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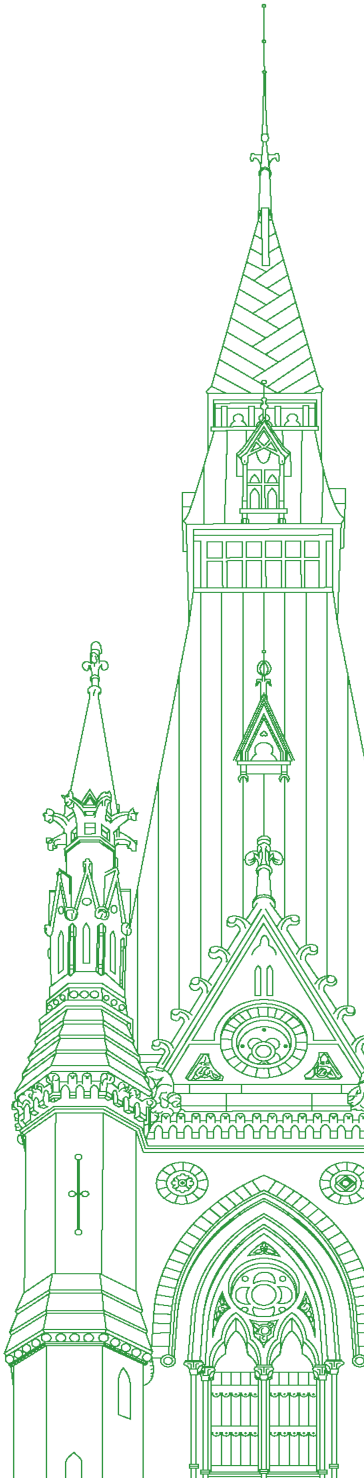

Co-Chairs:
The Honourable Marc GarneauThe Honourable Yonah Martin

Special Joint Committee on Medical Assistance in Dying

Tuesday, September 27, 2022

● (1830)

[*English*]

The Joint Chair (Hon. Marc Garneau (Notre-Dame-de-Grâce—Westmount, Lib.)): Good evening. I would like to call this meeting to order.

[*Translation*]

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

I welcome the committee members, our witness and those watching this meeting on the web.

My name is Mark Garneau, and I am the House of Commons joint co-chair of this committee. I am joined by the Honourable Yonah Martin, the Senate joint co-chair.

[*English*]

Today we are continuing our examination of the statutory review of the provisions of the Criminal Code relating to medical assistance in dying and their application.

I'd like to remind members and witnesses to keep their microphones muted unless recognized by name by one of the joint chairs. Just as a reminder, all comments should be addressed through the joint chairs. When speaking, please speak slowly and clearly. Interpretation in this video conference 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 witness for panel one, who is here to discuss MAID when a mental disorder is the sole underlying medical condition.

Welcome to Professor Jennifer Chandler, who is a professor of law at the University of Ottawa.

Thank you for joining us.

We'll begin with your opening remarks, Professor Chandler. You will have five minutes, which will be followed by a question period.

We'll go over to you, Professor Chandler.

Professor Jennifer Chandler (Professor, As an Individual): First, thank you very much to the committee for having me here today. It's an honour to address you, and I hope the remarks I can contribute will be helpful to you in your consideration of a difficult issue.

As Mr. Garneau mentioned, my name is Jennifer Chandler. I'm a full professor of law at the University of Ottawa, where I teach health law and specialize in mental health law, neuroethics, issues around brain interventions and the law.

I am speaking as an individual, of course, and don't represent the university or the expert advisory panel of which I was a member, nor do I represent the views of the CCA panel, of which I was also a member.

I was thinking to myself what I could say in these opening remarks that would be of use to this group in light of what other witnesses before me have brought to you, and have done an excellent job bringing to you. I thought that perhaps, given that I'm a lawyer, I would speak from a legal perspective and talk about the question of discrimination, because this is invoked as a central issue in trying to decide what to do about eligibility of people with an SUMC, sole underlying medical condition, being mental disorder.

At the moment, as you know, the law excludes a particular category of people from eligibility, namely, those suffering solely from mental disorder. This exclusion is defined on the basis of a specific class of disability.

There are two arguments out there, which you have heard, about how this is or is not discriminatory.

One view holds that excluding a group of people is discriminatory when done on the basis of mental disability, because it withholds from them a benefit or an option that's available to others, and this is unjustified when they meet all the other eligibility criteria that others meet.

Another view holds that offering medical assistance in dying to people with disabilities, including mental disabilities, is discriminatory because it exposes them and only them, people with disabilities, to an increased risk of death by suggesting perhaps that death might be a good option in their circumstances and/or by making it easier for them to access death.

In other words, then, to summarize, in one case we have access to an option that's viewed as a benefit, which is unfairly withheld, and on the other hand access to an option, which is a harm, which is unfairly imposed. How does one reconcile these views?

I think one can be confident that people holding both of these views hold them in good faith and strongly believe in the justice of the view they're espousing with respect to discrimination.

In fact, as you've heard—I was watching the proceedings from Friday—people with lived experience hold these these opposing views as well.

I propose to offer a few thoughts from a legal perspective on how these opposing views, what's discriminatory and what is just or unjust in these circumstances, can be reconciled. Evidently, my view is a legal one and should be tempered with the insights of those with lived experience and those who provide care, and in recognition that others might differ with my reading of the cases and my interpretation of the law.

Essentially the Supreme Court of Canada has had to address this particular problem on multiple occasions in the past of whether differential treatment of a group with a disability is discriminatory. In those cases, it has noted the challenge of what it came to call the "difference dilemma". In essence, what this alludes to is that in some cases to achieve equality, to promote dignity, it's necessary to treat people differently, whereas in others it's necessary to treat them in the same way.

To give you a concrete example from a case involving segregated schooling for children with severe physical disabilities, the court said that a separate or segregated stream of schooling could protect equality or violate equality depending upon the needs, capacities and circumstances of the particular child in question.

This difference dilemma means it's very hard to point to exact same treatment or differential treatment to really get at this question of what best promotes equality.

How then do we figure it out?

● (1835)

If you look at the range of questions that has come to the Supreme Court posing this particular type of problem in a range of cases, whether it's schooling or whether it's access to particular workers' compensation benefits for physical versus mental injuries, my reading is that the Supreme Court is quite uncomfortable with blanket attributions of a specific set of needs capacities and circumstances to a group as a whole. It is very much more likely to be comfortable with a regime, if it is possible to do so, that provides for individualized assessments to verify that any presumptions are in fact accurate in individual cases.

We come to the blanket exclusion of all people with mental disorders. This would seem to be a problem. This is a very heterogeneous group of people with very different needs, capacities and circumstances. The question I think for you is, do criteria in the Criminal Code, along with recommended measures that the expert advisory panel put in place, offer an adequate framework to do this kind of individualized assessment safely? I think so. I was a member of that expert advisory panel, so, of course, I would think that we had put something forward that could work, with certain caveats that I'd like to draw to your attention.

This question of adequate funding is a key safeguard. It's an adequate funding question in two directions. Adequate funding of social supports is key to ensuring that those who can be supported, whose suffering can be alleviated, will have the opportunity to have it alleviated. A good and compassionate society will try to do its best to help those who are struggling. At the same time, we have to note that there are situations in which just about any social supports will not be sufficient to alleviate intolerable suffering.

In a second way, adequate funding pertains to the kind of funding that's available to assessors and the infrastructure made available for assessors to do a careful and thorough assessment. The kind of thorough multidisciplinary assessment required here involves a long process and multiple people involved in coordinating a range of potential supports. This will take time and resources to do properly.

If those funds are not available, I see a twin risk. One, people will withdraw from providing assessments to people who are suffering intolerably, because they won't feel that they can do it properly, or conversely, some might do a rushed assessment with risk in the other direction.

I think the kinds of things we put forward in our report with respect to the infrastructure are quite important to consider and to put in place within the realm of what's reasonable and possible.

The other safeguard—

The Joint Chair (Hon. Marc Garneau): Sorry, Professor, but could you wrap it up, please, so we can get to the questions.

Prof. Jennifer Chandler: Certainly.

I was just going to say that the other safeguard that is critical is the detailed collection of information. I understand the reporting regulations are being amended to come into force this January, with the addition of a range of other details which will be exceptionally important in having the actual data about what's happening, as opposed to guessing about what might be happening.

Thank you.

● (1840)

The Joint Chair (Hon. Marc Garneau): Thank you, Professor.

I'll now turn it over to my co-chair, Senator Martin.

The Joint Chair (Hon. Yonah Martin (Senator, British Columbia, C)): Thank you to my co-chair.

We'll go into the first round of questions with MPs. For the first five minutes, I have Mr. Barrett starting us off.

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): Thanks, Madam Joint Chair.

Good afternoon, Professor, and thank you very much for joining us.

We have limited time and I'd like to get through a couple questions with you, if I could. I'm going to read them to be succinct as well.

First, in my reading of the expert panel report, it appears that there's a contradiction I would like you to help me resolve. I'll paraphrase, but it says that the current legal framework can apply to MAID where mental disorder is the sole underlying medical condition, with no new legislation or additional safeguards, but it also says that irremediability in the case of MD-SUMC is difficult, if not impossible, to predict. The report fails to offer evidence that it is possible, or provide specific guidelines on how to determine it.

In order for a person to be eligible for MAID, irremediability must be determined. How do we reconcile this challenge? Without a clearly defined road map in determining that a person's mental disorder is irremediable, it would seem that MAID with mental disorder as the sole underlying medical condition is not compatible with the existing law.

Prof. Jennifer Chandler: I'd say two things.

As a point of clarification, the term “irremediable” is not a medical or scientific term. It's a legal term that's been put into a piece of legislation, and in fact is defined in the law in terms of incurability and so forth, the three sub parts.

Together, the question you raised is a good one. What degree of certainty do we have to have with respect to the future in order to satisfy that criteria? I think it's going to be impossible to have absolute certainty. It's also going to be impossible to be certain in any individual case, if one were to gather group data that on average a specific set of characteristics is a certain percentage likelihood to be incurable or not. It will be hard from that average group to be certain that it applies to any one individual.

It's clear that 100% certainty cannot be what's meant by the legislation, nor achievable in any case. We're left with the question of how much certainty, and on what basis of what type of evidence do we think we have met these legal criteria of incurability, non-alleviability, and so forth.

Mr. Michael Barrett: I appreciate that, and thank you for that succinct answer to a pretty broad question.

It's important to note that in the final report it does say that the evolution of an individual's mental disorder cannot be predicted as it can for certain types of cancers, for example. I think that is certainly a challenge.

My next question is with respect to media reports. I'm not sure if you're familiar with this, but this summer there were CBC reports about a woman from Ottawa who had applied for MAID three times—two times before the passage of Bill C-7 and then one time since the eligibility was expanded. This individual was denied each time, but then was connected to a MAID assessor in Toronto, and she was approved for MAID.

Does it concern you that different MAID assessors are coming to different conclusions with respect to what conditions are acceptable for MAID and that kind of shopping around for an assessor who's going to give them the answer they're looking for instead of one that's based on the intent of the law?

Prof. Jennifer Chandler: I'm afraid I don't know the details of the case you're referring to, so I'm not sure I can give a perfectly tailored answer.

In order to answer that question, I would want to go and look at what might have changed between those assessments to determine if there was any justification for a different result. If nothing had changed, then perhaps we should look at that in one way. If there had been new evidence that had come to light, that would also be relevant.

I think one of the recommendations that we made was that collateral information and the existence of prior requests should be accessible to subsequent assessors to inform them and to also shed light on repeated assessments so that this could be determined, evaluated.

● (1845)

Mr. Michael Barrett: I think that's just about it for my first round. Thanks very much.

The Joint Chair (Hon. Yonah Martin): Next we will have Mr. Maloney for five minutes.

Mr. James Maloney (Etobicoke—Lakeshore, Lib.): Thanks, Madam Joint Chair.

Professor Chandler, thank you for joining us this evening. I'm going to ask questions very similar to what Mr. Barrett just put to you.

You talk about discrimination. If you exclude somebody solely on the basis of their condition, that is discrimination. The issue is whether or not that discrimination is justified. I will put this to you as a statement, and you can tell me whether you disagree or not.

If the basis for the discrimination of not including people with mental disorders is that the risk is high enough that the process could be wrong, that would be a justified basis for excluding them, perhaps. Is that a fair comment?

Prof. Jennifer Chandler: I think so, except I would have trouble with saying that solely about mental disorders. The reason for that is that people with mental disorders are already included if they have a physical disability, for example.

Mr. James Maloney: I was going to get to that, yes.

Prof. Jennifer Chandler: So, it's hard to regard it, the risk of error, to be unreasonably elevated in one context and not in the other. We'd have to explain that difference.

Mr. James Maloney: Right. I was going to get to that in a moment, so I'll go there now.

If a patient has terminal cancer but also has a mental disorder, as the law currently stands and as it did under Bill C-14 and Bill C-7, that person could qualify for MAID solely on the basis of the cancer diagnosis, but if they are not excluded from having access because they also have a mental disorder. That's the state of the law, correct?

Prof. Jennifer Chandler: Yes.

Mr. James Maloney: Okay. Then the question in that scenario becomes whether or not the mental condition is driving them to make that decision more so than it would, perhaps, if they didn't have a mental condition. Is that fair?

Prof. Jennifer Chandler: To my knowledge, the courts have said that assessment of suffering has to be made on the basis of the totality of the circumstances and is not to be tied to one particular condition that the person might have.

Mr. James Maloney: As the law stands, if the one condition is a mental disorder, they wouldn't qualify at all. I'm saying that, as the law stands now, it's not a barrier as opposed to giving them access to the process.

Let me go back. You referred to some examples of Supreme Court of Canada cases where the Supreme Court dealt with discrimination in situations dealing with schools or receiving benefits. That's markedly different from terminating one's life, I would say, so I'm not sure that those cases are.... It's not apples and apples, if I can put it that way.

We get into this situation where, as you said, “irremediable” is a legal term, not a medical term. What we're talking about is whether a mental disorder is permanent and cannot be cured, which would allow a person to qualify for MAID. That's the heart of what we're talking about.

In order to do that, you need to have certain protections built into the system, so you need to be confident that doctors assessing somebody with a mental disorder are as capable of making that assessment as doctors who are dealing with somebody who has cancer, to use the example I referred to earlier.

Are you confident, based on your experience through the panel process and whatnot, that there are safeguards in place enough that it will work with people with solely mental disorders?

Prof. Jennifer Chandler: Yes, I think I am. I want to step back to say that I think we shouldn't perhaps be comparing the cases of sole SUMC with cancer cases. We should perhaps be comparing the track two-type cases of physical disability with track two-type cases of sole underlying condition being a mental disorder. In both those cases, there are often uncertainties about whether a person will come to have suffering that's alleviated with the prognosis and so forth.

To me, the question would be, can we separate out the treatment of mental disorder and leave in place the physical disability cases on track two? That is one point to justify. The other thing I would say in response is, if we stay with the comparison of the cancer cases and the solely mental disorder cases, we already have cases where people with a mental disorder, as you point out, have a cancer and are seeking MAID. We have to assess capacity in that context, so one presumes that one can assess capacity across both types, and doctors have experience in assessing capacity in solely mental disorder cases as of other high-stake decisions of refusing—

● (1850)

Mr. James Maloney: I'm running out of time, but the difference is there when there's another medical condition. You're assessing capacity. If it's solely the medical disorder, you're not just assessing capacity, you're assessing the permanent nature of the condition, so it's a little bit different. Is that fair?

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

Next we will go to Monsieur Thériault for five minutes.

[*Translation*]

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

Welcome, Ms Chandler.

You participated in the expert report. I followed your presentation establishing the principles on the issue of discrimination, and I understand them very well.

Am I wrong in saying that the recommendations were designed to become the way to proceed so that the process would be morally and ethically acceptable in the event that eligibility for medical assistance in dying is not questioned? So, at the end of the day, these are guidelines.

Am I correct in saying that the recommendations are intended as guidelines?

Prof. Jennifer Chandler: I understand French perfectly, but I will answer in English if that's okay with you.

[*English*]

Yes, I think we had in mind that these were recommendations that we thought would be good to adopt in order to allow for the safe unfolding of MAID-SUMC. One question is exactly which body in a federal state is best placed to put these kinds of things into effect, whether it can be done within the Criminal Code or regulations versus at the provincial legislative level or, in fact, with professional bodies or medical regulators, but I think we anticipated that the structure itself put in place—

[*Translation*]

Mr. Luc Thériault: So the recommendations will not necessarily end up in the Criminal Code. There could simply be a sunset provision that gives access to people whose only medical issue invoked to obtain medical assistance in dying consists in mental disorders. It will then be up to the practitioners conducting the assessments to ultimately apply these recommendations in their assessment.

For instance, I understand that any suicidal person in a state of crisis will never have access to medical assistance in dying, as long as they are in such a state. This strikes a chord in the collective imagination. People often wonder if we will end up giving access to medical assistance in dying to young depressed people. Yet that is not the case.

In other words, when we take the whole report into account, we see that, before it can be determined that a patient with a mental disorder meets the eligibility criteria for medical assistance in dying, it must be established that their disorder is chronic and that the patient has undergone a number of therapies, received therapeutic care and even taken medication over a long period of time, perhaps even a decade.

So there are plenty of people who could apply for medical assistance in dying that will ultimately be denied.

[*English*]

Prof. Jennifer Chandler: I think you're absolutely correct.

We had a long discussion. Could we talk about a certain number of treatments? Could we talk about a certain number of years of experience? We realized that it had to be a case-by-case evaluation given the heterogeneity of cases. But you're entirely right that it's not possible to establish the incurability, the irremediability, the fact that suffering cannot be alleviated without having tried quite a few treatments. That's what the expert panel says: that for the person who is in crisis, who is very early on in their experience, who has had no treatments, it will not be possible to establish that they meet the eligibility criteria.

● (1855)

[*Translation*]

Mr. Luc Thériault: Some psychiatrists have claimed that there is a treatment for everything, a treatment to relieve suffering in any psychiatric condition.

Isn't that based on something of a relentless treatment quest?

Prof. Jennifer Chandler: I'm sorry, but I'm not sure what you mean.

Mr. Luc Thériault: Could someone explain?

Prof. Jennifer Chandler: I understood the rest, but not that last part.

[*English*]

The Joint Chair (Hon. Marc Garneau): There's a bit of an obsession with continuing with therapies.

Prof. Jennifer Chandler: Obsession. Thank you.

I'm not trained in psychiatry, so I hesitate to critique without that training. However, my observation as someone external to it is that hope and a dedication to the recovery of patients are frequently part of the psychiatric self-concept. Yes, I think it's important to believe that all is possible, but there are people who have been through an awful lot of treatment and who continue to suffer intolerably. So, this concept of the refractory intractable condition is out there, and after a certain amount of time, from what I've heard, it becomes more reasonable to predict that it might continue.

The Joint Chair (Hon. Yonah Martin): Next we will have Mr. MacGregor for five minutes.

Mr. Alistair MacGregor (Cowichan—Malahat—Langford, NDP): Thank you so much, Madam Joint Chair.

Professor Chandler, I'd like to take this opportunity to thank you for appearing before our committee.

My question deals with treatments and a person's capacity to accept those treatments. The Criminal Code does make mention of an intolerable condition, suffering that cannot be relieved under conditions that they consider acceptable. I was hoping maybe you could inform the committee, or just walk us through the existing law and how it interprets this.

We're dealing with hypotheticals here. What if we had a hypothetical situation in which a physician knew of a treatment that might be beneficial to a patient who was suffering from a mental disorder and they had knowledge that the patient had applied for medical assistance in dying? How does the law work through that thorny issue of a patient perhaps feeling that a treatment is unacceptable and having made an application for medical assistance in dying?

I think these are some of the hypothetical and thorny issues that many committee members and indeed some of our witnesses have been struggling with. I'd appreciate any thoughts you could offer on those.

Prof. Jennifer Chandler: Yes. The crux of the problem is knowing whether the suffering can be alleviated. There are three criteria about this prognostication into the future. One is this incurability. One is the irreversibility of decline. One is the alleviation of suffering under conditions acceptable to the person.

The preceding two criteria don't refer to conditions acceptable to the person and the third does. The question then would be, if a clinician is aware of the treatment that they think would be helpful and that on balance is not unreasonable in terms of the burdens versus potential benefits and so forth, and a person was refusing it, what would happen?

The way our panel tried to approach this was by talking about the assessor and the requester coming to a shared understanding. It would be up to the requester to be able to refuse any treatment they didn't want to accept, but it might be under those circumstances, where there's a reasonable treatment available that the clinician thinks might actually help, that it's impossible for that clinician to come to the opinion that it is incurable or irreversible.

This is a tricky point. You asked me how the law would interpret this. We have proposals of how this law should be interpreted and our proposal is that under such circumstances it may not be possible for the requester to conclude that it is incurable, if there's something reasonable that hasn't been tried.

● (1900)

Mr. Alistair MacGregor: I appreciate that. Thank you very much.

This is my final question. We have this final report of the expert panel on medical assistance in dying for a mental disorder as the sole underlying medical condition. As a joint parliamentary committee, we still have our job to do. This area is one of the five major themes that was tasked to us by both the Senate and the House of Commons.

In that context, in your capacity and with the obvious expertise that you have, what would you ultimately like to see in this committee's report to the federal government in terms of recommendations? What areas do you think parliamentarians still have to address under this particular theme?

You made mention of the fact that mental health funding may be inadequate. I would agree with you and so would many others.

If you can elaborate on that part, it would be appreciated.

Prof. Jennifer Chandler: Certainly.

On the funding and resourcing in general, I would say the social support funding is very important as a safeguard.

I also think the recommendations we made in relation to both pre- and post-evaluation of files would be very useful. That's an important safeguard. That's in place in some of the other jurisdictions that have gone ahead. This helps to ensure transparency and promote public trust. That's very important. This, of course, has to be resourced as well.

The resourcing has to be in place for assessors to do a good job of this and to have the time and space to do this job properly.

The reporting recommendations that we put into the report are also essential. There will be a tricky balance to strike in terms of the privacy of the people involved, the level of detail that's being gathered and how much of it is to be made accessible. I think it should be made accessible for transparency and public trust reasons, but redacted as much as possible to preserve the privacy of the people involved. That's essential.

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

We've come to the end of this time.

I'm going to turn it over to my co-chair, so we can do questions from senators.

Thank you.

[*Translation*]

The Joint Chair (Hon. Marc Garneau): Thank you, Senator Martin.

Will will move on to questions from senators, starting with Senator Mégie.

You have three minutes, Senator Mégie.

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

Thank you for being with us, Ms. Chandler.

My question relates to the essential constitutional rights of people whose medical issue is only mental. What rights are affected if they are denied access to medical assistance in dying?

[*English*]

Prof. Jennifer Chandler: I think the rights that have been invoked in the cases so far are section 7, the right to life, liberty and security of the person, and also the right to equality, section 15. Both of those rights I think would be at issue if people are excluded. Section 15 would be discrimination on the basis of disability.

[*Translation*]

Hon. Marie-Françoise Mégie: Let's suppose our efforts result in a ban. Will it be possible to justify this restriction?

[*English*]

Prof. Jennifer Chandler: Yes. The way the charter is set up is that indeed one can have an infringement of a right, but those infringements can be justified under section 1 of the charter. A limitation on a right that's “reasonable...in a free and democratic society” is the language of section 1.

I can think of a potential justification, which might be that it simply.... We don't have the data to support this, and this is why it's so important to collect data. However, one could take the position that it is not possible to safely do the assessments that are required to distinguish between those who satisfy the criteria and those who do not, for example. That might be one justification.

I don't think we have the evidence that would support that argument at this point. We have lots of speculation that this is the case, but we don't have.... We have a lot of people saying, “We do these kinds of assessments of capacity in very high-consequence contexts with mental disorder already—the refusal of necessary treatment with fatal consequences—and so we can do capacity assessment.”

We don't exclude people who are vulnerable and marginalized from making decisions that might have fatal consequences. So it becomes really hard to justify the exclusion in this context when it's tolerated in a whole range of other contexts.

● (1905)

[*Translation*]

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

Thank you, Mr. Chair.

The Joint Chair (Hon. Marc Garneau): Thank you, Senator Mégie.

We are continuing with Senator Kutcher.

Senator, you have three minutes.

[*English*]

Hon. Stanley Kutcher (Senator, Nova Scotia, ISG): Thank you.

I think Senator Mégie suggested that I could get her extra minute.

Is that okay with you, Chair?

The Joint Chair (Hon. Marc Garneau): No, you have three minutes. We've clarified the rules.

Hon. Stanley Kutcher: Okay.

In a brief submission to the Senate Standing Committee on Legal and Constitutional Affairs in February 2021, Sheppard and Jones of McGill addressed the access to MAID. They wrote:

> The express exclusion of persons with mental illnesses undermines substantive equality by reinforcing and perpetuating stereotypes about persons with mental illnesses and [thus] disadvantaging them.

I'd like your thoughts on that statement in terms of charter rights.

As another thought, we talked about treatment being unacceptable to people with a sole mental illness and choosing not to accept it. Are there instances in other conditions, such as cancer treatment or pain treatment, where people will say, “No, I've gone through all these treatments and there may be another treatment possible. Who knows, it may work or it may not work. It may be experimental, and I just do not want to have that.” Cancer patients can say they do not want to have that treatment.

I'd like to keep it in the context of what else happens in that instance.

Prof. Jennifer Chandler: I'll take your second question first, and say I think that's entirely correct that a cancer patient is allowed to decide they are done with treatment. Someone on dialysis is entitled to say they are done with treatment, including if they have mental disorder.

Listening to my colleagues who are psychiatrists, if someone is refusing a treatment that has a very good profile in terms of benefits and potential risks, there will be scrutiny to ensure there's full understanding and so forth. However, it still remains that a person can refuse it.

Hon. Stanley Kutcher: That's in reference to medicine. It's not unique to psychiatric cases.

Prof. Jennifer Chandler: Exactly.

Could I trouble you to remind me of your first question?

Hon. Stanley Kutcher: It was on whether that statement about substantive equality perpetuates stereotypes and disadvantages people with a mental illness.

Prof. Jennifer Chandler: Yes. I think that's certainly a view that I'd endorse as well. If we are excluding people solely on the basis of a certain kind of disability, one has to ask the question why. It has to, in some way, be based on the suspicion that even if they're capable, they maybe have a diminished capacity. So there's a signalling that perhaps their ability to assess their own circumstances and options is suspect, whereas it wouldn't be for someone with a different kind of disability.

That does have the potential for fostering stigma about mental disorder, that their views are not to be taken as authentic and entitled to equal weight and credit as that of others.

Hon. Stanley Kutcher: In terms of that particular perspective, could it be possible that a physician or a psychiatrist who feels that a person who is completely competent and may make a decision about MAID could be stigmatizing that person, maybe inadvertently, that they are not competent or that they can't be treated like any other Canadian?

Prof. Jennifer Chandler: It's possible, yes.

The Joint Chair (Hon. Marc Garneau): Thank you, Senator Kutcher.

[*Translation*]

Senator Dalphond, the floor is yours for three minutes.

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

Ms. Chandler, you are an expert not only on law, but also on ethical and political issues. My question is about framing, as there are some concerns about that. For instance, there is a concern that the standards will not be applied in the same way from region to region or from province to province.

Do you think this calls for us to enact more regulations, since the report is not about making amendments to the Criminal Code? If so, will that be done by the provinces, by the federal government or by professional bodies?

Without regulating everything, what should be left to ethics?

● (1910)

[*English*]

Prof. Jennifer Chandler: This is a difficult question, but a critical one.

Hon. Pierre Dalphond: But you're an expert.

Prof. Jennifer Chandler: I think this is sufficiently new to Canada and excites sufficient concern amongst the public that it would be important to try to harmonize to the greatest extent possible the process and the safeguards across the country. In a federal state, that's difficult. I was rereading again what we said about the interpretation of these legal terms in the Criminal Code, asking myself if something could somehow be put into the code about those interpretations. We define many legal terms. Could we try to define some of those terms more clearly within the Criminal Code? That would be helpful, but it would be awfully difficult, especially given the nuance that we've tried to explain in terms of the meaning of “incurable”, “irreversible” and so forth. I don't think it's impossible, but it's a possibility.

Short of that, I don't think it's possible to put a lot into the regulations because the current code delegates the power with respect to monitoring. Perhaps a greater delegation could allow for more detail to be put into the regulations under the Criminal Code. That might be another way, but of course, then you run into the difficulty of the federal government starting to do too much that looks a little too much like health care. You have, in the Government of Canada, many of the best Canadian constitutional lawyers who can advise you on just how far you can go in terms of that.

That leaves this: Where else should it go? If we leave it to the provinces, the provinces may not be consistent. They may take varying approaches. I think that a lot can be done by asking for professional associations, for example, of psychiatrists, of MAID providers and so forth to promulgate guidelines, because these offer a very important regulatory effect. Even if they're not laws, people who don't abide by what is clearly the standard of care expose themselves to malpractice claims and all sorts of things.

There are various ways to impose law without having it in the Criminal Code. The question is this: Can you get all those things properly enacted to apply nationally? I believe there are steps well under way to do that just now with CAMAP and with others. I think that's another way to provide the kind of cross-country protection that would be advisable here.

The Joint Chair (Hon. Marc Garneau): Thank you.

[*Translation*]

Hon. Pierre Dalphond: I would like a clarification, Mr. Chair.

Could the witness send us the reference to the regulations that were just amended and would go into effect in January?

[*English*]

The Joint Chair (Hon. Marc Garneau): You mentioned....

Prof. Jennifer Chandler: Yes. I don't have a copy of it myself, but if you go to the website of Health Canada, you can see that the regulation that was passed in 2018 for the reporting requirements sets out the fields of what must be reported. It says that there's a new one coming to respond to the change of the law in 2021. This is a discussion that we also had in the committee about other things that should go into it.

The Joint Chair (Hon. Marc Garneau): I don't want to interrupt you, but the analyst will provide it to all of the committee members. She has access to it. Thank you.

We'll go to Senator Martin for three minutes.

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

Thank you for being here.

You noted that adequate funding is a necessary safeguard for MAID MD-SUMC and for both social supports and assessors. For clarity, does that mean that MAID should not be available to someone who has not been able to access treatment due to a lack of funding?

I ask this because we've heard at this committee there are people on five-year-long waiting lists for specialized treatment, so funding is a key issue, but what do we do in that case? If that's not the case, how is funding a safeguard, and would we require a change in legislation in order to offer MAID to those who are waiting for treatment? There are a lot of complexities.

Prof. Jennifer Chandler: I would distinguish between access to treatment and access to social supports—housing support, income support and things like that—because, if a person has not already undergone extensive treatment, so has necessarily had access to a lot of treatment already, it won't be possible to conclude that their condition is incurable, their decline irreversible and so forth. It's this wait for treatment itself that forecloses people from access to MAID, because they won't have that track record of experience in treatment to demonstrate that it didn't work.

My comments about funding were directed more to the section of track two that refers to exploring available community supports. We recommended that, for those community supports, the language in the law be interpreted to include things like housing, income support and so forth. I was speaking to those kinds of things in terms of ensuring that reasonable provision is made for them while understanding that, in some cases, they might help alleviate suffering, and in others, they might not.

● (1915)

The Joint Chair (Hon. Yonah Martin): In terms of funding for assessors, are you concerned that the complexity surrounding sole mental illness might lead to inconsistencies and perhaps even to MAID being misapplied, depending on who the assessor is? How can we ensure the inconsistencies are not there, case by case?

Prof. Jennifer Chandler: My expectation is that there will be a relatively small group of people in this practice area who will be speaking with each other, comparing notes and developing best practices. These are the kinds of things we've recommended be done, certainly, to ensure the professional development of all the people working in this area.

In a way, the likelihood of a relatively small number of people being involved has a downside, in the sense of access. It might be very hard for people to get an assessment for MAID in this context, but it also means that a small group will be able to professionally develop and compare notes, and, in so doing, address concerns about inconsistency.

The Joint Chair (Hon. Yonah Martin): You said it will take time to make it available, so I'm curious about the looming March 2023 deadline. Are you concerned about the time frame? It's a big country.

Prof. Jennifer Chandler: It is coming quite quickly; it's true.

I come back to what I've heard from people practising in this area. They are already doing assessments in the context of track two, and the many kinds of considerations we're discussing here are shared with all track two assessments. They have been developing track two processes for a certain number of months, and they're already assessing capacity in the context of mental disorder, not just on track two but on track one.

This is not starting from nothing, shall we say. There is a certain amount of experience developed already.

The Joint Chair (Hon. Marc Garneau): Thank you, Professor Chandler.

I'm going to turn it back to my co-chair.

The Joint Chair (Hon. Yonah Martin): We're going to have a second round, and we're going to go back to Mr. Barrett for three minutes.

Mr. Michael Barrett: Thanks very much, Madam Co-Chair.

Professor Chandler, you mentioned in our first lightning round that you recommended a safeguard with respect to data collection and sharing among clinicians and assessors. Why is that important?

Prof. Jennifer Chandler: Sorry, data sharing among....

Mr. Michael Barrett: You mentioned that one recommendation of yours was that, should someone be shopping for an assessment after having been declined, the information would be shared. There would be a requirement for that information to be shared across assessors.

Prof. Jennifer Chandler: I think a person's history of requests for MAID could be relevant to a subsequent request. The reasoning for a refusal could be relevant to a subsequent assessment. There's always a bit of a trick. Someone could have applied the criteria too stringently and turned down someone who ought to be eligible. It can go both ways, but I think it's part of the whole picture, and it would help a subsequent assessor to see the kinds of considerations made by someone who did a prior assessment. One of—

Mr. Michael Barrett: Sorry, and please continue, but that's not in place now. Is that correct?

Prof. Jennifer Chandler: I think the way medical records are kept and shared depends on the jurisdiction and the legislation in place for the privacy of personal health information, which is at the provincial level. It might define circles of care in specific ways, so I don't think I could speak for all of Canada. What we said was that an assessor should be entitled to explore, with a requester, a range of collateral information. This might include talking to family members, if they have a good faith, bona fide reason to think it might be relevant and helpful, and also speaking with prior treatment teams.

A person can refuse, but the assessor should be able to ask. If they feel there's information they don't have access to that is pertinent to their assessment, they may be unable to reach an assessment of eligibility.

● (1920)

Mr. Michael Barrett: We've been conducting a study at the Standing Committee on Health with respect to our health care system across Canada.

You said it depends if this information is being shared, based on the state of each province.

Based on what we've heard from the health care community across this country, it's being shared poorly, various states of poorly, in each province. There are some best practices that could be applied, but we don't have any kind of pan-Canadian data sharing. Even within regions of our country, the sharing of that information is not happening.

Thanks.

The Joint Chair (Hon. Yonah Martin): I have three minutes for Monsieur Arseneault.

[*Translation*]

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

Welcome, Ms. Chandler. Thank you for your answers. Feel free to answer me in your mother tongue.

The May 2022 report of the Expert Panel on Medical Assistance in Dying and Mental Illness concludes that each of the 19 recommendations can be fulfilled without adding new legislative safeguards to the Criminal Code, even in the case of a request for medical assistance in dying for patients with only mental disorders.

Do you agree with that claim?

[*English*]

Prof. Jennifer Chandler: Yes, I think so, as long as the various safeguards that we recommended are put in place at the level at which they can be put in place.

Mr. René Arseneault: Thank you.

[*Translation*]

I will stay in the legal field, since that is your area of expertise.

Have you had a chance to analyze and compare what is happening in the Netherlands, Belgium and Luxembourg, for example? Do those countries have safeguards that we don't have for people with only mental disorders? Is it possible to make comparisons?

[*English*]

Prof. Jennifer Chandler: We have done some looking at what's done in the other jurisdictions. It's taken me back to the days of the CCA report in 2018 where we looked at this in a fair amount of detail. We looked at this in this report as well.

I think some of the concepts that we have here were borrowed from those other jurisdictions, such as the idea that in addition to capacity, we would want a request to be well considered, for example. This is suggesting that something in addition to capacity is required, something that is sufficiently stable and is not fluctuating too much over time. It's concepts like this.

We suggested that this idea of “well considered” should mean the person shouldn't be able to just reply, “Yes, I understand the information here.” They should be genuinely open to the possibility that a given treatment might actually help them.

These are the sorts of ideas that we've taken from looking at the way things are done in these other jurisdictions.

In addition, the Netherlands, I believe, has a committee that looks *ex post* at the cases, analyzes them and provides reports and practice recommendations. These are things we looked at as useful, which we could adopt here.

[*Translation*]

Mr. René Arseneault: Let's stay in the legal realm.

According to recommendation 12 of the final report, the patient's assessment team may request that the question be pursued further, that additional information be sought or even that discussions be held with the patient's family members, for example.

This recommendation seems to suggest that a patient could even be denied treatment if they do not agree to further probing of their records. In your opinion, is there a line that should not be crossed in order to maintain patient confidentiality, in the case of a request for medical assistance in dying for people with only mental disorders? What are your comments on that line?

[*English*]

The Joint Chair (Hon. Yonah Martin): It's time, but just answer very briefly.

Prof. Jennifer Chandler: Yes, I think there are going to be cases where it would not be appropriate to go into a person's prior history. It may be risky. There might be difficult relationships with family members where a person might be put at risk. I think there are certainly going to be cases where there will be a line.

● (1925)

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

We'll next have the lightning round.

We'll have Mr. MacGregor for two minutes, followed by Monsieur Thériault.

Mr. Alistair MacGregor: Madam Co-Chair, I believe the Bloc might be in front of me.

The Joint Chair (Hon. Yonah Martin): It says you first. I think they've switched the order on the second round, so you can begin for two minutes and then Monsieur Thériault will do two.

Mr. Alistair MacGregor: Okay. I'll be very quick.

Professor Chandler, I think we've reached the point in the committee hearing where most of the good questions have been asked and answered.

Maybe I'll just use this opportunity to thank you for appearing and invite you to expand on anything you feel you needed a bit more time to explain.

Prof. Jennifer Chandler: Let me think. I had some in mind, but now I've forgotten what they are.

Perhaps, rather than take your time, I will see if I can recall them and come back to you in a moment. I can't think of them right now. I'm sorry.

The Joint Chair (Hon. Yonah Martin): Would you like Monsieur Thériault to ask his questions, then, Mr. MacGregor?

Mr. Alistair MacGregor: I'm fine, Madam Chair. If you want to go to Monsieur Thériault, and then maybe....

[*Translation*]

Mr. Luc Thériault: Thank you.

Earlier, I said that the recommendations in the report were guidelines of sorts. In fact, in each of the recommendations, they use the verb “should”. If it were considered as such, it could solve a number of problems.

Let's take recommendation 10. Even in the psychiatric expert community, there is resistance. The Association des psychiatres du Québec says we should go ahead, while psychiatrists have told us the opposite. This has led to Quebec deciding not to move forward on mental health cases.

In this recommendation, it is stated that it is imperative that the competent assessor, who is a psychiatrist, be “independent from the treating team/provider”.

Is this realistic, given the resources available, especially in the regions? Shouldn't this be more flexible? If it were more flexible, would it diminish the legitimacy or rigour of the assessment exercise?

[*English*]

Prof. Jennifer Chandler: That's an excellent point, and this is something that we struggle with a fair bit, recognizing that the number of people available to do assessments would be restricted certainly in small locations. We thought about the possibility, which expanded during COVID, of virtual and telemedicine assessments as well.

I think the problem you're raising is that every safeguard has a flip side to it. It increases the difficulty of access. It increases safety, while imposing barriers at the same time. There's an inevitable pairing of those things, so it has to be weighed in terms of whether the additional safety to be achieved is justified in light of the additional burdens it imposes.

A number of my colleagues felt it was quite important to have an independent psychiatrist to make sure there was a second view on things, independent of the type of relationship or other views that might accumulate in the treatment relationship. We also thought it was very important to have independent external assessors for people in particular circumstances that would raise the risk of coercion, such as people who are institutionalized or in prison, for example. I think there are some circumstances in which that independent assessment will be incredibly important, or even essential.

I don't think I can say any more than that, except that I think you're right; it will increase the difficulty of access.

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

We've come to the end of the first panel.

You have taken all of our questions. Thank you very much for being here.

Go ahead, Mr. Anandasangaree.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): Madam Joint Chair, if we've finished with the witness, I have a housekeeping matter that will take 30 seconds.

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

Thank you very much, Professor.

Yes, Mr. Anandasangaree.

Mr. Gary Anandasangaree: I would like to bring forward a motion, which says, “That the clerk of the committee be authorized to grant access to the committee's digital binder to the offices of the whips of each recognized party.”

It's a routine motion that's passed in a number of committees.

● (1930)

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

Is there any discussion?

(Motion agreed to)

The Joint Chair (Hon. Yonah Martin): We'll suspend for a few minutes to move to our second panel.

Thank you very much, Professor.

● (1930)

_____________________(Pause)_____________________

● (1935)

The Joint Chair (Hon. Yonah Martin): For the sake of our new witness, Dr. Donna Stewart, before speaking, please wait until I recognize you by name. This is a reminder that all comments should be addressed through the joint chairs. When speaking, please speak slowly and clearly. This goes for all of us. Interpretation in this video conference will work as it does in an in-person committee meeting. You have the choice at the bottom of your screen of floor, English or French. When you are not speaking, please keep your microphone on mute.

With that, I'd like to welcome our witness for panel two, who is also here to discuss MAID when a mental disorder is the sole underlying medical condition.

As an individual, we have Dr. Donna Stewart, professor, University of Toronto, senior scientist, Toronto General Hospital Research Institute, Centre for Mental Health.

We will first hear from our witness, Dr. Stewart, for five minutes.

Dr. Stewart, go ahead.

Dr. Donna Stewart (Professor, University of Toronto, Senior Scientist, Toronto General Research Institute, Centre for Mental Health, As an Individual): Good evening, and thank you for asking me to present today.

I should mention that I practised as a family doctor in northern Ontario before qualifying as a psychiatrist nearly 50 years ago. In 2014, I became a member of the Order of Canada. I am also a member of the Canadian Psychiatric Association working group on MAID for mental illness, the Canadian Association of MAID Assessors and Providers, and the University of Toronto Centre for Bioethics. As mentioned, I'm a senior scientist at the Toronto General Hospital Research Institute where I conduct research, including research on MAID. I have assessed over 300 MAID applications. I presented to the Senate committee on MAID in February 2021. My opinions are informed by my affiliations and experience, but I speak to you today in my personal capacity.

As a member of the expert panel on MAID and mental illness, I endorse all 19 recommendations, but I'd like to highlight now a few specific ones based on my personal experience in practice. The recommendations I do not comment on are equally important, but my time today is limited.

Expert panel recommendation number 1 is about collaboration between authorities. It's essential that federal, provincial and territorial governments work to facilitate collaboration between physician and nurse regulatory bodies in the development of standards of practice for MAID. I understand that substantial government and regulator work on MAID for mental illness is currently under way and that two sections of the MAID CAMAP curriculum have been written, reviewed, and are currently being revised. I know that other professional organizations are offering MAID education in various formats. As pointed out, the looming March 2023 deadline is a very powerful motivator.

With respect to recommendations 2 and 3, establishing incurability and irreversibility, clearly, MAID assessors must consider the severity and duration of illness, treatment attempts, outcomes and other evidence-based treatments that may improve the patient's condition while weighing their likely benefits and the burden. This will involve conditions lasting for many years with many multiple attempted interventions. It's my strong opinion that this determination should be a shared one between a psychiatrist, in the case of a mental disorder, and the patient and not only the patient's decision. This is clearly specified in the Netherlands' standards of practice where physician-assisted death for mental conditions has been available for almost 20 years, and where in 2020 there were 95% of physician-assisted death requests for a psychiatric disorder rejected. In fact, completed cases with respect only to mental disorders comprised only 1.3% of all physician-assisted deaths in the Netherlands.

A clinical example I can give you is a patient who insisted that only treatments based on natural plant products could be used, and I accordingly felt he did not meet the MAID criteria.

With respect to recommendation 4 related to suffering, while enduring and intolerable suffering is subjective and determined by the patient, it is also important that the MAID assessor or provider agree from a realistic perspective. For example, I assessed a middle-aged woman with mild osteoarthritis who stated that her suffering was intolerable because she was raised in the tropics and was nearly always cold in Canada, which aggravated her suffering. Clearly, I did not feel this met the criteria.

Recommendations 6 and 7 are on means to relieve the suffering. Clearly, multiple safeguards should always be seriously considered, including medical, psychological and social supports. I recently assessed a cancer patient who was also very depressed. Antidepressant medication and referral to palliative care resulted in her withdrawing her MAID request.

With respect to recommendations 10, 11 and 12, relating to independent assessment with an expert, involvement with other health care professionals and significant others, in the cases of MAID-SUMC, this should be a psychiatrist, in my opinion, independent of the treatment team to avoid bias.

With respect to recommendation 16 on prospective oversight, again, this is vital, in my opinion, for many track two cases, many of whom have comorbid mental disorders that have been poorly treated. This process is not to make judgments of eligibility, but rather to ensure that the assessments are in compliance with legal and professional standards. This should not result in lengthy delays, but should be an added safeguard by improving quality, safety and timely practice feedback to support patients and practitioners.

● (1940)

Recommendation 19 relates to research. As a senior scientist, I believe that regular and targeted investigation-initiated research on questions relating to MAID should be funded. Research in the Netherlands has informed revisions to their physician-assisted death safeguards and have been very important.

In closing, I want to emphasize the fulsome discussion of all recommendations and their salient related issues was conducted during the many hours that the expert panel, its subgroups and individuals met. Various interconnected safeguard mechanisms were available to us and for your consideration. These include legislated safeguards, professional standards, guidelines and education, each of which plays a unique, interrelated and essential role.

Thank you so much. I look forward to your questions.

● (1945)

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

We will begin with five minutes, starting with Madam Vien.

[*Translation*]

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

Dr. Stewart, welcome to the committee. Thank you for being here this evening and for providing us with your testimony.

Do you think the current safeguards are sufficient? Do you think we are protected against abuse?

[*English*]

Dr. Donna Stewart: No system is foolproof, but I would say it's very important that the various provincial, territorial and regulatory bodies co-operate to make sure that these are firmly established in the standards of practice. If that doesn't happen, then I think legislative safeguards would be needed, but I recognize the cumbersomeness of that. I certainly hope that standards of practice and guidance and education can deal with many of these issues.

[*Translation*]

Mrs. Dominique Vien: We put the question to the expert who appeared before you. 2023 will be here quickly, and all of it has to go into effect.

In your opinion, is 2023 too fast? Do we have enough time to see the costs coming and make sure that we choose the best possible path?

[*English*]

Dr. Donna Stewart: You raise a very important question. My reply is that that deadline is a very important motivator. I think the speed at which these things are being determined has picked up. Most of us worked during the summer, but not everyone. Hopefully, between now and the next few months some of these things will be put in place.

As I mentioned, I know some of the curriculum is currently being circulated and revised. Certainly, there are meetings going on. I would hope that things could be put in place. I don't know for sure, but I certainly hope so and trust that will happen.

[*Translation*]

Mrs. Dominique Vien: Dr. Stewart, you mentioned earlier that you had denied medical assistance in dying to some people who had requested it. I hope I understood you correctly.

Do you know what happened to those people? What happened next to those people who were denied medical assistance in dying? What happened to them?

[*English*]

Dr. Donna Stewart: I think that's a very important issue. What I will say to people is this: “We have discussed your case very carefully. I have thought about this very carefully. I can see that you're trying to deal with this situation, which is incredibly difficult. I honestly don't feel at this time that we can proceed by approving MAID for you. That does not mean it will never be approved, but I think you need to spend more time around the following issues.” I would then detail the things I thought needed to be addressed.

I think it's very important that these people do not feel rejected, because many of them are very ill and suffering in various ways. But I think in a kind but firm way assessors need to be clear in their own conscience and their own mind that what they are approving is correct.

[*Translation*]

Mrs. Dominique Vien: I would like to ask you one last question, Dr. Stewart.

As you know, Quebec is a very progressive province. I was part of the Quebec government when the first law was passed. The Quebec government decided not to put mental disorders as the only illness involved.

Has Quebec gone down the wrong path, in your opinion?

[*English*]

Dr. Donna Stewart: I would agree with you that Quebec is usually very progressive and has led the way in many aspects of this. I think that you were overly cautious in this regard, and I know that many Quebec physicians feel the same as I do about this, that it was too cautious, but time will tell.

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

● (1950)

[*Translation*]

Mrs. Dominique Vien: Thank you very much, Dr. Stewart.

We could talk about this some more later if we have any time left. I will share my time with my colleague; he definitely has questions for you.

[*English*]

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

We have our second panellist, as you can see.

Colleagues, if it's okay, I will invite Madam Doris Provencher, general director, to give her five-minute remarks, and then we will go to our second questioner, Dr. Fry.

Go ahead, Madam Provencher.

[*Translation*]

Ms. Doris Provencher (General Director, Association des groupes d'intervention en défense de droits en santé mentale du Québec): Thank you, Madam Chair.

Good evening, everyone. I apologize for being late; I had some technical issues.

I would like to begin by greeting the joint co-chairs, the Honourable Yonah Martin and the Honourable Marc Garneau, as well as all the members of the Special Joint Committee on Medical Assistance in Dying. Thank you for inviting the Association des groupes d'intervention en défense des droits en santé mentale du Québec, or AGIDD-SMQ, to share its thoughts on the possibility of allowing medical assistance in dying owing to mental health problems.

At the outset, I would like to make it clear that the AGIDD-SMQ never uses the terms “mental illness” and “mental disorders”. For us, these are people experiencing a mental health problem. So that is the term I will use.

Our association was founded in 1990, and its mission is to fight for the recognition and exercise of the rights of people living with or having experienced a mental health problem. In doing so, the association has acquired a unique expertise in the field. The AGIDD-SMQ takes a critical look at mental health practices and is involved in their renewal. The collective voice of people living with a mental health problem is at the heart of our practices; I would even say it is part of our DNA.

In the wake of the decision in the Truchon and Gladu case, in September 2019, medical assistance in dying for mental health problems became a matter of consideration, and even more so when, in January 2020, the Quebec minister of health and social services announced that, as of March 12, 2020, medical assistance in dying would be accessible for mental health reasons. That announcement created a major shockwave. Of course, the pandemic put a sudden stop to any reflection or consultation on the subject. You know something about that because it was the same scenario at the federal level.

Not admitting defeat, in the fall of 2020, the AGIDD-SMQ decided to launch a consultation with its member groups, which are mostly made up people living with a mental health problem. For the association, it was essential that those affected by this issue be the first to give their opinion.

To date, we have not been able to hold a meeting with our members to discuss this issue, which is so sensitive and full of uncertainties and questions for many of them. On the other hand, some member groups were able to consult their members. It is the fruit of their reflections that we have gathered in the brief “Entendre. Écouter. Prendre en compte la parole des personnes vivant un problème de santé mentale. Rien sur nous, sans nous.”—hear, listen, take into account the voice of people living with mental health problems; nothing about us, without us. We submitted this brief to the Quebec MPs who were members of the Select Committee on the Evolution of the Act respecting end-of-life care in August 2021, and we have submitted it to you, as well.

Three findings emerged from this consultation. First, there is a lack of understanding of what the practice of medical assistance in dying is. Second, people are seeking help to live with dignity and need hope. Finally, people with mental health problems need to be consulted—they want to be consulted—and involved in medical assistance in dying for mental health reasons.

Our association does not have an official position because, as I just said, we have not been able to meet to discuss it. On the other hand, for more than 30 years, the AGIDD-SMQ has been at the forefront of denouncing abusive or discriminatory situations against people. Since the ruling in the Truchon and Gladu case, we have spoken out to denounce the double standard between the seriousness given to physical health problems and the ignorance of the suffering experienced by people with a mental health problem.

The stigma and paternalism surrounding mental health problems make it difficult to believe that a request for medical assistance in dying can be made “consciously” in these circumstances. When a psychiatric diagnosis is made, the person concerned loses all credibility. Moreover, a number of people have told us that they feared that if they requested medical assistance in dying they would be hospitalized against their will, as they would then be considered dangerous to themselves or to others.

Who is in a better position to judge the sustainability or unsustainability of suffering than the person living with persistent and intolerable suffering? Deciding to die with dignity is legitimate, and accepting it is a matter of respect for the person. We believe that every individual should have the right to make choices about his or her own life, especially when those choices closely affect human dignity.

Five minutes is a short time to talk about such a complex and important topic.

I will be happy to take the time to discuss this issue with you.

Thank you.

● (1955)

[*English*]

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

Next we will have Dr. Fry.

You have five minutes.

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

Thank you for coming to present to us this afternoon.

I really want to focus on something that has been a recurring theme throughout this whole question on mental illness being a sole underlying condition. Inherent in this, from everything I've heard, are two very important things that I took away from the discussions of everyone else who has talked to us.

One of them is that this has to be done on an individual case-by-case basis. One cannot set blanket laws and blanket decisions for people. In fact, the whole Supreme Court decision on this issue said clearly that this had to be a case-by-case basis, because we all know—and I happen to be a physician—that when you deal with a patient with illness, even physical illnesses....

Let's just look at physical illnesses for a moment. Fifty people with the same physical illness are not going to respond to treatment in the same manner. We have to understand the nature of the individual when making these decisions.

The second piece that I took away from this is that there seems to be a huge level of discrimination against people who have mental illness as a sole underlying condition. The idea that people with mental illnesses do not have compos mentis, the ability to make decisions or to decide what is intolerable suffering for them and, working with a physician, would be able to come up with a decision that is reasonable for them....

We keep talking about blanket decisions and whether we should make a generic decision about this or that. I'd like to know your position on that situation. Should we make blanket decisions, legislative or otherwise, or should we deal with this on an individual case-by-case basis? Should we try not to discriminate between mental illness and physical illness?

I'd like Dr. Stewart to answer first, and then perhaps Ms. Provencher would be able to answer.

Dr. Donna Stewart: Dr. Fry, I completely agree with you. These do need to be looked at on a case-by-case decision. I think the A.B. decision in the Ontario Superior Court made it clear that, in fact, this was not a matter for the courts, that this was a matter for physicians to think about and make decisions about based on the entire situation the patient finds themselves in.

Hon. Hedy Fry: Thank you.

Please go ahead, Ms. Provencher.

[*Translation*]

Ms. Doris Provencher: I also think that this has to be considered on a case-by-case basis because every situation is different.

All I would personally want, regarding discrimination, is for people with mental health problems to be treated the same as those with physical problems when requesting medical assistance in dying.

Also, since the criterion that natural death be reasonably foreseeable is no longer in the legislation, we certainly have to take a case-by-case approach. I am still concerned about discrimination and stigma because people with mental disorders are subjected to that a lot, even within the public health system. In short, we must indeed take a case-by-case approach, but we must also believe what these people tell us. I don't know how to include that in a piece of legislation, but I think it's important.

● (2000)

[*English*]

Hon. Hedy Fry: Thank you, Ms. Provencher.

Madam Chair, how long do I have?

The Joint Chair (Hon. Yonah Martin): You have one minute and 15 seconds.

Hon. Hedy Fry: I will try to get a succinct answer. You are all very succinct.

A lot of people have been concerned that people with suicidal ideation may decide they want MAID. I have heard answers from physicians and psychiatrists who say that's a decision the physician and the psychiatrist who understand their case can make, a decision between whether a person only has suicidal ideation or whether that person is indeed suffering intolerably and has tried all methods they wish to try. I want to use the words "wish to try".

Go ahead, Dr. Stewart.

Dr. Donna Stewart: Every day psychiatrists make decisions about suicidal patients. You see them in the emergency department, in the community and in the hospital. This is part of a psychiatrist's role, to sort out suicidality from a well-considered request for MAID after somebody has suffered for many years, tried many treatments, has carefully thought this out and feels that this is best for them, and they meet the criteria.

Hon. Hedy Fry: Thank you very much.

Ms. Provencher.

[*Translation*]

Ms. Doris Provencher: Of course, there is the issue of suicidal ideation, but my understanding of medical assistance in dying is that, just because I make a request, it doesn't mean I'm going to get the response I want. There are a lot of steps involved. As the Association des médecins psychiatres du Québec said, the decision should be made based on the person's history. I think a person who has suicidal thoughts and really wants to end it is going to take action anyway. You have to listen to them and check that with them.

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

[*English*]

Next we have Monsieur Thériault for five minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

My first question will be for Dr. Stewart.

Dr. Stewart, in your testimony before the standing Senate committee on Bill C-7, you talked about safeguards, which I think are reflected in the recommendations of the expert report. In that sense, don't you find that the report and the recommendations are also, through the guidelines that they command, additional safeguards that don't need to be written into law, but would frame practices and practitioners?

[*English*]

Dr. Donna Stewart: I think I mentioned in my report that there are various mechanisms available to consider. We would hope that practice standards, guidance and education would be enough, but you know, there are people who feel that there need to be specific additions to the legislation. I do not personally feel that, but I think it's a valid consideration that you need to make.

[*Translation*]

Mr. Luc Thériault: I am concerned about the feasibility of this. You said that the deadline, set for March 2023, was a great motivator. Your words are very elegant, noble and motivating, but at the same time, there are practical problems. For example, are there enough assessors? What about the resistance of the psychiatric medical profession? Will we be able to find assessors and providers across the country?

I would also like to hear from you on prospective oversight. Is the notion of an independent assessor realistic? What about prospective oversight? There are some things that are involved on a practical level. Tell me about how you think this prospective oversight may play out.

[*English*]

Dr. Donna Stewart: I think, as Professor Chandler said earlier, there will probably be a small group of people who talk with each other, experts who talk with each other about some of these issues. I think that, certainly, there is some anxiety about doing this, particularly until we know what the standards are going to be.

I think that the prospective oversight should not take a long time to put in place. For example, in Ontario, we have the Ontario capacity and review committee that meets within seven days to consider the treatment of mentally ill people. A similar mechanism could be put in place for people who meet MAID criteria. As others have said, I think that's going to be a tiny number of people. Based on the Dutch experience, 95% of these people get rejected and would never come before such a committee. They comprise about 1% of all physician-assisted deaths. We're not talking about large numbers of people who reach this level. I think they deserve a sober second thought through prospective oversight.

● (2005)

[*Translation*]

Mr. Luc Thériault: Who would make up such an oversight committee? Should all cases be subject to this prospective oversight?

Wouldn't we end up in a situation where, as was once the case with therapeutic abortion committees, these committees would not be equally accessible from coast to coast to coast, which would be a barrier to medical assistance in dying?

[*English*]

Dr. Donna Stewart: I'm old enough that I will remember those abortion committees, having served on a few of them. I would hope that we don't replicate that.

As an early step to make sure that these things are proceeding smoothly and that people are not getting physician-assisted deaths who should not be getting them, I think some oversight at the beginning is very reassuring, both to patients and to practitioners. I know that the Canadian Psychiatric Association strongly endorsed this and felt that they would really welcome such oversight.

You ask who should be on such a committee. Off the top of my head, I think we should clearly have one or more psychiatrists. We should have one or two good legal experts. We probably should have one or two bioethicists. Perhaps we should have a patient representative.

I think that we need to think very carefully about who best would serve on such a committee. It should be small and nimble and it should be able to meet quickly.

[*Translation*]

Mr. Luc Thériault: That's getting to be a lot of people. This is increasing the concern I had earlier about feasibility. I'm concerned that all these people will have to be brought together to review decisions made by professionals. It is worthwhile to continue to explore what is meant by this prospective oversight. Usually, in ethics, we look at issues that are retrospective in nature.

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

Mr. Luc Thériault: So why do we need a committee that will end up being the one to decide if the practitioner, the assessor—

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

Mr. Luc Thériault: —the psychiatrist really did their job properly?

Could there be a contrary decision?

[*English*]

Dr. Donna Stewart: With respect, I have named four categories.

The Joint Chair (Hon. Yonah Martin): I'm sorry, but we're well over the time. Thank you very much.

We'll go to Mr. MacGregor for five minutes.

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

I want to thank both of our witnesses for helping guide our committee through this study.

Ms. Provencher, I'd like to start with you.

You were talking about the advocacy work that your organization does. Our previous witness was talking about the Charter of Rights and Freedoms and how it applies, such as section 7, which says that everyone has the right to life, liberty and security of the person, and also section 15, which says that everyone has the right to be equal under the law.

You know more than anyone around this committee table that a high degree of stigma exists in our society when we are talking about people who suffer from mental health conditions, as you like to say. Your organization is not taking a position one way or another. Maybe you can put your answer in the context of those charter rights, the case-by-case basis and how important it is to try to combat that stigma and to understand that people who are living with mental health conditions do have that agency and that capacity.

Is there anything more that you want to add to this conversation so that not only this committee understands the issue, but also the wider Canadian public that is listening to this?

● (2010)

[*Translation*]

Ms. Doris Provencher: Thank you.

I don't know if I would go that far. As you said, the Quebec Charter of Human Rights and Freedoms and the Canadian Charter of Rights and Freedoms include the sections you mentioned and the issue of discrimination. It is the decision in Truchon and Gladu that would really provide the main support for these two sections of the charter.

As you know, just because I have a mental health disorder, that does not mean that I lose my ability to consent. I am able to consent until there is proof to the contrary. As a society, we will therefore have to consider persons with a mental health disorder as being able to make decisions, even serious decisions, such as making a MAID request. It will take a lot of work to get there though.

The Association des groupes d'intervention en défense des droits en santé mentale du Québec, AGIDD-SMQ, maintains that the best approach would be for people with mental health disorders to speak out publicly. For my part, I have worked with people with mental health disorders for 30 years, and I can guarantee that they are like you and me. They are people dealing with emotions and problems. Who doesn't have problems? Our view of people with mental health disorders is fundamentally discriminatory because we consider them unable to make decisions.

How can we change that view of people with mental health disorders?

We have been working on it for 30 years. Including these people in legislation such as this, putting them on the same footing as all Canadians who have rights, would in my opinion already be a step in the right direction.

[*English*]

Mr. Alistair MacGregor: Thank you. I really appreciate that.

Dr. Stewart, in the limited time I have, I'd like to ask you, on the same theme, if you have an answer on the stigma part on a similar question.

The other thing, too, is that this issue of capacity keeps on coming up because every province has something. In my home province we have the Mental Health Act. It does allow for people to be involuntarily held if a physician feels there is a medical reason for doing so.

These are the kinds of thorny issues we're trying to assess when it comes to that issue of capacity and consent. If you can add anything more to the answer, I'd appreciate it.

Dr. Donna Stewart: I agree with Madam Provencher. In general, mental patients have equal capacity, but a few don't. Of those who don't, they're the ones who end up as involuntary patients.

Mr. Alistair MacGregor: Yes.

Finally, you know the work that has been done by the expert panel. Do you have any final recommendations you would like us as parliamentarians to put in our report to the federal government? What other areas does the government need to address?

The Joint Chair (Hon. Yonah Martin): Very briefly, Doctor.

Dr. Donna Stewart: I think I addressed that in my presentation. I think all of it, but the ones I specifically mentioned are especially important.

Mr. Alistair MacGregor: Okay, I appreciate that. Thank you.

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

That concludes the round of questions from the MPs.

I'll turn this over to the joint chair for the senators' questions.

The Joint Chair (Hon. Marc Garneau): Thank you, Senator Martin.

[*Translation*]

We will now move on to questions from senators. Each person has three minutes. Let us begin with Senator Mégie.

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

Thank you to the witnesses for being here.

My first question is for you, Dr. Stewart.

If I may, I would like to talk again about the establishment of practice standards for MAID. How can we ensure that health care professionals who conduct assessments and provide MAID services are properly trained?

I also have a sub-question, since I have just three minutes. What are the greatest challenges that these assessors and providers of MAID services would face if persons with mental health disorders become eligible?

[*English*]

Dr. Donna Stewart: First of all, I think there are educational curricula currently being developed by CAMAP. Certainly, the Canadian Psychiatric Association has been very involved in its working group around trying to develop some standards for practice. I think that all of these things need to proceed. I think the various regulatory colleges for both physicians and nurse practitioners need to weigh in on this. I think the work is well under way and needs to keep moving along in a rapid pace to meet the deadlines.

You asked about the main concerns. The main concern is the uncertainty that currently exists about what the standards are going to be. The sooner this can be firmed up, the more reassured the practitioners will be.

I conducted some research with 131 Canadian MAID assessors and providers from across Canada, now published in the Journal of Palliative Care. It was very clear that one of their main concerns, their main stressors, was wanting to know what the standards were going to be so they felt as though they were operating within the safety of clear standards, rather than having to make decisions that weren't clearly defined at the present time.

I would urge you to include the expert panel recommendations very clearly and to endorse some of the CAMAP educational materials and the college regulatory requirements as they appear.

● (2015)

[*Translation*]

Hon. Marie-Françoise Mégie: Thank you for your reply.

Do I still have a few seconds?

The Joint Chair (Hon. Marc Garneau): You have 38 seconds left.

Hon. Marie-Françoise Mégie: Very well.

My next question is for you again, Dr. Stewart. In all your research and discussions of practice standards, was there any mention of support services for the professionals practising MAID? From colleagues, I have heard that some of them were suffering. They provide the service but feel unhappy and suffer afterwards. Have you heard of any such cases? Have you heard that resources are provided to support them?

[*English*]

Dr. Donna Stewart: These currently exist. CAMAP, the Canadian Association of MAID Assessors and Providers, provides a forum for providers, and it's a very active forum where people talk about their difficulties and their feelings. People share suggestions. It's very powerful.

I should point out that in our research we found that although there were stressors to this practice, there were many more personal rewards. People felt this was very important work, very compassionate work, and many felt that it was some of the most important professional work they do.

It's a combination of both stressors and protective factors, and there are a lot of protective factors, but the CAMAP forum offers a big support.

The Joint Chair (Hon. Marc Garneau): Thank you.

[*Translation*]

I will now give the floor to Senator Kutcher.

[*English*]

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

Thank you to the witnesses for being here.

My first question is for Ms. Provencher.

Do you think that denying access to a MAID assessment for a competent person with a mental health condition who meets all other criteria for that assessment could be a form of stigma against people who have a mental health condition?

[*Translation*]

Ms. Doris Provencher: If you put it that way, I have to say yes. If the person meets all the criteria, why does the process stall at that stage?

If I may, I would like to make a few comments on training.

I would urge you to include people who have mental health problems. To my mind, it is essential for the professionals being trained to hear what they have to say.

Getting back to your question, I would say the following. It is indeed discrimination. On what basis is the person refused? Is it solely on the basis that the person has a mental health disorder? If that is the case, it is stigmatization if not discrimination.

[*English*]

Hon. Stanley Kutcher: Thank you very much for that. I certainly agree with your comments about training and the role of people with lived experience.

Dr. Stewart, I'm going to share a quote with you from The Globe and Mail of something an individual has said, and I'd like you to respond to the statement.

> [A]ny attempt at identifying who [would] have access to MAiD will make large numbers of mistakes, and people who would have experienced improvements in their symptoms and no longer wish to die will die by MAiD.

What do you think of that statement?

● (2020)

Dr. Donna Stewart: Well, I think that statement echoes one that was also written, perhaps by the same person or groups of people who said that we're trying to fill our graveyards with mentally ill people through MAID. Those kinds of statements are extremely unhelpful and hyperbolic. That kind of misinformation fuels the public anxiety and to some extent the professional anxiety about this. I think we need to be very clear and very factual in these kinds of things, and I wish that people would stop writing and printing this kind of misinformation and fearmongering.

Hon. Stanley Kutcher: Thank you.

The Joint Chair (Hon. Marc Garneau): Thank you.

I'm sorry, Senator.

We'll go to Senator Dalphond.

[*Translation*]

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

Thank you also to the witnesses.

My question is for Ms. Provencher.

I read with great interest the brief you tabled in Quebec's National Assembly, in which you present your group's position. I have the recommendations in front of me. One of your conclusions was that people with a mental disorder should not be excluded from accessing MAID, as that amounts to stigmatization and discrimination.

In your brief, you recommend establishing standards, training and social measures, as well as clearly defining the parameters. On page 40 of your report, you talk about criteria and parameters.

After reviewing the report of the Special Joint Committee on Medical Assistance in Dying, would you say that the proposed parameters are sufficient?

Ms. Doris Provencher: As to the parameters mentioned here, it is the people themselves who set those parameters for us. I have to say that some of the parameters are very interesting, but [*inaudible*] what role do the people play? That is the question that always comes to mind.

The people do want parameters. Dr. Stewart said that and we see that in the papers: people with mental disorders think that we want to kill them, assassinate them. So the government has a big job to do informing people.

As to the remaining recommendations, they are roughly in line with want we want, with some nuances, of course.

Hon. Pierre Dalphond: Your association was concerned about MAID coming into effect, since the guiding principles are being taught and given to all psychiatrists and to those providing MAID services.

Ms. Doris Provencher: We are not concerned about MAID coming into effect. As we said, the issue is not whether we support or oppose MAID. Our basic question is whether people with a mental health disorder can make a request, like any citizen in Canada. That is our most basic concern.

There was a question earlier about Quebec, about the last committee on the end-of-life care act and how it had been addressed. We were very disappointed with the conclusions of that committee, because it closes the door to any discussion of giving people with a mental health disorder access to MAID. That is what Quebec is doing now, and it is unfortunate. Yes, there is work to be done, the parameters have to be established, training is needed, but let us please keep the discussion open. They are human beings.

In any case, even if those people are excluded from the act, someone at some point will take legal action, will claim discrimination, and will win. You will be in the same situation.

● (2025)

The Joint Chair (Hon. Marc Garneau): Thank you, Ms. Provencher.

[*English*]

We'll now proceed to Senator Martin for the last questions.

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

My questions are for Dr. Stewart. I'll ask them all together and you can answer.

We've heard a lot of people say at this committee that MAID is not suicide, and it is clearly important to differentiate MAID from suicide. This is really at the heart of this issue. In the spring, psychiatrists told this committee that MAID for sole mental disorder blurs the line between suicide prevention and suicide assistance.

Given the uncertainty around determining irremediability in the case of sole mental illness, how can this line be defined? How do we distinguish between intolerable suffering and suicidality?

What additional safeguards do you think are necessary to ensure that the MAID regime does not provide assisted suicide?

Dr. Donna Stewart: Thank you, Senator.

It is true that there are a few psychiatrists who express exactly those views. They are certainly not the majority. The working group of the Canadian Psychiatric Association did not express that.

Psychiatrists make this determination every day of their practice around suicidality, as I said earlier, in communities, emergency departments and hospitals. It's an essential part of being a psychiatrist to assess suicidal risk.

I submit that a request for MAID that is carefully considered and meets the safeguards is not the same as suicide.

The Joint Chair (Hon. Yonah Martin): The fact that MAID for sole mental disorder requires very specific safeguards, did you want to add anything else regarding specific safeguards that you would recommend?

[*Translation*]

Ms. Doris Provencher: Parameters are of course needed, just as they are needed in cases of MAID for a physical health problem. Some people have said that two psychiatrists would be needed, others said three psychiatrists.

If I may, I would like to go back to the topic of suicide. The professionals should also really listen to the people, should do more and overcome the prejudices we all have.

As the Quebec association of psychiatrists said, it depends on the person's background, their history of suffering. Everything is related.

It will not be determined by a diagnosis, but rather by the person's history, what they are experiencing. For this law not to be discriminatory, the professionals will have to take all of that into consideration in their assessment, decision and analysis of the request, but above all they must listen to the people, listen to what they have to say about it all. That is my greatest wish.

The Joint Chair (Hon. Marc Garneau): Thank you very much.

That concludes our meeting this evening.

I would like to thank the witnesses, Ms. Provencher and Dr. Stewart.

[*English*]

Thank you very much for agreeing to answer our questions and for your opening statements. You're very important witnesses in this very important analysis that we as committee members are trying to do. We very much appreciate your candour and your very straight shooting with respect to all of the questions that were asked this evening. Thank you very much.

With that, this committee is adjourned.

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