choose one's death is not the right to die with dignity. Choice and dignity are not synonymous, nor are autonomy and dignity. I did not choose to be born in Canada, although I'm very happy likewise. I did not choose to be Anglophone, though I would have preferred to be Francophone. I did not choose my temperament. I did not choose my parents. I did not choose to be even born. Do these lacks of choice somehow rob me of my dignity? The only way to safeguard dignity is to identify with the subject, no matter what choices he or she makes.

More importantly, is my autonomy isolated from your autonomy? If I push the right to be euthanized, am I not obliging you to kill me? If I insist on a legal enshrinement of my choice, am I not radically changing the justice system? If I ask the very person to whom I entrust my health to terminate my life, am I not undermining the relationship of trust that health care professionals worked so hard to earn? If I demand that my autonomy trump other principles and values, am I not breaking with the Western tradition of safeguarding life? And, if the basis for helping someone end her life is her autonomy, her choice, when a friend attempts suicide, am I not left helpless before her right to choose?

Life is complex, and each person is an entire universe. Our health care professionals are being asked to be experts in medicine, in ethics and in compassion. It is a challenging situation to be in. Clear guidelines are required, precisely because extremely complex cases exist

and clashes of values occur. If there is still one principle, one fixed principle that can be agreed upon internationally so as to guide our decisions in difficult circumstances, it is the sacredness of human life. Isn't that the lesson learned by Captain Semrau and the entire world? The judge's statement is quite clear: it is not up to you to decide who should live and who should die. Are we not asking our medical staff to do just that? The point is, however, that we are agreeing that human life is disposable. And, when you put a price on human life, the price quickly goes down. We might argue that this is only the case in restricted circumstances and by choice, but that would be to fool ourselves.

The Dutch Government concedes that patients euthanized without prior consultation, that is patients killed against their will, are certainly a matter of concern. Should not their deaths be an incentive to us to protect the lives of vulnerable people rather than place them in the same danger? Each of us, in particular those with legislative power, are called to ask ourselves: Am I willing to assume responsibility for the murder of even one patient, no matter how near I think, or anyone, any doctor, nurse or family member thinks they are to death or how much I, or a doctor, or a nurse, or a family member might think she is suffering? Is not this the exact opposite of the respect for autonomy pushing us to open up legal exceptions?

Difficult and challenging cases do exist, there is no denying that. But, precisely in these complex situations, we are called to rise above a two-dimensional either-or paradigm. Respecting the dignity of the person does not mean ceding to their every request. More fundamentally, it means recognizing the person as an end and never as a means. We cannot allow a single life to be disposed of, even if at the person's request, without threatening the life of every person — I skipped some parts.

La Présidente (Mme Hivon): Merci beaucoup. Thank you. Alors, on va passer à la partie des échanges avec Mme la députée de Mille-Îles.

Mme Charbonneau: Merci, Mme la Présidente. Good afternoon. I'm trying to think of how I'm going to put the question. So, I might be slow, but it's not my habit.

You talk a lot about the right to choose. And when you say, «I didn't choose to be born and I didn't choose to be born in Canada», and you were lucky, you still have the choice to change things. That's... I'll give you the way I see it. You can choose to learn French.

Mme Valle (Natalie): ...je suis en train d'apprendre le français.

Mme Charbonneau: C'est bon. You can choose to move to another country. Now that you are a grown person, «un adulte», you can choose. And some people came to us and said, «There is something unfair in my country with my right to choose.» And I'm sure you're ready for that question, because I think that you are not alone, and you have people that talked to you, and you talked to people about this very important question. But, when a person thinks that they have the right to choose, that they are at that moment of their life where they can ask for something, that is not a demand that I do every day and I don't wake up in the morning saying to myself, «I should ask to die today because it's a bad day, it's raining.»

No, they have a certain path of life, and they did things, and they are at that moment where they think... You know, I'll put it as when they think, because we can argue on that. But they are not depressive, and they have loved ones with them. And the situation is this particular that they just don't want to wait for it. Maybe it's in a week, maybe it's in a year, but they just don't want to wait for that moment where physically they will choke to death, they will not have that serenity and that peacefulness of death that they think they would have if they choose that moment.

Now let's just be clear on one thing: I'm not talking of someone who just wake up, and they have a perfect health, and everything is doing right. I'm talking about someone who has a «diagnostic» of dying. They know they're going to die, everybody knows it. They just want to choose when, and sometimes they even want to choose how. But they just don't want to do it in a way where the family is going to have to wait for the call of the police because they jumped off the bridge. They want to do it in a way where they are going to be in a room, peacefulness, love, everything is at the rendezvous. They think they have a right. What do I say to those people?

● (16 h 10) ●

Mme Valle (Natalie): What do you say to those people? Well, I mean, when you were speaking, a couple of things came to mind, because really what's happening is that the thrust of the argument is choice, right? They think they have a right, and it's a question of choice.

So, what comes to mind is a situation that I lived two years ago. My roommate, within 24 hours, tried to commit suicide twice. It was her choice. She didn't want to go to the emergency room. I took her anyway. I just said, «We're going, we're going.» And thank God she was friend enough just to go along. But she's an adult. She's very intelligent. If she was suffering a depression, it was very slight, it wasn't clinical. What do I tell her? What do I tell her? It's your choice? Or do I try to work with her and try to help her to see that there are other options, that maybe there's something else, there's something other, some other reason that's pushing her to decide. That's one scenario that comes to mind.

The other point that comes to mind is really... I think the thrust of what I'm trying to say here is that choices are very important, autonomy is a good thing. But, when autonomy begins to trump other rights, then it's out of context and it's no longer what it's meant to be, because we have... Why do we have choices? Well, to try to make ourselves better people. If I think it's better for me to move to another country, I'll move, right, because... out of my choice.

And I was listening recently to a conference given by a psychiatrist who works at the Douglas. He works with women, girls suffering anorexia. And he was saying that there are girls that are convinced that they should be... that anorexia is a good thing, but his therapy with them is to help them to see. He tells them to ask themselves: Is this really in my best interest? Where am I going with all of this? Well, I think that theoretically... Again, this is theoretical, because, you know, each person is a world into themselves, and suffering is a very complex issue. So, theoretically, I think that that would be more of the approach to take, because, once you lose your life, you've lost your autonomy too, you know.

But, that aside, in very particular circumstances, one of my main concerns with this is: What culture are

we creating? And what abuses are we opening ourselves up to? Because I don't think... And that's why I say I think we're fooling ourselves if we say this is something that's going to be restricted to very exceptional cases where the patient, over a period of time, has asked to be killed, and we see that they're not depressive. Besides, who are we to judge that a depressive person can't kill themselves and a person who's not depressive can? I mean, that becomes discrimination, you know. So, it's like... it's starting to get very complex. But what that we see happening in Holland is that there are people who have not asked to be euthanized, and they are killed. So, I think that, as soon as that possibility comes up, we have to ask ourselves... You know, probably we all think deep down that the more natural right is the right to live, right, to continue with our life, but we don't start asking everybody: Well, do you want to be killed? You know, we assume that people want to live. So, if, to meet the appeals of a small group of people that unfortunately — I think we can all say unfortunately — want to die, innocent people, people that don't want to die are going to be killed, I think that the balance weighs in the favor of the people that want to live. That would be my answer.

La Présidente (Mme Hivon): M. le député de Marquette.

M. Ouimet: Merci, Mme la Présidente. Thank you very much for your testimony. I have a couple of questions.

In our own system, are we sure, 100% sure that, even though the right to euthanasia does not exist, that there could be some cases in the hospitals where people are euthanized without their consent?

Mme Valle (Natalie): I'm not an expert in this, but I think there are documented cases where it does happen. I would have assumed that it does happen.

M. Ouimet: And second question: If we give Mrs. Smith the right to choose her death, extreme circumstances, worst case scenario, what does it take away from you as an individual if she chooses to exercise that right?

Mme Valle (Natalie): Laws have a very important role in culture. Just think, for example, the whole thrust in trying to improve the health of people, especially young people, by discouraging smoking. What path did the Government take? Laws, right? Restrict smoking areas. And now, if you look at statistics, the drop is significant, I mean, it's working. People are smoking less, thank God.

I think the answer is there. I think that, if a law... And even, actually, looking at Holland's case. And apparently, I mean, it's not easy to get statistics on this. I got this information, it's all foot notice in the memoir that I wrote, but from a magazine, online magazine, I guess, published by the Netherlands, in Holland. And it said that, two years before legal exceptions to euthanasia were made, that's year 2000, because apparently it was semilegalized and people would not be prosecuted, in 2002, public opinion was 50-50, right? Now, more recent surveys show that, in 2009... And this was in the year 2000, the 50-50 split was in worst case scenarios, right, unfortunate scenarios, terrible scenarios, no option scenarios, apparently. In 2009, a survey was done about whether or not this new movement

that has begun, called Tired of living... Imagine that, a culture tired of living, tired of living. So, this group advocates for the right of 70-year-old and over to have access to euthanasia no worst case scenario and assisted suicide. And over 70%, I think 74% of the population thought that was great. No problem, assisted suicide.

So, you see that what I'm saying is law changes, law shapes culture. So, with that...

M. Ouimet: Would your answer be different if Mrs. Smith was pregnant and chose to terminate her pregnancy?

Mme Valle (Natalie): Oh, but that's a different issue. I don't know where you're going with that.

M. Ouimet: I'm just trying to determine if your answer would be the same in terms of choosing to end a life. Our society, through the courts initially and then through Parliament, has decided to legalize abortions, so women, nowadays, have the right to terminate their pregnancies.

So, you were drawing a parallel before in terms of: laws shape culture. So, I'm just trying to determine is your answer the same or is it different.

Mme Valle (Natalie): Well, my answer to your question about euthanasia, because I think that's the topic that we're looking at...

M. Ouimet: I'm just drawing a parallel.

Mme Valle (Natalie): I don't see the connection.

M. Ouimet: You don't see the parallel.

Mme Valle (Natalie): No. But what would you say like as a legislator, yourself?

M. Ouimet: Well, we're here to try to hear what the population has to say, right, so we'll make our own decisions ultimately, you know.

Mme Valle (Natalie): Then I don't have an answer. I don't have an answer like what... I mean I didn't live through that, I don't have an answer. What I saw more firsthand was... — and I know this is a less, perhaps, controversial topic — were the smoking laws.

M. Ouimet: That's an easy one.

Mme Valle (Natalie): Yes, thank God there are some easy ones out there. But there you could have said also «right to choose», I mean.

M. Ouimet: All right. Thank you.

La Présidente (Mme Hivon): C'est correct? O.K. Si vous avez quelque chose à ajouter... M. le député de Deux-Montagnes.

M. Charette: Merci, Mme la Présidente. Merci. Ce fut un plaisir de vous entendre. On a eu le privilège d'entendre bien d'autres groupes et individus avant vous, plusieurs médecins qui étaient opposés à toute libéralisation

des pratiques en matière d'euthanasie, sinon de suicide assisté, également un certain nombre de médecins qui étaient en faveur de cette libéralisation-là, plusieurs citoyens comme vous qui étaient contre, plusieurs qui étaient pour.

Est-ce qu'on pourrait penser à un système qui voudrait que celles et ceux qui sont pour mettre fin à leurs jours aient la possibilité d'être accompagnés par des médecins qui sont pour cette pratique-là et non pas contraindre des médecins qui sont contre de le faire, non pas de les forcer à le faire, bref laisser chacun agir selon sa propre conscience? Donc, celles et ceux qui sont contre auraient la possibilité de terminer leur vie selon leurs désirs, selon leurs croyances, selon leur système de valeurs, et, du côté médical, offrir aux médecins la possibilité de choisir aussi si leur système de valeurs leur permet ou pas de procéder à cet acte-là, qui serait perçu en bonne et due forme comme étant un acte médical comme un autre acte médical pourrait être reconnu.

● (16 h 20) ●

Mme Valle (Natalie): I hope I'll answer your question. I hope I understood your question.

But, before I do, I got caught up a little bit in your terminology, because, first of all, you speak about people, doctors who are in favor of liberalization. I don't think it's liberalization at all, precisely for the reasons that I've brought up here, that we're creating a culture of burden, like think of the people as burdens, and also we're creating a culture where we enshrine the disposal of life. You know, there's a person that's living. They are fed up, it's over for them, and we say, «OK, great, end it, you know, I'll be right here when you're ready to take that pill or whatever.» And that right in the place where we would hope to have... to find medical treatment, comfort, health, right? So, I don't see it at all as a liberalization.

In terms of values, ending our lives with our values, I mean, I think that comes back to the point of really what I'm trying to argue here, that autonomy is not absolute. I'm a human being and I have life. I can kill myself, like I could walk out of this room right now and kill myself. And I think that's actually very human, sometimes a very human sentiment to have, but one hopes that we get out of that. I think that, I mean... And really your question is... it's very vast, but I come back to my point here, and that is: when you open up a procedure by which you dispose of human life, then all human lives are in danger. And that's why, you know, there were 1,000 people, in 1990, that were killed against their will in Holland. A recent article in the *National Post* cites the same number in 2005. And they are supposed to be working on this, on keeping the measures very restrictive. Those 1,000 people, I mean, I would say that they are affected by that law. I would say that Mrs. Smith's right issues has affected them. And I would say that their right to die by their values has affected my right.

M. Charette: Oui. Merci pour votre...

Mme Valle (Natalie): But I don't know if I answered your question.

M. Charette: Merci pour votre réponse. Oui, tout à fait. Mais, en vous la posant, j'ai constaté une omission importante dans ma propre formulation. Lorsqu'il est question de médecins qui sont en faveur, il est aussi question

de balises extrêmement précises. Donc, on ne parle pas de reconnaître le droit à mourir à une personne qui est bien portante, ou qui, par exemple, pourrait être inapte, ou qui... Bref, on parle de balises reconnues. Donc, c'est mon omission. J'aurais dû le préciser dans la question que je vous formule.

Autre question, sinon. Vous avez évoqué des statistiques qu'on a entendues à plusieurs reprises, que ce soit dans les Pays-Bas. On a d'autres statistiques qui nous ont été rapportées, par exemple pour les États américains qui avaient davantage opté pour le suicide assisté. Malgré toutes ces données qui peuvent être inquiétantes a priori, on constate une chose, c'est la constance... ou, à tout le moins, ces États-là n'ont pas jugé bon retourner en arrière. Donc, certainement qu'ils prennent acte de certaines lacunes, certainement qu'ils mettent les efforts nécessaires pour améliorer les pratiques, mais aucun de ces États n'a jugé la situation à ce point critique pour retourner à l'époque où la prohibition, elle était complète.

N'est-ce pas là une autre façon ou une occasion de penser qu'avec de bonnes balises on peut s'assurer qu'il n'y a pas de dérapage?

Mme Valle (Natalie): 1,000 people, 2005, killed against their will. I think there's a problem with the restrictions.

M. Charette: J'ai entendu...

Mme Valle (Natalie): And, I mean, again, you know, I'm not an expert in law, so I don't have very many cases to go by. I just pick up popular culture. We're going back on smoking. We thought it was great before, maybe with... I don't know if it was completely transparent or not. And now we're coming back with more restrictions, finding ways, creative ways to improve people's health.

When it comes to these different States, I mean, your question is basically: How come they're not retracting? Is that your question?

M. Charette: Oui, essentiellement.

Mme Valle (Natalie): I mean, I guess you would have to ask them, I don't know why they're not retracting. But what I know is that there are people being killed against their will. And that, for me, like just one person being killed against their will is enough to say: That can't be a just society.

M. Charette: Je vous amène avec une autre perspective. Plusieurs des personnes défendant ce droit-là nous ont témoigné de leur goût de vivre, de leur joie de vivre, de leur goût de poursuivre leur vie le plus longtemps possible, mais cette revendication-là qu'ils nous adressaient était en quelque sorte cette sortie de secours pour la journée où leur corps ne répondrait plus. Et c'est vrai, vous avez évoqué dans vos exemples le suicide. C'est une réalité qu'on ne peut pas nier, encore moins au Québec. Vous avez évoqué des cas de cancer. Dans ces deux perspectives-là, il y a une possibilité d'accompagnement qui est réelle, mais, dans un certain nombre de maladies ou d'accompagnements, même les médecins l'admettent, les possibilités de soulager la douleur ne sont pas les mêmes. La possibilité de venir en aide à ces personnes-là, parce que leur handicap ou leur maladie est à ce point importante, ne sont pas les mêmes.

Donc, pour un certain nombre de ces personnes qui ont ce goût de vivre malgré les épreuves avec lesquelles ils doivent composer, ils se disent: Bien, voici, je sais que j'ai la possibilité, ce qui fait que ça me permet, moi, de mieux profiter du moment présent. Et la journée — et je la souhaite la plus lointaine possible — la journée où je ne serai plus capable, j'aurai cette avenue-là. Et ce qu'ils nous disent, ce que ces personnes-là nous disent, c'est que ça va vraisemblablement leur permettre de vivre plus longtemps.

On l'a évoqué tout à l'heure à travers la question de mes collègues, on a eu des témoignages fort troublants où des gens se sont suicidés, ont mis fin à leurs jours alors qu'ils avaient une certaine mobilité, ils avaient la possibilité physique de le faire, parce que quelques semaines, quelques mois ou sinon une année plus tard leur corps ne leur aurait pas permis cette possibilité-là. Donc, ces gens-là, à travers leurs proches, nous laissent entendre que, s'ils avaient eu la possibilité, ils auraient sans doute vécu quelques semaines, quelques mois, sinon une année ou des années de plus. Ils ne voulaient pas perdre cette possibilité d'agir sur leur propre vie, en quelque sorte.

Et petite... Vous aimez les statistiques, on peut en évoquer quelques-unes. Du côté américain, les statistiques sont assez intéressantes. Il y a une très, très faible proportion des gens qui ont obtenu le droit de mettre fin à leurs jours qui vont exercer ce droit-là. Donc, pour ces gens-là, ça constitue essentiellement ce que je vous dis, ça constitue cette porte de sortie. Donc, ils savent qu'ils ont la possibilité de le faire, mais un très faible pourcentage vont s'en prévaloir. C'est uniquement le petit geste ou la petite confirmation qui leur permet d'affronter, en quelque sorte, les épreuves et surtout profiter de la vie qu'il leur reste.

● (16 h 30) ●

Mme Valle (Natalie): Very interesting. I'm not sure exactly what your question is, like, I mean, you're presenting with me... you're presenting to me the possibility, like basically the reality that exists out there and... Sorry, I'll respond to it as best I can. But what I see is that, you know, every human being is... I mean, I'm repeating myself, but they are universe. And there's a lot of complexity, there's incredible levels of existence, of choices, of means, of desires. So, it's difficult to come and say whatever, because it's too theoretical, right? Like, I mean, I don't know how those people that have received their pill or their lethal dosage and have decided not to take it, it's sitting there on their night table.

What I find from what you're saying is that, well, we touch this complexity because we see so many contradictions, so many contradictions, right, in the sense that here we have people, and we admitted ourselves that really where this is coming down to is autonomy, right? People, if they want to, should have a right to. Right? And, on the other hand, you're pointing out to me a situation where people want to be able to die surrounded by others before that they reach a situation where they can no longer communicate, at least that's what I understood at one point you were referring to. So, we see this absolute autonomy and, on the other hand, this need to be accompanied. Very complex. And I think the only way to steer a safe route through these different challenging situations are clear guidelines. And I think once we remove the clear guideline that life is not... I mean, it's not up to me to decide when a person should end their life or not. That's... Yes. Then, I think, once we lose that, wow! then, we're in a mess of

situations, we're in a mess of situations and we begin to muddle things where it's not clear if the person is willing to die because they feel a burden, they don't feel loved, or if it's because they really, I mean, well, as someone else pointed out, they really have no signs of depression. It's not clear, there's too many layers going on. But I think, if we lose our clear guideline of life that no one has the right to take someone else's life, then we're lost. We're absolutely lost. I mean, when you think about it, we've come so far as a culture to recognize the right to life of every single person, that, if we start to backtrack, it's really scary.

M. Charette: Merci.

La Présidente (Mme Hivon): Merci beaucoup, au nom de la commission, Mme Valle... Valle ou Valle?

Mme Valle (Natalie): Valle.

La Présidente (Mme Hivon): ...Valle, Mme Valle, pour votre présentation. Merci beaucoup de votre générosité et de vos convictions et de les avoir partagées avec nous avec autant de disponibilité. Alors, merci beaucoup.

Alors, on va suspendre quelques minutes pour attendre notre prochain témoin, Mme Lepore.

(Suspension de la séance à 16 h 31)

(Reprise à 16 h 38)

Le Président (M. Kelley): Alors, la commission reprend ses travaux.

Our next witness is Maria Lepore. So, welcome, Mrs Lepore, and it's your turn.

Mme Maria G. Lepore

Mme Lepore (Maria G.): Thank you. So, I don't know how to start. I would like to say hello, and hopefully I can get my message across.

So, to start with, dear Sir and Madam, it is a fundamental right to uphold life whenever possible until it's natural course has come to its final end. By natural, I mean whenever the body expires, whether it is due to disease, old age or cessation of brain activity. If one chooses to take measures to end his or her life before it's natural course, then it is considered suicide. If a practitioner administers a drug to provoke the cessation of life, then this is, by definition, assisted suicide, either of which is contrary to the Hippocratic Oath and to the sanctity of human life.

I do not believe that one should suffer needlessly or constantly: the medical field should preserve life as it is morally obligated to do so until there is no other recourse. In the meantime, the practitioner should provide medical treatments that alleviate the suffering of the patient until they naturally expire. The medical field is sophisticated enough to aid those even in their most dire moments leading up to death. Death is a natural process by which no one can escape, but medicine has made it so that we can find cures and ways to cope with such issues.

If extraordinary means are required to preserve life but offer no benefits, then the afflicted or the proxy

can decide whether to take this offer or not. If he or she chooses not to and this brings him or her to their natural death, then this is not suicide. It is an act of free conscience to decide what treatment would be best for him or her.

● (16 h 40) ●

The medical field can rise to the occasion and offer hope for the patient in that the suffering, even in dire situations, can be alleviated, as to ease the patient's mind and body as well as those caring for the afflicted. They should concentrate more on how to help cure diseases and ease pain, both psychological and physical, rather than offering to end one's life. It seems that the burden to provide special care and attention to those afflicted by disease/disability is too much for our society when in fact it should be our concern to comfort those afflicted and their families. It is proven scientifically that we can cure patients and alleviate their pain and even allow them to die peacefully, with dignity, when great care is given.

It seems that what the Québec Government is proposing is that our society does not have any place for those who are left behind, and so, this is an easy way out, which is to end the life of the afflicted. The afflicted don't value themselves because they are not accepted or able to integrate into society. As a result, they are either neglected or rejected. We have to change our way of perceiving those who suffer.

Where euthanasia appears, quality end-of-life care disappears. Decriminalization of euthanasia and assisted suicide would create unwarranted pressure on the chronically ill, the severely disabled and those who require a lot of assistance or expensive treatments: the vulnerable could begin to think that they are an undue burden on their loved ones, on our society, and that they should consider euthanasia or assisted suicide. Euthanasia might well dangerously distort social attitudes toward the seriously ill, the disabled and the old.

In conclusion, the focus should be on the improvement of services to the afflicted and a change in societal values that are geared to accept illnesses, disabilities and old age in ways that allow the afflicted to feel that they are not alone and are valued. Measures should be taken to deal with the illness and alleviate suffering until the natural cessation of their life. The family members of those afflicted should have support both financially and emotionally. If society and the Government do not change their view on the chronically ill, the old and the disabled, then we will become like the ancient Spartans who kill their infants and the weak to relieve themselves of such burdens and create a supreme society.

Where will this all lead? Will it lead us back to the 19th and 20th century debates from the leading Darwinist in Germany, Ernst Haeckel, who believed in eugenics, infanticide, abortion, involuntary euthanasia and suicide as a measure to bring a better society? Here is a quote from Richard Weikart, a book written in 2004, *From Darwin to Hitler: Evolutionary Ethics, Eugenics, and Racism in Germany*. «Not only did Haeckel justify infanticide, abortion, and assisted suicide or voluntary euthanasia, but he also supported the involuntary killing of the mentally ill. He condemned the idea that all human life should be preserved, even when it is totally worthless. He called cretinism and microcephaly decisive proof for the physical basis of the soul, since those suffering from these conditions spend their entire life at a lower animal stage of development in their

soul's activity. He complained that not only are many mentally ill people burdens to society, but so are lepers, cancer patients, and others with incurable illnesses. "Why not just spare ourselves much pain and money, he asked, by just giving them a shot of morphine"? To safeguard against abuse, Haeckel proposed that a commission of physicians make the final decision in each case, but the individual being reviewed would have no voice. The leading Darwinist in Germany thus gave his scientific imprimatur to murdering the disabled, both in infancy and in adulthood.»

During the 1990s in the United States, the State of Oregon passed legislation allowing physician-assisted suicide, and two Federal Appeals Courts ruled that State laws banning assisted suicide are unconstitutional. In these instances, physician-assisted suicide was viewed as promoting death with dignity. The U.S. Supreme Court, however, upheld State laws against assisted suicide. The Supreme Court recognized a strong State interest in criminalizing physician-assisted suicide because the practice of legally assisted suicide may lead to episodes of nonvoluntary and even involuntary euthanasia. The Supreme Court invoked the popular slippery-slope argument that, once assisted suicide is legalized, all forms of euthanasia may follow without restraint. Several Justices cited the experience of the Netherlands, where some data suggest that euthanasia now occurs without patient consent, that is, involuntarily. The recurrent fear is that human lives, especially the lives of the vulnerable or unwanted, will be ended against their will, that patients will be pressured into requesting a death that they do not desire, and that depressed patients will choose easy death rather than receive appropriate medical care.

So, I pray to you that you understand the implications of this very serious issue and that you do extensive research from other countries who have legalized euthanasia and see the statistics there and that there are many negative implications.

So, I hope that I can give you some more information. And I don't know how much more time I have at this point?

Le Président (M. Kelley): Well, you know, you've taken about eight minutes. You have up to 15 minutes to present...

Mme Lepore (Maria G.): I have up to 15 minutes? I just want to show some studies that have been done in the University of Manitoba, Department of Psychiatry. *Desire for death in the terminally ill* is the study. The objective was to investigate the prevalence of the desire for death in terminally ill patients, the stability of this desire over time and its association with psychiatric disorders.

The method that they used was that they took 200 terminally ill in-patients and they were given semi-structured interviews that assess their desire for death and evaluated them for major and minor depressive episodes according to the Research Diagnostic Criteria. Each patient also completed a short form of the Beck Depression Inventory and provided ratings of pain and social support.

When possible, patients who express a desire for death received the follow-up interview after a two-week interval, the results: although occasional wishes that death would come soon were common — a reported 44.5% of the patients — Only 17, that is, 8.5% of these individuals acknowledged a serious and pervasive desire to die. The

desire for death was correlated with ratings of pain and low family support, but most significantly with measures of depression. The prevalence of diagnosed depressive syndromes was 58.8% among patients with a desire to die and a 7.7% among patients without such a desire.

Follow-up interviews were conducted with six patients. In four cases, the desire to die had decreased during the two-week interval. So, the conclusions that they were able to make through the study was that the desire for death in the terminally ill patients is closely associated with clinical depression, a potentially treatable condition, and can also decrease over time. Informed debate about euthanasia should recognize the importance of psychiatric considerations as well as the inherent transience of many patients' expressed desire to die.

Another study, made from the same university, which was done recently... of last year, February, reducing the potential for suffering in older adults with advanced cancer... The objective was to deliver quality care at the end of life, understanding the impact of various changes and life transitions that occur in older age is essential. This review seeks to uncover potential sources of distress in elders' physical, psychological, social and spiritual well-being to shed light on the unique challenges and needs facing this age group.

The methods they used were papers relating to older adults, age 65 years and older or a mean age of 65 years with advanced terminal cancer, receiving palliative, hospice or end-of-life care, published after 1998, were reviewed. The results: older adults with advanced cancer have unique needs related to changes in their physical, psychological, social and spiritual well-being. Changes in each of these domains offer not only the risk of causing distress, but also the potential for growth and development during the final stages of advanced cancer.

Significance of the results: that being aware of the various changes that occur with aging will help health care professionals tailor interventions to promote dignity, conserving care, and greatly reduce the potential for suffering at the end of life. And that's pretty much what I would like to say. Obvious... I think, perhaps if you have any questions for me, maybe I can shed some more light on other issues.

● (16 h 50) ●

Le Président (M. Kelley): Thank you very much, Mrs. Lepore, for your presentation. Mme la députée de Mille-Îles.

Mme Charbonneau: Merci, M. le Président. Bonjour. You called... you used a name that I never heard before, the «afflicted». So, I'm going to use it again, just to make sure. They say you retain 80% of what you say. So...

Mme Lepore (Maria G.): OK.

Mme Charbonneau: ...if I say «afflicted» enough times, I'll retain it.

What do I say to someone who's afflicted, who's asking to die? And, before you answer, let me give you... We had specialists come and see us and they told us that, in certain countries, when they opened the door to the opportunity, the afflicted person who asked for death and was accorded didn't use it. All they wanted was the opportunity, the door, the second choice, the not-suffering

choice. So, if the person or the afflicted person is well, not suffering from depression, the full state is OK, goes through the battery, the doctor, the «psychologue», «l'ergothérapeute», all the specialists and, at the end, sticks to the plan, says: I want to choose when and where, what's my answer, in the place where I live, what I want to do is respect everybody? So, I don't want people to die when that's not their choice, I don't want doctors to do it if the people are not asking for it, I don't want the family to choose for that person, but, if that person wants to, what's my answer?

Mme Lepore (Maria G.): Obviously, in that case, I mentioned many times nonvoluntary, involuntary euthanasia. This is called... what we call «active euthanasia», where the person decides for themselves. I think the reason why I brought up the study about depression and the terminally ill is because, more often than not, they see their case as being hopeless, as there's a net... evident end to their situation and they know how it's going to end. I think, if we focus more, as a society, on alleviating that pain, that suffering, offering comfort, support, offering assistance, that this will alleviate, in the person's mind, their sense of dread of what is to come.

We all know that, at some point in our lives, we have to suffer, we all know that we have challenges. What do we decide, as a people, as a society, what is... what merits death and what doesn't? How do we know that there won't be a cure in a few years? How do we know that, you know, miracles can happen, regardless of our faith or if we have one or not. There's always hope, there's always a change and a turn of events.

I have a close friend of mine who has MS, who has reached the final stages... well, almost the final stages and begun to use a wheelchair. She sought the controversial operations in Europe and it has worked for her. She saw hope. Had she still been in the state that she was, she would have probably considered euthanasia. But I do believe, and that's why I stressed in my presentation, that science, the medical science field has many ways to go and has reached heights that maybe 50 years ago we never would have thought. So, we have to keep on hoping and believing and we have to give hope to even those dying, even those with a death sentence of some illness or to disabled people.

I mean, if euthanasia was so easy as to say: Well, the person wants it... but what message does that give out to other people who are fighting their illness, who have a chance? What does that say? Their actions reflect what society is. And, if they choose to opt out, if they choose to... excuse the expression, «take the easy way out»... maybe that's what it is or it isn't, but, if they choose that, what does that say for other people who are fighting for their lives and maybe have a chance? And there have been a lot of people who have been cured from terminally... from very rare diseases, diseases which doctors have said there's probably no way out.

Two years ago, I had my sister who was very ill with a bacterial infection and which the doctor pronounced her as dying and said: She may have a chance because she's young and her body may have a chance of fighting it. What if we had given up then? What if we said: Look, we don't want to go through the fight? It was a long fight. She spent weeks in the hospital in intensive care. What if we gave up? I almost did. I thought the... Seeing her suffer was unbearable and it caused me great and serious pain.

But, if we lose hope, we lose everything. And, until we don't, as a people, as a society, and, in the medical field, realize that life is worth saving, so long as there is a chance, so long as there's hope, and even when there's an imminent end, that there's ways to deal with it that can give comfort both to the dying and to the family, that's what I believe.

Mme Charbonneau: So, if I take an example, palliative sedation, and, let's say, a friend... let's not take a family member... a friend is dying and the doctor knows, medical, can't do anything. The pain is there and the only solution is to put them to sleep until they die, and they have four to five days to go, but they're going to sleep, they're just waiting for the body to die because there's nothing to do and there's just time, do you think it would be a bad choice to not put them to sleep for five days, but to help them that day?

Mme Lepore (Maria G.): I see what you're trying to say and I understand. I am, after all, human and I feel. And I've had people close to me die, and, not too long ago, an uncle of mine died of cancer, who was terminally ill, and he died much in the same manner as you're depicting. He was going to palliative care but he didn't make it.

It's awful to see your loved ones suffering, and I think that's what causes the most stress, sometimes more for the people watching than for the patients themselves. But, at the same time, the sedation you speak of, I think it's practiced already; it's being done, obviously. But, at the same time, I don't know to what extent we have power of life and death in our hands. So, if we're going to start deciding... These are extreme situations and which, obviously, have to be carefully considered. But, once euthanasia is legalized, you do realize there's other implications. You do realize that these are not the only cases that are going to come up. And this is why I mentioned the other cases. I could only pray for those in those situations, I could only pray for their families, I could only hope that science can make their death as comfortable as possible.

Until then, we have to not just see it in that perspective, in just that one instancing case, we have to see it as a whole. And, if we can not see it as a whole, then we're missing out on very important issues.

● (17 heures) ●

Mme Charbonneau: One last thing, and you said it, and I think it's the most important thing: It's already done. Isn't it scary to think that right now nobody has to talk about it? It's secretly done and nobody... We don't know how many. We'll never know. That's a scary thought.

Mme Lepore (Maria G.): Yes, it's scary. And it comes to mind, I mean: Where is it being done? How frequently? To whom? Who are... When doctors take this kind of decision in their own hands or people are deciding it for someone else, it's very scary to think about it, and, yes, it should be talked about, and I'm glad that we're having this discussion.

I'm not necessarily saying people who choose it are bad or something like that, what I'm saying is you got to look at it as a whole and you ought to see what's already happening in our society, and legalizing it has other implications. And already, if this is happening in the dark, as we say, imagine what will happen when it comes to light.

And I have mentioned the different problems that can arise: the sense of eugenics that we're going to have, the... Who is going to be permitted to live and who is going to be permitted to die? Who has the right to choose? Will the persons themselves in the situation, the afflicted, have the right to choose? What if they cannot choose, who chooses for them and how will that choice be made? These are very, very difficult questions to answer. But, at the same time, by legalizing it, it will open the doors to many other problems, I think. And I have...

I mean, there's the situation where already, for example... I have an example here of the murder of Charles-Antoine Blais, it's called the murder of Charles-Antoine Blais. I don't know if you've heard of it. It happened here in Montréal. He was an autistic boy, and his mother killed him at the age of six by drowning him, and the mother was showered with letters of support from other parents who have autistic children. What does that say about the disabled? What does that say about the vulnerable young who don't... It is not their fault for what they have, but their parents are having a difficult time coping. Why? Does our society meet the needs to help these disabled people? I work part time as a teacher and I see the struggles of teachers and I know the struggles of parents with children who have learning disabilities. But our needs are not being met, there's always a shortage of something. I think, if society changes and starts to show a lot of compassion, aid and the right support, that these things would happen less frequently. Obviously, there's always going to be a case here and there, but the fact that it's being accepted because they're a burden, these children are a burden, so the mother's crime wasn't looked down as something bad. The fact is the child was murdered. He was disabled and he was murdered.

And what is this going to do when euthanasia is legalized? Will parents have the right to kill their disabled children because they're a burden or their old parents? I don't know. These are things you, as legislation, have to think about seriously, and I'm just hoping you weigh it out. And I think the best way to do it is to look at it on all sides and to also look at other countries that practice it and see that more and more people are afraid of going to hospitals because of the fact that euthanasia is legalized. They have fears and worries. I don't have all the statistics, I mean. I could bring papers and papers of statistics but I hope that you have, you know, the capacity to look into that and weigh it out and listen to many... I guess that's what you're doing now, which I appreciate, you're listening to us, the public, both for and against, and that's my view.

Le Président (M. Kelley): Mme la députée de Joliette.

Mme Hivon: Oui. Merci beaucoup. Ça va, si je vous pose les questions en français? Vous n'avez pas besoin... O.K.

Donc, je veux juste... Si je comprends, vous ne croyez pas du tout aux balises, à la possibilité de mettre des règles, parce que vous dites: Qui choisira? Qui déciderions-nous de faire mourir? Évidemment, les gens qui plaident pour une ouverture, pour une aide à mourir, pour eux, c'est fondamental, puisque justement toute l'assise est sur l'autonomie de la personne, que ça vienne de la personne. Donc, vous, je comprends que ça ne vous rassure pas si on dit que ça devrait venir d'une personne et que

les médecins devraient exercer le contrôle pour s'assurer du consentement libre et éclairé?

Mme Lepore (Maria G.): I could answer, as you can tell from the presentation that I gave, that I am against it for various reasons and various important reasons. As I said, a person requesting euthanasia has to be well informed, has to be diagnosed for psychiatric reasons to make sure that the person is indeed well aware of their situation. But also they have to be made aware of... that there is alternatives, that there is alternative care and compassionate care and that this can greatly change their views, and this has not been brought up, so... A person may change their mind as was done in the study that I presented in the University of Manitoba, especially among the terminally ill.

The question here doesn't lie with this one incident, this one extreme incident where a person is dying and doesn't want to suffer anymore. We're talking about... Globally, we're talking about people who will have depression and see that suicide or assisted suicide is the only way out.

I mean, what message are we sending to people? You keep bringing up the fact that... What if a person was suffering and they can't take it anymore? What about the people who are misinformed or feel left out, neglected and see that death is the only way out? What if we have a compassionate caring society that is able to provide the necessary care to change that person and allow them the dignity to live till the end of their natural life? That is my question to you.

Mme Hivon: C'est une bonne question, mais, nous, la raison pour qu'on vous pose des questions, c'est parce qu'on a des gens qui viennent exactement nous poser des questions autres que celles que vous nous posez et qui nous disent pourquoi les cas qui, peut-être, sont exceptionnels, mais de personnes qui souffrent et qui n'en peuvent plus de souffrir de leur agonie, bien qu'entourées, bien que suivies, bien qu'ayant des soins palliatifs — c'est ça, le paradoxe. En gros, qu'est-ce que ça enlèverait à tous ceux qui veulent aller jusqu'à leur dernier souffle de leur dernière agonie, entourés ou pas entourés? Alors, vous comprenez? C'est l'argument qui nous est présenté, et c'est pour ça...

Je ne vous repose pas la question, je pense que votre point de vue est très clair. Mais, nous, c'est ce qui nous est aussi demandé. Alors, nous, il faut juste se poser toutes les questions, et c'est pour ça qu'avec vous on essaie de cheminer et de les poser aussi. Ce n'est pas parce qu'on veut être redondants, ou qu'on ne comprend pas, ou que ça ne s'est pas rendu jusqu'à nous; c'est vraiment parce qu'on veut en même temps avoir un dialogue avec les gens qui viennent ici, qui nous présentent des positions très étouffées, très intéressantes, la vôtre en est une, d'autres en sont aussi. Et on vous considère assez pour vouloir aller jusqu'au bout du raisonnement avec vous. Peut-être... Oui, je ne sais pas si vous voulez ajouter...

Mme Lepore (Maria G.): Oui, est-ce que c'est... Is it possible that I can add something else to this? Another... probably a few excerpts from a debate done in... that was brought up in London, is it possible?

● (17 h 10) ●

Une voix: ...

Mme Lepore (Maria G.): OK. The debate was whether mercy killing of disabled babies should be allowed. The call for legalizing this type of, if you want, killing, I think, is part of what we're talking about. If euthanasia is legalized, I'm saying: What would that bring? It's going to allow people to do certain acts of mercy killing or of assisted suicide and have no reprimand, no recourse for reprimand. How do we deal with this?

Already these situations are happening, as in the case that I mentioned before, with the autistic child. There is no recourse, there is no justice for the child. Yet people can understand and — how do you say — feel sorry for the parent because of her situation. Well, compassion or feeling sorry for someone and justice don't always go hand in hand. And my question... Not my question, but my answer is that legalizing euthanasia will ultimately bring about other debates and other issues that I don't think our society is... not ready, but I don't think it's moral, if you ask me.

Be then a question of moral, what is moral? What are morals? I mean, it's all dependent on the person. And, as a society, I think we're losing touch with the fact that, you know, choosing who lives and dies, whether it be our own choice or whether it be we make it for someone else is very, very tricky. And, just think, as this one, mercy killings of disabled children, doctors say: «The study comes against the background of growing acceptance of the ideas of euthanasia, suicide and hastening death for the mortally sick adults and the dying elderly.» These doctors say that euthanasia and babies... «If assisted dying legislation is to be anticipated or enacted at the other end of life, now would be the pertinent time to discuss this.» So, if we can enact legislation to assist the dying and the elderly, what's going to prevent us or prevent them from assisting parents in killing or letting their babies die, because they're disabled, or severely disabled, or mentally sick, or sick? I mean, you're, as they say, opening Pandora's box. You know, if it's already happening, how is legalizing it going to make it more controlled or better? I just don't see it.

Le Président (M. Kelley): Thank you very much, Mrs. Lepore, for your contribution to our reflection this afternoon. I will... Je vais suspendre quelques instants et je vais demander à notre prochain témoin, Christine Leduc, de prendre place à la table.

(Suspension de la séance à 17 h 13)

(Reprise à 17 h 15)

Le Président (M. Kelley): La commission reprend ses travaux. Juste avant de commencer, nous avons reçu deux demandes d'intervention au micro ouvert après, alors il y a deux courtes interventions après le témoignage de Mme Leduc, mais sans plus tarder, Mme Leduc, la parole est à vous.

Mme Christine Leduc

Mme Leduc (Christine): Oui, bonsoir, messieurs dames. La première observation qui s'est imposée à moi en faisant les études sur la mort et en me rendant conjointement auprès des personnes en fin de vie fut la grande solitude

dans laquelle, bien souvent, ces personnes se trouvaient. Isolé dans une chambre et, par surcroît, doublement isolé dans une unité de soins palliatifs, le mourant est à l'abri, semble-t-il, mais bien plus encore est à l'abri toute une société qui, sans trop s'en rendre compte, afin de se protéger d'une mort qui pourrait illusoirement s'attraper, désapprend peu à peu ce que des suites de générations ont transmis. Par exemple, l'écoute des dernières paroles, servant de transition entre le vivant et le défunt, une mémoire vivante, un fil invisible venait tisser un lien qui créait solidarité.

D'un événement concernant tout le monde, cette période de vie s'est rabattue dans des espaces de plus en plus clos, provoquant à la longue chez les proches et les groupes sociaux une sorte de sentiment d'incompétence, d'indifférence face au mourir. Maintenant, le mourant, trop souvent, et bien avant qu'il le soit, juste après l'annonce de son diagnostic, se retrouve du jour au lendemain propulsé dans un no man's land. Il n'est pas surprenant qu'on finisse par vouloir escamoter cette étape de vie, pourtant incroyablement porteuse d'énergie, et souhaiter en finir au plus vite, même si la lumière d'automne n'a jamais été si belle.

Nous ne pouvons certes pas reculer dans le temps et plaquer sur notre culture ce qu'une autre a construit pour se définir, se circonscrire, se rassurer, ce qui d'ailleurs devait parfaitement bien lui convenir, mais nous pouvons, à partir de ce que nous sommes, arrêter la course vertigineuse vers la pure et froide efficacité technologique et nous questionner sur ce qui nous conviendrait actuellement lorsque nous devons infailliblement faire face à cette dernière étape de vie.

Selon Michel de M'Uzan, dans *Le travail du trépas*, il pourrait se condenser dans l'appareil psychique, au moment du trépas, une quantité d'énergie libidinale impressionnante permettant à un individu de compléter l'histoire de sa vie. Le caractère subitement précieux du temps ferait en sorte que des désirs, des envies, des pulsions inassouvies, les contraintes de la vie l'ayant obligé à les mettre bien souvent de côté, reviendraient avec force et insistance et chercheraient à tout prix à s'actualiser. Néanmoins, une condition s'impose pour que se réalise cet événement toujours étonnant: être en relation, faire dyade avec quelqu'un.

Je cite de M'Uzan: «Profondément, le mourant attend qu'on ne se soustraine pas à cette relation, à cet engagement réciproque qu'il propose presque secrètement, parfois à son insu, et dont va dépendre le déroulement du travail du trépas. En fait, il s'engage, en vertu de ce que j'imagine comme une sorte de savoir de l'espèce, dans une ultime expérience relationnelle. Alors que les liens qui l'attachent aux autres sont sur le point de se défaire, il est paradoxalement soulevé par un mouvement puissant, à certains égards passionnels. Par là, il surinvestit ses objets d'amour, car ceux-ci sont indispensables à son dernier effort pour assimiler tout ce qui n'a pu l'être jusque-là dans sa vie pulsionnelle, comme s'il tentait de se mettre complètement au monde avant de disparaître.»

Interloqué face à lui-même, libéré des défenses que son Moi lui imposait afin de transiger avec la réalité, le grand malade se verra peut-être capable de faire des choix dont il sera le premier surpris, afin de donner un ultime sens à sa vie.

En effet, il peut se jouer, en fin de vie, un concentré d'énergie, source directe du dur désir de durer. Par exemple, Esther Valiquette, cinéaste québécoise, s'est retrouvée atteinte du sida. Munie de cette nouvelle identité qu'elle

n'avait pas cherchée, elle a quitté sa ville et est allée la confronter avec la civilisation minoenne qui s'était vue, elle aussi, dévastée, anéantie. L'énergie lui a été donnée, une force d'urgence qu'elle a fait sienne, et malgré les affres de la maladie, elle a su transcender son état et accomplir un grand oeuvre: *Le singe bleu*.

● (17 h 20) ●

Cependant, il n'est pas nécessaire que la réalisation soit grandiose; le seul fait de s'investir intensément en donnant, en recevant, que ce soit dans une relation à consonance amoureuse ou dans la réalisation de vieux désirs, suffit. C'est que cette énergie spécifique, à ce temps pri-mordial de l'existence, n'est alors pas escamotée et que, bien au-delà de ce que l'on peut estimer, elle donne l'énergie nécessaire pour vivre ce qui vient.

Malheureusement, on incite le mourant à amorcer trop rapidement et trop précocement le deuil de sa vie quand, en réalité, il n'est pas encore près de baisser les bras. Au fil des jours, de guerre lasse, il finira, parfois, peut-être, par réclamer l'euthanasie, bien avant qu'il ne soit temps.

Pourtant, je cite encore de M'Uzan: «La nécessité d'abréger les souffrances d'un individu pour préserver la dignité de sa fin, qui ne la reconnaîtrait? Seulement, on ne peut pas ignorer qu'elle entraîne indirectement à neutraliser [un] travail psychique que le moribond peut accomplir naturellement.»

En réalité, en réclamant l'euthanasie, qui lui est souvent, implicitement suggérée, le grand malade crie sa solitude, espère qu'un regard se pose sur lui et confirme que ce corps ravagé par la maladie, qu'est le sien, puisse se situer bien au-delà de ses souffrances, et que les quelques pas qui lui restent à faire, même s'ils sont pénibles, valent encore la peine. Bref, le moment de la mort est plein de vie et l'escamoter priverait un être humain d'expérimenter cette dernière histoire qui lui est unique.

A l'intérieur de mes études de maîtrise, je suis allée recueillir le récit de vie de deux personnes dont le pronostic était limité à quelques mois de vie. Le terrain effectué avec mes deux co-chercheurs confirme que, même en étant très malades et sans espoir de guérison, ils désirent être en relation et en lien avec les gens de leur entourage; ils cherchent et continuent intensément de s'actualiser dans leur vie.

Laurent, alors âgé de 83 ans, insistera pour vivre seul dans sa maison. Puis, son médecin le mettra en lien avec une bénévole. Celle-ci commencera à lui rendre visite sur une base hebdomadaire. Ces visites, au début anodines, deviendront importantes et significatives pour Laurent. Au fil des jours et des rencontres, cette personne deviendra une amie précieuse. Il tombera amoureux, mais il comprendra que cet amour est d'un autre ordre. Mine de rien, en une courte phrase, il indiquera comment se sublime cet amour: «Ça ne paraît pas, mais elle me donne beaucoup d'amour.» Un amour qui se joue dans le rêve, dans les regards, dans la subtilité de la voix, dans les échanges, dans les silences. Un amour incroyablement porteur de vie qui ouvrira sur le dernier passage.

Marie Uguay, grande poète québécoise, alors atteinte d'un cancer, révélera dans son journal tout l'amour qu'elle porte à un médecin soignant. Dans la même veine que Laurent, Uguay écrira: «Même si je ne puis le toucher, malgré la sclérose de nos rôles sociaux, l'éloignement de nos positions, l'impossibilité de mes sentiments, je garde

mon plaisir plus subtilement de l'aimer sans attache véritable dans la pure gratuité de ce printemps. [...] Je suis unie à lui par des liens étranges qui n'ont rien à voir avec les stéréotypes de l'amour même s'ils les empruntent. Je suis liée à lui par des forces ténues et sauvages.»

Cette dyade, autant pour Laurent que pour Marie Uguay, leur permet de vivre le moment du trépas avec intensité. Cette montée libidinale donnera à Marie Uguay le désir d'écrire malgré la maladie. Je la cite: «Vaut mieux achever par les mots ce qui ne s'accomplira peut-être autrement, exorciser cette féroce soif.» Quant à Laurent, il y trouvera l'énergie de traverser ce temps avec plus de sérénité, de simplement le traverser.

Pour Mamie, ma deuxième co-chercheur, l'annonce de sa maladie et l'éventualité d'une mort prochaine lui feront réviser sérieusement sa vie. Elle prendra conscience du mal infligé à ses enfants. Elle demandera pardon à chacun d'eux. Elle réparera au mieux le mal causé, puis elle trouvera d'autres modes de contact qui s'établiront davantage à partir des rapports tactiles. L'expression des sentiments prendra de nouvelles voies: prendre ses enfants par le cou, se serrer dans les bras, jaser, pleurer avec sa fille. Les corps veulent se rapprocher, reprendre en quelque sorte le temps perdu; les corps voudront ressentir à travers la sensualité le simple fait d'être vivant.

Elle continuera à vaquer à ses occupations malgré d'énormes difficultés à juste faire un pas. Tout ce qu'elle fait, elle doit le faire assise dans sa chaise roulante. Tout est beaucoup plus lent et demande une patience et un effort considérables, comme étendre son linge sur la corde. «Je trouve ça dur d'aller étendre mon linge; j'ouvre la porte, là, je prends ma canne, je me lève, je mets mon linge sur la petite table, je referme la porte et je commence à étendre mon linge. Si j'attends après quelqu'un, je vais attendre longtemps, fait que... Imaginez!» Je l'ai imaginée continuer à faire sa besogne, s'intégrer à la vie en des gestes quotidiens où elle garde contact avec les objets, même si cela est très exigeant. La sécheuse à linge est là, à portée de main, mais étendre son linge sur la corde, au grand vent, au grand soleil, lui procure encore plus de plaisir, et cela vaut l'effort. «Ça sent-u assez bon!» La perspective de sa mort lui fait apprécier d'autant plus la vie, et c'est une façon pour elle de tenir la première à distance.

Nos ancêtres savaient beaucoup mieux que nous prendre soin de ces passages de la vie pour se rassurer et se préserver; ils le faisaient instinctivement. Ils étaient réceptifs et attentifs aux signaux du corps et des sens, par lesquels ils entraient en relation avec la nature et le cosmos.

La première image que ce mémoire dévoile, la trop grande solitude des mourants, reflète ni plus ni moins où nous en sommes rendus dans notre façon de nous traiter. Cette dernière mise en scène, aseptisée, souvent planifiée, indique à quel point nous avons perdu, en tant que société, les gestes, les paroles, les symboles, les ritournelles qui savaient réconforter le mourant et nous rassuraient tout autant par le simple fait de maintenir un sentiment d'appartenance et de préserver une cohésion de groupe.

On a l'impression que les rituels, à la fois simples et riches, sont remplacés par toute une série d'interventions médicales. On pourrait parfois imaginer que le médecin sert d'officier, d'ailleurs souvent absent, et délègue aux infirmiers et techniciens les marches à suivre. Nous demeurons abasourdis autour de notre proche, ne sachant plus trop

si on peut s'approcher, si on peut le toucher, sans parler de tous les fils de raccordement, des bips obsédants et menaçants qui nous font chercher une porte de sortie, mieux, une sortie de secours, afin de calmer notre propre angoisse. Car nous sommes finalement bien souvent laissés à nous-mêmes pendant ces moments mystérieux qui passent inaperçus et qui pourtant n'auraient pas besoin d'un grand cérémonial pour prendre sens.

Mais revenons à cette deuxième image où le mourant, à l'annonce de son pronostic, se voit propulsé dans un no man's land. Nous pouvons continuer de réfléchir sur le pour ou le contre de l'euthanasie, mais pourrions-nous préalablement réfléchir sur comment nous interagissons avec un grand malade? Pourquoi se sent-il souvent à l'écart, inutile? Pourquoi, sans trop nous en rendre compte, l'incitons-nous à faire trop rapidement le deuil de son existence? Pourquoi son identité, soudainement, se résume à sa carte d'assurance maladie et à ses cartes d'hôpital? Nous pourrions transformer ce no man's land en un «human's land» en allant à sa rencontre dans cet espace, en l'habitant par des actions menées en commun, par du temps consacré à la rencontre et aux échanges avec lui. Ralentir le pas, écouter ce que le malade a à dire, saisir ce qui devient important pour lui et faire en sorte que nous puissions participer un peu à la réalisation de ses désirs. Il verrait dans le regard de l'autre comment est important ce qu'il vit, comment il peut s'y attarder sans crainte de déranger.

Walter Benjamin avait saisi l'importance du partage entre le mourant et les siens. Écoutons-le: «C'est surtout chez le mourant que prend forme communicable non seulement le savoir ou la sagesse d'un homme, mais au premier chef la vie qu'il a vécue, c'est-à-dire la manière dont sont faites les histoires..»

● (17 h 30) ●

Le Président (M. Kelley): Merci beaucoup, Mme Leduc, et merci beaucoup d'entrée de jeu pour la qualité de votre mémoire, c'est très bien écrit, c'est de la poésie. Alors, je veux juste vous féliciter, c'est de toute évidence beaucoup de réflexion, beaucoup de travail que vous avez fait dans la préparation du mémoire. Alors, je pense... Au nom de l'ensemble des membres de la commission, merci beaucoup pour le travail accompli.

Et juste dans le troisième paragraphe avant la fin, vous nous interpellez, et je veux juste rappeler le mandat de la commission: «Pourrons-nous préalablement réfléchir sur comment nous interagissons avec un grand malade?», c'est un petit peu ça qu'on voulait faire comme commission. On ne peut pas contrôler les sujets que les témoins veulent amener devant nous dans une journée donnée, mais c'est l'ensemble de ces facteurs qu'on veut, soit les soins palliatifs, soit la question des traitements. Parce qu'on a eu même des médecins qui sont venus pour dire que parfois, peut-être il y a trop de traitements et peut-être il y a d'autres manières de faire la gestion de fin de vie. Et, quand un des médecins bien connu à Montréal, le Dr Vinay, même a parlé des traitements inutiles, comme membres de la commission, je pense, c'est toutes les choses qui nous ont intrigués. Parce qu'effectivement notre notion de dignité, c'est ça qu'on cherche, et il n'y a pas juste un modèle ou une vision, c'est quoi, une mort digne; c'est ça qu'on cherche. Alors, merci beaucoup pour le rappel ici, parce que qu'est-ce qu'on cherchait, ce n'est pas uniquement de faire... On pouvait faire une commission sur la question de l'euthanasie et avoir juste une question à poser à nos témoins, mais

notre objectif au départ était d'élargir le débat sur l'ensemble de ces questions. Alors, merci beaucoup pour le rappel.
Mme la députée de Hull.

Mme Gaudreault: Merci beaucoup, Mme Leduc. Il est très touchant, votre mémoire. On croirait que vous avez été morte à plusieurs reprises. Vous avez suscité, tellement vous avez su bien, à mon avis, bien cerner comment une personne en fin de vie peut se sentir à différentes périodes de sa fin de vie... parce qu'on évolue, comme vous l'avez bien mentionné, à la fin de sa vie.

Vous avez parlé des soins palliatifs, de l'isolement qu'une personne peut ressentir dans une maison de soins palliatifs, et vous avez parlé aussi de comment une personne peut être un peu troublée par toutes les machines qui l'entourent dans un département de soins intensifs aussi, dans un hôpital, qui est aussi à la fin de sa vie.

Il y a des gens qui sont venus nous voir pour réclamer l'offre des soins palliatifs vraiment à toute la population, il y a d'autres qui ont souhaité surtout aussi les soins à domicile, et je voudrais savoir, vous, votre position à vous, Mme Leduc, avec toutes les recherches, les études que vous avez faites, dans un monde idéal, en 2010, ce serait quoi... idéalement, comment on pourrait souhaiter la fin de la vie à tout le monde, là?

Mme Leduc (Christine): Bien, je pense qu'il y a des... tout le monde idéalise maintenant l'idée de mourir chez soi puisque c'est ce qui était avant. On commence à réfléchir que c'est possible. Moi, je ne suis pas contre les soins palliatifs. Tout ce que je voyais, c'est qu'il y avait... il semblait y avoir, de plus en plus, une très grande distance entre la vie et la mort, et qu'en plus c'était un lieu privilégié qui se limite à... on ne peut pas dire à une très grande population, même juste dans tout l'hôpital, c'est un privilège presque d'être là. Mais je verrais, oui, que les patients soient de plus en plus chez eux, mais qu'il y ait une communauté autre que juste la famille, mais une communauté de quartier, une communauté de village qui soit là à faire des relais selon leurs forces, selon leurs capacités d'être là, de façon de plus en plus simple et naturelle, face à cette personne-là. On les considère souvent... on les prend un peu en pitié, on n'a pas une attitude où on parle également avec eux.

C'est juste le corps... Bien, évidemment que ça peut affecter un peu l'esprit, mais c'est le corps qui se dégrade. Mais il y a beaucoup de gens qui ont fait toute une recherche intérieure en même temps qui n'est pas vue. Mais, comme on est habitués de performer, rendu à ces moments-là, l'image qu'on a de soi ou qu'on a toujours eue ne correspond plus, et ça fait un décalage épouvantable pour certaines personnes qui ont des tendances un peu plus narcissiques que d'autres peut-être mais qui ne peuvent pas bien gérer avec cette situation-là.

Parce que tout le côté spirituel, je ne parle pas d'une religion, mais c'est des étapes où les gens peuvent vraiment réfléchir à un niveau plus élevé dans ces temps-là. Et les personnes, justement, comme ce que Walter Benjamin dit à la fin, il faut vraiment les écouter, c'est une richesse. Leur vie, si humble a-t-elle été, c'est très précieux pour nous, êtres humains, d'être là à leur écoute. Mais, pour compléter votre question, je verrais de plus en plus que la mort se rapproche, oui, de la vie.

Mme Gaudreault: Autre petite question.

Le Président (M. Kelley): Mme la députée de Hull.

Mme Gaudreault: Autre petite question. Il y a plusieurs médecins qui sont venus nous voir et puis il était évident que ce n'est pas tous les médecins qui sont bien outillés pour accompagner des personnes en fin de vie. Alors, vous comprendrez que ce n'est certainement pas tous les citoyens qui sont aussi habilités pour passer un peu de temps par semaine auprès des personnes en fin de vie. Comment vous voyez ça, si vous souhaitez qu'il y ait une plus grande prise de conscience de la société, des communautés?

Mme Leduc (Christine): C'est drôle, mais, moi, j'ai l'impression que ma grand-mère, qui n'avait pas tellement d'études, a très bien su accompagner son... son vieux, son mari, et qu'il y a un bon sens, un sens commun qui est là et il faut lui faire confiance. D'autre part, il peut y avoir, comme justement dans les hôpitaux ou dans les... où les gens vont se faire traiter, des personnes qui pourraient former davantage. Et même les médecins, les médecins sont très, très mal équipés, je pense, dans leurs études de médecine. Alors, tout ça devrait, actuellement, énormément... on devrait dépenser beaucoup d'argent à ces niveaux-là pour que la qualité, ensuite, s'améliore et que l'euthanasie... En fait, on le sait que ça se vit, mais je ne vois pas que ce soit... je ne vois pas qu'une loi puisse changer énormément les choses. De toute façon, c'est quelque chose d'intime, de personnel qui peut se jouer avec le médecin. Mais le médecin, dans le fond, est souvent très, très seul, je trouve. Et, s'il y avait vraiment équipe avec lui, qu'il n'aurait pas sur les épaules toutes ces décisions-là à prendre, qu'il y aurait une réflexion sur la personne, aussi, et que cette personne-là ait le premier droit de parole, on aurait beaucoup moins de demandes d'euthanasie.

Mme Gaudreault: Merci.

Le Président (M. Kelley): M. le député de Laurier-Dorion.

M. Sklavounos: Bonsoir, Mme Leduc. Merci beaucoup pour votre présentation, c'était fascinant, et ça a provoqué beaucoup de réflexion. J'aimerais vous poser une question. Certaines personnes ont suggéré que nous avons ce travail préalable à faire pour assurer cette prise en charge des personnes qui sont mourantes avant d'explorer la possibilité d'aller sur le chemin de l'euthanasie et le suicide assisté.

Est-ce que vous êtes de cet avis-là qu'il faut que ce travail préalable se fasse, ce retour en arrière, si vous voulez, à ces fondements, à cette participation, comme vous dites, communautaire, à cette personnalisation, si vous voulez, de la mort, des derniers moments de... Est-ce que c'est quelque chose qui doit se faire au préalable? Est-ce que vous trouvez la question d'explorer le chemin de l'euthanasie et le suicide assisté comme étant prématurée en ce moment vu que ce travail-là n'est pas fait?

Mme Leduc (Christine): Oui. Oui, puis d'autant plus qu'on le sait qu'il se pratique une euthanasie. C'est à deux temps: on donne une médication pour que les gens ne souffrent pas, mais on sait bien qu'en deuxième temps il

va y avoir la mort. Mais je trouve que c'est vraiment de travailler dans la communauté, dans les gens qui s'occupent de ces personnes-là. C'est vrai qu'on leur demande d'être en deuil trop vite, à faire le deuil: Ah! c'est... Tu sais, de regretter que ce n'est plus comme avant de... vraiment d'être en deuil, alors qu'il y a vraiment un... Je l'ai vu, moi, en tout cas, sur deux personnes et d'autres, quand j'étais à accompagner les mourants: il y a une énergie. Elle n'est pas longue, l'énergie, mais elle est intense, et on ne peut pas négliger ça. On peut... En réalité, je trouve que ce serait de tout repenser à partir du moment où une personne a un diagnostic de fin de vie, même au début, sans que ce soit une fin de vie des traitements, là, comment on doit interagir avec eux, comment on doit être en relation avec eux, et qu'ils aient une place à part égale.

● (17 h 40) ●

M. Sklavounos: Cependant, vous pouvez aussi, j'imagine, imaginer des situations où quelqu'un qui a profité de ces moments, qui a fait ce cheminement puisse quand même arriver à une conclusion que, pour cette personne-là, le temps de partir sera un petit peu avant le temps naturel, si vous voulez.

Est-ce que les deux peuvent coexister? Qu'une personne décide de dire: Oui, je vais profiter de ces moments, ou: Oui, je comprends, je n'ai jamais vu la vie comme je la vois maintenant que je sais que je vais partir?

C'est drôle, parce que je suis en train de lire.... Vous m'avez fait penser à quelque chose, et je suis en train de lire Dostoïevski, et un des personnages de Dostoïevski disait que les plus grands moments de lucidité qu'il vivait, c'était d'avant de faire... juste avant de faire une crise épileptique où il perdait complètement connaissance et ne savait pas où il était. Il décrivait ces derniers moments juste avant comme étant les moments où il avait la lucidité la plus énorme, la plus développée. Il voyait tout, sentait tout autour de lui et...

Mais pouvez-vous imaginer que quelqu'un puisse faire ce travail, puisse faire ce cheminement, puisse profiter de ces moments et par la suite décider: Oui, je l'ai fait, tout ça, c'est le temps de partir ici, qui serait un petit peu avant le... ce que, naturellement, si vous voulez, serait la fin de sa vie?

Mme Leduc (Christine): Bien, c'est vrai que ça se fait en deux temps. La personne avec un diagnostic de fin de vie a encore plein de choses à vivre, et c'est là qu'il faut faire très attention. Mais, à un moment donné, veux veux pas, la personne a moins d'énergie; à la fin, elle est... C'est comme deux étapes, et, dans cette deuxième étape-là, je vois beaucoup plus de silence: qu'on entoure ces gens-là, qu'on les touche énormément. On ne les touche pas, ou même, que ce soit des couvertures chaudes, qu'on chante, tous les sens pourraient être... Mais c'est un temps... Puis on sait très bien qu'on ne peut pas supporter qu'il souffre au-delà de ses capacités. Oui, effectivement, il faut diminuer les douleurs, mais il faut être là aussi, mais de façon très différente.

M. Sklavounos: Alors, si je... Est-ce qu'il reste du temps, M. le Président?

Le Président (M. Kelley): Oui, une dernière question.

M. Sklavounos: O.K. Alors, si je comprends bien ce que vous voulez vraiment nous dire, qu'il ne faudrait

pas bousculer la personne dans le temps, qu'il faut laisser le temps, laisser ces occasions-là vivre pleinement. Et vous êtes d'accord qu'à un moment donné on fait notre passage ou on arrive à ce qui est le passage, au point de passage, il faut être là, mais ce qu'il ne faut surtout pas faire, c'est comme, je ne sais pas... c'est le dépliant qui arrive des fois chez certaines personnes, dans certains États, disant: Écoutez, l'euthanasie est gratuite; si vous voulez, vous avez juste à appeler ce numéro. Il ne faut pas bousculer la personne.

Mme Leduc (Christine): Non. Et puis peut-être que, si c'est à portée de main, ça deviendra un choix trop facile pour tout le monde. Et, moi, je ne voudrais pas être à la place du corps médical, les pressions qu'il va recevoir. Je pense, ça devrait devenir un travail d'équipe constant, ne pas laisser ni les malades ni ceux qui les soignent dans la solitude, dans le peu... le pas de possibilité de s'exprimer, de partager les peurs, de partager tout ce qui en est. Non, effectivement, il y a... C'est un très beau temps aussi, l'agonie, la fin.

M. Sklavounos: Merci, madame.

Le Président (M. Kelley): M. le député de Deux-Montagnes.

M. Charette: Merci, M. le Président. Merci, Mme Leduc, très éclairant. J'ai aussi noté le ton poétique souligné par notre président, avec un timbre de voix qui allait aussi dans le même sens. Une simple question...

Mme Leduc (Christine): Je n'ai pas l'habitude de faire des prestations publiques.

M. Charette: Bien, vous avez très, très bien fait, honnêtement. Question très, très générale. On l'a dit et redit, on a reçu des dizaines de spécialistes de toutes sortes, autant au niveau de la médecine que de l'éthique, psychologie, travailleurs sociaux, infirmiers, infirmières, bref, un horizon assez intéressant, mais aussi un certain nombre de citoyens qui ne se prétendent pas experts ou expertes — vous l'incarnez fort bien. Mais ma question en est plus une de curiosité.

Qu'est-ce qui peut amener un citoyen... C'était notre souhait, hein, au départ, il faut le répéter, mais qu'est-ce qui peut amener un citoyen comme vous l'êtes à s'immiscer dans cette démarche-là, à vouloir y participer? Est-ce que, dans votre cas, cette idée ou la conception que vous nous avez présentée, est-ce qu'elle a toujours été la vôtre ou c'est à travers l'exercice de préparation pour venir nous rencontrer ou à travers le formulaire peut-être, qui a été mis en ligne, que vous avez pu parfaire ou peaufiner votre position?

Et la question démontre une certaine admiration. C'est exactement ce que l'on souhaite susciter, et vous avez très bien répondu à cette invitation, mais votre cheminement m'intrigue. Qu'est-ce qui vous a amenée à vous présenter devant nous aujourd'hui?

Mme Leduc (Christine): Bien, j'ai fait quatre ans d'études que je viens de finir en septembre dernier. J'ai fait des études sur la mort pour continuer à faire une maîtrise avec le professeur avec qui j'étais. Et donc ça a été quatre ans intenses de réflexion et aussi d'accompagnement aux mourants, parce que je ne voulais pas rester seulement

dans la théorie. Et puis ce qui peut peut-être vous intriguer, ce qui peut souvent amener les gens à aller dans ces domaines-là: j'ai perdu un enfant qui avait 10 ans il y a 15 ans. Mais j'ai attendu 10 ans avant de m'intéresser, si on peut dire, aux autres, et puis à cette question-là. Je suis très concernée, en effet.

M. Charette: Dans tous les cas, merci pour votre témoignage et votre présence parmi nous aujourd'hui. Merci.

Le Président (M. Kelley): Merci beaucoup. Sur ça, je vais suspendre quelques instants.

On a trois demandes d'intervention. Alors, la première, c'est Amy Hasbrouck. Alors, je demande à Mme Hasbrouck de prendre place pour une courte intervention.

(Suspension de la séance à 17 h 46)

(Reprise à 17 h 47)

Le Président (M. Kelley): Alors, la commission reprend ses travaux. La dernière période, c'est micro ouvert. Nous avons reçu trois demandes. En rappelant les règles du jeu, c'est pour les personnes qui n'ont pas soumis un mémoire ni formulé une demande d'intervention mais qui veulent quand même s'exprimer sur ce sujet important.

I believe our first witness would like to testify in English. So...

Mme Hasbrouck (Amy): ...

Le Président (M. Kelley): Non? En français? O.K., parfait. Nous avons reçu le texte. Alors, si vous pouvez, faites une courte déclaration basée sur votre texte. Tous les membres ont reçu copie papier de vos commentaires, mais, si on peut résumer ça dans un maximum de cinq minutes, s'il vous plaît. Et, après, il y a Marie-Claude Pastorel et Hélène Couture. Est-ce que c'est bien ça, «Pastorel»? Oui. Alors, dans cet ordre.

Alors, sans plus tarder, Mme Hasbrouck, pour cinq minutes, s'il vous plaît.

Mme Amy Hasbrouck

Mme Hasbrouck (Amy): O.K. Bonjour. Je voudrais d'abord faire mes excuses pour mon français, ce n'est pas ma première langue mais je le parle en solidarité avec le peuple québécois dont je veux devenir...

Moi, je suis née aux États-Unis, au Massachusetts, mais je suis venue au Québec en 2003. J'habite à Valleyfield maintenant. J'ai des bacs en journalisme et droit. Et je suis aveugle légalement et j'ai aussi le lupus, qui est une maladie auto-immune, quasiment dégénérative; ça devient pire, des fois. Et j'ai d'autres incapacités qui sont arrivées plus tard.

Je suis membre du conseil d'administration d'un groupe qui s'appelle Not Dead Yet, ou «Pas tout à fait mort», si on veut dire en français, et c'est un groupe international des personnes ayant des incapacités, et nous étions établis en 1996 pour lutter contre la mort médicalisée, l'euthanasie et le suicide assisté.

Nous faisons une analyse différente des autres. Nous ne sommes pas du tout reliés à des organismes religieux, nous n'avons pas de position sur le «pro-life»,

sur la question d'avortement. Nous sommes basés sur l'idée que les personnes ayant des incapacités ont le droit de traitements égal et de choix libre, mais que le choix libre n'est pas possible dans la situation comme telle.

● (17 h 50) ●

Le Not Dead Yet soutient l'idée que la personne peut refuser le traitement, que ça, c'est une possibilité, mais que les lois qui permettent le suicide assisté et l'euthanasie, ça, c'est une menace pour toutes les personnes ayant des incapacités.

Les politiques de suicide assisté et d'euthanasie sont basées sur un préjugé sur la vie handicapée, ça veut dire que la vie handicapée, c'est pire que la mort, et c'est une croyance très, très commune. Les personnes handicapées suicidaires sont privées des services de prévention de suicide et aussi sont privées des droits de la pleine participation dans le suicide... pardon, dans la société.

Le message de mon témoignage est que, pendant qu'il y a de telles discriminations, des préjugés, le suicide assisté et l'euthanasie menacent la vie des personnes handicapées. Et pourquoi je ne fais référence qu'aux personnes handicapées? C'est facile que les personnes en fin de vie et les personnes handicapées soient le même groupe, et des fois on essaie de faire des distinctions, mais nous avons tous des limitations de choses qu'on fait de base quotidienne, et nous sommes tous... subi à la discrimination, des barrières dans la société et les préjugés, et ce sont ces deux facteurs qui nous relient.

La voix de ce groupe doit être entendue, mais c'est surtout les médecins, les familles, les membres de la famille qui parlent de notre part, au lieu de nous laisser parler. Et Le mouvement pour la défense des droits des personnes handicapées disent toujours rien à propos de nous, sans nous. Donc, ça, c'est pourquoi je suis ici.

On voit qu'on investit beaucoup de ressources publiques dans la politique de prévention du suicide, mais, quand une personne ayant une incapacité essaie d'accéder aux programmes pour prévention de suicide, il trouve que son désir de se suicider est pensé comme normal, que ses émotions, comme dépression, désespoir, colère, isolation, sont attribuées à son incapacité et pas à la discrimination qu'il subit tout le temps.

Encore, il rencontre le préjugé que la vie avec une incapacité est pire que la mort, et les gens pensent que c'est une gentillesse de le laisser mourir ou de le tuer, de le libérer de cette vie insupportable. La personne est permise, même encouragée et aidée à se suicider, et ce qui est important ici, c'est que le suicide assisté garantit que la personne va réussir à... distingue que les personnes non handicapées qui ont essayé de se tuer ont une chance de... de «fail»... de ne pas réussir. Et cette chance est basée sur le fait que souvent un essai de suicide n'est pas... c'est un cri du cœur. Et c'est la même chose avec les personnes handicapées, mais, si on les aide par l'euthanasie ou d'autres façons de se suicider, ça va réussir. Tout ça, c'est discriminatoire, et, si l'Assemblée nationale permet une politique comme ça de devenir une loi, ça va être une violation des chartes des droits, parce que c'est un traitement inégal.

Le Président (M. Kelley): Je vous invite vers la conclusion, s'il vous plaît.

Mme Hasbrouck (Amy): O.K. On parle de souffrances des personnes handicapées, et la souffrance vient

vraiment de la discrimination qu'on rencontre. C'est les barrières qu'on rencontre tous les jours: le manque de services et les services qui sont fournis sur la base de l'orientation de l'institution, séparés où on vit et pas l'expérience de vivre dans la communauté avec une pleine participation dans la vie.

Et j'aimerais bien répondre aux questions si vous en avez.

Le Président (M. Kelley): Non, non, la période de micro ouvert, c'est vraiment les courtes déclarations des personnes qui ne participent pas autrement dans les travaux de la commission. Alors, merci beaucoup, M. Hasbrouck... Mme Hasbrouck, pardon, pour votre participation. Et je vais inviter maintenant au micro Marie-Claude Pastorel.

Bonsoir, Mme Pastorel. Quand vous êtes prête, vous avez un temps de parole de cinq minutes.

Mme Marie-Claude Pastorel

Mme Pastorel (Marie-Claude): Parfait, merci. Mesdames, messieurs, je suis une jeune artiste et intellectuelle qui réfléchit en ce moment sur ses semblables et mon époque, cette jeunesse dont je fais partie et qu'on dit souvent sans repères et apolitique. Je me sens, face à la société actuelle, comme si nous étions à la fin d'une époque et au début d'une autre, étrangement comme à l'époque de l'entre-deux guerres, en fait. Je m'inquiète de ma génération et me questionne depuis bien des années quant aux dérives que peut entraîner l'absence de repères fixes dans une société.

J'arrive, pour une deuxième fois, de l'exposition sur Otto Dix, au Musée des beaux-arts de Montréal, avec mes étudiants. Son art s'opposait tant à l'idéal national-socialiste du corps sain et de la perfection de la machine humaine, qu'une grande partie de ses œuvres, 260 au total, ont été brûlées par les nazis. Le message de Dix est clair: L'humain n'est pas perfectible, la vie nous échappe toujours au moment où l'on s'y attend le moins, la mort fait partie de la vie, le beau côtoie le laid, qui parfois le dépasse en vérité et en authenticité. Ainsi, si la société est réglée à l'image de l'homme, la quête de son sens doit nécessairement être la même que celle du sens de la vie.

Aucune société contemporaine ne peut se substituer à la Nature ni à Dieu en la matière. Certaines sociétés modernes l'ont tenté et leur échec n'en a été que plus retentissant. L'Allemagne d'Otto Dix, celle des années vingt et trente, cherchait à fuir la laideur humaine qui montrait alors son visage dans tous les milieux sociaux depuis la fin de la guerre en 1918. Elle a cru trouver son sauveur dans la personne d'un Führer, le Führer, un leader, car c'est bien un guide qu'elle cherchait, une marche à suivre face au doute, des réponses devant les horreurs du début du siècle qui était somme toute sanglant, devant en fait la vie, ce qu'elle peut avoir de plus laid et de plus absurde. La société proposée alors par les national-socialistes promettait entre autres de parfaire l'homme en choisissant ses gènes et en éliminant les plus faibles, elle promettait le triomphe de l'être humain sur la Nature.

Vouloir prévoir nos enfants au moment précis où nous les désirons, les concevoir exactement de la même manière que nous, à notre image, sans défaut aucun, ni tare ni maladie, c'est exactement la même chose que de vouloir contrôler le moment exact où nous quitterons ce monde. De quelle manière nous le ferons, surtout; vouloir à tout

prix le faire avec grâce et dignité alors que la vie nous en empêche bien souvent, s'amusant à nous prendre par surprise au moment où l'on croyait tout risque, tout danger écartés.

● (18 heures) ●

Aujourd'hui encore, comme à l'époque du régime nazi, l'homme place tous ses espoirs dans la science, les nouvelles technologies, les avancées médicales qui lui apporteront le savoir nécessaire pour faire face à la vie et à ses imperfections, à les éviter surtout, et à contrôler complètement tous les imprévus imaginables que la Terre puisse porter. Or, la vie, et la mort, qui, selon moi, n'est qu'une part indissociable et dépendante de la première, n'ont pas le sens qu'on voudrait bien leur attribuer. Elles demeurent une quête d'inconnu et d'imprévisible où le curieux, celui qui se questionne et appréhende chaque nouveauté avec l'ouverture de l'esprit, s'en tire mieux que celui qui, choqué par les situations difficiles, cherche par tous les moyens à les éviter, sinon à les atténuer ou à en diminuer l'intensité et l'impact qu'elles auront sur sa vie. Celui-ci, dans l'urgence de la précaution, dans son désir de trouver rapidement les moyens de se prémunir contre les aléas du destin, oublie bien souvent de vivre et n'a, pour ainsi dire, rien appris sur le sens véritable de ces événements difficiles qu'il aura à affronter. Si bien qu'il se trouve désarmé, une fois la bataille engagée, le combat ayant pris des allures imprévisibles. La situation ne s'étant pas présentée comme le prévoyait le protocole scientifique, l'homme, perdu, refuse son échec sur sa vie, refuse son impuissance et accuse l'autre, le scientifique, d'avoir mal exécuté son travail. Il le fustige, il cherche à alimenter le débat scientifique d'un énième exemple individuel de l'échec du système. Ce qu'il ne comprend pas, c'est que la sacro-sainte médecine n'est qu'une science. Elle n'est ni objective ni exacte. Les scientifiques ne sont que des chercheurs, et la vie humaine, le sujet de leurs recherches, un sujet complexe et la plupart du temps insaisissable.

Vouloir réglementer la vie et la mort par le biais de l'État est chose impensable, dès lors. C'est vouloir identifier le responsable de notre malheur, vouloir matérialiser le grand responsable du drame humain. Or, ni Dieu, ni la nature, ni Bouddha n'ont de figure humaine et matérielle. La société étant, elle aussi, à la merci des imprévus, l'État ne peut être le représentant de la justice divine sur terre comme à l'époque des empereurs romains ou des rois. La démocratie, en ce sens, diffère de l'aristocratie, car elle ne descend pas de Dieu.

Vouloir que l'État régisse des questions de vie ou de mort, c'est demander que l'État se préoccupe à nouveau du sens spirituel de la vie. C'est demander un remariage de l'État avec l'Église, même si cette Église n'a plus le même visage qu'elle avait au moment de son divorce, en 1789.

Demander à l'État de réglementer une question aussi complexe que celle de l'euthanasie, c'est demander qu'il fasse le partage entre ceux qui y auront droit et ceux qui ne pourront y avoir recours. C'est lui demander d'être à la fois juge et partie dans le débat, chose impensable en droit et qui va à l'encontre de la... démocratie elle-même, pardon.

La vie et la mort sont des questions qui relèvent de l'être humain, des questions qui ne sauraient faire l'objet de politiques étatiques. L'homme est bel et bien seul face à la mort. C'est parce que je crains les dérives qui pourraient mener à la montée de solutions extrêmes au sein d'une

société en perte de repères que je suis ici, parce que je souhaite que l'État ne tente plus jamais de s'élever au-dessus de la vie et de l'être humain. S'il n'y a pas de réponse claire devant une telle question, il n'y a pas non plus de marche à suivre face à la vie. Nous ne pouvons dès lors que nous méfier lorsqu'une société ou un groupe donnés offrent de nous donner des réponses à des questions somme toute philosophiques. Nous avons en fait le devoir de nous y opposer.

Le Président (M. Kelley): Merci beaucoup, Mme Pastorel. Et notre dernière demande d'intervention, c'est Mme Hélène Couture.

Mme Hélène Couture

Mme Couture (Hélène): ...je viens vous lire juste quatre petits paragraphes qui confirment malheureusement mes peurs des dérives criminelles qui aboutissent à la suite de la législation de l'euthanasie et du suicide assisté. Alors, cet article-là a paru dans *La Presse* le 4 octobre. Il a été écrit par un médecin qui pratique aux Pays-Bas et qui fait probablement, là, présentement son doctorat au Scientific Institute of Quality for Healthcare.

Alors, l'euthanasie adoptée aux Pays-Bas s'appelle l'Euthanasia Act et il a été adopté en 2002. Et il permet l'euthanasie et le suicide médicalement assisté lorsque la demande du patient est libre et considérée, que celui-ci vit une souffrance insupportable et sans espoir d'amélioration, et que le médecin traitant a consulté un autre collègue. Le médecin est également tenu de déclarer son geste afin qu'un comité indépendant évalue si les critères de bonne pratique ont été respectés, faute de quoi des poursuites criminelles peuvent être intentées contre lui. Alors, ça ressemble assez à ce que nous avons sous les yeux présentement.

Alors, fait troublant, dans 19 % des cas d'euthanasie, le médecin a administré un médicament provoquant la mort sans que le patient en fasse la demande et parfois sans discussion préalable avec la famille ou un collègue. Aux Pays-Bas, des médecins ont pratiqué l'euthanasie sur des nouveau-nés, des personnes avec des problèmes de santé mentale et des personnes âgées atteintes de problèmes cognitifs. Probablement l'alzheimer.

Alors, en 2005, soit seulement trois ans après l'adoption de ce Euthanasia Act aux Pays-Bas, les médecins ont provoqué intentionnellement la mort de plus de 1 000 personnes sans leur demande explicite ou sans rapporter leur geste aux autorités. Alors, la légalisation de l'euthanasie comporte des risques importants, comme le démontre ici l'expérience des Pays-Bas, où les balises légales en place ne sont pas respectées dans un cas d'euthanasie sur cinq. Je vous remercie.

Le Président (M. Kelley): Merci beaucoup, Mme Couture. Et je veux juste rappeler... Parce qu'il y avait une autre demande d'intervention de quelqu'un qui va témoigner demain, et, je pense, l'idée du micro ouvert, c'est vraiment pour les personnes qui n'ont pas autre moyen de participer dans notre réflexion.

Alors, sur ça, je vais suspendre nos travaux à 19 h 30. Merci beaucoup.

(Suspension de la séance à 18 h 6)

(Reprise à 19 h 33)

Le Président (M. Kelley): Alors, à l'ordre, s'il vous plaît! Bonsoir, les membres de la commission.

On a quatre témoins qui ont fait les demandes d'intervention. Ça veut dire une présentation d'une quinzaine de minutes, suivie par une courte période d'échange avec les membres de la commission. Alors, la première qui a demandé la parole pour une présentation ce soir, c'est Mme Paola Diadori.

Mme Paola Diadori

Mme Diadori (Paola): Bonsoir.

Le Président (M. Kelley): Bonsoir, Mme Diadori. La parole est à vous pour 15 minutes.

Mme Diadori (Paola): Merci. J'aimerais d'abord vous remercier de m'avoir donné le temps pour m'exprimer.

Je suis neurologue pour enfants, je travaille en milieu universitaire à Montréal et j'ai une maîtrise en bioéthique de l'Université Leuven. En fait, j'ai étudié aussi aux Pays-Bas pendant ma formation en éthique. Je siège sur le comité de bioéthique, je fais partie de l'unité d'éthique du milieu, et un de mes collègues, c'est M. Doucet.

Je tenais à vous exposer mon point de vue, car les voix d'une population sont négligées dans ce discours. Il s'agit de celles du nouveau-né, de l'enfant et de l'adolescent, surtout celles d'enfants lourdement handicapés. M. Doucet a fait allusion à cette population quand il parlait de modèles pour guider les professionnels en milieu adulte quant à l'importance de donner des soins de qualité humaine. Mais ce n'est pas cela que je veux aborder ce soir. Je veux aborder deux thèmes, ceux de la qualité de vie et de la dignité. Les réflexions sont des fruits de plus de 20 ans de pratique en milieu académique, de mon intérêt et travail en neuroéthique et des références dans la littérature médicale et éthique.

D'abord, la dignité. Les points saillants que je veux exposer sur une conception de la dignité que je soutiens sont les suivants. Premier, les chartes constitutionnelles reconnaissent le statut spécial de personne et conséquemment soutiennent le concept d'une dignité inhérente ou intrinsèque de la personne. Toutes espèces qui vivent ont une dignité intrinsèque, mais l'être humain a la plus haute dignité intrinsèque. Par contre, toutes personnes ont la même valeur intrinsèque.

Deuxième point, il y a une confusion quant à ce que ça veut dire, soutenir la dignité de la personne. Avoir les capacités typiques de l'humain, comme la conscience, le langage, l'agence morale, l'autonomie, le sens de l'esthétique, certes c'est toutes des caractéristiques qui augmentent les dignités qu'on peut dire attribuées. Attention, ce sont les mêmes caractéristiques qu'on donne pour exprimer une dignité intrinsèque, et je pense que c'est là où des fois la confusion survient. C'est certain que la maladie peut diminuer les dignités attribuées. On peut certainement dire que vivre sans autonomie n'est pas digne d'une personne, mais cela ne veut pas dire que la personne n'a pas de dignité. Le rôle de la médecine est de faire le plus possible pour augmenter les dignités attribuées, mais il y a quand même une limite à ce rôle.

Troisième point, une agence morale qui est associée avec une dignité intrinsèque est associée aussi à des

obligations. La plus importante obligation est de reconnaître et respecter la dignité intrinsèque chez soi et l'autre. C'est certain qu'augmenter les dignités attribuées est une façon de rendre concrète l'obligation de respecter la dignité intrinsèque. Je veux promouvoir l'intérêt de l'autre, avant tout parce qu'il est une personne avec dignité intrinsèque. Sans ce respect primaire, il n'y a pas de raison pour la moralité interpersonnelle.

Quatrième point, dans notre société, la souffrance et la perte d'autonomie équivalent à une perte de dignité. Attention, moi, je pense qu'on réfère à des dignités attribuées, qui, encore là, deviennent confuses avec la dignité intrinsèque. Comme société, nous devons répondre honnêtement les questions suivantes: Est-ce qu'il existe un homme qui par sa nature d'être humain n'est pas digne? Le corollaire de la phrase précédente est: Est-ce que la dignité de la personne dérive seulement des attributs qu'on veut lui accorder comme des attributs dignes et, dans l'absence de ceux-ci, la personne n'a aucune valeur intrinsèque?

À mon avis, c'est une réduction de la vie que de s'acharner au concept d'autonomie. Est-ce que les patients que je traite dans mon bureau, qui n'ont pas d'autonomie, ne sont pas des personnes avec la même dignité intrinsèque? Quand les enfants perdent leurs parents, est-ce qu'ils sont moins dignes? Juste pour utiliser un exemple, on s'acharne à améliorer la qualité de vie d'enfants en Haïti et d'autres pays. Est-ce qu'on ferait ça s'ils n'ont pas la même valeur comme d'autres personnes qui n'ont pas d'autonomie?

● (19 h 40) ●

Je trouve l'absence de discussions plus approfondies sur la définition et le concept de dignité, pour une commission avec le mot «dignité» dans le titre, un peu décevante. Comment expliquons des normes pour la fin de vie complètement opposées en utilisant le même mot? La majorité veut utiliser le concept de dignité attribuée et oublier le concept de dignité inhérente. Je dirais, ceci n'est pas surprenant pour une société qui a majoritairement oublié ses racines judéo-chrétiennes. Mais, même sur une base purement logique, sans question de foi, toute personne avec jugement dirait que toute personne est digne, sinon on n'aurait pas des chartes constitutionnelles et il n'y aurait pas de base pour dire que la vie est inviolable.

J'aimerais proposer un argument contre l'euthanasie en utilisant des concepts éthiques de principes et de valeurs attribués au concept de la dignité. Ceci est tiré d'une référence, je peux vous la donner si ça vous intéresse: Chaque humain a une dignité intrinsèque. La maladie change les dignités attribuées. Parce qu'il y a une finitude à l'existence d'une personne, l'obligation du principe de faire tout possible pour augmenter les dignités attribuées est imparfaite. L'intention de détruire l'humain qui souffre d'indignité attribuée ne peut pas être une approche pour diminuer la souffrance, car le tuer diminuerait la dignité intrinsèque, ce qui donne la raison pour augmenter les dignités attribuées.

Maintenant, ceci n'implique pas qu'il faut faire tout technologiquement possible pour prolonger la vie d'un individu. La dignité intrinsèque est une valeur suprême, mais avec finitude.

Deuxième, qualité de vie. Je me pose comme question comment une société peut justifier des soins de très haut niveau pour des personnes qui ne seront jamais productives, dans le sens économique — je me réfère, encore là, à la population que je soigne — et non d'accepter de

soigner des personnes en fin de vie, après une vie productive. Si on affirme que dans le deuxième scénario la personne est autonome à décider pour elle-même, alors quelle valeur on accorde à la vie des personnes qui ne sont pas autonomes?

Je travaille auprès d'enfants et de familles avec handicaps sévères, avec beaucoup de souffrances, qui sont présents toute une vie, souvent dès la naissance. Il s'agit d'enfants avec des déficiences motrices et intellectuelles, des maladies neuromusculaires, des maladies dégénératives du système nerveux central. Ces patients sont complètement dépendants. Mais mon expérience auprès de ces familles me rend stupéfiée face à leur ténacité, leur amour de leurs enfants handicapés. Ces familles donnent tout pour garder leurs enfants lourdement handicapés non seulement en vie, mais dans leur milieu.

Mais je vois aussi une peur du handicap. L'argument de diminution de la qualité de vie est utilisé pour limitation des soins, mais on sait que le terme «qualité de vie» n'a pas une définition universelle. En fait, plusieurs études démontrent que les enfants handicapés rapportent une qualité de vie pareille à ceux non handicapés. D'autres études montrent que la qualité de vie est jugée inférieure par les professionnels de la santé quand ce ne l'est pas pour le patient handicapé.

L'individu n'est pas un organisme biologique qui vient avec une fonction et un coût. Est-ce que la qualité de vie serait plutôt en lien avec la nécessité de trouver le bonheur, de trouver un sens à la maladie? Je pense, «qualité de vie» est un concept qui se réfère surtout à des rapports relationnels. Je préférerais parler plutôt de qualité de santé et non qualité de vie. La santé est seulement un des facteurs qui donne qualité à notre vie. Si la signification de notre vie est réduite à une mesure de qualité de vie, en termes utilitaristes ou biologiques, la valeur de la personne devient réduite et relative à l'état ou l'environnement socioculturel. Est-ce ceci, respecter la dignité de la personne?

Ça vaut d'être répété, il y a une distinction importante entre une terminaison expresse de la vie et le retrait d'un traitement. Dans le premier cas, la décision est basée sur la suffisance de la vie, et dans le deuxième cas la décision se base sur les bénéfices escomptés et les fardeaux sur la qualité de santé, et est seulement un des éléments nécessaires pour arriver à la décision d'un retrait de traitements.

Je vous défie de me donner une définition de «qualité de vie» valable et, plus important, de me dire avec honnêteté que vous... n'importe qui pourra prédire la qualité de vie pour un autre. Cette mesure sera variable selon les évaluateurs et même les personnes atteintes. Alors, pourquoi cette acceptation de l'euthanasie? Je pense, parce que dans notre société «qualité de vie» est confondu avec les concepts d'autonomie et de dignité. En fait, ils sont égaux. Permettez-moi d'exprimer que la qualité de vie n'est pas une fin en soi, mais un moyen pour donner un sens à notre vie. La santé est une valeur importante, mais pas la seule à donner sens à notre existence.

Je conclus. Les dérives corollaires d'une approche individualiste. Comme société qui se considère avancée, intelligente, on a l'obligation à ne pas répéter les mêmes fautes du passé. Vous pensez que vous allez prévenir les abus dans le système avec des balises. Je peux vous dire qu'il y a déjà 10 ans, aux Pays-Bas, mon professeur clinicien éthicien nous parlait de dérapages dans le contexte d'euthanasie, comme on a entendu et qui a été publié récemment.

M. Kelley répondait à un commentaire sur l'eugénisme la dernière fois. Je me demande comment je dois interpréter le fait suivant: sous le prétexte qu'on veut prévenir toute souffrance humaine évitable, un souhait louable mais impossible, selon mon humble opinion, on fait le dépistage systémique de trisomie 21, pour ensuite proposer des interruptions de grossesse. On faisait, il y a 30 ans aussi et encore, le dépistage pour la fibrose kystique. Mais depuis on reconnaît maintenant que les personnes atteintes de fibrose kystique peuvent vivre jusqu'à l'âge adulte grâce à l'amélioration des soins respiratoires. Je peux vous dire qu'il y a un bon nombre d'enfants avec trisomie 21 qui vivent une bonne vie, selon eux et leurs familles. Je peux aussi vous dire que je fais le suivi des enfants qui sont beaucoup plus handicapés, la majorité avec des maladies qui ne peuvent pas être dépistées.

Quel message est-ce qu'on envoie aux personnes handicapées? Leurs vies ont moindre valeur et qu'un jour ils risquent d'être pénalisés parce qu'ils ont choisi de vivre avec un handicap? Dans mon travail quotidien, je peux vous en parler, d'exemples de dérive. Dans notre propre centre, il n'y a pas de consensus entre spécialistes. Quand proposer des limitations de soins dans des scénarios de conditions neurologiques ou autres où il y a un potentiel de handicap et pauvre qualité de vie? Je peux vous dire par contre que les spécialistes qui ont peu de suivi ou de contacts avec ces patients et qui connaissent moins les conditions chroniques sont moins tolérants à une vie de handicap que ceux qui suivent les patients à long terme.

On fait le dépistage prénatal et on trouve beaucoup d'anomalies dont la signification n'est pas claire et dont le pronostic est imprécis. Les décisions pour arrêt de soins ou arrêt de grossesse sont prises sur la base d'un, peut-être, handicap où, s'il y a moindre de chances que l'enfant ne sera pas normal, les parents ne voudront pas poursuivre la grossesse. Il y a eu aussi des cas d'interruption de grossesse de troisième trimestre pour des raisons esthétiques. Oui, c'est légal, mais je peux vous dire qu'une majorité ou moins... beaucoup de médecins ne trouvent pas cela éthique. Pourquoi? Moi, je pense, c'est pour le fait que la personne n'est pas respectée dans ce cas.

Bientôt, le dépistage de tout le génome d'un individu sera facile, et on trouvera toutes sortes de mutations génétiques où on n'aura aucune connaissance sur les conséquences cliniques ultérieures. Déjà, un dépistage génétique prénatal se fait aux États-Unis à la recherche de l'enfant parfait. Combien de mutations sera suffisant pour détruire une vie?

Tout cela pour vous dire que le non-respect pour la dignité de la personne, ça existe déjà. L'instrumentalisation de la vie, ça existe déjà. On n'a pas besoin d'une loi pour favoriser ceci davantage.

● (19 h 50) ●

L'art de la médecine est l'idéal. Je me demande comment concilier une vision d'une médecine humble et compatissante avec une médecine technique et utilitariste. Dans le premier, le médecin réalise que ce n'est pas ses traitements ni séances qui donnent sens à la vie, que la réponse de la condition humaine dérive d'une autre perspective.

Est-ce qu'on devrait abandonner face à nos ignorances, éliminer ceux qu'on ne pense pas aider? Pour des millénaires, la médecine se force pour la vie et santé contre la maladie et la mort. La preuve en est évidente dans nos pays occidentaux. La médecine technique et utilitariste

réduit l'humain et oublie la nature digne de la personne. Renverser ce qui a été interdit pour des millénaires changerait la nature même de la médecine. Merci.

Le Président (M. Kelley): Merci beaucoup. On va passer maintenant à une période d'échange avec les membres de la commission. Je suis prêt à céder la parole au député de Marquette.

M. Ouimet: Merci, M. le Président. Bonsoir, Mme Diadori. Merci pour votre témoignage, pour votre présentation. Pour les définitions que vous nous offrez de la dignité, je ne veux pas embarquer dans les distinctions que vous faites entre «dignité attribuée» et «dignité inhérente», ce n'est pas mon propos, mais est-ce que je vous interprète mal en disant que, si on accepte votre définition de «dignité», ça nous conduit à proscrire l'euthanasie ou être contre toute notion d'acceptation d'euthanasie sous quelque forme que ce soit?

Mme Diadori (Paola): Sur ce concept de «dignité», effectivement la personne a une dignité intrinsèque et que la médecine, comme les soins palliatifs, agit pour augmenter les dignités attribuées. Mais la raison pourquoi on veut augmenter les dignités attribuées, c'est parce que justement la personne a une dignité intrinsèque. Si on euthanasie quelqu'un, on diminue la dignité intrinsèque de la personne, ce qui donne la force pour donner des dignités attribuées. Alors, sur ce concept-là, oui.

M. Ouimet: Bien. Vous acceptez que tous n'ont pas la même définition de «dignité» et... Très bien. Parce que j'allais vous citer quelques passages des jugements rendus par la Cour suprême du Canada, qui interprète le mot «dignité». Et je me permets de vous lire un passage de l'arrêt... je pense, c'est Morgentaler, et repris dans Oakes et dans deux ou trois autres jugements de la Cour suprême. Je cite le passage suivant: «La notion de dignité humaine trouve son expression dans presque tous les droits et libertés garantis par la charte. Les individus se voient offrir le droit de choisir leur propre religion et leur propre philosophie de vie, de choisir qui ils fréquenteront et comment ils s'exprimeront, où ils vivront et à quelle occupation ils se livreront. [...] l'État respectera les choix de chacun.»

Alors, dans cette conception de dignité exprimée par la Cour suprême du Canada, qui dit clairement que l'État doit respecter les choix de chacun, il me semble que quelqu'un qui revendique le droit à l'autodétermination de sa personne et qui voudrait, à un moment x de sa vie, dans certaines circonstances — je ne veux pas entrer dans ce débat-là — mais ça se ferait dans le respect de la conception définie par la Cour suprême du Canada, au niveau de la dignité, qui serait un peu à l'encontre de la définition que vous nous offrez.

Mme Diadori (Paola): Je ne suis pas convaincue que c'est à l'encontre, mais, je pense, c'est ce type de discussion qui devrait avoir lieu. Moi, je pense que justement les chartes soutiennent une dignité intrinsèque dont je parle. Donc, qu'est-ce que vous me lisez là, je pense qu'il s'agit d'une dignité intrinsèque. Mais, comme je vous disais, avec cette notion d'agence morale basée sur le fait qu'il y a une dignité intrinsèque d'un individu, il y a quand même des obligations, et la personne a une obligation de

faire tout qu'est-ce qui est possible pour soutenir la dignité intrinsèque de l'humain, O.K.? Alors, quand on augmente les dignités attribuées, on le fait parce que justement il y a cette dignité intrinsèque.

Je suis d'accord avec vous qu'il y a des gens qui disent: Il n'y a aucune dignité intrinsèque, ça n'existe pas, O.K.? Mais il y a des contre-arguments contre ça. On pourrait dire que, si on veut argumenter de cette façon... moi, je peux répliquer: Si c'est le cas, s'il n'y a pas de valeur intrinsèque comme telle et pas de dignité intrinsèque, ça veut dire que l'homme devient la mesure de toutes les choses. Ça veut dire, donc, que dans une interaction humaine et dans un contexte éthique il n'y a pas de raison vraiment pour respecter la personne, qui alors... Celle-ci ne peut pas obliger une conduite morale envers elle et donc elle n'est pas protégée.

Alors, je pense qu'il y a d'autres qui disent... bon, ils voient la dignité intrinsèque justement réservée à la classe de personnes qui ont toutes ces caractéristiques d'autonomie, conscience, langage, sens moral, et tout. Et encore là on pourrait dire que, oui, quand on perd ces caractéristiques-là, on perd les dignités attribuées, mais on reste quand même avec une dignité intrinsèque.

Alors, je suis d'accord avec vous qu'il y a toutes sortes de façons de concevoir le concept de dignité et je trouve que c'est important pour vous de revoir ces différents concepts-là et de justement en parler et en discuter avec différents théologiens, philosophes, éthiciens... Tu sais, il y a tout un bouquin sur juste le concept de dignité que j'ai lu récemment et qui... d'un point de vue légal, d'un point de vue théologique, etc. Donc, ça enrichit la discussion, parce que, quand les gens disent: Bon, mourir dans la dignité... moi, je pense que les gens veulent dire: Écoute, moi, au bout de la ligne, je ne veux pas me retrouver dans un hôpital où on ne me soigne pas, on ne me regarde pas, on ne s'occupe pas de moi, je vis dans un contexte isolé, je suis vulnérable, O.K.? Et je les comprends. Ils se sentent vulnérables, démunis, et c'est certain que ça leur fait peur. Et donc c'est certain que je suis d'accord que leur dignité attribuée est diminuée. Mais la valeur de la personne reste pareille. Et donc, si on dit qu'on veut abolir ces souffrances en disant: Bon, O.K., c'est correct, oui, bien, on va vous éliminer, bien vous éliminez la valeur de la personne, qui donne raison pour augmenter ces dignités attribuées.

Le Président (M. Kelley): Parce qu'on n'a que 15 minutes, alors... Et c'est plus court qu'un autre parce que c'est juste une demande d'intervention. Alors, Mme la députée de Joliette, il vous reste environ sept minutes.

Mme Hivon: Oui. Merci beaucoup. En fait, dans nos premiers échanges qu'on a eus à l'hiver dernier avec des experts de différents domaines, on a eu effectivement des éthiciens et des théologiens notamment — je ne sais pas si vous avez suivi à ce moment-là un peu — qui nous ont beaucoup parlé des concepts de dignité, donc on a quand même approfondi ça à ce moment-là. C'est vrai que là, dans les derniers jours, on est moins revenus sur cette notion-là, mais, je veux juste vous rassurer, c'est quelque chose quand même qu'on regarde avec intérêt.

Et, moi, j'ai une question. Je suis bien ce que vous dites entre «dignité attribuée» et «dignité intrinsèque», qui cohabitent, si je comprends bien, à quelques égards, c'est ça. Et, moi, je veux juste... je suis curieuse. Vous y avez

fait un petit peu référence, mais je suis curieuse de vous entendre. Dans les chartes, on parle de droit à la dignité et on parle... on a des expressions: «droit à la dignité» et «sauvegarde de la dignité». Et, moi, je me dis: Si dans nos chartes... Parce que vous semblez dire que vous pensez que dans nos chartes on parle de la dignité inhérente. Comment alors peut-on parler de sauvegarde de la dignité, ce qui voudrait dire qu'on peut la perdre, si on est face à la notion de dignité inhérente?

C'est quelque chose... Je vous dis, quand vous dites... J'y ai réfléchi, parce qu'on a eu des présentations sur la dignité, puis je suis allée lire après ce qu'on disait dans nos chartes.

● (20 heures) ●

Mme Diadori (Paola): Que «sauvegarder» veut dire plutôt «soutenir» ou...

Mme Hivon: «Soutenir» ou... Je ne sais pas, mais il me semble que, si on ne peut pas la perdre... Je ne comprends pas comment on parle d'un droit à la dignité. Droit à la liberté, tout le monde le comprend, c'est parce qu'on pourrait venir empêcher un droit à la liberté, qui n'aurait pas cette liberté-là. On parle de droit à la dignité puis on parle de sauvegarde de la dignité. En tout cas, je vous le soumets. Puis, quand j'entends mon collègue lire des extraits de décisions... En tout cas, assurément, je pense qu'il n'y a pas une entente parfaite sur le sens qu'on a voulu donner, parce qu'il y a des expressions comme celle-là. Si je vous suis correctement, vous, vous êtes d'avis que, dans nos textes fondateurs ou... ça devrait être la dignité intrinsèque.

Mme Diadori (Paola): Je ne connais pas assez la loi...

Mme Hivon: Je ne veux pas vous amener sur...

Mme Diadori (Paola): ...ou les textes pour répondre à ça.

Mme Hivon: Ce n'est pas une colle, c'est juste une question que je me pose, vous comprenez? Mais, enfin, voilà. Je veux juste vous dire qu'on y réfléchit, nous aussi.

L'autre... Vous avez dit tantôt que vous aimiez mieux parler de... vous aviez une autre notion, plus tôt, de qualité de vie, là, en lien avec santé.

Mme Diadori (Paola): Qualité de santé.

Mme Hivon: Qualité de santé. Bon. Puis, là encore, vous me corrigerez, je veux juste comprendre bien les notions. Vous semblez dire que la qualité de vie ou la qualité de santé, c'est une notion... C'est un petit peu difficile d'avoir un jugement objectif sur ça. Vous donnez l'exemple que certaines personnes qui ont plus d'inconfort ou moins de connaissances par rapport à certains handicaps vont estimer qu'il n'y a pas de qualité de vie chez certaines personnes, alors qu'elles-mêmes trouvent qu'il y a une très bonne qualité de vie ou celles qui les côtoient depuis plus longtemps vont trouver effectivement qu'il y a une bonne qualité de vie. Et vous semblez, dans ce contexte-là — mais peut-être que j'ai... — accorder une certaine importance au regard que la personne porte sur elle-même pour déterminer cette qualité de vie ou de santé. Moi, ce

que je veux savoir, c'est, quand on se réfère à la notion de dignité, la place que vous laissez au regard que la personne porte sur elle-même sur sa propre dignité, pour faire l'évaluation de ce qui est bon pour elle.

Mme Diadori (Paola): Encore là, je pense qu'il faut rappeler, la personne, de quelle dignité il parle. Comme je le disais tantôt, la personne se sent diminuée... dans un contexte de faiblesse, donc certain que ces dignités attribuées sont affectées, mais on ne le rappelle pas suffisamment. Peut-être, c'est notre faute, de société, de rappeler les gens que, même s'ils ne sont plus autonomes, même s'ils sont faibles, et tout le reste, il y a quand même une valeur, que cette personne-là a quand même encore une valeur, O.K.? Alors, je pense que c'est important de rappeler, les gens, de quel type de dignité ils parlent.

Et c'est pour ça que le rôle de la médecine et les soins palliatifs, c'est d'essayer d'améliorer ces caractéristiques-là, pour que... En fait, c'est ça, le rôle des soins palliatifs, c'est de faire augmenter ces dignités attribuées. Et, comme je vous dis, si on retourne au fait qu'on exclut la notion de dignité intrinsèque, bien là, on va aller directement à dire: O.K., on peut éliminer la souffrance, hein, et éliminer les indignités qui sont attribuées avec l'euthanasie. Mais ça, ce n'est pas soutenir une dignité inhérente de la personne. C'est ça, l'idée.

Mme Hivon: C'est clair. Merci beaucoup.

Le Président (M. Kelley): Juste en conclusion — merci beaucoup — un des objectifs de notre métier comme parlementaires, c'est de provoquer un débat. Alors, votre réflexion sur le mot «dignité», je pense, d'une certaine façon, est la preuve qu'on a eu une bonne idée de mettre ça dans le titre, parce que c'est un concept qui est très important. Vous avez beaucoup alimenté notre réflexion sur le sens du mot «dignité». Mais, moi, je veux présider un débat serein de la société québécoise sur plusieurs de ces concepts. Alors, je pense, votre témoignage, c'est la preuve que le mot est juste. Alors, merci beaucoup pour l'ajout à notre réflexion.

Et je vais suspendre quelques instants. Et je vais demander à M. Maiolo de prendre place à la table des témoins.

(Suspension de la séance à 20 h 5)

(Reprise à 20 h 6)

Le Président (M. Kelley): Alors, la commission reprend ses travaux. Le prochain témoin, également c'est une demande d'intervention, alors une présentation de 15 minutes, suivie par un échange de 15 minutes avec les membres de la commission, c'est M. Giuseppe Maiolo. Alors, M. Maiolo, la parole est à vous.

M. Giuseppe Maiolo

M. Maiolo (Giuseppe): Well, good evening everyone.

Le Président (M. Kelley): Good evening. Sorry. OK. I didn't... Welcome.

M. Maiolo (Giuseppe): Well, that's OK. No, no, I feel more comfortable in English, but I speak French quite well. So, anyway, thank you very much for giving me this opportunity to be here tonight, because I think it is important at this moment in time for us to reflect, as a collective, and the needs and the challenges faced by dying persons.

It is often said that society is to be judged by how it treats its most vulnerable members. Well, terminally ill and dying individuals certainly fit this category. It is therefore the duty of all of us to insure that their dignity is preserved until and even after they pass away.

For the past 30 years, I have worked in private practice as well as in various long-term facilities, focusing most of my professional efforts towards geriatric care. I have countless times witnessed the last breath of my patients, sometimes comforted by their loved ones, other times surrounded only by health care staff. I have, in some exceptional instances, seen people struggling to hold on to life so that they could be surrounded by their loved ones before passing peacefully. I have seen terminally ill patients struggling with pain and passing away in the relief of death. In all cases, I notice that the dying and their families have needs from us as a society, but unfortunately who often struggle to meet these needs.

Their needs range from simple things such as the availability of comfortable rooms capable of accommodating their loved ones to the availability of religious or moral support. Obviously, for those who suffer physically, alleviation of pain to the wide range of medical knowledge and techniques is an important provision. This physical suffering is often accompanied by psychological suffering and loneliness.

I think the role of the family, in this respect, can not be over emphasized. When one passes, families and friends are left grieving, and their needs are part of the needs of the dying. As such, supporting the role of the family and loved ones is crucial to uphold that dignity of dying... of the dying person. However, many of our institutions are structurally unwelcoming for family members. Rooms are often too small and ill equipped. Much of the staff, albeit competent medically, is at times ill prepared to deal with the psychological consequences of the dying person and their family. In certain instances, rather than providing professional psychological support, they often fall into mere sentimentality.

● (20 h 10) ●

We all have beliefs, whether in a supreme being or not. I have found that the presence of someone who shares the same belief on death, often a religious minister or a friend, is able to relieve much of the anxiety which can be associated with death. It is interesting to note that in this respect, many international instruments related to health care, and notably the Geneva convention, which deals with the extreme situation of health care in armed conflict, put religious and medical personnel on the same foot.

In the past, one of the most difficult situations I've encountered is the control of pain in terminally ill persons. In this respect, I have noted a marked evolution, in the past years, in understanding the cause of pain and treatments. In my early years, there was almost a fear of using opiates, for various reasons such as addiction and possibly respiratory arrest. Nowadays, thanks to years of research, opiates are used to effectively manage pain.

Recent research goes as far as suggesting that pain catastrophizing, which refers to an excess of negative perception of the pain experience, is significantly associated with activity in the brain areas related to the anticipation of pain, attention to pain, emotional aspect of pain and motor control. These results support the hypothesis that catastrophizing influences pain perception through altering attention anticipation and heightens the emotional response to pain. In brief, we have an ever-growing and better understanding of how the body process and modulates pain. Despite all of these advances, many times these remedies are not available. In my experience, getting appointment at pain clinic can take up to a year and getting a counsel of palliative care expert can be very difficult. More resources are needed in the field of pain control, particularly more palliative care centers and more experts in pain control.

I believe the issue of euthanasia and assisted suicide has been brought forward to this commission a number of times. It has often been presented as a solution to pain and suffering, as a mean of allowing a person to die with dignity. However, I am deeply concerned with this understanding from a practical aspect, given that degrees of pain and suffering are highly susceptible to perception from the patient, as I have explained in the catastrophizing of pain.

I am worried of the unknown consequences of introducing such a radical option. How will this affect the decision making of our patients? How will people, who would have never considered euthanasia or assisted suicide, react when they know that a fellow person has been terminated in this way? Never mind the perception of death, how will this influence the perception of pain and suffering of those patients alive? How will the relationship between families and their elderly be affected? How will this affect the understanding of the medical staff's role in society? The palliative care community may be severely affected by such decision in short and long term. I have clearly expressed my dissatisfaction with our society's ability to cope with unknown variables, and now I find myself with the possibility of a new option that risks creating severe havoc in the treatment of patients. «No man is an island», we'll leave consequences behind us.

I hope that now I have made myself clear that, as a medical community, I think we should focus our efforts on pain relief and palliative care for our dying patients. In other words, we should practice medicine. As for those maladies that medicine has not been able to relieve all the pain of yet, I think humility is in order: medecine cannot cure everything, and that fact should not let us console ourselves in death, which is what euthanasia and assisted suicide propose.

When we cannot cure our patients, we must care for them. Unfortunately, in euthanasia, we are beginning to stretch the boundaries of medecine and entering into a realm of pure ethics. Thus this end of life discussions are not medical issue per se. Let's us not confuse ourselves in believing that assisted suicide and euthanasia are in anyway a cure or a solution for pain and suffering, nor is it a form of care. This is not medecine, it is, in a matter of fact, the killing of a human being.

During my medical career, starting as a medical student, I have always noted a strong ethic in the whole and noble profession. The Hippocratic oath is more than a mere text of ancient words. It is a promise from the part of doctors to behave ethically towards their patients in

the community at large. It is a commitment on the part of society to produce doctors who will not compromise care and respect of the patient.

This oath has taken different forms in history to emphasize different aspects of its ethic, but a clear respect of human life has constantly defined its soul. This is the route of our understanding of the relief of sufferance. As such, the person is the ambition of my profession and not the malady. This is indeed a noble ambition. I have seen myself... I have seen in my medical experience, in Italy at the University of Florence, in Canada at the University of Ottawa, University of Montréal and McGill, this ethic be applied universally. However, I fear that the proposition for euthanasia and assisted suicide are an affront to the nobility of the medicine, because they go directly against life.

Le Président (M. Kelley): Thank you very much, Dr. Maiolo. Are you done or...

M. Maiolo (Giuseppe): Yes.

Le Président (M. Kelley): Sorry, I just... We'll pass now to a period of exchange with Mme la députée de Hull.

Mme Gaudreault: Merci beaucoup, M. le Président. Alors, Dr Maiolo, si je vous pose une question en français, vous pouvez répondre en anglais, il n'y a pas de problème, il y a de la traduction disponible.

Alors, je l'ai mentionné à plusieurs reprises, c'est toujours un privilège, à mon avis, d'avoir des médecins qui viennent ici témoigner de leurs longues années de pratique et de leur expérience. Et on a eu, comme je le mentionne, le privilège d'en rencontrer dans différentes villes depuis le début de nos travaux.

On a aussi beaucoup parlé du contrôle de la douleur, comme vous l'avez fait, puisqu'enfin... À la dernière période de la vie, je pense que c'est beaucoup une question... Vous êtes une équipe multidisciplinaire qui vous questionnez beaucoup par rapport aux sensations, la douleur, comment la contrôler, et tout ça. Il y a beaucoup de gens, des oncologues, des spécialistes, qui sont venus faire l'apologie justement des avancées pharmacologiques par rapport à la fin de la vie.

Mais vous savez que, dans les cas de mort imminente, surtout dans les départements de soins palliatifs et aussi départements de soins intensifs — vous l'avez dit, vous l'avez mentionné — la médecine ne peut pas tout régler. Et il y a certains médecins, dont le Collège des médecins, qui se sont même avancés jusqu'à dire que, dans des cas exceptionnels, l'euthanasie pourrait être un soin approprié en fin de vie, des médecins avec une longue histoire... une longue pratique en soins palliatifs, des gens très humains et tout ça, mais qui, devant un constat d'échec à certaines occasions, pensent que l'euthanasie pourrait être une option. Quelle est votre opinion à ce sujet?

M. Maiolo (Giuseppe): I'm totally against it. I think that, today, we might not have in every place the tools to do it, but — there's even anesthesia, general anesthesia that we use — we can alleviate the pain to a level that is acceptable. Then pain is not only controlled by mere medication. I don't think we make good use of our psychologists, I don't think we make good use of our

psychiatrists in the centers. Some of the pain clinics have it. They have psychology and psychiatry.

Most time, when people are yelling for pain, they only want to be heard, at least that's my personal experience. Once I sit down with them, it changes. I recently had a 55 year-old lady that came to my center, where I work at. The first thing the nurses said: She won't see you. She said she just wants to die. Give her something to die, that's all she's asking for. So, in time, we sat down, we discussed. She was a drug addict, alcoholic, she lost her husband. She has a son, haven't spoken to the son for about five years. She has one sister, God knows when was the last time she spoke to her.

In time, yes, she had a mass, she had a pelvic mass. She was yelling and screaming of pain. She had been I don't know to how many clinics and how many emergency rooms, and everybody gave her opiates. Everybody gave her medications. Finally, she trusted in me, I discussed situation with her. She finally started talking to her son. She made contact with her sister. You know, the most of the medication we've eliminated. And she says: Well, thank you very much, and you're the only person that care so far, that I've met. But, I said, it's not me, it's the whole team that participated. But that's what she needed.

So we cannot take the easy route out. And at what level do we stop the pain? To a tolerable level.

• (20 h 20) •

Mme Gaudreault: Mais je ne sais pas si, dans votre pratique, vous avez déjà côtoyé des personnes vraiment à quelques heures de la fin ou une journée, 24 heures, dans cette situation de mort imminente. Quelquefois, la douleur est incontrôlable. Et c'est dans ces occasions exceptionnelles que le Collège des médecins voudrait pouvoir ajouter ce soin, l'euthanasie...

M. Maiolo (Giuseppe): Non.

Mme Gaudreault: ...en fin de vie.

M. Maiolo (Giuseppe): Sorry. The deliberate killing of a person is deliberate. To alleviate pain, with whatever medication, whatever interventions we have, it's acceptable. I might give morphine, two, three, four milligrams every hour, every... The person might die, by the consequences of what? The illness or the medication, but it's definitely not my intention to kill a human being. And you know what? Not too many people like that word «killing». When we hear that word, everybody, you know, I see the faces... makes very uncomfortable feeling.

I had this discussion with the nurses at my center, and I said: Listen, euthanasia is becoming possibly a fact. Some agreed to it, some absolutely not, for whatever reason. So then I said: Well, you agree with euthanasia, right? We have... Mrs So-and-so was in this state like you're describing right now. The family comes over to us. Euthanasia is legal and accepted, we have to follow it. So I come by and I say: OK, give her 50 milligrams, a 100 milligrams of morphine, whatever the lethal dose will be. I sign and I leave. Who among you will give the lethal injection? «Oh! no, not me, I'm sorry.» But, sorry, I thought you agreed to euthanasia. So this is another problem: Who's going to do it? The passing away of a human being has consequences on all of us. So we cannot hide from that.

So I congratulate our Government for, you know, giving us the opportunity to speak freely about this situation, but it definitely would not... you know. If I can read, I believe, from... Margaret Doody, an attorney from Washington, says that legalizing assisted suicide and euthanasia will create new pass of abuse of the most vulnerable. And, in my years of practice, I have one just recently. The daughter of this person who was demented, in stage dementia, comes in for the first day, he's agitated, he doesn't eat and he cannot swallow. Fine. In the days to come, the person was able to eat on his own, swallow quite well, never agitated. So I did not have to give any neuroleptics, that we call, or very strong tranquilizer. The person was fine.

After about a month, the daughter was very upset with me: How dare you to not follow my order? And I said: Your father is alive and he is doing well, what's the problem? You should not be force-feeding him! Force-feeding him, I said, why are you saying that? The nurse is there with me, takes the glass of juice, puts it over there like that, the gentleman takes the glass and drinks. I say: He is drinking on his own, nobody is forcing him. He is doing well. Then she says: Well, you have to respect my opinion too. Well, I said, what is your opinion?

So this is a dangerous path. And I would not go further into this case, because it gets very complicated. But I think that the attorney Doody is very, very much on when she says: It's quite a dangerous situation for abuse of the elderly and probably ill people. I don't know what the cause... Because then I got involved with a head nurse, with the DPS, and they all came to the same conclusion: Yes, this person wants to hasten the death of this person. Is that the road we want to go on, leave this type of legacy? I don't think so.

I think our legacy should be one that we respect and we honor life, and therefore do our best to maintain life, and, yes, help them through their suffering, their psychological pain and physical pain. We're starting to have the means. Psychiatric did great advances, psychologists too. And, you know, I could almost understand if we were having this discussion like 50 years ago, we were not equipped. Today, we are. We are equipped with specialists, we are equipped with modality so... pain control. We're finally starting to understand pain. And now we're saying: Well, you know what, we have reached this point it's time that we call it quits. Sorry.

Le Président (M. Kelley): Mme la députée de Joliette.

Mme Hivon: Oui. Merci beaucoup, docteur. Moi, il y a juste un élément quand vous évoquez, comme plusieurs personnes devant nous, les risques d'abus qu'il pourrait y avoir, est-ce que ce n'est pas un peu — puis je le dis pour faire l'avocat du diable, parce que je veux vous entendre — est-ce que ce n'est pas un peu manquer de confiance dans le corps médical de penser qu'ils vont se laisser soumettre à des pressions ou des influences?

M. Maiolo (Giuseppe): Experience talks. Look what's happening in the other countries. Some of the euthanasia, doctors don't even see them, they just sign them.

Mme Hivon: Donc, vous pensez qu'il y a des médecins qui...

M. Maiolo (Giuseppe): Listen, everybody is human, and there is... Yes, there is that tremendous risk of doing that. The easy way out. Mind you, when they go home, I don't know what they think, if they sleep properly. But it is a risk, because, in the other countries that have this, and even Doody, the attorney in Washington, speaks of Oregon and Washington... they say: It's very highly possible. And not only that, not only the doctors. I don't know why the daughter was asking me to sedate this person to a tremendous level. Was it financial? Was it because she really care and she truly believe of the suffering? I don't know. But the possibility of the abuse is there, for whatever reason.

Mme Hivon: Vous avez résisté parce que la personne ne le demandait pas. La personne mangeait, la personne voulait vivre.

M. Maiolo (Giuseppe): C'était la fille qui me demandait de faire ça.

Mme Hivon: Oui, c'est ça. Et vous avez résisté parce que la personne elle-même ne le demandait pas.

M. Maiolo (Giuseppe): Mais certainement.

Mme Hivon: Moi, ça me met plutôt en confiance, je dois vous dire.

M. Maiolo (Giuseppe): La fin est un peu triste...

Mme Hivon: O.K. Puis l'autre question, c'est: Dans l'état actuel des choses, il y aurait déjà possibilité ou de l'espace pour des abus, parce que... par exemple, débrancher quelqu'un d'un respirateur, influencer quelqu'un à refuser un traitement parce qu'il est âgé ou qu'on se dit: Ça ne vaut pas la peine, il faut libérer des lits, les pressions des proches qui disent: Bien là, ça fait longtemps qu'il est branché sur un respirateur, il me semble qu'il n'y a plus d'espoir, alors qu'on pense qu'il peut... Puis, pourtant, il ne semble pas y avoir d'abus. La question, c'est: Pourquoi, avec la possibilité de donner une injection létale, là il y aurait des abus du corps médical?

M. Maiolo (Giuseppe): No. I think... You're right, and I agree with you. I think we're just adding more to it. What you explained is true, you know. And therefore what do we need? Better training, better understanding of what happens in the situation. You know, family have to take a responsibility where they are families. When we send somebody... When somebody comes to my office, etc., I sort of like it when there's a family member, because they only take home a couple of percent of what I tell them. The same thing.

So, in these situations, like you're saying, I will convince the patient not to go through whatever treatment necessary, etc. Sure there could be an abuse. And now we're going to add another one? In this other one, I don't know if you... waste the other ones, but it's definitely there and it's very powerful. At least, this is my experience of about a month ago, which was quite dramatic to the whole team.

Mme Hivon: Et, dans votre petite soumission pour votre demande d'intervention, vous disiez: «We can help

most people to have peaceful natural deaths.» Alors, ceux qu'on ne peut pas aider, ceux qui ne sont pas dans la plupart, qu'est-ce qu'on fait? Qu'est-ce qu'on leur propose?

M. Maiolo (Giuseppe): Again, a team approach. A lot of them... You know, they are exceptions, sort of thing, but a lot of times I get called that the person went down for supper, came upstairs, after an hour, they pass away. Others, no. There is the whole process of dying that may last a couple of days, etc. But we treat whatever we can in the sense of pain and also human contacts.

It's amazing how much an individual... We don't understand that yet. There is an incredible situation that... And we see it actually. I said, «exceptionally», but we see it quite often. You know, in today's world, you have a son that is in Vancouver, another child in California, etc. and you know this person is going to die. They have not been eating, they are going to die very soon. You know what? They hang on until the last child is there, and then, within minutes, they pass away very peacefully.

So what do we do? We try to understand what's the need of that particular human being, not a whole, but that particular human being at that time. And that's what, I think, we have to do more, especially in nursing homes. We know, the sort of thing, a lot of them are terminally ill. That's where we need more psychologists, which we don't have, more consult to psychiatry, very difficult to have. And some support, moral support and religious support. Today, we're sort of afraid to speak of religion, but religion is there, it's always been and it always will be. So... And these people do much better. I've seen, sort of thing, people, you know, looking up to their cross in relief. So that's why. Let's continue supporting life, not death.

● (20 h 30) ●

Le Président (M. Kelley): Thank you very much for sharing your professional experience and these other things. As I say, a lot of the questions of my colleague from Hull, a lot of the origin of this debate comes from your profession, not ours. I mean, this notion that euthanasia should be seen as a treatment, that wasn't the committee that came up with that idea, that's something that we were given, a bit of a hot potato from your profession back to us and say: Do something with it. So we're struggling with these ideas because we hear conflicting views and conflicting opinions. But what is always useful is someone who has worked at the bedside of dying people for many, many years. So thank you for your commitment to our society, to those people who are in those most extreme moments, end of life. So thank you for your contribution, both intellectual and professional, to our discussion tonight.

M. Maiolo (Giuseppe): Thank you very much.

Le Président (M. Kelley): Je vais suspendre quelques instants. And I'll ask Clarissa Foley de prendre place à la table, to take your place.

(Suspension de la séance à 20 h 32)

(Reprise à 20 h 33)

Le Président (M. Kelley): La commission reprend ses travaux. Our next witness is Clarissa Foley.

So, roughly a presentation of 15 minutes followed by an exchange with the Members of the committee.

Mme Clarissa Foley

Mme Foley (Clarissa): My presentation will be rather short. I am a retired health care professional. My work, along with other health care workers, was to help cure illnesses, alleviate suffering and, when this is not possible, enable the patient to die with dignity.

Dignity of life, simply described, refers to the value we put on human life. Dignity influences how we treat each other. The dignity of humanness, including both body and soul, is what separates us from the animal world.

Euthanasia interferes with the natural process of life, being born and dying. It removes the power and the value of personhood. Canada has removed the death penalty from its laws and murder is one of the worst crimes. Why then would we, as a society that greatly values human life, sanction the taking of life from the weakest and most vulnerable members of our society?

One main argument for euthanasia, I believe, is the alleviation of pain and suffering. Today's medicine is so advanced that the vast majority of patients can have pain control. We need to work further in that area. I am not advocating keeping persons to life artificially, as it's possible today, but rather to allow nature to follow its course. Because humans and therefore society do err in rational behavior from acceptable moral standards, I believe that legalizing euthanasia is a very slippery slope. We need only look at the Holocaust, it is an example of man's faulty rationalization. Already, there have been documented cases in the Netherlands, where euthanasia is legal, of persons euthanized without their consent. With legalized euthanasia, first, it will be the terminally ill, then perhaps the persons with dementia, then perhaps the paralytics, and maybe then those over 90.

I have, in the last two years, witnessed the death with dignity of two close family members and pain control was excellent and it was a very peaceful death. Our Canadian Québec society has a responsibility to value life from beginning to end. When we start judging or choosing people instead of supporting them as they are, we are reducing life, not fostering it. That's the end.

Le Président (M. Kelley): Thank you very much, Mrs. Foley. We'll pass... Mme la députée de Mille-Îles.

Mme Charbonneau: Merci, M. le Président. Good evening. I'm going to submit to you something we had to think about. I'm going to submit it to you because it's something that I keep with myself every time I leave this room to go home and come back. The name of the person was Mme Gladu. She's a real person. Mme Gladu had a wonderful life but filled with challenge. She had polio, and then she got better, and then after she got post-polio which is not very nice in a life, but she took the challenge, she faced it and she lived a wonderful life. Mme Gladu applied to Dignitas, in Switzerland, she applied to a place that's called Dignitas. That's a place where you can go and they help you die. It's not in Canada and it's specially not in Québec, it's in Switzerland, right?

● (20 h 40) ●

Une voix: Yes.

Mme Charbonneau: Yes. Because sometimes I get mixed up and I change the place, but it's in Switzerland. So she applied and she was accepted. And right now she has a deal with herself that, when she decides that she can't take it anymore, she chose a friend, who responded very clearly and very positively, that's going to go with her there because you go there by plane in a seat but you don't come back in that seat. What she was telling us is that it was sad to her to know that she had to go in another country to feel that she was respected in her dignity, in her way of seeing things, in the respect of herself, with the choice she wanted for herself. And when she came to us, I have to be very truthful with you, she was very accurate and she didn't seem like someone that was missing love, that didn't live or that was suffering, but she knew what was coming and she didn't want to go through it, so she said: This is the way I see life. Pointing to us, she said: Maybe you don't understand the way I see life because it's my eye, it's my heart, but this is what I choose. So I'm telling you, as «un témoin», as someone who is coming to you as a witness, we should respect at a certain quality that demand that people ask. I remind you that she didn't have cancer. She wasn't waiting for «soins palliatifs». She wasn't suffering at the moment that we saw her. So, when she left in a wheelchair, I cannot forget what she said which doesn't make less important what you said, but in my mind this is going to finish one day and I'll have to think it further. So help me with it. What should I do with that witness?

Mme Foley (Clarissa): With this lady? Well, that is her choice. Society is another story. With assisted euthanasia and assisted death, we are deciding for other people, and I do not think we have the right to do that and I feel that down the road... Maybe, this lady, she goes to Switzerland, she does it and she does what she wants. I'm not going to judge her, that's her choice, but there are many people who are probably in worse shape than her, who cannot decide and who may not want to die but they will be... you can be sure it will happen that slowly, slowly, slowly there will be more and more people being put to death before their time, and we will not be able to understand their mental situation and we have no right to shorten their life in that respect.

Mme Charbonneau: And you don't think that's happening right now?

Mme Foley (Clarissa): That is... What's happening right now?

Mme Charbonneau: Euthanasia is happening right now. You don't think it is?

Mme Foley (Clarissa): I would doubt that it... it probably is, but when you legalize it totally, it's certainly a different story. It's happening and often as a result of the pain killers, in that, the person may die. We're all going to die. But the intention of making the life peaceful in the end is not to kill the person, it is simply to give them their last minutes with their family. If they don't have a family that's fine too, but they're entitled to those minutes themselves. That's how I feel.

Le Président (M. Kelley): Mme la députée de Joliette.

Mme Hivon: Ça va être mon collègue.

Le Président (M. Kelley): M. le député de Deux-Montagnes.

M. Charette: Merci, M. le Président. Madame, ce fut un plaisir de vous entendre. Une question par rapport à votre témoignage. Vous avez dit...

Mme Foley (Clarissa): Do you speak English?

M. Charette: Non, mais par contre vous pouvez bénéficier, vous, du service de traduction en... Ce ne sera pas tellement long.

Mme Foley (Clarissa): I understand French but not well. So...

Le Président (M. Kelley): Feel free to answer in English, but my colleague is much more comfortable asking his question in French. So either we can wait 30 seconds and grab one of these earphones so that you can hear his question translated. We have a wonderful service in the corner that has been translating all day long and...

Mme Foley (Clarissa): They can translate it, please, just so that I would understand...

Le Président (M. Kelley): OK. So it will give me a chance, while you're getting set up, Mrs. Foley, it will give me a chance just to... Merci beaucoup pour les personnes au coin. Thank you very much for translators who have worked very hard all day long doing this, so thank you very much. Merci beaucoup pour un travail formidable.

So now that I've done my plug for our translators, Mrs. Foley, you're ready, so, à mon collègue de Deux-Montagnes, vous pouvez poser votre question, s'il vous plaît.

M. Charette: C'est gentil. Merci. Donc, est-ce que vous entendez la traduction?

Mme Foley (Clarissa): It's in French what you're saying. Maybe it's...

M. Charette: Donc, on essaie de nouveau. Est-ce que vous pouvez m'entendre? Est-ce que vous avez la traduction en anglais?

Mme Foley (Clarissa): I prefer in English but it's still in French. What he is saying is in French.

M. Charette: On essaie de cette façon-ci. Vous avez dit au début de votre présentation... Juste nous assurer que ça fonctionne bien à votre convenance.

Mme Foley (Clarissa): What is it?

Une voix: Numéro un.

M. Charette: Oui. D'accord. D'accord. Donc, voilà. Bien, merci d'abord pour votre témoignage. En début de présentation, vous avez mentionné qu'à travers le Code criminel la notion de meurtre est sans doute la notion qui est la plus sévèrement punie, c'est bien vrai. Dans notre

système de justice, c'est certainement un des crimes les plus sévèrement punis. Mais, en même temps, j'ai de la difficulté, je vous le dis bien franchement, à associer ces réflexions ou cette pratique que pourraient être l'euthanasie et le suicide assisté à... les comparer à un meurtre, et je ne prends pas position en vous disant ça, parce que, oui, il y a certainement des risques, il y a certainement des précautions à prendre éventuellement, mais ce qui me fait douter de la comparaison au terme de «meurtre» ou de «tuer», c'est tous les témoignages de médecins que nous avons entendus. Plusieurs sont contre, certainement, mais un certain nombre, aussi, se sont présentés devant nous en demandant ou en jugeant que ce serait un outil supplémentaire à leur arc ou à leur pratique de pouvoir permettre cette pratique-là, et, bien honnêtement, je ne reconnaissais aucune intention malicieuse dans leur propos. Ils avaient un argumentaire qui se défend, comme ceux et celles qui s'y opposent ont un argumentaire qui se défend.

Mais ne trouvez-vous pas que le terme «meurtre» ou «tuer» est lourd de sens et peut-être difficilement compatible avec la volonté de ces professionnels? Oui, dans certains cas, ce sont des médecins, mais il y a eu d'autres professionnels aussi, que ce soient infirmiers, infirmières, travailleurs sociaux, qui se sont présentés en défendant cette pratique-là. Encore une fois, je ne la cautionne pas, je questionne plutôt l'emploi des termes ou l'emploi des mots.

Mme Foley (Clarissa): Well, I feel the end result is the same. So whether you die from euthanasia or murder, you're still dead. And if it's... Maybe it's a little harsh to say it that way, but I feel that we have no right to decide when that will be, if we don't even decide it for our worst criminals. We put them in jail forever, in Canada. Why would we be killing people in hospitals?

M. Charette: ...comprendre, on se rejoint dans une certaine interprétation. Je peux comprendre qu'on soit contre. Ce que je questionnais, c'était davantage l'emploi des termes qui sont très, très lourds de sens.

Mme Foley (Clarissa): Well, perhaps they are, but as I say the end result is the same: the person is no longer in this world, in either case. So you can use milder terminology, which is often used these days to soften the effect of the action, but it's still the same result, so...

We tend to rationalize a lot, nowadays, and say well, you know, maybe it's this way, and maybe it's that way, and maybe it's not really so, and maybe they really want it, and maybe they don't, but I've seen many cases where elderly people were not treated well, mostly by the families, not by the health care people. So that is one area that I would fear greatly that our society would lead to. All family members don't love each other. OK?

M. Charette: Merci.

Le Président (M. Kelley): This is the last point where you're saying... Mrs. Foley, just to remind you, in the Criminal Code, assisted suicide and murder are different concepts, they are not the same thing. I'm just...

Mme Foley (Clarissa): Yes, I understand.

Le Président (M. Kelley): «Murder» has quite a strong sense.

Mme Foley (Clarissa): Yes.

Le Président (M. Kelley): Just to keep things clear, we do divide them up in the Criminal Code, so that's this part of the way that the laws are set up for the country.

But for the rest, thank you very much for taking the time to come in. I notice from your dress you're a near neighbor, so thank you for coming in and sharing your concerns with the committee this evening.

Je vais suspendre quelques instants and I will ask Lorraine Baker to take her place, please.

(Suspension de la séance à 20 h 49)

(Reprise à 20 h 50)

Le Président (M. Kelley): Alors, la commission reprend ses travaux. Notre prochain témoin, c'est Mrs Lorraine Baker. Your turn. Bonsoir.

Mme Lorraine Baker

Mme Baker (Lorraine): Bonsoir. Je vais lire en français qu'est-ce que mon mari a traduit, que j'ai écrit en anglais. Ça fait que, si je me mélange un petit peu, ce n'est pas grave, hein? On va se comprendre pareil.

Le Président (M. Kelley): ...merci beaucoup.

Mme Baker (Lorraine): Merci de m'avoir invitée afin que je puisse vous exprimer ce qui vient du fond de mon cœur. Nous devons nous pencher très sérieusement sur ces sujets de mourir dans la dignité et du suicide assisté, parce qu'un jour nous serons tous, personnes âgées et jeunes, à la merci de votre décision.

Nous connaissons tous des amis ou des membres de notre famille qui ont reçu la nouvelle qu'ils ont peu de temps à vivre. Parfois, les médecins font erreur. Ils sont après tout des êtres humains. Ça serait une tragédie de se faire arracher des moments tellement précieux à la fin.

Il y a 10 jours, j'ai perdu un grand ami. La morphine lui a rendu ses derniers moments plus confortables. Les doses ont été ajustées selon sa douleur.

Certains hôpitaux insistent sur les délais prescrits avant la prochaine intervention au grand détriment du souffrant. Cette pratique devrait être modifiée.

Votre commission a une très grave responsabilité. Je vous demande de considérer tous les aspects, les aspects humains, lors de vos discussions, avant de tirer vos conclusions.

Nous, ici, au Canada, il est évident qu'on va prendre nos décisions selon nos considérations particulières. Cependant, je crois qu'il serait sage si cette importante décision prenait en considération les expériences vécues en Belgique et aux Pays-Bas, là où la pratique à l'étude existe déjà. Les dernières statistiques démontrent que 32 % des morts qui ont été prescrites l'ont été sans le consentement ni la demande des malades. Songez à ça juste un instant, ça fait peur.

Je me suis occupée, moi, personnellement de ma mère, mes beaux-parents, deux tantes et un oncle. Comprenez-vous? Je suis un enfant unique. Et puis mon père est mort quand j'avais quatre ans, alors l'obligation des soins reposait

sur moi. Je vous raconte ceci pour vous dire que jamais l'une ou l'autre n'a demandé de mourir, jamais. Puis il y a eu des morts difficiles.

Je sais très bien que certains le demandent. Je crois sincèrement que la majorité de ces personnes sont souvent seules, placées, oubliées et déprimées. Ils ne veulent pas être seuls, ils veulent la compassion, l'accompagnement, l'amour et sûrement les médications qui soulagent. L'instinct de survivre est très fort et très naturel; accordons à chaque personne cette chance.

Les coûts de la santé augmentent de plus en plus. Les baby-boomers comme moi seront la majorité de la population très bientôt. Est-ce que ceci pourrait être la raison derrière l'intérêt du gouvernement envers cette idée? Si le médecin prescrit des morts assistées, le coût de la santé sera certainement réduit considérablement.

Est-ce que nous voulons aussi considérer l'âge des gens, l'économie? Est-ce que ça serait que nous voulons... Est-ce que c'est ça que nous voulons vraiment? Comme citoyennes et citoyens, nous aimerons avoir confiance que notre gouvernement agira honorairement. Est-ce que nous pouvons avoir confiance qu'un programme gouvernemental sera fondé sur qu'est-ce qui est mieux pour la société ou est-ce que ce serait plutôt déterminé par les besoins économiques? Est-ce qu'on est prêts à prendre un risque pareil?

Si vous facilitez l'option de mourir dans la dignité, soit l'euthanasie ou le suicide assisté, vous ouvrez la porte à d'autres choix éventuellement. Est-ce que, plus tard, on va choisir les personnes avec les maladies incurables, les maladies affaiblissantes ou on peut aller aux personnes diminuées? Ces choix, où est-ce que c'est qu'ils vont arrêter? Je vous demande vivement de ne pas permettre ce choix, s'il vous plaît. La commission a le pouvoir de se prononcer et d'arrêter ceci avant qu'il soit trop tard. Les citoyens attendent votre réponse. Merci. Là, je suis prête à parler, à cette heure que j'ai lu.

Le Président (M. Kelley): Merci beaucoup. Préférez-vous des questions en anglais ou en français?

Mme Baker (Lorraine): Non, je suis capable de répondre en français aussi.

Le Président (M. Kelley): Au juste, je vais juste clarifier. La commission n'est pas l'idée du gouvernement.

Mme Baker (Lorraine): J'ai compris ça avec le docteur qui a parlé, tout à fait, mais...

Le Président (M. Kelley): Mais je pense... Non, mais c'est important...

Mme Baker (Lorraine): Oui, oui.

Le Président (M. Kelley): ...parce que ce n'est pas de dire que le gouvernement veut faire ci, le gouvernement veut faire ça.

Mme Baker (Lorraine): C'est dans vos mains, c'est vous qui va prendre...

Le Président (M. Kelley): Non, non. Mais nous ne sommes pas non plus... nous sommes une création de

l'Assemblée nationale. Donc, les quatre formations politiques, à l'Assemblée nationale, ont toutes choisi ce sujet à explorer, mais aucunement, ni le ministre de la Santé, ni le premier ministre du Québec, ou toutes ces autres personnes, ce n'est pas leur choix, mais c'est le choix des parlementaires, des députés de regarder cette question. Mais je pense que c'est très important. Et en grande partie à l'origine de tout ça est la profession médicale. A la fois le Collège des médecins, à la fois la Fédération des médecins spécialistes et la Fédération des médecins omnipraticiens ont dit aux parlementaires: Il existe, dans nos pratiques, certaines zones grises. Pouvez-vous les éclairer pour nous?

Je pense que c'est très important parce que de présumer que ça, c'est le gouvernement et c'est quelque chose qui est fait dans l'objet de faire des économies dans les coûts, ce n'est pas du tout ça, l'origine du mandat, et je pense que c'est très important de le dire parce qu'à l'origine c'est vraiment... Si vous cherchez le coupable, je pense que le premier suspect doit être le Collège des médecins, qui a fait une réflexion interne, qui est arrivé à la conclusion... et c'est très controversé. Je ne dis pas que j'endosse, mais c'est eux autres qui ont avancé l'idée de l'euthanasie comme un traitement en fin de vie, un soin. L'idée est controversée, l'idée est originale, mais ça ne vient pas de nous. C'est un petit peu... Nous autres, on a le défi qui vient du monde médical, comme députés.

Une voix: ...

Le Président (M. Kelley): Non, non, et c'est pourquoi je veux le dire, je dis ça en tout respect, ce n'est pas... Mais je pense que c'est très important parce que c'est un argument qui est soulevé. Et honnêtement on peut blâmer le gouvernement pour beaucoup de choses, mais, dans ce cas précis, ce n'est pas la faute du gouvernement, et je pense que c'est important de le dire ce soir.

Est-ce qu'il y a une question à ma... Mme la députée de Mille-Îles.

● (21 heures) ●

Mme Charbonneau: Merci, M. le Président. Je n'en ferai pas une longue et pénible, je vais en faire une très courte. La plupart des gens qu'on a rencontrés, qui sont pour, nous ont parlé de compassion. Je ne peux pas faire autrement que, après vous avoir entendue ou, je devrais dire, vous avoir écoutée, revenir sur le principe de la compassion. Vous êtes ici depuis le début de la soirée, je pense, et vous avez entendu les différents principes qui ont été énoncés, et les gens qui sont venus nous voir sont dans une des catégories des gens que vous avez avec ciblé, en disant: C'est quoi, la prochaine affaire? La prochaine affaire, ça va-tu être les gens qui ont des maladies dégénératives?

Je l'ai dit plus tôt, je vais le redire encore, les gens qui sont venus faire des témoignages n'étaient pas des gens qui avaient le cancer, ce n'étaient pas des gens qui étaient en phase terminale d'un cancer du pancréas ou quelque chose comme ça; ce n'étaient pas non plus des membres de familles de gens qui sont morts du cancer; ce sont tous des gens qui avaient des maladies dégénératives, donc, et la plupart des gens, sinon tous, sont venus nous dire: Laissez-nous le choix; par compassion et par volonté sur ma vie, laissez-nous le choix.

Alors, comment je fais pour calculer cette compassion-là comparée à celle où je vais leur dire: Non, vous n'avez pas le choix, vous devez aller jusqu'au bout de votre

maladie? Et, comme nous rassurent certains médecins... il y en a qui m'ont inquiétée, je vous le dis tout de suite, là, il y en a qui m'ont parlé de traitements inutiles, il y en a qui m'ont dit que ça se faisait mais qu'on n'en parlait pas, puis que je ne peux pas le calculer, puis je ne peux pas avoir de statistiques, puis il n'y a personne qui me donne des comptes de ça, là. Ça, ça m'inquiète.

Mais, ceci dit, les gens sont venus nous dire: Par compassion, laissez-nous nous rendre où on veut, dans les choix qu'on veut. Puis on ne veut pas, nous, imposer ça aux autres. Quelqu'un qui ne veut pas mourir... Parce qu'initialement on veut tous vivre, hein? Il n'y a rien... Il n'y a jamais personne qui veut plus vivre que quelqu'un qui vient d'avoir un diagnostic qu'il va mourir. Même si on le sait tous que c'est une conséquence. Si tu nais, tu meurs. Ceci dit, comment je fais pour mesurer ma compassion? Comment je fais pour bien répondre à ces gens-là?

Mme Baker (Lorraine): Ce n'est pas facile. Ce n'est certainement pas facile. Sauf que, vous savez, la société... Si une personne veut en principe se suicider, c'est une tragédie, mais il n'y a rien qu'on peut faire. Mais faire en loi qu'on peut l'aider ou qu'on peut... un docteur peut l'aider d'une façon ou d'une autre, ça, c'est toute une autre histoire. La compassion, c'est très important, parce qu'il n'y a rien de plus triste que quelqu'un malade. Sauf qu'il y a tellement de choses qu'on peut aider, vous savez. Comme... j'ai parlé de la morphine. C'est quelque chose... Écoutez, je n'ai aucune expérience médicale, je ne peux pas dire, mais sauf que je le sais que ça, c'est quelque chose qui est utilisé beaucoup. Il y a beaucoup d'autres choses qu'ils peuvent user, voyez-vous? Vous avez parlé de votre dame, madame...

Mme Charbonneau: Gladu.

Mme Baker (Lorraine): Gladu. C'était son choix personnel. Alors... Mais elle n'a pas le droit de nous demander de faire comme elle ou avec elle. Comprenez-vous qu'est-ce que j'essaie de dire?

Mme Charbonneau: Tout à fait.

Mme Baker (Lorraine): Vous savez, c'est comme la société dit: On ne peut pas — puis je n'utilise pas le mot «tuer» comme ça — mais on ne peut pas tuer son prochain, mais il y en a qui le font. Mais la loi dit non, mais ça n'empêche pas quelqu'un de le faire, ou de se suicider, ou de se jeter en bas du pont, ou de... Ça n'empêche rien, ça. Sauf que la personne qui veut vraiment se suicider va le faire.

Mais je crois qu'on n'a pas le droit d'embarquer d'autre monde dans notre histoire, parce que c'est nous après, le monde qui aide, qu'il faut qu'il dorme la nuit, qu'il faut qu'il pense à qu'est-ce qu'on a fait. Parce que des fois, comme le docteur a dit... Parce que, moi, j'avais une tante qui était placée. Et puis il y a des pauvres gens qui sont là pour des années. Il n'y a personne qui vient à Noël. Il n'y a personne qui vient à la fête des Mères. Il n'y a personne, O.K.? Ils en ont, des enfants. Le bon Dieu seul le sait où est-ce qu'ils sont. Mais, aussitôt qu'on leur parle, on amène un petit cadeau, une fleur, un bonbon, quelque chose, ils sont tellement heureux, ils deviennent une autre personne, vous savez.

O.K., moi, je n'ai pas l'expérience pour dire comment qu'on règle la maladie. Mais d'un autre côté je suis d'accord quand les autres ont dit que souvent c'est l'environnement. Moi, ma mère et ma belle-mère sont mortes dans nos bras, dans la maison, O.K.? Et puis je vais vous dire que ça a été des belles morts. Ça ne veut pas dire qu'ils n'ont pas souffert, mais ils ont passé doucement, en paix. Ils étaient chez eux, ils avaient leurs choses. Comprenez-vous qu'est-ce que...

Écoutez, on peut finir dans un foyer. On ne sait pas qu'est-ce qui nous attend. Puis il y a des très bons foyers aussi. Mais on espérerait de ne pas être obligé de s'inquiéter que, tu sais, si je ne souris pas, ils vont me donner la piqûre, vous savez. C'est inquiétant, vous savez, pour les gens d'un certain âge. On va y arriver très vite. Les baby-boomers, en tout les cas, on va y arriver très vite et puis on se demande est-ce qu'on doit s'inquiéter de ça, comprenez-vous?

La compassion, ça vient du coeur, et puis on ne peut pas déléguer ça. Soit on l'a ou on ne l'a pas. Mais je pense que les familles... Je le sais qu'elles sont tout épargnées. Moi aussi, là, j'ai des enfants, puis ils sont... Mais il faut que les... Bien, c'est une mentalité d'abandonnement maintenant. Mais avant ce n'était pas comme ça. Puis, moi, je n'ai pas été élevée comme ça. Puis je suis fière de dire que je n'ai pas fait ça non plus. Mais il faut garder nos vieux avec nous. Ce n'est pas des vidanges, vous savez. Puis, si on commence à... je sais, en compassion, là, de... Ce n'est pas nécessairement qu'ils ont plus mal qu'un autre. C'est simplement qu'ils ont leur mal seuls, ils gèrent ça tout seuls. Vous savez, si on ne file pas puis on peut dire à quelqu'un: Tu sais quoi, je ne file vraiment pas aujourd'hui, on dirait qu'on file mieux. Mais, si on est seul, là, puis on ne peut jamais parler à personne sauf une garde ou un docteur qui rentrent vite, vite, ce n'est pas la même chose. C'est la seule réponse que je peux vous donner.

Mme Charbonneau: C'est une bonne réponse. Merci.

Le Président (M. Kelley): Mme la députée de Joliette.

Mme Hivon: Merci beaucoup pour vos propos très sentis. Puis on aime beaucoup ça avoir des témoignages, là, aussi humains, aussi vrais, qui viennent autant du fond du coeur. Moi, je pense qu'une grande conclusion de nos premiers jours, c'est évidemment... d'auditions avec des gens comme vous, qui ont des opinions très différentes, c'est que les gens sont très, très marqués par leurs expériences personnelles. Puis c'est normal. C'est fondamental. C'est ça qui fait la richesse de notre vie en société.

Et, quand on regarde la compassion c'est quoi, vous, vous avez eu la chance d'accompagner vos deux parents et même plus, parce que vous étiez visiblement une ressource importante pour votre famille, puis on peut comprendre pourquoi. Puis je suis certaine, convaincue, juste à vous entendre, que vous les avez très bien accompagnés, avec toute la compassion du monde, et qu'ils étaient chanceux de vous avoir. Et puis je pense que la très, très grande majorité des gens ont un coeur et espèrent accompagner le mieux possible les gens qu'ils aiment à la fin de leur vie, c'est certain.

Mais il y a des gens aussi qui sont comme vous, qui veulent accompagner leurs proches de la manière la

plus extraordinaire, mais que leurs proches, eux, ont un regard différent sur leurs maladies, sur leurs souffrances, sur leurs maladies dégénératives. Et on nous parlait que l'accompagnement fait une grande différence. J'en suis convaincue. Je pense que tout le monde en est convaincu. Je pense que les gens qui nous demandent d'ouvrir pour qu'il y ait une ouverture à une aide médicale à mourir en sont complètement convaincus. D'ailleurs, on a des infirmières qui sont venues nous parler, qui travaillent en soins palliatifs, qui ont dit, eux... Ils estimaient à peu près à 30 % les gens en fin de vie qui pouvaient exprimer un désir d'être aidés à mourir mais que, quand leur douleur était bien soulagée, et qu'ils étaient bien accompagnés, et qu'on regardait s'il y avait des symptômes dépressifs, tout ça, cela chutait à peu près 7 %.

Mais, mettons, pour ce 7 % là, et qui sont accompagnés par des proches... Et on en a eu, de ces proches-là. Soit qu'ils nous ont dit que leurs proches leur faisaient une demande répétée de mourir et qu'on donnait le meilleur accompagnement possible, ils étaient en soins palliatifs, mais la demande demeurait, ou on nous a dit: Mon proche avait une maladie dégénérative, et c'était très, très difficile à vivre pour lui. Il avait de la douleur, mais il avait énormément d'anxiété, il se projetait. Et il y a une famille qui est venue nous voir avec le meilleur... En tout cas, moi, à les voir, je pense qu'ils ont dû donner un bon accompagnement, mais la personne voulait tellement mourir qu'elle a décidé de se suicider avant que l'heure soit venue parce qu'elle avait trop peur de perdre tout contrôle et de souffrir. Bon, on peut...

Alors, pour ces personnes-là, la compassion comme ils nous l'expriment, ces proches-là, les gens, évidemment, ils le demandaient, là. Toutes leurs énergies étaient mises à espérer pouvoir avoir cette possibilité-là, cette porte de sortie, comme ils disent. Mais les proches aussi. Pour eux, je pense que c'est comme un échec. On peut voir l'échec de différentes manières, mais, eux, comment ils nous le disent, c'est un échec parce qu'ils n'ont pas pu permettre à la personne qu'ils aiment le plus au monde de mourir comme elle le souhaitait.

Alors, vous comprenez un peu, quand je dis qu'on est marqués par nos expériences. Et, nous, après, on est marqués par toutes les expériences qui nous sont relatées, la vôtre, qui est extraordinaire aussi, et celles de ces gens-là, et le défi, c'est d'essayer de réconcilier ça pour après savoir, de ces expériences-là, comme société, c'est quoi, la bonne réponse. Et je ne sais pas si ça vous inspire quelque chose, parce que tantôt vous avez dit quelque chose qui m'a frappé. Vous avez dit: Il faut que ces gens, les proches, dorment la nuit, après. Mais il y en a certains pour qui, pour des situations tout à fait inverses, parce qu'on leur demandait, on demandait aux proches l'aide à mourir... ils ont peut-être eu de la difficulté aussi.

Mme Baker (Lorraine): Ça se peut fort bien. Mais, vous savez, il y a différentes choses que les docteurs peuvent faire aussi pour aider le 7 % qui n'est pas... Est-ce qu'ils avaient des médicaments? Est-ce qu'ils étaient en douleur, et c'était simplement la peur?

Mme Hivon: Il y a les deux. Il y a de la douleur chronique, qui est difficile à contrôler, parce que, moi, je pense que la médecine est très, très avancée, mais il n'y a pas une science qui est parfaite, parfaite, parfaite, là.

Mais il y a aussi beaucoup, effectivement, on nous dit, beaucoup de souffrance existentielle, d'anxiété, et tout ça, effectivement.

● (21 h 10) ●

Mme Baker (Lorraine): Bien, je crois qu'il y a des médicaments pour aider ça. Demandez-moi pas c'est quoi, parce que je n'ai aucune idée. Mais je suis certaine... Parce qu'il y a des gens qui font des dépressions, puis ils sont déprimés, et puis il y a des médicaments pour calmer le dedans, vous savez, la tête.

Je ne le sais pas qu'est-ce que c'est qui est la réponse. Je vais vous le dire honnêtement, je ne le sais pas. Mais je ne crois pas que... qu'un suicide assisté ou une euthanasie, là, que c'est la réponse. Il faudrait presque connaître la personne qui veut, vous savez, je veux dire, qui veut mourir, qui ne veut pas faire le trajet naturel. Il faudrait presque savoir son cas.

Mais à part de ça je crois qu'il y a beaucoup de choses qu'aujourd'hui ce n'est pas nécessairement... Ils n'utilisent pas tout ici qu'il y a à utiliser. Il y a d'autres pays... Puis là je ne parle pas de l'euthanasie, mais je parle qu'il y a d'autres drogues, d'autres façons de faire les choses, qui marchent très bien, qui fonctionnent très bien, mais qu'ici, pour une raison ou une autre... Je ne sais pas s'ils n'ont pas le droit, ou ils ne veulent pas, ou c'est trop cher, je ne le sais pas, les raisons, mais il y a beaucoup de choses en dehors de... les petites choses qu'on connaît ici, qu'on pourrait incorporer, puis peut-être ça pourrait prendre soin de ces 7 % là. Peut-être. Je ne le sais pas.

Mme Hivon: Merci beaucoup. Merci.

Le Président (M. Kelley): Mme Baker, merci beaucoup pour votre contribution à notre réflexion ce soir.

Avant d'ajourner, pour les personnes à la table, en arrière, de la sécurité, à l'accueil, pour notre équipe sonore, nos recherches, pas pire, c'est 9 h 10. Alors, vous avez 20 minutes off grâce à votre président. Alors, merci beaucoup pour votre soutien à notre travail, toujours travailler dans l'ombre un petit peu, mais c'est très apprécié.

Sur ça, je vais ajourner nos travaux à demain matin, 9 h 30, dans cette même salle.

(Fin de la séance à 21 h 12)