HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

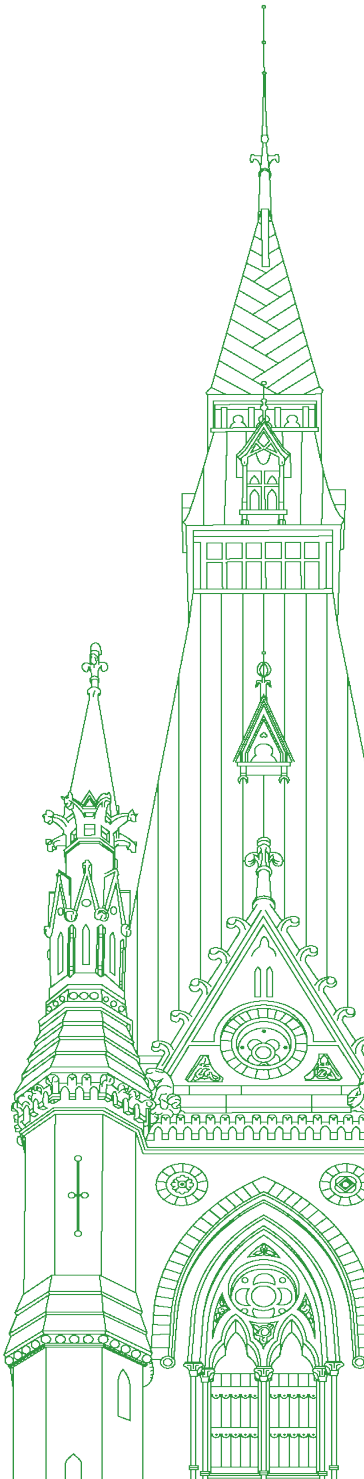
44th PARLIAMENT, 1st SESSION

Special Joint Committee on Medical Assistance in Dying

EVIDENCE

NUMBER 002

Wednesday, April 13, 2022



Co-Chairs:
The Honourable Marc GarneauThe Honourable Yonah Martin

Special Joint Committee on Medical Assistance in Dying

Wednesday, April 13, 2022

● (1440)

[*English*]

The Joint Chair (Hon. Yonah Martin, Senator, British Columbia, C): I call the meeting to order, as co-chair along with member of Parliament Michael Barrett.

[*Translation*]

Good afternoon.

Welcome to meeting number two of the Special Joint Committee on Medical Assistance in Dying.

Welcome to the committee members, witnesses and members of the public who are watching the proceedings online.

My name is Yonah Martin, and I am a joint chair of the committee.

[*English*]

Mr. James Maloney (Etobicoke—Lakeshore, Lib.): Madam Chair, excuse me. I'm hearing both you and the interpretation simultaneously. I don't know if anybody else is experiencing that as well.

The Joint Chair (Hon. Yonah Martin): Yes, I have it on English. You're right. I shall remember to take that off. Thank you. I'm sorry about that.

Mr. James Maloney: That's okay.

The Joint Chair (Hon. Yonah Martin): I think everyone did hear the echo but heard me nonetheless, so I will continue.

Is Mr. Anandasangaree [*Technical difficulty—Editor*] this time?

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): Thank you, Madam Chair.

The Joint Chair (Hon. Yonah Martin): Okay, today we are starting our examination [*Technical difficulty—Editor*]

We're not hearing the sound in the committee room, so I'll just continue for now.

Today we're starting our examination of the Criminal Code relating to medical assistance in dying and its applications.

Before we begin, I'd like to remind members and witnesses to keep their microphones muted at all times—we have had a few technical difficulties already—unless recognized by name by the joint chairs.

I will remind you also that all comments should be addressed through the joint chairs. When speaking, please speak slowly and clearly, and interpretation in this video will work like an in-person committee meeting. You have the choice at the bottom of your screen of "floor", "English" or "French".

With that, I would like to welcome our witnesses.

From the Department of Health, we have Abby Hoffman, senior executive adviser to the deputy minister; Jacquie Lemaire, senior policy adviser, end of life care unit, strategic policy branch; and Venetia Lawless, manager, end of life care unit, strategic policy branch.

From the Department of Justice, we have Joanne Klineberg, senior counsel, and Jay Potter, acting senior counsel.

Thank you all for joining us at this important second meeting of the committee.

We'll begin with opening remarks shortly by Ms. Hoffman, followed by Ms. Klineberg. Each of our witnesses today has five minutes. I have a stopwatch next to me for timing all speakers and I will try to give you a 30-second warning before the end of your time.

With that, I would like to invite our first witness, Ms. Hoffman.

Mr. Gary Anandasangaree: Madam Chair, I have a point of order at the outset—

The Joint Chair (Hon. Yonah Martin): Yes, go ahead.

Mr. Gary Anandasangaree: Very briefly, I would like about 15 minutes at the end to discuss committee business. I'm very appreciative of the witnesses who are here and I don't want to delay proceedings at this point, but close to the end of the meeting, Mr. Barrett and Ms. Martin, could we have about 15 minutes to finalize committee business?

The Joint Chair (Hon. Yonah Martin): Noted.

We will begin with our first witness, Ms. Hoffman.

Ms. Abby Hoffman (Senior Executive Advisor to the Deputy Minister, Department of Health): Thank you, Madam Chair.

Good afternoon and good morning to all of you.

When I addressed the committee last year, I drew on the government's annual report on MAID to provide a statistical overview of assisted dying in Canada. You have access to our latest report for the calendar year 2020, so I will note just a few key points.

In 2020, 7,595 individuals received a medically assisted death, accounting for 2.5% of all deaths in Canada. This reflects steady and expected year-over-year growth. MAID procedures as a proportion of all deaths will likely level off at approximately 4%.

Since the inception of MAID in Canada in 2016, these are the facts: The average age is 75. The most frequently occurring medical condition is cancer. The percentage of written requests resulting in a MAID death is approximately 75%. The urban-rural split is equivalent to population distribution. The proportion of requesters who have accessed palliative care is slightly more than 80%. The most common manifestation of suffering reported by requesters is their seriously diminished quality of life, including the inability to manage activities of daily living. As well, the proportion of provider-administered versus self-administered procedures, more than 99%, has remained more or less constant.

We know that the picture of MAID in Canada will evolve over time in light of the changes authorized in Bill C-7, We won't have comprehensive data available in the time frame of your review, but we have some insights from preliminary data for 2021 and anecdotal sources, including the following.

The number of MAID cases continues to increase, approaching 10,000 in 2021. Despite COVID, this was an increase of approximately 30%. Around 2% of those cases, or just over 200, involved persons whose natural death was not reasonably foreseeable. As expected, these individuals are slightly younger, and their predominant medical conditions are much more likely to be neurological in nature, such as Parkinson's, MS, or chronic pain.

We have been working on the new regulatory requirements for the provision of data about MAID. These will be in place by January 1, 2023. The new data will document MAID cases where the requester is not facing imminent death and cases where the requester approved for MAID has made an agreement with the provider for a waiver of their final consent.

The new regulations will also ensure reporting on the application of the strengthened safeguards that apply to cases when the requester's natural death is not reasonably foreseeable. These include consultations with an expert in the person's condition, the offer of available services and supports to relieve the person's suffering, and agreement by the provider and the person requesting MAID that the person has given serious consideration to these means.

We will be authorized as well to require MAID providers to collect and report information about the requester's race, indigenous identity, disability and other characteristics, providing that the individual consents. This will help establish the presence of any inequalities, including systemic inequality, in Canada's MAID system.

I'll say just a few words about cases in which natural death is not reasonably foreseeable. These cases are challenging because of the complexity of each requester's circumstances, the need for clinical analysis of each element of the eligibility criteria, and the application of rigorous safeguards. We have heard from some practitioners that doing these assessments is extremely difficult, which we anticipated.

To facilitate the consistent and safe application of the new legislative framework, Health Canada is funding the Canadian Association of MAID Assessors and Providers to develop resources for MAID practitioners. Over the next four years, CAMAP will develop and disseminate a nationally accredited MAID curriculum that will provide high-quality in-person and online training for providers across Canada. Modules will cover such topics as assessing for capacity to give informed consent, vulnerability, navigating complex cases and conditions, and MAID in the context of mental illness. We anticipate that this training program will help ensure high-quality services for Canadians and support the recruitment and retention of participating health providers.

I can speak further—

● (1445)

The Joint Chair (Hon. Yonah Martin): You have 10 seconds.

Ms. Abby Hoffman: Yes. Thank you.

I can speak further about research that we will also be supporting to complement the federal monitoring system.

We also want to review the various approaches to MAID delivery and oversight adopted across Canada to identify challenges and successes, which can then inform policy and planning.

Madam Chair, my colleagues and I will be happy to respond to your questions about MAID generally or the specific subjects of your review. Thank you.

● (1450)

The Joint Chair (Hon. Yonah Martin): You're right on time. Thank you, Ms. Hoffman. I know that you bring a lot of expertise today.

We will go to our first round of questions, which will be for five minutes each. We'll begin with Mr. Cooper for the opposition Conservatives, followed by a member of the Liberal Party.

I'm curious as to which—

Mr. Gary Anandasangaree: Madam Chair, I have a point of order.

The Joint Chair (Hon. Yonah Martin): Yes, Mr. Anandasangaree?

Mr. Gary Anandasangaree: I believe there are other officials. There is at least one other official who is able to do a presentation, in this case from the Department of Justice.

The Joint Chair (Hon. Yonah Martin): I apologize. I was too eager with round one. You're right on the next witness. Thank you.

Mr. Jay Potter (Acting Senior Counsel, Department of Justice): Good afternoon, and thank you, members of the committee. My name is Jay Potter. I'll be giving remarks from Justice Canada today.

I'm pleased to be here to support your review of medical assistance in dying. My comments will be consistent with those of Ms. Klineberg from last year and will provide an overview of the federal MAID framework and highlight some considerations that you may wish to bear in mind as you study the complex and important issues that are before you.

As you know, our law has evolved considerably since the 2015 decision of Carter by the Supreme Court of Canada. In less than a decade, the law's approach has transformed from an absolute prohibition on MAID in all circumstances to a sophisticated regime that permits it as a legitimate response to intolerable medical suffering, while also providing for eligibility criteria, procedural safeguards and a monitoring regime to protect vulnerable persons.

Thousands of Canadians have accessed MAID, most of whom did so under the initial framework set out by former Bill C-14. As you all know, that framework changed last year through former Bill C-7, which responded to the Truchon decision.

The most significant change made by former Bill C-7 was to eligibility criteria. The law now permits MAID irrespective of whether or not a person's natural death is reasonably foreseeable, but that concept is used to determine the procedural safeguards that will apply to a request. There's also a temporary exclusion for requests where a mental illness is the sole underlying medical condition, which will expire in March of 2023.

There were also a number of changes made to procedural safeguards, including providing for a waiver of final consent, which allows MAID to be provided to an incapable person in certain defined circumstances: specifically, where such a person has a reasonably foreseeable death and, while they had capacity, they requested MAID, were assessed and approved for it, had scheduled the procedure for a specific date and agreed with their practitioner to receive MAID on or before that date if they lost capacity.

As you move forward with your work, it may be helpful to recall that the framework governing MAID is shared between the federal and provincial governments. Parliament is responsible for the criminal law, which is the foundation for the federal framework, and the Criminal Code provides exemptions from offences of culpable homicide and assisting suicide so that practitioners and those who support them are not criminally liable for providing or being involved in the lawful provision of MAID. The criteria and safeguards form the key elements of those exemptions.

In contrast, the delivery of health services is generally a matter of provincial responsibility. This includes organizing access to MAID, the regulation of health care professionals and enforcement, whether that be at the professional disciplinary level or with respect to the enforcement of the criminal law. As a matter of health law, provinces or professional regulatory bodies could supplement the federal framework with additional requirements concerning MAID; however, they could generally not permit something that falls outside of the exemptions. That type of change would require federal legislation.

Relatedly, I would note that the issue of advance requests for MAID raises particular complexity in this regard. The criminal law exemptions are oriented towards a single point in time, which is when the practitioner administers a substance to cause a person's death or provides them with a lethal substance for self-administration. In an advance request scenario, a second point in time is relevant, too, which is when the request is prepared by the person who at that time is not immediately seeking MAID. This earlier point in time does not obviously involve the commission of a criminal offence that requires an exemption, so there's legal complexity in considering how the criminal law might provide for procedural safeguards or other requirements to govern it. Those would ordinarily be matters of health law.

Finally, in support of your study, I would remind the committee of the three reports of the Council of Canadian Academies. These were prepared pursuant to former Bill C-14 and address many of the issues that are before you. No doubt you'll also be interested in the forthcoming recommendations of the expert panel on MAID and mental illness, which was established last year to consider safeguards, protocols and guidance for the provision of MAID in those circumstances.

Those conclude my opening remarks. I'd be pleased as well, with my colleagues, to respond to the committee's questions.

Thank you.

● (1455)

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Potter. Thank you for your patience as we continue.

For our first round of questions, we will begin with Mr. Cooper for five minutes. Mr. Cooper will be followed by Mr. Maloney. I will give a 30-second warning to all so that we can keep within our time.

Mr. Cooper, go ahead.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you, Madam Chair, and thank you to the officials for being here.

As a starting point, can the officials from Health Canada or from the Department of Justice speak to any data on issues of non-compliance with eligibility and safeguard requirements provided for under the Criminal Code?

Ms. Abby Hoffman: Madam Chair, I'd be pleased to make some initial comments on this point.

While we collect, at the federal level, data on virtually every aspect of the requirements that are set out in the Criminal Code—and we publish that, as you know—the responsibility for actual oversight and compliance with the law is principally the responsibility of provinces and territories.

Each has its own particular methods of going about this. In some cases, for example, the medical examiner or the chief coroner's office investigates and reports on every single case. In other instances, there is some sort of dedicated oversight or review committee. In some cases, as well, there are provisions of the medical regulatory bodies that also have a role in the jurisdiction.

The number of cases of concern about compliance that we are aware of and which have been reported is very small. In the cases we are most familiar with, the provider in question.... By way of example, one case involved a practitioner who proceeded with a MAID case in an institution where there was concern about whether it was reasonable for that institution to allow that kind of access. That case was one of those that we know about in which the provider and the provider's behaviour were ultimately exonerated—

Mr. Michael Cooper: Thank you. I apologize, but my time is short. I appreciate your answer, but very simply, is there national data of any kind?

Ms. Abby Hoffman: No, there is not.

Mr. Michael Cooper: You just said that non-compliance is very low. On what basis do you reach that conclusion in the absence of national data?

Ms. Abby Hoffman: That is based on reports from provinces and territories about MAID cases in their jurisdiction. They have responsibility for enforcement and compliance, so it would be natural that we would rely on data about their activities.

As I say, in most cases this involves a hands-on approach to every single MAID case.

Mr. Michael Cooper: Thank you. Are you able to quantify what "very small" is?

Ms. Abby Hoffman: To our knowledge, it would fewer than 10.

Mr. Michael Cooper: That's interesting, because in its April 2019 report, the commission on end-of-life care in the province of Quebec ruled that 13 cases didn't comply with the law. Are you saying it's 10 cases in the province of Quebec? The end-of-life commission report cited 13 cases.

I would further note that in Ontario, the chief coroner's office announced a review of 2,000 cases in which the coroner raised "compliance concerns with both the Criminal Code and the regulatory body policy expectations, some of which have recurred over time." It doesn't sound to me like these are minor issues.

Ms. Abby Hoffman: I would make a distinction—

Mr. Michael Cooper: At the end of the day, if you're not monitoring compliance in the law, what are you monitoring?

Ms. Abby Hoffman: Madam Chair, if I could respond to that, I'll simply say that we are monitoring the practice of MAID in Canada and fulfilling our role as the federal government.

Compliance, as I said, is the responsibility of provinces and territories. I would also note that in the early days of MAID, there might have been some administrative shortfalls, and that's not to say that they might not persist among some new providers.

If we're talking about whether a statement had the correct date or the date was omitted or something of that nature, I'm distinguishing in terms of cases in which there might be some reason to believe that there had been a significant misstep—

● (1500)

Mr. Michael Cooper: All I would say in the time I have is that the number you cited—10—understates the findings of non-compliance in one province in one year.

Ms. Abby Hoffman: I'm referring to serious non-compliance, not to administrative missteps that are inconsequential to the actual eligibility decision and the decision by the provider to proceed with MAID.

Mr. Michael Cooper: The non-compliance was non-compliance with the law, and that law is the Criminal Code.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Cooper.

We'll go next to Mr. Maloney for five minutes.

Mr. James Maloney: Thanks, Madam Chair.

Thank you to both of the witnesses for being here today, for your presentations, and for everything you've done to get us to the point we're at now, which I think Mr. Potter quite accurately pointed out is very complicated.

I'm going to address two of the topics we're dealing with, which are mature minors and mental disorders. I'm putting them together because I think they present, when we are dealing with them, an issue in common, which I'm going to call objective versus subjective assessment.

In the case of a mental disorder, a medical determination has to be made as to whether or not the disorder satisfies the criteria. Similarly, in the case of mature minors, somebody is going to have to make a subjective assessment—I'm calling it subjective, but maybe you'll disagree with me—as to whether or not that person is mature enough to make that decision.

First of all, would you both agree that's a fair characterization?

The Joint Chair (Hon. Yonah Martin): Go ahead, Mr. Potter.

Mr. Jay Potter: I guess one point on which I might be able to assist is that if the committee were to look at expanding availability of MAID to mature minors, it would be open to the committee to also specify safeguards or conditions under which that would occur. Safeguards could address issues pertaining to capacity assessment, for instance. Just as the eligibility criteria, as they exist now, for adults provide, for example, that a person is eligible only if they've made a voluntary request and an informed request for MAID. Then there are safeguards that are practical things a practitioner needs to do in advance to satisfy themselves that the criteria are met. It would be open to the committee, when looking at mature minors, given their unique situation as being underage, to determine if there are measures that might be appropriate for those cases to help give confidence that, for example, the person is capable of making that kind of very significant decision.

Mr. James Maloney: Thank you.

Let's deal with mature minors, then.

With an adult, you're dealing with informed consent, but with a minor, you have the added layer of complication of determining whether they're able to make a decision and whether they even know what informed consent is. That's the challenge. I know there are other countries in which minors have access to medical assistance in dying. I've looked at some of the statistics, the numbers, and from what I can tell, they are very low. Is there data available on the criteria that are used in those countries in making a determination of whether or not somebody is mature enough?

The second part of my question is this: Is there data available about the number of minors who have sought this right to medical assistance in dying and have been refused, so we can get an idea of how well the criteria, to the extent they exist, are actually being applied?

Mr. Jay Potter: I'm not aware of specific figures from the other jurisdictions you've referenced. It would most likely be places like Belgium, for instance, that would provide that. There is certainly information that's more easily available regarding, for example, what the criteria are, such as, for example, what the ages are, what the requirements are, such as whether or not parental consent is required, or if it is simply consultation with parents.

To go back to the first part of your question, there's the issue of whether capacity assessment is subjective or objective. Maybe a way of looking at it is that capacity assessment, as I understand it, in Canada doesn't mean that a person decides for themselves whether they are capable. It's an assessment made by the practitioners, an objective determination. Generally, for adults, there's a presumption that people are capable of making medical decisions for themselves, but if the practitioner has reason to doubt that, then they're able to engage in an assessment using various instruments to help validate whether the person has capacity to make a particular type of decision.

For mature minors, for example, if that is something the committee is interested in exploring—

● (1505)

The Joint Chair (Hon. Yonah Martin): You have 30 seconds.

Mr. Jay Potter: As I said earlier, you could look at whether or not there ought to be required elements in that kind of assessment.

Mr. James Maloney: I'll pursue this further again, but somebody's going to have to convince me that deciding whether somebody's mature enough is an objective assessment and not a subjective assessment.

Thank you, Madam Chair.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Maloney.

Our next questioner will be Monsieur Thériault.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Thank you, Madam Chair.

Thank you to the witnesses for being here today.

To start, I have a very straightforward question for Mr. Potter, since he brought up the expert panel and its forthcoming report.

Do you happen to know when the report might be released? That may help the committee with its work plan.

[*English*]

The Joint Chair (Hon. Yonah Martin): Go ahead, Mr. Potter.

Mr. Jay Potter: Madam Chair, if it's all right, I'll allow my colleague Ms. Hoffman at Health Canada to answer this one.

The Joint Chair (Hon. Yonah Martin): Yes, go ahead.

Ms. Abby Hoffman: Thank you, Madam Chair. Thank you, Mr. Thériault.

Health Canada acts as the secretariat and supports the work of the panel. As required in the legislation, it is an entirely independent process. I think I can assure you that the panel's report will be available in the month of May; it may be in the latter half of that month.

I can also tell you that the panel and the process is pretty much at its end inasmuch as production, translation and fine tuning from the production standpoint are under way right now.

The panel is very conscious of this committee, its work and its anticipated interest in their report, so every effort is being made to make sure that the report will be tabled in a time frame that allows proper and thorough review by the committee.

I should also note, if I may, Madam Chair, that the tabling date is at the discretion of the two ministers, Minister Lametti and Minister Duclos, but they too are obviously aware of the importance of this committee and its review of the report.

The Joint Chair (Hon. Yonah Martin): Thank you.

Go ahead, Monsieur Thériault.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

Ms. Hoffman, back in June, you told us what the primary settings for the administration of MAID were in 2020: private residences accounted for 47%, hospitals accounted for 28%, palliative care facilities accounted for 17% and long-term care facilities accounted for 5.7%.

Today, you said in your opening statement that, despite the pandemic, the number of MAID cases rose by 30% in 2021, approaching 10,000 cases.

Do you know the breakdown for the administration of MAID by setting for 2021? Are those numbers available?

[*English*]

Ms. Abby Hoffman: Madam Chair and Mr. Thériault, no, we do not have that date yet. It will be published in the annual report for 2021, which, unfortunately, will likely be some few weeks after this committee completes its work.

I would say, based on our observation and reports from the provider community, that there is nothing to suggest that the profile of where these procedures have taken place is any different. We're not observing or aware of any significant difference from prior years, so I think that distribution that you cited would remain pretty much in place in 2021.

● (1510)

The Joint Chair (Hon. Yonah Martin): Monsieur Thériault, you have—

[*Translation*]

Mr. Luc Thériault: You're saying, then, that, despite the pandemic, you didn't necessarily observe any changes in how MAID cases were broken down amongst the various settings. That's helpful. Thank you for that answer.

Mr. Potter, as far as the regulatory framework is concerned, you said that territories and provinces could impose additional requirements. Can you give us examples of such requirements? Can you also tell us how much they could impact access to MAID?

[*English*]

Mr. Jay Potter: As I mentioned—

The Joint Chair (Hon. Yonah Martin): You have 30 seconds.

Mr. Jay Potter: —for health law, very quickly, provinces, as a matter of regulating their health professionals, could impose requirements about how they are to do the assessment of a patient, for instance, over and above what the criminal law safeguards do.

Recall that the criminal law safeguards effectively set a standard minimum floor across the country because a provider can only offer MAID and be exempt from criminal liability if they comply with all the federal requirements, but a province or a regulatory body, as a matter of health law or health practice, could impose additional and more specific requirements that exceed the criminal law, if that was their intent.

The Joint Chair (Hon. Yonah Martin): Thank you.

Our last speaker in this first round before the senators is Mr. MacGregor.

Mr. Alistair MacGregor (Cowichan—Malahat—Langford, NDP): Thank you very much, Madam Chair, and thank you to our witnesses for appearing before our committee and providing an update.

After Bill C-7 was passed, we're now faced with an impending deadline next year, when mental illness as an underlying condition will be removed.

Ms. Hoffman, you did say in your opening remarks that you anticipated the new regime would be difficult for practitioners, and I understand that's in the context of Bill C-7 coming into force. I also think you could use the future tense of that verb in that you anticipate that the new regime coming into effect in March of 2023 will also be quite difficult.

In the context of mental illness and the fact that it will now be considered to be an illness, disease or disability—and I understand that patients will also have to meet other requirements that they are in an advanced state of irreversible decline and that it also causes them enduring psychological suffering—given that Health Canada is working with this deadline in less than a year, what are your conversations like as a department with practitioners? What kinds of conversations are going on and how are they going to develop the guidelines to deal with this very fundamental change to Canadian law?

Ms. Abby Hoffman: There are just a couple of comments I could make.

One is that I think we have seen this same sort of situation play out in the early days of MAID. I think practitioners at the time were very concerned about their ability and their capacity and, frankly, whether they would have the legal protections they needed if they proceeded with their practice of MAID. I think we are now, for sure, encountering more challenging cases, such as cases in which natural death is not reasonably foreseeable and, as you indicated, cases of mental illness.

The conversations we've had with practitioners have absolutely pointed to concerns that they have. There are certainly some practitioners who have indicated that they may not wish to practise MAID in cases other than those in which a natural death is reasonably foreseeable. What we are hearing more often, particularly in our interactions with providers who are associated with this organization I mentioned, CAMAP, is that they want to have the tools and they want the education and they want the interaction with their colleagues. This will assist them to make the kinds of very complex clinical judgments that have to be made about whether or not a person actually qualifies in terms of the characteristics you enumerated of a grievous and irremediable medical condition. They also need support to apply the safeguards, particularly those safeguards that have to do with the offer of available supports and services that might alleviate the suffering of a person.

What I think we're observing, and we expect this will continue, is that while the number of providers involved in MAID is increasing, in fact the increase in the number of cases is being dealt with by fewer people; that is, more MAID practitioners are doing more cases. What we're seeing is the evolution of a specialty. That's why support for this accreditation training program is so vital: It's because it is going to require a level of expertise to address all of these standard concerns, which everybody agrees are legitimate concerns about mental illness, for example, and incurability and irreversibility.

Other concerns are about how to assess competence and capacity, and what about suicidality? What about other vulnerable circumstances that play into the person's condition and therefore the assessment?

We're hearing...I don't know if I want to call it “concern”, but what we're hearing is the need for support. The MAID community has, in our view, really stepped up to work to try to address these issues. It's not to say there will not be some attrition among some providers who have concerns. I think that is natural and understandable.

● (1515)

The Joint Chair (Hon. Yonah Martin): There are 30 seconds remaining.

Mr. Alistair MacGregor: Thank you, Chair. I'll donate that back to the committee so that I have more time in the next round.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. MacGregor.

We'll go to the senators next. We have Senator Mégie, followed by Senator Kutcher. Each senator will have three minutes.

[*Translation*]

Hon. Marie-Françoise Mégie (Senator, Quebec (Rougemont), ISG): Thank you, Madam Chair.

My question is for Ms. Hoffman.

You said in your opening statement that MAID providers were going to be required to collect information about the requester’s race, indigenous identity, disability and other characteristics, and that this would help establish the presence of any inequalities, including systemic inequality, in Canada’s MAID system.

Do you have any information thus far on systemic inequality in the MAID system?

[*English*]

Ms. Abby Hoffman: I cannot speak with absolute certainty, but the impression that one has talking to providers and looking at some of the data—and frankly, some of this is anecdotal data—is that the individuals who seek MAID are generally reasonably well educated. They may be middle-class professionals. They are people who appear to have had positive ongoing engagement with the health system, and this is a very important point. These are not people who are disenfranchised in terms of access to health care; they are people who have had a respectful and positive relationship with health care providers. We don't know, but we think they are largely white. Again, we don't have solid data on that. This is an impression.

The data we collect will help with some understanding, but that data has to be complemented by other research that involves actually dealing with people, speaking to people who are seeking MAID, for better understanding of the circumstances that are driving their requests and understanding the totality of their circumstances. We plan to support that type of research.

We're also using the data that we are collecting through the monitoring system to link it to health care utilization data, Statistics Canada data that is collected, and data collected and accessible through the Canada Revenue Agency. We will try to assemble all of these sources to have a better sense about access, and frankly about how MAID cases from people in different population groups are delivered, but more importantly how they are experienced by the people who enter that system or who choose not to enter it, because their motivations may be important as well.

The Joint Chair (Hon. Yonah Martin): Senator, there are only about 10 seconds left.

[*Translation*]

Hon. Marie-Françoise Mégie: Thank you for your answer, Ms. Hoffman.

I want to use my remaining 10 seconds to have you confirm something. You have no data on how many Black or racialized individuals have requested MAID. That is what I took your answer to mean. Is that right?

[*English*]

Ms. Abby Hoffman: That is correct at the present time, and that is absolutely something we need to fix. Bill C-7 directed the Minister of Health to develop regulations that would ensure that we would collect that kind of data. That is what we are doing.

● (1520)

[*Translation*]

Hon. Marie-Françoise Mégie: All right. Thank you.

The Joint Chair (Hon. Yonah Martin): Thank you.

[*English*]

Senator Kutcher is next.

Hon. Stanley Kutcher (Senator, Nova Scotia, ISG): Thank you very much, Madam Chair.

Thank you to all of the witnesses. I want to acknowledge your expertise on this incredibly challenging topic.

I have two questions together for Ms. Hoffman.

First, about 15% of Canadians have a mental disorder. What proportion of those receiving MAID currently would have a comorbid mental disorder?

Second, for those who've received MAID, what proportion would identify psychosocial factors, as opposed to physical factors such as pain, as the primary reason for requesting MAID?

Ms. Abby Hoffman: Thank you, Senator Kutcher.

Maybe one of my colleagues from Health Canada can, but off the top of my head I cannot give you an indication of the number of individuals who have a comorbid situation of a physical illness and a psychological or mental condition. If one of my colleagues can answer that, I will ask them to do so, but I think at this point we don't really have that data.

In terms of psychosocial factors, when you look at the explanations given by persons requesting MAID and documented by the providers who complete the reports that are required under the monitoring system, the things they say about what is causing their suffering.... If you have terminal cancer and a very short life expectancy, then the physical pain is clearly going to be very high. When people talk about the fact that they feel they no longer can do the things they formerly did and they need more assistance than they feel it is dignified to receive in order to carry out the normal activities of daily living, I would describe that as falling under the psychosocial dimension.

I think what we want to get at, particularly in the cases that are starting to come into the MAID system now of people whose death is not reasonably foreseeable, is whether those psychosocial circumstances can be alleviated in any way through supports. With people whose death is imminent, we generally see that they are, to be candid, sort of beyond the point where more income support or more social interaction would actually cause them to say that they're not going to proceed with their MAID request.

We are entering a new world in which documenting—and that's why the safeguards are so important—the kinds of support that are offered and then considered by people requesting MAID is going to tell us much more about how psychosocial circumstances and other forms of status in society play into a person's request for MAID. We don't see that now as such a critical factor in cases of MAID for people whose death is reasonably foreseeable.

Hon. Stanley Kutcher: Thank you very much for that.

Certainly what you said makes sense about this other group having.... We need the guidelines, the guardrails and the safeguards. Hopefully, we'll get that from the committee's reports.

Would it be fair to say that in this current situation, the majority of people seeking MAID do it primarily for psychosocial factors?

Ms. Abby Hoffman: I think it's hard to tease out the difference between the suffering, the pain, the lack of capacity, lack of mobility, difficulties communicating, and particularly the intense pain associated with a very serious medical condition and all of those kinds of things. It's very hard to separate those from the person's anxiety and their existential questioning.

When you speak—and I hope you will—to some MAID providers, I think they can probably give you a stronger sense—a more "at the bedside" sense, shall we say—of what the mentality is of individuals who seek MAID.

The Joint Chair (Hon. Yonah Martin): Thank you.

Senator Dalphond, you'll have four minutes. I will make sure I add more to Senator Mégie in the next round, because there are only four senators now. I will have three minutes following you.

Go ahead, Senator Dalphond.

[*Translation*]

Hon. Pierre Dalphond (Senator, Quebec (De Lorimier, PSG): Thank you, Madam Chair.

My question is for both the health and justice officials. It's about policy.

In Canada, there is significant support for allowing advance directives for medical assistance in dying. In fact, it was a recommendation made by the Senate, as well as a previous joint committee in 2016.

Policy-wise, do you anticipate moving towards a more comprehensive system that includes the regulation of advanced directives? Conversely, do you expect the possibility to be provided for in the Criminal Code, leaving it up to the provinces to determine the rules around recording and preserving consent, verifying witnesses and so forth?

● (1525)

[*English*]

The Joint Chair (Hon. Yonah Martin): I'm sorry, Senator Dalphond. The interpreters are having difficulty hearing. Could you move your microphone up?

[*Translation*]

Thank you.

Hon. Pierre Dalphond: I was actually done asking my question.

[*English*]

The Joint Chair (Hon. Yonah Martin): I paused the time, so....

The Joint Chair (Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC)): Senator Dalphond, could you start your question from the beginning, now that we have your microphone adjusted?

We'll restart the clock for you.

[*Translation*]

Hon. Pierre Dalphond: Thank you, Mr. Chair.

My question is about advance directives. Surveys show that Canadians are strongly in favour of allowing advance directives, a measure recommended by the Senate as well as the 2016 joint committee.

I am wondering whether the officials here today can tell us whether they anticipate moving towards a comprehensive regulatory system from a policy standpoint, or a system whereby advance directives would simply be allowed under the Criminal Code? In that case, it would be up to the provinces to regulate the preservation and periodic review of advance directives, witness requirements and so on.

[*English*]

Mr. Jay Potter: I can perhaps start with a response to the senator's question.

The scope of a federal regime for advance requests, if that's the will of Parliament, is one issue that this committee should certainly consider. Some of the features, as I mentioned earlier, are if it is desirable for Parliament or if there is interest in putting in frameworks on both of the points in time I mentioned.

On the area of the time when the request is made, without federal safeguards or procedures for that period of time, then for the practitioner who actually administers MAID, perhaps years later, there wouldn't necessarily be a guaranteed standard in place for them to know why they can have confidence in the integrity of that request or in the information the patient was given, for example, and why that request can be said to be truly representative of what their wishes were in the past.

That's one point in time that is, as I mentioned, more typically dealt with as a matter of health law but where Parliament may wish to give consideration if there's a desire for standardization. Otherwise, there is a possibility that if provinces do not occupy the field, there could be variance across Canada in how advance requests are created, stored and documented, and then how they would ultimately be used.

I think we would all agree that for that second practitioner who is going to administer MAID to be very confident in that original request is an important consideration in ensuring that it's voluntary. I think you're right to point to the issues of how that gets constructed. It's certainly a very important issue.

The Joint Chair (Hon. Yonah Martin): Go ahead, Ms. Hoffman.

Ms. Abby Hoffman: I will only add to what Mr. Potter has said.

Even today, when it comes to advance directives, which in many cases are much less significant in their consequences, they are mainly distinguished from an advance request because they are only about the withdrawal of treatment.

The systems within provinces and territories, within institutions and across the country are not only diverse, but they are frankly not all that functional. A request that may be MAID, or a directive that a person may file in the context of their interaction with a family physician, a visit to a hospital or whatever, may or may not surface again on some future occasion. There would be an enormous amount of work to be done, not just at the level of the legislation and the permissibility of such a regime in the Criminal Code, but in the actual implementation within the health care system.

I'm not offering an opinion about whether or not advance requests should be permitted. I'm just commenting on the infrastructure that would be needed, including, for example, periodic renewal of the request, so that any last request that is made is as proximal as possible to the point in time when the person has identified that they would like that advance request to be acted on.

● (1530)

[*Translation*]

Hon. Pierre Dalphond: Thank you.

[*English*]

The Joint Chair (Mr. Michael Barrett): Thank you, Ms. Hoffman. Thank you, Senator Dalphond.

Next we'll turn to Senator Martin for four minutes.

Go ahead, Senator Martin.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Co-Chair.

This is a question for Abby Hoffman.

You mentioned that the federal government was funding some training for MAID providers. Health is provincially directed, and whether it's training or whatnot, it would be done at the provincial level.

I'm just wondering what you meant by funding. Is it with specific provinces? We know there are different advancements of the MAID practice, depending on the province. Can you clarify the role of the federal government in doing such funding?

Ms. Abby Hoffman: Sure. This is not untypical of the sorts of things that the federal government takes on, whether it's in large quantities of money through the Canada health transfer or through smaller projects. Obviously, the federal government plays a role in various aspects of health care.

What we're specifically speaking about here is what emanated from the practice community of MAID. That led to the creation of the Canadian Association of MAID Assessors and Providers. They were the ones, through the interaction with their communities, who said that we need to regularize practice, and a good way to do that is through an accredited training program.

I will also note that across the board in the health care system, specialist training is accredited by the Royal College of Physicians and Surgeons. The expectation here is that MAID training would be accredited through that same system. It would be up to individual provinces and territories to decide whether or not to make this training and this accreditation mandatory for a provider in order to practice MAID in that province.

As well, a lot of these things work through collaboration among national bodies and provincial bodies and the provincial regulatory bodies for physicians and nurse practitioners. They too would be part of this discussion, but this is a normal kind of approach.

The Joint Chair (Hon. Yonah Martin): Thank you.

Naturally, there will be differences. I'm concerned about those challenges that are faced between rural and urban providers. Who is addressing these differences in how things are administered? How will we achieve consistency?

Ms. Abby Hoffman: In quite a few provinces, there are MAID coordination networks so that somebody, regardless of where they live, can actually enter the system through this coordination network. The resources that are needed—I'm not talking about the financial resources, but mainly about the human and professional resources—are then allocated to the individual in question. As far as the training is concerned, it will be delivered both online and in person. Hopefully, that will help with providers from smaller communities.

Look, I'm not going to misrepresent the situation. In the new cases of access to MAID for people whose death is not reasonably foreseeable, it is a much more complex assessment process. There needs to be an expert in the person's condition.

The Joint Chair (Mr. Michael Barrett): You have 30 seconds.

Ms. Abby Hoffman: If one of the two assessors or providers does not have that information, it is very challenging. A lot of efforts are going to have to be made to make sure that access is equitable for people who are living in smaller communities, because it is a much more complex process.

The Joint Chair (Hon. Yonah Martin): Thank you. In my second round, I'll ask again about the complexity of that.

Thank you, Mr. Barrett.

We'll now go to the second round for the House members. We'll begin with Mr. Barrett for three minutes, followed by Dr. Fry for three minutes.

Go ahead, Mr. Barrett.

The Joint Chair (Mr. Michael Barrett): Thank you, Madam Chair.

For my first question, I'm looking to see if the government acknowledges the contention made by the World Health Organization, the Canadian Hospice Palliative Care Association and the Canadian Society of Palliative Care Physicians that MAID and palliative care are separate and distinct practices.

● (1535)

Ms. Abby Hoffman: I would say that the actions of the palliative care community would suggest that they are not completely separate and distinct. I think Senator Kutcher, or perhaps one of the other members who spoke, mentioned that a significant number of MAID procedures actually take place in palliative care units. When it comes to the providers who are involved in MAID processes, a significant proportion of those providers actually are physicians with a palliative care specialty.

I think it was the case in the early days of MAID and in the lead-up to the original framework in the Criminal Code that there was a bit of a standoff between the palliative care community and palliative care providers versus the MAID community, but I think over time there has been an inclination to look at end-of-life care in all of its facets and components and for many palliative care providers to see that MAID is not a testament to the failure of palliative care. It is a reality that sometimes palliative care will not believe in individual suffering, so we don't see this kind of antagonism, shall we say, between MAID and palliative care.

The Joint Chair (Mr. Michael Barrett): Thank you, Ms. Hoffman.

The two leading Canadian palliative care associations have called for “prioritization of, adequate investment in, and enhancement of palliative care services as a separate service from MAiD”. How has the Government of Canada responded to these calls and requests?

Ms. Abby Hoffman: I'll start with a response to that.

First of all, although we have provided to the provinces some very significant amounts of money through the recent health accords for home and community care, including palliative care, we cannot and we do not direct provinces in terms of exactly what they should do and how much of their resources they should direct to palliative care. We know they are making improvements and we also know that the palliative care system is not as strong as it should be.

If you are a person who is suffering grievously with cancer, the continuity of care system that works in the cancer world will likely ensure that you get access to the palliative care you need, but in the case of many other diseases, that may not be the case at all.

The other thing—

The Joint Chair (Hon. Yonah Martin): Thank you, Ms. Hoffman. I apologize, but we're past three minutes.

Ms. Abby Hoffman: Okay.

The Joint Chair (Hon. Yonah Martin): We will go to Dr. Fry next.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Chairs.

Thank you again to Ms. Hoffman and Mr. Potter for coming in and sharing your information with us.

I must say that I'm impressed by Ms. Hoffman's ability to answer these very complex questions with her own complex knowledge of the issues. She has been really following up on everything.

I have two quick things I want to ask about. One of them goes back to the issue of advance directives. Before MAID and before the Carter decision, etc., physicians were providing advance directives with their patients for ages. They were doing it under the guideline of the colleges to talk about ethical decision-making with a patient who feels they want to have an advance directive, and it's been done under those jurisdictions.

I want to know why, and whether, there is intent by the Government of Canada to decide that it will enter into the College of Physicians and Surgeons' ethical and knowledgeable decision-making by which it guides physicians and suddenly impose some sort of heavy-handed legislation on how physicians should practise with regard to things like advance directives, which are very physician-patient-related and therefore involve privileged decision-making. That is the first question.

This is the second question, and then I'll let you guys go after it.

We know that on the question of social vulnerabilities and other vulnerabilities, many countries have had a long-standing practice of MAID. There are Luxembourg, Belgium and Switzerland, as well as the states of Washington and Oregon, and so on. We know that in fact two—the Netherlands and Oregon— stand out with regard to looking at the issue of how to protect vulnerable persons in terms of how MAID is done, and they now have a good evidence-based decision with respect to how that worked and whether or not it worked.

Have you guys been looking at what the evidence from those jurisdictions is now telling us?

Thank you.

● (1540)

The Joint Chair (Hon. Yonah Martin): There's only one minute remaining, so we'll hear from Mr. Potter first, or Ms. Hoffman, and you'll both have to be very brief.

Mr. Jay Potter: I might answer very briefly on the first question.

I would just note that advance directives and MAID are very different things, and that advance directives as they currently exist are for refusal of care, which people have always had a right to do, whereas MAID legally is an act that requires a criminal exemption because it actively ends a person's life. There is an important distinction there, at least from a legal perspective.

I'll let my colleague Ms. Hoffman add on.

The Joint Chair (Hon. Yonah Martin): You have 30 seconds.

Ms. Abby Hoffman: We'll have to come back to these issues that Dr. Fry has raised, because they are very important ones.

On vulnerability, I have just two quick points. One is that the new safeguards, for cases in which people are not dying, do try to ensure that the provider gets at the totality of the person's circumstances to look at anything that could relieve those features of the person's vulnerability beyond their medical condition, and that there is an opportunity to address those.

The other thing I want to say about vulnerability, in the experience with these other countries and within the plan in Canada, is that it has to be assessed in the context of each person. We cannot say that because someone is a member of a group, they are therefore vulnerable and therefore they cannot get MAID. That is absolutely—

Hon. Hedy Fry: Thank you.

The Joint Chair (Hon. Yonah Martin): We will return to this hopefully in the next round.

We will go back to the five-minute time slots, and the questioner will be Mr. Barrett, actually, or did you want to go back to Mr. Cooper? It's a five-minute round.

Mr. Michael Cooper: I'm prepared to go, but I thought it was Madam Vien.

The Joint Chair (Mr. Michael Barrett): That's correct.

The Joint Chair (Hon. Yonah Martin): Okay, thank you very much.

Go ahead, Madame Vien.

[*Translation*]

Mrs. Dominique Vien (Bellechasse—Les Etchemins—Lévis, CPC): Thank you very much, Madam Chair.

Good afternoon, everyone.

Thank you to our witnesses for being with us this afternoon.

Ms. Hoffman, perhaps I misunderstood, but you can let me know. In your opening remarks earlier today, you said that, according to 2020 data, the proportion of deaths by MAID procedures, as a proportion of the total number of deaths, will probably stabilize at around 4%.

First of all, how do you estimate that it will be 4%? Why do you estimate that the proportion of MAID cases will stabilize at 4%, when we know that access to MAID will be extended to other situations, particularly with regard to mental health? How did you arrive at that percentage, given the changing situation?

[*English*]

Ms. Abby Hoffman: The reason we're saying that involves two things. One, we're looking at other what we'll call “progressive regimes” of MAID in other countries—the Netherlands, as an example— and over time it rose and eventually reached the point of approximately 4% of all deaths, and we think that is likely in Canada, but there's no more science to it than that kind of international comparability. We will have to see how this plays out.

Two, I mentioned that there were 200 MAID deaths associated with people whose death was not reasonably foreseeable. This is a small number, understandably, in the first year after the new legislation. We'll see, but we are not anticipating right now that vast numbers of people whose natural death is not foreseeable will be seeking a MAID death, or people whose principal underlying condition is a mental illness. We may be proven wrong, but that is what we see at the present time.

I'll just say that we know the rates in some parts of the country are higher—in Quebec, for example, and on Vancouver Island. Whether that will be the case across the country remains to be seen. It's a combination of the will of individuals and the receptivity and preparedness of the health system. Both need to be place to influence the rate of MAID procedures.

[*Translation*]

Mrs. Dominique Vien: Ms. Hoffman, you've opened a door for me.

As you said earlier in your presentation and in response to my colleague Mr. Thériault, the use of MAID has increased by 30%, which seems quite high to us.

That 30% increase in Canada is huge, but from what you're seeing across the country, I understand it's variable. The situation isn't the same across the country. What is the situation in each province?

● (1545)

[*English*]

Ms. Abby Hoffman: Some of you may have observed this, but I will just note, for example, that there was recently some television coverage of access to MAID on Vancouver Island. One thing that the physician who is in charge of MAID services in that part of the country said is that they are open, and they help ensure that every health care institution on Vancouver Island knows about and is prepared to accept and to deal with MAID requests. That is not the situation everywhere. Attitudes are different in different parts of the country. The rates in those parts of the country where citizens were less inclined to pursue MAID are starting to increase.

I don't want to be held to this 4%. I will just note that there are differences. Some of those differences will persist; but 4% is the number in a system in which MAID can be provided both by a practitioner and through self-administration. In those societies where MAID is.... At least in Canada—

The Joint Chair (Hon. Yonah Martin): You have 30 seconds.

Ms. Abby Hoffman: —where almost all of the cases are actually administered by a provider, not by the individual who wishes to see their life come to an end, this approximate 4% is in place. What we hope is that there will not be institutional or other barriers so that someone, for example, who's living in long-term care or is living out their life in a hospice is told, "Sorry; you cannot have access to MAID in this institution." That's a barrier we're concerned about.

The Joint Chair (Mr. Michael Barrett): Madam Co-Chair, just on procedure, I just would like clarification on the round that just concluded. We had three minutes for the Conservatives and three minutes for the Liberals. Should there have been time allotted in two-minute increments for both—

The Joint Chair (Hon. Yonah Martin): To the Bloc and the NDP, yes. I'm doing that next, and then we will.... Oh, you're saying that I skipped them by mistake. You're right, Mr. Barrett.

The Joint Chair (Mr. Michael Barrett): Yes, we would need to go back and do two minutes for Mr. Thériault and two minutes for Mr. MacGregor and then go back to the Liberals.

The Joint Chair (Hon. Yonah Martin): Yes. I apologize. I have all of this listed in front of me, but my eyes have played tricks on me. Thank you for that, Mr. Barrett.

In round two there should have been two minutes for the Bloc speaker and two minutes for the NDP, so I will return to that and then come back to these five-minute slots.

We have Mr. Thériault for two minutes, followed by Mr. MacGregor. My apologies.

[*Translation*]

Mr. Luc Thériault: I thank my colleague Mr. Barrett for raising this point.

We look forward to receiving the expert report on the fact that mental illness alone could be enough for a person to have access to MAID. In the meantime, there are things you can tell us about that to give us some direction.

Some countries do provide MAID to people with mental illness. Could you tell us about the protective measures put in place in those countries and tell us what we can learn from these experiences, which are rather few?

I'd like to hear what Ms. Hoffman, Ms. Klineberg or Mr. Potter has to say about this.

[*English*]

Mr. Jay Potter: I might begin by just saying that one significant difference between, say, Belgium and the Netherlands and Canada in terms of our MAID frameworks is that Belgium and the Netherlands have a criterion that effectively requires the other treatments or alternative means of alleviating the suffering to have been tried and failed, whereas in the Canadian MAID legal framework it's for the individual, the person seeking MAID, to determine whether any particular treatment is acceptable to them, or not, as a means of alleviating suffering. That's one important difference between the regimes that you might look at.

As a broader comment on lessons learned, while those jurisdictions certainly do have a longer experience with MAID outside of a very end-of-life context compared to Canada, these cases remain controversial and difficult even over there. There are also important differences in not just the legal framework but also in our health system and in our society that the committee may wish to consider as well in looking at this issue—the geography of Canada, the shared responsibility between the provinces and territories, and so on.

● (1550)

Ms. Abby Hoffman: Just very quickly, Madam Chair, if I could add, just apropos of—

The Joint Chair (Hon. Yonah Martin): I'm sorry, but these are two-minute slots. I'm assuming that we can continue with some of these answers later, but we have Mr. MacGregor scheduled next for two minutes.

Mr. Alistair MacGregor: Thank you, Co-Chair.

Mr. Potter, you have clearly illustrated the challenges that are before us if Parliament decides to approve advanced directives for medical assistance in dying. The practitioner is going to have to have confidence that the directive was done in a sound manner. An incredible length of time could have passed between when the directive was first made and when MAID is administered. It could have been made in a different provincial jurisdiction, etc.

My specific question to you is—and my time is limited—what kinds of challenges specifically do you see the criminal law having with an evolved understanding of diseases? Our medical understanding of living with various mental illnesses has evolved over the decades, and how do you think the Criminal Code could appropriately take that into account? With our evolved understanding, in maybe 10, 20 or 30 years from now there may be different ways of helping people cope through various mental illnesses that under our current regime may qualify them for medical assistance in dying. How would an advanced directive take that into account through the Criminal Code, or is that something the provinces are going to have to take into account?

Mr. Jay Potter: At a very high level, what I would offer you is that the provisions of the code are designed so that they're sort of condition-agnostic, so to speak; they don't focus on particular medical disorders or one disease or the other.

As part of the safeguard regimes, for example, Bill C-7 added that a person be offered consultations and has given serious consideration to other means of alleviating suffering. That type of language in a safeguard can evolve as treatment options evolve and as our understanding of illnesses evolve. What might be a treatment option in 2022.... Maybe we will have more treatment options in 2042, for instance.

The safeguards that are drafted in the current code may be able to evolve with the times, but if you're thinking about safeguards more generally for anything, it's important to bear in mind that you may not want something that only addresses one particular type of condition, because then it may be difficult to apply across a broader range of circumstances.

Mr. Alistair MacGregor: Thank you.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Potter.

We'll return to the next person with a five-minute round. It will be Mr. Arsenault, followed by Mr. Thériault.

[*Translation*]

Mr. René Arseneault (Madawaska—Restigouche, Lib.): Thank you, Madam Chair.

Of course, by the time we get to the end of the list of speakers, all the best questions have already been asked.

First of all, Ms. Hoffman and Mr. Potter, I want to tip my hat to you and your respective teams for your strong testimony and command of the subject.

And then I would like to ask you to send to our clerks, by the end of all our work, any data that becomes public and that the committee has not yet seen.

Of particular interest to me today is the relationship between palliative care and requests for MAID. According to the data you presented, not all patients seeking MAID have necessarily received palliative care. Can you go back to those statistics? I thought I heard that 17% of requests for MAID came from people who had access to palliative care and that the rest came from people who did not receive palliative care. Did I understand correctly?

● (1555)

[*English*]

Ms. Abby Hoffman: Mr. Arsenault, I apologize if what I said was a bit confusing. I have a couple of points.

First of all, the overwhelming majority of individuals who make a request for MAID and who receive MAID have had palliative care—not just access to palliative care, but over 80% have had palliative care.

Of the remaining group who have not had palliative care, the overwhelming majority had access to palliative care if they had wished to pursue it, but for whatever reason, they didn't want to, likely because it was very close to the end of their life. We're now talking about data that pertains to people whose natural death is reasonably foreseeable.

The 17% that I referred to was the proportion of MAID practitioners who are palliative care physicians. I was just making that point in the context of the relationship between palliative care and the practice of MAID and noting that there is now agreement among a substantial portion of the palliative care community that MAID is a legitimate practice that should be offered to people and responded to when a person requests it.

Now, having said all that, I'm not going to say that palliative care in Canada is perfect and that every person who has palliative care gets the amount and duration of palliative care they need. There are still many issues in terms of access to palliative care for people who are living in their own homes, who do not need to be hospitalized or who are living in institutional settings other than a hospital. Those are still big gaps that need to be filled.

I hope that clarifies the—

[*Translation*]

Mr. René Arseneault: Thank you, your answer clarifies many things. I had understood almost the opposite.

As you said, Ms. Hoffman, when we talk about a patient in palliative care, it can be someone at home receiving mobile palliative care provided by a nurse, a person residing in a private hospice or a person at the end of life on the palliative care floor in a hospital. Is there any data on these three categories of palliative care?

[*English*]

Ms. Abby Hoffman: Yes, we do. I cannot cite it off the top of my head, but a very robust study was done by the Canadian Institute for Health Information and published in 2018. I'd be happy to provide that to the committee.

It was very clear that, depending on the disease, particularly chronic obstructive pulmonary disease and cancer, there was a high probability of getting access to palliative care. If you were in a hospital, there was a higher prospect. If you were in a home situation, there was less of a prospect.

It's very clear also that one thing we need to do is move the delivery of palliative care from exclusively palliative care specialists to, for example, people like paramedics who can deliver palliative care in people's homes. There are programs that do this.

The Joint Chair (Hon. Yonah Martin): You have 30 seconds.

Ms. Abby Hoffman: Family physicians can be trained to be interlocutors for palliative care services as well.

[*Translation*]

Mr. René Arseneault: Could you please send us this data, if you haven't already done so?

Do you see any disparities in the provision of MAID services depending on whether you are in a rural or urban area, the Far North or a particular province?

[*English*]

Ms. Abby Hoffman: According to our data, no, but I think in reality it will arise under the new MAID legislation, particularly with the more complex cases. I think this is something that we really need to pay attention to or there will be disparities because of the complexity of the assessment process.

[*Translation*]

Mr. René Arseneault: Thank you very much.

[*English*]

The Joint Chair (Hon. Yonah Martin): Thank you.

I will call on Mr. Thériault next for five minutes, followed by Mr. MacGregor for five minutes.

Go ahead, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: First of all, I'd like to give Ms. Hoffman a chance to answer the question I asked earlier.

[*English*]

Ms. Abby Hoffman: Thank you, Chair, and Mr. Thériault.

In response to your comment and question, I wanted to comment about what we might learn from other countries with respect to the practice of MAID, especially in cases of mental illness. I'm reticent to comment too fully because you will hear from the expert panel later on in your process.

There are two things I will say. The first is that most of the guidance that is required is at the clinical level. It's direction to practitioners about what they should do to deal with the very complex challenges associated with these cases. With all due respect to my colleagues, Mr. Potter and Joanne Klineberg, you cannot put detailed clinical guidance in the Criminal Code. It's not the right place for it, because as Mr. MacGregor indicated, the understanding of diseases and conditions—their trajectory, treatment and so on—evolves.

The second thing I would say is that the human resource requirement will be very significant and intensive if a proper assessment—and that is the only assessment that should be allowed—is done of whether a condition is incurable or whether a decline that may be associated with that disease can be reversed, attenuated or relieved in some way. It's whether the person has capacity. Do they understand what they are being told about their condition? Do they understand what they are doing when they are seemingly making a request for MAID?

All of these informed consent, capacity and irremediability issues are incredibly complex, and they will take a lot of time. As with other cases in which the person is not dying, in order to understand whether or not treatments and interventions are effective, you have to reflect back on all the experiences that the person has already had with the health system. What have treatments yielded so far?

The bottom line here is that those cases will be very demanding. The human resources will have to be intensively applied. That is probably the paramount lesson I would put in front of the committee for its consideration.

● (1600)

[*Translation*]

Mr. Luc Thériault: That's probably why, in Quebec, as we can see in the report on the review of the act, the decision was made not to move forward on this issue.

When reading the Council of Canadian Academies' assessments of the state of knowledge on MAID for people whose only concern is a mental disorder, we can see repeatedly that there is no consensus on this issue, and even that people are divided on it.

I look forward to seeing what the expert panel recommends.

Moving on—

[*English*]

Ms. Abby Hoffman: I'll only just note, if I may, Madam Chair, that there's never been absolute consensus on any aspect of MAID. I think the question is this: Is there a safe and reasonable way for cases to proceed? That's really I think the fundamental question.

[*Translation*]

Mr. Luc Thériault: In fact, many aspects of MAID were not the subject of consensus, but it didn't seem to divide people almost equally. When you read all the reports on the mental health aspect, it seems that for every person who has a given opinion, there is another who has the opposite opinion.

I'd now like to talk about MAID for mature minors. This is a practice in very few countries, that is, only in the Netherlands and Belgium. The Netherlands allows children 12 years of age or older to use it, but parental consent is required for children 12 to 16 years of age. For Belgium, there is no minimum age, but parental consent is also required.

Is there a single MAID process for mature minors that doesn't involve parents or require their consent? I haven't seen any to date. Parental involvement and consent seems intrinsically connected to the process, even if there are very few cases.

● (1605)

[*English*]

The Joint Chair (Hon. Yonah Martin): We're at five minutes, Ms. Hoffman, so I think you'll have to answer this in Mr. Thériault's next two-minute round.

Colleagues, I have to pause to tell you about an additional witness who is available. With your consent, we could hear from this third witness. She's already been tested by the technicians on this call so that she'll be able to provide her testimony. She is Mausumi Banerjee, director, office for disability issues, from ESDC. She has been already tested for sound, so is there agreement to hear from this third witness before we go to the senators' round, when each senator will receive four minutes and I will take three?

Is there consent or agreement? Okay. Thank you.

We will invite our third witness to add to this very in-depth and complex conversation or dialogue that we are having at this committee.

Is our third witness ready to join and present?

[*Translation*]

It seems so. Thank you.

Welcome, Ms. Banerjee.

[*English*]

Ms. Mausumi Banerjee (Director, Office for Disability Issues, Employment and Social Development Canada): Thank you, Madam Chair.

Would you like me to speak now?

The Joint Chair (Hon. Yonah Martin): Yes, please.

Ms. Mausumi Banerjee: Hi. I'll introduce myself again. I'm Mausumi Banerjee, the director for the office for disability issues in ESDC.

My team works very closely with Health Canada to support them on MAID issues and the regulations that are being developed. Our main role in this work is to provide a disability inclusion lens to the work that is being done to ensure that organizations representing persons with disabilities are being engaged. We help with the types of questions that are being asked and we connect Health Canada with organizations and individuals that we think should be engaged with and we provide support in that way, as well as to our minister by providing her with briefings to be able to engage with the Minister of Health.

I don't have any other further remarks because our role is very much a support role and a disability inclusion lens role, but I'm available if there are questions.

Thank you very much.

The Joint Chair (Hon. Yonah Martin): Thank you very much.

Now we will go to our senators' round.

Mr. Alistair MacGregor: I have a point of order.

The Joint Chair (Hon. Yonah Martin): Yes, go ahead.

Mr. Alistair MacGregor: Senator Martin, I believe I have five minutes following Mr. Thériault.

The Joint Chair (Hon. Yonah Martin): I apologize. I thought I had completed that round. Yes, Mr. MacGregor, you will have five minutes.

Mr. Alistair MacGregor: Thank you very much.

My question is to Ms. Hoffman, and it's again on the subject of mental illness.

We know that the guidelines.... The amendment is coming into force soon. It will come into force next year.

Actually, I'm going to switch my question, because we have Ms. Banerjee here.

My question to you is on the subject of persons with disabilities. Do you have information to share with the committee on the population in Canada who are currently living below the poverty line?

Ms. Mausumi Banerjee: I actually don't have it off the top of my head, but I can send that information. That is information that we do have, and I can find that information.

Mr. Alistair MacGregor: It would be appreciated if you could provide a submission to the committee, a brief in written form.

Ms. Mausumi Banerjee: Sure.

Mr. Alistair MacGregor: Thank you.

Ms. Hoffman, I'll turn to you. I'm going to switch it up to stay on the subject of advance directives on medical assistance in dying. We know that there has been a 2021 report on the dementia strategy for Canada, and a lot of the report also touched on the stigma associated with people living with dementia.

Because our understanding of people living with dementia is going to be a central facet in Parliament's discussion on advance directives, I guess my question to you is this: From Health Canada's perspective, how is our understanding evolving in that respect? What are we learning in this day and age about people who are living with dementia, the stigma associated with it and the strategies that are now coming into place to assist people who are living with this disease?

● (1610)

Ms. Abby Hoffman: Thank you, Mr. MacGregor.

I'm not an expert on dementia or specific neurodegenerative diseases writ large, but I could make a couple of general comments nonetheless.

I think the discussion about dementia and the associated illnesses that have similar symptoms and manifestations is very helpful in reducing stigma. One now can imagine more acceptability of people with dementia when they are living with that disease for a significant portion of the time, in terms of being able to live in the community and having some sort of interaction, etc., outside of an institutional context.

I think the situation is changing, without overstating how quickly there is that sort of stigma reduction or, for that matter, the capacity for families to actually maintain in their own home support for a person living with dementia. I think it's still the case that there comes a point when that is extremely challenging and, unfortunately, very impractical, even with the best supports in the world.

Mr. Alistair MacGregor: Thank you.

I just want to sneak in a quick question on the mental health aspect.

The last two years of the pandemic have brought about a rise in mental health issues in Canada in terms of the number of cases that we're identifying. I guess what I want to know is this: When does a mental health condition become a basis for getting medical assistance in dying? That's with the understanding that they have to be in an advanced state of irreversible decline that has to cause enduring psychological suffering.

What strategies is Health Canada putting in place to ensure that people who have a mental health issue are not advancing to a state that meets those conditions? Can you inform the committee of the kinds of strategies that we're putting into place? Do we have adequate funding? Is this something that we need to address more in Canadian society?

Ms. Abby Hoffman: Well, despite actions, whether it's the mental health transfer to provinces or other specific initiatives, the reality probably is that we all know—we read it in the papers all the time—friends, neighbours and other families who are dealing with these challenges. Particularly for people with what I would say are lower acute conditions that may, as you're suggesting, deteriorate further in the absence of care, in mental health services there is a problem of the adequacy and sufficiency of intervention services.

That is something that I think all governments are working on, but as you have noted, through the pandemic it's become evident that particularly—but not only—among young people, there is kind of a pandemic of maybe COVID-related mental illness, or maybe it's just coming to the fore—

The Joint Chair (Hon. Yonah Martin): Okay. Thank you, Ms. Hoffman.

That's five minutes at this time.

Ms. Abby Hoffman: Thank you.

The Joint Chair (Hon. Yonah Martin): Also, I need to ask the committee about an earlier point of order from Mr. Anandasangaree to have 15 minutes for us to meet in camera. If I hear agreement with that point of order, the clerks will prepare a new link that will be given to us for the last 15 minutes. I know that we will have our witnesses until 5 p.m.

Until then, we'll continue with our order of speakers, so I'm going to turn this over.... First of all, before we do that, do we have agreement for that?

Mr. James Maloney: On a point of order, Madam Chair, I don't believe the request included that it be held in camera. I think it was simply that we use the last 15 minutes to discuss some issues. That would save time, because if we have to click off and click on, we're going to lose another 10 minutes. That makes a big difference.

The Joint Chair (Hon. Yonah Martin): I see.

Mr. Anandasangaree, was that your request? Was it just to use the last 15 minutes?

Mr. Gary Anandasangaree: That's right, Madam Chair.

The Joint Chair (Hon. Yonah Martin): That's fine.

Mr. Gary Anandasangaree: I did not request that we go in camera. Thank you.

The Joint Chair (Hon. Yonah Martin): I misunderstood. Thank you for that clarification.

I will turn this over to Mr. Barrett, my co-chair, for the questions from senators.

● (1615)

The Joint Chair (Mr. Michael Barrett): Thank you, Madam Co-Chair.

Next we go to Senator Mégie for four minutes.

Please go ahead, Senator.

[*Translation*]

Hon. Marie-Françoise Mégie: Thank you, Mr. Chair.

Ms. Hoffman, I'd like to come back to the regulations that will allow for the collection of more disaggregated data on racialized people, people with disabilities and so on.

Are these regulations in the works? If so, when will they be ready? Also, how will this data inform the government's future policy decisions on MAID?

[*English*]

Ms. Abby Hoffman: Thank you, Senator. I can respond to that question.

The regulations are being written now. We expect that in the next six weeks, they will be published in what's called Canada Gazette, part I. The regulations will be in place. There will be a further consultation period, and the final regulations, we expect, will be published in the fall. That means they will take effect on January 1, 2023.

This may seem like a long time, but what that means is that for all of the calendar year of 2023, we will have this considerably more detailed data. However, it also means that this data will not be available until the end of the first six months of 2024. How will the data help? That will depend also on what requesters are prepared to disclose. They may choose not to disclose this data, but as I mentioned before, we will use this data in conjunction with other research and linkages to other data to try to better understand how the intersection of different forms of inequality may be manifested in the MAID system.

[*Translation*]

Hon. Marie-Françoise Mégie: Thank you, Ms. Hoffman.

I will now move on to a completely different topic, which is palliative care budgets.

Discussions have already taken place to try to determine whether it was the lack of palliative care that prompted people to request MAID, but it turned out not to be quite that.

As you mentioned, 80% of people who requested MAID had access to palliative care. However, this sometimes causes hesitation in my circle. Even if the form indicates that a person has received palliative care, it isn't clear what level of palliative care is involved, whether the person received palliative care for only three days or for a long period of time.

Do the forms that MAID providers fill out tell you a little more about this? Does it say anywhere that a person has actually received palliative care or has only had one meeting with a palliative care team, for example?

[*English*]

The Joint Chair (Mr. Michael Barrett): You have 30 seconds.

Ms. Abby Hoffman: Senator, the implication of your question is correct. We have information about whether the individual has had palliative care, but the extent of that care is not well documented. It is the case in many parts of the country—in most parts of the country, in fact—that there are time limits on palliative care in terms of the amount of care one can get and the proximity to death one anticipates, and so on.

Insofar as this committee is looking at the state of palliative care in Canada in general, lots of positive developments have happened, but what remains is that 1% of specialists are palliative care specialists. That's a very small number. Resources are growing at this point, but not sufficiently to meet what should be a legitimate demand. I think those are fair conclusions.

● (1620)

The Joint Chair (Mr. Michael Barrett): Thank you, Ms. Hoffman.

Next, for four minutes, we have Senator Kutcher, please.

Hon. Stanley Kutcher: Thank you very much, Mr. Chair.

I have a clarification for Ms. Hoffman and then a question for Ms. Banerjee.

To date there has not been a nationally accredited program for MAID providers. I just want to make sure I understand this.

Ms. Abby Hoffman: That's correct.

Hon. Stanley Kutcher: Since the development of Bill C-7, there is currently an accredited training program under development. The purpose of it is to enhance the quality and standardization of MAID assessment and delivery. My understanding is that the accreditation will be by the most responsible national medical organization, such as the Royal College of Physicians and Surgeons. Thus, it will become a national standard, which is similar to how all medical practitioners are currently accredited. If you're a psychiatrist, a gastroenterologist or a palliative care specialist, it's the same kind of level of accreditation.

It is not the purview of provinces and territories to accredit; it's the purview of the national medical organizations to accredit, as they do for all specialists. Regulatory bodies such as colleges of physicians and surgeons in provinces and territories can, at their discretion, should they choose to do so, require that MAID practitioners be accredited. Is that correct?

Ms. Abby Hoffman: That is very well expressed, Senator Kutcher, yes.

Hon. Stanley Kutcher: All right, thank you. Maybe the record can show that.

This question is for Ms. Banerjee.

What proportion of individuals who have received MAID to date in Canada have had MAID provided solely on the basis of a disability? If you don't have that data at your fingertips, could you find that out for us, please?

Could you also find out, for other jurisdictions such as the Benelux countries, Switzerland and Washington and Oregon states, what those proportions would be—the number or proportion of people who had solely a disability and received MAID?

Ms. Mausumi Banerjee: I will definitely follow up on that question as well to see what numbers we have available.

Hon. Stanley Kutcher: Great. Thank you very much for that. It would be very appreciated.

I will cede the rest of my time to my colleague Pierre Dalphond, who is much more erudite and astute than I am.

The Joint Chair (Mr. Michael Barrett): Thank you, Senator Kutcher.

We'll move to Senator Dalphond for four minutes, please.

Hon. Pierre Dalphond: Thank you. Thank you, Stan.

My question is for Ms. Hoffman.

You referred to the fact that the health department report of the year 2020-21 will be released only after we have our report in, because we have a deadline coming this June. Is it possible for the department to send out a kind of draft or outline of what the report will be, or some rough data that has not been processed, in order for the committee to get access to this kind of critical information?

Ms. Abby Hoffman: Senator, we'll see what we can do. Just as I spoke last year about the 2020 data before it was published, we'll see what we can provide you with. We just want to be sure that we are not providing you with data that has not been properly and fully verified and then you ultimately include some data that's not correct. We will be happy to work with the committee to respond to your very reasonable request.

Hon. Pierre Dalphond: I assume that 95% of the report will be accurate, so you can have a big caveat on the first page, and we'll rely on the 95%.

[*Translation*]

I'd like to ask you another question.

The Quebec National Assembly is likely to pass an amendment to its law on the provision of health services to ban MAID for people suffering solely from mental illness. This is a decision that was made following a report produced by a Quebec group.

If a province ever decides to go in this direction, does the government have a strategy to see—

[*English*]

The Joint Chair (Mr. Michael Barrett): Excuse me, Senator Dalphond, and I've stopped the time there. Could you lower the boom on your microphone, please, for the interpreters?

[*Translation*]

Hon. Pierre Dalphond: Thank you.

In December 2021, a special committee of the Quebec National Assembly recommended that MAID not be made accessible to people for mental illness alone. I know that's something the committee will have to decide on. We look forward to the report of the ad hoc committee of experts that was formed last year.

Should access to MAID be extended to mental illness, how do you see working with the provinces? Without the co-operation of the provinces, services cannot be provided.

● (1625)

[*English*]

Ms. Abby Hoffman: That's absolutely right. A province could decide that it wishes to proceed with a regime that is more restrictive than that of the federal government. Depending on the nature of that more restrictive regime, that jurisdiction could be subject to legal challenge. I don't want to say that this is akin to the case of Truchon and Gladu, because that challenged the regime in both Quebec and Canada, but that risk certainly is there.

I think on the more positive side, shall we say, we have been and we will continue to be discussing this, and when the report of the expert panel is out, there will be extensive discussions with provinces and territories, as well as conversations going on among the clinician organizations, about how best to implement the recommendations that we expect the panel will make and that you will see as the next part of your work.

The Joint Chair (Mr. Michael Barrett): You have 30 seconds.

[*Translation*]

Hon. Pierre Dalphond: Thank you. I'm done.

[*English*]

The Joint Chair (Mr. Michael Barrett): Thank you, Senator.

We'll go to Senator Martin for three minutes, please.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Co-Chair.

My question is also again for Ms. Hoffman. It's regarding the indigenous communities in Canada. One of the most compelling witnesses we had at the Senate was a leader of the Dene Nation who spoke about the word “suicide” not even being in their language, he said, for a very long time, 300 years, which gives us the perspective from which he comes.

Are any consultations with the indigenous communities being done ahead of MAID being open to those who suffer from mental disorder as a sole underlying medical condition?

Ms. Abby Hoffman: Perhaps I can respond to that.

I think it probably makes sense to start by acknowledging that there have not been the consultations that are required with indigenous communities. I am not referring to indigenous people as one single population bloc; obviously the distinctions-based approach that's now conventional needs to be pursued in this particular case.

At Health Canada we are now in the process of working with representatives and stakeholders in indigenous communities to try to figure out what sorts of consultation activities would make sense. This may pertain to the recommendations that come from the panel on MAID and mental illness, but they also apply much more generally to MAID in Canada.

Just as an example, there's the training and accreditation program for MAID providers that I've mentioned a couple of times and that is being managed and supported by us. It will be very important that there will be dialogue with representatives of indigenous communities about how any of those modules that are being developed need to incorporate a cultural safety and awareness dimension so that any practitioners, whether they are indigenous practitioners or non-indigenous practitioners, can proceed with the appropriate sensitivity and awareness of concerns from the indigenous community.

I will also say that we need to bear in mind, as we've heard many times, that even in groups in which there is significant indigenous representation—

The Joint Chair (Mr. Michael Barrett): You have 30 seconds.

Ms. Abby Hoffman: —no single indigenous person can speak for the entirety of their community, and certainly not for all indigenous people. The question is this: How can people be sensitized so that they are aware of the kinds of considerations that should be introduced into a conversation about MAID or the practice of MAID when indigenous people are involved?

That is a process that we're engaged in right now. We will support whatever process the indigenous spokespersons say they want to pursue. If they want to have us involved, we will be. If they don't, we will not.

● (1630)

The Joint Chair (Mr. Michael Barrett): Thank you, Madam. That's your time, Senator.

The Joint Chair (Hon. Yonah Martin): Okay.

In fact, Mr. Barrett, in round two of this second round, it's your turn to have three minutes.

The Joint Chair (Mr. Michael Barrett): Thank you, Madam Co-Chair.

Palliative care must be made available to any patient who's thinking about MAID. It needs to be a safeguard for folks who feel like they don't have any other option. Through the testimony today, we have heard that a significant number of people are only able to discuss palliative care on the day of their MAID request or after their request is made. This is in addition to the gaps that have been identified across the country in palliative care.

When people aren't offered proper palliative care, or they're not afforded time for consideration or to make an informed decision before their request for MAID, does this not point to a systemic noncompliance with MAID safeguards?

Ms. Abby Hoffman: If the question is addressed to me, Mr. Barrett, I'll try to respond.

I don't think this is a systemic disregard for the legislation. The legislation says that someone can only give informed consent to receive medical assistance in dying after they have been informed of the means that are available to relieve their suffering, including palliative care. That is the requirement. There's no specific requirement that says when that palliative care service should have been offered to the person.

MAID is not set up to address every perceived—or, for that matter, real—deficiency in health care service delivery in Canada. It could not possibly take on that role. Palliative care has been given an important and prominent place in the original MAID legislation and in the new legislation. People who come forward for MAID are a product of all of their circumstances, including the kinds of services that they have had.

The sense that we have—and this is concerning for a different reason—is that the majority of people who come forward for MAID have had very positive interactions with the health system, for the most part. They are more likely to have been able to take advantage of what the system provides. The people whose experiences with the health system are negative are not the ones, by and large, who are coming forward for MAID.

The Joint Chair (Mr. Michael Barrett): Thank you. I just have about 30 seconds left.

I am curious about the accountability measures that are put in place when the federal government provides funds to the provinces for palliative care. Does that money stay in a palliative care envelope, or is it blended into administration or promotion of MAID?

While I don't think you have time to answer that, I wonder if you might be able to provide some of those details to the committee in writing prior to our preparing our report.

Ms. Abby Hoffman: I can do that, but I can tell you now that I don't see that money is being diverted from palliative care to the promotion of MAID. I don't think that's currently happening.

The Joint Chair (Mr. Michael Barrett): Thank you.

The Joint Chair (Hon. Yonah Martin): Thank you.

Next we have Mr. Anandasangaree for three minutes.

Mr. Gary Anandasangaree: Thank you, Madam Chair.

I want to focus my question to Ms. Banerjee.

Ms. Banerjee, would it be safe to say that from a disability lens, you have extensive engagement with the disability community in Canada?

Ms. Mausumi Banerjee: We do have extensive engagement with the disability community, not specifically related to MAID, but more in terms of the disability inclusion action plan that the government is working on.

Mr. Gary Anandasangaree: What are the overall perceptions, apprehensions and feelings toward MAID? Could you maybe give a sense of what the different perspectives are within the disability community with respect to MAID?

Ms. Mausumi Banerjee: The impression we have is that there are many different views throughout the disability community. Parts of the disability community very much want to have access to MAID. There are concerns from other persons with disabilities and from organizations about making sure to also have adequate access to supports and services.

It's quite divided throughout the community. I know that a priority of our department and of our minister is to make sure that the different voices are heard through the process.

● (1635)

Mr. Gary Anandasangaree: There have been a number of reports in the media about apprehensions. Could you talk about what kinds of fears exist?

Extending MAID to people with disabilities has been an issue of contention, but it does appear to be inconclusive. Can you give us some concrete suggestions as to what kinds of safeguards could be put in?

I don't know if you're in a position to do that today, but certainly you're welcome to submit further evidence by writing. Maybe you could give us a bit more in terms of the type of feedback you received, as well as what some of the safeguards are that may be required if MAID is extended.

The Joint Chair (Hon. Yonah Martin): You have 30 seconds.

Ms. Mausumi Banerjee: It might be better if I look into the data in more detail and get back to you on it, along with some other follow-up I have.

Mr. Jay Potter: If there's 10 seconds, Madam Chair, I would like to add to this.

The Joint Chair (Hon. Yonah Martin): Yes, go ahead.

Mr. Jay Potter: When Bill C-7 was passed, the safeguards related to a death that was not reasonably foreseeable included a safeguard that required the person to be offered consultations with various professionals, including disability support services. That was part of, as I understand it, responding to concerns that were expressed by the disability community. There is obviously much more that can be said on this issue.

The committee could look to members of that community and to disability rights organizations to provide evidence to inform its considerations.

Mr. Gary Anandasangaree: Thank you.

The Joint Chair (Hon. Yonah Martin): Thank you.

Next we will have Mr. Thériault for two minutes, followed by Mr. MacGregor.

Go ahead, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

[*English*]

The Joint Chair (Hon. Yonah Martin): There was a question unanswered....

[*Translation*]

Mr. Luc Thériault: What did you say, Madam Chair? I didn't hear you.

[*English*]

The Joint Chair (Hon. Yonah Martin): Go ahead, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: Okay. Thank you.

As outlined in the report by the Council of Canadian Academies on advance requests, "[advance directives] may include the advance consent to, or refusal of, specific treatments ... such as foregoing the use of blood and blood products ... resuscitation in the event of cardiac or respiratory arrest, or refusing artificial nutrition and hydration". It is already possible to give advance directives. They are regulated and applied in Quebec and the provinces. However, advance requests are only for MAID. In this regard, the report states that "a legal regime for ARs for MAID, established in federal criminal legislation, would form one part of the regulatory picture in Canada; practical implementation would depend on provincial and territorial legislation, as well as professional regulatory schemes".

Given that people are already used to dealing with advance requests, would expanding MAID to include advance requests pose much fewer practice and implementation issues?

The question is for Mr. Potter.

[*English*]

The Joint Chair (Hon. Yonah Martin): You have 40 seconds.

Mr. Jay Potter: Thank you, Madam Chair.

What I might offer is to recall what the criminal law does: It exempts the practitioner who administers MAID from criminal responsibility. The criminal law would need to provide a level of certainty and a level of specificity to understand, for the practitioner's purpose, when they are able to proceed.

As I mentioned, part of that involves the practitioner being confident that the request remains the voluntary will of the incapable person who is before them. Part of that goes to the content of the request. Is it clear enough? Is it specific enough? How do we know the request still represents the will? Part of it also goes to looking backwards in time when there may have been very different people and treatment teams involved.

I think it's appropriate to know that this can be an area of shared responsibility. As I mentioned earlier, if provinces were not to legislate in this area or not to provide a framework, for example, to store, track, and maintain advance directives, it would be difficult for the provider at the time of offering MAID to be confident that the document that's before them was in fact made by the person and that it was a voluntary expression of that person's interest, etc.

If there's not a—

● (1640)

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Potter.

Mr. Jay Potter: Okay. Thank you.

The Joint Chair (Hon. Yonah Martin): Go ahead, Mr. MacGregor.

Mr. Alistair MacGregor: Thank you, Madam Co-Chair.

Very quickly, Ms. Hoffman, does Health Canada have data on the number of people in Canada who are under the age of 18 and who suffer from a grievous and irremediable medical condition as defined in the Criminal Code?

Ms. Abby Hoffman: No, we do not.

Mr. Alistair MacGregor: Is it possible to get that data? Is work being done to obtain it?

Ms. Abby Hoffman: It isn't. I think there is some information we could get from the pediatric medical community about incidence. You could find information about, for example, pediatric cancer and the outcomes in terms of morbidity and mortality, but not for most other diseases.

Mr. Alistair MacGregor: Okay. Thank you.

I would like to get to Mr. Potter.

Mr. Potter, in British Columbia we have the Infants Act, which defines what mature minor consent is. Basically, a health care provider can accept consent from a child if they are sure that the child understands the need for health care, what the health care involves, and what the benefits and risks are.

Is there similar provincial law across the board in Canada and the territories? If we're going to tackle the subject of mature minors, we have to have an understanding of the provincial groundwork we're dealing with.

Mr. Jay Potter: I understand there's some variation. I'd refer you again to the Council of Canadian Academies' study, because I believe there is a useful summary there that compares the jurisdictions. I understand there is variation, and in particular in some jurisdictions it may not be as specific as the British Columbia statute you mentioned. It may be more a matter of how the case law has evolved and is implemented by common law.

Again, I would commend to you the CCA study, because I think that provides your answer.

Mr. Alistair MacGregor: Would the Criminal Code have to entertain such a definition in order to have some uniformity?

Mr. Jay Potter: If Parliament wanted to allow MAID for mature minors, then—

The Joint Chair (Hon. Yonah Martin): You have 10 seconds.

Mr. Jay Potter: —it may need to address what is meant by a "mature minor". It could do that in relation to provincial legislation or it may need to set out a specific term. It really depends on what the objective of Parliament is in doing that.

Mr. Alistair MacGregor: Thank you.

The Joint Chair (Hon. Yonah Martin): Thank you.

We'll go back to the top of the list. I will invite Mr. Cooper for five minutes.

Mr. Michael Cooper: Thank you, Madam Joint Chair.

My questions relate to the first and second annual reports. Neither report discusses how many incomplete or inaccurate MAID reports were submitted to Health Canada, and how those were corrected. Could any of the officials comment on how many inaccurate reports were submitted and how that was corrected to ensure accuracy?

Ms. Abby Hoffman: I can respond to that.

I can't give you an exact number, but I can tell you that for every report that comes to us for every case from each provider, if there is information missing or it appears that an answer may be incomplete, then there is communication back to the provider. In the case of provinces that file reports with us on behalf of all of their providers, there is a conversation that goes on to make sure that the report is actually completed as required.

I will just note that the overwhelming majority of reports come to us from the provinces on behalf of all of the MAID providers who have been active on a case in the period in question. Those provinces often collect additional information of their own, so there is a quality control check on that data before it actually comes to us. Therefore, we're pretty confident that—

Mr. Michael Cooper: Thank you. I appreciate that. That's helpful, but as you note, some data goes directly to Health Canada and not through a provincial body. The second report that I was reviewing makes reference to an electronic verification system to ensure completeness, but is that it? I understand that these reports take not more than 10 minutes to complete. For example, if a report on its face appears to be complete insofar as all of the boxes are ticked, what's the assurance that the report is in fact complete and accurate?

● (1645)

Ms. Abby Hoffman: I think that at a certain point in time you have to have some trust in these providers. I think that anyone who has dealt with the MAID community of practitioners has been struck by the due diligence—

Mr. Michael Cooper: Okay, but I appreciate that—

Ms. Abby Hoffman: —that these people exercise. If the report is incomplete, we go back to the person who submitted it.

Mr. Michael Cooper: How do you know if it's complete or not, if there's no additional verification?

Ms. Abby Hoffman: We are not out there auditing every single—

Mr. Michael Cooper: I'm not asking.... Sorry, my time is limited. I don't mean to interrupt.

I'm not suggesting that it would be practicable to audit every single report, but surely there must be some additional check in place to ensure accuracy. What you're telling me, as I understand it, is that there's nothing.

Ms. Abby Hoffman: No, I'm not telling you that. I'm telling you the report—

Mr. Michael Cooper: Maybe I'll ask you a specific question. Are there any on-site reviews, for example, of randomly selected cases across the country? That might be a way—

Ms. Abby Hoffman: Not conducted by us, but I mentioned earlier in response to another question that there are oversight mechanisms in provinces and there are quality review procedures, and the oversight of MAID is generally, in our opinion, quite good. We are not concerned at this point. We don't have reason or evidence to be concerned that there are MAID reports being filed by practitioners that have incomplete or inaccurate or fraudulent data. That is not our observation. In fact, as I say, because of these additional mechanisms that are in place in provinces, some of which are for quality reviews and some of which are for oversight and compliance, we think the system is working pretty well.

I would say also that it takes more than 10 minutes to respond and that the new datasets will be considerably more complex and require more time.

Mr. Michael Cooper: Again, not all of the reporting is going through provincial bodies.

Ms. Abby Hoffman: That's correct. A small proportion of the total number of MAID cases comes to us.

Mr. Michael Cooper: What proportion?

Ms. Abby Hoffman: It would represent probably less than 10% of all MAID cases in Canada.

Mr. Michael Cooper: With respect to those cases that are being submitted directly to Health Canada, is there any mechanism in place to ensure that federally collected monitoring data in respect of those cases is being shared with local enforcement agencies as the regulations permit?

Ms. Abby Hoffman: Mr. Cooper, I think you asked me this question last year, and I think I indicated at that time that enforcement is not the job of the federal government, and it is not the role of the monitoring system.

In the rare occasion—or a hypothetical occasion—that there was some reason to believe the report was incomplete, we would interact with the person who provided the report, but we do not have the kind of data that would make it reasonable for us to advise law enforcement.

These are responsibilities of the provinces. That's very clear.

The Joint Chair (Hon. Yonah Martin): Thank you, Ms. Hoffman.

I'm back to my original order for the Liberal MPs, but because there's an even number, it would be Mr. Maloney again, for five minutes.

Is that correct?

Mr. James Maloney: I believe that's right, Madam Chair.

I'll share my time with Dr. Fry.

The Joint Chair (Hon. Yonah Martin): Thank you. You have five minutes.

Mr. James Maloney: Thank you.

I'm going to ask a couple of questions quickly and then pass the time over.

Ms. Hoffman, thanks for mentioning Victoria. I watched that show you were referring to, and it was Dr. Stefanie Green who was the practitioner involved. I believe the number on Vancouver Island is 7%. Do you have an explanation for why it's so high? There could be a greater number of seniors, for example.

Ms. Abby Hoffman: I think it's a little bit the demography: the nature of the population, the age, the education and so on. The other thing—I alluded to this earlier—is that there has been an incredible effort in the health authorities operating on Vancouver Island to make sure that MAID is accessible.

It clearly has made a difference when you combine these two factors: the demography, socio-economic status and so on, and the availability of a very open, receptive and responsive MAID system.

Mr. James Maloney: Thanks. I was asking that in conjunction with the 4% figure. It's not cause for concern is really what I'm getting at.

Ms. Abby Hoffman: It's not at this point.

Look, there is variability across the country. We know that. Everybody knows that the rate in Quebec in terms of the whole province is considerably higher than that of Ontario and B.C. I think that if we saw a rapid spike to 7% across the whole country, which I don't anticipate but if we saw that, then I think it might be wise and prudent to look into that. We're not seeing that as a trend.

● (1650)

Mr. James Maloney: Fair enough.

Senator Kutcher asked a question that I was going to ask. It was about the percentage of cases in which there's a mental disorder involved as an overlay to the other diagnosis. I'm not sure we had the answer to that, but is getting the answer to that possible?

Ms. Abby Hoffman: We can try, but I think we don't have good data on that under the current data collection system. It's more focused on the main underlying conditions. I'll defer to my colleague Jacquie Lemaire, if I may, Madam Chair, to just quickly respond to Mr. Maloney's question.

The Joint Chair (Hon. Yonah Martin): As a note, we're about halfway now.

Mr. James Maloney: I'll leave it this way. If it is available and if you could get it to us, that would be great.

Ms. Jacquie Lemaire (Senior Policy Advisor, End-of-Life Care Unit, Strategic Policy Branch, Department of Health): I have a quick answer. It isn't. We do indicate where there are multiple comorbidities, but we don't break that down.

The Joint Chair (Hon. Yonah Martin): Thank you.

Mr. James Maloney: Thank you. I'll stop there and turn it over to Dr. Fry.

Hon. Hedy Fry: Thank you very much, James. I appreciate your generosity in allowing me to share this time.

There are a couple of things here. When you look at the Carter decision and what subsequently became Canadian legislation, now we're looking to see whether in fact things worked or didn't work. Do you have any idea, Ms. Hoffman, of what percentage of people who requested MAID were denied or what percentage of people requested MAID and then changed their minds? Do you have any data on that?

Ms. Abby Hoffman: We do have data, and it's in the annual reports, Dr. Fry, so rather than my expanding on that data, I'm happy to follow up with the actual chart that shows you that information and how it's evolved over the life of MAID so far.

What I will tell you is that the number of requests that are declined is a smaller proportion than one might think. I'm sorry. I'm going off the top of my head here, but I think it's in the 15% to 17% range.

I will tell you that part of the reason for that is not that MAID practitioners are saying yes to everything. Part of it is that often the interaction that a person seeking MAID will have with a provider leads to a conversation about whether or not they are likely to be deemed eligible, and if they are not, they do not proceed with a formal request. Therefore, the refusals that I'm talking about, those numbers, are with respect to the formal written requests, which is a little bit different.

We also have detailed information about withdrawal of requests or requests that are approved but that do not lead to a MAID death. In many cases, it is because the person died before the procedure could be undertaken. There is a very small number—though not insignificant—of people who actually withdraw very close to the day or even on the day of their MAID request. They simply say, "I no longer wish to proceed." There are also some in the middle who have received palliative care or other support who simply say, "I can carry on. I do not see that I need to pursue MAID right now."

The Joint Chair (Hon. Yonah Martin): Okay. Thank you. That is time.

I'm sorry, Dr. Fry.

Hon. Hedy Fry: Thank you, Ms. Hoffman. I would appreciate your sending that graph to us, please. Send it to the clerk.

The Joint Chair (Hon. Yonah Martin): Monsieur Thériault, you have five minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

With regard to mental health as the only medical issue raised, I'd like to provide an example to demonstrate the difficulty we'll have in ruling on this issue. You can tell me what you think afterwards. In fact, I'm trying to find out if this is the main challenge.

I'll quote again from the Council of Canadian Academies report:

> A particular challenge for some people who request [medical assistance in dying where a mental disorder is the sole underlying medical condition] is that their desire to die could be a symptom of their mental disorder. Suicidal ideation is a common symptom of some mental disorders, and some mental disorders can distort a person's thoughts and emotions, leading to a desire to die, hopelessness, and a negative view of the future. It may be difficult for a clinician to distinguish between a capable person who is making an autonomous decision for MAID MD-SUMC and a person whose pathological desire to die is a symptom of their mental disorder that impairs their decision-making.

When I read that, I say to myself that I'm looking forward to reading the report of the expert panel on this issue. We won't be able to spare them from appearing before our committee so that they can explain to us, among other things, how we can get out of this kind of difficulty.

What do you think?

● (1655)

[*English*]

Ms. Abby Hoffman: I agree absolutely. That is precisely what the panel has set out to do. These are undoubtedly complex and difficult decisions, but I think it is important not to enter into the discussion with, if I may use this word, "biases". The fact of the matter is that an impulse to commit suicide manifests as a symptom of some mental illnesses, but the overwhelming majority of mental illnesses do not have suicidality as a symptom or a characteristic.

We need to be sure. Look, I shouldn't speak further about this. The experts on the panel, I'm sure, will be happy to meet fully with this committee. They can tell you more about the professional practice that lies behind the kind of point I have just made and other means to clinically assess a person relative to the MAID criteria, the eligibility criteria, and the safeguards that are in place today.

[*Translation*]

Mr. Luc Thériault: The suicidal state is known to be reversible, but according to the literature, the irremediable nature of the illness seems quite difficult to pin down, given the evolution of a mental illness or disorder in a particular individual and the different states they may present.

In short, there is a lot of work ahead of us, and I'm a bit anxious about the time we have to make decisions on this.

On another note, we were talking earlier about mature minors. There is very little data on MAID, which is now also available to mature minors in the Netherlands and Belgium. What protections are in place in these countries around requests for MAID for mature minors?

[*English*]

Mr. Jay Potter: I might be able to begin. Very quickly, I'd refer you again to the Council of Canadian Academies' report because it overviews those jurisdictions.

In the Netherlands, for instance—to your earlier question, Monsieur Thériault—if you're between 12 and 16, parental consent is required. If you're between 16 and 18, the parents must be consulted but they don't have a veto. I hope that answers your earlier question, but generally I'd refer you back to that report as a starting point.

Ms. Abby Hoffman: I'll add if I may, Madam Chair, that in some countries the person—

[*Translation*]

Mr. Luc Thériault: I know, I read the…

Okay, go ahead, Ms. Hoffman.

[*English*]

Ms. Abby Hoffman: I'm sorry. I was just going to note very quickly that in some of the Benelux countries the only minors who are eligible for an assisted death are those whose condition is terminal, so there would be no equivalent to our situation of people whose death is not reasonably foreseeable.

[*Translation*]

Mr. Luc Thériault: That's absolutely right.

[*English*]

The Joint Chair (Hon. Yonah Martin): That is five minutes. Thank you.

The next five minutes will be Mr. MacGregor.

Mr. Alistair MacGregor: Thank you very much, Madam Joint Chair.

Maybe I'll turn to Ms. Banerjee and ESDC. What I would like to know, for persons who live with disabilities in Canada, from your viewpoint and the feedback that you receive serving this population, what's the main feedback you get in terms of the obstacles that are in their way for achieving real quality of life in Canada? Is there anything about which you can help inform the committee in our work on this very sensitive subject?

● (1700)

Ms. Mausumi Banerjee: Like I said, we've been doing more engagement more generally on disability inclusion rather than MAID specifically, and we also have relationships with a number of stakeholders. Certainly financial security is a concern and the impacts that the pandemic has had on persons with disabilities is a concern, and all of this is serving to inform the work that we're doing on a disability inclusion action plan.

They also talk about barriers and obstacles, whether they're attitudinal or physical, so we're taking all of these into account in going forward with the disability inclusion action plan and in terms of developing the Canada disability benefit that was announced in the 2020 Speech from the Throne.

Mr. Alistair MacGregor: In trying to achieve inclusion, do you think the responses lean more heavily towards financial security, or is it in general supports that are available, whether that be access to services, mobility access and so on? Can you illuminate that a little bit more?

Ms. Mausumi Banerjee: I think the overwhelming concerns that have been raised have been with respect to financial security and employment, so very heavily weighted on that. Certainly, in more general terms, access to programs has been raised and just ensuring that anything that we do federally, whether it's a disability benefit or other, has an overall beneficial impact on persons with disabilities so that they don't lose other supports that they may be eligible for.

Mr. Alistair MacGregor: Thank you very much.

Ms. Hoffman, on the subject of palliative care, in Health Canada's 2019 action plan on that subject, one of the goals is to foster improved access for underserved populations. Do we have an idea of what that gap is currently? How much more is required so that Canadians, no matter what part of the country they reside in, have fair and equitable access to palliative care? Do you have an idea of the timeline that will be needed to achieve those goals and of how much more funding we need to earmark to ensure that it's a reality?

Ms. Abby Hoffman: I don't think I could respond, Mr. MacGregor, with real data that says here's the actual gap. We know that there are gaps very significantly when it comes to the provision of palliative care in people's own homes, when people are needing palliative care but their situation is not such that they need to be hospitalized. We are also taking a bit of a sectoral approach through various initiatives and projects and money that we received in budget 2021 that are all designed to deal with some of those gaps that were identified in the action plan.

With respect to underserved populations, not surprisingly, indigenous communities are significantly underserved. There was a special allotment of money near the beginning of the initiative aimed at this specifically. We work with Indigenous Services Canada and indigenous groups to find the best ways to allocate that money, but those are not decisions taken so much by us. They are more done in conjunction with the communities and ISC.

On the data that you're looking for, I can ask my colleagues if we can speak to that, but I think the gap is not documented in the detail that would be great to have and that you're requesting. I don't think we have it.

I'm looking to my colleagues to see if anyone wants to answer that or to add anything.

Ms. Venetia Lawless (Manager, End-of-Life Care Unit, Strategic Policy Branch, Department of Health): I would agree with that. We don't have the data on the size of the gap. We do know that it is large. We're working with provinces and territories and partners to see how we can fill those gaps together.

Mr. Alistair MacGregor: Thank you.

The Joint Chair (Hon. Yonah Martin): Okay. Thank you.

The Joint Chair (Mr. Michael Barrett): Folks, we have 11 minutes remaining and we have 12 minutes of question time left for our senators, so we'll be strict with our time.

We'll begin a three-minute round with Senator Mégie.

● (1705)

[*Translation*]

Hon. Marie-Françoise Mégie: Thank you, Mr. Chair.

I'd like to address the issue of mental illness.

There's often a link between mental illness and social inequality. What safeguards have other countries put in place for people with mental illness?

Can the federal government invest in improving access to support services for people with mental health issues? This could help these individuals make their way through the process before they apply for medical assistance in dying.

I don't know which of the witnesses can answer these questions.

[*English*]

Ms. Abby Hoffman: Senator, maybe I can start by saying that we know that the panel has looked very closely at measures taken in other jurisdictions when it comes to safeguards for dealing with cases involving mental illness. Rather than my trying to speculate on what the panel will say in their report, I would ask that you wait for the report and the opportunity to question the leaders of the panel.

[*Translation*]

Hon. Marie-Françoise Mégie: Thank you.

Okay.

[*English*]

The Joint Chair (Mr. Michael Barrett): You have one minute and 30 seconds remaining, Senator. Are you going to yield the time or continue?

[*Translation*]

Hon. Marie-Françoise Mégie: I'll give the floor to one of my colleagues.

[*English*]

The Joint Chair (Mr. Michael Barrett): Thank you, Senator.

We'll move to Senator Kutcher for three minutes, please.

Hon. Stanley Kutcher: Thank you very much, Chair.

Ms. Hoffman, you mentioned earlier in the discussion that consensus around MAID has not been a phenomenon all the way through this process. Is there any way you could give us some idea of the numbers or the proportion of medical practitioners, let's say when Bill C-14 came into place, who were comfortable with and supported MAID, and then the percentage of those who didn't? In the palliative care community, what was that proportion when MAID was first introduced? Has that changed? Has there been a change in the consensus over time?

Ms. Abby Hoffman: First of all, I think when MAID first came in there was a small critical mass of providers who were ready to proceed. There were individuals who had done everything but assisted dying with their patients at the end of life and they were ready to proceed, but fairly quickly we got to the point where there are close to 1,500 providers now and assessors. Not all of them are doing numerous cases. Some are doing relatively few cases.

I can tell you that going back to the outset surveys that were done by the Canadian Medical Association, for example, their own community indicated not unanimity in favour of MAID, but relatively high support for MAID and the willingness to be a MAID assessor or provider. Those are not exactly the same things.

What I think we've seen is an increase in receptivity to MAID, generally, and an increase in the number of individuals who are prepared to take on MAID assessment and provision functions. We know that there is going to be I think a pause, shall we call it, as providers start to receive these so-called track-two cases, which some may give serious consideration. It could be partly because they have some reservations about providing an assisted death to someone who's not dying. It may equally be because they know a particular specialized skill set is required and unless they want to become a kind of specialist MAID practitioner this may be a route they don't want to go.

That's why I mentioned earlier that we've already seen a trend of some practitioners doing more cases and we expect that it is going to be a significant place for growth into the future. I can't tell you exactly how many were agreed and how many were opposed. I think people's views change over time, and that has happened in the medical community. We have seen that.

Hon. Stanley Kutcher: Thank you very much.

The Joint Chair (Mr. Michael Barrett): Thank you, Senator.

Thank you, Ms. Hoffman.

We'll hear from Senator Dalphond. You have three minutes, please.

● (1710)

[*Translation*]

Hon. Pierre Dalphond: Thank you, Mr. Chair.

Ms. Hoffman, I understand the right to self-determination. I also understand that there are situations where people with mental illness can be assessed on a case-by-case basis.

However, in terms of general policy, don't you think it would be more acceptable to Canadians if this change were accompanied by an additional infusion of public funds into mental health treatment? During the pandemic, we saw that resources were woefully inadequate in this area.

[*English*]

Ms. Abby Hoffman: I think as a general matter, clearly when it's widely recognized that there is an area where that the services are not sufficient, it would make sense to have more services available and for those services to be better resourced.

Let me just note, though, that when we're talking about MAID in cases in which the sole underlying medical condition is a mental illness, these are likely going to be cases that have not responded to treatment. If you look even at the regime that is in place now for cases in which the person's death is not reasonably foreseeable, and then you think about what you will hear, inevitably, from the expert panel about additional safeguards, I think what you'll start to see is a picture of access to MAID for people who have a significant mental illness and there's been an extensive review of all of the treatments and supports and interventions over a long period of time.

These are more likely going to be individuals who might be considered for MAID who have had the benefit of an extensive interaction with psychiatric care modalities. These are not the people for whom all of a sudden some newly diagnosed bipolar disorder or something like that appears, and a month later they show up on the doorstep of a MAID practitioner with a request for MAID.

Anyway, the expert panel will talk in their expert fashion—not my vernacular version—and will describe all of this. I think these are related issues, but they are somewhat different issues: the general availability of mental health and wellness services and the situation and the access to treatment for someone with mental illness who gets to the point where they're seeking MAID.

[*Translation*]

Hon. Pierre Dalphond: Thank you.

[*English*]

The Joint Chair (Mr. Michael Barrett): Thank you, Senator.

Senator Martin, you have three minutes. Please go ahead.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Vice-Chair.

I have one question for you, Ms. Hoffman. In regard to palliative care, we did hear witnesses—I'm a British Columbian—regarding not a competition for funds but that sometimes funds were being directed for MAID that perhaps should have also been made available to palliative care. There's a bit of a competition for funding.

My question goes back to what Mr. Barrett asked. Is it possible for the federal government to be in touch with the provinces to find out exactly what is being spent on palliative care versus MAID? Is that information something that we could ask you to come back to us with or to send to our committee?

Ms. Abby Hoffman: If I may, Senator Martin, I'll ask Venetia Lawless to respond to that question.

Ms. Venetia Lawless: Thank you.

If you're referring to the common statement of principles bilateral agreements funding, we do have a broad-strokes understanding of how much is being spent on palliative care through the action plans that they have agreed to. Those are all public documents. It's hard to pin down exact amounts of money. For example, in Ontario the money came in and ended up merged into a pot of their full home and community palliative care expenditures. It includes their own provincial funds. There's a lot of crossover.

We don't have exact numbers, but we can certainly get broad strokes of how much money is being spent on the palliative care envelope for that allocation. We would follow up and provide it to you.

The Joint Chair (Hon. Yonah Martin): That would be helpful. I guess it's about the accuracy and transparency as much as possible, so that we know that palliative care is not having to compete in any way or that funding is lost as a result of increased MAID.

Thank you very much, Mr. Vice-Chair.

At this time, as a committee we'd like to thank all of the officials who made presentations and answered our questions today. We wish we could have many more hours with you, but for today, thank you very much.

● (1715)

Ms. Abby Hoffman: Thank you, Madam Chair.

Mr. Jay Potter: Thank you very much, Madam Chair.

Ms. Mausumi Banerjee: Thank you very much.

The Joint Chair (Hon. Yonah Martin): Members, before we move to the request from Mr. Anandasangaree to have a discussion in the final 15 minutes of our committee meeting, I want to remind you to submit your list of suggested witnesses to the joint clerks by tomorrow at 4 p.m., Eastern Time. It doesn't give us much time, but I know that we've all been working on these lists already. The clerks and analysts will review and compile the list of witnesses for the committee's consideration. Again, tomorrow's deadline is 4 p.m., Eastern Time.

I will now invite Mr. Anandasangaree to bring to us the item that we had agreed to look at in these final 15 minutes.

Mr. Gary Anandasangaree: Thank you, Madam Chair.

Thank you, colleagues, for the indulgence.

Given the short nature of the time we have in order to complete this study and table it by June 23, I think it would be important to have a subcommittee meeting where the witnesses could be both finalized and prioritized, and we could have some agreement on the number of meetings and the availability of House resources for those meetings.

I'm proposing, and I don't know if this needs to be a formal motion, that we have a subcommittee meeting next Wednesday, April 20, from 1:30 to 3:30 to discuss the matter. Then I believe the House availability for the meeting would be on Monday, April 25. At that meeting we could submit the report and have it approved by members and continue with our witnesses.

I just wanted to canvass people on how they felt about this. A deeper dive could take place on Wednesday so that we could actually hammer out the work plan for the next few weeks.

The Joint Chair (Hon. Yonah Martin): Thank you.

The motion is for the subcommittee to meet next Wednesday, April 20, at, did you say, 11:30 a.m.?

Mr. Gary Anandasangaree: It's 1:30 to 3:30.

The Joint Chair (Hon. Yonah Martin): Are there any questions or comments before we ask for consent? Seeing none, I think that is approved.

We will have a subcommittee meeting next week on April 20.

For that subcommittee meeting, I'm just wondering. Did we get the nomination of the additional Liberal member to sit on the subcommittee? We can also confirm from the Senate that we have agreed on Senator Kutcher being a part of the subcommittee. Do we know which additional Liberal member will be part of the subcommittee?

Mr. Gary Anandasangaree: I would be prepared to serve, Madam Chair, if the committee wishes.

The Joint Chair (Hon. Yonah Martin): Okay. Is there such a motion, or acceptance of the offer?

Mr. James Maloney: I will move that.

The Joint Chair (Hon. Yonah Martin): Mr. Maloney moves that. Okay. That is carried.

Colleagues, thank you again. It was a three-hour session, but we all were able to keep to our time for the most part. We appreciate the work of the clerks behind the scenes to get us ready for today, and of all of our staff who took part as well.

Happy Easter and happy holidays to everyone. I know you're working hard during your constituency weeks as well.

Thank you. I declare this meeting adjourned.